Back to the Community

Money Follows the Person
Agenda

➢ Overview of MFP
  • Rebalancing
  • *Open Doors* - the New York Association on Independent Living
    • Transition Centers
    • Peer Outreach programs
    • Nursing Home Outreach and Section Q

➢ Impact of MFP
  • Quality of Live Survey

➢ Q&A
What is Money Follows the Person?
## What is MFP?

<table>
<thead>
<tr>
<th>Federal Demonstration</th>
<th>Rebalancing Initiative</th>
<th>Transition Assistance through <em>Open Doors</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Originated under the Deficit Reduction Act of 2005</td>
<td>• Rebalance the Long-Term Care system from institution to community</td>
<td>• Assists participants to transition from Long-Term Care facilities to the community</td>
</tr>
<tr>
<td>• Expanded by the Affordable Care Act</td>
<td>• Enhanced federal match earned on HCBS for each MFP participant enrolled in a constituent HCBS program following discharge from a qualified institution</td>
<td>• Provide peer support for participants to support these transitions</td>
</tr>
</tbody>
</table>
Participating States

MFP States with Peer Programs

SOURCE: Kaiser Family Foundation's Commission on Medicaid and the Uninsured (KCMU) survey of state MFP demonstrations, as of July 2015
Why is MFP Important?

Decrease Institutional Services

Decrease Costs

Increase HCBS Services

Improve Quality Of Life
Role of the Olmstead Decision


• “Unjustified isolation” of persons with disabilities is a form of discrimination in violation of Title II of the Americans with Disabilities Act (ADA)
Rebalancing initiatives

- Enhanced federal match earned for each Medicaid dollar spent on HCBS for qualified MFP participants
- MUST be reinvested in the Long-Term Care system
  - Enhanced Identification and Outreach Services
  - Access to Assistive Technology and Durable Medical Equipment (TRAID)
  - Access to Guardianship
  - Volunteer Caregivers
  - Housing Education and Accessible Housing Registry
  - Community Care Connections
Technology Related Assistance for Persons with Disabilities (TRAIT)

- Memorandum of Understanding (MOU) with the NYS Justice Center
- 12 Regional TRAID Centers across NYS
- TRAID Centers purchase devices to provide:
  - Device demonstrations
  - Device loans
- TRAID Centers also provide:
  - Outreach to persons in institutions and Area Agencies on Aging
  - Quarterly reporting on outcomes
Types of rebalancing initiatives in 2015
State Approaches to Using MFP Rebalancing Funds


Note: States may spend rebalancing funds on multiple types of initiatives and can be counted in multiple categories. N = 35 grantee states.
State Level Collaboration and Partnerships

- Office for People with Developmental Disabilities
- Division of Nursing Homes and ICF/IID
- Bureau of Managed Long Term Care
- Office of Mental Health
- Justice Center
- Division of Veterans’ Affairs
- Office of Community Transitions
- Homes and Community Renewal/MRT Supportive Housing
MFP and Managed Long Term Care

• Managed Long-Term Care added to MFP as a constituent population (retroactive to 7/1/15)

• **MFP and MLTC: a natural partnership**
  - MFP adds value to MLTC by expediting transition to community based services; MLTC adds value to MFP by increasing access to more robust services
    - Transition Specialists can provide the bridge from the facility to the community; MLTC plans can provide the services needed for people to return to the community
    - MLTC Care Managers may have members who express a desire to return to the community; Transition specialists can assist with the discharge process

  *A natural, mutually-beneficial, cross-referral relationship*
MFP Eligibility

Who is eligible for MFP*?

Individuals who:

✓ Have Medicaid for at least one day before transition
✓ Have lived in a nursing home, hospital, or intermediate care facility for at least 90 days
✓ Have needs that can be met in the community
✓ Move to a qualified setting, including house, apartment, or small group home
✓ Have a physical or developmental disability, traumatic brain injury, or are elderly (including those with mental health needs)
Transition Activities

Open Doors: Provides assistance to participants to transition from Long-Term Care facilities to the community, and peer support for participants to support these transitions

• **Transition Center Project**: Identifies potential participants in nursing homes and intermediate care facilities and facilitates successful transitions to one’s community of choice

• **Peer Outreach and Referral Program**: Provides outreach and peer support to individuals and families interested in transitioning to community living

• **Nursing Home Outreach Education**: Provides information about the Local Contact Agency (LCA) and Section Q of the Minimum Data Set (MDS)
Infrastructure

Transition Centers
- 9 Regional Lead Independent Living Centers and 15 Auxiliaries
- Regional Transition Coordinator/Liaison in the 9 Regions
- Over 60 Transition Specialists statewide

Peer Outreach and Referral
- 137 peers available at ILCs across the State
- Approximate the demographic characteristics of the MFP participants
- Live independently in the community

Nursing Home Outreach and Education
- 5 dedicated staff regionally based
- Education on MFP and Local Contact Agency referral
Transition Specialist Role:

