



Money Follows the Person and Community Transitions

Update for Service Providers

September 2014



Agenda

- Overview of community transitions and Money Follows the Person (MFP) Demonstration
- Outreach & Referral Processes
- Provider Responsibilities
- ICF Transitions Plan Update
- Community Transitions/MFP Information and Resources
- Provider Experience
- Q & A



**Be part of the
Community**

**OVERVIEW OF
COMMUNITY TRANSITIONS
& MFP**

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**Be part of the
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Purpose of MFP

The purpose of the New York State MFP Demonstration is to enable New York State to transform long-term care (LTC) systems to ensure that seniors and individuals with physical and intellectual/ developmental disabilities (I/DD) have access to community-based services.

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Background

- **MFP is a federal Demonstration:**
 - ❑ Originated under the Deficit Reduction Act of 2006
 - ❑ Extended through the Affordable Care Act
- **MFP involves:**
 - ❑ Assisting eligible individuals from ICFs & DCs to transition to qualified community settings
 - ❑ Enhanced federal reimbursement
 - ❑ Using enhanced funding for rebalancing activities
- **“Money Follows the Person” is a misnomer.** Federal funding derived from MFP goes to NYS to advance systems’ change related to deinstitutionalization, not directly to providers for support individual plans.

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MFP – Part of OPWDD’s Larger Transformation

- OPWDD’s participation in MFP is just one part of OPWDD’s larger system transformation.
- Residential transformation - serving people in the least restrictive environment, enabling people to move into more integrated settings – is part of the Transformation Agreement with CMS.
- OPWDD has an ICF Transition Plan with ambitious annual targets; Plan is now approved by CMS.
- Not every person who leaves an ICF will participate in MFP. **Not all new community settings must be four or fewer people.** However, eventually all settings will be compliant with CMS expectations on HCBS settings.

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Background on NY's MFP Demonstration

- The NYS Department of Health (DOH) is the lead agency on the NYS MFP Demonstration. DOH has participated in MFP for about 7 years.
- NYS must provide outreach to individuals in institutional settings.
- OPWDD officially began participating in MFP on April 1, 2013.
- OPWDD must track MFP participants' eligibility, participation dates, and experience in the community, and provide monthly reports to DOH, which then sends the information to CMS.

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Eligibility for MFP Participation

- Individuals must have resided in a qualified institution for at least 90 days.
- The individual must have received at least one day of Medicaid in-patient service prior to leaving the institution.
- The individuals must be enrolled in the HCBS Waiver.
- Individuals must transition to a qualified residence.

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Qualified Residences

- A home owned or leased by the individual or his/her family member.
- An apartment with an individual lease.
- A community-based residence in which no more than four unrelated individuals reside.
- Family Care homes and IRAs are qualified residences.

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Quality of Life Surveys

- Baseline Survey – done within 30 days of leaving the institutional setting.
- 11-month, 24-month follow-up surveys.
- Data is sent to DOH each month, reported to CMS.
- OPWDD is also analyzing the data to determine needed transition process improvements.

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MFP Goals

Calendar Year	People Transitioned	ICF Residents Contacted
CY 2013	65	300
CY 2014	215	800
CY 2015	280	1,000
CY 2016	315	1,200
Total	875	3,300

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OPWDD's MFP Progress

As of 8/31/14

	2013 Goal	2013 Actual	2014 Goal	2014 Actual*
Total MFP participants	65	94	215	79 <u>+29</u> 108
Total outreach	300	717	800	227

*Years run from January 1-December 31, 2014; will end December 31, 2014.

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MFP Reporting Requirements

Monthly

- QOL completion dates, or reason not completed
- Participation Data - type of qualified institution & residence, enrollment start and end dates, re-enrollment dates, reason for participation ending

Semi-Annually (a summary)

- People who moved, # assessed but not enrolled in MFP, reasons why
- People who were re-institutionalized
- People who completed 365 days in MFP
- Time from assessment to transition
- Improvements and challenges
- Outreach accomplishments
- Challenges to secure housing
- Incidents of abuse, neglect, involvement with law enforcement
- Calls for emergency back-up, how well they were handled

Annually – Financial Projections

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OUTREACH & REFERRAL

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MFP Outreach

- OPWDD is **required** to inform its staff, voluntary service providers, individuals, family members and others about MFP and opportunities for more integrated support.
- Peer-based outreach to the individual through SANYS – in all institutional settings (ICFs, DCs, nursing homes)
- Outreach visits began in fall 2013.
- Providers should **NOT** keep individuals from participating in outreach visits.

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Peer Outreach Process

1. SANYS contacts a residential manager to plan date/time of peer-visit.
2. The residential manager notifies family members and advocates of the date/time of the visit.
3. A SANYS coordinator and self-advocate visit the facility and use video and oral presentation to discuss opportunities to move with individuals and families. They leave flyers and posters.

