



# Money Follows the Person: An Overview



Presentation to: Interested Stakeholders/General Public

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# Mission

## The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

*We are dedicated to A Healthy Georgia.*



# Presentation Overview

- What to Look For in This Presentation
- Overview of the MFP Demonstration Project
- MFP and Integrated Services for Community Living
- Overview of Home & Community Based Services
- Overview of Housing Resources
- Contract information



# What to Look For In This Presentation

During this presentation, look for the following -

- Five Goals of MFP
- Five Project Benchmarks of MFP
- 19 MFP Transition Services
- Planning Process for Transition
- Person-Centered Planning & the Circle of Support
- The Individualized Transition Plan (ITP)
- Who Supports the Participant in the Community
- Three MFP Qualified Residence Types
- Scenarios – Optional - What Do You Think?



# Overview: What is MFP?



- A Rebalancing demonstration project funded by CMS
  - Single largest investment in Medicaid Long-Term Services and Support (LTSS)
  - 45 States and D.C. utilizing \$4 billion
  - Grant Authorized Through the 2005 Federal Deficit Reduction Act, amended and reauthorized Through the 2010 Affordable Care Act
  - Shift Medicaid long-term spending from institutional (nursing facilities) to home and community-based services (HCBS), aka Waiver Services

# Overview: Goals of MFP in Georgia



- Medicaid-eligible persons receive support for Home & Community-Based Services (HCBS) in an approved setting
- Increase use of Medicaid HCBS waiver services
- Encourage Participant-Direction of services
- Increase the ability of the State to provide HCBS
- Eliminate barriers in State law, State Medicaid Plan and State budgets that prevent or restrict the flexible use of Medicaid funds



# Overview: MFP Eligibility Criteria



- MFP participants meet the following requirements--
  - Reside in an inpatient facility (nursing home, hospital, ICF or PRTF) for at least 90 consecutive days, short-term rehab stays are not counted
  - Receive Medicaid benefits for facility services for at least one day during their recent stay
  - Continue to meet institutional level of care criteria
  - Transition to a 'qualified residence' type
  - Participate in the MFP Transition Planning Process



# Overview: Five Project Benchmarks



1. Transition 2,705 participants by the end of CY 2016
2. Increase HCBS expenditures each year
3. Increase the Number of Transitions each year
4. Increase HCBS expenditures relative to institutional LTSS expenditures each year
5. Increase number of participants living on their own or with family instead of in a group setting each year

# Overview: MFP Transition Services (Slide 1 of 2)

- Peer Community Support
- Trial Visits with Personal Support Services
- Household Furnishings
- Household Goods and Supplies
- Moving Expenses
- Utility Deposits
- Security Deposits
- Transition Support
- Transportation
- Life Skills Coaching



# Overview: MFP Transition Services (Slide 2 of 2)

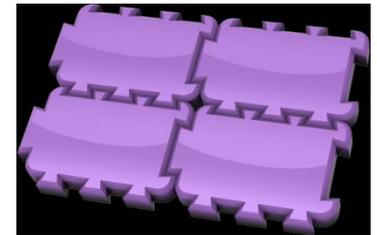
- Skilled Out-of-Home Respite
- Caregiver Outreach & Education
- Home Care Ombudsman Visits
- Equipment, Vision, Dental & Hearing Services
- Specialized Medical Supplies
- Vehicle Adaptations
- Environmental Modifications
- Home Inspection
- Supported Employment Evaluation



# Overview: MFP Planning Process



- Outreach and Recruiting
- Screening and Application to Appropriate Waiver
- Convene Circle of Support; Begin Person-Centered Planning
- Complete MFP Individualized Transition Plan (ITP)
- Establish Community Access (Locate Housing, Transportation, etc)
- Authorize and Begin MFP Services
- Complete Baseline Quality of Life Survey
- **Day of Discharge; Waiver Services Begin**
- Monthly Contract; Review/Revise ITP; Complete 1<sup>st</sup> yr. QoL Survey
- Links to Community (Peer Support, Transportation, Employment, etc.)
  - Note that there is a Different Planning Process for MFP Participants with Developmental Disabilities and for CBAY Youth with Mental Illness



# Who's on the MFP Transition Team?



- MFP participant
- MFP Field Personnel (OC, TC, PLA, CE, CME)
- Circle of Support – family, friends, at least one community volunteer, etc.
- Inpatient Facility Discharge Planner
- Waiver Case Manager/Care Coordinator
- Providers and other individuals as requested by participant or deemed necessary



