MONEY FOLLOWS THE PERSON DEMONSTRATION SUSTAINABILITY ANALYSIS

TRANSITIONING BEYOND 2020

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Department of Health and Human Services

Division of Medical Assistance

State of North Carolina

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EXECUTIVE SUMMARY

With the Money Follows the Person (MFP) program winding down at the federal level, many states are looking at ways to maintain their programs beyond the life of the federal grant. In pursuit of this effort, North Carolina's Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA), the NC Money Follows the Person program contracted with Mercer Government Human Services Consulting (Mercer) in November 2017 to complete a sustainability analysis of its MFP program. North Carolina anticipates its participation in the federal MFP program will end in December of 2020.

The outputs of the analysis include:

- A description of the current transition landscape.
- An analysis of current functions and processes within the current transition landscape.
- Recommendations for improvement in the current MFP program.
- Recommendations for an interim transition program.
- Projections of future need for Long-Term Services and Supports (LTSS) for certain target populations.

The analysis, while broad in its scope, focused on the following populations:

- Medicaid beneficiaries in nursing facilities over 90 days (excluding Medicare Part A) (priority).
- Medicaid beneficiaries in nursing facilities under 90 days.
- Medicaid beneficiaries in adult care homes (ACHs) who do not qualify for the Transitions to Community Living(TCLI) Program.
- Medicaid Beneficiaries (or anticipated beneficiaries) discharging from acute care facilities who meet nursing facility or domiciliary level of care (LOC) criteria.

Three crucial elements of any MFP program include effective transition coordinators, the ability to cover one-time expenses, and extra support from transition coordinators or home- and community-based services (HCBS) programs beyond what regular Medicaid programs typically cover. Additionally, states that operate high performing MFP programs (high number of transitions, with lower than average re-institutionalization rates) have several common attributes. These include standardized processes to ensure collaboration between MFP transition coordinators and Medicaid HCBS waiver programs, increased time spent by transition coordinators with individuals with greater needs, and the use of housing specialists who work alongside transition coordinators. [i]

North Carolina's transition landscape is complex with many entities providing transition-related activities across a variety of programs and populations, and through a variety of funding sources. This network provided the basis on which the North Carolina MFP program was built. Transitions provided through the MFP program have grown every year since the program started in 2009. The program has transitioned 972 individuals from institutions to community settings through April of 2018. Last year, the program transitioned one hundred and fifty-five individuals, the most in a single year since the program inception. Capacity challenges within the MFP program and North Carolina's LTSS delivery system may have impacted this number. When compared to other MFP grant programs of a similar size and over the same period of time, North Carolina's transition numbers have exceeded the number in Oklahoma and are significantly lower than those achieved by Illinois.[ii]

In addition to the MFP program, North Carolina established the TCLI in response to a Department of Justice (DOJ) settlement agreement. This program was designed after the MFP program and has successfully transitioned several thousand individuals from ACH and State operated Institutions for Mental Disease.

To understand the transition landscape, it is important to reflect on aspects of the Medicaid program where transitions occur. Since 2009, nursing facility and ACH bed capacity continued to grow despite flat nursing facility bed day utilization rates and expansion of the HCBS waiver programs. Mercer's analysis of claims data shows a $2,548 or a 42% reduction in expenditures for each older adult and person with disabilities transitioned under the MFP program and conservatively projects a $518 million in reduced LTSS expenditures associated with HCBS provided to individuals in the Community Alternative Program for Disabled Adults (CAP/DA) waiver vs nursing facilities from 2010 through 2015.[iii]

> **North Carolina MFP Facts**
>
> - One hundred and fifty-five individuals transitioned in 2017 — the highest annual total in the program's history.
> - Quality of Life surveys show improvement in five out of seven categories — "Satisfaction with Living Arrangement" improved by 45% over the pre-transition baseline.
> - Post-transition total cost of services was 42% less than pre-transition costs for older adults and people with disabilities.

Consistent with the national MFP evaluation results, this study found that the transition program was effective in improving the MFP participant's quality of life while providing LTSS services in a community-based setting at a lower cost than facility based care.[iv] In North Carolina, five out of the seven categories measure improved and the "Satisfaction with Living Arrangement" increased by forty-five percent over the pre-transition baseline. It is recommended that the transition program become part of the permanent LTSS landscape. The State should capitalize on the impact of the program and look to identify how facilities can diversify to become part of the community-based program paradigm.[v]

This report includes a number of recommendations for the current MFP program. These recommendations focus on improvements in process, outcomes and streamlining in the areas of: in-reach activities, transition coordination, case management and access to services. Recommendations include bolstering in-reach activities to increase awareness of the program, increasing the number of transition coordinators in order to meet the demands created by increased in-reach activities and increasing access to waiver slots. The recommendations identified come at a price, but the cost effectiveness demonstrated by both transition and diversion programs justify the expense long term.

Recommendations for systematic changes in North Carolina's current LTSS delivery system are included as well. These recommendations acknowledge the role the current array of LTSS services available in the State play in meeting the needs of individuals and focus on equalizing opportunities for access to information and services across populations. North Carolina is a 1634 state with a medically needy program.[vi] Under today's criteria, individuals remain in nursing facilities due to an inability to meet their deductible along with their costs for living in the community. This not only results in individuals being institutionalized unnecessarily, but also increases states' costs. The report will explore how adding the 217 group[vii] to its waiver populations would expand opportunities for individuals to be served in the community rather than nursing facilities.

Also, recommendations for an interim transition program (between when MFP ends and the State moves to managed long-term services and supports [MLTSS]) are included as well as recommendations for how transition-related activities should be included in a MLTSS environment.

Finally, the report includes analysis of the population of individuals that will potentially need waiver services in the future. Growth projections for individuals ages 18–64 were developed to gain an understanding of the potential need for the expansion of community-based options. The overall population growth for this group is projected to increase from 255,925 in 2018 to 284,905 in 2033 for a total increase of 28,980 people. When factoring in the growth of the over 110,000 additional seniors who may need LTSS by 2033, the pressing need for community-based alternatives becomes even greater.[viii]

The significant growth in the need for LTSS comes at a time when North Carolina is in a downward trend in terms of its support for community-based LTSS. According to the American Association of Retired Persons (AARP) LTSS State Scorecard 2017 Edition, the State is ranked 38th for making progress towards improvement of their long-term care (LTC) programs. This is down from a high score of 24th in the 2011 AARP Scorecard. The State should consider the findings of this report and the move toward MLTSS as an opportunity to strengthen and expand its transition and diversion programs to ensure a robust continuum of LTSS is available to meet the future needs of North Carolinians.
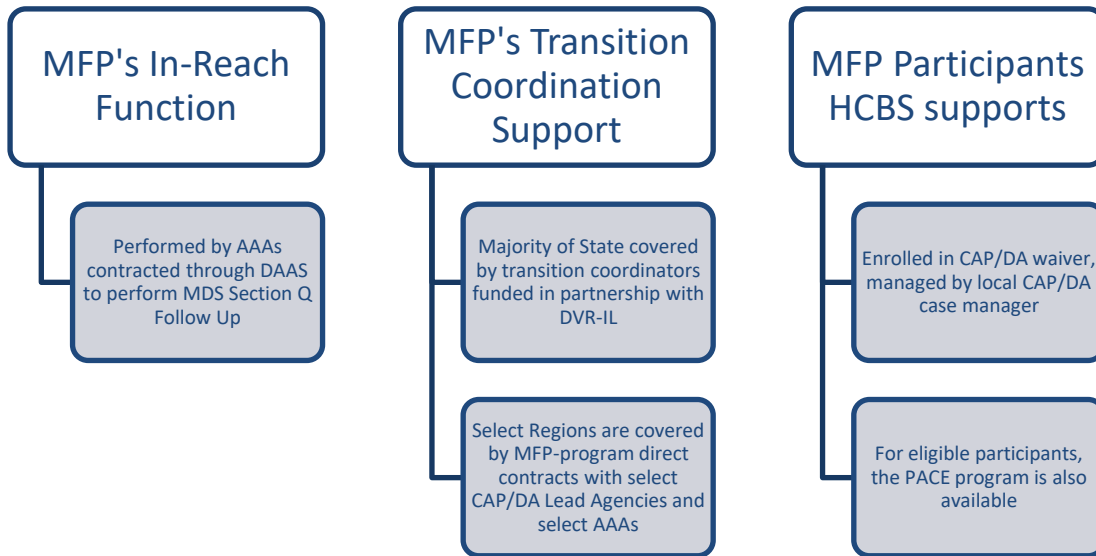
2
DESCRIPTION OF CURRENT PROGRAM

North Carolina began its participation in the federal MFP program in May 2007, and in collaboration with its extensive network of stakeholders developed its first Operational Protocol in 2008. The State began supporting transitions in 2009. The program targets older adults (over the age of 65), people with physical disabilities (under the age of 65) and individuals with intellectual or developmental disabilities (I/DDs) who reside, for at least 90 days,[ix] in a qualified inpatient facility such as a nursing facility, hospital, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) or a Psychiatric Residential Treatment Facility (PRTF). North Carolina's MFP program is embedded in its LTSS and Behavioral Health delivery systems requiring that individuals at the time of discharge enroll in the CAP/DA, Innovations Waiver or the Program for All-Inclusive Care for the Elderly (PACE). [x]

The program has grown over time with transitions increasing every year. As of April 30, 2018, 972 individuals transitioned through the program with support from the program's network of transition coordinators. At present, the MFP program contracts with the Division of Vocational Rehabilitation-Independent Living (DVR-IL), select Area Agencies on Aging (AAA) and select CAP/DA Lead Agencies to provide statewide transition coordination services. Additionally, the AAAs serve as the Local Contact Agency (LCA) for purposes of Section Q, Minimum Data Set (MDS) referrals.[xi] They provide in-reach services either directly or through a subcontract with a local partner, to nursing facility residents who through the MDS Section Q process have expressed an interest in returning to the community. Currently, the MFP program does not utilize MDS data to identify individuals for in-reach activities, but rather relies on referrals made from the nursing facilities.

FIGURE 1: DIAGRAM OF MFP TRANSITION-RELATED FUNCTIONS FOR AGING AND PHYSICAL DISABILITY POPULATIONS

MFP's In-Reach Function	MFP's Transition Coordination Support	MFP Participants HCBS supports
Performed by AAAs contracted through DAAS to perform MDS Section Q Follow Up	Majority of State covered by transition coordinators funded in partnership with DVR-IL	Enrolled in CAP/DA waiver, managed by local CAP/DA case manager
	Select Regions are covered by MFP-program direct contracts with select CAP/DA Lead Agencies and select AAAs	For eligible participants, the PACE program is also available

Since North Carolina's MFP program has remained relatively small, with measured growth over time, it has been able to adapt and change as the State has become more experienced and knowledgeable about transition-related activities and processes, in addition to accommodating systemic reforms related to NCTracks, NCFAST and managed care. As a result, the program has well defined transition processes for pre-transition, transition and post-transition activities and has identified five distinct yet interconnected stages (See Figure 2) of quality transition planning and works through all five stages in its transition practices. The five stages are:

1. In-Reach (aka "Fully Deciding"): Ensuring individuals in facility settings have the information needed to make a fully informed decision about where to receive services.

2. Effectively Preparing: Developing a comprehensive and effective transition planning process that ensures community-based support needs are identified and effectively addressed through transition planning.

3. Comfortably Transitioning: Working to "pay attention to the details" at the time of transition, ensuring inevitable loose ends and unexpected issues are promptly addressed.

4. Effective Follow Along: Developing a flexible "follow along" practice that closely tracks the participant's post-transition experience.

5. Supporting People to Thrive: Working to build transition practices that facilitate long-range quality outcomes in a person's life, such as improved health, improved community network and improved sense of contribution.

These stages of planning recognize the complexity of transition work, the importance of follow along once a person is discharged to ensure health and safety and the need for community integration post discharge. Additionally, transition coordination contracts clearly define the breadth of planning activity required for successful transitions and the program's quality strategy reinforces the program's person-centered approach.

**FIGURE 2: THE ASPIRATIONAL STAGES OF TRANSITION PLANNING**

The program tracks, reviews and discusses data points consistently to improve the program and make it as efficient as possible. The quality of the program is reflected in not only the high level of satisfaction with the services but also in the focused efforts to improve the program.

QUALITY OF LIFE SURVEY ANALYSIS

The MFP program collected a significant number of Quality of Life (QoL) surveys during the course of the six years analyzed; however, due to difficulties with the linking of key data elements, a smaller sample size of surveys was used in this analysis to ensure that information was conveyed from only those participants that could be tracked over time. While this matching decreased the representative sample, it improved the quality of the findings significantly and important insights can be gained from this information. Analysis of the QoL survey results shows the positive impact of the program. The QoL survey has been conducted over the lifetime of the program. This survey was developed by Centers for Medicare & Medicaid (CMS) and Mathematica, the MFP national evaluator, to understand the impact of the program at the individual level. Baseline QoL surveys were conducted with individuals prior to transition and subsequently 11 months after transition. The survey is conducted on a voluntary basis; individuals can choose not to participate. It should be noted that Mercer's analysis has similar limitations to those experienced by the national evaluators.

In Figure 3, the QoL survey data illustrates the individual responses from the baseline year and first follow-up within 11 months' post-transition. The satisfaction of individuals transitioning improved significantly from the time of institutional placement through their transition to the community in five out of seven key areas listed. Analysis shows no improvement in the areas of depressive mood or community integration both of which increased slightly over the baseline. The growth in depressive symptoms and lack of improvement in the area of community integration is consistent with stakeholder feedback indicating that individuals sometimes have difficulty adjusting to the solitude of community living and need for community engagement or activities after discharge from a facility. Recommendations in this report include assessing pre-transition engagement around emotional support needs for individuals returning to the community as well as assessing caregiver preparedness for their loved ones return home.

FIGURE 3: QUALITY OF LIFE OVER TIME OF NORTH CAROLINA MFP PARTICIPANTS, CALENDAR YEARS 2009 – 2016
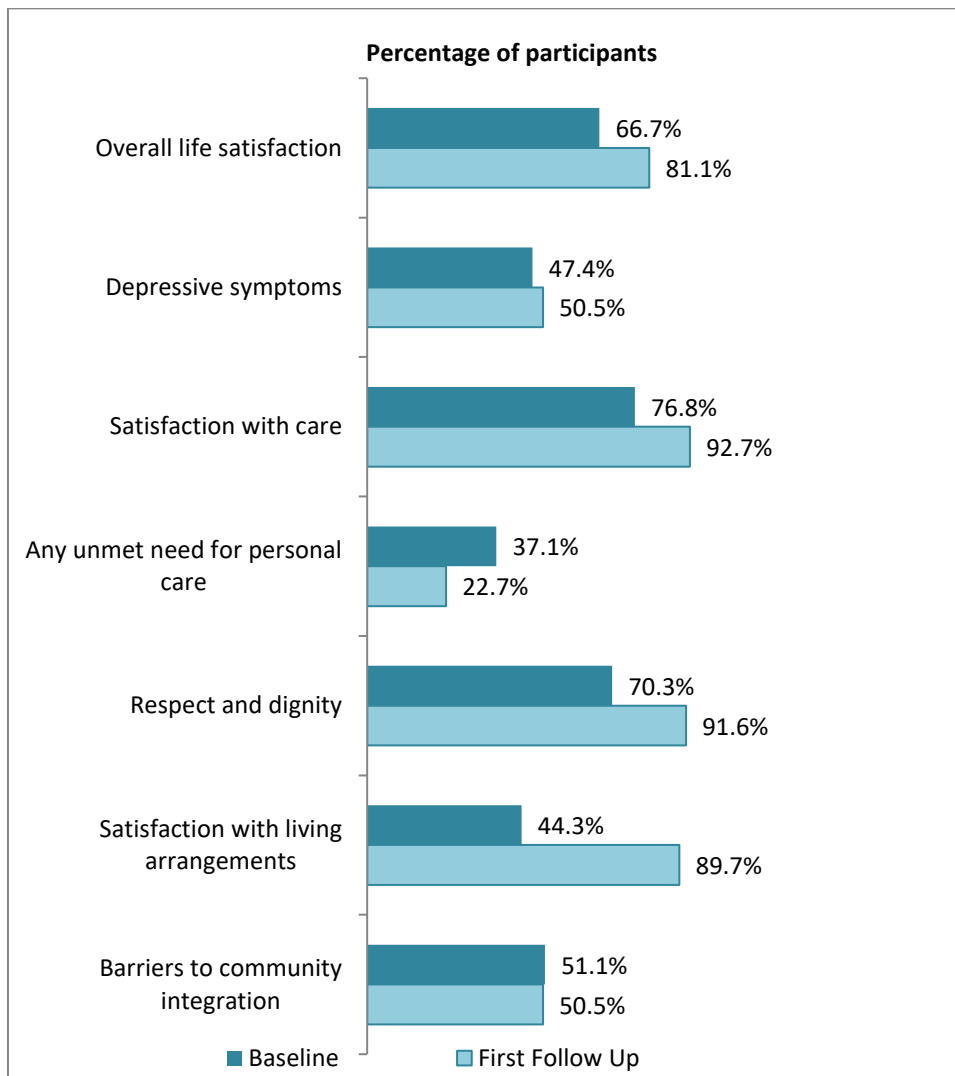
Source: Mercer's analysis of MFP QoL surveys and program participation data collected by North Carolina through January 2017.
Note: Number of observations = 97, excludes data when key data elements were not matched.

Among the areas of improvement over the baseline scores, "satisfaction with care" was the strongest QoL indicator, followed by respect and dignity, satisfaction with living arrangements and overall satisfaction. Another improvement was reflected in the decreasing percentage of the unmet personal care needs score that reflects fewer unmet needs in bathing, eating, medication management and toileting. The QoL survey results clearly indicate positive results for individuals who have transitioned and reinforce the program's strengths.

MFP PARTICIPANTS AND HEALTH AND SAFETY

Another important component of the MFP program is the ability to address health and safety concerns and incidents that might occur post-transition. People with multiple chronic conditions are served in the MFP program and this can play a role in incidents that impact participants. Figure 4 below shows the significant number of chronic conditions that transitioners' experience:

FIGURE 4: ADULT MFP PARTICIPANTS WITH CHRONIC CONDITIONS

Percentage of Adult MFP Participants with Chronic Conditions*
(CY 2012 through 2016)
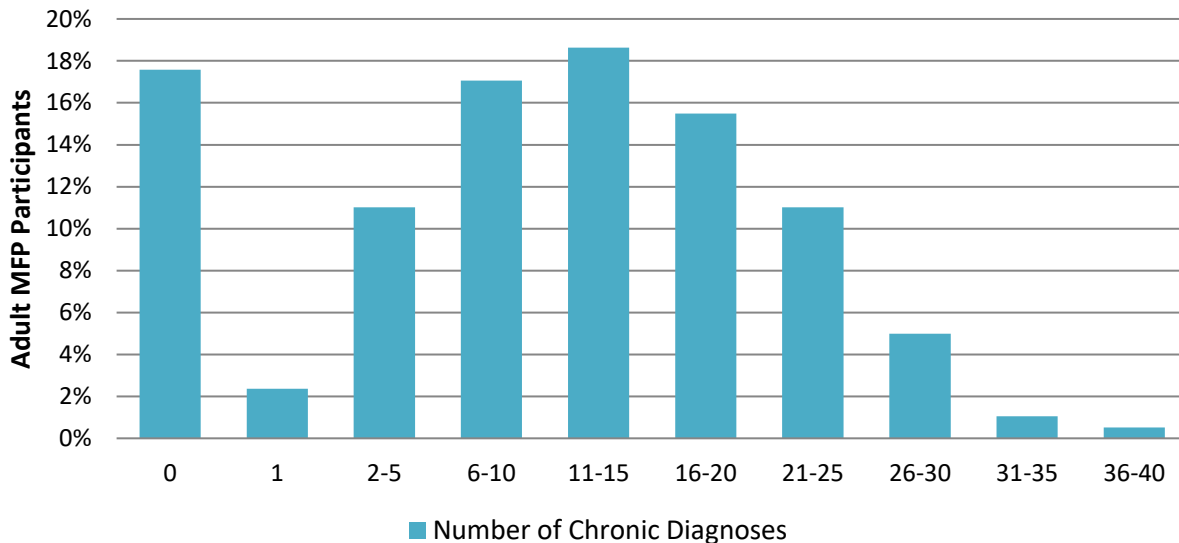
Source: North Carolina MFP Program Data – DMMA Business Information Team
*For 381 MFP adults, 18 and over, CY 2012-2016, which diagnoses are 'chronic' conditions is defined by the Clinical Classification Software for ICD-9 and ICD-10:
 www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp
 www.hcup-us.ahrq.gov/toolssoftware/ccs10/ccs10.jsp
All chronic diagnoses experienced by MFP participants were clustered into 152 CCS diagnosis categories.

Eighty percent of MFP's aging and physical disability cohort over the age of 18 had two or more chronic conditions. Significant support for these individuals is provided through a person-centered service plan, which authorizes in-home services as well as identifies back up plans for interruptions in service and emergencies. When a person is in post-transition status, the transition coordinator reports incidents to the MFP program office and the information is relayed to the appropriate CAP/DA case manager for entry into the e-CAP system

and investigation. Transition coordinators do not typically enter information directly into the e-CAP system that tracks incidents. Monthly incident management staff meetings are conducted by MFP program staff to review data, analyze trends and discuss specific cases. DVR-IL transition staff participate in a separate but similar process of review.

FIGURE 5: TYPES OF INCIDENTS REPORTED IN E-CAP

**Types of Incidents Reported in e-CAP
for MFP Participants
(2014 through 2017)**
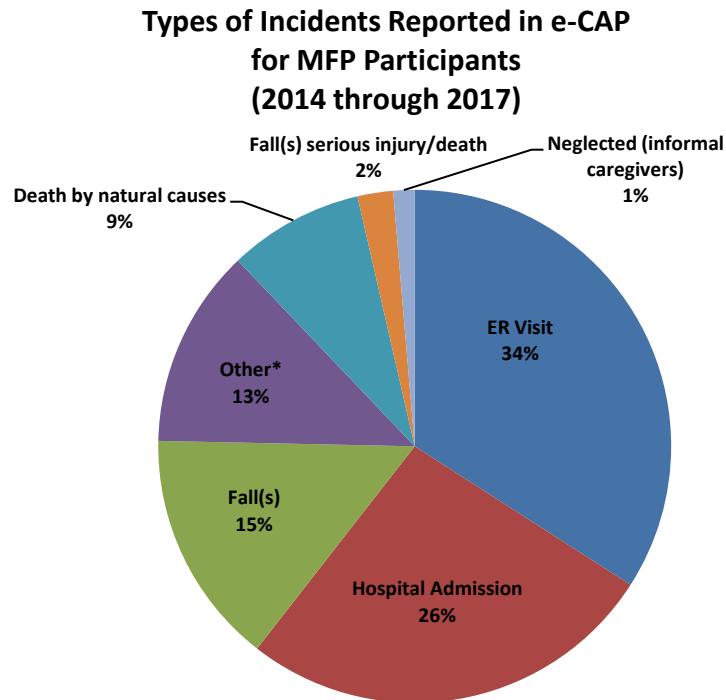
* Includes some uncategorized incidents and all onetime reported items such as theft, self-abuse, abuse by others, beneficiary left unattended, care equipment failure and choking.

Considering the significant number of chronic conditions and recognizing the elevated number of emergency room (ER) visits and hospitalizations among transitioners, the MFP program office in 2016 began requesting ER and hospital admissions claims data. In reviewing the claims data, program staff found that the total number of incidents reported in e-CAP by waiver care mangers and transition coordinators was not consistent with the number of hospitalizations and ER visits represented in the claims data. In Figure 5, the types and percentages of incidents reported in e-CAP is provided for MFP participants. Hospital and ER visits represent 60% of all incidents for MFP participants. To address this issue, the program has instituted increased follow along that requires personal outreach and contact for individuals with high needs during the first three months' post transition.

In addition, an informal pilot program was started recently between MFP and two Community Care of North Carolina (CCNC) regional networks — Community Care of Wake and Johnston Counties and Carolina Collaborative Community Care. The pilot program involves the development of a follow along program that is designed to promote collaboration among coordinating entities on a person's care team and track the transitioners' health-related support needs (prescription adherence, physician visits, etc.) and related

challenges to addressing these needs. The goal is to minimize ER utilization and hospitalizations of MFP participants by focusing on "upstream" prevention and faster post-hospitalization follow-up where possible. While the pilot shows great promise for reducing ER and resulting hospitalization rates, there are several recommendations made later in this report to address the potential actions that can be taken to improve the incident management process.

As a result of review and analysis of North Carolina's MFP program, Mercer has identified strengths and challenges of the MFP program as well as the LTSS delivery system as a whole.

STRENGTHS OF CURRENT MFP PROGRAM
- The program's year over year transitions have grown in most years since its inception.
- The program has an experienced and passionate State level MFP team.
- The program has well defined processes for transition coordination activities.
- The program is agile and able to modify processes quickly in order to better meet individual's needs.
- The program has strong stakeholder engagement that includes a diverse group of stakeholders throughout the State who have provided feedback and support throughout the life of the project.
- The program has knowledgeable and skilled transition coordinators who are passionate about their work.
- There is a clear vision for the MFP program.
- The program has robust training offerings for transition coordinators including the NC Community Transitions Institute.
- The program has coordinated and collaborated with other Divisions within DHHS leveraging funds from programs across the department.
- The program has strong State and Local partnerships that have brought together entities that may not have historically worked together.
- MFP funding has provided financial support for projects within DHHS and outside of DHHS resulting in administrative and programmatic collaboration.
- The program staff and transition coordinators have flexibility to "think outside of the box" to help meet an individual's needs.
- Nursing facility in-reach activities are clearly defined for the Local Contact Agencies.
- The program provides access to housing subsidies through the Targeting/Key Program.

LTSS SYSTEM STRENGTHS
- Robust Medicaid State Plan Personal Care Service (PCS), with expedited access for individuals who are transitioning.
- Conflict free practices with a third party vendor completing LOC assessments.
- CAP/DA waiver clinical policy has prescribed post discharge follow along processes.
- Local Management Entities-Managed Care Organizations (LME-MCOs) have well defined transition coordination activities for individuals participating in the TCLI program. Transition coordination activities provided by LME-MCOs for individuals participating in the TCLI program are similar in nature to the transition coordination activities provided through MFP.
- TCLI program provides access to specialty services such as tenancy management and support.
- Strong investment of resources in the TCLI program.

- Dedicated LME-MCO staff has resulted in a positive effort by the LME-MCO to complete in-reach activities in ACHs.
- Other programs such as DVR-IL or Centers for Independent Living (CILs) are able to complete transition work when a person is not MFP eligible.
- DVR-IL provides resources for such things as home modifications that can help supplement waiver and MFP services.
- DVR-IL has no length of stay requirements for non-MFP DVR-IL transition support.
- Expansion of PACE sites to other parts of the State currently not served or underserved.
- Integration of lessons learned from MFP into CAP/DA renewal.

CHALLENGES IN CURRENT MFP PROGRAM

In-reach Activities
- Due to frequent turnover, many social workers in nursing facilities are not familiar with MFP or community living options.
- Support for transition-related activities is inconsistent among nursing facilities.
- Low visibility of MFP program in nursing facilities and no overarching marketing strategy.
- Many nursing homes are not making referrals to the MDS Call Center.
- No use of MDS data in identifying potential nursing facility residents for LCA visits.
- Hospitals and nursing homes are not aware of the programs that are available to individuals with a traumatic/acquired brain injury.

Diversion Activities
- No obvious "front door" to LTSS delivery system. AAAs perform options counseling and LCA functions, but currently do not have infrastructure to support statewide front door designation.
- No formalized statewide process for making referrals from hospitals to AAAs for options counseling or directly to HCBS.

Housing
- Despite the highly successful Targeting/Key Program there remains a lack of affordable/accessible housing options. Metro areas have long waiting lists and housing options in rural areas are limited.
- Existing housing stock often does not have characteristics that individuals who are transitioning need such as being on a bus route.
- Some MFP participants have criminal convictions that prohibit them from living in publicly subsidized housing.
- Some individuals have challenges maintaining housing, for example, not following rules of the apartment complex by allowing unauthorized roommates, smoking, etc.

Services
Service needs can be attributed to many factors including: quality issues, waiting lists, insufficient supply of providers or service is not currently Medicaid reimbursable.

Effectively Preparing

- There are several challenges related to home modifications including: inability to get needed home modifications as they cannot be completed under CAP/DA cost caps; inability to get needed home modification prior to discharge from the nursing facility (this is allowed under the CAP/DA waiver, but the policy is applied differently by CAP/DA agencies throughout the State) and inability to find funding sources for needed home modifications.

- There are long waiting lists for home delivered meals in certain areas.

- There is no remote monitoring as a strategy to reduce service costs for individuals who have supervision needs.

- Direct service worker shortage was reported. With the growth in the populations needing community-based service, in the future, this could create a barrier to transitions and diversion programs.

Comfortably Transitioning

- Individuals have challenges with Medicaid transportation unwilling to cross county lines for medical appointments and with transportation arriving late resulting in missed appointments or long wait times to return home. Flexible, reliable non-medical transportation options are needed.

- There is a shortage of therapy providers (Physical Therapy, Occupational Therapy and Speech Therapy) who serve individuals with dual mental health diagnoses.

Effectively Following Along

- Once an individual moves into their apartment, they sometimes have challenges in maintaining the terms of their lease. There is limited availability of tenancy support.

Supporting People to Thrive

- Individuals do not understand how employment will impact their benefits and are sometimes hesitant to pursue employment as a result. Access to benefits counseling services are limited.

- Limited availability of peer support to individuals participating in the TCLI program or who live in an area where a CIL is located. Otherwise, there is no access to peer support.

Transition-Related Activities

- Insufficient number of transition coordinators resulting in unmanageable caseloads in larger regions and diminished ability to effectively meet programmatic and quality requirements of the program.
- MFP transition process can average over 180 days[xii] and some nursing facility residents move prior to completing the process.
- Turnover among transition coordinators is common, resulting in time and resources spent on hiring and training.
- The screening process for MFP participation does not effectively prioritize transitions.

- Transitioning individuals are not consistently provided opportunities to build their own skills and prepare for transition. This is especially true for individuals who have not lived with a disability in a community setting.
- Transition planning does not always adequately address supports needed to mitigate the social isolation that may be experienced upon transition.
- Families are not always prepared to take on caregiving responsibilities.
- Services do not effectively address the lack of caregiver support that many people experience.
- Technology and service solutions appear to be discounted without exploration.
- Nursing facilities do not fully understand all of the steps in the MFP transition process.
- Facilities reported that the MFP paperwork is time consuming.
- The rate of ER utilization is higher than national MFP average.

LTSS Delivery System

- There are waiting lists for CAP/DA, Community Alternatives Program for Children (CAP/C) and Innovations waivers as well as difficulties with the movement of waiver slots across counties.
- There is a misalignment between institutional and home- and community-based expenditures for LTSS services. Funding for nursing facility services and HCBS are in different lines in the State budget. Since nursing facilities are considered an entitlement, services for nursing facilities are fully funded where HCBS funding is limited to State budget allocations. This approach does not allow the flexibility to move funding from the nursing facility line item to the HCBS line item easily. The State also makes significant investments in other programs such as Special Assistance that are not HCBS programs.
- The Special Assistance-In Home (SA/IH) program, managed at the county level, may have waiting lists (depending on county) while Special Assistance-ACH is fully funded. Differences in income standards between the two components of the SA/IH program require an individual to be categorically eligible for Medicaid with an income at or below 100% federal poverty level (FPL).
- There are no options for individuals whose income is too high for Special Assistance, but who cannot afford to pay privately for Assisted Living.
- There is no overarching statewide LTSS strategy that guides work across the delivery system resulting in practices that do not align with goals of MFP program such as nursing facility bed availability increasing during a time when waiver participation and expenditures were level or decreasing.
- NCTracks defects result in challenges with waiver providers and CAP/DA agencies getting claims paid.
- The Medically Needy program results in a system whereby individuals who are interested and able to live in the community cannot afford to pay their Medicaid deductible and pay their community living expenses leaving them no alternative, but to remain in the nursing facility.
- There are defects in the Medicaid eligibility information technology (IT) system related to waiver indicators, which result in delayed or complicated enrollment into waiver services.
- Inconsistent understanding of MFP requirements among local Departments of Social Services (DSS) LTSS eligibility units as well as inconsistency in their level of response to inquiries from MFP transition coordinators and others affiliated with transition process.

- There is a disparity between how financial eligibility is determined between PACE and CAP/DA waiver, resulting in inequity of access to community-based LTSS for individuals who are not eligible for PACE due to age restriction or who live in an area where PACE is not available.
- PACE programs are highly selective about who they will enroll in their program leaving out individuals who may benefit from the program, but who are deemed ineligible due to care needs being too great.

Adult Care Homes

- There is a lack of formal in-reach process for residents of ACHs who do not qualify for TCLI. This coupled with the lack of access to transition coordination services, outside of the TCLI program, results in individuals not having consistent access to information about all available support options.
- Unless eligible for the TCLI program, residents of ACHs do not have access to information about HCBS options or transition-related services.

Division of Vocational Rehabilitation–Independent Living (DVR-IL)

- The DVR-IL Counselor (Non-MFP transition coordination) role is limited in scope and varies among IL regions. In many regions, the position seems to focus primarily on information and referral and assessing the need for and authorizing services that can be covered by DVR-IL such as home modification and assistive devices.
- Since DVR-IL is a State agency, certain transition practices (such as administering MFP demonstration services) are administratively burdensome.
- There are an insufficient number of transition coordinators to meet the needs of the State's transitioning population.

Centers for Independent Living (CIL)

- CIL transition activities seem to vary among centers. Some CILs appear to provide robust transition-related services, which seem to be duplicative of MFP and DVR-IL efforts while other CILs focus on transition-related services for the non-MFP target population.
- Contractual expectations from DVR-IL are minimal. Funding for staff to perform transition activities is a barrier for CILs.
- Misalignment between CILs independent living philosophy with some of the CMS MFP requirements resulted in discontinuation of CILs' role as a transition coordinator.

Community Alternative Program/Disabled Adults (CAP/DA)

- Synchronizing waiver enrollment process with MFP transition timeline can be challenging. Sometimes secured housing is lost because of eligibility determination process timeframe.
- The large number of CAP/DA agencies results in an increased likelihood of variations in interpretation of waiver policy across CAP/DA lead agencies, which leads to confusion among transition coordinators, families and individuals.
- Local CAP/DA agencies' individual policies result in different processes in the administration of the waiver.
- The large number of CAP/DA agencies results in difficulty with maintaining consistency in program oversight and service delivery practices.