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Peer Outreach Process

4. The SANYS coordinator and self-advocate leave names of people who are interested in moving with the residential manager.
5. SANYS reports to Central Office its outreach visits and the names that have been referred.
6. Residential managers obtain signed Informed Consent forms during follow-up conversations so that Quality of Life surveys can be done.
7. MFP Regional “Leads” contact providers to confirm follow-up.

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Outreach Message

1. People with disabilities can live in smaller homes and be a part of their communities.
2. New York State is offering people who reside in larger institutional settings the opportunity to live and have their needs met in the community.
3. If you would like to find out if you could possibly move from this home to a new home in the community, we will take your name and have someone follow up with you about how that might be possible.

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Outreach Message

4. Moving takes a lot of planning and does not happen quickly. If you think you might want to move, we can have someone from OPWDD contact you and the people who help you to talk about what might work for you.
5. That meeting will take some time and will not happen for several weeks.
6. If you are interested in moving to a new, smaller home in the community and do not hear back from anyone about it, please let a staff person know. The staff person can notify a manager responsible for your services that you want to start planning for a new, smaller home in the community.

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Provider Follow-Up on Referrals

- It is expected that the agency will plan a meeting with each referred individual and his/her family member or guardian to discuss community settings.
- OPWDD will be working to support greater levels of need in community settings, so during follow-up, identify needs and obstacles, but do not say moving is impossible. It may not be.

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Provider Follow-Up on Referrals

1. Follow-up: When a residential manager receives a referral, it is expected that staff will have a discussion with the referred individual regarding living in a community setting.
2. Report: After the discussion, the outcome of the discussion is communicated to OPWDD via community.transitions@opwdd.ny.gov.

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Provider Follow-Up on Referrals

3. Send Informed Consent form: If the individual wants to pursue a community setting after the discussion, your agency must ask the person to sign an informed consent form and send it to community.transitions@opwdd.ny.gov.
4. Participate in and facilitate discharge planning: Work with OPWDD regional office to develop a transition plan
5. Complete QoL baseline survey and submit to OPWDD at community.transitions@opwdd.ny.gov.

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Coming Soon: Outreach & Referral/Transition Centers

- DOH has issued a Request for Applications for statewide outreach and regional Transition Centers.
- One or two statewide contract(s) are expected to be in place by late 2014/early 2015.
- Outreach contractor will provide outreach to all populations in nursing homes and to individuals in OPWDD ICFs.
- Transition Centers will assist with transition planning, temporary service coordination, referral follow-up, Quality of Life surveys, and data collection for all NYS MFP participants – those with developmental disabilities and others who live in institutional settings.

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Transition Centers will:

- Take referrals from outreach visits, individuals, families & other sources.
- Help connect people to OPWDD’s Front Door and Vacancy Management Process, not directly connect to MSC.
- Assist with connection to community supports.
- Assist the individual and family with readiness skills, counseling.
- **Gather information from providers for CMS reporting.**

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PROVIDER REPORTING RESPONSIBILITY

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MSC Role in MFP

- Connecting transitioning individuals to MSC **PRIOR TO MOVING** – ***VERY IMPORTANT***
- MSC agencies can bill an enhanced transitional rate, three times the regular rate, for people leaving ICFs, for one month, either the month of transition or the month after transition.
- In NYS, OPWDD's MFP participants must enroll in the HCBS Waiver upon discharge from the facility.
- CMS expects no gap in services for transitioning individuals.

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MSC Role in MFP

- OPWDD obtains much needed MFP information from State Operations Offices, Regional Offices & residential providers.
- Waiver Service Providers may need to obtain some key information from MSCs – e.g. calls for emergency back-up, re-institutionalizations, moves to new homes.
- MSCs may be the best source of some of this information.

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MSC Role in MFP

- OPWDD Central Office will also email MSC agencies at the close of each month to obtain data on people who moved into non-certified settings.
- Data elements will be:
 - Did the person move to a different location? (If yes, what kind of setting, where and when?)
 - Did the person re-enter an institution? (If yes, where and when?)
- We'll ask for a one week turnaround.

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Residential Provider Reporting

When someone is planning to move to an MFP qualifying setting or his/her ICF will convert to a 4-person or smaller IRA providers should email your regional MFP Lead.

- Tell us:
 - Name of Individual
 - TABS ID Number
 - Type of residence person will move to (IRA of 4 people or smaller, Family Care, private home)
 - Date of planned move
 - If person will live with family or not
 - MSC Agency & Contact Person (if known)
 - Agency's MFP Contact Person and contact information

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Residential Provider Reporting

- Complete MFP Informed Consent form
- Complete Baseline QoL Survey

**Scan and submit both to
Community.Transitions@OPWDD.ny.gov**

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Residential Provider Reporting

When someone has already moved from an ICF & enrolled in MFP:

- OPWDD will send monthly MFP Participant Tracker Sheets listing all MFP participants who are supported in certified settings to the residential service provider. *
- Providers should respond within 7 days to confirm and provide any updates to the data.
- OPWDD reports this data monthly to DOH and CMS.