# What is Person Centered Planning?



## Person-Centered Planning –

- Puts the Participant in a Decision Making Role
- Identifies and Convenes a Circle-of-Support/Natural Supports
- Identifies the Participant's Vision for Living in the Community
- Identifies Goals, Barriers, Resources and Needs
  - Identifies Risks to Participant Health, Welfare and Safety and Plans to Reduce Risks
  - Identifies Risks for Abuse, Neglect, & Exploitation and Plans Prevention
  - Allows for Dignity of Risk – Respect for Participant Decisions that do not appear to be in their best interests
- Results of Person-Centered Planning is Documented in the Individualized Transition Plan (ITP/ISP)



# What's in the Individualized Transition Plan (ITP)



Documents Community Living Goals

- from Person-Centered Planning Process

Documents Barriers and Resources Needed to Achieve Goals

- Housing/living situation needs, barriers and resources
- Existing supports/strengths and waiver service needs



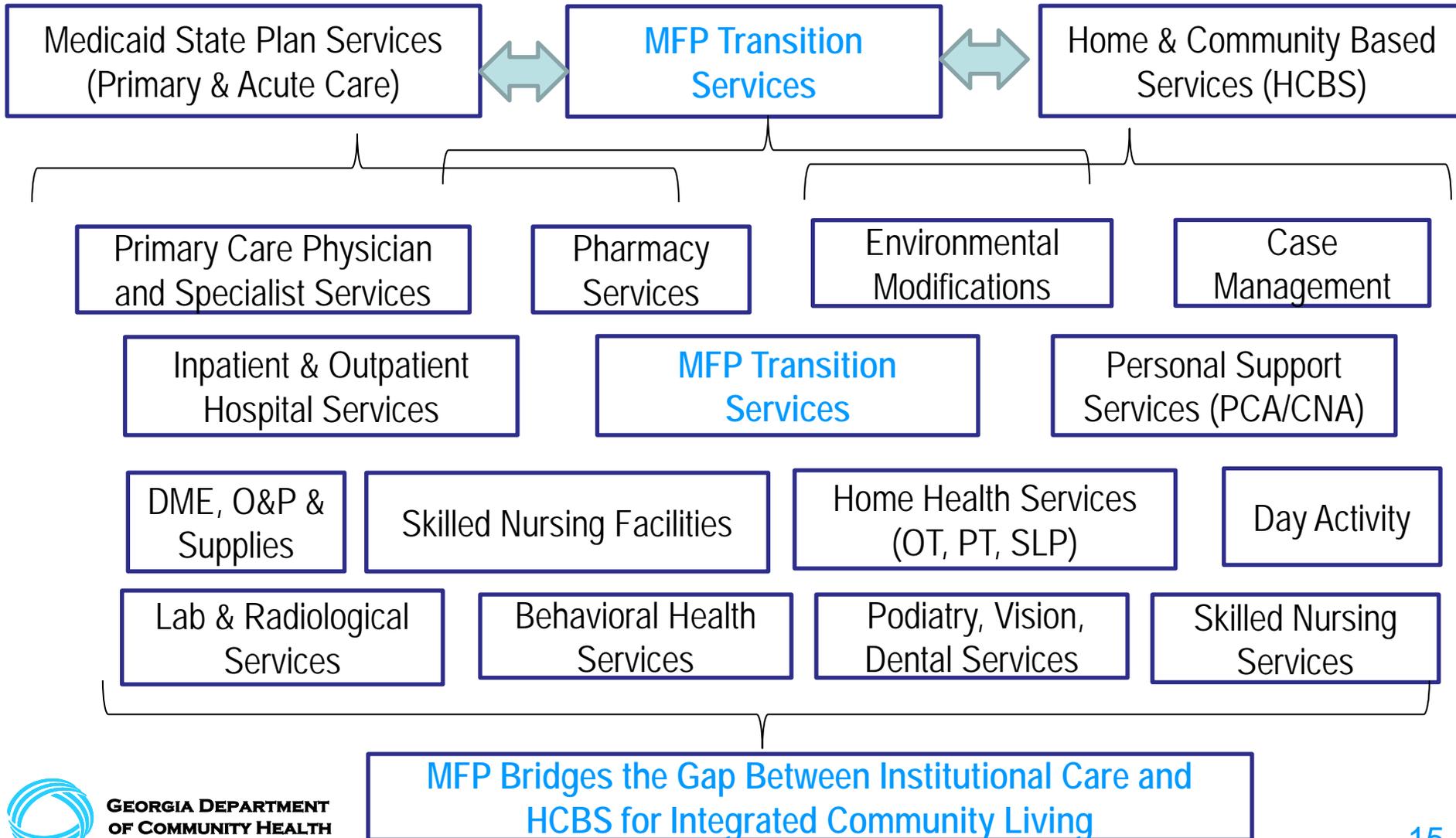
Describes MFP Transition Services

- Selected by the Participant/Circle of Support/Transition Team
- Attaches a Budget to Each MFP Transition Service Selected