- Most CAP/DA agencies' missions were not originally focused on supporting individuals living independently in the community; as a result, it has taken time for agencies to move away from using compliance with processes as a measure of success to focusing on QoL outcomes for the people they serve.
- Individuals who have little or no family or informal support are often times unable to transition due to programmatic limits in the CAP/DA program. The waiver is unable to meet complex support needs of participants due to low budget limits and limited service options for those who do not have informal supports.
- Transition planning for short-term stays appears comprehensive and is outlined in the waiver as well as CAP/DA policy; however, transition practice and interest varies among counties.
- Waiver limitations make it difficult to continue providing waiver services to individuals as they age or as their health declines.
- There is an inconsistency between SA/IH being available for Innovations waiver members but not for CAP/DA waiver members.
- Certain waiver services are paid to the provider directly from the CAP/DA agency. In some instances, a CAP/DA agency may not approve an expensive item (such as a home modification) because they do not want to front the money and then wait to be reimbursed from the State (challenges at times due to NCTracks). This practice varies across the State.

3
TRANSITION ACTIVITY LANDSCAPE ANALYSIS

In support of the State's MFP sustainability planning Mercer completed an analysis of the current transition activity landscape ("landscape analysis") for the various entities in the State that perform transition-related activities, with a specific emphasis on those organizations involved with:

- Medicaid eligible individuals in nursing facilities, regardless of their length of stay.

- Residents of ACHs who are not eligible for the TCLI program.

- Individuals discharging from acute care facilities who meet a nursing facility or domiciliary LOC.

The purpose of this analysis was to provide a detailed description of the various networks' activities along with an analysis of their strengths and opportunities for improvement. This information has helped inform the recommendations contained in this final Sustainability Analysis Report. Mercer included analysis on additional networks such as nursing facilities, hospitals, LME-MCOs, PACE and to a more limited extent, CCNC as these entities each play an important role in the LTSS delivery system and is worth noting as part of the analysis. Building off the transition stages relied upon by North Carolina MFP, this analysis reviews the following transition-related activities: in-reach, preparing for transition, transitioning, follow along after transition and supporting people to thrive in their homes and communities. Mercer gathered information through a variety of means including an electronic survey of the transition network (i.e., Transition-Related Activities Survey from this point forward identified as "the survey"), telephonic and in-person discussions and interviews with key stakeholders in the various networks, in-person discussions with a sampling of MFP transitioners, reviews of documents either supplied by the State or publicly available along with review and analysis of data supplied by the State.

General Landscape Themes Identified Across Entities and Among Stakeholders
Despite the high variability among surveyed entities, a number of general themes within North Carolina's LTSS "landscape" emerged from the information gathered.

Transitioning Individual Profile
- Most individuals supported by surveyed entities receive Social Security (SS), Social Security Disability (SSD), or Supplemental Security Income (SSI) and are enrolled in Medicare, Medicaid or both.
- Most individuals transition from nursing facilities into their own home/apartment or with family.

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Transitioning Activity among Surveyed Organizations

- Since 2013, the number of organizations providing transition-related services in North Carolina has grown.
- Most entities do not have individual staff members who are dedicated 100% to transition work. There is considerable variability around other duties performed including case management, independent living skills training, advocacy, caregiver education and support and clerical tasks.
- Program requirements varied significantly based on the organization responding, (e.g., length of stay, required settings, age and income).

Identified Challenges to Quality Transitions

Challenges identified by different entities are summarized in Figure 15. While reported challenges were often specific to a particular entity or transition function, four systemic challenges were identified by multiple entities:

- Inadequate understanding of HCBS options, including MFP, due to insufficient outreach and facility staff turnover.
- Limited HCBS options for an individual with few or no family/natural support (includes absent, unable, unwilling or unreliable).
- Lack of affordable and accessible community-based housing (includes assisted living and private living arrangements).
- Lack of community support resources (such as Meals on Wheels, transportation).

Area Agencies on Aging-Local Contact Agencies: Providing In-Reach through LCA function and Community-Based Resources to Transitioned Individuals

General Overview

Authorized through the Older Americans Act, North Carolina's 16 AAAs support older adults through advocacy, planning, program and resource development, information brokerage (options counseling) and funds administration quality assurance. In North Carolina, the AAAs are located within regional Councils of Government and typically do not provide services directly to individuals. AAAs are funded through a combination of reoccurring federal, State and Local appropriations as well as through contracts with third parties including MFP.

Role in Transition-Related Activities

In 2010, concurrent with changes made to the MDS assessment used for nursing facility residents, states were required to designate LCAs who would provide options counseling to nursing facility residents who, through Section Q of the MDS, express an interest in returning to the community and request additional information about HCBS options. Building on the AAAs' experience with options counseling, North Carolina's MFP program partnered with the Division of Aging and Adult Services (DAAS) to contract with each regional AAA to provide LCA functions in their area.

LCA functions include telephonic and in-person in-reach activities to referred nursing facility residents in order to provide education about community care options. Additionally, LCAs conduct outreach and education to nursing facilities about home and community service options in their areas. AAAs are permitted to perform LCA activities directly or sub-contract with other entities. Currently, there are four AAAs that sub-contract LCA activities: Southwestern Planning and Development Commission, Land of Sky, Piedmont Triad and Cape Fear. AAAs subcontract LCA functions in some areas to entities such as county senior services agencies or CILs. The AAAs' LCA role seems well defined serving primarily nursing facility residents who are older adults or adults with disabilities regardless of source of income or insurance type (although most individuals are on Medicare, Medicaid, Dually Eligible and on SS, SSD or SSI). There is no waiting list for LCA services, except for one sub-contractor who indicates it has a waiting list. Most referred individuals receive an in-person visit from the LCA within seven days of the date of referral. As self-reported through the Survey, LCA staff report receiving a wide variety of training including: transition best practices, community resources, person-centered planning and Medicaid eligibility.

Additionally, MFP contracts with two AAAs, Southwestern Commission (SWC) and the Eastern Carolina Council of Governments (ECCOG) for the provision of transition coordination services in their regions in order to determine if housing the in-reach and transition coordination activities within the same agency would streamline the in-reach and transition planning processes. The SWC AAA region has a smaller number of nursing facilities in its region compared to other AAA regions and has completed relatively few transitions. The SWC AAA also has a staff person that is specifically assigned to conducting in-reach activities and other staff that perform the transition function. The ECCOG AAA has a larger number of facilities in its catchment area, which likely contributes to its higher number of transitions. ECCOG AAA also has the same staff person performing LCA and transition coordination functions and has found that this increases continuity of the relationship with both the person transitioning and the facility social worker.

Description of MDS/LCA Processes and Identified Trends
Building on the AAAs' experience with options counseling has resulted in a well-qualified workforce of staff that are knowledgeable about local community resources. Other strengths noted by the network include its organizational experience working with older adults and people with disabilities and a person-centered approach to working with people. Challenges noted by the AAAs are reflected in Figure 15.

In order to comply with federal MDS 3.0 requirements, North Carolina's DHHS has established a statewide call center function through which nursing facilities are to direct all appropriate Section Q referrals. Call center staff then provide referral information to a State LCA Coordinator, housed in the DAAS. This coordinator logs referrals and distributes to the appropriate AAA, who initiates the LCA function. A LCA representative then calls and meets with the interested resident within contractually specified timeframes.

Figure 6 reflects the multi-year trends in this particular process. Mercer reviewed the number of facilities making referrals to the LCA call centers as well as the total overall number of referrals. The number of nursing facilities that refer individuals has increased over time from a low in 2011 of 92 to a high in 2017 of 172 with 40% of all nursing facilities making at least one referral. Facility referrals to the LCA are typically the result of MDS Section Q questions regarding the individual's interest in returning to the community. Section Q data has

not been available to the LCAs as a method to pursue contact with individuals. This means that facilities must actively make referrals to the call center in order for the LCA to be aware that an individual is interested in returning home. In other states, like Ohio, Minnesota and Connecticut, referrals are made to the LCAs based on Section Q data to augment facility based referrals and as a means to make sure individuals interested in returning home have been reviewed by the LCA and/or the MFP program.[xiii]

While the number of referring nursing facilities has improved over time, national MDS data for Section Q indicates that referrals to the LCA may not be happening at the level expected. Figure 6 shows that LCAs received over 600 individual options counseling referrals from nursing facilities in 2017. To determine what the potential number of referrals could have been from all facilities in the State, Mercer reviewed North Carolina specific CMS published MDS aggregate response data. The Mercer review of Section Q aggregate data from 2012 to 2017 indicates that nursing homes may not be making LCA referrals for all individuals that have asked to be referred. Based on analysis of national responses to question Q0600 that asks, "Has a referral been made to the LCA?" and the response "Yes" should have resulted in nearly 1,300 individual referrals to the LCA annually on average through 2017.[xiv] In North Carolina, these referrals are made through a call center for referral to local LCAs for options counseling.

FIGURE 6: LCA REFERRALS

Source: MDS Call Center Facilities Referral Totals — North Carolina MFP Program Data

Referrals to Long-Term Care Call Center for Options Couseling by the Number of Facilities (2011 through 2017)
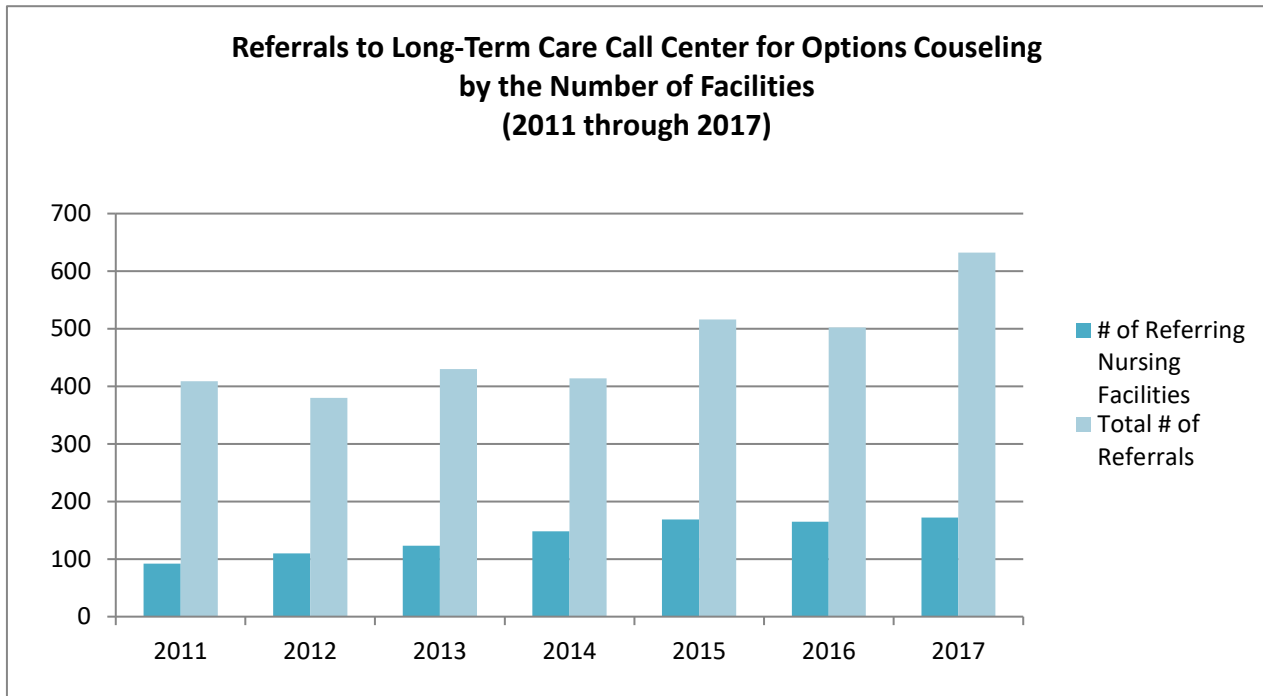
Upon visiting the identified resident, a LCA representative may determine that the resident meets the threshold qualifications of the MFP program and works with the resident and others to submit an MFP application. If the MFP program determines the resident meets the MFP threshold qualifications,[xv] the program will assign a transition coordinator to follow up with resident and conduct a more thorough assessment/planning process. Because of factors not reflected in the initial MFP application, many individuals who express interest in transitioning and are enrolled in MFP, may not actually be able to transition.

Because of initial differences in tracking methods between the MDS referral activity and MFP transition outcomes, it is not possible to conclude a clear causal relationship over time between LCA activity and resulting MFP transitions. However, MFP's nationally reported data related to LCA-initiated MFP applications suggest that approximately 30% of all MDS referrals would meet the criteria for MFP enrollment [based on 2016 Semi Annual data]. MFP data also suggest that increased engagement by the LCA network produces more MFP applications. It is important to note that as the application quantity increases, the Project will need to take steps to ensure those subsequently enrolled have a likelihood of transitioning. Failure to do so will result in the transition coordination network being overly burdened by applications for individuals who may not be able to transition.

Nursing Facilities: Providing Residential Option for Individuals requiring LTSS: Facilitating Access to Options Counseling and Facilitating Discharge

General Overview

In North Carolina, there are approximately 421 licensed nursing facilities (401 that accept Medicaid) with approximately 44,000 total beds.[xvi] Licensing of nursing facilities is performed through the DHHS, Division of Health Services Regulation. Based on published per diem rates for 2018, the average annual Medicaid cost for a nursing facility is $65,110[xvii] and the occupancy rates are at approximately 82.0% based on the most recent data available.[xviii] Nursing facilities are funded through a combination of Medicare, Medicaid, LTC Insurance, Veterans Affairs (VA) or private pay with Medicaid primarily covering the cost for long-term stays/custodial care. Individuals who meet the criteria for a nursing facility level of care (NF LOC) as well as financial eligibility under North Carolina's Aged, Blind, Disabled (ABD) eligibility categories are eligible for Medicaid coverage for their nursing facility stay.

While the majority of nursing facilities in North Carolina are freestanding with primary emphasis on populations who meet NF LOC, others may actually serve populations with different LOC within the same facility. In North Carolina, hospitals are permitted to have nursing facility beds although this is not common. About half of all nursing facilities also have ACH beds.

Role in Transition-Related Activities

Per federal and State rules, nursing facilities are required to make referrals to the LCA as a result of residents' affirmative responses to questions contained in the Section Q of the MDS and, as referenced earlier, there is variability around the number of referrals that are actually made based on individual preferences for referral.[xix]

Nursing facility social workers play a key role in the transition team as individuals plan for their discharge. Specifically nursing facility social workers can:[xx]

- Arrange and participate in discharge planning meetings.
- Link an individual with community resources.
- Provide referrals for and/or arrange for supports and services (including personal care, durable medical equipment, home modifications and other essential supports).
- Link with medical resources such as primary care physician (PCP), medical specialists, skilled services including therapies and pharmacy.
- Identify and document back up services and supports.
- Facilitate medication reconciliation with nursing staff prior to discharge.

See Figure 15 for transition-related challenges identified by nursing facilities.

North Carolina's Certificate of Need Process and Identified Facility Utilization Trends

Finally, the process for developing a state's nursing facility network is a critical part of a state's overarching landscape. In North Carolina, the State Health Coordinating Council (SHCC), authorized by executive order, conducts the State's Certificate of Need (CON) program that reviews the need for health facilities like nursing facilities in the State based on population review. The SHCC has 25 representatives appointed by the governor. The SHCC is responsible for the development of the CON methodology and then applying the methodology. [xxi]

A CON process helps ensure facilities are only authorized to be developed if there is an identified need to do so. The process can serve as an important lever in facilitating a state's rebalancing priorities.

The CON methodology focuses on bed deficits or surpluses in a service area, typically by county. Generally, the methodology analyzes the number of beds, number of people in a nursing facility and the population of the service area over a five-year period. This information is used to calculate the bed use projections and any surplus or deficit. CBAs for individuals who meet the applicable facility criteria are not a factor in determining North Carolina's facility need.

The North Carolina CON process has resulted in a slow growth in the number of nursing facility beds available statewide. However, database information available through the DHHS website,[xxii] indicates a growth in bed capacity that is inconsistent with the overall reduction in the overall number of total (all payers) bed days reported. This trend is reflected in the Figure 7.

FIGURE 7: NURSING HOME BEDS AND BED DAYS

**Total Licensed Nursing Home Beds and Bed Days
(2010 through 2016)**
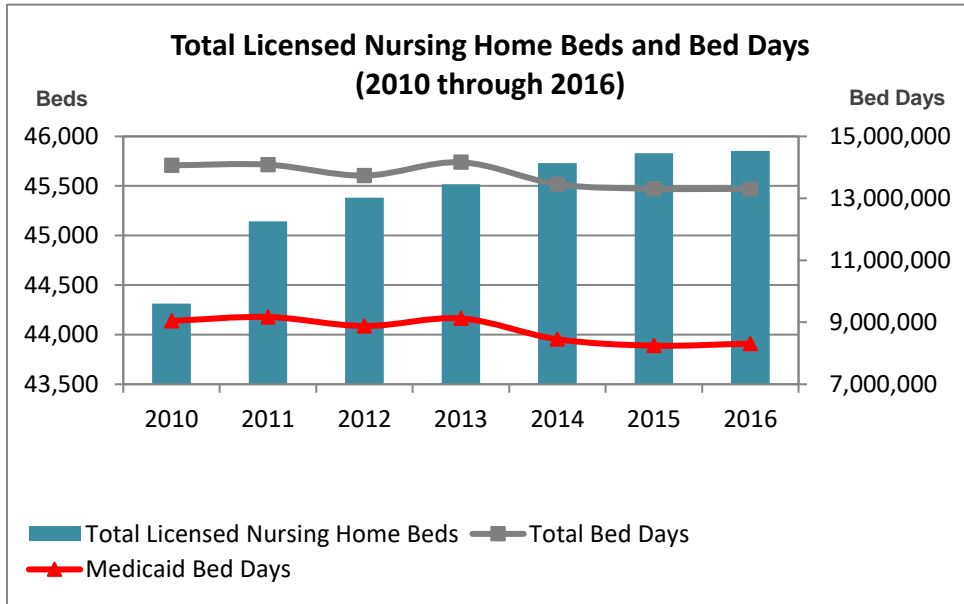
Source: State Medical Facilities and Plan - Nursing Facility Data Base

Notably, between 2010 and 2016, the average number of bed days that *Medicaid* reimbursed ranges from a high of 9.17 million days in 2011 to a low of 8.25 million days in 2015. During this same period, Medicaid institutional spending (Figure 8) has decreased from $1.9 billion in 2010 to $1.3 billion in 2015, a decrease of 31.0% over eight years.[xxiii] While attribution of this reduction in days and expenditures is difficult to pin point, the MFP program, CAP/DA waiver and the reliance on ACH for individuals may be impacting the utilization of this institutional option. Future analysis of this trend could be warranted to determine how growing cost effective diversion and transition activities may be having an impact and by analyzing cost and acuity of individuals being served in ACH.

FIGURE 8: MEDICAID INSTITUTIONAL SPENDING

Total North Carolina Medicaid Institutional Spending (2010 through 2015)

[Bar chart showing Total Medicaid Institutional Spending for years 2010–2015. Y-axis ranges from $- to $2,500,000,000 in $500,000,000 increments. Bars: 2010 ≈ $1,950,000,000; 2011 ≈ $1,950,000,000; 2012 ≈ $1,920,000,000; 2013 ≈ $1,500,000,000; 2014 ≈ $1,370,000,000; 2015 ≈ $1,350,000,000.]

■ Total Medicaid Institutional Spending
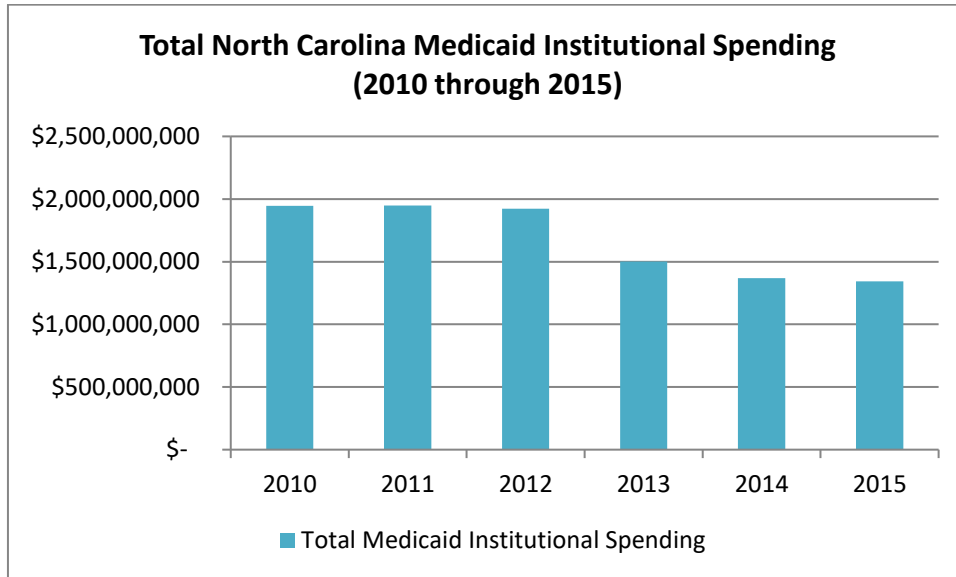
Source: Medicaid Expenditures for LTSS Reports for Federal Fiscal 2014 and 2015, Truven Health Analytics for Mathematica under contract with CMS.

Hospitals: Facilitating Discharges from Acute Care

General Overview

Currently in North Carolina there are 126 licensed hospitals located in 83 counties. Hospitals are permitted to have nursing facility and ACH beds although this is not a common practice. Additionally, there are 12 Long-Term Acute Care Hospitals (LTACHs) in North Carolina. A LTACH is a hospital that specializes in serving individuals who require extended hospitalization. LTACHs are typically either free standing or are located within a hospital.

Role in Transition-Related Activities

Related to discharge planning, per the North Carolina DMA Clinical Coverage Policy, 2A-1, acute inpatient hospitals are required to:

• Arrange/participate in discharge planning meetings.
• Refer for and/or arrange supports and services.
• Link with medical resources such as PCP, medical specialists, skilled services including therapies and pharmacy.

Additionally, State MFP staff report some hospitals utilize Coleman Model of Care Transitions. The Coleman Model is a care intervention that utilizes a transition coach that helps individuals and/or their caregiver learn self-management skills that help ensure an individual's needs are met as they are transitioning from the hospital to home. While there is no target population specifically designated, the Coleman Model appears to target individuals who are cognitively able to participate in the management of their care or who have an active/involved caregiver who may do so on their behalf. Key features of the model include:

- Visits by the transition coach while the individual is in hospital (if possible).
- Help with problem solving.
- Home visits after discharge.[xxiv]

See Figure 15 for transition-related challenges identified by hospitals.

Community Alternatives Program for Disabled Adults Lead Agencies: Providing HCBS Supports to Transitioned Individuals

General Overview

In North Carolina, there are three 1915 (c) waivers designed to meet the home- and community-based care needs of children and adults: CAP/DA, CAP/C and Innovations. [xxv] The CAP/DA, CAP/C and Innovations waivers all offer self-direction components. In the CAP/DA waiver, this self-directed option is referred to as CAP/Choice. Individuals who participate in MFP are enrolled in the CAP/DA, CAP/Choice or Innovations waiver.

The CAP/DA waiver serves older adults and people with disabilities over the age of 18 who meet income, NF LOC and other waiver requirements including the ability to have their needs safely met at home. Slots for the CAP/DA program are limited and are distributed among North Carolina's 100 counties with each county receiving an allocation. There is a waiting list for the CAP/DA waiver in some counties although individuals participating in MFP receive priority access to a CAP/DA waiver slot. The wait time for individuals seeking to secure a CAP/DA waiver slot varies by county, but may exceed 180 days. Typically, the length of time an individual is required to wait for a CAP/DA waiver slot is 30–90 days. The CAP/DA waiver is administered through 90 different entities referred to as CAP/DA Lead Agencies. The CAP/DA Lead Agencies represent a diverse group of organizations including, but not limited to, County DSS, Home Health Agencies (HHAs), County Aging Services organizations and hospitals and regional medical centers. While CAP/DA is a Medicaid-reimbursed program, the organizations housing the CAP/DA Lead Agency functions receive funding through a variety of sources including, but not limited to, Medicaid, State and Local funds, third party contracts (including MFP), etc. The CAP/DA Lead Agency is responsible for determining waiver eligibility as well as providing case management services to individuals enrolled on the CAP/DA waiver. Case management within CAP/DA is a waiver service reimbursed through Medicaid and limited to 80 hours a year. LOC for waiver enrollment is reviewed and authorized by an independent entity contracted by the State. Once the LOC is determined, the CAP/DA case manager initiates a comprehensive assessment and when appropriate, the plan of care development process. Most CAP/DA Lead Agencies indicate through survey responses that they have prescribed timelines by which assessments and eligibility determinations must be completed. Most indicate that the eligibility determination should be made within 45 days from date of their receipt of the CAP/DA referral. As self-reported in the survey, CAP/DA agencies provide case managers training on a variety of topics with most respondents indicating that training on MFP practices as well as training on person-centered practices and community resources is provided.

Role in Transition-Related Activities

The CAP/DA case manager is an integral part of an individual's transition team not only determining eligibility for the CAP/DA waiver but also authorizing waiver services including Transition Services (helps cover one-time startup expenses up to $2,500) provided through the CAP/DA waiver. Many of the CAP/DA agencies that responded to the survey indicated they provided in-reach activities to educate nursing facility residents about community care options. This is important to note as this is not a formalized prescribed role. Survey results indicate the majority of CAP/DA agencies view themselves as partners with the MFP transition coordinator in assisting individuals with returning to the community. Feedback from CAP/DA agencies that participated in the survey indicates that beyond their role as a transition coordinator, CAP/DA agencies see themselves actively participating in transition-related activities through their case management role for the CAP/DA waiver by determining eligibility for the waiver as well as service planning for post discharge. Additionally, CAP/DA case managers have a well-developed role to provide monitoring and follow along to transitioned individuals through telephonic contact and home visits, monitoring of services and the service plan as well as some linkage and referral to community resources to help meet unmet needs.

The services described above are not exclusively available to individuals participating in the MFP program, but any individual determined eligible for the CAP/DA waiver. Notably, the CAP/DA waiver makes specific considerations for transitioning individuals, including short-term stay individuals who are not eligible for MFP.

When determining if essential services are in place at the time of transition, survey results indicate most CAP/DA agencies rely on verbal confirmation from the individual, family or provider that essential services have been initiated after discharge from the facility. Self-reported information obtained via the survey indicates CAP/DA Lead Agencies think their strengths include person-centered approach, knowledge of community resources and organizational experience with providing transition services, knowledgeable and qualified staff and their ability to complete transitions quickly. Transition-related barriers identified by CAP/DA agencies can be found in Figure 15.

The MFP program contracts directly with two CAP/DA Lead Agencies (Cape Fear Valley Health Systems and Senior Services) for the provision of transition coordination services. This partnership provides opportunity to streamline MFP and CAP/DA processes. Alignment in the mission of MFP and CAP/DA is one of the most significant differences in this model that helps contribute to positive outcomes for people. Additionally, in seven counties, the local CAP/DA Lead Agency provides transition coordination services to MFP participants on a fee-for-service (FFS) basis.

Feedback from MFP stakeholders indicates that coordination with CAP/DA agencies can sometimes be challenging. Specific challenges include, delays in determining waiver eligibility, differences across CAP/DA agencies in waiver practice (including agency specific policies and differing interpretations of waiver rules) and a lack of understanding or appreciation of the value of the MFP program. Other challenges with the CAP/DA waiver not specifically related to the lead agencies include, lack of informal support required for waiver enrollment, inability to meet individual's needs within cost cap and deductible along with living expenses, a shortage of personal care aides, and lack of non-medical transportation.

Identified Cost and Utilization Trends

The CAP/DA program has seen an overall slowing of expenditures and participation in the waiver as represented in the charts below. The change in expenditures from 2010 to 2015 represents an overall decrease of 10% or $25.5 million. Despite the cumulative reduction in spending, the projected difference between the actual cost of services under the waiver and the average cost of nursing facility service was $518 million during this period.[xxvi]

FIGURE 9: CAP/DA TOTAL WAIVER EXPENDITURES
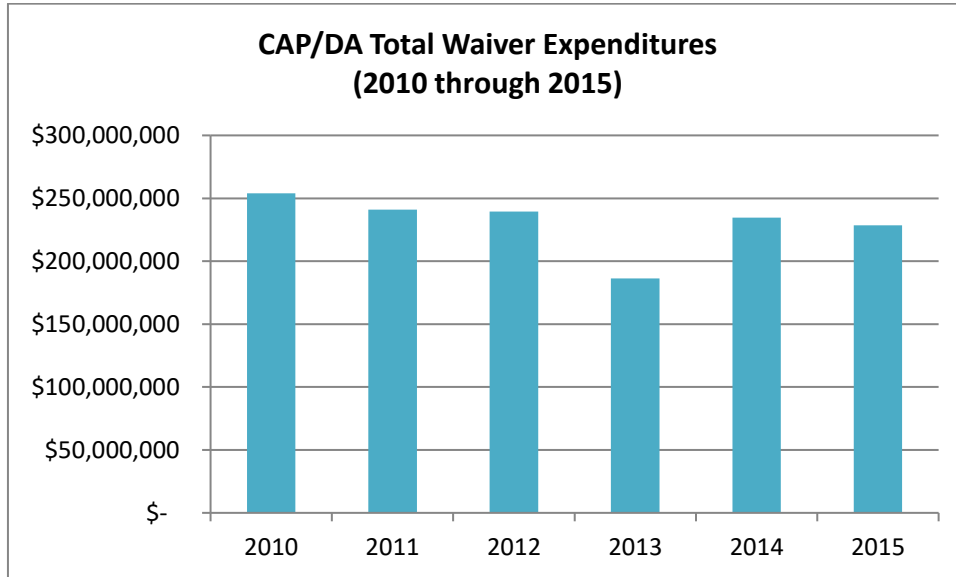
Source: CMS 372 Reports

The number of participants in the waiver also decreased during the six-year period reviewed. According to the CMS 372 reports in 2010, 14,929 individuals participated in the waiver, dropping by 2,968 by 2015. Figure 10 shows the change in waiver enrollment over time.

FIGURE 10: TOTAL CAP/DA PARTICIPANTS
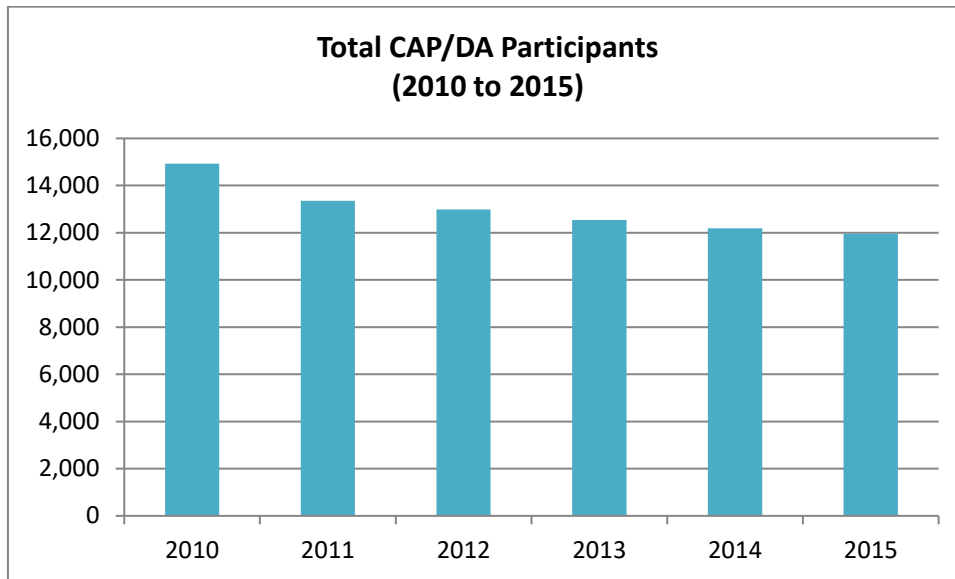
Source: CMS 372 Reports

PACE: Providing HCBS Supports to Transitioned Individuals
General Overview

PACE is a managed care program for older adults. This program features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE providers receive a capitated Medicare and a separate capitated Medicaid rate. Individuals enrolled in PACE have their Medicaid eligibility determined via the institutional methodology allowing more individuals to have greater income than the CAP/DA waiver and requiring the payment of a patient monthly liability (PML) rather than a deductible. The PML is paid directly to the PACE provider.

Currently, in North Carolina there are 12 PACE sites serving an average of 2,500 individuals statewide. Currently there is no waiting list for PACE services. This program is an option for some individuals participating in MFP who are transitioning from nursing facilities. To be eligible for PACE an individual must be Medicaid, Medicare, dually Medicare/Medicaid eligible or able to pay privately and:

- Be 55 years of age or older.
- Be determined to need the LOC required under the State Medicaid Plan for coverage of nursing facility services.
- Reside in the PACE organization's service area.
- Be able to live in a community setting when enrolled without jeopardizing health or safety.
- Meet program-specific eligibility conditions imposed under the respective PACE agreement.

PACE centers include a primary care clinic, an adult day health program, areas for therapeutic recreation, restorative therapies, socialization, personal care and dining that serves as the focal point for coordination and provision of most PACE services.[xxvii]

Role in Transition-Related Activities

Two of the 12 PACE sites responded to the survey. This cannot be interpreted as a representative sample. Nonetheless, there are important responses to note including: PACE sites self-identified as conducting in-reach activities in nursing homes, there are no requirements on timeliness of assessments from the point of referral, PACE staff receive training on transition best practices, North Carolina MFP overview, community resources and Medicaid eligibility and PACE site rely on the MFP transition coordinator to validate that services have been initiated at the time of transition. Per the survey results, PACE providers indicated the following transition-related challenges: lack of housing and transportation options, unreliable informal back up support and families' lack of willingness to consider HCBS options for their loved ones residing in a nursing facility.

While PACE is an option for some MFP participants, it is not an option for all MFP participants due to age restrictions and the lack of availability of PACE sites in certain areas of the State. Individuals who are transitioning from a nursing facility into the PACE program are able to access transition year stability resources and may receive transition coordination from a contracted entity. In some cases, the PACE site provides the transition coordination directly although they receive no separate reimbursement from the MFP program for this activity. There is interest at the State level of expanding the number of PACE sites to make it more readily available to eligible individuals. Additionally, in 2012 the MFP program began targeted engagement with the PACE organizations to improve transition-related collaboration. While some PACE organizations now initiate MFP-related transitions, most continue to rely on MFP's transition coordination network to assist with the transition process.

