2009

Virginia's Money Follows the Person Demonstration

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Volume 24 Number 1 Winter 2009

age in action

Activities in geriatrics and gerontology education and research
Virginia Center on Aging
and
Virginia Department for the Aging

Case Study

Virginia's Money Follows the Person Demonstration

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Educational Objectives

1. Describe Virginia's Money Follows the Person Demonstration project, including the new services available to individuals through Virginia's Medicaid-funded home and community-based waiver program.
2. Explain how Virginia's Money Follows the Person Demonstration project, being administered by the Virginia Department of Medical Assistance Services (DMAS), would assist an individual in transitioning from a long-term care facility to the community.
3. Illustrate how someone might experience the MFP processes from pre-transition through post-transition.

Background

The Money Follows the Person Demonstration (MFP) is a national initiative of the federal Centers for Medicare and Medicaid Services (CMS). The MFP Demonstration's vision is to create a system of long-term services and supports that enables available funds to "follow the person" by supporting individuals who choose to transition from long-term care institutions into the community. Nationally, $1.4 billion was allocated to the 31 states participating in the program, with an estimated 37,000 individuals projected to transition to the community over the four-year demonstration. Virginia's MFP Demonstration went "live" on July 1, 2008 and will operate through September 20, 2011.

Activating MFP in Virginia

The MFP Demonstration gives individuals of all ages and all disabilities who currently live in institutions in Virginia options for community living not previously offered. To accomplish this, Virginia's MFP Demonstration will make permanent changes to Virginia's long-term support system, enabling individuals to use one of five Medicaid home and community based waivers or one of Virginia's Programs for All-Inclusive Care for the Elderly (PACE). The changes also reflect Virginia's commitment to rebalance further its long term support system and encourage community-based supports in lieu of institutional care.

The MFP Demonstration has three major goals. They are:

Goal 1. To give individuals who live in nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities/Mental Retardation and Related Conditions, and long-stay hospitals more informed choices and options about where they might live and receive services.

Goal 2. To assist individuals in making the transition from these institutions, if they choose to live in the community.

Goal 3. To promote quality care through services that are person-centered, appropriate, and based on individual needs.

The MFP Demonstration Project anticipates achieving these goals by

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adding both new and existing waiver services to select Medicaid home and community-based waivers. Specifically, the MFP Demonstration created the following two new home and community-based waiver services:

Transition Services: A one-time, life-time $5,000 benefit for those individuals transitioning from a qualified institution to a qualified community setting to assist with items and services needed for a successful transition. Examples of transition services include rental deposits, utility deposits, and essential household appliances and furnishings.

Transition Coordination: A time-limited service similar to case management that provides needed support for the individual with activities that are associated with transitioning, including the development and implementation of the transition and service plan.

In addition to the new waiver services, DMAS added certain existing waiver services to select home and community-based waivers. The following chart illustrates these additions, as a result of the MFP Demonstration:

Waiver	Waiver Service to be Added
Elderly and Disabled with Consumer Direction (EDCD)	Environmental Modifications Assistive Technology Transition Coordination Transition Services
HIV/AIDS (AIDS)	Environmental Modifications Assistive Technology Transition Services
Technology Assisted (TECH)	Personal Emergency Response System Transition Services
Individual and Family Developmental Disabilities Supports (DD)	Transition Services
Mental Retardation (MR)	Transition Services

DMAS anticipates that 1,041 individuals across Virginia will make the transition from institutions into home and community-based settings during the MFP Demonstration's four-year implementation period.

