

# MONEY FOLLOWS THE PERSON PLANNING COMMITTEE

Friday • July 20, 2007 • 1:00 P.M. - 3:30 P.M.

DHS Cherry Avenue Office • Large Conference Room • 3420 Cherry Avenue NE, Keizer, Oregon

## Attendees:

Tawnya Baer  
Sheila Barker  
Cindy Becker  
Pat Budo  
Jeanette Burket  
Cathy Cooper  
Meredith Cote

Dianne Dverscheidt  
Mary Lee Fay  
Mary Gear  
Julia Greenfield (for Jim  
Wrigley)  
Megan Hornby  
Julia Huddleston  
Jonah Kushner

Scott Lay  
Bill Lynch  
Ruth McEwen  
Lucy Morgan  
Cynthia Owens  
Jean Palmateer  
Jon Pelkey  
Lucille Pugh

Lauren Rhoades  
Judi Richards  
Cheryl Sanders  
Renee Shearer  
Sherry Stock  
Michael Volpe  
Bob Weir  
Joonkoo Yun

## Welcome/Introductions

Cathy Cooper welcomed the meeting participants. Meeting participants introduced themselves and explained their interests in MFP. Cathy explained that the Centers for Medicaid and Medicare Services (CMS) have challenged states across the nation to work toward deinstitutionalization, focusing on nursing facilities, hospitals, and intermediate care facilities for people with mental retardation (ICFMR) and have offered incentives to states to try to rebalance their Medicaid dollars and to move people into community based settings. Pointed out that Oregon continues to lead the nation in having individuals in home and community based settings.

## Overview of MFP Project - MFP Glossary

### MFP Glossary:

- MFP: Money Follows the Person
- QA: Quality Assurance
- QI: Quality Improvement
- ICF/MR: Intermediate Care Facility for the Mentally Retarded (Oregon has one – the Eastern Oregon Training Center)
- NF: Nursing Facility (Oregon has 142 as of June 8, 2007)
- SPD: The Seniors and People with Disabilities Division of the Oregon Department of Human Services
- DMAP: The Division of Medical Assistance Programs of the Oregon Department of Human Services
- DHS: The Oregon Department of Human Services

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HCBS: Home and Community Based Services

## Overview of MFP Project - What it is and how it works

### Demonstration projects authorized by Deficit Reduction Act of 2005

- Objectives
  - Rebalancing long-term service systems towards home and community-based; away from institutions
  - Allow flexible funding
  - Increase ability of states to provide home and community-based services
  - Ensure that QA and QI is at least comparable to what's in place for HCBS waivers

## Overview of MFP Project - Eligible Individuals

### Eligible Individuals

- Immediately before MFP:
  - Lives in an institution for not less than 6 months, and
  - Is receiving Medicaid benefits, and
  - Continues to need institutional “level of care”
  - Institutions are:
    - Hospital
    - Nursing Facilities
    - ICF/MR
- Moves to community residence; in MFP demonstration for 12 months

## Overview of MFP Project - MFP : Qualified Residences in the Community

### Qualified Residences in the Community

- A home owned or leased by the individual or by a family member; or
- An apartment with an individual lease; lockable entry and exit and living, sleeping, bathing and cooking areas, over which the individual or the family has “domain and control”; or

A community residential setting of no more than 4 unrelated individuals

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## Overview of MFP Project - MFP Funding

### MFP Funding

- MFP covers long-term services and supports
  - Acute care is still covered by regular Medicaid (DMAP)
- Three buckets of MFP services
  - “Qualified Home and Community-Based Program”
  - Home and Community-Based Demonstration Services
  - Supplemental Demonstration Services
- Administration (project staff) billable at regular administration rates

## Overview of MFP Project - MFP Services

### MFP Services

- Qualified Home and Community-Based Program
  - Available on the date of transition from the institution
  - Remain available through Medicaid waivers or state plan after the 12 months of the MFP demonstration
  - Enhanced Federal dollars
- Home and Community-Based Demonstration Services
  - Medicaid services not included in the “Program” Services
  - No obligation to continue after the 12 months of the MFP demonstration
  - Enhanced Federal dollars
- Supplemental Demonstration Services
  - Not usually reimbursed by Medicaid
  - One time or transitional
  - “... things that may make a difference in whether a person believes that he or she can transition successfully to the community...”
  - Will be paid for by demonstration dollars at regular Medicaid rate
- For example:

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- “Program Services” are services available today under one of the Home and Community-Based waivers that Oregon uses, or through the Medicaid state plan.
- “Demonstration Services” would be available today if Oregon chose to offer them.
- “Supplemental Services” are not available today through Medicaid. This category could include things as different computer purchases and substance abuse treatment.