DVR-IL: Facilitating Transitions and Providing Community-Based Resources to Transitioned Individuals

Overview

DHHS, Division of Vocational Rehabilitation Services operates an Independent Living program in North Carolina. The DVR-IL program, through its 16 regional offices, provides either directly through a contracted entity or in coordination with a community organization a wide variety of services to people with disabilities including:

- Guidance and counseling.
- Rehabilitation engineering.
- Home and vehicle modifications.
- IL skills training.
- Qualified equipment purchases.
- Assistance with leisure activities.
- Personal assistance services.
- Service animals for people with disabilities.[xxviii]

DVR-IL serves primarily people with disabilities and older adults and most respondents to the survey indicated they did not have a waiting list for transition-related services, although certain programs such as the Personal Care Attendant (PCA) program may have a waiting list. In 2015, 2,989 individuals received services from

DVR-IL under an Individualized Plan for Independent Living).[xxix] One entity did indicate a waiting list of 31–90 days for new referrals. DVR-IL serves individuals with a broad range of income sources and insurance types with SS, SSD, SSI, Medicaid and Medicare being the most common. Some of the DVR-IL services are available to individuals regardless of their income. Most of DVR-IL's funding comes from a State appropriation; however, they also receive some federal funds along with funding from MFP for their role as a transition coordinator. Survey respondents indicate timeliness requirements for the completion of assessment/eligibility determinations vary from within seven days of referral to within 60 days of referral.

Role in Transition-Related Activities

MFP contracts with the DVR-IL program for transition coordination services and according to State MFP staff, seven of the 16 regional DVR-IL offices currently have transition coordinators who are providing transition coordination to MFP participants. DVR-IL also provides transition-related activities outside of MFP, oftentimes completing transitions when a person is determined ineligible for MFP or CAP/DA. DVR-IL may help with home modifications, medical equipment, vehicle modifications, assistance with furniture, food and utilities, personal assistant services, and targeted housing assistance. The level of transition support for non-MFP participants seems to vary by region with regions housing MFP transition coordinators having more robust support available. Other regions seem to provide more of a support role for non-MFP transitions as there are no designated transition coordinators and IL Counselors do not perform solely transition-related activities. Training for staff includes transition best practices, independent living philosophy and MFP overview. Validation of the initiation of essential services seems to happen most often through verbal confirmation with the individual, family or case management entity.

Additional Identified Trends

FIGURE 11: DVR-IL TRANSITIONS
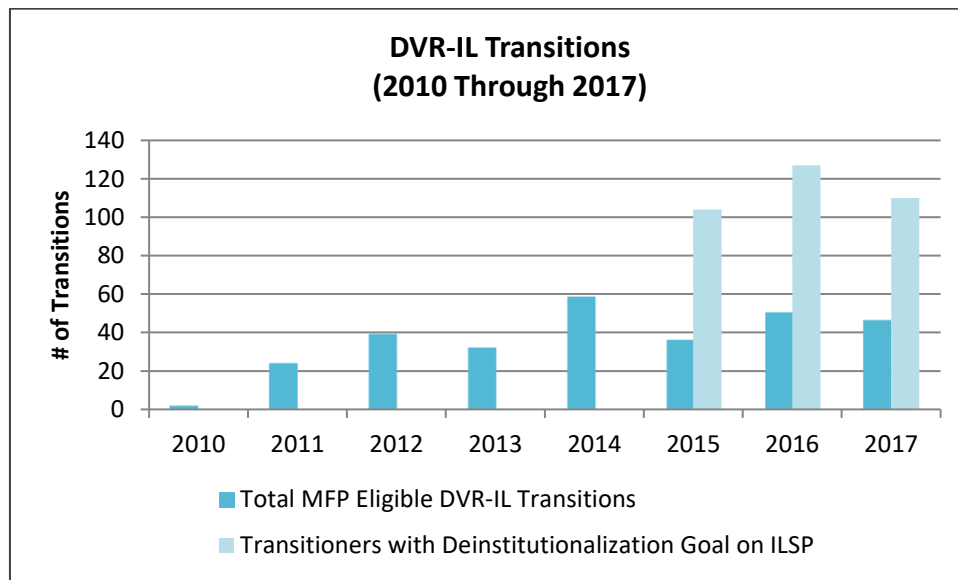
Source: MFP reports and most recently available data from DVR-IL*

To receive transition support from DVR-IL an individual does not have to the meet length of stay or Medicaid eligibility requirements or reside in a particular type of facility. DVR-IL can help individuals transition from a variety of settings including ACHs, shelters and families' homes. Individuals do have to be able to make their own decisions and agree to follow an IL plan in order to be eligible for transition services. As shown in the chart above, DVR-IL has transitioned over 100 individuals annually with 91% of these being outside of the MFP process.[xxx] As indicated in transition-related activities survey, DVR-IL strengths include organizational experience working with people with disabilities, person-centered approach, knowledgeable and experienced staff and knowledge of community resources. Self-identified challenges as indicated in the survey include lack of affordable housing and other housing-related challenges, (e.g., individual is a smoker/cannot find an apartment that allows smoking), lack of timeliness of CAP/DA waiver assessments and individuals with a history of a substance use disorder (SUD), with no treatment.

DVR-IL is the Designated State Unit for the CILs. Although there may be some overlap in transition-related services, DVR-IL provides access to some services the CILs cannot and the CILs provide some services such as individual advocacy and peer support that DVR-IL does not provide. See Figure 15 for transition-related challenges identified by DVR-IL.

CILs: Facilitating Transitions and Providing Community-Based Resources to Transitioned Individuals
General Overview

Currently, in North Carolina, there are eight CILs. CILs are non-residential, 501(c) (3) non-profit corporations. They are consumer-controlled, community-based organizations that provide programs and services for people with all types of disabilities. The goal of the CILs is to promote and support opportunities for people with disabilities to fully participate in an integrated community and search for the possibilities to live as they choose. By federal statute, 51% of the boards of directors of a CIL are persons with disabilities.[xxxi] At a minimum all CILs provide assistance in the following areas:

•   Information and referral.
•   Individual advocacy.
•   IL skills training.
•   Systems advocacy.
•   Peer mentoring and support.
•   Youth transitions.
•   Diversions from institutions.
•   Transitions to community living.[xxxii]

The DHHS DVR-IL is the Designated State Unit in North Carolina and not only submits the State Plan for Independent Living, but is also the pass-through agency for the distribution of federal funds to CILs. Although funded primarily through federal dollars, $2.5 million in 2017, CILs do receive funding from other sources including local funding, revenue generated through third party contracts, fund raising and grants. CILs provide services to individuals with a wide range of disabilities regardless of their income source and generally do not have a waiting list.

Role in Transition-Related Activities

In North Carolina, CILs provide a diverse mix of transition-related services (in-reach to facilities to discuss community care options, help with finding housing, linkage and referral to community resources, peer support, IL skills training, etc.) to individuals in a variety of settings including nursing facilities, hospitals, prisons and homeless shelters. Half of the CIL survey respondents indicate they do have timeliness requirements (within seven days from referral) related to eligibility determinations. CIL staff receives training on a variety of topics most significantly transition practices, independent living philosophy and community resources. While supporting community transitions is core activity for all CILs, each CIL operationalizes this activity differently. Per the results of the survey, most CILs rely on verbal reports from individuals, families, providers or case managers that essential services were initiated at the time of transition. While CILs may not have access to the full array of services available through a program like MFP, their ability to respond to individual situations quickly and flexibly is advantageous. CILs see their organizational experience working with people with disabilities, their person-centered approach along with knowledgeable and experienced staff as being their greatest strengths. Funding for staff to perform transition activities is a barrier for CILs. They, like all other entities performing this work, identify housing as a barrier to an individual's ability to transition into the community. In the past, the MFP program had contracted with two of the CILs to provide transition coordination; however, these contracts were ended as the interplay between CILs independent living philosophy with some of the CMS MFP requirements did not mesh well.

Adult Care Homes: Providing Residential Options to Individuals with LTSS Needs

General Overview

While MFP does not currently work with ACH residents directly, ACHs are currently the focus of North Carolina's TCLI program and play an important part in the State's LTSS delivery system. Accordingly, they are included here. An ACH is a licensed facility that provides room, board and supervision to older adults and people with disabilities who require assistance with daily living activities and may require up to 24-hour per day supervision. ACHs can vary in size from two to well over 100 beds. Family Care Homes are smaller and range from two to six (most commonly four to six) beds. Currently, there are 593 ACHs and 629 Family Care Homes in the State. ACHs are licensed by the DHHS, Division of Health Service Regulation. According to the *State Medical Facilities Plan* (2016), 11.0% of all ACH beds, not including Family Care Homes, are located in nursing facilities and it is estimated that about half of all nursing facilities have some adult care beds.[xxxiii] Hospitals with this type of licensed bed have been on the decline and represent a fraction of a percent of all beds in the State. Fluidity exists between in these types of facilities with residents moving back and forth between a nursing facility and ACH bed based on their needs and depending on bed availability. Additionally, ACHs are enrolled with the DHHS DMA as a provider of PCS and non-emergency medical transportation and bill Medicaid directly for the provision of these services to their residents. The amount of PCSs a person receives is determined by an outside assessment entity contracted by the State. ACHs are able to determine their own admissions policies with some taking only private pay individuals.

ACHs by law, except on a short-term basis, do not provide care to individuals who:

- Are ventilator dependent.
- Require continuous nursing care provided by licensed personnel.

- Have acquired certificate from their physician that placement is no longer appropriate.
- Have health needs that cannot be met in an ACH.
- Have other medical and functional care needs that cannot be properly met in an ACH.

Currently, there are almost 30,000 individuals who reside in ACHs most of whom are over the age of 55. At present, over 92.0% of all ACH residents are over the age of 55, with 38.0% being 85 years of age or older. Over 40.0% of ACHs residents have a diagnosis of Alzheimer's or Dementia, 16.0% have a diagnosis of a mental illness and almost 5.0% a diagnosis of an intellectual or developmental disability.[xxxiv] A review of data since 2010 shows a trend in ACHs serving more individuals with Alzheimer's or Dementia and fewer individuals with a mental illness. This may be attributed in large part to the State's concerted efforts to move targeted individuals out of ACHs through its TCLI program. The number of individuals with I/DD has remained fairly constant over the same period. Although the demographics of the ACH residents has shifted during this time period, occupancy rates have remained steady between a low of 71.0% and a high of 78.0% and currently at 74.0%.[xxxv] ACHs, except for Family Care Homes, are subject to the State's CON process. The most recent analysis performed as part of that process indicates there are only four or five counties in North Carolina that have unmet ACH bed needs. Figure 12 below illustrates an average annual growth of 4.0% in the number of the licensed ACH beds.[xxxvi] This does not include Family Care Homes that are not subject to the CON process. Per feedback from staff from the Division of Health Services Regulation, new Family Care Homes open frequently, although it is noted that for as many Family Care Homes that opened just as many closed.

FIGURE 12: LICENSED ADULT CARE HOME BEDS
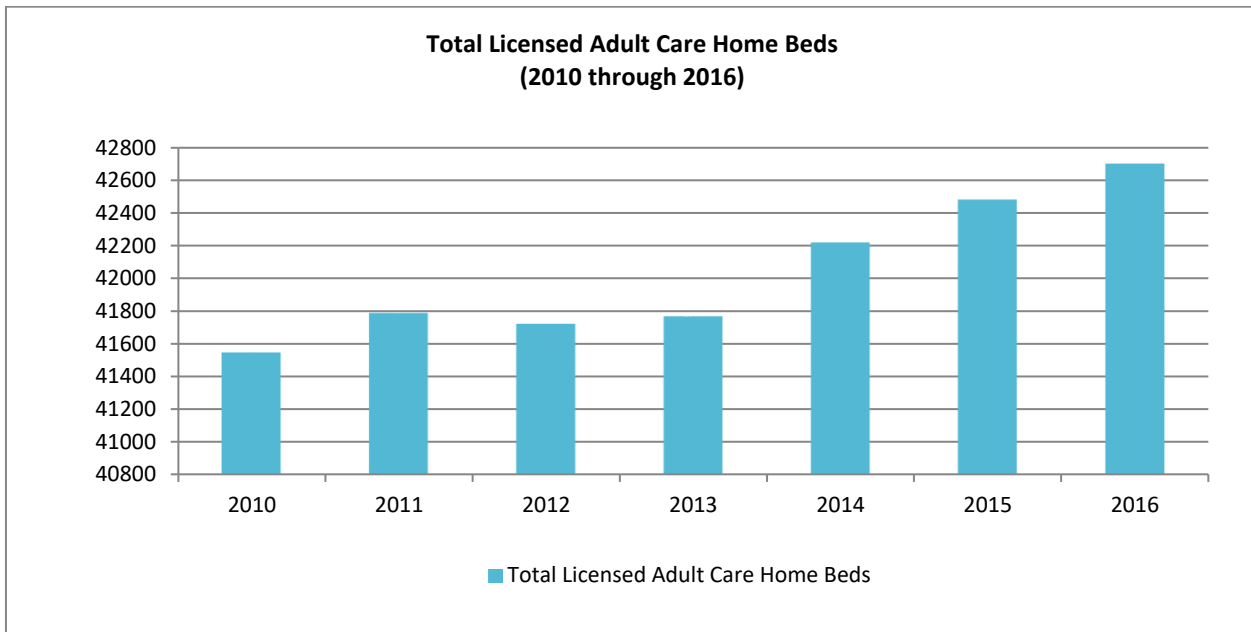
Source: State Health Coordinating Council, State Medical Facilities Plans 2010 through 2016

Role in Transition-Related Activities

ACHs, particularly those who serve primarily older adults, have some turnover within their facilities. As individuals age and their care needs become greater some ACH residents move to nursing facilities. ACHs most frequent interaction with transition-related activities is through the TCLI program. North Carolina's LME-MCOs contract with the State to provide an array of services for individuals with behavioral health and I/DD needs in a capitated program. LME-MCOs perform in-reach into ACHs in order to identify individuals with a mental illness who are interested in transitioning into their own homes with supports and then work with the individuals and the ACH to facilitate that transition. There is no other formal in-reach program for ACH residents and they are not considered a qualified institution for purposes of participation in the MFP program. Some entities, however, such as DVR-IL and CILs, indicate they do provide support to non-TCLI individuals in moving from an ACH into the community.

ACHs provide both services and residential support to nearly 30,000 individuals. ACHs seem to fulfill a particular need for individuals whose LOC does not require them to be in a nursing facility, but who may not have access to sufficient community-based supports. It is important to note however, that ACHs are congregate, multi-bed entities that typically have a design and physical plant similar to nursing facilities. The ACH design potentially limits a residents' ability to fully integrate into the community. See Figure 15 for transition-related challenges identified by ACHs.

Overview and Identified Trends related to the North Carolina Special Assistance Program

While some residents of ACHs are private pay or utilize other funding sources such as funding through the federal VA, most residents pay for their ACH stay through North Carolina's Special Assistance Adult Care Home (SA/ACH) program. Special Assistance (SA) is a statewide program administered by the DHHS DAAS, through local County DSS offices. The Special Assistance program is North Carolina's Optional State Supplement program that provides cash payments to low income individuals to supplement the federal SSI payment. Established in 1974, the special assistance is provided to all ABD adults living in ACHs who meet a domiciliary LOC. Children who are legally blind may also be eligible for optional supplementation through the Special Assistance Program. Special Assistance payment levels for ACHs are broken down into two levels: basic and enhanced. Individuals receiving Special Assistance for ACHs are determined categorically needy for Medicaid eligibility purposes and receive Medicaid without a "spend down" even if their income exceeds 100% of FPL. Currently, there are 17,930 individuals who receive SA/ACH.[xxxvii] The program is funded through State and County funds (50/50) and there is no waiting list. Based on feedback from an ACH owner, approval for SA/ACH takes about a month and individuals do not have to be Medicaid eligible prior to their application and approval. There is no waiting list for SA/ACH.

In addition, Special Assistance may be available to certain individuals who are residing in their own homes. The SA/IH program first piloted in 2000 and provides cash supplements up to the amount paid to an ACH to low income individuals who are at risk for entering a residential facility, but prefer to reside in their own homes. Individuals must have income at or below 100% of the FPL and go through an assessment process to determine their eligibility for the program. Individuals who receive SA/IH must have their Medicaid eligibility established prior to being determined eligible for the SA/IH program. Currently, there are 3,120 people enrolled in SA/IH.[xxxviii] The program is funded through State and County funds (50/50) with limited slots for the program. There is a waiting list for the program.

LME-MCO's: Facilitating In-Reach, Transition Support and HCBS Supports for Covered Populations

While not the primary focus of this Transition Landscape Analysis, Mercer analyzed identified LME-MCO transition functions for comparison purposes.

General Overview

LME-MCOs are regional managed care entities that are responsible for providing both community-based, inpatient Medicaid funded mental health, DD and SUD services through a concurrent 1915 (b/c) waiver. LME-MCOs are contractually required to provide transition-related services including diversion activities to Medicaid eligible individuals with a mental illness through the TCLI program and to individuals with I/DD who reside in private ICFs/IID or public developmental centers. Individuals with I/DD who are transitioning from facility based care may participate in MFP with the transition coordination provided by the LME-MCO. MFP participants with I/DD are eligible to receive Transition Year Stability Resources (TYSR) funds and have access to expedited housing slots. There is no separate payment to the LME-MCO from MFP for the provision of transition coordination services as this is built into the LME-MCOs capitation payment received from the State.

LME-MCOs transition individuals from a wide variety of setting including nursing facility, hospitals, State-operated psychiatric inpatient facilities, ACHs, PRTFs , ICF/IID (private) and State operated Developmental Centers and occasionally, nursing facilities. LME-MCOs typically do not have waiting lists for services once an individual has been identified for a waiver slot although one of the survey respondents indicate they have a waiting list of 91 to 180 days. Half of the LME-MCOs indicate they have timeliness requirements for the completion of assessments, with those who responded all indicating assessment must be completed within seven days from the date of the referral. LME-MCO staff receives training on a variety of topics including transition best practices, Medicaid eligibility, MFP overview and person-centered planning.

Role in Transition-Related Activities

The LME-MCO's role for transition-related activities seems to be well defined for individuals participating in the TCLI program, aligning with expectations for MFP transition coordinators. Within the TCLI program, LME-MCOs provide the full array of transition-related services from in-reach to facilities (including ACHs), to transition planning, help with moving, post move monitoring and follow along. Unless otherwise eligible for care management, follow along ends 90 days' post discharge. Validation of the initiation of essential services is most likely to occur via verbal confirmation from individual, family or provider.

Transition activities for individuals with I/DD while well-defined, do not seem in practice to be as robust as those in the TCLI program and requirements are not as clearly supported in the LME-MCO contract. Transition-related requirements for I/DD transitions appear to largely stem from MFP's direct requirements. While LME-MCOs are required to engage facility residents in annual planning and may provide in-reach activities to public developmental centers and private ICFs/IID, informal feedback from MFP Stakeholders indicates the lack of slots for the Innovations waiver results in less than assertive in-reach efforts. Based on additional informal stakeholder feedback we would recommend continued analysis of ways to improve in-reach practices to beneficiaries current residing in State or private ICFs.

FIGURE 13: LME-MCO MFP I/DD ELIGIBLE TRANSITIONS
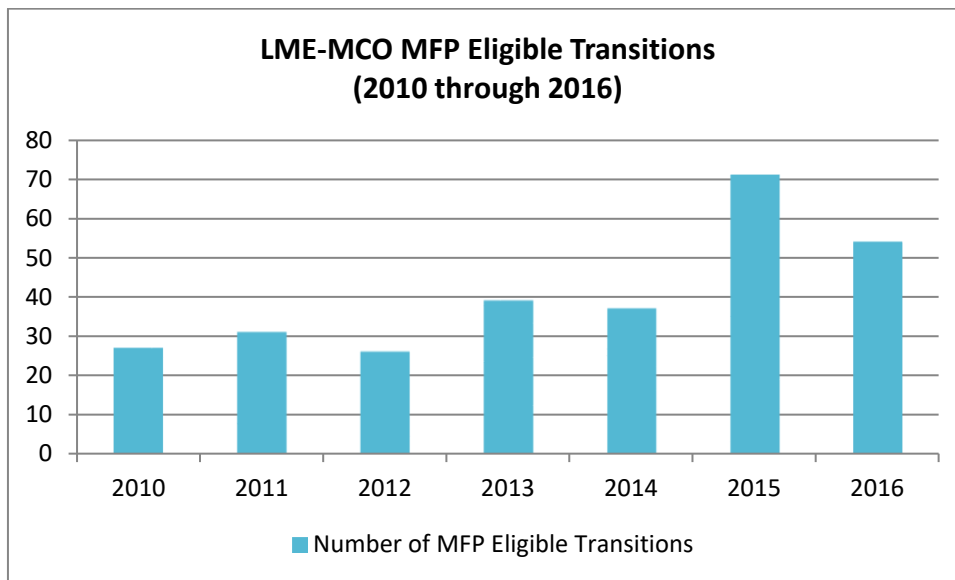
Source: LME-MCO reported data to North Carolina MFP program

LME-MCOs self-identified strengths include organizational experience serving people with disabilities, specialized training for transitioning individuals and caregivers, person-centered approach and knowledge of community resources. The ability to access PCSs in an expedited manner along with access to tenancy support services were identified as being important in the success of supporting individuals through the TCLI program. Challenges faced by LME-MCOs are reflected in Figure 15.

Community Care of North Carolina (CCNC): Providing Clinical Care Management to Enrolled LTSS Medicaid Beneficiaries

CCNC plays an important role in the delivery of acute care services to individuals enrolled in Medicaid.

General Overview

CCNC is a public-private partnership that brings together regional networks of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organizations to provide coordinated care through the Medical Home Model. This approach matches each patient with a PCP who leads a health care team that addresses the patient's health needs.[xxxix]

Role in Transition-Related Activities

CCNC's initial transition efforts focus on hospital to community transitions with individuals who are eligible through the Medicaid ABD category of eligibility. Due to the success of working with this population, the program has been expanded to additional populations, such as high risk/high cost individuals and those dually-eligible. Elements of CCNC's model include:

- Participating in discharge planning meetings (nurse case managers and behavioral health specialist embedded in hospital).
- Home visit within three days of post discharge from hospital.
- Arranging necessary supports and services such as personal care, durable medical equipment, etc.
- Linking with medical resources such as PCP, medical specialists, skilled services including therapies and pharmacy.[xl]

Transition-Related Entity Landscape Analysis: Summary Elements

The scope of the table in Figure 14 is specific to transition-related services and does not include the broad dimension of services provided by a given entity. The information contained in the table is based on survey results and supplemented by targeted interviews with applicable subject matter experts. Figure 14 summarizes six key elements:

- Priority groups and eligibility requirements of each entity.
- Allowable time frames for program assessment and enrollment.
- Systemic training received on transition practices by each entity.
- Funding allocated for transition specific activities, including funding sources.
- Typical Method used by entity for ensuring essential services are identified and established day one of transition into a community setting.
- The self-identified strengths of each program that supports the NCDHHS' broader objectives.

FIGURE 14: TRANSITION-RELATED ENTITY LANDSCAPE ANALYSIS: SUMMARY ELEMENTS

PRIORITY GROUPS AND ELIGIBILITY REQUIREMENTS OF EACH ENTITY	ALLOWABLE TIME FRAMES FOR PROGRAM ASSESSMENT AND ENROLLMENT	SYSTEMIC TRAINING RECEIVED ON TRANSITION PRACTICES BY EACH ENTITY	FUNDING ALLOCATED FOR TRANSITION SPECIFIC ACTIVITIES, INCLUDING FUNDING SOURCES	TYPICAL METHOD USED BY ENTITY FOR ENSURING ESSENTIAL SERVICES ARE IDENTIFIED AND ESTABLISHED DAY ONE OF TRANSITION INTO A COMMUNITY SETTING	THE SELF-IDENTIFIED STRENGTHS OF EACH PROGRAM, THAT SUPPORTS THE DHHS' BROADER OBJECTIVES
Area Agencies on Aging – Local Contact Agencies					
Older adults and adults with disabilities regardless of source of income or insurance type. LCA functions are prioritized for referrals received through the MDS call center.	Most LCA referrals are followed up with a bedside visit to the referring nursing facility resident within seven days of the date of referral.	Transition best practices, community resources, person-centered planning and Medicaid eligibility.	AAA functions funded through a combination of Federal, State and Local funds as well as contracts with third parties including MFP. LCA functions funded specifically with MFP administrative funding.	N/A – outside current function's scope.	Well-qualified workforce of staff that is knowledgeable about community resources. Other strengths noted by the network include organizational experience working with older adults and people with disabilities and a person-centered approach to working with people.

PRIORITY GROUPS AND ELIGIBILITY REQUIREMENTS OF EACH ENTITY	ALLOWABLE TIME FRAMES FOR PROGRAM ASSESSMENT AND ENROLLMENT	SYSTEMIC TRAINING RECEIVED ON TRANSITION PRACTICES BY EACH ENTITY	FUNDING ALLOCATED FOR TRANSITION SPECIFIC ACTIVITIES, INCLUDING FUNDING SOURCES	TYPICAL METHOD USED BY ENTITY FOR ENSURING ESSENTIAL SERVICES ARE IDENTIFIED AND ESTABLISHED DAY ONE OF TRANSITION INTO A COMMUNITY SETTING	THE SELF-IDENTIFIED STRENGTHS OF EACH PROGRAM, THAT SUPPORTS THE DHHS' BROADER OBJECTIVES
Nursing Facilities					
Across payers and/or Medicaid eligible individuals who meet a NF LOC across age groups and disability types.	N/A	No formal requirements outside regulatory compliance on discharge practice, but there are on-going outreach and education made to nursing facilities on the LCA role and the MFP program. More formal training opportunities are offered on an on-going basis.	Short-term rehabilitation services may be funded under Medicare or Medicaid. Long-range custodial care covered by Medicaid only. Benefits through the Veteran's Administration, commercial and private LTC policies may also apply. Residents may also pay out of pocket.	N/A – are required to ensure residents safely transition from one care setting to another.	Experienced and knowledgeable staff.

PRIORITY GROUPS AND ELIGIBILITY REQUIREMENTS OF EACH ENTITY	ALLOWABLE TIME FRAMES FOR PROGRAM ASSESSMENT AND ENROLLMENT	SYSTEMIC TRAINING RECEIVED ON TRANSITION PRACTICES BY EACH ENTITY	FUNDING ALLOCATED FOR TRANSITION SPECIFIC ACTIVITIES, INCLUDING FUNDING SOURCES	TYPICAL METHOD USED BY ENTITY FOR ENSURING ESSENTIAL SERVICES ARE IDENTIFIED AND ESTABLISHED DAY ONE OF TRANSITION INTO A COMMUNITY SETTING	THE SELF-IDENTIFIED STRENGTHS OF EACH PROGRAM, THAT SUPPORTS THE DHHS' BROADER OBJECTIVES
Hospitals					
Individuals of any age, across population groups who require hospitals services across payers.	N/A	Training provided on Coleman Method of Care Transitions in those hospitals who utilize.	Commercial insurance, Medicare, Medicaid, VA, private pay or indigent care resources may also cover.	N/A – are required to ensure patients safely transition from one care setting to another.	Discharge planning requirements prescribed, per the North Carolina DMA Clinical Coverage Policy, 2A-1. Some hospitals use the Coleman Method of Care Transitions.
Community Alternatives Program for Disabled Adults Lead Agencies					
Must be Medicaid eligible. Older adults and people with disabilities over the age of 18 who meet income, NF LOC and other waiver requirements including having their needs safely met in a community setting. Priority waiver slots available for MFP participants.	Eligibility determination should be made within 60 days from date of that an individual is referred to the program.	MFP practices, person-centered practices, Medicaid eligibility and community resources.	CAP/DA Lead Agency organizations may receive Medicaid, State and Local funds, third party contracts (including MFP). CAP/DA-specific services are Medicaid funded.	Verbal confirmation from the individual, family or provider.	Person-centered approach, knowledge of community resources, and organizational experience with providing transition services, knowledgeable and qualified staff and ability to complete transitions quickly.

PRIORITY GROUPS AND ELIGIBILITY REQUIREMENTS OF EACH ENTITY	ALLOWABLE TIME FRAMES FOR PROGRAM ASSESSMENT AND ENROLLMENT	SYSTEMIC TRAINING RECEIVED ON TRANSITION PRACTICES BY EACH ENTITY	FUNDING ALLOCATED FOR TRANSITION SPECIFIC ACTIVITIES, INCLUDING FUNDING SOURCES	TYPICAL METHOD USED BY ENTITY FOR ENSURING ESSENTIAL SERVICES ARE IDENTIFIED AND ESTABLISHED DAY ONE OF TRANSITION INTO A COMMUNITY SETTING	THE SELF-IDENTIFIED STRENGTHS OF EACH PROGRAM, THAT SUPPORTS THE DHHS' BROADER OBJECTIVES
Program of All-Inclusive Care for the Elderly					
55 years of age or older who meet NF LOC requirements, live in a PACE service area, and can have their needs met safely in a community setting. Enrolled on Medicare, Medicaid or able to pay privately.	No prescribed timeframe.	Transition best practices, North Carolina MFP overview, community resources, Medicaid eligibility.	Medicaid, Medicare, dually Medicare/ Medicaid eligible or private pay.	Reliance on transition coordination/PACE staff to validate.	Person-centered approach.
Division of Vocational Rehabilitation – Independent Living Program					
People with disabilities of all ages, who can make their own decisions and participate in the development of an individual Independent Living Plan. Some programs, including Personal Assistance Services, have income limits.	Variability in survey responses from within seven days of referral to within 60 days of referral.	Transition best practices, independent living philosophy and MFP overview.	Most of DVR-IL's funding comes from a State appropriation; however, they receive some federal funds as well as funding from MFP for their role as a transition coordinator.	Verbal confirmation with the individual, family or case management entity.	Organizational experience working with people with disabilities, person-centered approach, knowledgeable and experienced staff and knowledge of community resources.

PRIORITY GROUPS AND ELIGIBILITY REQUIREMENTS OF EACH ENTITY	ALLOWABLE TIME FRAMES FOR PROGRAM ASSESSMENT AND ENROLLMENT	SYSTEMIC TRAINING RECEIVED ON TRANSITION PRACTICES BY EACH ENTITY	FUNDING ALLOCATED FOR TRANSITION SPECIFIC ACTIVITIES, INCLUDING FUNDING SOURCES	TYPICAL METHOD USED BY ENTITY FOR ENSURING ESSENTIAL SERVICES ARE IDENTIFIED AND ESTABLISHED DAY ONE OF TRANSITION INTO A COMMUNITY SETTING	THE SELF-IDENTIFIED STRENGTHS OF EACH PROGRAM, THAT SUPPORTS THE DHHS' BROADER OBJECTIVES
Centers for Independent Living					
Individuals with a wide range of disabilities regardless of their income source or amount.	Variability in survey responses. Half of the CIL survey respondents indicate they do have timeliness requirements (within seven days from referral) related to eligibility determinations.	Transition practices, independent living philosophy and community resources.	Although funded primarily through federal dollars CILs do receive funding from other sources including local funding, revenue generated through third party contracts, fund raising and grants.	Verbal confirmation from individuals, families, providers or case managers.	Ability to respond to individual situations quickly and flexibly. Experience working with people with disabilities, person-centered approach along with knowledgeable and experienced staff.
Adult Care Homes					
Older adults and people with disabilities who require assistance with daily living activities and may require up to 24 hour per day supervision regardless of income source or amount.	Admissions for eligible individuals may occur within 1–2 days. Medicaid eligibility may be determined after entry to nursing facility.	Not reviewed	Special Assistance Program, VA and private pay. Majority of ACHs provide Medicaid-funded PCS to eligible residents.	N/A	Large statewide network. Provides supervision and housing resource to vulnerable populations.

PRIORITY GROUPS AND ELIGIBILITY REQUIREMENTS OF EACH ENTITY	ALLOWABLE TIME FRAMES FOR PROGRAM ASSESSMENT AND ENROLLMENT	SYSTEMIC TRAINING RECEIVED ON TRANSITION PRACTICES BY EACH ENTITY	FUNDING ALLOCATED FOR TRANSITION SPECIFIC ACTIVITIES, INCLUDING FUNDING SOURCES	TYPICAL METHOD USED BY ENTITY FOR ENSURING ESSENTIAL SERVICES ARE IDENTIFIED AND ESTABLISHED DAY ONE OF TRANSITION INTO A COMMUNITY SETTING	THE SELF-IDENTIFIED STRENGTHS OF EACH PROGRAM, THAT SUPPORTS THE DHHS' BROADER OBJECTIVES
Local Management Entity – Managed Care Organization					
Must be Medicaid eligible for MCO/ Medicaid-affiliated services.

Individuals who meet specified mental illness criteria in or at risk of admission to ACH or State Psychiatric Hospitals through the TCLI program and individuals with I/DD who reside in private ICFs/IID or public developmental centers. | Half of the LME-MCOs indicate they have timeliness requirements for the completion of assessments with those who responded all indicating assessment must be completed within seven days from the date of the referral. | Transition best practices, Medicaid eligibility, TCLI-specific trainings, MFP overview and person-centered planning. | LME functions funded through State appropriations or federal grant funding. MCO functions are funded through Medicaid per member per month (PMPM). LME-MCOs may also secure additional private grant funding or local resources. | Verbal confirmation from individual, family or provider. | Organizational experience serving people with disabilities specialized training for transitioning individuals and caregivers, person-centered approach and knowledge of community resources. The ability to access PCS in an expedited manner along with access to tenancy support services through B 3 waiver. |

PRIORITY GROUPS AND ELIGIBILITY REQUIREMENTS OF EACH ENTITY	ALLOWABLE TIME FRAMES FOR PROGRAM ASSESSMENT AND ENROLLMENT	SYSTEMIC TRAINING RECEIVED ON TRANSITION PRACTICES BY EACH ENTITY	FUNDING ALLOCATED FOR TRANSITION SPECIFIC ACTIVITIES, INCLUDING FUNDING SOURCES	TYPICAL METHOD USED BY ENTITY FOR ENSURING ESSENTIAL SERVICES ARE IDENTIFIED AND ESTABLISHED DAY ONE OF TRANSITION INTO A COMMUNITY SETTING	THE SELF-IDENTIFIED STRENGTHS OF EACH PROGRAM, THAT SUPPORTS THE DHHS' BROADER OBJECTIVES
Community Care of North Carolina					
Covers most Medicaid eligibility categories, including individuals who are in the Medicaid ABD category of eligibility. Expanded to additional populations, such as high risk/high cost individuals and those dually-eligible (Medicaid/Medicare). Does not enroll nursing facility beneficiaries.	N/A	Not reviewed.	Not fully reviewed. CCNC networks and affiliated providers receive Medicaid PMPM for enrolled Medicaid beneficiaries.	Not Reviewed.	CCNC as a whole researched and validated as an effective approach.

