Illinois’ Money Follows The Person Demonstration “Pathways to Community Living”

MFP Staff Initial Training

Revised March 2015
MFP Rebalancing Demonstration Program

- Created by the Deficit Reduction Act of 2005, Money Follows the Person now operates in 43 states and the District of Columbia.
- Under the Affordable Care Act, MFP was extended through September 30, 2016.
- As of Dec., 2014 over 51,000 individuals have transitioned under MFP since the program’s inception.
- Last day for Illinois MFP referrals is June 30, 2017
- Illinois transitioned their first participants in 2009 and will complete its final transitions by December 31, 2017.
- Post-transition 365 days for Illinois MFP Eligibility is December 31, 2018.

MFP Requirements

Each state participating in the MFP demonstration must establish a program that has two components:

- A transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and assists them with transition.
- A rebalancing initiative designed to restructure state Medicaid long-term care systems so they rely less on costly institutional care and individuals have a choice of where they live and receive services.
Money Follows the Person Goals

- **Rebalancing** - Increase the use of Home and Community Based Services (HCBS) and reduce the use of Institutional services

- **Individual Choice** - Eliminate state barriers that prevent the use of Medicaid funds to enable individuals to receive care in the settings of their choice

- **Transfer of funds** - Eliminate state barriers that prevent the use of Medicaid funds to enable individuals to receive care in the settings of their choice

- **Continuity of Service** - Strengthen the ability of Medicaid programs to assure continued provision of HCBS

- **Quality Assurance** - Ensure procedures are in place to provide quality assurance and continued quality improvement
Centers for Medicare & Medicaid Services (CMS)  
MFP Quality Requirements

- MFP States must have the following three quality requirements in place in order to assure the health and welfare of MFP participants upon discharge to a community setting.
  - A risk assessment and mitigation protocol and a process to ensure that the protocol is working as planned;
  - A critical incident reporting and management system and a process to ensure that the system is working as planned;
  - A 24-hour back-up plan/service to address a lapse in the provision of essential health and support services or other circumstances that could have a negative effect on the participant’s health and welfare.
Centers for Medicare & Medicaid Services (CMS) MFP Quality Requirements

Quality of Life Survey: A CMS form developed by the national research firm – Mathematica

- Transition Coordinators administer survey prior to transition
- Representatives of the UIC College of Nursing to administer follow-up surveys (except in DDD where the ISC staff administer follow up QOL surveys)
Eligibility Requirements

1. Must have resided in a qualified institution (nursing home or Intermediate Care Facility for the Developmentally Disabled (ICF/DD)) for at least 90 days
2. Must be a Medicaid beneficiary/recipient
3. Must meet an institutional level of care - nursing home level of care or an ICF/DD level of care for DDD
4. Must be interested in transitioning to a qualified community setting

Note: Please document the Informed Consent signature date and upload the signed informed consent in CRM webapp so that MFP eligibility can be established in advance of transition date.
Qualified Community Settings

1. Home owned or leased by the individual or a family member of the individual
2. Apartment with individual lease, secure access & living, sleeping, bathing & cooking areas over which the individual or his/her family has control
3. Community-based residential settings with no more than four unrelated individuals
4. Supportive Living Facility (SLF)
Role of UIC

- HFS contracts with the University of Illinois at Chicago, College of Nursing for the following:
  - Provision of quality assurance & compliance with MFP quality requirements
  - Training of Transition Coordinators
  - Analysis of Data for Trends
  - Clinical Consultation with Transition Coordinators
Illinois’ MFP: Benchmarks

- Federal CMS requires states to set annual benchmarks.
- Two benchmarks are federally required
  - Transition goals
  - Annual increase in community service expenditures
- A minimum of 3 other benchmarks must be selected by each state.
- Illinois’ benchmarks were revised in 2012.
## Benchmark - Transitions

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</thead>
<tbody>
<tr>
<td>Elderly</td>
<td>12</td>
<td>55</td>
<td>81</td>
<td>61</td>
<td>66</td>
<td>37</td>
<td>49</td>
<td>361</td>
<td>44</td>
</tr>
<tr>
<td>Physically Disabled (PD)</td>
<td>18</td>
<td>29</td>
<td>68</td>
<td>100</td>
<td>81</td>
<td>50</td>
<td>45</td>
<td>391</td>
<td>61</td>
</tr>
<tr>
<td>Serious Mental Illness (SMI)</td>
<td>27</td>
<td>100</td>
<td>95</td>
<td>54</td>
<td>37</td>
<td>41</td>
<td>25</td>
<td>379</td>
<td>40</td>
</tr>
<tr>
<td>Intellectually Disabled (DD)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>75</td>
<td>35</td>
<td>113</td>
<td>73</td>
<td>297</td>
<td>40</td>
</tr>
<tr>
<td>Colbert Class</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>116</td>
<td>386</td>
<td>463</td>
<td>965</td>
<td>360</td>
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<tr>
<td>Totals</td>
<td>57</td>
<td>184</td>
<td>244</td>
<td>290</td>
<td>335</td>
<td>627</td>
<td>655</td>
<td>2,393</td>
<td>545</td>
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Benchmark – Successful Transitions

- Increase the percentage of participants remaining in the community for the entire year.
- For persons who transitioned in 2011, 74% remained in the community for 365 days.

