



# Understanding Housing Options

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# Transformation Agreement

**NY State's Transformation Agreement with CMS contains commitments for OPWDD related specifically to:**

- **Money Follows the Person (MFP) Demonstration**
- **Balancing Incentives Program (BIP)**
- **1915 b/c Applications**
- **Residential Transitions and Supportive Housing**
- **Supported Employment Services and Competitive Employment**
- **Self-Direction**



# Defining Community Settings

## **CMS is redefining Community Settings —**

**For people in the HCBS waiver— even if not participating in MFP – CMS wants to know how NYS will provide “home-like” settings including:**

- Opportunities for employment, community engagement
- Opportunities to control personal resources
- Autonomy in deciding with whom one interacts

**In provider-controlled housing:**

- Privacy in living quarters
- Sharing of units is by the individual’s choice only
- Access to food at any time
- Ability to set one’s own schedule & have visitors any time



# People in Institutional Settings

- Campus ICFs – 996 people, 8 locations
- Community ICFs – 6135 people, 570 locations
  - voluntary - 5559 people, 532 locations
  - state - 576 people, 38 locations
- SNFs – approximately 100 people



# Money Follows the Person

Purpose: To help states rebalance their long-term care systems by offering people opportunities to move out of institutions into the community

Program Goals:

1. Increase use of HCBS, reduce institutional services
2. Eliminate barriers that restrict the use of Medicaid funds to provide long-term supports in settings of choice
3. Strengthen ability to provide HCBS to people who want to leave institutions
4. Put procedures in place to provide quality assurance and improvement of HCBS



# Money Follows the Person

## **The Affordable Care Act extends and expands MFP:**

- Extends MFP Program through Sept. 2016
- Expands the definition of who's eligible for MFP Program to include people that live in an institution for more than 90 consecutive days (was 6 months)

## **Individuals Must:**

- Have resided in an institution for at least 90 days
- Receive Medicaid for at least one day prior to transition
- Transition into a qualified residence
- Must meet waiver enrollment criteria including ICF/DD LOC

## **States Receive:**

- 100% funding for certain related administrative costs
- 25% FMAP for each participant for 12 months following transition



# Money Follows the Person

## OPWDD Participation

- Effective April 1, 2013 and runs through 2016.
- Will transition individuals from DCs and community-based ICF/IIDs and Skilled Nursing Facilities into community settings
- Acceptable community settings = individual's private home, his or her family's home or a community residence that is home to four or fewer unrelated individuals.
- ICF-IIDs can be converted to 4-person IRAs.
- OPWDD will transition 875 individuals into community settings.



# OPWDD MFP Goals

- 2013 65 individuals
- 2014 215 individuals
- 2015 280 individuals
- 2016 315 individuals
- Total MFP Goal for OPWDD 875 individuals
- 875 individuals will leave institutions:  
campus ICFs, community ICFs or SNFs and  
move to their own homes or provider homes  
of 4 or fewer



# Money Follows the Person

## OPWDD Implementation

### State Staff

#### Central Office

MFP Program Coordinator – DSD (Project Management)

MFP Program Specialist – DPCS (Coordinate Required Data  
Collection and Reporting)