FIGURE 15: TRANSITION CHALLENGES

CHALLENGES IDENTIFIED BY SURVEYED ENTITIES OR OTHER STAKEHOLDERS	STAKEHOLDER FEEDBACK	LCA	NURSING FACILITY	HOSPITAL	CAP/DA LEAD AGENCY	PACE PROGRAM	DVR-IL	CILS	ACH	MCO
Inadequate understanding of HCBS options, including MFP, due to insufficient outreach and facility staff turnover.	★	★			★					
Facility staff inability to see person's community living potential.	★	★								
Lack of interest among some facilities to refer to options counseling resources (MDS).		★								
Limited HCBS options for an individual with limited family/natural support (includes absent, unable, unwilling or unreliable).		★	★		★	★				
The individual has no income.										
Medicaid deductible renders community living untenable.			★		★					
Unable to receive waiver services (because of income or support needs).			★							
Lack of affordable and accessible community-based housing (includes assisted living and private living arrangements).	★		★	★	★	★	★			
Lack of community support resources (such as Meals on Wheels, transportation).			★	★		★				
Shortage of direct support workforce.	★				★					
Difficulty in coordination with waiver services (eligibility delay, variance in policy interpretation and interest in transition activity).	★						★			
Community-based resources do not adequately address medical or behavioral complexities.	★						★			★
The administrative burden of securing needed resources.	★						★			

CHALLENGES IDENTIFIED BY SURVEYED ENTITIES OR OTHER STAKEHOLDERS	STAKEHOLDER FEEDBACK	LCA	NURSING FACILITY	HOSPITAL	CAP/DA LEAD AGENCY	PACE PROGRAM	DVR-IL	CILS	ACH	MCO
Insufficient transition coordination staff to provide services.	★							★		
Inadequately prepared transition coordinators.	★								★	
Services not effectively in place at the time of transition.	★								★	
Lack of waiver slots.	★									★

4
TRANSITION-RELATED FUNCTIONS AND PROCESSES

This section outlines North Carolina's standards for transition-related activities and provides observations about how these standards are being experienced in actual activities.

During the development of the report, Mercer reviewed several documents and interviewed numerous organizations to better understand the transition-related functions and processes and how "on the ground activities" compared with North Carolina's aspirational standards. The review included contracts, job descriptions and service definitions that were provided by transition-related organizations.

FULLY DECIDING: THE IN-REACH FUNCTION IN NORTH CAROLINA

Aspirational Standard

Ensuring individuals in facility settings have the information needed to make a fully informed decision about where to receive services.

What This Standard Requires:

- In-reach activities are responsive to requests and proactively provide information about community-based options to facility residents.
- In-reach specialists are well informed on Medicaid and State-sponsored programs that may be available to assist the resident in making an informed decision.
- In-reach specialists have clear communication and strong working relationships with nursing facility discharge planners, program eligibility/enrollment staffers and others who may assist a person in accessing HCBS.

FIGURE 16: IN-REACH ANALYSIS

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
LCA-Options Counseling (Managed by Area Agencies on Aging)	• Provides clearly defined statewide in-reach function, but only applies to MDS referrals. • Is not consistently available to all nursing facility residents. • Is not available to ACH residents. • Within LCA (AAA), there is variability around types of staff (from clerical to professional level) who perform LCA activities.
MFP Transition Coordinator	• Transition coordinators required to partner with identified LCA to participate in in-reach and outreach activities, however level of engagement by individual transition coordinators is inconsistent across the State. • Identified transition coordinators contractors housed within two LCA organizations to test streamlining referral process.
Nursing Facilities	• Require referral to LCA as indicated by Section Q MDS. • Section Q not consistently completed across all nursing facilities. • Great variability across the State in number of LCA referrals/referral rate.
Hospitals	• No formalized statewide process for making referrals for options counseling.
ACH	• No requirement for ACHs to inform non-TCLI residents of individualized housing/support options. ACHs that are attached to a nursing facility may move individuals from the nursing facility into ACH if a bed is available. • There is certain fluidity among these types of facilities where people may go back and forth depending on their need and the facilities bed capacity.
CAP/DA	• Individual Lead Agencies may identify potential CAP/DA beneficiaries in facility settings, but practice is not statewide. • May work with local LCA partner.
DVR-IL (Non-MFP)	• While regional IL staff may perform some in-reach activities, it is not a prescribed role nor is it a statewide practice.
CILs	• Some CILs perform in-reach to individuals residing in facilities (nursing facility, psychiatric hospital, ACH, shelter, etc.). • This practice is not consistent across all CILs. • CIL network is not statewide.

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
LME-MCOs	• In-reach activities for aging and disability populations not typically initiated by LME-MCOs. However, LME-MCOs will partner on transitions if a person experiences a mental health support need or a traumatic brain injury (TBI). • Transition-related expectations for LME-MCOs exist for I/DD and seriously and persistently mentally ill (SPMI) populations, but were not examined in detail. • Anecdotal observations are included in "Additional Observations" in larger Sustainability Report.
CCNC	• No prescribed role in this area.

EFFECTIVELY PREPARING: TRANSITION COORDINATION AND PLANNING IN NORTH CAROLINA

Aspirational Standard

Developing a comprehensive and effective transition planning process that ensures community-based support needs are identified and effectively addressed through transition planning.

What This Standard Requires

Holistic Planning

Transition teams assess and consider the community-based support needs and preferences from a holistic perspective. Transition teams also work with the transitioning individual to identify and ameliorate anticipated challenges related to the person's history or circumstance that may negatively impact the person's community experience.

Planning elements include, but may not be limited to:

- Identifying and engaging family and other informal support relationships.
- Identifying community relationships and opportunities.
- Mitigating risk.
- Arranging/securing housing and tenancy support (as needed), including needed utilities, furniture and housewares.
- Arranging/securing necessary personal aide services.
- Arranging/securing supplies, durable medical equipment (DME), home modifications.
- Arranging/securing clinical support needs related to primary and needed specialists; therapies; chronic condition management; behavioral health; pharmacology.
- Arranging/securing needed community-based benefits.
- Ensuring effective transfer of benefits.
- Arranging/securing community support needs related to:
  - Transportation.
  - Financial management.

– Community engagement.

Effective Collaboration and Communication
• Transition teams coordinate effectively to minimize unnecessary delays, to most effectively leverage limited resources and to facilitate the best possible transition outcome for the beneficiaries.

Pre-Transition Capacity Building
• Transition teams create opportunities for individuals to:
    – Meet and train their anticipated community-based support staff.
    – Prepare for the transition through homestays or skill building.

FIGURE 17: EFFECTIVELY PREPARING

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
LCA (Managed by Area Agencies on Aging)	• No prescribed role in this area. • In two contracted agencies that also perform MFP transition coordination the same staff person may perform both functions and participate in these activities.
MFP Transition Coordinator	• Transition planning requirements established for all, but actual planning process varies. • Challenge with transition coordinator role when transition coordination provider is not also CAP/DA agency. Given dependency on waiver enrollment, transition coordinator effectiveness can be limited. • AAA participation as contracted transition coordination provider has been limited in one region due to a lack of referrals. • CAP/DA agencies that provide MFP transition coordination appear to have merged the role of transition coordinator and waiver case manager into one role intended to provide a seamless array of services from prior to discharge from facility to community move, waiver enrollment and monitoring of wavier services. Only two agencies are currently providing this model of integration. Although experience has been good, the unique nature of the agencies raises questions about the State's ability to replicate this model statewide. • The integrated waiver case manager/MFP transition coordinator role has similar duties to the MFP transition coordinator, but is broader in scope providing, for example, streamlining waiver assessment timelines.

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
Nursing Facilities	• Discharge planning prescribed per policy, but specific activities not prescribed; however, role of nursing facility social worker in discharge planning varies from facility to facility. • Some nursing facility social workers heavily involved with team and transition planning while others defer work to transition coordinator. • Frequent turnover in nursing facilities often results in inexperienced social workers who are unaware of MFP, community care options or community resources.
Hospitals	• Applicable State Medicaid Clinical Coverage policy defines hospital discharge planning responsibilities. • Coleman Method of Care Transitions endorsed by North Carolina Hospital Association: – While some hospitals utilize this method of transition planning, the rate of adoption among hospitals is unknown. Also, the Coleman method may not appropriate for all individuals.
ACH	• Individual facilities may initiate person-specific transitions, based on person's interest in transition, but practice is person and facility dependent.
CAP/DA	• Transition planning for short-term stays appears comprehensive and is outlined in waiver as well as CAP/DA policy, however transition and level of transition activity practice varies among counties.
DVR-IL (Non-MFP)	• Emphasis of DVR-IL counselor is on assessing and planning for DVR-sponsored activities and services. While DVR-IL counselors may assist in transitions and will sometimes initiate non-MFP transitions, the practice varies by region. • No prescribed transition practice process outside of MFP role. • DVR-IL currently serves as a backup for eligible individuals who are not eligible for MFP and who desire to transition.
CILs	• CIL transition activities seem to vary among CILs. Some CILs seem to provide robust transition-related services, which seem to be duplicative of MFP and DVR-IL efforts while other CILs focus transition-related services for non-MFP target population. • Contractual expectations from DVR are limited in scope.
LME-MCOs	• Transition-related expectations for LME-MCOs exist for I/DD and SPMI populations, but were not examined in detail. Recommendations for I/DD and TCLI-related transitions are outside the scope of this analysis. Anecdotal observations are included in "Additional Observations" in larger Sustainability Report.

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
CCNC	• Participation in interdisciplinary team discharge planning activities as well as providing linkage and referral assistance to both medical and non-medical services. • Target population for transition activities limited to hospitalized adults in ABD category of Medicaid eligibility, duals or other "high-risk" groups.

COMFORTABLY TRANSITIONING: TRANSITION COORDINATION AT THE TIME OF TRANSITION

Aspirational Standard

Working to "pay attention to the details" at the time of transition, ensuring inevitable loose ends and unexpected issues are promptly addressed.

What This Standard Requires

• Assessment and enrollment processes ensure essential services are in place on the day of transition.
• Transition coordination practices mitigate the risk of gaps in benefits, income and medication that may arise during the transition.

FIGURE 18: TRANSITION COORDINATION AT TIME OF TRANSITION

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
LCA (Managed by Area Agencies on Aging)	• No prescribed role in this area. • In two contracted agencies that also perform MFP transition coordinator, the same staff person may perform both functions and participate in these activities.
MFP Transition Coordinator	• Increased emphasis on these activities over the life of MFP. • Prescribed processes for MFP transition coordinators. The practice seems to align with expectations with no regional or provider specific differences noted.
Nursing Facilities	• Post discharge check-in calls may occur depending on the nursing facility. Per 42 CFR 1396r (c) (2) (C) "A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."
Hospitals	• No prescribed role in this area. • State reports on State and hospital sponsored learning initiatives to improve care transitions. • State reports that hospitals may utilize Coleman Method of Care Transitions model.

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
ACH	• ACHs do not typically initiate this type of assistance but will assist in externally initiated transition activities.
CAP/DA	• Waiver and clinical policy have prescribed processes for follow up and monitoring. • Focus is on ensuring immediate health and safety concerns are addressed and that services are initiated; however, practice varies. • Follow up requirements may result in a delay in incident reporting.
DVR-IL (Non-MFP)	• Emphasis of DVR-IL counselor is on assessing and planning for DVR-sponsored activities and services. While DVR-IL counselors may assist in transitions and will sometimes initiate non-MFP transitions, the practice varies by region.
CILs	• Practice varies depending on the CIL and most are not providing these types of supports.
LME-MCOs	• No stated requirements regarding a role in aging and disability transition that may also require TBI or mental health services. Transition-related expectations for LME-MCOs exist for I/DD and SPMI populations, but were not examined in detail. Recommendations for I/DD and TCLI-related transitions are outside the scope of this analysis. Anecdotal observations are included in "Additional Observations" in larger Sustainability Report.
CCNC	• Post-discharge activity includes home visit and additional follow up within specified timeframes post discharge from hospital.

EFFECTIVELY FOLLOWING ALONG: TRANSITION COORDINATION AFTER THE TRANSITION

Aspirational Standard

Transition coordinators and teams develop a flexible "follow along" practice that closely tracks the participant's post-transition experience.

What This Standard Requires

Follow up practices are timely, coordinated and sufficient to promptly identify and address emerging issues and are tightly coordinated if multiple agencies are involved.

FIGURE 19: FOLLOW ALONG PRACTICES AFTER THE TRANSITION

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
LCA (Managed by Area Agencies on Aging)	• No prescribed role in this area.
MFP Transition Coordinator	• MFP transition coordination requirements have evolved over time and now include one year of follow along post discharge for individuals who meet "High Engagement Criteria". • All other MFP participants receive 90 days of follow along that includes telephonic and in-person monitoring.
Nursing Facilities	• Per 42 CFR 1396r (c)(2)(C) "A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."
Hospitals	• Section 1311(h) of the Affordable Care Act requires Qualified Health Plans (QHP) to contract with certain hospitals that use patient safety evaluation systems and implement comprehensive hospital discharge programs; and requires QHPs to contract with health care providers who implement health care quality improvement mechanisms.
ACH	• No prescribed role in this area.
CAP/DA	• CAP/DA has a robust description of required follow along requirements although practice varies from county to county. • Follow along occurs as long as the individual is enrolled on waiver.
DVR-IL (Non-MFP)	• No prescribed role in this area.
CILs	• No prescribed role in this area.
LME-MCOs	• Transition-related expectations for LME-MCOs exist for I/DD and SPMI populations, but were not examined in detail. Recommendations for I/DD and TCLI-related transitions are outside the scope of this analysis. Anecdotal observations are included in "Additional Observations" in larger Sustainability Report.
CCNC	• No prescribed role in this area.

SUPPORTING PEOPLE TO THRIVE: THE ROLE OF TRANSITION COORDINATION IN FACILITATING MEANINGFUL COMMUNITY LIFE OUTCOMES

Aspirational Standard

Working to build transition practices that facilitate long-range quality outcomes in a person's life, such as improved health, improved community network and improved sense of contribution.

What This Standard Requires

• Transitions that promote access to employment, community engagement and improved health outcomes.

FIGURE 20: SUPPORTING PEOPLE TO THRIVE

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
LCA (Managed by Area Agencies on Aging)	• No prescribed role in this area.
MFP Transition Coordinator	• Transition coordinators tend to focus on priority needs related to the transition, including securing equipment, clinical care and reliable transportation. • Transition coordinators do not consistently link participants to social, vocational or educational resources.
Nursing Facilities	• No prescribed role in this area.
Hospitals	• No prescribed role in this area.
ACH	• No prescribed role in this area.
CAP/DA	• Clinical policy sets forth expectations that case manager provides referral and related activities to "link a beneficiary with medical, behavioral, social, and other programs, services and supports to address identified needs and achieve goals specified in the care plan." • No consistent practice linking individuals to employment supports and other community engagement opportunities.
DVR-IL (Non-MFP)	• May provide linkage and referral to employment and community activities post discharge. • Actual practice varies by region.
CILs	• Promoting employment and community engagement is a core CIL activity. • Actual practice varies from CIL to CIL. • CIL network not statewide.

ROLE/ORGANIZATION	OBSERVATIONS ABOUT FUNCTION AS IMPLEMENTED
LME-MCOs	• Contract focuses on these activities for target transition populations within LME-MCO contract. • Recommendations for I/DD and TCLI-related transitions are outside the scope of this analysis. Anecdotal observations are included in "Additional Observations" in larger Sustainability Report.
CCNC	• No prescribed role in this area.

Sources: Nursing Facility Clinical Policy, North Carolina Administrative Code Rules, North Carolina Guidance to Surveyors for Long-Term Care Facilities, Acute Inpatient Clinical Policy, Coleman Model of Care Transitions, Eastern Carolina Council of Governments Position Description for Local Contact Agency Options Counselor, DAAS contract with AAA includes LCA functions, SW Area Agency on Aging Assistant Position Description (follow up call with AAA Director), CCOG AAA Aging Specialist with LCA duties position description, RN Care Coordinator Job Description-Cape Fear, CAP/DA Clinical Policy Transitions and Care Coordinator Job Description 11-1-16 Cape Fear, Eastern Carolina Council of Governments Transition Coordination Position Descriptions, Senior Services CAP/DA Transition Coordinator Position Description, Transition Coordinators Contract with CAP/DA lead agency (Cape Fear Valley Contract), Transition Coordinator Intra-Departmental Memorandum of Agreement (IMOA) with DVR-IL, Transition Coordinators Contract with AAA example, SW Area Agency on Aging-Aging Program Coordinator (includes TC activities) Position Description, Follow up Call with AAA Director ,DVR-IL Independent Living Counselors position description, Nursing Home Transitions Coordinator Position Description Disability Rights and Resources-Additional detail obtained through follow up phone call Director, DVR Contract Language with CIL's, BH LME-MCO Contract , CCNC Website, feedback Obtained Through Transition-Related Services Survey, Personal Interviews with State Staff and Community Partners, Sustainability Plan Advisory Committee and MFP Roundtable.

5
RECOMMENDATIONS

The following recommendations, unless otherwise indicated, are applicable to MFP target populations including individuals who are dually eligible and are applicable statewide. In addition to supporting short, mid and long ranges activities, Mercer recognizes that these recommendations can also support and advance the State's broader Olmstead strategy. Figure 21 is based on the program's MFP Defining Improvement table that was included in the State's New Initiative Memorandum. This table can be found in Appendix H.

FIGURE 21: MFP SUSTAINABILITY ANALYSIS: RECOMMENDATIONS FOR IMPROVEMENT

FUNCTION	IMPROVING QUALITY OF PROCESS	IMPROVING QUALITY OUTCOMES	IMPROVING TIMELINESS/ OPPORTUNITIES FOR STREAMLINING
In-Reach	• Amend MDS data use agreement (DUA) to access Section Q data. • Based on analysis of MDS data make referrals to LCA for in-person in-reach activity. • Reinforce existing contractual requirements in LCA contracts that require LCA staff to help with the completion of MFP application while in-person with nursing facility resident and then submitting directly to the State.	• Develop a comprehensive marketing strategy for MFP program or future transition program. • Hire a dedicated marketing/outreach contractor. • Develop or re-deploy transition-related marketing materials including, but not limited to video, posters, etc. • Post transition resources posters alongside LTC Ombudsman Posters within facilities. • Post a recorded webinar regarding MFP and HCBS options on MFP website for nursing home social workers. • Work with TBI partners to develop targeted training for hospitals and nursing	• Examine communication protocol between resident, transition team and Department of Social Services (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.

FUNCTION	IMPROVING QUALITY OF PROCESS	IMPROVING QUALITY OUTCOMES	IMPROVING TIMELINESS/ OPPORTUNITIES FOR STREAMLINING
		facilities regarding services/programs for individuals with a brain injury.	
Rationale for In-Reach Recommend-ations	• Currently, the MFP program relies primarily on referrals directly from nursing facilities. The most significant participation occurred in 2017 when approximately 40% of the facilities made at least one referral with some nursing facilities making no referrals to the program. Recently MFP has piloted a process using claims data to identify potential MFP candidates and sending lists to LCA's for follow up. Using MDS data has proven to be a much more effective way of identifying potential candidates. [xli] The State would need to amend its MDS DUA to obtain permission to use the data in this way. Once the DUA is approved, the State would need to develop coding to pull relevant data from MDS and develop a process for sending referrals to the LCA. • Stakeholders indicate that sometimes the	• There is a general lack of awareness by nursing facilities and the community at large regarding the MFP program. Taking a multi-pronged approach to marketing results in the program being less reliant on nursing facilities making referrals to the program.[xlii] • High social worker turnover rates in nursing homes requires an almost constant need to provide education about MFP, HCBS resources and specialized community programs such as those for individuals with brain injuries. Providing on-line recorded webinar presentations reduces the burden of developing and planning in-person or live trainings and allows nursing facility staff to view training at their convenience.	• Feedback from stakeholders indicates challenges occur when Medicaid eligibility determinations are completed late in the transition process. Expectations for transition have been set and sometimes housing has been secured only to be canceled if the individual is determined ineligible for Medicaid. Eligibility determinations early in the process established the necessary framework for transitions. Additionally, expedited Medicaid determinations help support diversion activities. [xliii] • Expedited Medicaid financial as well as HCBS determinations often result in enrollment in community-based LTSS rather than nursing facility admissions. It has been demonstrated that early use of community-based services has a significant impact on avoiding and shortening institutional stays.[xliv]

FUNCTION	IMPROVING QUALITY OF PROCESS	IMPROVING QUALITY OUTCOMES	IMPROVING TIMELINESS/ OPPORTUNITIES FOR STREAMLINING
	length of it time it takes for nursing facility residents to engage with MFP program is a barrier to participation. In some cases, individuals move before they make it through the process. MFP will increase emphasis on LCA completing the MFP application with the individual during the in-person in-reach visit which will help expedite the process.		
Transition Coordination Function	• Develop readiness assessment to be used by transition coordinators that includes an assessment of psychosocial impacts of transition. • Include SUD screening in readiness assessment. • Develop and implement a family readiness assessment to help educate families about their caregiving role. • Increase visibility of incident management by expanding data access to ED use and hospitalizations.	• Increase the number of transition coordinators. Using TCLI program data as a proxy there should be at least 100 transition coordinators available statewide for MFP's aging and disability populations.[xlv] Hiring and contracting processes should be reviewed and modified as necessary. From January 2014 to June of 2017, LME-MCO annual reports indicate they have transitioned over 4,200 people from these settings to the community with the resources they have in place. • Jointly staff critical incidents. Currently, incident management staffing meetings are conducted by MFP program staff and DVR-IL	

FUNCTION	IMPROVING QUALITY OF PROCESS	IMPROVING QUALITY OUTCOMES	IMPROVING TIMELINESS/ OPPORTUNITIES FOR STREAMLINING
		separately but in a similar manner. However, it is unclear if the follow-up is consistent between the partners. Staffing incidents together could help provide a more consistent and effective approach to incident management. • Consider providing access to e-CAP for all transition coordinators for progress input and access to incident information. • Include incident management training in a Lunch and Learn session and in Community Transitions Institute curriculum or leverage existing CAP/DA training to include additional training on incident management.	
		• Add claims level data to the e-CAP system or at least add functionality to connect ED and hospital utilization to the incident management system.	
Rationale for Transition Coordination Recommend - ations	• Quality of life survey findings and feedback from stakeholders indicate challenges both pre and post-transition related to: – Isolation and loneliness – SUD issues	• The number of transitions is proportional to the emphasis that is placed on the effort. In reviewing contracting vehicles and information associated with the provision of transition coordination, less than 50% of the MFP funding is allocated for this purpose. Having enough transition coordinators is critical to meeting the	

FUNCTION	IMPROVING QUALITY OF PROCESS	IMPROVING QUALITY OUTCOMES	IMPROVING TIMELINESS/ OPPORTUNITIES FOR STREAMLINING
	– Families being ill prepared for caregiving duties. • By identifying these issues early in the transition planning process linkage and referral to community resources to help address these issues as well as frank discussions establishing realistic expectations can occur prior to discharge. • Additionally, information from readiness assessments can help the MFP program prioritize referrals as the program continues to grow. • While the CCNC and MFP Quality Transitions Partnership work will yield important information about how ED and hospitalizations can be identified through follow-along practice, it is predominantly targeted toward prevention of incidents and understanding risks. All transition coordinators need to be able to access information in a timelier manner to better document and respond to ED visits and	demands of the recommended increases in marketing and outreach. • Additionally, adding more transition coordinators is central to implementing other recommendations, which require more person-centered, person-specific engagement than is currently happening. • Incident management is not only critical to the well-being of transitioning individuals, the OIG and other parties within DHHS are starting to focus on the issue as a result of high profile state reviews that have identified failures of the incident management system for individuals with intellectual disabilities.[xlvii] [xlviii] Staffing incidents together could further best practice activities like management and investigation, auditing and monitoring, mortality review and quality assurance.[xlix] • Currently MFP program staff is able to pull incident reports from the e-CAP system and receive claims data to cross-reference reported incidents with ED and hospital admissions, however, transition coordinators have to go through the MFP program office in order to access	

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FUNCTION	IMPROVING QUALITY OF PROCESS	IMPROVING QUALITY OUTCOMES	IMPROVING TIMELINESS/ OPPORTUNITIES FOR STREAMLINING
	hospitalizations as critical incidents experienced by transitioners. The Federal Department of Health and Human Services (DHHS), Office of Inspector General (OIG) have reviewed incident management practices and found that nationally, incident reports associated with ED use were not being reported and managed properly by remediating the risk and providing follow along services.[xlvi]	this information. Additionally, they must report incidents to the MFP office and not via e-CAP for the reporting incidents. Follow up actions by CAP/DA agencies are not known to transition coordinators. • Nationally, programs are discovering that current incident management system are not adequately leveraging the available data as stated in the report jointly issued which recommends that states identified in the report should "provide access to Medicaid claims data" for the purpose of identifying incidents and follow-up.[l] • Training would ensure that staff and providers have a better understanding of incident management and investigation practices. [li]	
Case Management Function	• Review local CAP/DA agency specific policies that may act as a barrier to transitions. • Incident Management recommendations included in transition coordination also recommended for case management functions. • Confirm local understanding of required timelines related to the CAP/DA assessment and enrollment process.	• Consider contractual and Clinical Policy provisions to incent CAP/DA Lead Agency engagement in transition activity. • Address issues related to local variation in practices among CAP/DA Lead Agencies. • Separate transition coordination from case management functions, with each function having coordinated but delineated	

FUNCTION	IMPROVING QUALITY OF PROCESS	IMPROVING QUALITY OUTCOMES	IMPROVING TIMELINESS/ OPPORTUNITIES FOR STREAMLINING
	Ensure 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.).	roles and individual reimbursements. • Provide on-going training to CAP/DA agencies on philosophy of MFP and community living.	
Rationale for Case Management Recommendations	• During the research portion of the project stakeholders consistently indicated that CAP/DA agency specific policies, (e.g., differing home modifications processes), resulted in barriers for MFP participants. • A common theme in stakeholder feedback was the length of time it took to get a CAP/DA waiver determination. Clarifying expectations should help address this issue.	• Stakeholder feedback indicates that the degree of buy-in from CAP/DA agencies for the MFP program varies across the State. Strengthening contractual and clinical policy language will help address this. • Additional feedback from stakeholders indicates a wide variability in the implementation of waiver policies such as the ability to receive a home modification prior to nursing facility discharge. Recommended strategies to address include clarification and training on required practices, increased, in-person technical assistance (TA) and examination of oversight models (e.g., regionalization, contract agreements, etc.) that promote consistency among local practice. • A blended case management/transition coordination role often results in a diminished	

FUNCTION	IMPROVING QUALITY OF PROCESS	IMPROVING QUALITY OUTCOMES	IMPROVING TIMELINESS/ OPPORTUNITIES FOR STREAMLINING
		focus on transition activities. Transition coordination is a specific set of activities that is separate and distinct from case management. • As the HCBS, rules focus on community-based services and supports with an emphasis on person-centeredness, most CAP/DA agencies missions were not focused on supporting individuals living independently in the community. As a result, it has taken time to move from focusing on process-based outcomes associated with meeting the waiver requirements to focusing on QoL outcomes based on an individual person-centered plan.	
Access to Services		• Develop a legislative strategy to identify appropriations necessary to reduce and eventually eliminate waiting lists for CAP/DA and Innovations waivers. • 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. • Review cost neutrality calculations in CAP/DA	• 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.

FUNCTION	IMPROVING QUALITY OF PROCESS	IMPROVING QUALITY OUTCOMES	IMPROVING TIMELINESS/ OPPORTUNITIES FOR STREAMLINING
		waiver and evaluate the feasibility of increasing cost cap in order serve people with more complex needs. • Review durable medical equipment clinical policies; consider expanding coverage for items that help support people in the community rather than providing DME that may not be appropriate to the individual's needs.	
Rationale for Access to Services Recommend-ations		• Stakeholder feedback indicates that some MFP participants are unable to enroll in the waiver as their care needs cannot be met under the cost cap or alternate funding sources had to be patched together for needed services (covered under the waiver) because there was no room in the cost cap. Based on a review of cost neutrality calculations this methodology should be reviewed and updated as appropriate. Also, stakeholder feedback indicates that DME policy is inflexible and does not provide for the types of equipment that people need to help them stay healthy and safe in the community. Additionally, sometimes individuals receive equipment that is not needed and not used.	• Stakeholder feedback indicates that some MFP participants are unable to access certain services such as home modifications because the CAP/DA agency is responsible for paying the provider directly and sometimes does not have the funds to pay for the service, creating inequity in access to the service. • With the continued growth of the MFP program and TCLI transitions, set aside slots should be increased at the average annual growth rate of these programs.

FIGURE 22: LTSS SYSTEMIC RECOMMENDATIONS

	RECOMMENDATION	JUSTIFICATION
1.	Add Medicaid eligibility group available under 42 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. [lii]	North Carolina is a 1634 state with a medically needy program. Under today's criteria, individuals remain in nursing facilities due to an inability meet their deductible along while also covering their costs to live in the community. This is a nearly impossible feat for individuals without family or natural supports. This not only results in individuals being institutionalized unnecessarily, but also increases States' costs. Currently, 44 states allow people whose functional needs require an institutional LOC to qualify for Medicaid under the SIL. [liii]
2.	Manage all Medicaid State funding for LTSS under one budget line item.[liv]	Putting all Medicaid LTSS funding together into one line item gives DHHS flexibility to spend money in a way that keeps up with the demand for HCBS services, (e.g., do not have to go back and ask for additional funds once all waiver slots are allocated).
3.	Fully fund 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.	Currently Special Assistance for ACHs is fully funded; however, there is a waiting list for SA/IH. This appropriation logic reflects/perpetuates facility-based bias in public resources.
4.	Consider the development of a program to incent ACH to transition their business model to a more independent/less congregate model.	Almost 30,000 individuals reside in ACHs, many of which have the look and feel of a nursing home resulting in a lack of opportunities to fully integrate into the community. The State spends considerable resources on ACHs between Special Assistance Funding and State share of Medicaid PCS. Given the ability to receive PCS in your own home the State should explore whether some of the funding used to support ACH's could be reinvested into expanding independent housing options for ACH residents.
5.	Allow for individuals enrolled in CAP/DA waiver to receive SA/IH	The Innovations waiver currently allows individuals to be enrolled on the waiver and receive SA/IH resulting in a disparity across the LTSS system.
6.	Review financial eligibility process for all LTSS programs (see also 1. above).	Disparity between how financial eligibility is determined between PACE and the CAP/DA waiver results in inequity of access to community-based LTSS for individuals who are not eligible for PACE due to age restriction or who live in an area where PACE is not available. Differences across LTSS programs in criteria for Medicaid financial eligibility results in disparities in access to the full continuum of LTSS.

	RECOMMENDATION	JUSTIFICATION
7.	As part of the State's CON process consider including the availability of HCBS available, as part of the bed need determination process.	Individuals who are determined NF LOC eligible could be diverted to CAP/DA waiver slots and be served in a home- and community-based setting at a lower cost. "A major concern for policymakers is that CON laws for nursing homes can act as a barrier to increase home- and community-based care because both Medicare and Medicaid are promoting community-based LTC to transition patients out of nursing homes faster".[lv] A CON process that considers the availability of such services would be able to use this factor in determining future need for nursing home beds. This type of change would require a request by DHHS to the State Coordinating Council. Note that several states have a moratorium on the development and growth of nursing facility beds.[lvi] By way of example, Pennsylvania replaced the CON process with a participation review process that considers HCBS availability when approving nursing facility bed requests.[lvii]
8.	Address NCTracks defects that impact the ability for waiver claims payment. 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.	Defects with NCTracks effects timeliness of payment for waiver services making providers reluctant to continue to provide waiver services and potentially creating access issues for individuals enrolled on the waiver.
9.	Provide MFP Training to DSS eligibility workers.	Stakeholder feedback indicates that there is an inconsistent understanding of MFP requirements among local decision support system LTSS eligibility units as well as inconsistency in their level of response to inquiries from MFP transition coordinators and others affiliated with the transition process.
10.	Educate CAP/DA case managers on ability to be on Medicaid Buy-In for Workers with Disabilities (MBIWD) and CAP/DA waiver.	Feedback from stakeholders indicates that individuals enrolled on CAP/DA cannot be in the MBIWD category of Medicaid eligibility. This is not true and not consistent with the CAP/DA waiver. DHHS should consider putting together a "Myth Busters" educational document to address this and other misconceptions about CAP/DA program.
11.	Consider regionalization or other administrative mechanisms for creating more consistent practices among CAP/DA agencies.	Currently, there are 90 different CAP/DA agencies administering the waiver in all 100 of North Carolina's counties increasing the likelihood that there is variation in how the program is administered. Oversight of that many agencies is administratively burdensome and can be significantly improved by standardization and oversight requirements for these entities administering the waiver.

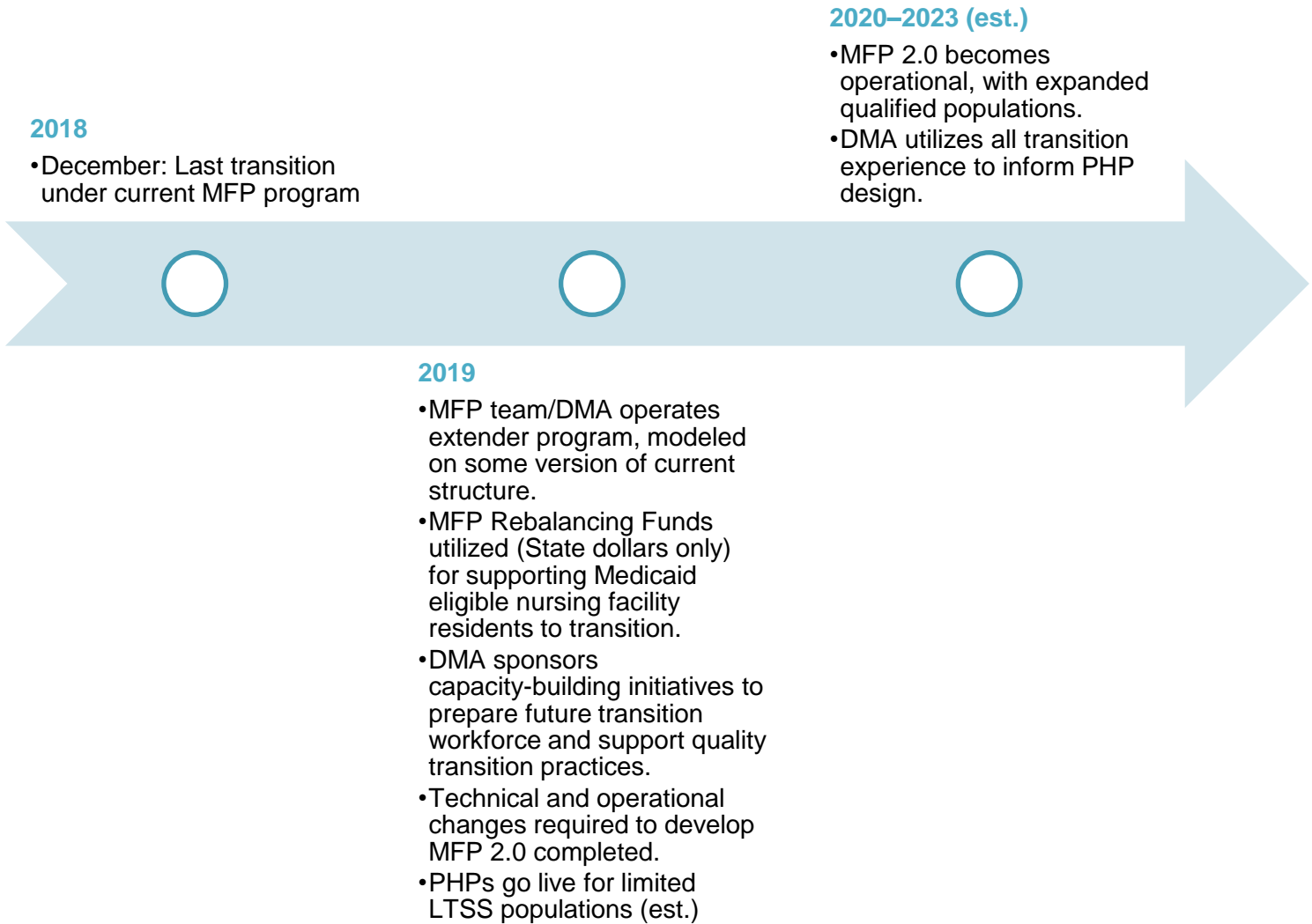|	RECOMMENDATION	JUSTIFICATION
12.	Continue efforts to expand the availability of affordable/accessible housing, in order to equalize access for all transitioning beneficiaries.	While the State has made great strides in this area, housing continues to be a barrier to transitions, particularly in certain "high rent" areas of the State. In addition, most priority slots in the Targeted Key program go to TCLI members (due to the DOJ settlement). Access to this program needs to be equalized across transition populations.
13.	Maintain MFP Roundtable as a stand-alone stakeholder group to advise the State on an array of LTSS issues.	The MFP Roundtable is comprised of a wide array of stakeholders whose on-going input and feedback is critical as the MFP program and the LTSS system evolves.