## Overview of MFP Project - MFP Federal Match

### MFP Federal Match

- Qualified Home and Community Based Program Services
  - MFP federal match for 12 months of demonstration
  - Program federal match after
- Home and Community Based Demonstration Services
  - MFP federal match for 12 months of demonstration
- Supplemental Demonstration Services
  - Program federal match for 12 months of MFP demonstration
- Acute care services
  - Program federal match
- Administration
  - 50% federal match

## After the 12 Month MFP Demonstration

- The State must continue to provide home and community based services to the participant as long as the person remains eligible for Medicaid and the state continues to operate its Home and Community-Based Program(s).
- MFP began January 1, 2007.

MFP ends September 30, 2011 unless Congress reauthorizes the law.

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## Oregon's MFP Application - Who?

### 4 populations identified:

- In Nursing Facilities
  - Kids
  - Seniors
  - Adults under 65 with physical and/or developmental disabilities
- Eastern Oregon Training Center

## Oregon's MFP Application - When?

### Transitions happened in distinct phases:

- Kids (10/2007)
- Seniors (1/2008)
- Adults with physical and/or developmental disabilities (1/2009)
- EOTC residents (1/2009)

## Oregon's MFP Application - How?

### How:

- More individual living models
  - Family homes
  - Group homes for 4 or fewer people
  - Apartments
- More nursing support
- Wraparound packages of services and supports

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## Oregon's MFP Application - Concerns

### Concerns:

- Housing
  - Transportation
  - Mental Health Resources
  - Respite Funds and Resources
  - Provider Supports
  - Case management and monitoring
  - Lack of substance abuse resources
  - Workforce concerns
  - Long-term provider viability
- 
- Submitted November 1, 2006
  - Approved effective May 1, 2007

## Current Thinking - Timing

### Timing:

- Pre-Implementation Planning
  - July 2007 through January 2008
- Submit Operational Protocol/ Report to Legislature
  - February 2008
- MFP transitions begin
  - April through June 2008

## Current Thinking - Staffing

### Staffing

- For pre-implementation planning
  - Project Director

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- Lead program developers
- Lead quality and research analyst
- Housing and transportation specialist
- Community resource development specialist
- Business systems analyst
- Project coordinator
  - First wave of hiring August 2007
  - Second wave October through December 2007
- Phases and start dates?
- Field staffing?
- New Models?

Tweaks to existing models?

## **Pre-Implementation Timeline**

### **Pre-Implementation Timeline:**

#### **June 2007:**

- Project Director assigned
- Project Planning Committee formed

#### **July 2007:**

- First meeting of overall project planning committee (July 20)
- Issue groups identified:
  - Service models (2 tracks)
  - Benefit packages (2 tracks)
  - Participant identification (2 tracks)
  - Housing and transportation issues
  - Assistive technology
  - Quality assurance and quality management

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- Data and finance reporting and monitoring

- Project staff hiring process begins

## **August 2007:**

- First wave staff hiring complete
- Issue groups begin meeting bi-weekly to develop key issues lists

## **September 2007:**

- Issue groups continue meeting bi-weekly.
- Planning Committee meets
- Review of population phase-in plans; review progress reports and key issues from Issue groups
- Second wave staff hiring begins

## **October and November 2007:**

- All Issue groups continue bi-weekly meetings developing response frameworks from key issues
- Operational Protocol drafting begins

## **December 2007:**

- Planning Committee meets
- Planning Committee reviews Operational Protocol draft
- All Issue groups continue bi-weekly meetings; issue moves to detailed implementation plans

## **January 2008:**

- Operational Protocol finalized
- Planning Committee reviews final Operational Protocol revisions
- Issue groups continue to develop detailed implementation plans
- Final Central Office hiring completed

## **February 1, 2008:**

- Operational Protocol submitted to CMS
- Implementation phase begins

## **April 1, 2008:**

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Target Implementation Date

## Questions and Answers

1. What role does cost play in the motivation for MFP?

**Answer:** Some. The Federal government is likely in the same place as the states on long-term care – worried about the impact of the coming age wave.

2. How are we going to present it to the legislature in a way that they are motivated to support MFP?

**Answer:** We will need to develop communication strategies.

3. How is the grant funded?

**Answer:** CMS has awarded the state about \$80,000 to pay for some project staff for the first year. They will continue to provide funding to SPD for project staff over the life of the project. Most of the project funding will come through the ability to access enhanced Federal match dollars once the Operational Protocol is approved and project participants begin to transition.

