Money Follows the Person Rebalancing Demonstration

HOUSE HEALTH AND HUMAN SERVICES
FINANCE COMMITTEE

MARCH 3, 2011

Money Follows the Person Demonstration (MFP)

Centers for Medicaid and Medicare (CMS) grant opportunity

PURPOSE

- Support the transition of Medical Assistance (MA, Minnesota's Medicaid program) participants from institutions to the community.
- Rebalance each state's long-term care system to achieve a sustainable balance of institutional and community-based services.

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Background

PROCESS

- Grant application submitted January 7
- Award notification received February 22
- Terms and conditions currently in negotiation with CMS

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Background

- MFP program authorized by Congress through passage of the 2005 Deficit Reduction Act
- Minnesota is one of 13 states awarded in 2011 that will join 29 States and the District of Columbia already operating MFP programs.
- Thus far, over 12,000 individuals have transitioned into the community from institutional settings through MFP programs
- Additional funding through the Affordable Care Act available from 2011-2016 (no-cost extension to 2020)

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Grant Award

Department of Human Services leverages federal dollars to deliver better care

"The U.S. Department of Health and Human Services today announced that Minnesota will receive $187.4 million to improve community services and support people in their homes rather than institutions. These new dollars will help DHS provide more individualized care for some of Minnesota's most vulnerable residents. First-year funding is $13.4 million."

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Benefits to States

BENEFITS

- Opportunity to improve cost-effective home and community-based services to better serve Minnesotans with the most complex needs, reducing use of higher cost institutional services
- Enhanced federal match for services to eligible demonstration participants
- Administrative cost reimbursement for implementation activities
- National technical assistance

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Requirements

Collaboration

- Agency Partners include:
  - Continuing Care Administration with Disability Services, Nursing Facilities, and Aging & Adult Services
  - Community Partnerships/Housing
  - State Operated Services
  - Health Care and Managed Care
  - Adult and Children's Mental Health

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Requirements

Stakeholders engagement with:

- Counties and Lead Agencies
- Providers
- Consumers
- Families
- Housing organizations
- Advocacy groups

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Requirements

Eligible Individuals

- Medicaid eligible (and receiving MA for at least one day prior to enrollment in MFP)
- Resides (and has resided), for at least 90 consecutive days in a qualified institution

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Requirements

Qualified Institutions

Inpatient facilities as defined in Section 6071(b)(3) of the Deficit Reduction Act:

- Hospitals
- Nursing facilities
- Intermediate Care Facilities
- Institutions for mental diseases to the extent services there are covered by MA

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Requirements

Qualified Residence

As defined in Section 6071(b)(6) of the Deficit Reduction Act:

- Home owned or leased by the individual or the individual's family member
- Apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; or
- Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

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Minnesota MFP Strategies

1. Simplify and improve the effectiveness of transition services.
2. Advance more consistently individualized approaches to Home and Community-Based Services to better serve individuals with complex needs.
3. Increase stability of individuals in the community by strengthening connections among healthcare, community support and housing systems.
4. Decrease reliance on institutional care and increase use of Home and Community-Based Services.

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Strategy 1.

Simplify and improve the effectiveness of transition services.

- Identify eligible individuals who are on MA and have lived for 90 days or more in Qualified Institutions
- Clarify roles and functions among transition coordinators
- Build on promising practices of existing programs such as Housing Access Services, Return to Community, and Live Well at Home
- Expand use of tools like fiscal support entities and consumer-directed community supports

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Strategy 2.

Advance more consistently individualized approaches to Home and Community-Based Services to better serve individuals with complex needs.

- Choose and integrate collaborative and person-centered practices for all transitions that include disability, mental health, housing and healthcare expertise
- Advance practices and benefits to increase stability in community settings and reduce use of higher cost crisis services
- Collaborate with Minnesota's Health Care Home Program, an MDH/DHS initiative to improve health and quality of life across health and community systems
- Design a methodology for the individualized allocation of benefits

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Strategy 3.

Increase stability of individuals in the community by strengthening connections among healthcare, community support and housing systems.

- Maintain Minnesota's information, referral, and assistance systems, including Linkage Lines, MinnesotaHelp.info and HousingLink, to improve access to housing and community supports
- Ensure inclusion of housing system expertise in transition practice.
- Increase affordable housing options by strengthening and improving relationships with housing providers and programs
- Increase access to Employment and Benefits Counseling, fiscal support entities, and informal supports

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Strategy 4.

Decrease reliance on institutional care and increase use of Home and Community-Based Services.

- Continue reduction of ICF/DD utilization through a statewide planning and implementation process involving stakeholders.
- Reduce admissions, readmissions and length of stay to state children's psychiatric hospitals, beginning with children in Child and Adolescent Behavioral Health Services (CABHS).

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Questions?

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