NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

MFP Roundtable

May 19, 2023

What is MFP?

- It is a Demonstration grant awarded to North Carolina by the Centers for Medicare and Medicaid Services (CMS)
  - Transition people from institutions to the community
  - Identify and eliminate barriers keeping people from moving to the community
  - Improve and increase capacity to provide services in the community
  - Ensure quality improvement of community-based services and supports
- Reduces the overall financial cost of long-term care by providing supports in the community instead of institutions

MFP Key Points

- 2005: Federal MFP legislation passes
- 2006: NC application
- 2009: Transition services begin in NC
- 2010: Extended as part of the Affordable Care Act
- 2020:
  - Funding extended through Omnibus spending bill
  - CMS announces supplemental funding opportunities and capacity building grant opportunities
- 2021: NC receives $5 million capacity building grant
- 2022:
  - NC launches Collective Impact Capacity Building initiative with 4 grantees tackline barriers related to housing, transportation, paid supports, and natural supports
  - Proposal developed for $2 million supplemental services funding
  - Funding extended again

Key Statistics (*)

1683 over the life of the program

- 2022: 147 transitions
  - 28 – Older Adult
  - 39 – Physical Disability
  - 80 - I/DD

- 2023: 51 transitions
  - 11 – Older Adult
  - 15 – Physical Disability
  - 25 - I/DD



Nationally:
- 41 States and 2 Territories (Puerto Rico and America Samoa)
- 107,128 transitions

*Statistics as of May 12, 2023

MONEY FOLLOWS THE PERSON
DEMONSTRATION PROJECT

NCDHHS Innovations

Supported Living 2&3

Learning & Living Together

May 19, 2023

Linda Kendall Fields, UNC Chapel Hill
School of Social Work, Cares Program

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

What is Supported Living?

“Supported living is a simple concept …

a person with a disability, who requires long-term, publicly funded, organized assistance, allies with an agency whose role is to arrange or provide whatever assistance is necessary for the person to live in a decent and secure home of the person's own.”

O'Brien, J. (1993). "Supported Living: What's the Difference?" Lithonia, GA: Responsive Systems Associates.

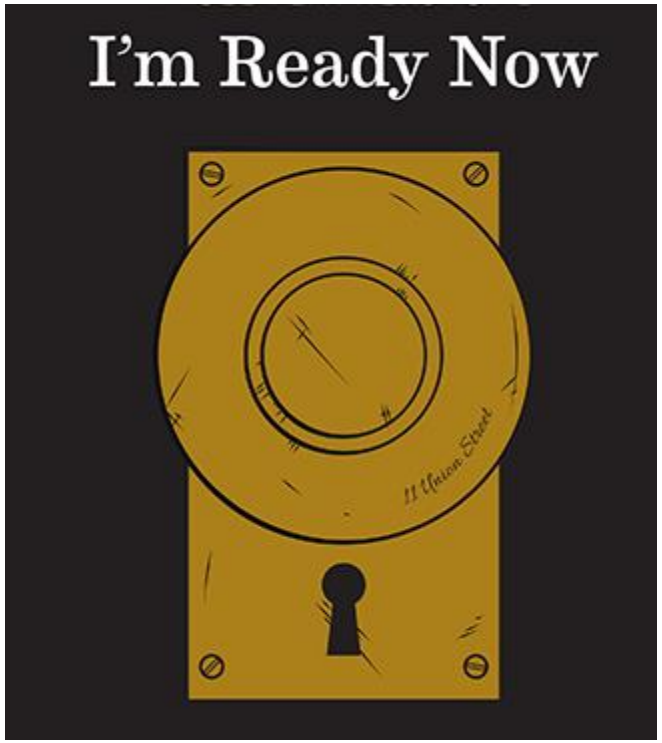
The Supported Living Definition under the NC Innovations Waiver

2016

What I Wish People Knew About Supported Living

11/22 – Krisan Walker, Sandhills

- All you have to do is have a desire to live alone and Innovations Funding. There are no criteria to receive this kind of support. Since what occurs is individually designed, the only prerequisite is that you are over 18 years old.



This could be your Forever Home

- Unlike other residential options your housing is not dependent on an agency.
- You do not have to move because your support staff or the agency changes.

*Entire Ppt available upon request



The Numbers…

(as of 9/30/22)

Supported Living 1: 54

Supported Living 2: 110

Supported Living 3: 86

Total: 250

Total in SL 2/3: 196

There’s still a lot to do!!

Innovations Waiver Supported Living Levels 2&3

Shared Aspiration & Purpose

Shared Aspiration of the Team:

"Individuals and families will be able to use all levels within the Innovations Waiver to experience greater access to quality Supported Living Services."

