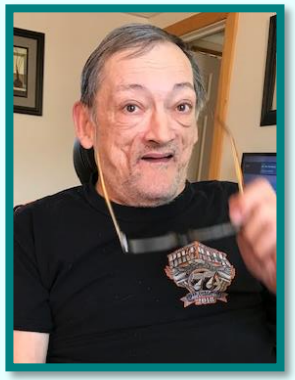
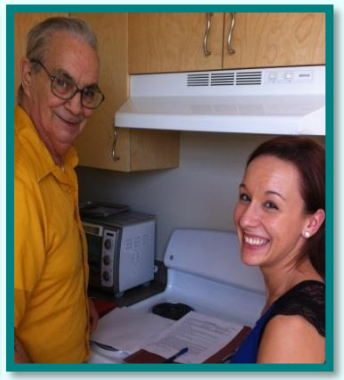
# Money Follows the Person






# What We Would Like to Accomplish Today

**Money Follows the Person (MFP) Grant Discussion:**

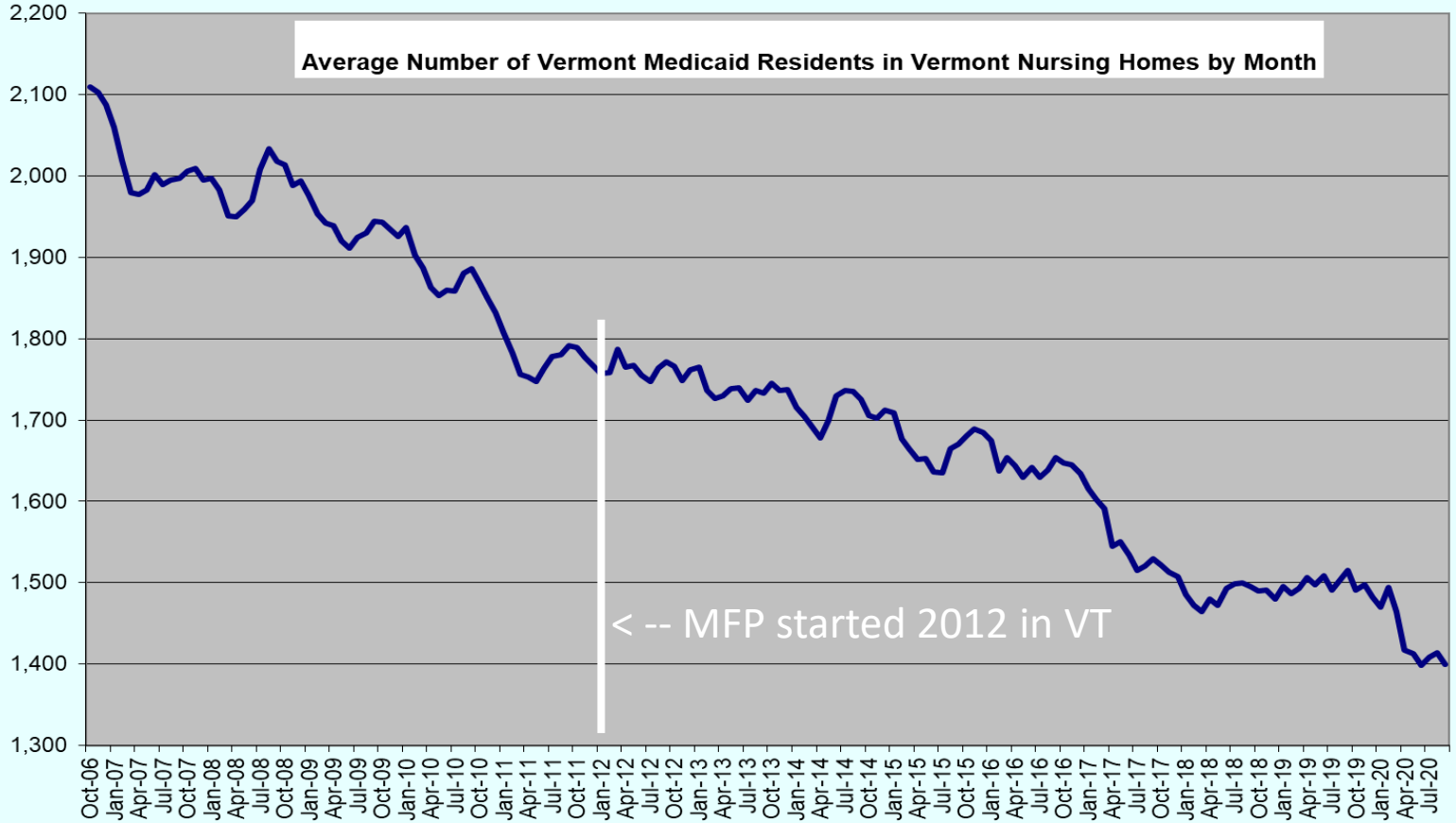
- ❑ Provide an update on the current status of the Vermont's MFP Grant
- ❑ Educate about the availability of a new MFP Supplemental Grant
- ❑ Discuss the key initiatives under consideration to be addressed by this supplemental grant
- ❑ Obtain feedback from the advisory board on:
  - ✓ Do you see the initiatives under consideration as critical gaps in our LTSS system?
  - ✓ Do you have other initiatives or additional feedback you want DAIL to consider?

