



# **Money Follows the Person and Community Transitions**

**Provider Educational Sessions**

March 2014



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Dixie Yonkers

**WELCOME**



# Agenda

- Overview of community transitions and Money Follows the Person (MFP)
- Outreach Process
- Referral Process and the Provider Role
- Reporting Requirements
- Q & A



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# **OVERVIEW OF COMMUNITY TRANSITIONS AND MFP**



## 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 Accountable Care Act
- MFP involves:
  - Transitioning eligible individuals from facilities 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.



## MFP – Part of OPWDD’s Larger Transformation

- OPWDD’s participation in MFP is just one part of OPWDD’s larger system transformation.
- Residential transformation is about serving people in the least restrictive environment, enabling people to move into more integrated settings.
- 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.



## 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 5 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.



## 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.



## Quality of Life Surveys

- Baseline Survey – done within 30 days of leaving the institutional setting
- 11-month, 24-month follow-up surveys
- Surveys are completed by DQI staff.
- 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
<b>Total</b>	<b>875</b>	<b>3,300</b>



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# OPWDD's MFP Progress

	2013 Goal	2013 Actual	2014 Goal	2014 Actual*
Total MFP participants	65	101	215	9
Total outreach	300	717	800	0

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



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# OUTREACH PROCESS



## 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.



# 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.



## 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.



## 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.



# Outreach & Referral will Change

- 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.
- 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.**



Anne Swartwout and Cathy Turck

# REFERRAL PROCESS AND THE PROVIDER ROLE



## Referring Individuals with all Levels of Need

- MFP Referrals may be from a variety of sources including a peer outreach session, staff, family or the team planning process.
- MFP referrals occur because the individual or someone who knows the individual indicates an interest in learning more about a community setting.



## Referring Individuals with all Levels of Need

- 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.



## OPWDD's Role with Referrals

1. Identify/Confirm the residential managers
2. Email referrals to residential managers
3. Track the follow-up to the referrals and the outcomes of the referrals, noting the need for QOL surveys. MFP "Leads" will contact you to follow up on referrals.



## Provider's Role with 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 your agency's MFP lead. (Now through e-mail, later through Choices)



## Provider's Role with 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](mailto:community.transitions@opwdd.ny.gov).
4. Participate in and facilitate discharge planning: Work with OPWDD regional office to develop a transition plan



# The discussion after the referral

- Some questions to ask during the discussion are:
  - What interested you about the presentation that you heard from SANYS?
  - What do you want to do that you can't now?
  - What things do you do now? Are there things that you want to do more?
  - What barriers do you face in your life now?
  - How can we better support you in overcoming these barriers?



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## **Possible Outcomes of the Discussion**

- The individual and his/her family or advocate choose to pursue a more integrated community setting.
- The individual chooses to remain where he/she is, but wishes to change some of the services or supports that he/she receives within that residence.
- The individual chooses to continue with services as they are.



Anne Swartwout

# REPORTING REQUIREMENTS



## Provider's Responsibilities

- If an individual signs an MFP Informed Consent form, the agency is responsible for providing the information that is described below.
- This information must be reported to OPWDD MFP Leads as soon as the information is known.
- This information will soon be captured on a form in CHOICES.
  - Agencies will need to ensure that they have a user who can complete the information in CHOICES.



## Basic Information

- Individual's identifying information
  - Individual's full name
  - Medicaid ID Number
  - TABS ID
- Agency's information
  - Agency's name
  - DDSO that agency is located in
  - Agency's designated MFP Contact name, phone number, and email address



## Referral information

- Date of referral
- Date of follow up conversation with the individual
- Date the MFP informed consent form was signed



## MFP Eligibility Information

- Medicaid enrollment date
- Waiver enrollment date
- Individual was in receipt of at least one day of Medicaid funded services while in the institution
- Institutional setting that the individual was leaving and if they lived there for at least 90 consecutive days



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## **MFP Participation Information**

- MFP qualifying community setting
- The type of MFP qualifying community setting
- Anticipated date of discharge from institution
- Date of new placement
- Living with family
- MFP enrollment date (pre-populated)



## Re-institutionalization and MFP Enrollment End Information

- Was the individual re-institutionalized?
  - If so, length of stay
  - Date of the re-institutionalization
- MFP enrollment end date
  - Reason that MFP ended
  - If it ended due to a re-institutionalization, the reason for the re-institutionalization



## Additional Information

- Quality of Life (QOL) Surveys
  - A pre-calculated date for the 11 and 24 month
- Receives CSS and/or self-directed Community Hab
  - Dates these services began
  - If services ended, date and reason
- Requests for emergency backup service
  - e.g. worker not showing up, transportation to medical appointments



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# MFP RESOURCES



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## OPWDD Resources

- Community Transitions/MFP Web Page  
[www.opwdd.ny.gov](http://www.opwdd.ny.gov)
- Resources include:
  - MFP Overview Fact Sheet
  - FAQ
  - Transformation Flyer for Families
  - MFP Referral Process Map
  - OPWDD's Regional MFP Leads
  - Informed Consent Form
  - Outreach Flyer and Poster
  - Link to request *We Have Choices* video
  - [Community.Transitions@opwdd.ny.gov](mailto:Community.Transitions@opwdd.ny.gov) for questions



**QUESTIONS?**



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**Any Further Questions  
Can Be Directed To:**



**[community.transitions@opwdd.ny.gov](mailto:community.transitions@opwdd.ny.gov)**