6
INTERIM TRANSITION PROGRAM

Operational since 2009, North Carolina's MFP program has established effective transition practices and partnerships that have laid the foundation for transition-related activities to be integrated into the State's Medicaid program. Demonstrating its value for people by increasing independence and choice, and to the North Carolina General Assembly by demonstrating that individuals can be served more cost effectively in the community, MFP is well situated to make a significant impact on the Medicaid program in the coming years as the State moves from a predominantly FFS model to a managed care model. Although, older adults, children and adults enrolled on the CAP/DA and CAP/C waivers along with nursing facility residents with lengths of stay over 90 days and individuals who are dually eligible (eligible for both Medicaid and Medicare) are the last to be enrolled into the State's managed care program, time is of the essence, with the MFP program in its current form ending at the end of 2020, DHHS needs to take steps now to integrate transition-related activities into the Medicaid FFS program and the emerging managed care program in order to ensure there is no disruption in access to transition-related activities. This section describes the recommended interim approach, cost effectiveness of the current program, possible factors that influence transition coordination rate development and additional considerations moving forward with interim MFP program, MFP 2.0. MFP 2.0 as described here begins in January of 2020 or once the necessary administrative, programmatic and technical requirements are completed. MFP 2.0 will provide an array of transition-related services to individuals of all ages across disability groups that promote independence and choice in where and how individuals receive their LTSS.

To maintain the current Program's momentum, Mercer assumes MFP will maintain the same or similar structure as it has now, funded with MFP Rebalancing Funds, until MFP 2.0 can be operational. DMA has secured approval from CMS to utilize Rebalancing Funds for this purpose. The timeline below provides key dates for the transition from the current MFP, federal grant-sponsored program, to DMA's interim, MFP 2.0 Program.

FIGURE 23: MFP TIMELINE

2020–2023 (est.)
- MFP 2.0 becomes operational, with expanded qualified populations.
- DMA utilizes all transition experience to inform PHP design.

2018
- December: Last transition under current MFP program

2019
- MFP team/DMA operates extender program, modeled on some version of current structure.
- MFP Rebalancing Funds utilized (State dollars only) for supporting Medicaid eligible nursing facility residents to transition.
- DMA sponsors capacity-building initiatives to prepare future transition workforce and support quality transition practices.
- Technical and operational changes required to develop MFP 2.0 completed.
- PHPs go live for limited LTSS populations (est.)

OVERVIEW OF INTERIM TRANSITION PROGRAM

An essential component of MFP 2.0 is a strong front door to the LTSS delivery system. Having a clearly defined "go to place" for individuals to receive non-biased information about LTSS options helps support individuals and families in making informed decisions. These activities would complement and not supplant the role planned for the statewide assessment vendor (See more detailed description below). In-reach activities will extend to ACHs for non-TCLI residents and hospitals. MDS data will be used to help identify individuals for nursing home in-reach activities.

Additionally, in MFP 2.0 the types of settings from which a person can transition from will be expanded to include ACHs. The current 90-day length of stay requirement will be maintained; however, Medicare days will be considered a part of the total length of stay and transition planning will be permitted to start prior to the length of stay requirement being met if it is anticipated it will be met. Given the robust array of community-based LTSS provided under North Carolina's State Plan, including PCS, eligibility for transition services will be delinked from waiver and PACE enrollment.

Transition coordination will be added as a discrete waiver service (separate from case management service and separate from community transitions services described below) to the CAP/DA waiver. As required by the waiver, transition coordination will have provider specifications and statewide rates established via an actuarially sound methodology. What is currently being provided through the MFP program as TYSR will continue to be available as community transition services in the CAP/DA waiver.

Transition coordination for individuals who are not enrolled on a waiver or who are not participating in the TCLI program will be provided through North Carolina's newly contracted prepaid health plans (PHPs). Transition coordination will be a component of case management with a requirement that it be delegated to qualified community providers.

Community transition services will be available as a service under the State's 1115 demonstration waiver to individuals transitioning only with the support of State Plan services. Pre-transition case management has been identified as a vital piece to planning for smooth transitions for individuals who are enrolling on waivers. Pre-transition case management will be included in the definition of waiver case management. Pre-transition case management will be a component of case management provided by the PHP to non-waiver transitioners. For its existing members the PACE provider will be responsible for transition-related activities. For new PACE enrollees, transition coordination and community transition services will be provided by the PACE provider through a separate contract with DHHS.

Additional detail regarding recommendations and action steps required to make MFP 2.0 operational are described later in this chapter.

COST EFFECTIVENESS ANALYSIS

The MFP grant program will have infused over $44M into transition-related activities (this includes the first 365 days of service funding for individuals transitioning) by the time grant funding ends in 2020. It should continue to be cost effective as demonstrated in this analysis of individuals served in the program from 2010 through 2016. MFP is transitioning individuals who have higher costs while in nursing facilities than other transitioners. In Figure 24 below, the total MFP and Medicaid cost of care by nursing facility transition population has been provided. The table contains the total monthly cost of MFP transitions by age cohort and those that transition outside of MFP or "other transitions". MFP participants with I/DD, whose transition activity is under the LME-MCO umbrella, are not included as data were not readily available and such review was outside the scope of this analysis. Pre-transition costs are driven by the institutional cost associated with nursing facility use. Overall, Medicaid costs for people who transitioned into the community through MFP are lower than their costs in the nursing facility with expenditures for older adults on average 36% less and expenditures for adults

with disabilities 45% less. The cost effectiveness of the program and community-based care is clearly demonstrated.

Like the MFP national evaluation, Mercer's analysis looked at the Medicaid pre- and post-transition cost of both individuals that transitioned through MFP and those who transitioned outside of the program. This analysis was conducted to determine if individuals who transition through North Carolina's MFP program have a different level and mix of post-transition expenditures and services than individuals who transitioned outside of MFP. A transition, for individuals categorized as "other transitions", was identified by at least three contiguous months of institutional LTC claims followed by a claim for community-based LTSS (or records of enrollment) into a 1915(c) waiver programs in the month of transition or in either of the next two months following the last LTC facility claim. While there were some limitations in matching MFP and non-MFP transitioners' acuity levels (see Methodology section), MFP post-transition costs for community-based LTSS and "Other" Medicaid services were higher than those for other transitions. The national evaluation also found that community-based costs for MFP transitions were higher. These higher costs were attributed to first year costs associated with transition planning, home modifications and other costs. The increased "Other" costs for MFP transitions were driven by higher utilization of primary care and increased prescription costs post-transition. It is notable that individuals that transitioned outside of MFP had higher monthly inpatient and nursing facility costs post transition. This may be a reflection of the emphasis placed on post-transition coordination of care for MFP participants.

FIGURE 24: AVERAGE MONTHLY COST COMPARISONS FOR INDIVIDUALS TRANSITIONING FROM NURSING FACILITIES

POPULATION W/DISABILITY	MFP TRANSITIONS			OTHER TRANSITIONS		
	AVERAGE PER MONTH COSTS		%	AVERAGE PER MONTH COST		%
	PRE	POST	DIFF	PRE	POST	DIFF
Over age 65	$4,514	$2,898	36%	$2,946	$1,850	37%
Ages 18–64	$7,752	$4,272	45%	$7,148	$3,532	51%

Source: Mercer's analysis of Medicaid/MFP claims and enrollment data for Medicaid beneficiaries was matched to the MFP master log to identify individuals who transitioned from institutional to community-based LTSS from January 2010 through October 2016.

While Medicare expenditures were not available for this analysis, the national evaluation found that Medicare spending for transitioners was higher in the community than it was pre-transition. The main reason cited for this increase was Medicare enrollment over time as participant's age into Medicare coverage or beneficiaries of the Social Security Disability Insurance program completing the two-year waiting period.[lviii] Figures 25 to 28 provide a detailed breakdown of expenditures by population, transition type and costs by category of service.

FIGURE 25: DISTRIBUTION OF PRE- AND POST-TRANSITION AVERAGE MONTHLY MEDICAID EXPENDITURES FOR OLDER ADULT MFP PARTICIPANTS TRANSITIONING FROM NURSING FACILITIES

	Pre-Transition	Post-Transition
Other	$244	$233
IP	$30	$25
ILTC	$4,200	$303
Community LTSS	$39	$2,337

Source: Mercer's analysis of Medicaid/MFP claims and enrollment data for Medicaid beneficiaries was matched to the MFP master log to identify individuals who transitioned from institutional to community-bas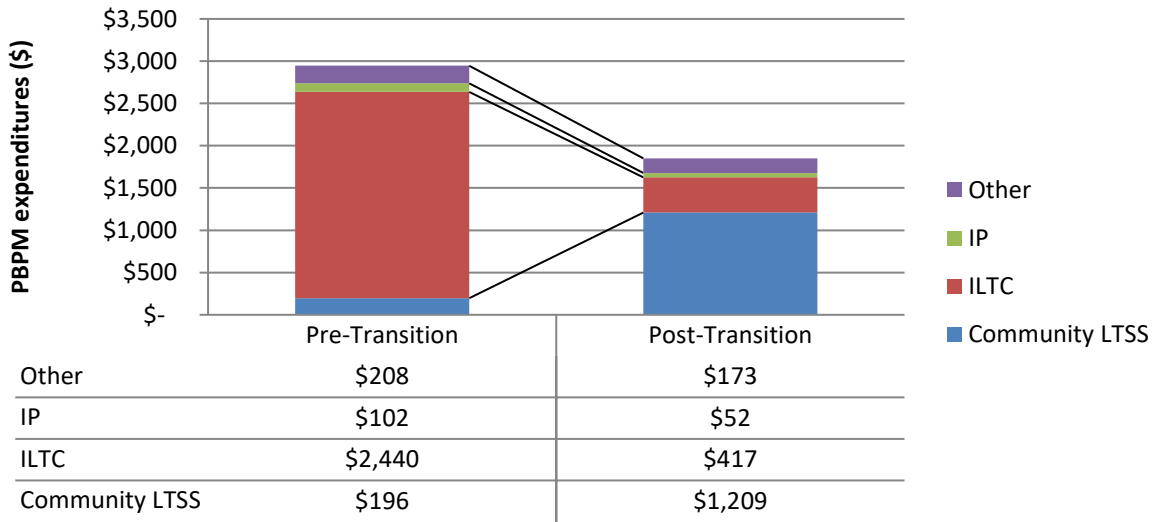ed LTSS from January 2010 through October 2016. Note: Monthly expenditures are based on 6 months of pre-transition data and 12 months of post-transition data. **ILTC =** institutional long-term care; **IP =** Medicaid-paid inpatient; **Other =** all other services, including, but not limited to, emergency department, physician, ambulatory surgery, durable medical equipment, outpatient radiology services, and pharmacy. Table reflects Per Beneficiary Per Month (PBPM) expenditures.

FIGURE 26: DISTRIBUTION OF PRE- AND POST- TRANSITION AVERAGE MONTHLY MEDICAID EXPENDITURES FOR OLDER ADULT OTHER TRANSITIONERS TRANSITIONING FROM NURSING FACILITIES

	Pre-Transition	Post-Transition
Other	$208	$173
IP	$102	$52
ILTC	$2,440	$417
Community LTSS	$196	$1,209

Source: Mercer's analysis of Medicaid claims and enrollment data for non-MFP Medicaid beneficiaries who transitioned from institutional to community-based LTSS from January 2010 through October 2016. Note: Monthly expenditures are based on 6 months of pre-transition data and 12 months of post-transition data. **ILTC =** institutional long-term care; **IP =** Medicaid-paid inpatient; **Other =** all other services, including, but not limited to, emergency department, physician, ambulatory surgery, durable medical equipment, outpatient radiology services, and pharmacy. Table reflects Per Beneficiary Per Month (PBPM) expenditures.

FIGURE 27: DISTRIBUTION OF PRE- AND POST-TRANSITION AVERAGE MONTHLY MEDICAID EXPENDITURES FOR MFP PARTICIPANTS WITH PHYSICAL DISABILITIES TRANSITIONING FROM NURSING FACILITIES

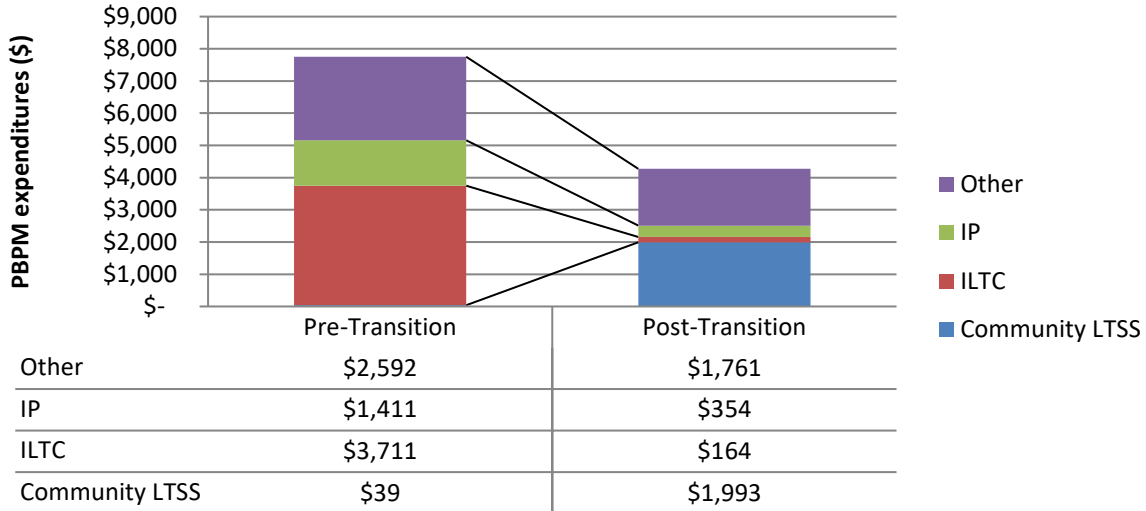|	Pre-Transition	Post-Transition
Other	$2,592	$1,761
IP	$1,411	$354
ILTC	$3,711	$164
Community LTSS	$39	$1,993

Source: Mercer's analysis of Medicaid/MFP claims and enrollment data for Medicaid beneficiaries was matched to the MFP master log to identify individuals who transitioned from institutional to community-based LTSS from January 2010 through October 2016. Note: Monthly expenditures are based on 6 months of pre-transition data and 12 months of post-transition data. **ILTC =** institutional long-term care; **IP =** Medicaid-paid inpatient; **Other =** all other services, including, but not limited to, emergency department, physician, ambulatory surgery, durable medical equipment, outpatient radiology services, and pharmacy. Table reflects Per Beneficiary Per Month (PBPM) expenditures.

FIGURE 28: DISTRIBUTION OF PRE- AND POST-TRANSITION AVERAGE MONTHLY MEDICAID EXPENDITURES FOR OTHER TRANSITIONERS WITH PHYSICAL DISABILITIES TRANSITIONING FROM NURSING FACILITIES

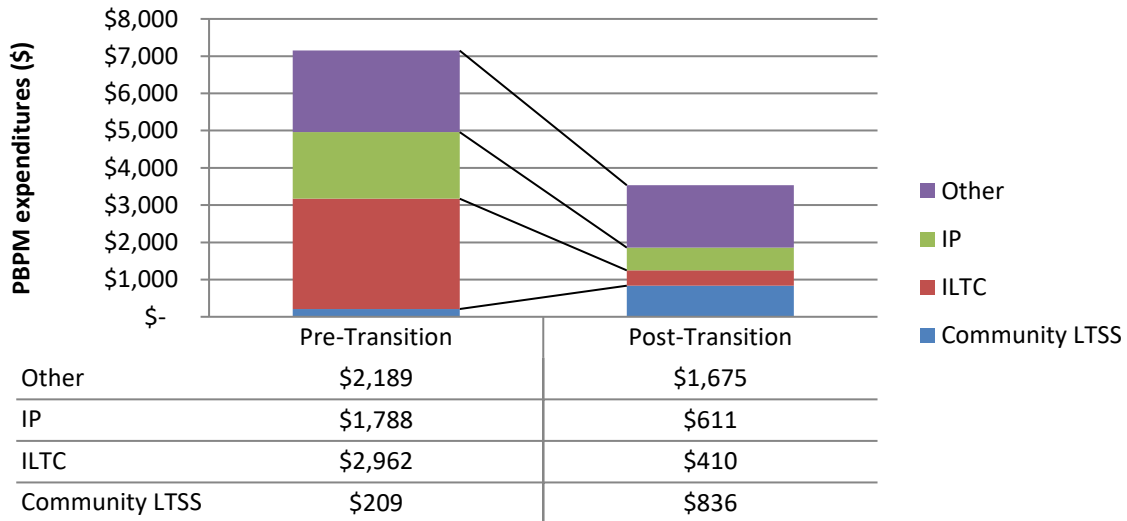|	Pre-Transition	Post-Transition
Other	$2,189	$1,675
IP	$1,788	$611
ILTC	$2,962	$410
Community LTSS	$209	$836

Source: Mercer's analysis of Medicaid claims and enrollment data for Medicaid Non-MFP beneficiaries who transitioned from institutional to community-based LTSS from January 2010 through October 2016. Note: Monthly expenditures are based on 6 months of pre-transition data and 12 months of post-transition data. **ILTC =** institutional long-term care; **IP =** Medicaid-paid inpatient; **Other =** all other services, including, but not limited to, emergency department, physician, ambulatory surgery, durable medical equipment, outpatient radiology services, and pharmacy. Table reflects Per Beneficiary Per Month (PBPM) expenditures.

Mercer observed that the "Other" cost for people age 18–64 were significantly higher than people age 65 and above. It also appears that there may be an increased cost to Medicaid for this population due to the lack of Medicare eligibility at the time of service consistent with the findings in the national evaluation.[ii] It is likely that year two costs for both MFP populations would normalize based on the reduction of one-time expenses associated with year one transition cost and an increase Medicare eligibility over time.[lix]

PAYMENT METHODOLOGIES FOR TRANSITION COORDINATION

As indicated previously, Mercer is recommending that transition coordination become a waiver service with detailed service specifications, provider requirements and a statewide reimbursement rate. As the State considers rate development for transition coordination, Mercer reviewed the MFP program's current reimbursement mechanisms for transition coordination as well as developed recommendations for rate considerations if transition coordination were to become a Medicaid reimbursable service.

Overview of Current Payment Methodologies

MFP currently pays vendors and governmental entities for community transition coordination activities using one of two methodologies, depending on the vendor and the transition coordination strategy being tested. An overview of both methodologies is provided below. Importantly, this report does not comment on the quality of the work performed by identified contractors or the quality-related advantages or disadvantages of either methodology.

Payment Methodology #1 — Overview and Experience

One payment methodology used by MFP pays vendors a contractually agreed upon amount based on the number of transition coordinators employed. This methodology is currently used by MFP in their transition coordination service contracting with the DVR-IL and local CAP/DA entities. Payments made to DVR-IL and contracted CAP/DA entities provide funding for personnel expenses to allow these entities to hire/maintain transition coordinators. Contracts include annual transition benchmarks proportionate to the size of their region with required minimum thresholds established. The average length of transition time, from the date of application approval until the date of transition, for these vendors is 165 days. Based on information received from MFP related to these contracted arrangements, three of the current transition coordination service vendor contracts operate under this payment system. Based on the number of reported transitions and associated contract expenses during the 2017-time period, the cost of a single transition ranged by the entity from approximately $2,059–$10,500 and with an overall average cost of $3,325 per transition. See Figure 29 below for an outline of 2017 expenses and transitions for payment methodology #1.

FIGURE 29: TRANSITION EXPERIENCE FOR PAYMENT METHODOLOGY #1

TRANSITION VENDOR CONTRACTS	DVR-IL	CAP/DA AGENCY 1	CAP/DA AGENCY 2	OVERALL
Contracted Transition Spending Amount	$96,762	$63,000	$63,000	$222,762
Number of Transitions for 2017	46	6	14	66
Actual Cost per Transition	$2,104	$10,500	$4,500	$3,375

Payment Methodology #2 — Overview and Experience

The second payment methodology used by MFP for community transition coordination services makes payments to the vendor only after a pre-defined, process based milestone has been achieved. These milestones are not only the actual achievement of a transition into the community, but also include many of the pre-transition activities required to ensure a recipient has the proper supports and resources available (e.g., secure housing and establishment of natural supports) as well as some extended follow along once the transition has occurred. Average length of transition time for these vendors is 169 days.

Based on information received from MFP, two of the current MFP transition vendor contracts operate under this milestone-based methodology. Both vendors receive the same fee for each of the milestones, which are outlined in Figure 30. If a vendor works with a recipient to successfully meet all milestones (i.e., the recipient successfully transitions to the community for three months or more), the vendor receives total payments of $3,725. The fee schedule also allows vendors to receive partial funding for those recipients who ultimately do not complete a successful transition, as long as the vendor is completing activities to identify and evaluate recipients for transitions.

FIGURE 30: MILESTONE PAYMENTS FOR METHODOLOGY #2

TRANSITION MILESTONE	CONTRACT AMOUNT PER MILESTONE
Service Request Form, Initial Meeting, Pre-transition Planning Meeting	$325
Natural Supports (Established or Plan to Establish Submitted)	$600
Housing (Secured)	$600
Transition	$1,500
Follow Along (Paid at 3 Months)	$700
Total	**$3,725**

Using the information provided by MFP related to the two vendors that are operating under payment methodology #2, Figure 31 below summarizes the 2017 total expenses and transitions for each vendor and includes payments for recipient milestones as well as additional payments for overhead costs for program maintenance. As the table reflects, the average cost per successful transition ranged from $4,583 to $6,069 with the average cost per transition being $5,178. This average is higher than payment methodology #1, though the range is much less variable.

FIGURE 31: TRANSITION EXPERIENCE FOR PAYMENT METHODOLOGY #2

TRANSITION VENDOR CONTRACTS	AAA 1	AAA 2	OVERALL
Actual Transition Spending	$24,275	$27,500	$51,775
Number of Transitions for 2017	4	6	10
Actual Cost per Transition	$6,069	$4,583	$5,178

Assessment of Current Payment Methodologies

With each payment methodology, there are advantages and disadvantages that MFP will need to consider when evaluating how effective each methodology is in helping them to achieve their goal of successfully transitioning recipients into the community.

Payment Methodology #1 — Considerations

Payment methodology #1, as outlined earlier, is a more streamlined system for MFP to administer. Payments to the vendor are highly predictable and have less volatility as they are pre-defined based on the number of transition coordinators an entity employs and a set amount for each employee. The financial advantage to MFP under this methodology is that it allows for budget predictability. Similarly, there is less financial risk on the part of the transition vendor in that they know how much funding they will receive to perform the transition function. While these payments are tied to contractual requirements, the payments to the vendor are not tied to any milestone, so their revenues do not change regardless of the number of transitions completed or the length of time it takes transitions to be completed in a given time period.

However, this system leaves MFP at some risk since they have less oversight of how the vendor is utilizing Medicaid funds to serve recipients and vendors have less of an incentive to remain in compliance with documentation-related deliverables or process-oriented requirements. The system also creates greater discrepancies in the MFP incurred transition cost of each recipient, as is shown by the range of costs per transition in Figure 29.

Payment Methodology #2 — Considerations

Payment methodology #2 allows MFP to more effectively monitor the process and outcomes of the vendor, by aligning payments with their intended milestones. It also ensures recipients are receiving a more consistent set of services from all vendors and incents vendors to provide timely updates on an individual's status.

Additionally, the milestones are established in a way that requires the vendor to ensure certain social and support needs are in place prior to the transition, which may increase the success rate of these life-changing events. Lastly, as observed in Figure 31, the cost per transition is generally less variable than those metrics under payment methodology #1.

At the same time, this payment methodology has an increased complexity for MFP to administer, as it requires MFP to fully define each milestone, which may be difficult. However, the use of milestone-based reimbursements has increased in recent years and this methodology builds on that experience. Additionally, it is likely more difficult to project annual State budgets since the amount of individuals hitting any given milestone within a fiscal year is not pre-established and will vary year-to-year and it is difficult to see how much vendors are actually investing in the transition coordinator role within their agency.

Payment methodology #2 also gives the vendors more financial incentive to achieve successful transitions than methodology #1 as they are only being paid when certain milestones are achieved. This also means financial risk may exist for the vendor in that they are required to invest time and incur expenses to identify and perform initial transition activities prior to receiving any funding, and depending on the recipient, may not achieve any or all milestones. This leads to a different balance in where the financial risk is held (i.e., more risk is given to the vendor under payment methodology #2, which is a financial advantage to MFP as it may incentivize vendors under this arrangement to drive more transitions and ensure they are successful. However, it may discourage vendors from investing in full-time transition coordination staff, which is critical to the success of the program.

Alternative Payment Methodologies for Consideration

As MFP looks to expand and enhance their support of recipients who are transitioning into the community, they will need to consider how best to recruit and fund all vendors to achieve the intended outcomes. From a payment methodology perspective, a recommended approach for MFP consideration is to develop a statewide, standardized fee schedule payable to all willing and able vendors, which would be based on a milestones approach similar to the current payment methodology #2. Under this approach, MFP would establish transition milestones and utilize a market-based methodology, as described below, to develop the fee schedule payment for achieving each milestone. The fees would be statewide and across all providers.

MFP could consider including an enhancement to each milestone payment for "hard-to-serve" individuals such as individuals with certain criminal convictions for whom relocation is especially challenging. Should MFP include an enhanced fee as part of the milestone-based fee schedule, it will be imperative to fully define the criteria and conditions under which a provider would be eligible to receive the enhanced payment to avoid unnecessary expense to the State. There is a precedent for this proposed milestone-based rate structure. For example, Mercer recently assisted a state client in developing outcomes-based fees for supports coordination where a set fee was paid for the initial development of the individualized service plan for new waiver participants, rather than paying for this using only 15-minute units of service. Additionally, Mercer worked with a different state client to determine appropriate milestone payments for their waiver employment services.

Market-based Methodology Overview

This statewide fee schedule would be established using a market-based approach to fee development, which is an allowable approach from CMS' perspective and aligns with the fee development methodology used by Mercer when assisting DHHS with other 1915(c) waiver fee schedule development projects. Developing modeled fees using a market-based approach requires Mercer and MFP to review and build upon existing knowledge of service definitions to understand the key requirements of the service, including provider qualifications, licensing requirements, staffing requirements and other general information related to the delivery of the service. As part of this, MFP would review and update the milestones to ensure they best align with what they want to pay for.

Based on this review and understanding of the service definitions, key cost components would then be identified by Mercer so that the fees fully consider costs that are reasonable, necessary and related to the delivery of the service. The major cost components considered for each milestone may include:

•   **Direct Care Costs**: Salary expenses for the required staffing (e.g., transition coordinators and other transition support staff), adjusted to include consideration for employee-related expenses such as benefits, taxes and productivity.

•   **Indirect Costs**: Supervisory expenses and other non-personnel costs that are integral to successful transitions.

•   **Time Allowance**: To develop costs of achieving each milestone, an assumed number of staffing hours and caseloads will need to be considered.

•   **Administrative costs**: Additional allowable costs a vendor may incur related to the cost of doing business.

Once these cost components are identified, market-based research and discussion between Mercer and MFP would occur to establish reasonable cost assumptions for each component. This would include a review of publicly available information, such as wages and employee-related expenses, for applicable occupations as available from the Bureau of Labor Statistics. It may also include outreach to vendors currently performing transition coordination services to better understand how their business and staff structures work. Lastly, a key component of this process is a discussion between Mercer and individuals within MFP, who are familiar with this service, to ensure the assumptions align with their expectations. These market-based cost assumptions would then be compiled to model the full, reasonable cost (and subsequently the fee) for a typical vendor to achieve the required milestones.

To ensure the modeled result is reasonable, Mercer and MFP will also want to benchmark these results against the current cost metrics as outlined in Figures 29 and 31 as well as other similar services paid for by Medicaid. For example, case management costs within the CAP/DA program, along with various time allowance considerations as outlined above, may be a reasonable proxy to use to evaluate whether the fees are reasonable compared to other fees paid by DHHS for similar populations.

Market-based Methodology Considerations

Similar to payment methodology #2, this statewide fee schedule would require time and effort for MFP to implement. It would also allow MFP to monitor the program's required transition processes by incorporating costs for only the service components that MFP determines important to the delivery of transition coordination services. Lastly, it may decrease the State's administrative oversight of these vendors as it would not require separate contracts be established with each entity to perform these services.

Given that this would be a large change for some vendors performing transition activities today (e.g., DVR-IL and CAP/DA entities) currently paid under payment methodology #1, it will be important to communicate these changes to stakeholders and potentially look for opportunities to receive their feedback prior to implementation. Additionally, it will be important during the early years of this new payment system for MFP to identify methods to evaluate whether the fees are financially reasonable (i.e., not leading to large over/under payment for any one milestone) and adjust as appropriate.

RECOMMENDATIONS TO OPERATIONALIZE MFP 2.0

1. Add transition coordination, distinct from case management, as a discrete waiver service to the CAP/DA and CAP/C waivers

While certain aspects of transition coordination such as information and referral could fall under the broader case management umbrella due to the need for focused attention on transition-related tasks and the specialized skill set needed for effective transition coordination, it is recommended that transition coordination be a separate waiver service. As required by the waiver, transition coordination will have a service definition and provider specifications. DHHS should tailor these definitions and specifications to meet the unique needs of each waiver population. It is recommended that requirements for provider enrollment be focused on proven experience and expertise in performing transition coordination activities. Current provider qualifications and contractual expectations should serve as the basis for these definitions. Transition coordination providers will be paid a statewide rate developed via an actuarially sound methodology — options for which are described above. Adding transition coordination as a waiver service could result in some current providers no longer providing these services due to not meeting provider requirements, not wanting to become a Medicaid provider or unwillingness to perform work at prescribed rates. Planning and coordination with current and future transition coordination providers will be required to ensure continued access to the service between the time the grant-based MFP program is winding down and the MFP 2.0 is operational. Additional administrative expenses may also be incurred. These include claims system updates in order to add new service codes, edits and rates, increased workload for provider enrollment and oversight staff and increases costs associated with recruitment and training of an adequate provider pool.

2. Emphasize availability of State Plan Personal Care Services as an allowable "program" that an individual can transition into

Not all individuals residing in facilities require waiver or PACE services to be healthy and safe in the community. However, due to their inability to access transition related services they are unable to move and remain in more expensive and restrictive environments. The availability of personal care services through the State Plan enables individuals with few support needs to live in the community if transition related services are

made available to them. Broadening the definition of allowable "programs" that individuals can transition into increases access to transition related services.

3. Add transition coordination as a Prepaid Health Plan function under NC's 1115 waiver

North Carolina's 1115 waiver contracting with PHPs afford the State the opportunity to expand the transition administrative care coordination component of the capitation payments paid by the State to the PHPs. The Plan would be required through contract to delegate transition-related activities to qualified community-based entities.

4. Integrate Community Transition Services ("startup funds") into 1115 Waiver

Access to needed goods and services required to establish housing and other community essentials is key to a successful transition. Adding Transition Services as a service under the 1115 waiver enables individuals who are transitioning only with State Plan support to access this important service. As it is a service, Community Transition Services would be eligible for FFP at the service level.

5. Strengthen State funded transition coordination function to assist with transitions not covered under MFP 2.0 or under the 1115 waiver

Even with the requirement that the PHPs provide transition coordination services to its members, there are still individuals on Medicaid who will not have access to transition coordination, including individuals who are dual eligible or individuals who are enrolling in PACE. Therefore, it is recommended that a State funded transition coordination function be made available to individuals in qualified settings who are unable to access transition coordination perhaps through existing programs such as DVR-IL.

6. Include adult care homes as a qualified facility from which an individual can receive transition services

Currently most of the residents of ACHs (outside of those participating in the TCLI program) do not have access to transition-related services resulting in individuals who have a desire and an ability to live in the community being stuck in facilities because they don't have access to the proper transition supports. This recommendation is built on the previous recommendations to add transition coordination to the PHPs' responsibilities along with the addition of community transition services to the 1115 demonstration waiver. In order to ensure safe and sustainable transitions for ACH residents these recommendations must be implemented simultaneously. Including adding specific language in PHP contracts describing expectations for transition-related activities targeted to non-TCLI ACH residents. This serves as the foundation for successfully adding this population to the States existing transition program.

7. Amend waivers in order to expand pre-transition case management in CAP/DA and CAP/C to be available 180 days prior to the transition

The MFP program's transition experience revealed the need for active engagement by the waiver case manager prior to the individual's discharge from the facility. The case manger's role is to facilitate the waiver eligibility determination, enrollment and person-centered service plan development and is not a duplication of the transition coordinator's role and responsibilities. Federal waiver rules allow for the provision of case

management services for 180 days prior to the date of discharge. This expansion of the service does not impact how FFP is drawn for the service.