- Provide objective information about services available in the community
- Work with Discharge Planners, Service Coordinators, and Care Managers to develop a transition plan that meets the resident’s needs and links individuals to the programs that will best meet their individual needs
- Community Preparedness Education for Day One in the community
- Referral to peers who share experiences of living independently in the community
- Resolve barriers to transition, e.g., housing
- Administer Quality of Life survey
NY State MFP Referrals and Transitions

Number Assessed and Transitioned
2008 - 2017

Assessed: 7622
Transitioned: 2918

Source: NYS Money Follows the Person Semi-Annual Progress Report, submitted to CMS August 2017
Cumulative NY State MFP Participants by Target Population 2008 - 2017

- Traumatic Brain Injury: 25%
- Elderly: 27%
- Physical Disability: 29%
- Intellectual Disability/Developmental Disability: 19%
Peer Role:

- Characteristics of peers approximate the MFP participants (age, physical and/or developmental disability, veteran status)
- Provide outreach to families and individuals living in long-term care facilities
- Provide one-on-one peer support to individuals and families interested in transitioning to community living
- Share experiences of living with a disability or long-term health care needs in the community with participants
- Promote successful transitions through community integration
# Open Doors Peers

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Number of Participants With Peer Visits</th>
<th>Number of Peer Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual/Developmental Disability</td>
<td>56</td>
<td>89</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>25</td>
<td>134</td>
</tr>
<tr>
<td>ELD</td>
<td>112</td>
<td>783</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>204</td>
<td>1715</td>
</tr>
<tr>
<td>Unknown</td>
<td>75</td>
<td>571</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>472</strong></td>
<td><strong>3292</strong></td>
</tr>
</tbody>
</table>
Nursing Home Outreach

- Dedicated Outreach and Education staff
- Educate nursing home staff about MDS Section Q and LCA referral
- Will provide outreach and education to every facility in NY State over a 2-year period
- Referrals have increased as a result
- Most successful transitions result from referrals from nursing home staff rather than algorithm
Identification of Nursing Home Residents

• Section Q of Minimum Data Set (MDS) is used to identify individuals who wish to explore their options for returning to their community of choice, to live and receive services

Q0500: “Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?”

• Nursing Facilities are required to refer all individuals who answer ‘Yes’ to Q0500 to the Local Contact Agency (LCA)

• MDS Algorithm

• Referrals also from self, family, other providers, MLTC care managers, etc.
Recent Guidance

The US Department of Health and Human Services’ (DHHS) Office for Civil Rights issued, “Guidance and Resources for Long Term Care Facilities: Using the Minimum Data Set to Facilitate Opportunities to Live in the Most Integrated Setting.”

- Help long-term care facilities comply with their civil rights obligations
- Corrects misinterpretations of the Section Q requirements prevalent in the field
Helping Facilities Comply with Guidance

• Encourage development of strong working relationships with the Local Contact Agency
• Clarify proper administration of MDS Section Q
• Reinforce timely referral to the Local Contact Agency
• Support updating of policies and procedures, and providing periodic training to comply with the guidance
Section Q “Cheat Sheet”

### Q0400. Discharge Plan

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Is active discharge planning already occurring for the resident to return to the community?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. <strong>Yes</strong> ▶ Skip to Q0600, Referral</td>
</tr>
</tbody>
</table>

**Answer YES ONLY if:**  
- LCA (Open Doors) already involved  
- Discharge date is < 3 months and referral to LCA cannot improve plan

### Q0490. Resident's Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99  
**02, 06, 99 = Quarterly Assessment types**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. <strong>Yes</strong> ▶ Skip to Q0600, Referral</td>
</tr>
</tbody>
</table>

### Q0500. Return to Community

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): &quot;Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. <strong>Yes</strong></td>
</tr>
<tr>
<td></td>
<td>9. Unknown or uncertain</td>
</tr>
</tbody>
</table>

**MUST ASK THIS Question unless resident has ACTIVE discharge plan!! DON'T judge whether resident can be discharged to community.**  
**If YES, MUST REFER TO LCA (Open Doors). LCA will provide information and explore possibility of alternate settings so resident can make informed choice.**
MFP Accomplishments

Key Findings from the National Evaluation

More than 75,000 Transitions thru 2016

Cumulative Total Number of MFP Transitions
Across All Participating States
June 2008 to December 2016

Distribution of MFP participants transitioned by targeted population 2015 and 2016

Type of qualified residence by targeted population, January to December 2016

Re-institutionalization

When a long-term institutional stay occurs, early use of HCBS is associated with:

• Slightly higher transition rates back to the community
• Increased likelihood beneficiaries will receive HCBS when they transition back to the community
• Reduced likelihood of re-admission to institutional care among older adults

## Costs Decline After Transition

Monthly expenditures for MFP participants transitioning from nursing homes

<table>
<thead>
<tr>
<th></th>
<th>Pre-Transition</th>
<th>Post-Transition</th>
<th>Decrease in Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Adults</td>
<td>$8,079</td>
<td>$6,239</td>
<td>$1,840 (23%)</td>
</tr>
<tr>
<td>Younger Adults with Physical Disabilities</td>
<td>$7,759</td>
<td>$5,976</td>
<td>$1,783 (23%)</td>
</tr>
<tr>
<td>Individuals with Intellectual Disabilities</td>
<td>$13,469</td>
<td>$9,456</td>
<td>$4,013 (30%)</td>
</tr>
</tbody>
</table>

Total health care expenditures for MFP participants ... decline when they transition to the community. Furthermore, total expenditures keep declining after MFP participants leave the demonstration.”