* The tracker sheet will include people living in Family Care.

** OPWDD will collect information on individuals living in non-certified settings from MSCs.

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Agency, Referral & MFP Participation Information

- Agency's designated MFP Contact name, phone number, and email address
- Date the MFP Informed Consent form was signed
- Data on residential placement for each person

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Re-institutionalization and MFP Enrollment End Information

- Was the individual re-institutionalized (hospital, ICF, psychiatric center)?
 - If so, length of stay
 - Date of the re-institutionalization
- MFP enrollment end date (if ended)
 - Reason that MFP ended (moved to non-qualifying setting, completed 365 days since transition, died)
 - If it ended due to a re-institutionalization, the reason for the re-institutionalization

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Additional Information

- Quality of Life (QoL) Surveys
 - Date of Baseline QoL Survey
 - A pre-calculated date for the 11 and 24 month
- Does individual receive self-directed services?
 - Dates these services began
 - If services ended, date and reason
- # of Requests for emergency backup service (may need to confirm with MSC) and how responded
 - e.g. worker not showing up, transportation to medical appointments

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ICF TRANSITIONS PLAN

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ICF Transition Plan

Housing Options	8/1/13	9/3/14	12/31/14 Goal	12/31/15 Goal	12/31/16 Goal	12/31/17 Goal	10/1/18 Goal
SO ICF-Campus	994	605	731	493	268	181	150
SO ICF-Community	659	524	593	504	428	257	0
VO ICF	5669	5559	5102	4337	3686	2211	456*
Total	7322	6688	6426	5334	4382	2649	606

We must achieve 457 transitions out of VOICFs in 2014.

* 456 VOICF opportunities that remain reflect Children’s Residential Program opportunities.

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Increasing IRA Capacity

Housing Options	8/1/13	9/3/14	12/31/14 Goal	12/31/15 Goal	12/31/16 Goal	12/31/17 Goal	10/1/18 Goal
IRA Supportive	2227	2125	2326	2475	2624	2823	3221
IRA Supervised	26685	27011	27088	27693	28298	29104	30721
Total	28912	29136	29414	30168	30922	31927	33924

2014 Increases Needed:

77 Supervised IRA opportunities
201 Supportive IRA opportunities
 278 total new IRA opportunities

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Implementing the ICF Transitions Plan

OPWDD has been working with provider agency representatives since May to address questions related to:

- Funding for ICF conversions, downsizing & closure
- How to make greater use of non-certified residential settings
- How to advise providers to downsize ICF use
- How to ensure new IRA settings meet new HCBS settings and person-centered planning standards
- How to motivate movements of people currently in supervised IRAs – to less restrictive settings

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First Phase – Conversions

- ICFs serving 14 or fewer people may convert from ICF operations to IRA operations without downsizing.
- These conversions will be held to new HCBS settings standards and Person-Centered Planning standards.
- Conversions will need to demonstrate that they are much more than a name change.
- Providers will be asked to submit proposals to their DDRO using a Conversion Proposal template.
- OPWDD will be tracking closely the individuals proposed for transition (through conversions and downsizings) and reporting the change in ICF census and IRA census to CMS.

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Guidance on ICF Transitions

OPWDD has been working with providers and has recently (or will soon) release:

- Message to Stakeholders
- ICF Transition Implementation Strategy
- Fiscal Policy for ICF Conversion
- ICF Conversion Guidance *(To be released soon)*
- Conversion/Transition Proposal Template *(To be released soon)*
- Communication tools for providers to use with individuals, families and the public (PPTs, Brochures) *(To be released soon)*

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COMMUNITY TRANSITIONS/MFP INFORMATION & RESOURCES

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OPWDD's Community Transitions & MFP Resources

Community Transitions/MFP Web Page – Information for Providers
<http://www.opwdd.ny.gov/transformation-agreement/mfp/overview>

- MFP Overview Fact Sheet
- MFP Reporting Guidance & Tracking Spreadsheet
- Fiscal Policy for ICF Conversions
- ICF Conversion Guidance & Proposal Template (**soon**)
- ICF Transition Implementation Strategy
- ICF Transition Communication Tools for Providers (**soon**)
- Transformation Flyer for Families
- OPWDD's Regional MFP Leads
- Quality of Life Survey and Guidance
- Informed Consent Form
- Outreach Flyer
- Link to request *We Have Choices* video
- Community.Transitions@opwdd.ny.gov for questions

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PROVIDER EXPERIENCE

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QUESTIONS?

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