8.   Establish a community-based entity as the front door for LTSS

DHHS should work to identify a community-based entity to serve as the front door to the LTSS delivery system and to provide LTSS options counseling to anyone seeking LTSS regardless of payer. By providing options counseling regarding HCBS services to non-Medicaid individuals can actually delay or prevent the need for Medicaid services. These activities are not duplicative of the current vision of having all LTSS assessment functions performed by one statewide vendor and in fact, support the concept of conflict-free practice within the LTSS delivery system by having separate entities perform options counseling and assessment functions. The "front door" would provide options counseling and make referrals to the single assessment entity as appropriate. Essential to the success of this recommendation is the development of the necessary processes for drawing down Federal Financial Participation (FFP) i.e. administrative match for these activities. "Federal matching funds under Medicaid are available for the cost of administrative activities that directly support efforts to identify and enroll individuals potentially eligible into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan when those activities are performed either directly by the state Medicaid agency or through contract or interagency agreement by another entity. There must be a clear methodology to determine such costs, and in no case can claimed expenditures exceed actual expenditures for the activities by the governmental entity performing such activities."[lx] As long as the activities are related to enrolling in or accessing Medicaid the following front door activities may be eligible for administrative FFP: public outreach and linking with referral sources, person-centered options counseling related to enrollment in Medicaid, or accessing Medicaid services as well, as providing support for Medicaid application and eligibility determination processes. DHHS will need to add staff dedicated to managing and providing oversight to this new "front door". These positions would be eligible for administrative FFP. [lxi]

9.   Expand in-reach activities to discharging hospital patients and non-TCLI adult care home residents

Currently, there is no formal in-reach process for ACH residents who are not eligible for the TCLI program. By expanding the LCA function to include ACHs, those residents are provided the opportunity to learn about community-based options. Since ACHs do not generate data similar to MDS, a process for the identification of potential candidates for transition will need to be developed.

10. Complete preadmission screening prior to nursing facility and adult care home admissions to discuss HCBS options and to provide seamless follow-up upon admission as needed

Oftentimes, individuals are admitted to nursing facilities without understanding the array of HCBS options available to them. Requiring an assessment prior to admission for all individuals where Medicaid is the payer promotes diversion and provides individuals the opportunity to make an educated decision about where their care needs can best be addressed. This activity could be included in the functions of the LTSS front door and will be considered an administrative activity for FFP.[lxii] Embedding options counselors in hospitals to perform this function could help support diversion activities.

11. 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

Strong staff training and clinical consultation are critical components of pre-transition activities to help support successful and sustainable transitions. This service would provide for individuals transitioning the opportunity to not only select the agency from whom they would receive services, but also interview and meet staff prior to their move.

ADDITIONAL RECOMMENDATIONS FOR SUPPORTING TRANSITIONS IN A MANAGED CARE LANDSCAPE

Listed here are additional recommendations for consideration as the State moves its aging and disability waivers and long-term nursing facility populations into managed care in 2023.

- It is unclear if the State is intending to maintain its 1915(c) waivers alongside of its 1115 demonstration waiver or if the services are being folded into the 1115 waiver. Either way it is recommended that transition coordination remain a separate and discrete service from case management/care coordination. While transition coordination is similar in some ways to case management it requires a very specific set of knowledge and competencies that focuses on the actions necessary to prepare for living in the community, (e.g., navigating complex housing systems). Additionally, when combined with a case management function, transition coordination activities tend to get lost in the day-to-day duties of a case manager who is supporting individual living independently in the community with multiple responsibilities across a diverse caseload.

- Payment for the service is the responsibility of the PHP; however, the activity should be delegated to qualified local entities. While transition coordination is sometimes provided directly by the PHP, this is typically done in states with mature managed care programs such as Tennessee. States with new managed LTSS programs sometimes find their plans, despite some of them being national plans, focused in the first several years of implementation on claims payment, ensuring continuity of waiver services and health and safety with little time to focus on transition activities. This strategy could be modified as the system matures and the PHPs gain more experience with managed LTSS.

- 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 institutional vs HCBS settings. In the first years of its managed care program, the State would collect data regarding these activities and establish baselines from which improvement would be measured. Not only does this send a message to the PHPs regarding the State's expectations for performance, but also it affirms to stakeholders the State's commitment to community-based LTSS programs.

- It is important to make sure that payments to the PHPs are aligned with the State's goals. When developing its capitation payment, the State should consider a blended rate for individuals with an institutional LOC regardless of setting (institutional vs community). This ensures that PHPs are not incentivized to keep individuals in nursing homes.
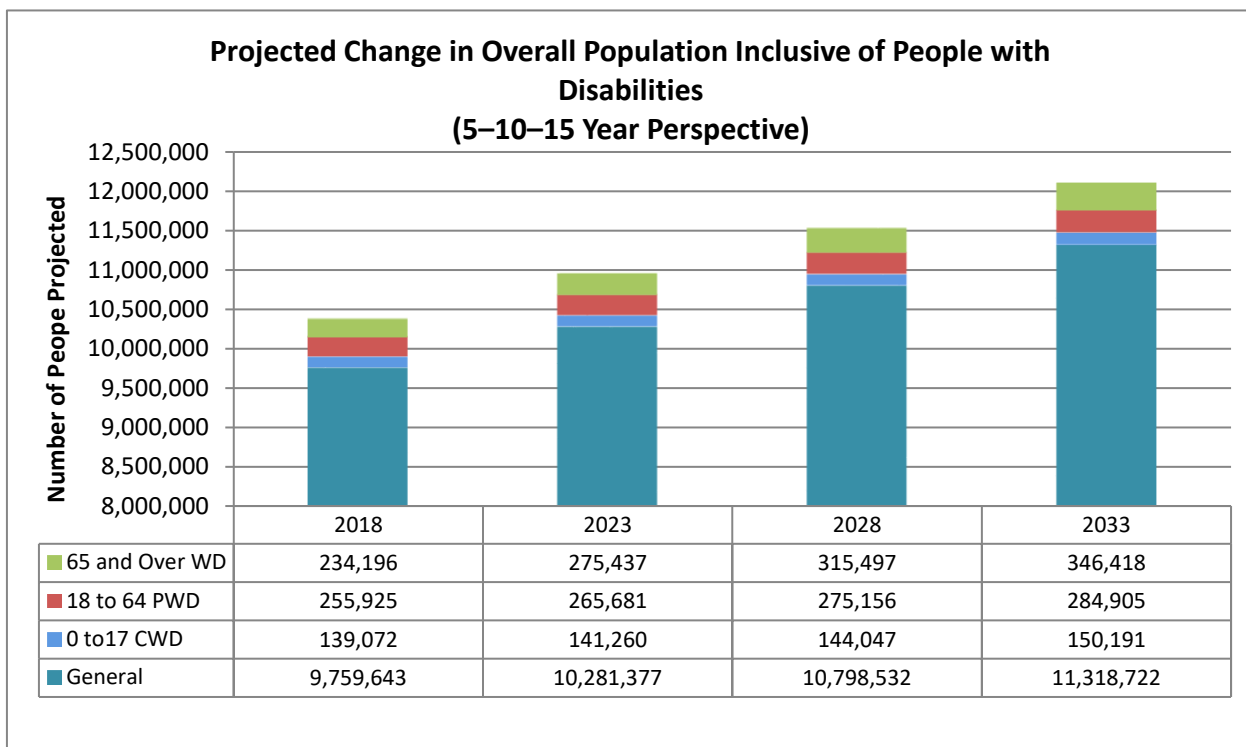
7

PREPARING FOR FUTURE LONG-TERM SERVICES AND SUPPORTS GROWTH

To help inform DHHS planning for future needs for LTSS, Mercer projected future trends in growth in North Carolina's under age 65 population of people with disabilities, specifically children from birth to age 17 and adults ages 18 to 64 years old. Data specifically for individuals with intellectual disabilities and serious mental illness were not included in this review. While adults with age-related disabilities are not the focus of this analysis, because they are a sub-group within the CAP/DA waiver and require transition-related services, Mercer included data on this population in the projections. This section reviews the growth in the targeted populations and the potential impact that growth could have on the CAP/DA and CAP/C waivers.

In order to complete this analysis, State population growth needed to be projected as well as the level of growth based on reliable sources for individuals with disabilities. The CAP/DA and CAP/C populations by age category are projected forward by 5, 10 and 15 years. Projections are based on trends identified in the enrollment data for the waivers, trends in the disabled population within the State identified in the Child Health Assessment and Monitoring Program (CHAMP) and American Community Survey (ACS) data, and projected State population from Office of State Budget and Management (OSBM).

FIGURE 32: NORTH CAROLINA POPULATION CHANGE PROJECTIONS

Projected Change in Overall Population Inclusive of People with Disabilities (5–10–15 Year Perspective)

	2018	2023	2028	2033
65 and Over WD	234,196	275,437	315,497	346,418
18 to 64 PWD	255,925	265,681	275,156	284,905
0 to17 CWD	139,072	141,260	144,047	150,191
General	9,759,643	10,281,377	10,798,532	11,318,722

Sources: U.S. Census Bureau, American Community Survey (ACS); State Center for Health Statistics, North Carolina Child Health Assessment and Monitoring Program (CHAMP) survey; and North Carolina population projections from the North Carolina State Office of Budget and Management (OSBM). Note that CHAMP data was used because ACS data on "Independent Living Disability" question was not asked of children ages 15 and under".[lxiii] Note: Overall projections from 2018 through 2033 are based on analysis of annual growth rates from 2010 through 2016. (See Chapter 11 Methodology for additional information)

Figure 32 shows the overall population growth for the State at about 1% annually. While studies have been conducted on the "silver tsunami" related to the older adult population, little research has been done on the projected growth of the under 65 with a disability population. It is important to remember when considering this data that projected increases in the number of children and people with disabilities does not equate to projecting the increase in waiver participation in the State. Therefore, while the number of children with disabilities is projected to climb by over 11,000 and individuals between the ages of 18–64 are projected to increase by nearly 30,000 from 2018 through 2033, this does not assume this total population will require waiver services. In order to consider the number of people that might need waiver services during that period, Mercer reviewed historical data on the CAP/DA and CAP/C programs to understand how the programs have changed in comparison with the population growth during the same period in an effort to anticipate demand for HCBS.

FIGURE 33: POTENTIAL GROWTH OF NORTH CAROLINA CAP/DA AND CAP/C WAIVER ENROLLMENT

Potential Growth in Waivers Based on Population Growth Projections (5–10–15 Years Perspective)

	2018	2023	2028	2033
CAP-DA (65 and Older)	7,586	7,973	8,380	8,808
CAP-DA (Ages 18-64)	5,257	5,525	5,807	6,103
CAP-C (Ages 0-17)*	2,760	2,826	2,906	3,049
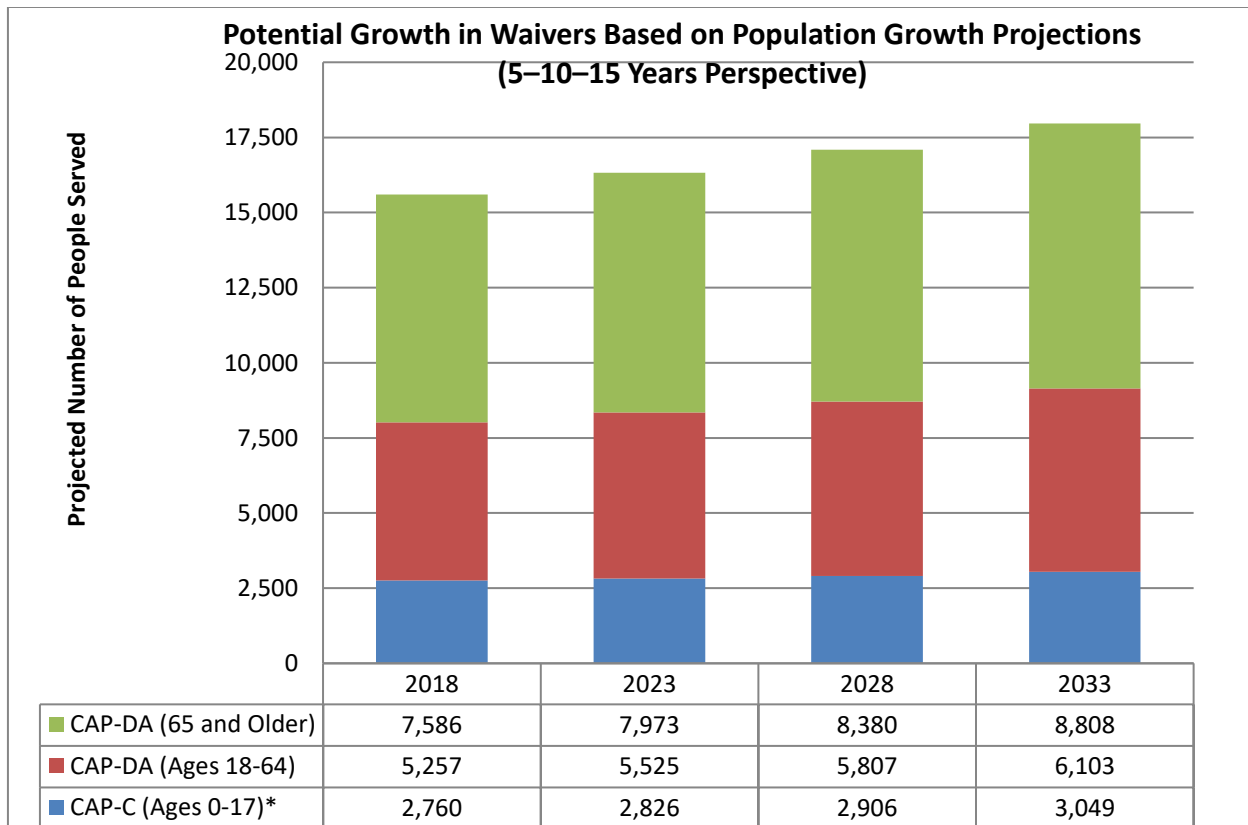
Source: U.S. Census Bureau, American Community Survey (ACS); State Center for Health Statistics, North Carolina Child Health Assessment and Monitoring Program (CHAMP) survey; North Carolina population projections from the North Carolina State Office of Budget and Management (OSBM); North Carolina CAP/C and CAP/D enrollment data.

As illustrated in Figure 33, the projected growth of the waiver populations will increase in the coming years. Economic pressures on states have limited the growth of waiver programs resulting in greater spending on entitlements under Medicaid like nursing home services, which must be funded. This report includes many recommendations that cover the need to grow and expand community-based options and how this might be accomplished. Over the next 15 years, children and adults from birth to 64 years of age that require waiver services will increase by over 1,300 people and when individuals ages 65 and over are included, this number will double. If North Carolina does not address the expanding need for the CAP/D waiver, individuals with disabilities will be forced to seek care in nursing facilities at a higher cost to the State's Medicaid program.

8
ADDITIONAL OBSERVATIONS

Analysis of neither the TCLI program nor transition-related activities for individuals with I/DD within the MFP program were within scope for this project; however, during the research process much information was shared regarding these programs and populations and is worth noting here. Below is a summary of observations:

- Within the TCLI program access to specialty services such as tenancy management and peer support are of particular benefit to any individual transitioning.

- Well-defined in-reach targets in contracts along with dedicated in reach LME-MCO staff has resulted in an assertive effort by the LME-MCO to complete in-reach activities in ACHs.

- The State has invested significant resources in the TCLI program.

- LME-MCOs have well defined transition coordination activities for individuals participating in the TCLI program. Transition coordination activities provided by LME-MCOs for individuals participating in the TCLI program are similar in nature to the transition coordination activities provided through MFP.

- Within LME-MCOs contracts, the emphasis on transition-related activities is focused primarily on the TCLI population with fewer requirements for I/DD except for individuals who are discharged from State developmental centers.

- There are transition-related activities performed by the LME-MCOs for individuals residing in ICFs; however, activities seem not as robust as TCLI or transitions coming out of nursing homes.

- MCO in-reach activities in nursing facilities to people with TBI populations are not typically initiated by LME-MCOs. However, LME-MCOs will partner on transitions if a person experiences a mental health support need or a TBI.

- LME-MCOs provide in-reach to individuals with SPMI in nursing facilities and ACHs through the TCLI program as well as to individuals with I/DD in private ICFs and public developmental centers according to feedback contained in the MFP transition-related services survey.

- In-reach activities for individuals with I/DD are impacted by a limited number of waiver slots for the Innovations waiver.

9
ADDITIONAL AREAS OF RESEARCH

Through the discovery process for this project, several areas for future research or consideration were identified including:

• Exploring the possibility of requiring PHPs and Dual Eligible Special Needs Plans (D-SNPs) operating in the State to enter into a Medicare Improvements for Patients and Providers Act agreement that requires data sharing and coordination between the plans and the D-SNPs. This would help support transition efforts for individuals who are dually eligible.

• Using an algorithm (similar to what was used in the TCLI rate development) to identify the number of transition coordinators needed to meet future need.

• Conducting an analysis to determine the financial impact of adding 217 group to waiver eligibility.

10
CONCLUSION

Started as words on a grant application, North Carolina's MFP program has evolved to become an integral component of North Carolina's LTSS delivery system. The MFP program has grown to serve 972 people over an almost 10-year period and is projected to break the 1,000th cumulative transition marks this year. The program has performed as designed by Congress and provides a genuine opportunity for people to gain a second chance at community living and has helped the State move toward rebalancing its LTSS landscape. Taken in conjunction with waiver diversion, home and community-based services and supports have produced considerable reductions in cost for the State and improved QoL for North Carolinians. This report illustrates the complexity of the current transition-related program landscape; considers the challenges and opportunity for improvement and addresses the many options for sustainability moving forward.

Much more is known about quality transition practices than when the program originated in 2009. Through MFP's transition experience, the State has gained a clearer understanding of those community-based dynamics faced by individuals transitioning out of nursing facilities and the critical need for comprehensive, interdisciplinary transition planning. Additionally, MFP has learned a tremendous amount about the staff capacities required to facilitate quality transitions and limitations and opportunities within Medicaid-funded and State-funded supports. MFP has subsequently worked to integrate these lessons into future transition activity. As the program continues to mature, Mercer would like to reinforce the Program's observations on the following needs. There is a considerable opportunity to improve training and behavioral supports for transitioners. The use of data can help alert transitioning organizations to the needs of people in the community and improve their outcomes at home. Engagement of community-based organizations like AAAs as active front door partners, counseling individuals on their options and adding tools like MDS information can create significant growth in the initiative.

A Transitioner's Story

The development of this report is an amalgam of information like this story of transitioners affected by the program.

Not wanting to be a burden to family but wanting to return to the community after many years in a nursing home, this North Carolinian with multiple chronic medical conditions, applied for the MFP program. Another resident's visiting family member mentioned the program in passing. The process turned out to be relatively simple from the MFP participant's perspective and did not take too long, if you consider the number of years they had already spent in a nursing facility. The year it took to return home was followed by some sadness over the newness of the neighbors and the quiet apartment. Despite the early drawbacks, family and new friends started visiting and the new level of independence made it all worth the effort. The sign over their door speaks volumes for MFP transitioners, "Grateful Hearts Live Here".

DVR-IL remains one of the strongest transition partners and there is opportunity to expand and create more linkage to support not only nursing facility, but also ACH transitions. The TCLI, with the weight of the settlement behind it, has proven how a well-funded program, designed after the MFP program, can perform. Despite these strides, there is rich opportunity for continued and expanded growth in transition-related services.

PRIORITIZING ANALYSIS RECOMMENDATIONS: PROPOSED FRAMEWORK

The report contains almost 60 recommendations. These recommendations come in the form of suggested program improvements that are short-term, mid-range and long-term in nature. A key to managing the significant number and types of recommendations will be the approach taken to prioritize them for action. Items that rise to the level of critical importance in the short-term include identifying transitioners more effectively, training for individuals and caregivers on the transition process and preparing for community living, supporting critical incident improvements and understanding the behavioral health needs of people transitioning. The mid-term recommendations include integrating the program more formally into the home- and community-based program strategy for diversion and transition activities. As such, it is critical to include institutional partners from the nursing facility and ACH industry to create an opportunity for diversification from a facility to a community orientation. Finally, the long-term goal of transition-related services inclusion in the broader managed LTC vision for North Carolina be will foreshadowed by the commitment to moving the system toward a balance of options for older adults and people with disabilities and the performance of the current transition and diversion programs to manage cost while providing improved quality of life for individual members.

Short-Range

- Improved Screening and Assessment Activities
- Modify Incident Management
- Expand Outreach Activities

Mid-Range

- Waiver Performance Improvements
- Expanding Access to Transition, Diversion & HCBS Services
- Interim Program Design

Long-Range

- LTSS Systems Change
- Integration of Programs into Managed Long-term Services and Supports
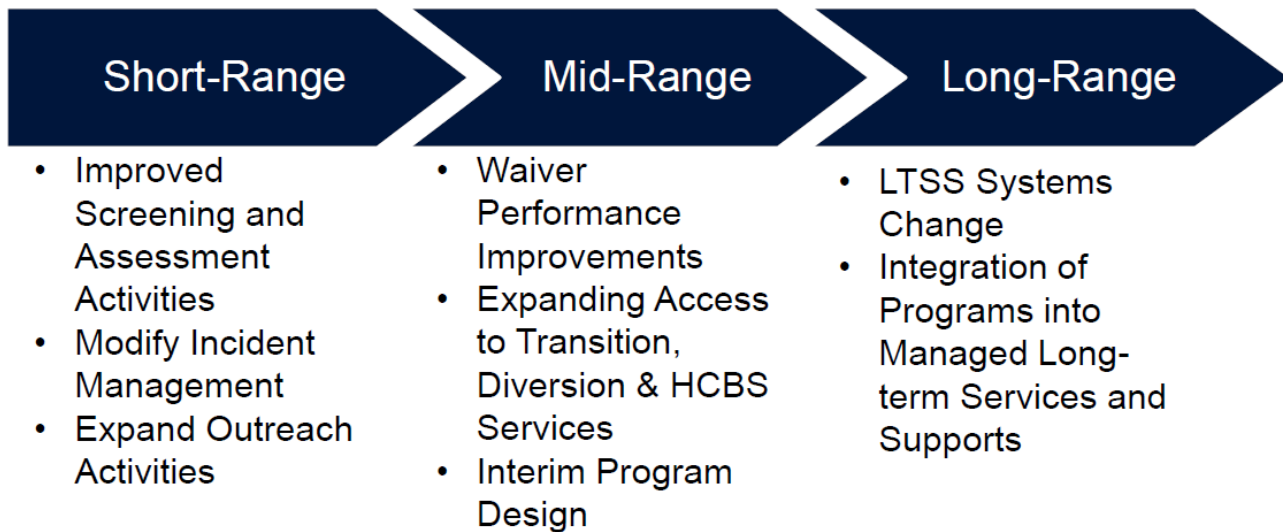
Since its modest beginning in 2009, the North Carolina MFP program has increasingly influenced the North Carolina LTSS landscape. In addition to playing a key role in facilitating a better QoL for those who have transitioned, it has served as a catalyst for collaboration between partner agencies within DHHS and with local partners throughout the State. Through this collaboration, DHHS has made significant strides in its understanding of what is required for quality transitions and what is necessary to support clear and equal access to community life. As a result, North Carolinians who depend on DHHS for their LTSS will have increased opportunity to remain in and return to their homes and communities long after the federal MFP grant program ends.

11
SUMMARY OF RESEARCH METHODS

In support of the development of North Carolina's MFP Sustainability Report, Mercer utilized a variety of research methods, including a detailed data review of: pre and post transition costs, QoL survey outcomes, and population and program growth projections. Data on transition activities and other publicly available information helped inform the landscape analysis was augmented by the deployment of an online survey of providers and programs impacted by and participating in transitioning activities as well as interviews with targeted stakeholders. Each section of the report contains relevant citations in addition to what is reflected in this summary.

METHODS USED TO ESTIMATE DIFFERENCES IN POST-TRANSITION COSTS AND UTILIZATION

A. Data

The analyses presented in the cost analysis use Medicaid claims and enrollment files from July 2009 through September 2017 and the MFP master tracking log to match claims during the period of analysis. After exclusions, these files allowed us to identify Medicaid beneficiaries who transitioned from institutional care to community-based LTSS from July 2010 to October 2016, beneficiaries who enrolled in the MFP demonstration, expenditures in the six months before and up to 12 months after the transition, and person-level characteristics. We included Medicaid detailed claims from inpatient, professional, pharmacy, and enrollment files submitted to Mercer for work on the budget neutrality waiver and Medicaid transformation. Enrollment and demographic information came from the detailed enrollment files and the MFP master-tracking log.

B. Identifying MFP participants and other transitioners

Mercer identified MFP participants as members with a transition date at any point in 2009 through 2017 on the MFP master-tracking log (n = 775). Like the national evaluation, only those MFP participants with at least one MFP-paid claim for community-based LTSS and 12 months of continuous enrollment prior to transition and 12 months after transition with no more than a one-month enrollment gap were included in this study. The comparison group, "other transitioners," includes all Medicaid beneficiaries identified in the available claims and enrollment data who transitioned from institutional care to community-based LTSS outside of the MFP demonstration, and who met the continuous enrollment criteria of 12 months prior to transition and 12 months after transition with no more than a one-month enrollment gap. A transition, for other transitioners, was defined as at least three contiguous months of institutional LTC claims followed by a claim for community-based LTSS (or record of enrollment the 1915(c) waiver programs: CAP/DA and CAP/C) in the month of transition or in either of the next two months.

C. Target populations

Mercer's analysis focused on adults and seniors with age related disabilities who participated in the MFP program. Calculations were based on the Medicaid beneficiary's age at the month of transition and the aid category code ("AB" for blind and "AD" for disabled) in a given year. Transitioners were divided into two target populations: (1) adults 65 and older who transitioned from nursing facilities, (2) people with physical disabilities under the age of 65 who transitioned from nursing facilities.

D. Exclusions

For our main analysis, we excluded people who: (1) had no record of receiving community-based LTSS after the transition, including MFP participants who had no claim for an MFP-financed community-based LTSS, (2) received Medicaid-paid hospice services prior to transition, (3) had Medicaid-paid hospice services in the month of transition or in either of the next two calendar months, (4) died within the first 12 months after transition and (5) had more than a one month gap in Medicaid enrollment in the 12 months before or after transition.

E. Measures of expenditures

There are three expenditure categories of interest: (1) total overall expenditures, (2) LTSS and (3) medical care expenditures. We further divide LTSS into community- or institutional-based LTSS. Medical expenditures are categorized as inpatient (acute hospital care), physician office visits, emergency department visits and pharmacy.

Total expenditures include all Medicaid-paid services. LTSS expenditures consist of all Medicaid payments for community- and institutional-based LTSS. Community-based LTSS were flagged based on claim header type ('6' for PCSs, 'H' for home health, or 'K' for private duty nursing). The State's categories of service codes identifying waiver services ('0055' for CAP/DA, '0057' for CAP/C, or '0085' for CAP/Choice) were also used to identify community-based LTSS. Institutional-based LTSS were flagged based on claim header type ('F' for nursing home or 'N' for adult care home). Medical care expenditures are all Medicaid payments not otherwise classified as LTSS expenditures. Inpatient expenditures were flagged by claim header type ("I" for inpatient or "A" for MEDICARE PART A CROSSOVER (INPATIENT)) that were also not ED visits. ED visits were classified by revenue codes ('0450' through '0459' or '0981') from institutional claims which were not classified as Inpatient, or by procedure codes ('99281', '99282', '99283', '99284', '99285') from professional claims. Pharmacy expenditures included all claims from the pharmacy files. Physician expenditures were flagged by claim header type ("P" for professional or "B" for MEDICARE PART B CROSSOVER [PROFESSIONAL]). All medical services not categorized as inpatient, physician, emergency and pharmacy (such as ambulatory surgery) were included in total or medical expenditures, but not in a specific category. Expenditures were defined using the claim line net payable amount field on Medicaid claims and when MFP grant funding was used for transition coordination or other demonstration services, this information was included in the community-LTSS service expenditures. Based on the month of service, we inflated expenditures by the monthly medical care Consumer Price Index to represent February 2018 dollars. We did not consider housing grants, out-of-pocket expenditures, or any administrative expenditures for the program operation. With transition dates of July 2010 through October 2016, the pre- and post-transition expenditures may span from 2010 through 2017.

F. Study limitations

This study has several limitations. One limitation is incomplete enrollment data. The compilation of data from 2009 through 2017 that was intended and used for different purposes meant that not all fields were available for use across all time periods. Some of the I/DD population may be included in the Older Adults or Physical Disabilities populations due to some limitations in the flagging criteria that were not available in the June 2009 through June 2014 data. Use of hospice services and mortality limited the analysis to those who survived at least a full year after the initial transition so that monthly analysis took into consideration at least 12 months of information. Similar to the limitations of the national evaluation, these exclusions are likely to influence the results, but the direction of that influence is not clear. [lxiv]

There are also important limitations to our cost estimates. This study models the methodology used in the Mathematica national evaluation of the MFP program and includes a sample of "other transitioner", however, it does not include a matched sample of other transitioners to MFP transitioners. Meaningful matching of the populations would require obtaining the nursing facility MDS assessment data, which was unavailable at the time of this study. So, in addition to the major confounding contextual factors identified in the national evaluation, including the great recession, changes to waiver programs and the facilities, this study does not attempt to minimize the potential differences in baseline characteristics between the two non-random groups of transitioners, which may make the costs between the two groups inexact and not as directly comparable.

PARTICIPANTS' QUALITY OF LIFE SURVEY ANALYSIS

A. Quality-of-Life Survey

The survey was designed to measure quality of life in seven domains: living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction, and health status. The seven domains capture three areas of participant quality of life: (1) overall life satisfaction, (2) QoL, and (3) community life. The survey was developed to be conducted with individuals with disabilities and long-term illnesses transitioning from institutions to the community. Since the beginning of the MFP demonstration, grantee states have been administering the MFP QoL survey to their participants at three points: (1) immediately before transitioning to the community, (2) one year after transitioning and (3) two years after transitioning, when participation in MFP has ended and they are regular Medicaid beneficiaries. Overall, the review followed and approximated the national evaluation survey analysis closely and identified similar limitations consistent with issues identified during that evaluation.

B. Data

The primary data source for the analyses presented includes QoL survey data submitted to Mercer collected from 2009 through 2016. When constructing the sample used in the analyses, we restricted it to include only completed surveys that matched to participants in the MFP tracking log with transition dates. When constructing the samples, we imposed the following restrictions: (1) participants must have completed a survey prior to transitioning (baseline) and one year after transitioning and (2) the completed one-year follow-up survey must have been conducted within 6–18 months of transitioning. Mercer relied on the coding within the survey data worksheet specifying baseline and one-year follow-up. All quality of life survey

information focused on the first year post transition to be consistent with analysis of cost in the report and due to the low levels of matching for two-year post transition surveys.

C. Analytic sample

Analysis of raw survey data included 487 baseline surveys, 155 one-year follow-up, and 85 two-year follow-up surveys for MFP participants with transition dates. Linking the surveys by Medicaid ID and name reduced the raw data to an analytic sample of 97 MFP participants with transition dates who had both a completed baseline and one-year post-transition QoL survey. This sample represents 13% of the 775 participants on the MFP tracking log with transition dates through January 2017 and was used to assess the change in QoL one year after someone transitions to community living. QoL survey responses that matched were not limited by population so some individuals with intellectual or developmental disabilities or their proxies may be included in the analysis.

D. Limitations

Several limitations of the QoL analysis should be considered. The analytic sample is only a small proportion of the total number of MFP transitioners, and may not be representative of the population as whole. Additionally, there are possible unmeasured factors that may influence QoL, so this survey analysis may not present a complete picture. In addition, Mercer has noted that some surveys were completed with assistance or by proxy (in analytic sample, 11% of baseline surveys completed by proxy, 27% and 24% for one-year and two-year follow-up surveys, respectively). This could be a possible source of bias for the results, if the person giving assistance or the proxy does not answer the questions as the member would have answered.

ESTIMATE AND PROJECTION OF GROWTH IN WAIVER AND DISABLED POPULATIONS

A. Data

The analyses presented in the population growth projections use Medicaid enrollment files from July 2009 through September 2017, 2010 US Census Summary File 1, 2010–2016 ACS 1-Year Estimates; North Carolina state population projections from the North Carolina OSBM; nursing facility and ACH census data from the 2010–2016 Nursing Homes databases for License Renewal Application available from the North Carolina Division of Health Service Regulation and North Carolina CHAMP Survey Data [2010,2011, 2012, 2013–14] from the State Center for Health Statistics, Raleigh, North Carolina.

B. Trends in CAP/DA and CAP/C populations

Enrollment trends in the CAP/DA and CAP/C waiver populations were analyzed by comparing unique member counts from detailed Medicaid enrollment files from July 2009 through September 2017. Members were identified with special coverage code ('CI','CS','ID','SD' for CAP/DA, and 'HC','IC','SC' for CAP/C), and last month of enrollment within each calendar year was selected for each member. Counts of members were summarized by waiver program, year and age category (0–17, 18–64, 65 and over).

C. Trends in physical disability populations

CHAMP survey data was analyzed to establish trends in the disability population of children in North Carolina needing assistance. The question that was used as a proxy was in the section on Children with Special Health Care Needs: "Is (CHILD) limited or prevented in any way in his/her ability to do the things most children of the same age do?" Note that CHAMP data was used because ACS data on "Independent Living Disability" question was not asked of children ages 15 and under".[lxv]

US Census and ACS data from 2010 were analyzed to establish a proxy for the adult disabled population in North Carolina that may need LTSS. Questions PCO5 (group quarters population in nursing facilities/ skilled-nursing facilities) and PCO6 (group quarters population in other institutional facilities) were summarized by age as a proxy for the institutional LTSS population, and question B18107 (IL Difficulty) was summarized by age category as a proxy for the HCBS LTSS population.

ACS data from 2011–2016 from question B18107 and CHAMP survey data were also compared against the North Carolina total state population figures from OSBM from 2011–2016, and from ACS S0101 Age and Sex tables from 2013–2016.

D. Trends in nursing facility and adult care home populations

Nursing facility and ACH populations were summarized over the years 2010–2016 by comparing census data from the Nursing Homes and ACH databases for License Renewal Application. Data from the "tblPatientCensus" table were categorized by age and reviewed for trends.

E. Population growth projections

CAP/DA and CAP/C populations by age category are projected forward by 5, 10 and 15 years based on trends identified in the enrollment data for the waivers, trends in the disabled population in the State identified in the CHAMP survey data and ACS data, using the projected State population from OSBM in future years.

STAKEHOLDER MEETINGS/INTERVIEWS

- Four home visits with individuals who have transitioned (three MFP, one TCLI).
- MFP Staff (in-person and telephonic).
- MFP Sustainability Plan Advisory Committee (in-person and telephonic).
- MFP Roundtable (in-person).
- Visits to three nursing homes in Wilmington (in-person).
- DHHS LTSS Leadership (in-person).
- DHSS, DVR-IL Leadership (in-person).
- Disability Rights and Resources CIL (telephonic).
- SWC on AAA (telephonic).
- CAP/DA Lead Agency Staff (telephonic).
- Alliance of Disability Advocates CIL (in-person).
- ACH Stakeholders including ACH Association representative, DHHS licensure staff and ACH operator (telephonic).
- DHHS, Division of Health Services Regulation Staff (telephonic).

- DHHS, Special Assistance Program Staff (telephonic).
- DHHS, Medicaid Eligibility Staff (telephonic).
- Eastern Carolina AAA (telephonic).
- Cape Fear Valley Health (telephonic).
- Cape Fear Council of Governments (telephonic).
- Upper Coastal Plain Council of Governments (telephonic).
- Land of Sky Regional Council (telephonic).
- Centralina Council of Governments (telephonic).
- Eastern Carolina Council of Governments (telephonic).