4. Will you be looking at new rate models as well?

**Answer:** Yes.

5. Who will have the overall responsibility at the community level?

**Answer:** It is an SPD program so the responsibility will fall on the DD county program, the local AAA office or the Seniors and People with Disabilities office.

6. As individuals move out of the nursing facilities will the beds be available to be filled?

**Answer:** Yes, they will be available for other people to move in to.

7. What role will resident consent play?

**Answer:** It will play a huge role! Individuals will not be moved without their consent.

8. Any chance that the workforce issues in MFP can dovetail with the workforce issues in the future of long-term care workgroup?

**Answer:** Absolutely!

9. What populations will be included in MFP?

**Answer:** Seniors, people with physical disabilities, and people with developmental disabilities. It's the population of people who have lived in nursing facilities for at least six months for whatever reason.

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10. Why do we need a separate issues group around housing, transportation, and assistive technology?

**Answer:** In some cases we wouldn't but there are many cases that do not have the resources available in the community. The HUD secretary has just encouraged Housing Authorities to work with states around access and affordability issues.

11. Would the individuals who, with access to appropriate medical equipment, would be able to move to other setting be given the opportunity to do so through MFP?

**Answer:** Yes.

12. Has there been any discussion around recruiting potential participants to sit on the workgroups?

**Answer:** Wants to have a discussion around the involvement of potential project participants.

13. When people with physical disabilities turn 65, they become seniors and their disability becomes a secondary issue. When people with developmental disabilities turn 65, does the disability become a secondary issue? How will that be handled?

**Answer:** Mary Lee Fay explained that many individuals with developmental disabilities do not usually change their services when they turn 65 if they are in the community.

14. Is Oregon going to receive a basic budget to bring in experts to look at some of the issues such as housing and assistive technology?

**Answer:** We will be looking at accessing existing resources available within the state and will be looking to leverage freely available resources available at the national level.

15. Where is the state match coming from?

**Answer:** Regular state general fund.

16. Will MFP impact Medicare?

**Answer:** MFP should not impact Medicare or OHP acute care.

17. Could supplemental demonstration funds be used for OHP "below the line" services?

**Answer:** That's certainly worth discussion.

18.. How broadly are you defining assistive technology?

**Answer:** As broadly as people think that we should. It can be defined as both system uses and individual uses.

19.. Will MFP use current service models or develop all new ones?

**Answer:** Probably both. We are trying to put together a county-by-county picture of nursing facilities, community-based care and clients as a starter for the conversation since issues will likely be different in different counties.

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20. Does DHS intend to work with providers to identify people who might be appropriate for transition?

**Answer:** DHS will work collaboratively with all of its partners. This project has the potential to be a “win win” for all the players – especially the people who move back to their communities.

## Planning Committee Participant Issues

1. Make sure that all issues committees and the state follow the principles and values of self-determination and choice for clients.
2. Make sure the program is flexible and family friendly and that there is choice for the client and family.
3. Consider the possibility that people will benefit from and become reliant on the services. Doesn't want the services to be taken away from the clients and families after the demonstration project. Pointed out that the Rebar project has a good system of keeping people apprised of systems changes and encouraged the MFP program to look at developing a similar system.
4. Emphasized importance on choice and honoring informed consent.
5. Make sure there is a high degree of clinical quality of performance improvement.
6. Wants to look at independent living skills training.
7. Importance of measuring progress with the MFP project.
8. Ways to encourage and grow the help of in-home providers and ways to educate and support them.
9. Educating and support for the families so they will be able to work with the MFP program and feel like they have a good understanding of what is happening.
10. Sustainability of services.
11. Quality and monitoring, how will the provider be supported and how will the provider be able to meet the needs of the client, assuring funding is available long-term after the grant ends, participants for MFP planning committees, workforce issues, how do we recruit providers.
12. Assessment, access issues, existing capacity, implementation date of April 2008 – same time as the new workforce requirements for increasing nursing facility staffing standards for CNAs.
13. Workforce issues - possibility of technology supplementing for workforce.
14. Increased workload for local agencies.

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15. Resources, public transportation, sustainability of access to services.
16. Adequately staff for implementation – number of staff versus number of clients.
17. Barriers to placement with relocation – title 19 clients without income.
18. Adapting current care settings to provide services, training for workforce.
19. Objective criteria for eligibility other than relying on nursing facilities to refer clients, benefit packages for all groups combined, communication between the two groups.
20. In response to cognitive disability and brain injury specific issues – case management, ongoing training of providers, increasing provider funding, consistency in staffing.
21. Geographical barriers – rural Oregonians.
22. A network to provide information about providers, resources, and services available.
23. Training for employers.