Case Study

Pre-Transition Period: Making the Decision

Ethel is a 64 year-old woman who receives Medicaid services and has lived in a large, state-run training center for 52 years. The seventh of nine children, she had lived with her family until her needs precipitated admission to this facility. She has a profound intellectual disability and bilateral foot deformities which keep her from walking independently, though she wears custom shoes and inserts. Ethel spends a lot of time in her wheelchair, which she propels using her feet. With assistance, she can stand in order to get in and out of bed, the shower, or her favorite recliner. Ethel does not speak, but sometimes makes vocal sounds when she is especially happy or unhappy. She expresses preferences through her visual gaze, through vocalizations or by wheeling herself away from an area. Ethel eats a pureed diet. She drinks from a cup and can feed herself small amounts, although she prefers for others to feed her. She seems to like upbeat country music, but otherwise shows little interest in her environment and seldom reacts to or reaches for objects around her. The facility has tried to promote greater awareness of herself and her environment, for example, by encouraging Ethel to make eye contact with others for brief periods and to look in a mirror. Ethel depends on others for all aspects of her care, and is generally cooperative with whatever needs to be done.

Interdisciplinary Teams at the training center are responsible for identifying individuals who may wish to participate in this Project. Ethel's Interdisciplinary Team suspected that she might be interested in living in the community, so it contacted her brother to discuss the possibilities, as well as potential risks to community living. When an individual in a Virginia state facility has a legal guardian, or if an Authorized Representative has been appointed, that representative must agree with community placement and give consent for transition planning to begin. Both of Ethel's parents are deceased but she had a brother living in the family's hometown and a sister in California. Ethel's brother had been appointed as her Authorized Representative. When the facility's social worker provided information about services available in the community and about Ethel's ability to participate in this Project, he strongly embraced the prospect of community placement and gave all of the necessary informed consents for discharge

planning to begin. This included his written permission for Ethel to participate in the MFP Demonstration. The facility began coordinating with the Community Services Board serving Ethel's home county in order to obtain a slot on the MR Waiver list for Ethel. Ethel met the criteria for this waiver, for the criteria for residency in the training center (which is an intermediate facility for individuals with intellectual disabilities/mental retardation) are the same as for the MR Waiver. Since Ethel was participating in the Project, she immediately received one of the 110 MR waiver slots reserved for those who need services under the Project's MR Waiver.

The Transition: Careful Coordination

Ethel's brother requested that community services be located as close to the family home as possible. At the same time, he decided that he did not want to take an active role in setting up Ethel's services but wished to be kept fully informed by the Community Services Board and the facility's social work staff. The Mental Retardation Director of the Community Services Board contacted several residential providers meeting the geographic criteria, both group home and sponsored residential placements, and invited them to the facility to meet Ethel and gather information from the team on her living unit. After considering available providers, their locations, their proximity to activities of interest to Ethel, and populations served by each provider, Ethel selected Apple Valley group home whose owner was eager to develop services for her in the community. The provider articulated a vision for a small three-bed group home located not far from the family home, which would be configured to meet Ethel's physical needs and which would offer a comfortable, safe environment with a gentle boost in the activities and stimulation available to her. The facility's social worker, who had established a close, trusting working relationship with the family over many years, endorsed this plan. Ethel's brother gave consent for transition planning to begin, and the provider started the process of identifying an appropriate house and appropriate housemates for Ethel. Her case manager administered the first Quality of Life Survey to Ethel, and her brother assisted her in responding. Unfortunately, Ethel's brother passed away soon after this, and there was a short interruption in transition planning. Ethel's sister in California was initially hesitant about Ethel's ability to live in the community. Training center staff connected Ethel's sister with the family of an individual who had moved into a group home several months ago. Ethel's sister spoke several times with the family, learning how many supports are now in the community to address individuals and their safety needs. After learning of these improvements, Ethel's sister was equally in favor of the community placement; it took a couple of weeks for the facility to designate her as an Authorized Representative and obtain the necessary informed consents, which included consent to participate in the Money Follows the Person Project. As can be seen, in the MFP program, any conflict or difficulty that might arise during the stages of the transition is dealt with individually on a case-by-case basis, involving the person who is transitioning, or the Authorized Representative, and the Case Manager/Transition Coordinator. This is due to the dynamic and unique nature of each transition planning/implementation process. When planning resumed, staff members from the facility and the group home coordinated a series of information-sharing and transitional activities:

