NEW YORK STATE MONEY FOLLOWS THE PERSON

Introduction

The Money Follows the Person (MFP) Demonstration is part of Federal and State initiatives designed to rebalance long-term care services, and promote consumer choice. As New York State continues to shift the focus of its long term care systems away from institutional care and towards integrated home and community-based care, support from the MFP program becomes valuable to Managed Care Organizations (MCOs). Managed Care Organizations and Money Follows the Person share the common goals of promoting choice, enhancing quality of life, and expanding options for community-based care delivered in the least restrictive setting.

MFP is designed to streamline the process of deinstitutionalization for vulnerable populations including older adults, individuals with physical, intellectual, and/or developmental disabilities, and individuals with traumatic brain injury. Under the name *Open Doors*, the MFP program funds Transition Specialists and Peer Support to assist these individuals to transition out of institutions such as nursing homes and intermediate care facilities, and into qualifying community settings. A qualified setting may be a house, an apartment, or a group home (with a maximum of four unrelated people). Certain adults with significant medical needs can receive cost-effective home and community-based services to remain in the most integrated settings.

As NYS Medicaid transforms itself into a system of care management for all consumers, MFP becomes an essential and valuable partner in helping MCOs to meet their goals.

Background

The New York State MFP Demonstration grant is awarded by the Centers for Medicare and Medicaid Services (CMS) under Section 6071 of the Deficit Reduction Act of 2005. The Affordable Care Act of 2010 extended the MFP Program through 2020.

The primary objective of MFP involves increasing the use of home and community-based services and reducing the use of institutionally-based services. MFP also strives to eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds for home and community-based services; strengthen the ability of Medicaid programs to provide home and community-based services to people who choose to transition out of institutions; and support procedures to provide quality assurance and improvement of home and community-based services. The program's goals serve a dual purpose of empowering individuals to lead more integrated lives while simultaneously lessening the economic impact that traditional institutionally-based care settings often place upon the long term care system. The New York MFP Demonstration has partnered with multiple New York State governmental entities to ensure that vulnerable persons have access to home and community-based services. To date, over 1,500 New Yorkers have successfully transitioned via New York State's MFP Demonstration.

Research shows that MFP is not only helping states to rebalance Medicaid dollars, but is also having a much broader effect on improving participants' quality of life (Irvin, Denny-Brown, Bohl, Schurrer, Wysocki, Coughlin, & Williams, 2015; O'Malley-Watts, Reaves & Musumeci, 2015). The national average monthly per capita cost of serving an MFP participant in the community

was $3,609 in 2015, down from an average of $3,934 in 2013 and $4,432 in 2012 (O'Malley-Watts, Reaves, & Musumeci, 2015). In comparison, the national average cost of a semi-private room in a skilled nursing facility was $6,692 per month (Genworth Financial Inc., 2015) in 2015. Furthermore, Mathematica's comprehensive evaluation for the CMS shows that participants experience positive increases across all seven domains of quality of life after transitioning to the community, and the improvements are largely sustained two years post-transition (Irvin et al., 2015).

Referral Process

Individuals with disabilities or chronic health needs may be eligible for MFP assistance to transition to the community if they have resided in a qualified institution such as a nursing facility or intermediate care facility for at least 90 days prior to their proposed transition date, and have had at least one day of their institutional stay paid by Medicaid.

All nursing facilities in New York are required by CMS to notify their Local Contact Agency (LCA) within 10 days when a resident answers yes to Section Q of the Minimum Data Set (MDS) 3.0. The MDS is administered to all nursing facility residents upon admission, quarterly, yearly, and whenever there is a significant change in condition. The Section Q question, "Do you want to talk to someone about the possibility of returning to live and receive services in the community?" is designed to support person-centered planning and participant choice by exploring with nursing facility residents the potential for their return to community settings. According to CMS's Responses to Section Q Questions, nursing facilities should not be determining the feasibility of a potential transition prior to making the referral to the LCA.