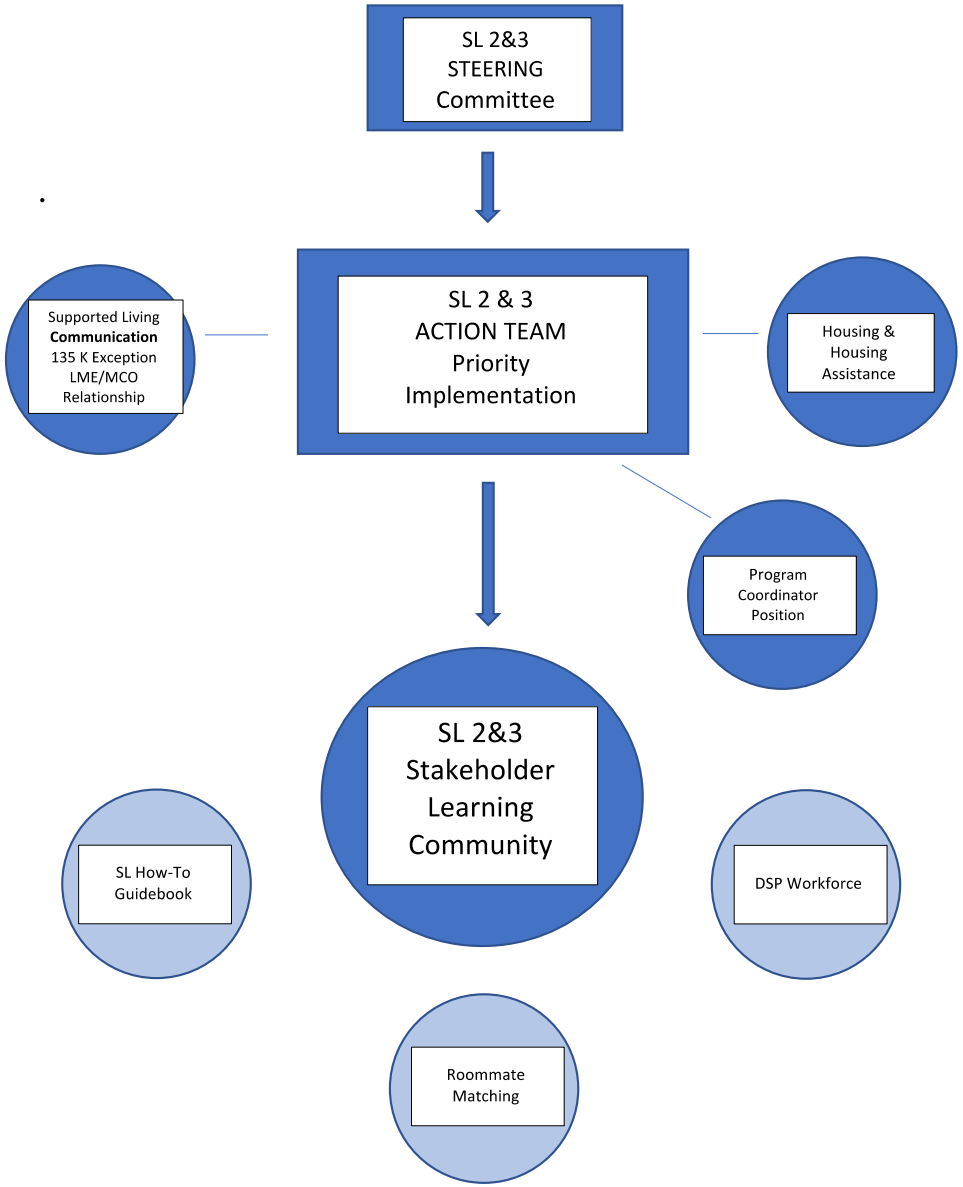
Purpose of the Team:

"To develop and initiate plans that will improve access to Innovations Supported Living Services, particularly for individuals and families receiving Levels 2 & 3 support through the Innovations waiver."