DATA ANALYSIS
- MFP Referral and Enrollment.
- LCA Referral/Process Including MDS Proxy and Call Center Data.
- Incident Management (MFP and CAP/DA).
- National MDS Section Q Data for Q0600 from 2012 to 2017.
- Administration for Community Living – CIL Annual Awards 2017.
- Nursing Facility and ACH Bed Capacity – State Medical Facilities and Plans 2010–2015 Nursing Home Bed Day Utilization and Cost – Nursing Facility and ACH Data Base CAP/DA Waiver 372 Reports
- Enrollment Data –CAP/DA and Community Alternative Program for Children (CAP/C) Waivers
- DVR-IL MFP and Other Transition Data.
- DHHS Claims Data-MFP and Non-MFP Transitioners.
- North Carolina MFP QoL Survey Data.
- MFP Financial Reporting.
- MFP Master Spreadsheet Data.

STATE SPECIFIC DOCUMENTS
- Annual and Semi-Annual MFP Reports.
- CAP/DA, CAP/C and Innovations Waiver Applications.
- State Plan Pages Related to Medicaid Eligibility and PCS.
- Nursing Facility Clinical Policy.
- North Carolina Administrative Code Rules.
- North Carolina Guidance to Surveyors for LTC Facilities.
- Acute Inpatient Clinical Policy.
- Eastern Carolina Council of Governments Position Description for LCA Options Counselor.
- CAP/DA Clinical Policy.
- PCS Policy.
- PACE Clinical Policy.
- DAAS Contract with AAA includes LCA functions.
- SW Area Agency on Aging-Aging Assistant Position Description.
- Centralina Council of Governments Area Agency on Aging-Aging Specialist with LCA Duties Position Description.
- RN Care Coordinator Job Description-Cape Fear Valley Health System.

- CAP/DA Clinical Policy Transitions and Care Coordinator Job Description 11-1-16 Cape Fear Valley Health System.
- Eastern Carolina Council of Governments Transition Coordination Position Descriptions.
- Senior Services CAP/DA Transition Coordinator Position Description.
- Transition Coordinator Contract with CAP-/DA lead agency (Cape Fear Valley Contract).
- Transition Coordinator Intra-Departmental Memorandum of Agreement (IMOA) with DVR-IL, Transition Coordinator Contract with AAA Example.
- SW Area Agency on Aging-Aging Program Coordinator (Includes Transition Coordinator Activities) Position Description.
- DVR-IL Counselors Position Description.
- Nursing Home Transitions Coordinator Position Description Disability Rights and Resources.
- North Carolina LME-MCO Contract Sample.

SURVEY TO TRANSITION ENTITIES

A survey regarding transition-related activities was disseminated among transition networks. A total of 112 distinct responses were received. Results were analyzed and used in a variety of ways throughout the report.

LITERATURE REVIEW

In addition to the specific citations provided within this report, Mercer also completed a literature review of transition and diversion practices. These can be found in their entirety as appendices to the report.

APPENDIX A
TRANSITION COORDINATION FUNDING OPTIONS

Transition coordination is a function that supports individuals and if applicable, their family/caregivers, through the process of transitioning from a LTC facility to the community. While the transition coordination function incorporates service planning and care coordination responsibilities, it should be viewed as a distinct function, separate from case management, with transition-specific skillsets.

North Carolina currently relies on MFP-grant funding or State dollars to fund its current transition coordination services for older adults and people with physical disabilities.

POSSIBLE LEGAL AUTHORITIES FOR MEDICAID FUNDING OF TRANSITION COORDINATION

Transition coordination can be funded under Medicaid through different case management, contract and HCBS authorities. Case management may be legally created under Medicaid regulations and statutes in five ways; however, not all of those authorities fully fund transition coordination. The following authorities may be used to fully fund transition coordination:

- Targeted case management (TCM) under the State Plan Amendment (SPA).

- Treatment planning for special needs enrollees in managed care.

- HCBS through a 1915(c) home- and community-based waiver or 1915(i) home- and community SPA.

Administrative case management and rehabilitative service coordination authorities can be used to fund Medicaid-related components of transition coordination. However, transition coordination cannot be fully utilized by those authorities because transition coordination requires the coordination of non-Medicaid service components, which cannot be funded under administrative case management or rehabilitation authority. The following table summarizes each type of authority, with federal financing mechanisms and coverage limitations also provided.

FIGURE 34: OPTIONS FOR LEGAL AUTHORITY TO FULLY FUND TRANSITION COORDINATION THROUGH MEDICAID

TYPE OF AUTHORITY	LEGAL CITATION	REIMBURSED AS A SEPARATE SERVICE	COORDINATES MEDICAID AND NON-MEDICAID SERVICES	MATCH RATE
TCM	42 CFR 440.169	Yes	Yes	Federal Medical Assistance Percentage (FMAP)
Managed care treatment planning	42 CFR 438.208	Built into capitation rate	Yes	FMAP
HCBS	42 CFR 441.300 (1915(c) waiver) 42 CFR 441.700 (1915i SPA)	Yes	Yes	FMAP

Option 1 – TCM

TCM is a SPA authority to finance transition coordination services provided by qualified community Medicaid providers. The purpose of services under TCM authority is to assist eligible individuals in gaining access to needed medical, social, educational and other services. TCM service activities include:

• Assessment to determine service needs.
• Development of a specific care plan.
• Referral to needed services.
• Monitoring and follow up.
• Rehabilitation services activities includes skill restoration related to maintaining community tenure.

Pros
• Relatively straightforward authority placed into the Medicaid SPA to perform generic rehabilitation activities and the four outlined duties of TCM: assess, develop care plan, refer and monitor.
• TCM allows states to create a target group of individuals for the case management activities (e.g., not all populations receive TCM).

Cons
• Scrutiny of this authority has led to CMS tightening rate-setting methodologies to more commercial care coordination staffing and reimbursement standards. Consequently, TCM reimburses at a lower rate than traditional models with transition coordination. For example, Massachusetts pays $23.74 per 15-minute units for Master's level care coordinators and $18.88 per 15-minute units for Bachelor's level care coordinators. These rates are typically considered insufficient to support transition coordination with its more intense contacts and correspondingly lower caseloads (e.g., 1:10 caseload).

- Scrutiny over the Rehabilitation authority has also led to skill restoration rates that are narrowly defined. Concerns over "bundled" rates have required states to create separate rates for TCM from Rehabilitation Supports.
- SPAs in TCM and Rehabilitation have not been reviewed by CMS in a timely manner. One state with standard TCM SPAs submitted in 2012 and still does not have the SPAs resolved. Rehabilitation SPAs can take from 1–3 years for approval.
- Transition coordination can only be provided for only 90 consecutive days prior to discharge.

Option 2 – Managed Care Treatment Planning

Managed care treatment planning is another authority used by managed care companies to finance MCO administrative staff or community-based providers to provide coordination services with transition coordination and tenancy supports. It is anticipated with the enrollment of LTC beneficiaries into North Carolina's anticipated transition to managed care, this funding option will be utilized to support the transition coordination function. Under this authority, the state selects criteria for special needs enrollees to be identified, assessed and to have treatment plans created. The state may have additional criteria for treatment planning in the managed care contract beyond federal requirements. Transition coordination funding may be either included in an administrative component or in the medical component of a capitated rate depending upon the state's requirements. Transition coordination costs are typically included in the numerator of a medical loss ratio because they are care coordination costs (45 CFR 158 et al).

Pros

- Authority within capitated managed care contracts allows states to mandate requirements for care coordination without seeking additional SPA or waiver authority. Most states do identify special needs populations in 1915(b) waivers, when those authorities are utilized.
- CMS allows states to build reasonable administrative costs into capitated contracts to reflect contractual requirements, but does not scrutinize beyond actuarial soundness for the required activities.
- Allows states to create a target group of individuals for the case management activities (e.g., not all populations receive treatment planning). The state could create additional criteria for the targeted population if a particular population is found to not be cost effective for this model or if research finds a new population with efficacy under the model.
- States must comply with the basic regulatory requirements of identification, assessment, treatment plan development and approval while providing direct access to specialists as appropriate.
- This action does not require SPA or waiver amendment.
- CMS allows states to create additional contractual requirements associated with implementing managed care treatment planning.

Cons

- The considerable administrative burden to implement: amending the 1915 (b) waiver, LME-MCO contracts and capitation payments.

Option 3 – HCBS Authority

Sections 1915(c) and 1915(i) of the Social Security Act authorizes the Secretary of the US DHHS to waive certain specific Medicaid statutory requirements so states can offer HCBS to targeted groups of Medicaid beneficiaries who meet an institutional LOC. In order to provide HCBS services to a state-identified target group, a state must submit either a 1915(c) HCBS waiver application if it wants to limit populations to those meeting an institutional LOC or a 1915(i) SPA if it wants to limit populations to those meeting a needs based level less than institutional admission criteria to CMS for approval. The state must demonstrate it has met to CMS' satisfaction, waiver assurances to ensure the quality of care. Under these authorities, transition coordination can be provided as a service for those that meet the eligibility criteria.

Pros

- 1915(c) – Allows states to implement in certain areas rather than on a statewide basis.
- 1915(i) – Allows states to require lower than institutional LOC for enrollment.
- Both authorities allow the state to limit to individuals meeting target population and risk criteria.
- Transition coordination can only be provided only for 180 days prior to discharge.

Cons

- 1915(c) – Requires states to impose an institutional LOC as a requirement for enrollment into the waiver.
- 1915(i) – Requires states to implement statewide, but CMS does allow for the flexibility to phase-in statewide implementation over a five-year period.
- HCBS – Requires the state to the create infrastructure to comply with all HCBS assurances and the new HCBS regulation.

APPENDIX B
NURSING FACILITY DIVERSION: DEMONSTRATED PRACTICES AND STATE EXAMPLES

The information included in this document summarizes various non-North Carolina state examples and emerging practices to support successful diversion from institutional settings. Key diversion practices include identification of individuals at risk of institutionalization, streamlined and expedited eligibility determinations, expanded Medicaid financial eligibility for LTSS, addition of pre-Medicaid services, support for informal caregivers, developing strategies to address workforce strategies, making and tracking LTSS decisions, tools used for assessment of need, asset disregards and increasing access to HCBS.

This summary contains both examples of activities that could be implemented in North Carolina's current FFS landscape and includes examples of LTSS design elements that may be better integrated into North Carolina's future 1115 waiver.

IDENTIFY INDIVIDUALS AT RISK OF INSTITUTIONALIZATION
Diversion efforts rely, in large part, on the identification of individuals at risk of institutionalization. The national Independent Living Network has identified strategies to identify these individuals, including:[lxvi]

Develop Standardized Tool to Assist Identified Entities to Screen for Risk of Institutional Placement.

Example: In 2015, LIFE Inc. created an "At-Risk Survey" as a standardized tool that consists of 14 questions to help CILs in Texas identify individuals at risk of institutional placement. The survey is used "in conjunction with other information obtained during the intake process to make a more informed assessment of the consumer's 'at-risk' status."[lxvii]

Develop Early Intervention Programs.

Example: Ability360 in Arizona administers an early intervention program in collaboration with rehabilitation hospitals to serve individuals after acquiring a profound disability.

"Ability360's experience with outreach to individuals going through rehabilitation is one example of a targeted approach to assisting someone to avoid institutionalization…" [Ibid.] The program provides outreach to individuals in the rehabilitation hospitals who are newly disabled.

Stronger Follow Along for Recently Transitioned Beneficiaries.

Example: Relocation from Nursing Facilities to Community Programs — CILs with relocation programs may routinely identify newly transitioned consumers as at-risk.

STREAMLINE ELIGIBILITY DETERMINATIONS

The timeliness of eligibility determinations is a primary factor in diversion efforts. Nursing facilities are better able to take on financial risk than community resources when an eligibility determination has not yet been made. States have adopted processes, like rapid eligibility determinations and presumptive eligibility to address this barrier to HCBS.

"Laura Summer and colleagues recently reviewed effective diversion programs in eight states and noted that those combining rapid functional and financial eligibility assessment with ongoing funding and support for community-based services were deemed to be most effective."[lxviii]

Fast Track Eligibility Determination

Washington State through a network of community-based contracted agencies uses a "fast track system" for eligibility determinations. "Face-to-face interviews must be conducted within two days of a case assignment and Medicaid nursing facility clients must be seen within seven days of admission."[lxix] The State also developed a computerized assessment tool to determine eligibility and determine a plan of care, and has adopted presumptive eligibility.

Assessment Hotline

Pennsylvania piloted a service for referrals to their Community Choice program, which provided a 24/7 hotline for applicants or agencies referring members to request an assessment for long-term care.[lxx]

Interim Waiver Services

Nebraska has adopted a "Waiver While Waiting" program to address the lag time between the need for HCBS and availability of services. Service coordinators can authorize waiver services for individuals who are likely eligible for Medicaid.

Centralize Eligibility for Waiver Programs

Indiana has a central enrollment unit to help with eligibility determinations for all waiver programs.

EXPAND LTSS FINANCIAL ELIGIBILITY CRITERIA

Expanded financial eligibility criteria, allows states to provide LTSS to individuals who would otherwise not be eligible for Medicaid. Forty-four states allow people whose functional needs require an institutional LOC to qualify for Medicaid with incomes up to 300% of the SSI level known as the "special income rule."[lxxi] Most states, but not all apply the Special Income Level (SIL) to both people in an institution, and people receiving LTSS services in the community. **"Aligning financial eligibility rules across LTC settings is important to eliminating programmatic bias toward institutional care. For example, if people can qualify for institutional services at higher incomes than required to qualify for community-based services, they may choose to enter a nursing facility when they need care instead of going without care while spending down to the lower HCBS level."[lxxii]

CONSIDER ADDITION OF PRE-MEDICAID SERVICES

Investment in HCBS services for individuals before they have a need for Medicaid-funded LTSS is a mechanism that may divert or put off the need for these supports. Under 1115 demonstration waiver authority,

Washington and Vermont are providing an array of services. Washington is providing a limited set of Medicaid-financed LTSS benefits — including specialized medical equipment, respite care, and assistance with housework, errands, and home-delivered meals — to individuals age 55 and older who are otherwise at-risk of becoming eligible for Medicaid in order to access LTSS. Similarly, Vermont provides limited Medicaid-financed LTSS benefits — including case management, homemaker and adult day services — to pre-Medicaid eligible adults who are assessed as having "moderate needs" in order to prevent their decline into a higher need category. States use different risk stratification methods for identifying individuals at-risk of nursing facility care who are eligible for the programs.[lxxiii]

Another strategy is to develop services that support informal caregivers. Many who are diverted from institutional care rely on family caregivers, and according to the 2017 LTSS scorecard, "more recognition and support for family caregivers is needed.[lxxiv] Examples of these efforts are described below:

Family Caregiver Assessments
South Carolina, Tennessee and Texas require managed care plans to use stand-alone assessment tools for family caregivers. Generally, plans develop the tools, but these states require family caregiver assessments to include elements such as measures of caregiver burnout, the need for instruction and services, whether the family caregiver is employed outside of the home and if the caregiver lives with the member."[lxxv]

Caregiver Training
Within their MLTSS programs, "California, Massachusetts, New Mexico and Wisconsin cover the instruction or training of caregivers to better enable them to carry out tasks at home. Massachusetts requires plans to develop family caregiver instruction. Participant-directed or self-directed programs, such as those in California and New Mexico, allow Medicaid members to hire the person who provides his or her services and to cover caregiver education. Centennial Care, New Mexico['s] Medicaid managed care program, offers a self-directed community benefits program option where care plan-related conference or class fees may be covered for both members or unpaid caregivers." [lxxvi]

Respite
Respite is a commonly available benefit under Medicaid LTSS, but the scope and type of respite services vary greatly from state to state. Plan administrators described generous Medicaid respite benefits in some states (e.g., up to 600 hours a year — in home or residential settings — in Arizona or up to 30 days a year in New Jersey), as well as more limited benefits in other states (e.g., 14 days of respite services in a residential setting only in South Carolina).

National Family Caregiver Support Program
"Since most plans are not familiar with the National Family Caregiver Support Program (NFCSP) under the Older Americans Act, there is an opportunity for better leveraging these services and supports in managed LTSS to target family caregivers in need. Established in 2000, the NFCSP provides grants to states and territories to fund a range of supports to help family caregivers care for relatives or close friends in their homes for as long as possible. However, available programs and services vary among states and communities, reflecting both limited federal resources and variation in local priorities. Services include informing family

caregivers about available services; assisting family caregivers in gaining access to supportive services; individual counseling, support groups, and family caregiver training; respite care; and supplemental services on a limited basis."[lxxvii]

DEVELOP STRATEGIES TO ADDRESS WORKFORCE SHORTAGES

States have adopted self-direction and "nurse delegation" as ways to address HCBS provider shortages. "Many HCBS programs incorporate some level of consumer direction, such as consumer choice in the allocation of service budgets or in the hiring and firing of service providers. By 2010, 44 states allowed consumer direction within some or all of their Medicaid HCBS programs."[lxxviii]

> In **Vermont**, half of the personal care services provided in HCBS waiver are consumer-directed. In Oregon, "lay caregivers who receive teaching and support can provide services in all settings except nursing facilities."[lxxix]

IMPROVE PREADMISSION ASSESSMENT AND OPTIONS COUNSELING

Several states mandate a pre-admission assessment before a nursing facility admission to ensure members are aware of their options for care; others require eligibility reassessments.

> **New Jersey** requires a pre-admission screening before a nursing facility admission: members are classified under two categories depending on their likelihood of remaining in the facility. Community Choice counselors work with members with shorter expected stays to develop a relocation plan. While **in Oregon,** the "eligibility review period is set depending on the person's condition at the time of admission to a nursing [facility]." [lxxx]

UNIFY ASSESSMENT OF NEED TOOLS

Uniform assessment of the level of need across LTSS programs and categories of eligibility promotes greater equity in service provision.[lxxxi] The Medicaid and CHIP Payment and Access Commission's (MACPAC's) analysis of states' functional assessment tools shows that there are at least 124 tools currently in use. On average, states are using three different tools each, as they generally use separate tools for different populations.[lxxxii] North Carolina relies on a number of program-specific LTSS assessment tools. [lxxxiii]

In March 2014, CMS awarded planning grants to Medicaid programs in nine states as part of a demonstration to test several tools related to LTSS quality and assessments, including a Functional Assessment Standardized Items (FASI) tool.[lxxxiv] This tool and the functional assessment items should be available to states in 2018.

"States that adopt MLTSS must make certain decisions about the use of assessment tools."[lxxxv]

"Some states (e.g., Minnesota and Texas) require all plans to use a certain tool, while others (e.g., Tennessee and Wisconsin) allow each plan to use the tool of its choosing, albeit with certain requirements or restrictions." [lxxxvi] While MACPAC decided to monitor developments on the issue of a single standardized assessment in the 2016 Report to Congress, the Medicare Payment Advisory Commission has recommended a common patient assessment tool for Medicare LTC providers.[lxxxvii] FASI tool is aligned with the assessment tools being

developed through this Medicare effort, which could help streamline data collection and measures across Medicare and Medicaid.

INCREASE ASSET DISREGARD [lxxxviii]

Low asset thresholds for Medicaid eligibility have been identified as a diversion obstacle; even if an individual has a home, they have to spend down so much that home maintenance becomes impossible. Several states have chosen to increase the asset threshold.

> **Pennsylvania** increased its threshold from $2,000 to $8,000. That is, if the individuals' income is below or equal to the 300% of the federal benefit level, the resource limit is $2,000 with an additional $6,000 resource disregard for individuals receiving HCBS waiver services.[lxxxix] Additionally, **Vermont** allows a $2,000 bump in the asset threshold for individuals who own their home.[xc]

INCREASE ACCESS TO HCBS

Researchers have identified certain successful strategies and initiatives used by states in the rebalancing of their LTSS systems. These include global budgeting, consolidated LTC agencies, single point of entry, consumer-directed care, institutional capacity reduction, nursing home diversion and transition programs and standardized assessment tools.[xci]

In its most recent AARP LTSS scorecard, the following policies were recommended for development and implementation by states to improve individuals' choice of setting and providers:[xcii]

- A greater proportion of Medicaid and state-only funding for HCBS, because on average funding can pay for 30 hours of service per week for three people in home- and community-based care for the cost of one person in a nursing facility.

- New Medicaid beneficiaries should first receive LTSS in the community, because it is more difficult to return home after a nursing facility admission.

- Participant-directed services to enable consumers and their families to decide how, when, and by whom care is provided — for example, by allowing consumers to manage their own publicly funded budgets for care or paying family caregivers with public funding.

- Access to home care workers so consumers with disabilities can live in their homes and communities.

- Residential care options for when living at home is no longer viable.

- Affordable housing by providing subsidies for lower-income individuals and investing in low-income rental units, especially for people with LTSS needs, which typically have lower incomes and higher costs for health care and supportive services.

"States such as **Oregon** and **Vermont,** that have legislative mandates to reinvest cost-savings from reductions in institutional care into the development of a home and community-based care have increased the

capacity to provide community-based care over the years. A related approach, in which 'money follows the person' from a nursing [facility] to the community can also enhance community capacity, but unless the funds remain in the budget for community-based care, the enhancement is temporary."[xciii]

New York created a new 1915 (c) HCBS waiver designed to divert or transition individuals from nursing homes. The waiver provides an array of services for younger individuals with physical disabilities and older adults, including respite, service coordination, assistive technology, community integration counseling, congregate and home-delivered meals, environmental modifications, home and community support services, and community transitional services (e.g., paying for security deposits, moving belongings, furnishings, and setting up utilities).[xciv]

"In states such as *Oregon* and *Washington* that have pooled funds for all long-term care services, funding for home and community-based care relative to institutional care is not limited. Most states, however, are authorized to serve a limited number of people through their waiver programs, which have separate budgets. By contrast, an applicant who meets the financial and functional eligibility criteria is entitled to nursing facility care. Nursing [facility] diversion programs cannot be successful if funds to provide community-based care are not available." [Ibid]

"Separate budgetary allocations for institutional and HCBS programs can work as a disincentive to rebalancing the LTSS system. A practice used in several states to foster rebalancing is global budgeting for all LTSS programs, or, more broadly, flexible accounting so that savings in institutional expenditures can be seamlessly reallocated to HCBS programs."[xcv]

APPENDIX C
REVIEW OF STATE'S MFP SUSTAINABILITY PLANS

GEORGIA [xcvi]

The goals of the sustainability plan are to transition 400 individuals per year from institutional settings while continuing to support diversion opportunities through ongoing work of Options Counselors.

Georgia's Sustainability Plan will:

- Integrate ongoing administrative support for rebalancing initiatives into the infrastructure including Options Counseling and staff resources.

- Sustain transition supports from institution to community through conversion of demonstration services into HCBS waivers.

- Strengthen Georgia's HCBS infrastructure by:

  - Revisiting and revising as necessary the design of case management to ensure enhanced and uniform practices and consistent outcomes with a focus on person-centered planning and service delivery.
  - Establishing a standardized electronic IT system to collect quality outcome data and investigate the viability of centralizing components of various HCBS information systems for quality management purposes.
  - Several MFP demonstration services will be converted to transition services (pending CMS) approval). Key transition services include, but are not limited to:
    › TCM
      - Modifications to Georgia's transition work focuses heavily on the creation of the "Transition Case Manager" role which will be boosted by enhancements to current case manager qualifications for the provider of this service.
      - The State will utilize rebalancing funds to standardize case management services across all waivers to increase the quality of transitions.
      - Georgia will engage in an initiative to design and validate a curriculum and certification process for all case managers to raise the bar and standardize practices leading to increased stability in the community for transitioned individuals who are better supported to exercise choice and control as well as enjoy improved health, safety and welfare.

    › Transition setup and move-in service.
    › Transition environmental modifications.
    › Transition adaptive technology, related services and supplies.
    › Transition peer support.

- The State will relax certain criteria that are required currently under MFP:
  - An institutional stay must be of a duration of at least 30 days rather than 90 days.
  - Qualifying residences will include no more than six unrelated individuals.

- The State will amend four 1915(c) waivers as part of the sustainability plan, including the following specific service changes outlined below:

  - **Peer Community Support**

    - A new wavier service called "Transition Peer Community Support" will be added to each waiver.
    - Georgia has a long history in recognizing the value of peer support services and we believe them to be an essential component to community stability by helping individuals becoming empowered to manage their service and overall living needs.

  - **Household Furnishings**

    - The State will retain and modify this service to create a new 1915(c) wavier service called "Transition Setup and Move-in Service."
    - The Transition Setup and Move-in waiver service will be offered to eligible members transitioning from inpatient stays of at least 30 consecutive days.
    - The service will be added to existing 1915(c) waivers, including New Options Waiver/Comprehensive Supports Waiver (NOW/COMP), Community Care Services Program/Service Options Using Resources in a Community Environment and Independent Care Waiver Program (ICWP).
    - Transition Setup and Move-in Service is designed to assist an eligible transitioning member to pay housing application fees, make security deposits, pay first month's rent, make utility deposits for a qualified residence and other essential services as determined to be medically necessary on a case-by-case basis without which the home would not be firmly established and/or community stability would be at risk.

  - **Household Good and Supplies**

    - The State will retain and modify this service to create a new 1915(c) wavier service called "Transition Setup and Move-in Service."
    - Moving Expenses – The State will retain and modify this service to create a new 1915(c) wavier service called "Transition Setup and Move-in Service." See description of modified service and rate under the subheading "Household Furnishings."

  - **Utility Deposits, Security Deposits and Transition Support.**

    - The State will retain and modify this service to create a new 1915(c) wavier service called "Transition Setup and Move-in Service."

- **Caregiver Outreach and Education.**

  - The State will retain and modify this service to create a new 1915(c) wavier service called "Transition Caregiver Outreach & Education."
  - The Transition Caregiver Outreach & Education waiver service will be offered to eligible members in the Elderly and Disabled Waiver and ICWP Waiver.
  - A similar service already exists in the NOW and COM Waivers.

- **Equipment, Vision, Dental and Hearing Services**

  - The State will retain and modify this service, along with Specialized Medical Supplies to create a new 1915(c) wavier service called "Transition Adaptive Technology, Related Services and Supplies."
  - The Transition Adaptive Technology, Related Services and Supplies will be added to the Elderly and Disabled Waiver.
  - Access to adaptive equipment was identified as most needed for success by elderly and disabled participants and transition coordinators. The other waivers already include a similar service.

- **Specialized Medical Supplies**

  - The State will retain and modify this service, along with Equipment, Vision, Dental and Hearing Services to create a new 1915(c) wavier service called, "Transition Adaptive Technology, Related Services and Supplies."
  - The Transition Adaptive Technology, Related Services and Supplies will be offered to eligible members transitioning from inpatient stays of at least 30 consecutive days.
  - The service will be added to the Elderly and Disabled Waiver. The ICWP, NOW and COM already include similar services.

- **Environmental Modifications**

  - The State will retain and modify this service along with the Home Inspection Service to create a new wavier service called, "Transition Environmental Modifications and Home Inspections."
  - The new waiver service will be offered to eligible members transitioning from inpatient stays of at least 30 consecutive days.
  - The service will be added to the Elderly and Disabled Waiver. The ICWP, NOW and COM already include a similar service.

- **Home Inspections**

  - The State will retain and modify this service along with Environmental Modifications to create a new waiver service called "Transition Environmental Modifications and Home Inspections."

- The service will be added to the Elderly and Disabled Waiver and a similar benefit already available in the ICW will be modified to add Home Inspections.

   – **Supported Employment Evaluation**

- The State will add Supported Employment Services to the waivers where this service is not already in place. The service will be added to the Elderly & Disabled Waiver and the ICWP.

   – **Fiscal Intermediary**

- "Financial Management Services (FMS)" which provide the functions of a Fiscal Intermediary are already available through each 1915(c) waiver. However, access to FMS is available only to those who select participant direction.
- The State will modify the service definition to allow the FMS provider to also support transition specific costs for which a traditional provider is not available (i.e., transition setup and move-in costs).

   – **Transition Coordination Services** [xcvii]

- The State will retain the current work of the MFP transition coordinator and modify and enhance it to create a new waiver service called "Transition Case Management."
- Transition Case Management's role will be refined to specify qualifications and will expand responsibilities to close gaps identified in demonstration and stakeholder feedback.
- For example, in addition to the current transition coordinator role, the new Transition Case Management will be responsible for convening an individual's circle-of-support, engaging the individual in person-centered planning, with added requirements ensuring that the Transition Case Manager has an effective working relationship with the waiver case manager, in addition to requirements for transition and waiver service authorization and enhanced service monitoring.

NEW YORK [xcviii]
New York's Sustainability Plan focuses on:
Expanding the State's "Open Doors" program

- "The New York Association of Independent Living (NYAIL) operates the Open Doors program as the backbone of New York State's MFP Demonstration.
- The purpose of the Open Doors project is to identify potential participants in nursing facilities, educate them on their return-to-community options and facilitate successful transitions to their community of choice.
- Open Doors programs have expanded their ability to reach out to the frail elderly, and physically and/or intellectually disabled individuals in New York state nursing homes, as well as Veterans, the elderly with mental health challenges and New Yorkers residing in out-of-state nursing facilities.

Continuing Transition Centers and Peer Outreach and Referral programs

- These programs will be extended beyond the end of the MFP Demonstration and into the future by transferring the program support to Medicaid administrative funds in 2020.
- NYAIL's Transition Centers provide transition planning and community readiness training to educate and support institutionalized individuals to prevent a potential "disconnect" between facility discharge planners and the community-based service providers.
- Transition Centers are responsible for informing, supporting and bridging the transition of individuals from pre-discharge, while in the facility, to early stages of transition within their community of choice.

Supporting caregivers of individuals who are receiving HCBS

- Caregiver support is occurring through the development and distribution of the caregiver guide.

Building the HCBS workforce

- New York State's Workforce Investment Program (WIP) makes available funds through the State's 1115 waiver for initiatives to recruit and retain health care workers in the LTC sector.
- The WIP targets direct care workers, with the goals of supporting the critical long-term health care workforce infrastructure through retraining, redeployment and enhancing skillsets.
- The WIP supports the expansion of home care and respite care, enabling those in need of LTC to remain in their homes and communities and reduce New York's Medicaid costs associated with LTC.

WISCONSIN [xcix]
Wisconsin's Sustainability Plan focuses on:

- Wisconsin's Sustainability Plan proposes to transition MFP to managed care and eliminate LTSS waitlists.

- The State did not identify any new demonstration and supplemental services in MFP because relocation and transition services were, and continue to be, part of authorized waivers.

- "One particularly noteworthy benefit of the MFP Demonstration in Wisconsin was the development of an automated referral system for people living in nursing homes who indicate in Section Q of the MDS 3.0 that they would like to talk with someone about the possibility of returning to the community."

- Automated referral system will continue after MFP funds expire.

MASSACHUSETTS [c]
Massachusetts' Sustainability Plan focuses on:
Existing HCBS Waivers

- Two HCBS waivers, in addition to its existing set of 1915(c) waivers, will be mechanisms to ensure sustained availability of home and community-based services for individuals transitioned from facilities under the demonstration.

Eligibility and Enrollment

- The most important factor related to this response was Massachusetts' creation of a dedicated MassHealth eligibility specialist position that verifies member eligibility, especially in complex situations, to meet the financial requirements needed for MFP participation in the community.
- Upon conclusion of the MFP Demonstration, this support will continue to be available to Aging and Disability Resource Centers partners and the No Wrong Door system.

Housing

- Upon conclusion of the MFP Demonstration, funds for security deposits will be made available through waiver Transitional Assistance Services.

Community Supports and Services

- Stakeholders have received comprehensive instruction on HCBS waivers, which included the waiver application process. This training included classroom and small group training forums, as well as the availability of an online waiver education module (note: this module ranks second in the number of online "hits" received for all Massachusetts MFP online trainings). This training module will continue to be available after the conclusion of the MFP Demonstration.

- As another source of support to Transition Entities related to HCBS waivers, MassHealth is in the process of developing a public information brochure that will outline all waivers the State operates, for use by Transition Entities, and pointed specifically toward members.

Transitional Goods and Services

- Services will be accessible through HCBS Waiver Transitional Assistance Services. Massachusetts will amend its Money Follows the Person-Community Living and Money Follows the Person-Residential Supports waivers to add Transitional Assistance Services upon conclusion of the MFP Demonstration.

LOUISIANA[ci]

Louisiana's Sustainability Plan focuses on:

MLTSS

- The State adopted MLTSS for the elders and adults with adult on-set disabilities population in 2015, and the I/DD population in 2016. MLTSS is the foundation of the Sustainability Plan.

Using existing transition protocols

- The transition protocols developed and tested by the MFP Demonstration will be transferred to operationalize expectations of the managed care plans operating the Elder and Physically Disabled MLTSS system and will be a consistent, standard expectation of their performance measure.

Leveraging diversion

- For the purpose of diversion, the State plans to offer priority waivers to persons who are currently residing in nursing facilities and who are deemed to meet NF LOC based on the MDS-home care and who are not in nursing facilities for a therapeutic/rehabilitative stay only.
- All must meet financial eligibility for Medicaid LTSS as well.
- These are the eligibility criteria for the State's proposed MLTSS system.

APPENDIX D
MFP TRANSITION BEST PRACTICES

This appendix contains best practice analysis that is organized by the aspirational phases of the North Carolina MFP program's transition activities of: (1) In-reach/Fully Deciding, (2) Effectively Transitioning/Effectively Preparing to ensure Comfortable Transitions, (3) Follow Along, (4) Support and Referral/Thriving and (5) "Other." Each category includes two parts, "general observations" and "state examples." In addition to the following informational resources, the MFP Self-Assessment developed by the TA Center should serve as a framework for the MFP innovations states have adopted.[cii]

1. IN-REACH/FULLY DECIDING
General Observations

Many MFP programs such as Colorado, Connecticut, Michigan, New Jersey, Virginia and Wisconsin employ dedicated outreach specialists who perform a variety of outreach and education tasks including:

- Researching and defining the outreach population.
- Developing a marketing plan and marketing budget.
- Creating marketing media.
- Educating stakeholders.
- Meeting with families, institutional staff and potential participants.

State Examples

Nevada: Use of a weekly LOC report for outreach strategy; report provides State staff with information about the most recent Medicaid beneficiaries who have been screened for nursing facility placement.[ciii]

Nebraska: Transition coordinators employed by the state reach out to transition candidates, nursing facilities and ICF/IID staff and other stakeholders to educate on LTSS resources.[civ]

2. PREPARING FOR AN EFFECTIVE TRANSITION/EFFECTIVELY PREPARING
General Observations

Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities, Kaiser Family Foundation Report

The most frequently cited essential pre-transition services were support from transition specialists (also known as transition coordinators or navigators), transition services that may include a budget for household items, set-up fees or deposits for utility access and housing assistance.