# MFP Demonstration Grant Goals

CMS Demonstration Grant **Goals**:

- ✓ **Increase the use of HCBS** and reduce the use of institutionally based services
- ✓ **Eliminate barriers** that restrict the use of Medicaid funds to enable LTSS Medicaid-eligible individuals to receive services in the settings of their choice
- ✓ Strengthen the ability of **Medicaid programs** to provide HCBS to people who choose to transition out of institutions
- ✓ Put procedures in place to provide **quality assurance** and improve HCBS

# Decrease Reliance on Institutional Services



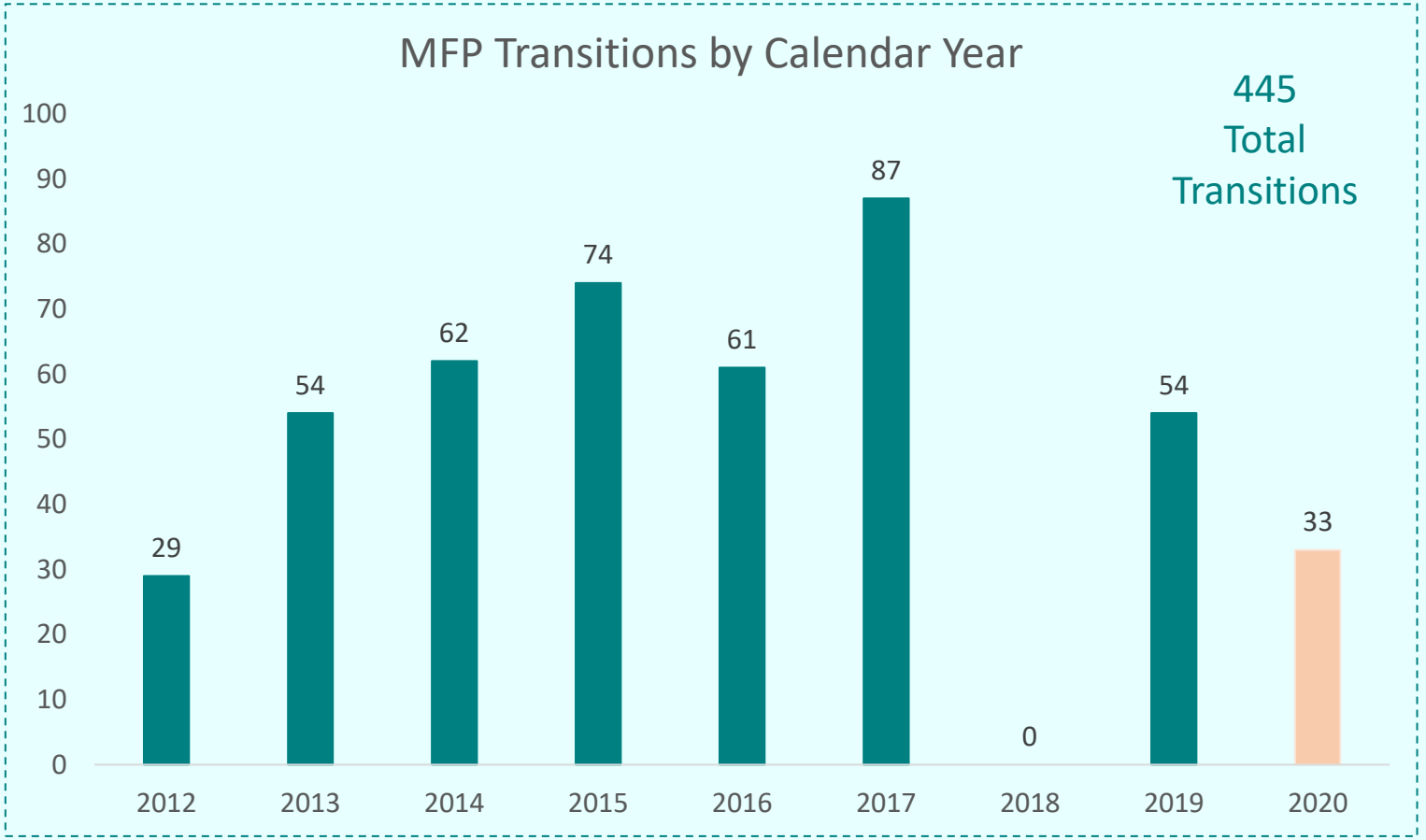

**Average Medicaid NH Residents**

| | |
|---|---|
| October 2006 = | 2,109 |
| September 2020 = | 1,400 |

**-34% Change During this Period**

**Reducing reliance on institutional services has long been a focus at DAIL**

# MFP Transition History




| | |
|---|---|
| **CY20 Transition Goal** | **44** |
| Actual Transitions | 24 |
| Transitions In process | 9 |
| Projected CY20 | 33 |

**We are currently projected to reach 75% of CY20 Transition Goal**

# MFP De-enrollment Reasons

| De-Enrollment Reasons | % of Total |
|---|---|
| Graduated * | 58% |
| SNF Re-Admission ( > 90 days) | 18% |
| Deceased | 14% |
| Other (Loss of Housing, LTC Medicaid etc.) | 7% |