#### Regional Offices

5 Regional Transition Leads - to coordinate outreach, referral  
and transition process work

### Contracted Functions (RFPs will be issued)

Statewide Peer-based Outreach Network

5 Regional MFP Transition Coordination Entities



# Money Follows the Person

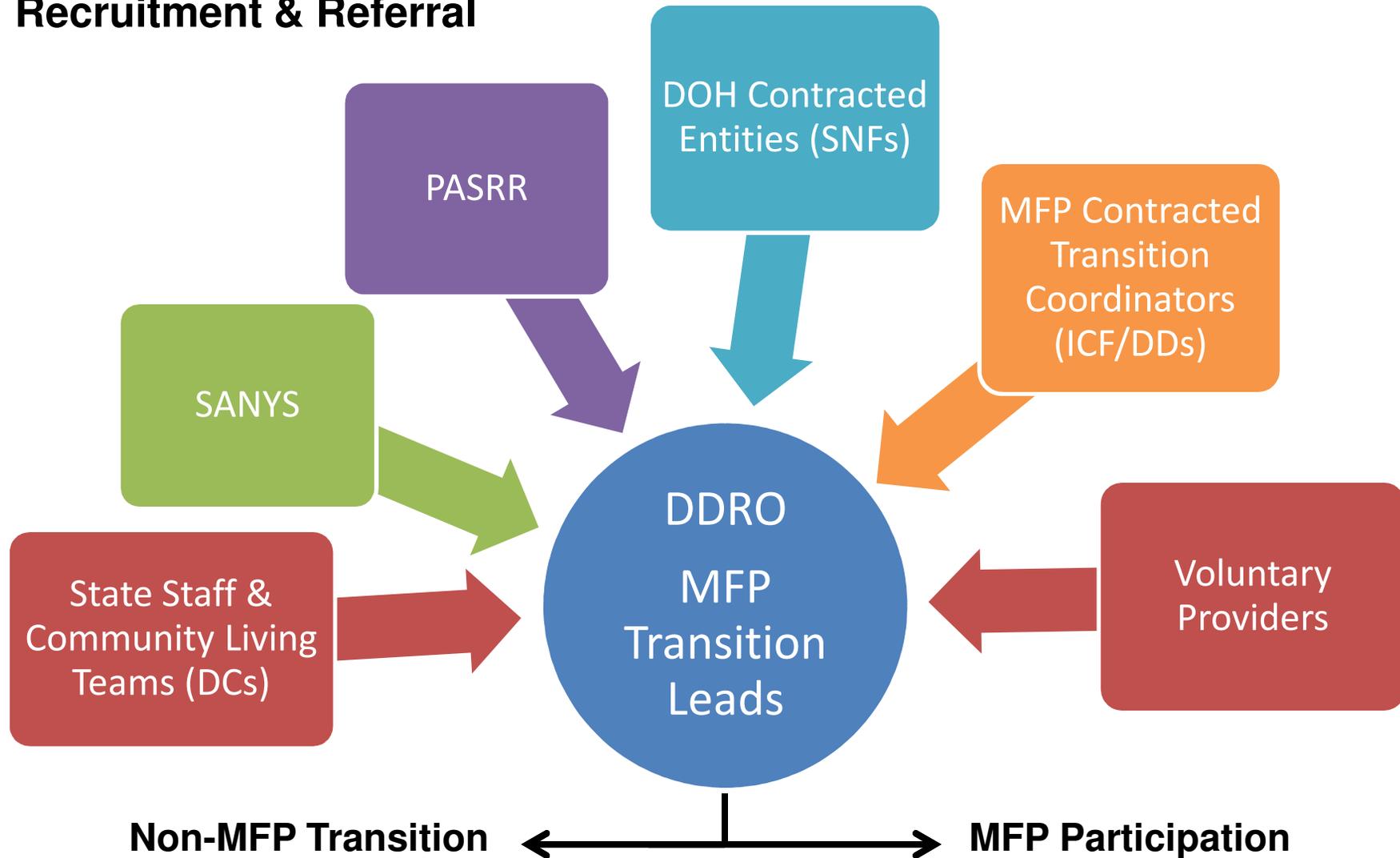
## **Contracted Transition Coordination Entities Responsibilities**

- Obtain and assist with waiver referrals for potential MFP participants
- Confirm eligibility for OPWDD services
- Explain MFP transition process to participants and families
- Develop transition plan for each MFP participant
- Assist in locating and securing qualified housing
- Assist service coordinators and care coordination teams to conduct person-centered planning
- Arrange for follow-up Quality of Life survey to be completed
- Follow-up monthly contact
- Maintain records on all transitions, submit reports to OPWDD staff
- Develop and hold MFP trainings for OPWDD staff, staff at ICF/DDs and others.



# Money Follows the Person

## Recruitment & Referral





# Money Follows the Person

## Two Types of MFP Funding

- Funding for System Redesign (broad infrastructure investments):
  - Roll-out of START Model for crisis prevention mental health services for individuals with developmental disabilities
  - Peer Mentoring
  - Person-Centered Planning Training & Development Contract
- Full Funding for Certain MFP Administrative Costs
- MFP funding is not directly available to meet the individual's support needs in the new community setting.