Action steps/tasks and Who is Responsible for Each Task

Transition Team/Circle-of-Support Sign-off

# Why is MFP Needed?



# Supporting Participants in the Community: Who is Involved



- Participant, Circle of Support/Friends and Family as available
- MDSQ Options Counselor (Referral & Screening)
- Inpatient Facility Discharge Planner
- MFP Transition Coordinator (ITP, Discharge, Follow-up)
- Waiver Assessment Personnel
- Waiver Case Manager/Care Coordinator/CME
- Service Providers/ Paraprofessionals
- Senior Aide
- LTCO/Home care Ombudsman
- Primary Care Physician, Specialists



# Overview of Home & Community Based Services (aka Waiver Services)



Elderly/Disabled Waivers (CCSP/SOURCE)	Independent Care Waiver Program (ICWP)	New Options Waiver (NOW) and Comprehensive Waiver
<ul style="list-style-type: none"> <li>• Adult Day Health</li> <li>• Alternative Living Services</li> <li>• Emergency Response Services</li> <li>• Enhanced Case Management</li> <li>• Financial Management Services for Consumer Directed PSS</li> <li>• Home-Delivered Meals</li> <li>• Home-Delivered Services</li> <li>• Out-of-Home Respite Services</li> <li>• Personal Support Services (PSS)/(PSSX)/ Consumer Directed Services</li> <li>• Skilled Nursing Services</li> <li>• Home Health Services</li> </ul>	<ul style="list-style-type: none"> <li>• Adult Day Care</li> <li>• Behavior Management</li> <li>• Case Management</li> <li>• Consumer-Directed PSS Counseling</li> <li>• Enhanced Case Management</li> <li>• Environmental Modification</li> <li>• Financial Management Services for Consumer Directed PSS</li> <li>• Personal Emergency Monitoring</li> <li>• Personal Emergency Response</li> <li>• Personal Emergency Response Installation</li> <li>• Personal Support Services</li> <li>• Respite Services</li> <li>• Skilled Nursing</li> <li>• Specialized Medical Equipment and Supplies</li> <li>• Vehicle Adaptation</li> <li>• Adult Living Services</li> <li>• Home Health Services</li> </ul>	<ul style="list-style-type: none"> <li>• Community Residential Alternative (COMP only)</li> <li>• Adult Occupational Therapy Services</li> <li>• Adult Physical Therapy Services</li> <li>• Adult Speech and Language Therapy Services</li> <li>• Behavioral Supports Consultation</li> <li>• Community Access</li> <li>• Community Guide</li> <li>• Community Living Support</li> <li>• Environmental Access Adaptation</li> <li>• Financial Support Services</li> <li>• Individual Directed Goods and Services</li> <li>• Natural Support Training</li> <li>• Prevocational Services</li> <li>• Respite Services</li> <li>• Specialized Medical Equipment</li> <li>• Specialized Medical Supplies</li> <li>• Support Coordination</li> <li>• Supported Employment</li> <li>• Transportation</li> <li>• Vehicle Adaptation</li> <li>• Home Health Services</li> </ul>

# Housing: What are Three MFP Qualified Residence Types?



- MFP Participants Must Enter A Qualified Residence Upon Discharge -
  1. A home owned or leased by the individual or the individual's family member,
  2. An apartment with an individual lease, with lockable access and egress, which includes living, sleeping, bathing and cooking areas over which the individual or the individual's family has domain and control
  3. A residence, in a community based residential setting, in which no more than 4 unrelated individuals reside