* - MFP Graduation is defined as someone that stay on the program for 365 days after their transition date

## Re-admission Reasons

Acute stay followed by Long-term Rehab

Deterioration in Cognitive Functioning

Deterioration in Health

Deterioration in Mental Health

Loss of Housing

Loss of Personal Care Giver

By request of participant or guardian

Lack of sufficient community services

**National MFP SNF Re-Admission Rate is about 8%**

# MFP Supplemental Funding Grant

DAIL may apply for an additional $5M from CMS through the MFP Demonstration Grant.  These funds can be used for:

- ❑ Planning and capacity building efforts to accelerate LTSS system **transformation**
- ❑ **Expanding HCBS capacities** (direct service workforce, caregiver / provider training, new HCBS services, SNF diversion strategies and payment reform)

grant_funding_notice

# MFP Supplemental Grant Milestones

- ❑ Internal and External Stakeholder Engagement (Ongoing since September)
- ❑ DAIL Advisory Board Feedback (December 10th)
- ❑ DAIL Approval on use of Supplemental Funds (December 18th)
- ❑ CY2021 Budget and Supplemental Request to CMS (December 31st)
- ❑ Estimated Funding Approval from CMS (February / March 2021)
- ❑ Supplemental Grant Application Deadline / Update (June 30, 2020)
- ❑ All Supplement Grants Funds to be spent by (September 30, 2025)