In New York State, the LCAs are known as Transition Centers and are operated by the NYS Department of Health's MFP contractor, the New York Association for Independent Living (NYAIL) under the name *"Open Doors."* In February 2015, the NYS Department of Health issued a Dear Administrator Letter (DAL) describing the requirements for the Section Q referral process and informing all NYS nursing facilities that NYAIL is the statewide contact for all Section Q referrals: (http://www.health.ny.gov/professionals/nursing_home_administrator/dal_nh_15-02_mds_3_change_of_designation_lca.htm).

Transition Specialists within each Center provide community preparedness education, peer support, and transition assistance (including helping participants identify and access needed supports, benefits, and services in their local community), for those individuals who wish to leave long term care facilities and return to their communities. Once the required referral is made, a Transition Specialist will meet with the individual and his or her family member(s)/guardian to assess the specific needs and wishes of the individual. Transition Specialists will also collaborate with nursing facility staff, plan care managers, and community service providers as needed to ensure safe transition back to the community. Once an individual moves to his or her community of choice, Transition Specialists conduct periodic quality of life surveys in order to assess adjustment to the community and ongoing service needs. The Transition Specialists/Centers provide a supportive link that bridges the transition process from pre-discharge to the delivery of supportive services in the community setting; therefore, they are a vital asset to MCOs.

Role of Managed Long Term Care Plans

1) All nursing facilities must appropriately administer Section Q of the MDS 3.0 and are charged with referring individuals who answer "yes" to Section Q to their LCA, the local *Open Doors* Transition Center, within ten business days. MCOs can encourage network nursing facility compliance with this requirement in order to capitalize on the availability of Transition Specialists to help the plans meet their goal to serve individuals in the least restrictive setting. CMS requires that nursing facility residents who express an interest in learning more about community living options are appropriately referred to designated LCAs within the ten-day timeframe.

2) Plans in particular are strongly encouraged to develop a process for Care Managers to refer directly to the NYAIL *Open Doors* Transition Centers, in order to leverage the local knowledge and experience (provided at no cost to the plan or participant) of the Transition Specialists, who specialize in person-centered transition planning, community preparedness education, and collaboration with nursing home discharge planners and community providers in their role as a bridge to stable community transitions.

3) In order to be eligible for MFP, an individual cannot have a gap in long term care Medicaid services. Individuals must have a safe discharge plan that includes community-based services that are available to the individual upon leaving the facility. MCOs are encouraged to support high quality discharge planning by nursing facilities in their network.

4) Early identification of an individual's needs and preferences is essential to successful community living and avoiding reinstitutionalization. Therefore, plan Care Managers should collaborate with *Open Doors* Transition Specialists and nursing home discharge planners, to the greatest extent possible, in order to ensure that MFP participants experience a seamless and successful transition to the community.

Contacts

To learn more about New York's Money Follows the Person program, please visit http://www.health.ny.gov/mfp. We also welcome questions by telephone at (518) 486-6562 or email at MFP@health.ny.gov.

For a list of designated Local Contact Agencies for MDS 3.0 Section Q referrals, please visit http://ilny.org/downloads/category/35-transition-center-resources?download=379:8-regional-lead-and-auxiliaries-primary-contacts-and-counties .

References

Genworth Financial Inc. (2015). *Genworth 2015 Cost of Care Survey.* Retrieved from https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_040115_gnw.pdf.

Irvin, C. V., Denny-Brown, N., Bohl, A., Schurrer, J., Wysocki, A., Coughlin, R., & Williams, S. R. (2015). *Money Follows the Person 2014 Annual Evaluation Report*. Retrieved from http://www.mathematica-mpr.com/~/media/publications/pdfs/health/mfp_2012_annual.pdf.

O'Malley-Watts, M., Reaves, E. L. & Musumeci, B. (2015). *Money Follows the Person: A 2015 state survey of transitions, services, and costs*. Retrieved from http://kff.org/medicaid/report/money-follows-the-person-a-2015-state-survey-of-transitions-services-and-costs/.