Other critical pre-transition supports identified by states include: options counseling (provided by local AAAs and CILs), intensive case management (that may include a readiness assessment to develop a plan for successful transition), peer mentorship, independent living skills training, assistive technology and access to non-medical transportation to obtain documentation for housing and/or locate housing.

Mathematica, The Right Supports at the Right Time: How MFP Programs Are Supporting Diverse Populations in the Community

Mathematica's report includes a variety of strategies to support MFP transitions for diverse populations. These include: needs and preferences should be identified early in the transition process (facilitates timely linkages to community services and helps avoid re-institutionalization), assessment instrument should capture a person's holistic needs and preferences, [cv] and methods for transitioning adult nursing home residents under age 65 to independent living, include peer networks, strong transition coordination services, flexible LTSS, high levels of motivation and networks of informal supports.[cvi]

Five study states (Connecticut, Maryland, New York, Texas and Washington) attributed their success with the nursing home population to transition coordinators and other staff, such as housing coordinators and specialized case managers, who provide critical services prior to transition.[cvii]

MFP Technical Assistance Website
Indiana is listed as a resource for MFP TA. Specifically, the TA references a "pre and post-transition checklist" which includes specific activities that must be completed.[cviii]

State Examples
Individual Assessment
Tennessee: Requires staff responsible for coordinating care in MLTSS program to assess individuals for their desire and ability to transition at least annually. In addition, to further incentivize MCOs, contracts with the State offer incentive payments upon (1) successful transition of each demonstration participant and (2) community living for the entire 365-day demonstration period without re-admission to a nursing facility.[cix]

Missouri: Thorough assessment process that uses the International Resident Assessment Instrument, or interRAI instrument, which is a nationally standardized assessment tool, to help determine what specific services and supports are appropriate for each individual.[cx]

Ohio: Assessment/transition planning process integrates "CAGE questionnaire" to screen for alcoholism and behavioral health needs; resulting in increased ability to match resources with individual needs. Ohio uses behavioral health clinicians as transition coordinators. By strengthening the assessment process, the program was able to put individualized supports in place for participants to give them the best chance at successfully maintaining their independence in the community. [cxi]

Oklahoma: When a candidate is assessed for transition, the transition coordinator contacts several sources of informal support to gauge how well the person will do in the community and whether the person will have a circle of informal support after the transition.[cxii]

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Person-Centered Plan

Illinois: Participants are matched with a "treatment team" based on individual needs (composed of service specialists like nurse, psychiatrist, etc.) who work to develop a plan of support that might address addiction, isolation, comorbidities and employment, etc.[cxiii]

Texas: Offers MFP participants participating in its Behavioral Health Pilot Cognitive Adaptation Training (CAT) as a service beginning up to six months before the person moves to the community. According to Texas, people with behavioral health needs enter nursing homes at a younger age and this population benefits from more customized services and supports.[cxiv]

Participant Education

New York: Transition specialists who are housed within the CILs provide community preparedness education and training to MFP participants to ensure that they have essential community living skills to reside independently in the community.[cxv]

Pre-Transition Expenses

Missouri: Identified upfront costs as a barrier to reentering the community. State offers $2,400 to participants for home modifications, security deposits, household items, etc.[cxvi]

Louisiana: MFP participants are permitted to use budget allotment if funds available under the waiver are not sufficient to cover the costs of certain non-recurring services or supports during the individual's first year of community living (beyond $3,000 limit).[cxvii]

New Jersey/Iowa: Offer one-time clothing allowance.[cxviii]

Specialized Staffing Roles

Washington: "Consumer choice guides" are new positions financed with MFP demonstration funding. This position was created to assist transition coordination staff when a participant has above average-needs. The State of Washington added consumer choice guides who work exclusively with participants determined to have high needs by the transition coordinators and require additional planning supports. The tasks may include educating the participant on how to access health services, connecting the participant with local resources such as his or her local YMCA, or setting up the MFP participant's new home with furniture and household goods.[cxix]

Ohio: Has begun training behavioral health specialists to serve as transition coordinators. This supplemental service is targeted to all individuals with behavioral health needs. The specialists are assigned to MFP participants already linked to the behavioral health system, ensuring continuity of care and increasing the likelihood that participants will remain connected to the behavioral health community after their transition. Ohio allows participants to choose their transition coordinators; for individuals with behavioral health needs, a behavioral health specialist is strongly suggested, although not always selected.[cxx]

3. FOLLOW ALONG

General Observations

Kaiser Family Foundation (KFF) Report

States identified service coordination/case management as the most critical service for MFP beneficiaries both pre- and post-transition.[cxxi]

Mathematica

Quality monitoring systems are key to track participants' outcomes in the community. Several states included in this study use the knowledge gained from their evaluation of quality monitoring data to improve service delivery for participants.[cxxii]

Data provided by grantees indicate that the most common causes of re-institutionalizations lasting 30 days or more were declining in physical or mental health and events (such as falls or accidents) that led to a hospitalization According to the study states, substance abuse is another common factor that contributes to re-institutionalizations among the younger adult population.[cxxiii]

For all states, the primary method for ensuring successful transitions is to collect quality-monitoring data on potential risks that could jeopardize the individual's placement in the community. However, many study states supplement this activity with quality specialists who monitor and analyze participants' well-being or independent evaluators who conduct in-depth assessments of transitions and related outcomes. The common goal for all states is to identify and mitigate potential risks before they cause the participant to return to an institutional setting.[cxxiv]

State Examples

Trial Period/Bed Holding

Georgia: Residential and personal care trials give participants the opportunity to make trial visits to new community residences and to use PCS on a trial basis before they make the transition. This supplemental service is available to any MFP participant with an identified need in his or her transition plan. This type of service gives people leaving a nursing home a chance for a trial run with the provider that will assist with services such as dressing, bathing or cooking. MFP participants collaborate with their transition coordinator to select a provider and then work with that provider on a one or two-day trial basis.[cxxv]

Washington: Offers a bed holding service for people in community long-term care settings. When an individual needs to be temporarily hospitalized or re-institutionalized, the bed hold program makes payments that hold the participant's place in an assisted living facility or adult family home. Bed holds may last up to 20 days. This service is a qualified service available to individuals living in adult family homes or in assisted living facilities through the State's waiver programs.[cxxvi]

Post-Transition MFP Demonstration or Supplemental Services

New Jersey: Provides intensive supports for IDD individuals during first 90 days of transition, including an "Olmstead resource team" to provide additional habilitation services to support physical, nutritional and/or

behavioral health needs. The team can also provide crisis response. The Olmstead resource team service model could be sustained through adding this service as a permanent amendment to one of its waivers.[cxxvii]

Illinois: Participants have a "representative payee" for six months post-transition (provide guidance on managing federal disability benefits).[cxxviii]

Washington: Transitional mental health services provide behavioral health services that address anxiety or other mental health needs during the actual transition as participant's experience disrupted routines. These transitional mental health services cover either behavioral health services not otherwise provided by Medicaid or service gaps. This demonstration service is available to any MFP participant with an identified need in their care plan. For example, if a participant is experiencing mild depression or anxiety related to the transition and does not meet Mental Health Access to Care standards, he or she may access transitional mental health services.[cxxix]

Washington: MFP participants have additional demonstration services (transitional behavioral services, community choice guides (contracted transition specialists) and consultation for challenging behaviors.[cxxx]

Ohio: Provides social work/counseling services to MFP participants, their guardian, caregiver or families to maintain a stable and supportive environment for the individual. Social work/counseling services may include crisis intervention, grief counseling or other social work interventions that support the participant's physical, social and emotional well-being. This is a demonstration service available to all MFP participants. From 2009 through 2013, Ohio reports 360 MFP participants used social work/counseling services (about 9% of all of Ohio's MFP participants) totaling almost $260,000 in costs.[cxxxi]

State Plan and Waiver Services
Louisiana: Received a Community Choice Waiver (CCW) to provide a larger array of LTSS services, which can continue past the one-year transition period. CCW provides three preauthorized services before the transition: (1) transition-intensive support coordination by nursing facility staff, which covers the cost of pre-transition planning, assessment, service planning and social networking, (2) home and environmental modifications and (3) transition services to determine service needs, the individual plan of care, referrals to help participants obtain needed services and follow-up and monitoring activities.[cxxxii]

Connecticut, Maryland, and Washington: Have flexible service offerings; they allow transition coordinators to customize person-centered plans to meet the needs of MFP participants who transition to the community.[cxxxiii] The flexibility takes the form of wraparound services that supplement what is available through the Medicaid state plan, expanded access to specialized services to help people achieve stabilization in the community or flexible funding to cover supports or environmental modifications a person needs to exit the nursing home.[cxxxiv]

New York: Reported that, compared to older adults, adults under age 65 more frequently access job training and development to help them attain employment goals. Additionally, younger adults are more likely to seek paratransit or independent living skills training to assist them with learning to become independent.[cxxxv]

Connecticut: Implemented a Community First Choice (CFC) state plan option to cover community-based PCA services (which were previously offered under the PCA waiver) to young adults between the ages of 18 and 64. PCAs can provide various services, including administering medication and helping the individual with employment. Under CFC, individuals receiving attendant care self-direct their own services. When CFC was launched, it provided people who self-direct and manage their own budgets with a much broader range of supports than they received previously, such as a support and planning coach, a health coach, assessments for assistive technologies, home-delivered meals and accessibility modification.[cxxxvi]

Maryland: CFC, individuals have access to personal attendant services, environmental assessments and accessibility adaptations; the latter benefit was enhanced to $15,000 over a three-year period, reflecting an increase above annual limits for the Older Adults and the Living at Home waiver. People transitioning to the community from institutional settings can also access transitional funds through CFC that they can use to pay for basic necessities such as rental security deposits and first month utilities. [cxxxvii]

Other Services

Nebraska: Use rebalancing funds for home and vehicle modifications and assistive technology. When in the community members with intellectual disabilities who meet ICF/IID LOC are served through Comprehensive Developmental Disabilities waiver (community living and day supports, respite services, prevocational services, etc.; in 2010, waiver was amended to include alternatives to sheltered workshops and established incentives to support IDD individuals with securing competitive employment).[cxxxviii]

Behavioral Health Supports/Coordination

Mississippi: In-person crisis supports and services are available around-the-clock to individuals in the transition process, and all MFP participants are eligible for this demonstration service. Initial contact may be made via telephone, but the crisis response staff meets with the individual and any other service or housing provider to address the crisis and keep the individual in the community. Transitional crisis support services are provided by transition coordination agencies. Since Mississippi began transitioning participants in 2012, 12 participants have used transitional crisis support services (about 8%of the State's total number of MFP transitions), and the State has reported over $5,000 in related expenditures.[cxxxix]

Nebraska: Nebraska's team behavioral consultation staff are organized into highly specialized teams with behavioral and psychological expertise. The teams provide on-site consultation when individuals with intellectual disabilities experience difficulties in their residential or work setting that arise from problematic behavior. This qualified service is available to children and adults covered under the Developmental Disabilities Waiver. The team behavioral consultation staff meet with the participant, a legal representative or parent, HCBS coordinator, providers, and staff from various service components (for example, day, respite or residential services). After the initial in-person meeting, the team conducts direct observations and interviews. The team collects data for the purpose of understanding a participant's behaviors and creating a behavioral plan with recommended evidence-based interventions. The team then reviews the recommended interventions with the provider; it also supports the provider in implementing the interventions by helping the provider understand the goals of the program, including how to track and monitor the specified goals. The provider tracks the participant's progress through data and meets with the team behavioral consultation staff

to discuss the participant and re-evaluate the plan if necessary. On-site follow-up continues until the entire team agrees that the behavior has been addressed and that the file should be closed. Since the start of Nebraska's MFP demonstration, 12 participants have used the service (about 4% of all of Nebraska's transitions).[cxl]

Maryland: MFP program's behavioral health specialist serves as a resource for MFP support planners by connecting the program to the State's Behavioral Health services system and collaborating with local mental health agencies to ensure participants receive adequate care.[cxli]

New York: MFP program bridges the gap between systems with transition coordinators who make referrals to behavioral health plans and mental health community-based supports when appropriate.[cxlii]

Connecticut: Embed MFP staff in Department of Mental Health and Addiction Services and Department of Developmental Services. The State expanded access to mental health services and PCA.[cxliii]

Texas: Behavioral Health Pilot program was established in 2008 that offers participants mental health and substance use treatment provided in coordination with community-based LTSS. To date, the Behavioral Health Pilot program has enrolled over 425 MFP participants (4% of MFP transitions). Pilot provides participants with an array of services through Medicaid MCOs, including CAT, community-based substance abuse treatment, transition assistance, relocation assistance, and 1915(c) waiver services.[cxliv]

Quality Assurance Mathematica
Quality monitoring systems are key to tracking participants' outcomes in the community. Strong partnerships with stakeholders are important to coordinate efforts around service delivery and propel system transformation efforts forward.[cxlv]

Connecticut: Transition coordinators provide strong upfront support and also complete surveys with participants in-person at a minimum of 3, 30, 60 and 90 days post-transition to monitor how they are faring in the community.[cxlvi]

Missouri: Use a web-based tracking system that enables all staff (MFP Program Staff, transition coordinators and regional coordinators) to update and monitor in real time how participants are faring in the community. System also is the infrastructure for MFP referrals, tracking the lifecycle of each transition from the time of the initial referral, transition planning and post-transition follow-ups; transition coordinators are able to report critical incidents.[cxlvii]

Louisiana: State hired nine regional transition coordinators who meet monthly with support coordination agencies and conduct home visits.[cxlviii]

Nebraska: Web-based system (Therapy Services) supports incident reporting, referral intake, service authorizations and provider billing.

New Jersey: "Risk management system" has helped minimize readmissions. The State hired quality assurance specialists to monitor services for MFP participants (collect and analyze data from case managers; for MFP participants who go back to the institution, interview them to improve the MFP program).[cxlix]

New York: Compares MFP-QoL data collected pre-transition, and one and two years later to identify trends and needs among MFP participants. The State also trains transition specialists to identify responses requiring follow-up with service coordinators to ensure needs, safety concerns and gaps in service are addressed timely.[cl]

Connecticut: Quality specialist in Connecticut reviews all critical incidents, determines if the incident is systemic in nature and elevates systemic concerns to program leadership, and investigates incidents related to untimely deaths. Use independent evaluators (UConn) to conduct ongoing assessments, which include follow-ups at six months and one year.[cli]

Maryland: Quality and compliance specialists follow MFP participants from the time of application through the move to the community. Once participants are residing in the community, quality and compliance specialists review all critical incidents and follow up with support planners to ensure proper supports are in place for participants in danger of re-institutionalization.[clii]

Washington: Uses a quality assurance department, housed within its Department of Social and Health Services, to monitor all of the State's LTSS waiver recipients, including MFP participants. The MFP program supplements these activities with two quality improvement specialists who conduct in-depth case reviews of participants living in the community. The specialists review data covering the first three months following a transition of a random selection of participants to confirm that supports are provided in a timely manner and transition plans are properly implemented. In all, quality specialists in Washington have reviewed over 500 cases (approximately 9% of all MFP transitions in the State).[cliii]

4. SUPPORT AND REFERRAL/THRIVING
General Observations

All study states improved the integration of mental health services with other community-based LTSS providers, which has benefitted former adult nursing home residents under age 65. Strategies include providing specialized behavioral health supports to MFP participants and modifying Medicaid waivers to better integrate mental health care for MFP participants.[cliv]

Respondents in one study state reported that peer networks have helped some adults under age 65 transition from the nursing home to IL. Those who move out in turn help friends who remain in the nursing home make the same transition. In Washington, many younger adults have decided to pursue transitioning through MFP after observing their peers in the nursing home move to the community and thrive in their apartments with the support of community-based LTSS. Of the six study states, four formally offer peer support services to MFP participants to provide them with first-hand experience of what it takes to reside independently in the community: Connecticut, Maryland, New York and Texas.[clv]

State Examples

Stakeholder Engagement

Missouri: Built a robust stakeholder network (including CILs, AAAs and others), able to leverage the network (e.g., public housing authorities) to secure preferences for MFP participants in select counties with high housing needs.[clvi]

New Jersey: Collaborates with the Division of Developmental Disabilities, Division of Aging Services and ombudsman's office.

Ohio: State established a behavioral health liaison position in 2011 to educate on MFP and developed a collaborative relationship with nursing homes and local legal rights agencies.[clvii]

Georgia: Community ombudsman program uses specially trained representatives to assist participants with advocacy strategies. Representatives help empower MFP participants to raise and resolve complaints related to their community-based services and supports. This supplemental service is available to all MFP participants. [clviii]

Incentives

Missouri: Pay for Performance, performance metrics (e.g., different payment rates for individuals who stay in the community for 6 and 12 months' post-transition). [clix]

Staff Training

Louisiana: Cross-train support coordination providers to account for high percentage of participants with dual medical and behavioral health needs; State developed two training curricula (one focused on behavioral health needs; one on medical, nursing and physical supports).[clx]

Illinois: Partnered with the University of Illinois at Chicago (contracted quality assurance vendor) to provide educational supports for transition coordinators, providers and program staff.[clxi]

Housing

New Jersey: State uses its rebalancing funds to cover housing acquisition/rehabilitation to develop four-bedroom group homes for individuals transitioning from a developmental center (12 new group homes created).[clxii]

Illinois: Provides housing subsidies through a bridge program (subsidies provided temporary funding until permanent housing can be found). State also hired three housing coordinators (duties include outreach to local public housing agencies, increased housing development and development of statewide housing registry of available units; also focus on implementing Section 811 Project Rental Assistance program in Illinois).[clxiii]

Wisconsin: Provides housing counseling services that go beyond locating housing for a participant. Housing counseling provides education and links participants to other resources available for homeownership, home financing and home maintenance and repair; rental counseling; accessibility consultation; weatherization and lead-based paint abatement evaluation; low-income energy assistance evaluation; access to transitional or

permanent housing; accessibility inventory design; health and safety evaluations of the property; debt/credit counseling; and homelessness and eviction prevention counseling. The housing counseling services are offered as qualified HCBS and are available to all participants who qualify for select HCBS waivers, including people outside the MFP demonstration. Provision of housing counseling services is based on an identified need during the care planning process, and the services are tailored to the individual's situation and goals. As a practical matter, housing counseling is often rolled into other care management services and is not always considered a distinct, separate service.[clxiv]

Washington: Provides transition coordination services and, according to one respondent, the transition specialists play an especially critical role for younger adults seeking independent housing. The contracted specialists can help potential MFP participants locate housing, take them on tours to view available housing or take photographs of the unit for viewing in the nursing home. [clxv]

Indiana: Applied for and received Department of Housing and Urban Development Shelter Plus Care grant to provide rental assistance for homeless and individuals with disabilities.

Indiana, Maryland, and Wisconsin: States revised their Qualified Allocation Plan, which governs the Low-Income Housing Tax Credit program, to align with Section 811 principles. Maryland and Indiana involved developers in the process.[clxvi]

APPENDIX E
MFP ADDITIONAL LITERATURE REVIEW

Highlights from "Money Follows the Person Demonstration: Overview of State Grantee Progress, January to December 2016"[clxvii]

Discussion
The last in the series of national evaluation reports was reviewed along with all the references already cited in the report. Findings below were not cited in the report in other places.

Challenges/Underutilization of Services
States continued to report several challenges that impede program growth, most notably insufficient affordable and accessible housing and rental vouchers. The data suggests that participants are underutilizing some of the services and supports available to them, such as employment services and the option to self-direct services.

Re-institutionalization
Aggregate population: Five states reported that less than 1% of participants were re-institutionalized for more than 30 days in 2016; of these, three states (Alabama, Iowa and Minnesota) reported that no participant was re-institutionalized for more than 30 days in 2016. California and Louisiana reported so few re-institutionalizations that the average rate is 0% for this state.

Older adult population: The percentage of participants re-institutionalized for more than 30 days was 0% in six states (Alabama, Iowa, Kentucky, Louisiana, Minnesota and New Hampshire).

Physical disabilities: Six states (Alabama, Delaware, Iowa, Maine, Minnesota and South Carolina) reported no re-institutionalizations for more than 30 days for individuals with physical disabilities.

Actual Transition Time
During 2016, six states (Hawaii, Indiana, Missouri, New Jersey, South Dakota and Tennessee) reported that the average length of time required from assessment to actual transition was two months or less (0–60 days). Of these six states, Missouri, New Jersey, South Dakota and Tennessee met or exceeded their 2016 transition goals, and Hawaii nearly did (99%).

Housing

Identifying housing is a central challenge for grantee states: Thirty-eight of 44 grantee states reported at least one challenge securing housing for MFP participants. The two most commonly reported challenges in both periods of 2016 were (1) an insufficient supply of affordable and accessible housing (32 states from January to June 2016; 26 states from July to December 2016) and (2) an insufficient supply of rental vouchers (17 states from January to June 2016; 18 states from July to December 2016). Grantee states continued to cite shortages in housing and rental vouchers as key challenges, as they have done since the beginning of the MFP demonstration.

Thirty-four of the 44 states reported implementing at least one strategy to address housing challenges and improve housing options for MFP participants during the year. Among a defined set of strategies, the two most frequently cited in 2016 were (1) increasing the supply of affordable and accessible housing (13 states from January to June 2016; 12 states from July to December 2016) and (2) developing an inventory for affordable and accessible housing (14 states from January to June 2016; 11 states from July to December 2016).

During 2016, many states also reported other strategies for addressing housing challenges, including developing partnerships with other agencies or landlords/developers to discuss the needs of the MFP population, increasing funding for home modifications, applying for or receiving grant funding, training, holding housing conferences and conducting education and outreach activities.

Life Satisfaction

Several factors place MFP participants at risk for depression, such as having multiple chronic conditions and reduced mobility. Other factors may include cognitive impairment, poor health status, social isolation, and lack of autonomy or unmet care needs resulting from reduced supervision in the community. Improved quality of life and increased community integration upon transitioning to the community may mitigate some of these risks.

Depressive symptoms: The reduction in depressive symptoms is consistent with the increased community involvement MFP participants report when they transition out of facilities and into the community. A previous analysis of QoL survey data found that community integration was higher among participants without depressive symptoms and that, upon moving to the community, participants whose mood status improved were also more likely to report increased community integration. Despite the decline in participants who report depressive symptoms upon moving to the community, the number of participants reporting depressive symptoms post-transition warrants attention: as of 2016, one in five MFP participants experienced depressive symptoms in the past week. Significant proportions of MFP participants were not currently volunteering or working for pay, but expressed an interest in doing so, this is an area that could be targeted to increase community involvement.
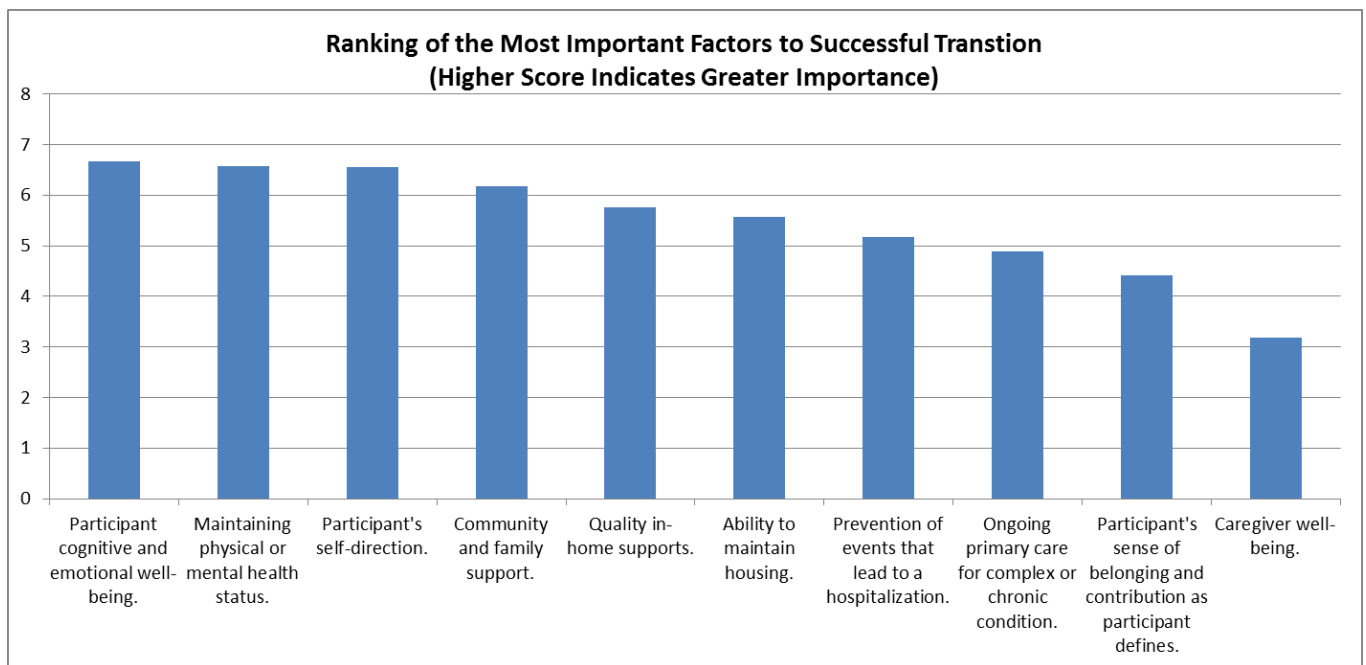
Unmet needs: One-year post-transition, most individuals indicate that their needs are being met. Assistance with bathing was the most frequently reported unmet need (4%), followed by toileting and medication administration (2% each) and assistance with preparing meals (1%).

Employment: Despite the wide range of services and supports offered by grantee states, there was no detectable impact on the rate of employment among participants. The significant share of participants who wish to work represents an opportunity for all states to increase participants' integration into the community. States currently offering employment services and supports may wish to focus on identifying participants interested in employment and targeting services to that group.

APPENDIX F
TRANSITION SURVEY: IMPORTANT FACTORS TO A SUCCESSFUL TRANSITION

Mercer, with the assistance of the MFP program, conducted an extensive survey of entities that are involved with transition-related activities in North Carolina. The findings of the survey have helped inform the overall study. It is important to highlight one set of findings from the survey that emphasizes what these organizations feel are critical to the success of the program. The ranking of important factors to a successful transition is highlighted because it represents the reflections that are consistent with those articulated during MFP participant interviews and what was considered one of the hardest questions to answer in the survey by most responders. This chart highlights the need to prepare individuals and families for the transition to the community; the importance of good health that has been emphasized in the provision of primary care in the community; the need for impactful and consistent follow-along and incident management also with the need for community integration activities.

Ranking of the Most Important Factors to Successful Transtion
(Higher Score Indicates Greater Importance)

APPENDIX G

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.

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.).

SHORT-RANGE RECOMMENDATIONS

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.

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.
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.

MID-RANGE RECOMMENDATIONS

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.

LONG-RANGE RECOMMENDATIONS	
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).

APPENDIX H
MFP Defining Improvement

MFP Sustainability Analysis: Defining *Improvement*			
	Improving Quality of Process Recommendation is anticipated to result in:	**Improving Quality Outcomes** Recommendation is anticipated to result in:	**Improving Timeliness/ Opportunities for Streamlining** Recommendation is anticipated to result in:
In-Reach Function		• improved ability to effectively advise on HCBS options	
Transition Coordination Function	• improved screening to better assess the viability of a person's ability to transition. • improved communication and information sharing between coordinating entities • improved coordination of planning meetings to better engage all required supports • improvements in transition planning tools to better meet overarching goals of a quality transition.	• improved ability to ensure essential services are in place on the day of transition. • practice is likely to decrease risk of returning to a facility setting • improves support alternatives for individuals with limited or no family support • reduction in post-transition hospitalization • improved access to pre-transition staff training	• improved response rates • for waiver candidates, improved synchronization/ alignment between transition coordination and case management functions. • improved access to housing and other essential services
Case Management Function	• improved coordination with other entities to better facilitate whole person planning and ongoing support. • expanded options to assist people in meeting health and safety criteria	• improved balance between individual's dignity of risk and ability to meet waiver's health and safety criteria, both prior to transition and after transition. • improved coordination with employment resources. • improved coordination with CCNC care managers.	• assessment process is refined to better identify viable transition candidates. • assessment and evaluation timeframes are responsive to transition-related needs such as retaining housing.
Access to Services		• improved ability to access essential services Day 1 of transition. • improved ability to secure pre-transition training between HCBS staff and client. • improved access to services that assist individuals in returning to or remaining in their own homes.	

Source: New Initiative Memorandum (NIM)#: DHHS-33109-16-01

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i https://www.disabilitypolicyresearch.org/~/media/publications/pdfs/.../mfpfieldrpt8.pdf

ii When looking at states with similar total grant awards such as Illinois (2,731) and Oklahoma (734), the North Carolina MFP totals transitions in 2016 (774). https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-grant-awards.pdf

iii Savings calculated by taking the total average cost per waiver participant and subtracting it from the average total Medicaid cost for individuals served in facilities and multiplying by the total number of waiver participants.

iv Report to the President and Congress The Money Follows the Person (MFP) Rebalancing Demonstration, Page 26, https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf

v State Strategies to Reduce the Risk of Long-Term Nursing Home Care after Hospitalization, Pages 9-10.

vi For purposes of determining Medicaid eligibility for individuals who are in the Aged, Blind or Disabled (ABD) category of Medicaid eligibility, North Carolina uses the 1634 option which means the state has entered into a "1634 agreement" with the Social Security Administration (SSA) whereby the SSA determines Medicaid eligibility for its aged, blind and disabled population. Under 1634, individuals found eligible for Supplemental Security Income (SSI) are automatically enrolled into Medicaid and do not have to separately apply for Medicaid benefits. Additionally, North Carolina has a medically needy program which allows the state to provide Medicaid to individuals with high medical expenses whose income exceeds the maximum threshold, but who would otherwise be eligible for Medicaid. In North Carolina, this means that individuals who are over income for Medicaid can gain eligibility after the date by which they have incurred medical costs in the amount of their deductible.

vii Allows for Medicaid to be provided to individuals who would otherwise be eligible for Medicaid in an institution, and who have an institutional level of care and who receive Medicaid HCBS services along with Special Income Level (SIL) methodology (allows for individuals with an institutional level of care to qualify for Medicaid with income up to 300% of Federal Benefit Rate).

viii Figure 32: North Carolina Population Change Projections

ix The Deficit Reduction Act included a 6-month length of stay requirement that was changed in the Affordable Care Act to the current 90 day requirement.

x North Carolina Operational Protocol https://dma.ncdhhs.gov/providers/program-services/money-follows-the-person-mfp

xi The Local Contact Agency (LCA) is a local community organization responsible for providing community options counseling to nursing facility residents. Nursing facilities are required to make referrals to the LCA based on resident's responses to MDS 3,0 Section Q questions related to interest in returning to the community.

xii North Carolina MFP Master Tracking log, Calendar Year 2017, Analysis of average days from application approval date to transition

xiii https://www.communitycarenc.org/what-we-do/care-management/transitional-support

xiv Mercer review of Long-Term Care Facility Resident Assessment Instrument 3.0, Section Q, Q0600 aggregate data from 2012 to 2017.

xv individuals meet qualified institution/facility prior to transition; is moving to a qualified residence, and is North Carolina Medicaid eligible

xvi https://www2.ncdhhs.gov/dhsr/reports.htm

xvii Calculated for 2018 — average of all Medicaid NF per diem rates times the number of days per year, 2018 Medicaid Nursing Facility Rates Fee Schedules, https://files.nc.gov/ncdma/documents/Fee-Schedules/Nursing_Facilities/Nursing_Facility_Rates_2018_01_01.xlsx

xviii Calculated for 2016 — North Carolina Division of Health Service Regulation, Healthcare Planning and Certificate of Need Section, 2016 Nursing Home Data, https://www2.ncdhhs.gov/dhsr/mfp/data/nursinghome.html

xix Using the Minimum Data Set (MDS) to Target MFP Outreach Activities, http://mfp-tac.com/system/files/library/MDS%20Issue%20Paper%20Aug%2015%20Final%20PDF.pdf, Pg.5 and Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.13, October 2015, Pg.Q-16

xx https://www.cms.gov/Regulations-and-Guidance/.../som107ap_pp_guidelines_ltcf.pdf

xxi State Health Coordinating Council, State Medical Facility Plan, https://www.ncdhhs.gov/dhsr/ncsmfp/2016/2016smfp.pdf

xxii https://www2.ncdhhs.gov/dhsr/mfp/data/

xxiii LTSS 2014 and 2015 Expenditures Reports, https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf
https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf

xxiv https://caretransitions.org/about-the-care-transitions-intervention/

xxv Comprehensive review of the Innovations waiver was largely outside the scope of this Analysis. The Innovations wavier is administered at the local level through a contract with the LME-MCOs. There is also a waiting list for the Innovations waiver as slots for this waiver are also limited.

xxvi Savings calculated by taking the total average cost per waiver participant and subtracting it from the average total Medicaid cost for individuals served in facilities and multiplying by the total number of waiver participants.

xxvii https://dma.ncdhhs.gov/providers/programs-services/long-term-care/program-of-all-inclusive-care-for-the-elderly

xxviii https://www.ncdhhs.gov/assistance/disability-services/independent-living-for-people-with-disabilities

xxix https://www.ncdhhs.gov/divisions/vocational-rehabilitation-services/vocational-rehabilitation-services-annual-reports

xxx Of these 341 cases identified, only 32 (9.4%) had MFP funded services purchased within the same 3-year time frame. This may indicate MFP transition activity for some individuals.

xxxi https://www.federalregister.gov/documents/2015/11/16/2015-28888/independent-living-services-and-centers-for-independent-living

xxxii http://www.ncsilc.org/centers/

xxxiii State Health Coordinating Council, State Medical Facility Plan https://www2.ncdhhs.gov/dhsr/ncsmfp/2016/2016smfp.pdf

xxxiv Adult Care Home Population information, North Carolina Department of Health and Human Services, Division of Health Service Regulation

xxxv Ibid

xxxvi State Health Coordinating Council, State Medical Facility Plans 2010–2016

xxxvii North Carolina, FAST, February 2018

xxxviii Ibid

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xl https://www.communitycarenc.org/what-we-do/care-management/transitional-support

xli https://www.medicaid.gov/medicaid/ltss/downloads/community-living/mds-3-0-section-q-implementation-q-a.pdf

xlii http://www.mfp-tac.com/grantee/toolkit/outreach-marketing-recruitment-and-enrollment

xliii Vincent Mor, Jacqueline Zinn, Pedro Gozalo, et al, "Prospects For Transferring Nursing Home Residents To The Community," Health Affairs Vol. 26 No. 6. November/December 2017. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.26.6.1762

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xlv Annual Report on North Carolina Supportive Housing Program

xlvi https://oig.hhs.gov/oas/reports/region1/11600001.pdf, https://oig.hhs.gov/oas/reports/region1/11400008.pdf

xlvii ibid.

xlviii https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf

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lv Momotazur Rahman, Omar Galarraga, Jacqueline S. Zinn, David C. Grabowski, Vincent Mor, The Impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4916841/

lvi http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx , Accessed 3-26-2018

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