# Transformation of our Community Transition System

Institutional Based Services

It Takes a Village

Home Based Services

## Community Transition & Support Initiatives

- ✓ Lower SNF re-admission rates by enhanced discharge planning and home-based supports
- ✓ Enhanced home-based services to create a more holistic person-centered based system

# Community Transition Medicaid Services

The goal of this initiative is to transform the current MFP grant operations into sustainably funded community-based services

- **The Pre-Transition service** will provide funding for enhanced discharge planning, options counseling and person-centered planning. There will be a focus on assembling a well-trained community transition team focused on the individual's abilities and care needs.
- **The Post-Transition service** will provide funding for services needed for a successful transition day and the post-transition follow-up required to ensure a successful and sustainable community transition. There will be a focus on the first 90 days of the transition including training and support in the home.
- **The Transition Funds service** will provide funding for to help remove identified barriers to transitioning and remaining on Home and Community Based Services.

**This initiative is part of our Sustainability Plan - The Supplemental Grant makes it possible for more comprehensive solutions.**

# Falls Prevention & Mobility

Expanded falls risk reduction effort among high-risk populations to reduce institutionalization and increase independence and mobility

- ❑ Pilot CAPABLE, a five-month structured evidence-based program delivered at home to decrease fall risk, improve safe mobility and improve ability to safely accomplish daily tasks.
- ❑ Conduct a falls risk assessment for Choices for Care participants transitioning home from a significant hospital or nursing home stay post-fall.
- ❑ Increase the use of Home Modification / Assistive Device funds to reduce falls and increase mobility when caregivers are not present. Strengthen partnership with Assistive Technology Program to expand options for individuals.
- ❑ Expand the use of remote monitoring services to support people's ability to remain home without falling or otherwise being safe.

# Adult Day Services

Our Adult Day providers are an integral part of our HCBS system.  Their recent closures have reduced a source of valuable respite time for caregivers and social inclusion for our participants.


Is there an opportunity to explore transformation of our Adult Day Programs to a more sustainable model?

# Expanded Mental Health Supports

There is an increasing need for expanded mental health supports for our Choices for Care Population.  We are exploring an expansion of Elder Care Clinician Services.  Program services could include:

- ❑ Clinical Assessment
- ❑ Individual and/or Family Therapy
- ❑ Service Planning and Coordination
- ❑ Community Supports
- ❑ Medication Management

# Direct Service Workforce

Vermont's Direct Service Workforce shortage continues to be an ever-pressing challenge in both our institutional and community-based settings.

**HCBS Workforce Types:**

- ❑ Agency Directed Services
- ❑ Self / Surrogate Directed Services
- ❑ Unpaid Caregiver (Family, friends & community)

We acknowledge that one of the biggest challenges contributing to this shortage is the Medicaid reimbursement rates for the Direct Service Workforce, but this level of grant funding is not adequate to make a sustainable impact on rates.

# Maximize Our Direct Service Workforce

New initiatives that we are considering:

- ❑ Enhance Community Volunteer Programs – We are planning to work with our partner agencies to expand their volunteer programs in a sustainable manner to offer more respite, companionship and care.

- ❑ Increase training and supports for our participants' unpaid natural supports. These caregivers are the backbone of our system.

- ❑ Partnering with DAIL's Vocational Rehabilitation Division in efforts related to Direct Service Workforce development in Vermont.

    - ✓ Education Scholarships / expenses
    - ✓ DOL registry of Direct Service Professionals
    - ✓ Direct Service Professionals Mentor Program

# Questions / Feedback

- ❑ Open discussion today as time permits today
- ❑ Written feedback requested by December 18, 2020
  - ✓ Angela Smith-Dieng Angela.Smith-Dieng@vermont.gov
  - ✓ Matt Corjay Matthew.Corjay@vermont.gov