• The residential manager and assistant manager from Apple Valley spent an entire evening shift and part of the following day shift on the living unit with Ethel and her staff, observing and learning her care routines. The facility provided on-grounds accommodations for the community group home (provider) staff;

• Staff members from the facility reviewed with provider staff the latter's responsibility to offer staffing in accordance with needs;

• A team of facility staff members who knew Ethel well, including staff from social work, direct care, and physical therapy, visited the prospective group home site to assess the property and provide recommendations for modifications to the physical plant based on Ethel's needs. Following this visit, the group home provider modified the property by installing a front porch ramp and a curb cutout, widening interior doorways, and fitting grab bars and a transfer seat in the bathroom and corner guards on furniture. Facility staff also recommended the correct height for Ethel's bed for the most effective transfers.

• Ethel's annual review fell within this period, and the provider's admissions coordinator attended her interdisciplinary team meeting. Up-to-date reports from all disciplines were provided, along with substantial anecdotal information. It was clear at the meeting that the facility's team members (a sizeable group) knew Ethel, cared about her, and were genuinely supportive of her move to the community.

• In late March, facility staff members brought Ethel to her new group home for a day visit that included lunch. Ethel also met the other two individuals who were living in the home; they all seemed to like each other. The visit was a success. The facility later gave glowing feedback on Ethel's apparent comfort level throughout the day and on how well prepared the group home staff members were. The residential provider had purchased a lounge chair very similar to Ethel's favorite chair on the facility living unit, as well as a full-length mirror similar to the one facility staff members had been teaching her to use.

• Facility nursing staff coordinated with Ethel's new community physician to share information and to schedule her first appointment. Nursing staff also coordinated the transfer of medications and physicians' orders to the group home.

Life after Transitioning into the Community

Ethel moved into her new home in the spring. In case Ethel needed to return, the facility placed her on "convalescent leave" with her discharge date being not until a month later. This precaution turned out to be completely unnecessary. Within the first month, Ethel was settled in, attending a Memorial Day picnic and some other events with undisguised pleasure, and even starting to pick out her favorite staff. Clearly, she was "home."

Although Ethel now lives in a different county from where she grew up, her original Community Services Board continues to provide her case management. This board assigned a case manager for Ethel shortly before her discharge from the facility; the case manager submitted the service authorization request and other required paperwork to the Office of Intellectual Disabilities for approval, and now visits Ethel at least every 90 days, monitors service delivery, maintains contact with her family, and fulfills the other functions required by waiver regulations

During Ethel's first 60 days in her new home, the group home provider conducted a comprehensive assessment of her skills and interests. Then, staff members met with Ethel and her case manager to develop a person-centered service plan for the coming year. (Ethel's sister was unable to attend, but was sent copies of all plan materials later.) Although staff had initially considered establishing training objectives like those at the facility (making brief eye contact, looking in a mirror) for the sake of consistency, they discovered that she was not nearly as detached from her surroundings as had been thought. Ethel was already making more and more eye contact with others and watching what people were doing. She laughed out loud during certain TV shows. Staff noticed that she enjoyed watching birds out the kitchen window from her seat at the breakfast table. Ethel was more ready for her new life than anyone had suspected.

Ethel will continue to receive these services even after her participation in the Money Follows the Project ends because the services she is receiving are a part of the MR Waiver. Staff members from the Department of Medical Assistance Services will visit Ethel at the end of one and two years following her transition to see how Ethel is doing and to complete the Quality of Life Survey as a part of evaluating the success of the MFP Demonstration.

Study Questions

1. What are the new home and community-based Medicaid waiver services created as a result of Virginia's Money Follows the Person Demonstration project?
2. What are the steps necessary for a successful transition under Virginia's Money Follows the Person Demonstration project?
3. Who should be involved in the process in order to ensure a positive transition into the community?

References

For more information about Virginia's Money Follows the Person Demonstration project, including eligibility requirements and a list of Transition Coordination Provider Agencies, visit:
www.olmsteadva.com/mfp
(Virginia's MFP Website)
http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp
(Federal MFP Website)

About the Authors

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