# Housing Resources



Housing Type	Searchable Resource
Housing Choice Vouchers	Contract Local Public Housing Authority
HUD 811 Program – Project Based Vouchers	Dept of Community Affairs – Voucher Administrator, Pat Brown at <a href="mailto:patrick.brown@dca.ga.gov">patrick.brown@dca.ga.gov</a> or <a href="http://www.dca.ga.gov">www.dca.ga.gov</a> for balance of state application information
Public Housing & Other Resources HUD Approved Housing Counseling	<a href="http://www.hud.gov/offices/pih/pha/contracts/states/ga.cfm">www.hud.gov/offices/pih/pha/contracts/states/ga.cfm</a> /Public Housing <a href="http://211online.unitedwayatlanta.org/search.aspx/Shelter/Housing">http://211online.unitedwayatlanta.org/search.aspx/Shelter/Housing</a> <a href="http://www.hud.gov/offices/hsg/sfh/hcc/hcs.cfm?&amp;webListAction=search&amp;searchstate=GA">http://www.hud.gov/offices/hsg/sfh/hcc/hcs.cfm?&amp;webListAction=search&amp;searchstate=GA</a>
Low-Income Housing Tax Credit	<a href="http://lihtc.huduser.org">http://lihtc.huduser.org</a>
Affordable (subsidized/Based on Income – BOI)	<a href="http://www.hud.gov/offices/pih/pha/contacts/states/ga.cfm">http://www.hud.gov/offices/pih/pha/contacts/states/ga.cfm</a> <a href="http://www.hud.gov/apps/section8/step2.cfm?state=GA%2CGeorgia">http://www.hud.gov/apps/section8/step2.cfm?state=GA%2CGeorgia</a> <a href="http://rdmfhrentals.sc.egov.usda.gov/RDMFHRentals/select_state.jsp">http://rdmfhrentals.sc.egov.usda.gov/RDMFHRentals/select_state.jsp</a> <a href="http://www.nahma.apartmentsmart.com/">http://www.nahma.apartmentsmart.com/</a>
Housemate Match Services	Marcus Jewish Center of Atlanta, 678-812-4000
Affordable (non-subsidized/Market-Rate)	<a href="http://www.forrent.com">www.forrent.com</a> <a href="http://www.lowincomeapartmentfinder.com">www.lowincomeapartmentfinder.com</a> <a href="http://www.affordablehousingonline.com">www.affordablehousingonline.com</a>



# Optional Scenario: What Services Could Bill Benefit From?

*(Name and picture have been changed)*

Bill is a 61 year old man who had a severe stroke which left him partially paralyzed on his right side and unable to communicate clearly. His speech is severely affected and a word or two maybe understood verbally. The stroke has prevented him from speaking the words he knows. He uses a manual wheelchair and propels with his left hand and left foot. After his stroke, he went into the nursing home for rehabilitation and never left. His family provides no support for him. He does not drive nor own a car.

Your task is to –

- Think about short and long term goals for Bill's ITP

At a minimum, identify the following issues -

- Background
- Housing needed/ Housing Choice/Living Arrangements
- Identify Waiver Services Bill will Benefit From
- Identify MFP Transition Services Bill Might Use
- Identify State Plan Medicaid Services that Bill Might Use
- Other issues unique to Bill and necessary for discharge (environmental modifications, transportation, referrals for Durable Medical Equipment (DME), etc. that are needed to transition Bill

Next, think about the following questions –

- How would you apply Person-Centered Planning?
- What were the essential things Bill needed to transition successfully to the community?





# Optional Scenario: What Services Could Sandra Benefit From?

Sandra (not her real name) is a 35 year old lady who has cerebral palsy. She has very limited use of her lower extremities and limited use of her arms and hands. She needs assistance with almost all Activities of Daily Living, although she does not know to ask for this assistance. She can be understood when speaking, if you are patient and do not interrupt her train of thought. She does have trouble with some reading, math and reasoning/critical thinking skills. She does not have a high school diploma. She has a power wheelchair that does not work and is using a manual chair. She does not drive nor own a car. She has requested to visit someone who has already transitioned into the community from a nursing home to see how they are doing things. Sandra has been in the nursing home for 15 years. When her mother passed away, her step father put her in a nursing home. She is her own guardian, but has never lived out on her own. She is open to moving out of the rural county where she now lives to a larger metro area where public transportation and housing may be available.

Your task is to –

- Think about short and long term goals for Sandra's ITP

At a minimum, identify the following issues -

- Background
- Housing needed/ Housing Choice/Living Arrangements
- Identify Waiver Services Sandra will Benefit From
- Identify MFP Transition Services Sandra Might Use
- Identify State Plan Medicaid Services that Sandra Might Use
- Other issues unique to Sandra and necessary for discharge (environmental modifications, transportation, referrals for Durable Medical Equipment (DME), etc. that are needed to transition Sandra

Next, think about the following questions –

- How would you apply Person-Centered Planning?
- What were the essential things Sandra needed to transition successfully to the community?

# MFP Contact Information



## DCH MFP Office Staff Contact:

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