- The National Evaluation of the MFP Demonstration, Mathematica Policy Research

Quality of Life Survey
Introduction to Quality of Life Survey

• Developed by Mathematica Policy Research (MPR) to evaluate effectiveness of MFP

• Administered before and after transition to the community
  • Modified by New York State MFP in 2017
  • Is voluntary

• Evaluates three areas, seven domains
  1. Life satisfaction
  2. Quality of care
  3. Community life
Improvements in Quality of Life

Quality of life of MFP participants
pre- and post-transition

Improvements in Quality of Life

Quality of life of MFP participants pre- and post-transition

Any Unmet Need For Personal Care

- Pre Transition: 18.3%
- One Year Post Transition: 7.6%
- Two Years Post Transition: 6.3%

Barriers to Participating in the Community

- Pre Transition: 51.8%
- One Year Post Transition: 34.0%
- Two Years Post Transition: 29.8%

Note: Lower percentages indicate an improvement. Unmet care needs include bathing, eating, medication management, or toileting.
Improvements in Quality of Life

Percentage of participants reporting they can get needed sleep by target population

<table>
<thead>
<tr>
<th>Population</th>
<th>Pre-transition</th>
<th>One year post-transition</th>
<th>Two years post-transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All populations</td>
<td>60.1%</td>
<td>87.6%</td>
<td>91.6%</td>
</tr>
<tr>
<td>Older adults</td>
<td>60.4%</td>
<td>88.2%</td>
<td>91.6%</td>
</tr>
<tr>
<td>Individuals with PD</td>
<td>56.2%</td>
<td>86.0%</td>
<td>77.8%</td>
</tr>
<tr>
<td>Individuals with ID/DD</td>
<td>59.5%</td>
<td>87.4%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Individuals with MI</td>
<td>68.1%</td>
<td>87.4%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Other individuals</td>
<td>72.6%</td>
<td>89.3%</td>
<td>88.7%</td>
</tr>
</tbody>
</table>


Note: Excludes data from Minnesota, South Dakota, and West Virginia. Based on a sample of 16,445 survey respondents.
New York State Quality of Life Survey Data (CY2017)

During the past week, have you been happy with the way you live your life?

- **Pre-Transition**: 57%  
- **Post-Transition**: 79%

Do you like where you live?

- **Pre-Transition**: 42%  
- **Post-Transition**: 94%

<table>
<thead>
<tr>
<th>Statement</th>
<th>% of Respondents Who Answered &quot;Agree&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I would recommend meeting with an Open Doors Peer to other people where I live.&quot;</td>
<td>88.20%</td>
</tr>
<tr>
<td>&quot;The peer helps me make informed decisions about my life, including having a say in my services and/or treatment options.&quot;</td>
<td>88.20%</td>
</tr>
<tr>
<td>&quot;The peer gets me the information I request, or helps me find it.&quot;</td>
<td>85.09%</td>
</tr>
<tr>
<td>&quot;I can discuss personal matters with the peer that I am unable to discuss with anyone else.&quot;</td>
<td>87.58%</td>
</tr>
<tr>
<td>&quot;The peer helps me talk about my feelings and concerns.&quot;</td>
<td>91.93%</td>
</tr>
<tr>
<td>&quot;We talk about topics that I want to discuss.&quot;</td>
<td>92.55%</td>
</tr>
<tr>
<td>&quot;I like the peer I am working with. We are a good match.&quot;</td>
<td>93.79%</td>
</tr>
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MFP Resources

New York State Department of Health MFP:
https://www.health.ny.gov/health_care/medicaid/redesign/nys_money_follows_person_demonstration.htm

Open Doors:
http://ilny.org/programs/mfp

CMS MFP:

Mathematica MFP :
Resources
Public Health Live on MFP

View the webcast to learn:
• the purpose of the *Money Follows the Person* demonstration
• principles of the Olmstead decision
• ways that a transition specialist or peer can help individuals return to their communities of choice
• steps to take when an individual expresses an interest to return to community living from an institution

The *Money Follows the Person* Program:
Facilitating Return to Community-based Settings
Webcast Recorded on: Thursday, February 16th, 2017, 9-10am
http://www.albany.edu/sph/cphce/phl_0217.shtml

“PUBLIC HEALTH LIVE is a monthly webcast series designed to provide continuing education opportunities on public health issues. Broadcasts are free and available to all who are interested in furthering their knowledge of public health.”
Contact Us

Andrea Juris, MFP Project Director

Stacey Agnello, Program Advisor

Karen Smith, Associate Health Planner

Division of Long Term Care
New York State Department of Health
mfp@health.ny.gov
518-486-6562