<table>
<thead>
<tr>
<th>Year</th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>82%</td>
<td>80.7%</td>
</tr>
<tr>
<td>2013</td>
<td>83%</td>
<td>82.6%</td>
</tr>
<tr>
<td>2014</td>
<td>84%</td>
<td>80%</td>
</tr>
<tr>
<td>2015</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>86%</td>
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</tbody>
</table>
Benchmark – Disenrollment Rate

- Decrease disenrollment rate.
- Disenrollment rate was 15% through 2011.
  - Illinois would like to decrease disenrollment due to readmission to a long term institutional setting or hospital.

<table>
<thead>
<tr>
<th>Year</th>
<th>Goal</th>
<th>Actual</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>14.75%</td>
<td>14.75%</td>
</tr>
<tr>
<td>2013</td>
<td>14.5%</td>
<td>10.8%</td>
</tr>
<tr>
<td>2014</td>
<td>14.25%</td>
<td>17.4%</td>
</tr>
<tr>
<td>2015</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>13.75%</td>
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</table>
Benchmarks – Case Notes

- HFS will conduct a random sample of reviewing case notes after critical incidents to ensure compliance with risk mitigation plans to inform quality improvement discussions.

- The purpose of these samples are to:
  - Provide oversight,
  - Inform program directives,
  - Ensure compliance with follow-up strategies,
  - Ensure the individuals’ needs are being appropriately met in the community.
Benchmarks - Housing

• Increase affordable, accessible, and supportive housing by:
  – Increasing coordination with public housing authorities and associations,
  – Increasing units on the housing locator website (www.ilhousingsearch.org),
  – Increase in transition coordinators utilizing the case worker portal (on the housing locator website),
  – Increase interagency communication regarding housing issues via bi-monthly conference calls,
  – Increase availability of rental subsidies for MFP participants.
Managed Care Coordination

- PA96-1501 (Medicaid Reform) requires that 50% of Medicaid clients be enrolled in care coordination programs by 2015.
- Care coordination will be provided to Medicaid clients by several “managed care entities”
  - Coordinated Care Entities (CCEs),
  - Managed Care Community Networks (MCCNs)
  - Managed Care Organizations (MCOs)
  - Accountable Care Entities (ACEs).

Resource link - Managed Care and Medicaid on illinois.gov:
https://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx
Care Coordination – Current Status

- Currently operating in 76 out of 103 counties across Illinois
- Table: Care Coordination Programs Operational and Relationship with MFP

<table>
<thead>
<tr>
<th>Program</th>
<th>MFP Population?</th>
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<tbody>
<tr>
<td>Care Coordination Entities (CCEs)</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicare Medicaid Alignment Initiative (MMAI)</td>
<td>Yes</td>
</tr>
<tr>
<td>Integrated Care Program (ICP)</td>
<td>Yes</td>
</tr>
<tr>
<td>Accountable Care Entities (ACEs)</td>
<td>Yes</td>
</tr>
<tr>
<td>Children with Special Needs (CNS CCE)</td>
<td>No</td>
</tr>
<tr>
<td>Family Health Plans (FHP-ACA)</td>
<td>Yes</td>
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</table>
Care Coordination and MFP

- The MFP program and Care Coordination expansion have aligned goals related to rebalancing the long term care system in Illinois.
- Coordination of the programs presents an opportunity for a collaborative approach.
- Coordination of MFP and Care Coordination does not include the Colbert or Williams consent decrees.
How will Coordination work for an MFP Provider?

- MFP providers will continue to act as the lead Transition Coordinators (TC) for individuals that are referred and enrolled in MFP
  - All current pre and post transition requirements remain in place for MFP providers
- All current required documentation must still be completed in the MFP web app
- UIC-CON will continue to provide the same Quality Assurance oversight and activities
- MFP providers will be expected to collaborate and coordinate with MCO staff
How will Coordination work for an MCO?

- MCO will act as the Care Coordinator, but will not be responsible for MFP specific requirements
- MCOs will have visibility of cases in the MFP CRM web app
- MCO staff will be required to:
  - Refer individuals through the MFP web referral form
  - Attend pre and post transition staffings and CI reviews
  - Case updates and notes on participants in CRM
  - Approve and Assist to Arrange Managed Long Term Care Services and Supports
  - Collaborate with MFP providers & state administrative staff
  - Provide incentive payments of $1,000 to the MFP provider at 3 months and 12 months post transition IF the individual remains in the community at that time
  - See more resources on MFP and MCO Collaboration here: [http://nursing-mfp.webhost.uic.edu/mco.shtml](http://nursing-mfp.webhost.uic.edu/mco.shtml)
Please visit the following websites for MFP Information and Resources

- MFP Web Referral Form
  - [https://mfp.hfs.illinois.gov/mfpreferral.aspx](https://mfp.hfs.illinois.gov/mfpreferral.aspx)

- MFP Program Website
  - [www.mfp.illinois.gov](http://www.mfp.illinois.gov)

- WebApp/CRM: [http://mfp.medicaid.illinois.gov](http://mfp.medicaid.illinois.gov)

- TC website and MFP Training materials
  - MFP/MCO Coordination Training Material and Contact List
    - [http://nursing-mfp.webhost.uic.edu/mco.shtml](http://nursing-mfp.webhost.uic.edu/mco.shtml)
  - MFP Contact Persons (HFS, State Agency and UIC)
    - [http://nursing-mfp.webhost.uic.edu/contact.pdf](http://nursing-mfp.webhost.uic.edu/contact.pdf)

- Question for HFS? Email - [HFS.MFP@illinois.gov](mailto:HFS.MFP@illinois.gov)