# LDA's Value Based Service System

## The Four Key Values of Our Proposal:

- Greater Independence
- Choice (self-determination)
- Integration
- Inclusion

These values are at the heart of the development of our planning process and the services/supports that reflect these values.



# LDA's Value Based Service System

## Key values:

- Expanded Opportunities
- Community Presence
- Participation
- Choice
- Respect for Individuals' Life Styles
- Control and Access to Needed Supports



# Supportive Apartment Conversion

## Rationale:

- People wanted to select the location of their apartment
- People wanted to decide whether or not to have a room mate
- People want more control over their supports (less agency policy and site based regulation)



# Supportive Apartment Conversion

## Outcomes:

- Each person in the program was provided habilitation supports that they wanted and designed through Person Centered Planning
- Each person was given ISS support to facilitate  
a move to an apartment of their choice, with the lease in their name, not the agency's
- Each person receives the medical supports needed to insure their health and safety



# Supportive Apartment Conversion

## Medical Support:

- Each Person's Circle of Support was included in identifying the medical issues that need to be addressed
- The RN evaluated each person's transition from Certified site services to Habilitation services to identify on-going supports needed
- A plan was designed and implemented with solutions and supports that were acceptable and appropriate
- FMS support was included that allowed an RN from our agency, who was familiar and consistent, to provide services throughout the conversion



# Medical Support:

RN support services include but are not limited to:

- Managing significant medical conditions such as diabetes, epilepsy, hypertension, etc.
- Monitoring the filling of medication boxes, understanding and interpreting Doctors' notes and orders, monitoring the follow through, diet, appointments, etc.



# Stable Homes Grant



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# Stable Homes Grant

**Home ownership through OPWDD's Home of Your Own program.**

**Rosita's story:** *the good, the bad and the ugly*

- Small repairs + Improvements = depleted savings
- Time + depleted savings = dangerous safety issues.

This pattern of deferred maintenance was common to the fixed income homeowner. LDA sought help from the housing community to supplement the agency's strengths as a support service provider.



# Stable Homes

- LDA has assisted seven people in purchasing a home through the “Home of Your Own” program.
- Older housing stock needs structural repairs, a roof, electrical and plumbing upgrades, etc.
- Our dilemma became: having assisted persons in owning a home now puts them in a financially precarious position.



# Stable Homes Solution

## ***'Shopping the Problem' / Finding a Solution:***

Utilizing Rosita's story:

- Meeting with various city housing departments and non-profit housing developers.
- Finding a partner with housing expertise, experience and knowledge of resources.
- The Heart of the City Neighborhoods, Inc. located a New York State grant for home.
- The collaboration secured the funding.



# The Stable Homes Grant

- **Home Owners**: 10 individuals who receive OPWDD services and are living in the city of Buffalo
- **Funding**: NYS Homes and Community Renewal Department
- **Cap**: Up to \$24,000 for each home
- **Additional services**: referral and assessment by NYS funded weatherization, energy and Lead Abatement Programs enhance the grant beyond the \$24,000



# Home of Her Own







# New Proposals

Our proposal is to provide high-quality individualized, comprehensive, and innovative services, which support, educate, and empower individuals with Developmental and Learning Disabilities. The LDA seeks to collaborate with nonprofit housing agencies to meet the housing needs of our service recipients.



# Proposal

LDA of WNY and LDA Life and Learning of the Genesee Valley will collaborate to establish the “Housing Consortium of Region One ”

## **The consortium will:**

- Foster affordable, accessible and safe housing opportunities specific to individuals’ needs.
- Advance relationships with municipalities, public and for-profit housing entities, to encourage inclusion and build awareness of the support services developmentally disabled individuals bring with them.
- Develop a database of housing options and a pool of pre-screened housing candidates



# New Project

- Convert IRA to a below market building
- Joint project between LDA and HOCN
- Utilize existing Federal and State housing programs and the sale of the IRA to finance the project



# Contact Information

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# We Want to Hear From You

- 1. What can you as the provider do to assist in facilitating and implementing these reforms?*
- 2. What has worked for those of you who have been doing this?*
- 3. What specific barriers and solutions do you see?*
- 4. What is the number one thing we must do to make it work?*
- 5. What would success look like to you?*