* Established January 2020 at the conclusion of the Vaya Supported Living Grant (2016-19)

Innovations Waiver Supported Living Levels 2 & 3 Organization

Purpose & Work Group Structure



Stories

- Panel of adults using Supported Living 2&3
- Parent stories

Eric’s Journey through Supported Living

April 28, 2022



SUCCESSES





CHALLENGES





Things to Think About



- Take time to plan
- Pull your team together
- Finding housing that works for you
  - Research
  - Don’t expect the provider to do it for you.
- Thinking about every detail
- Your involvement
- Use a checklist for details

SL 2&3 Action Team:
There were three priorities in 2022

- Housing & Housing Assistance
- Program Coordinator Role
- Communication between SL 2&3 Families, State, LME/MCOs, Providers

SL 2&3 Action Team: Ongoing Initiatives

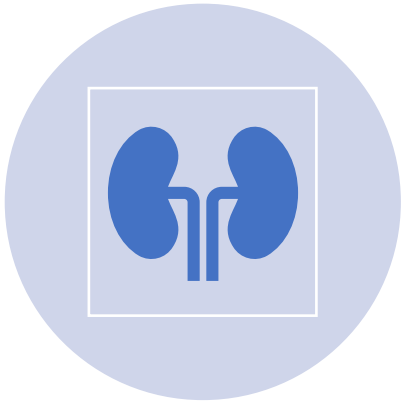
Supported Living How To Guidebook

Strengthening Direct Support Professional Workforce

2023 Priorities from New SL 2&3 Action Team



2023 Priorities



BETTER DATA FROM DHHS & LME/MCOS



TARGETED EDUCATION AND OUTREACH



RATES/FUNDING

Composition of the 2023 SL 2&3 Action Team

Emphasis on **ACTION** - Representation from all stakeholders

LME/MCOs – 6 all there

- Vaya Health
- Alliance Health
- Partners Behavioral Health Management
- Sandhills Center
- Trillium Health Resources
- Eastpointe

Providers – 4

Parents – 8

DHHS - 6

Self-advocates - represented at stakeholder meetings/stories

Meeting Schedule in 2023





Linda Kendall Fields M.Ed.
Clinical Associate Professor
UNC Chapel Hill School of Social Work
(828) 712-4003
lkfields@email.unc.edu

Updates

WRenia Bratts-Brown, MHA, CPM
Associate Director, Home and Community-Based Services
NC Medicaid, LTSS

Renee Stapleton
LTSS Service Operations Manager
NC Medicaid, LTSS

NC Department of Health and Human Services
Division of Health Benefits

2023 - 2028 CAP Waiver Overview

CAP Waiver

Overview of Program Operations

May 2023

CAP Coverage Overview

Coverage

CAP current waiver approval period: March 1, 2023 – February 29, 2028

CAP/DA current waiver approval period: November 1, 2019 – October 312, 2024

Target population: individuals 0 and older who are medically fragile and chronically ill and meet a nurse facility level of care(LOC)

Coverage

3 service options:

- Provider-led
- Consumer-directed
- Coordinated Caregiving

18 home and community-based services

Initial independent assessments planning

Legally responsible person to become paid caregiver, when qualifying conditions are met

Operational Processes

CAP Operations

CAP – 6,000 participant count by 2028; 500 each waiver year

CAP/DA - 11, 678 over 5-year waiver cycle

Program enrollment requirements:

- Referral
- Meet LOC
- Determination of need (initial independent assessment) to confirm medical fragility & identification of unmet needs/risk factors

CAP Operations

Enrollment service options:

- Provider-led
- Consumer-directed
- Coordinated caregiving

Categories of home and community-based services:

- Hands-on
- Supportive services
- Modification services

Managing beneficiary health, safety and well-being via:

- Monthly case management
- Quarterly face-to-face in-home visits

Person-Centered Planning

- A planning process directed by the waiver participant/caregiver that builds services around their strengths, preferences, and desired outcomes
- The planning process enables a personalized mix of paid and non-paid services and supports that assist the waiver beneficiary with achieving personally defined outcomes within the community



Service Options Descriptions

Provider-Led	Consumer-Directed	Coordinated Caregiving
Hands on support for assistance with ADLs and IADLs managed by an In-Home agency or a Home Health Agency: • CAP In-Home Aide • Pediatric Nurse Aide • Congregate Care • Respite services A legally responsible person can seek employment with an In-Home/Home Health Agency to become the paid caregiver for the above listed services other than respite	Personal assistance with ADLs/IADLs and other identified needs as directed by waiver participant/employer of record: • CAP In-Home Aide • Pediatric Nurse Aide • Congregate care • Attendant Nurse Care • Respite services A legally responsible person can qualify to be the paid employee for the above services other than respite	Supportive services to assist with ADLs/IADLs, adaptive skill development and skill-level intervention: • CAP In-Home Aide • Pediatric Nurse Aide • Congregate care • Attendant Nurse Care A stipend is paid to a live-in caregiver for providing supportive care to the waiver participant. Respite services can be arranged for the live-in caregiver.
Meet the hiring requirements of the In-Home Aide/Home Health Agency	Meet the competency assessment requirements, CPR, background check	Live in same home and willing to be a live-in caregiver

Person-centered Choices

Hands-on service options minimal hiring requirements

Provider-Led	Consumer Directed	Coordinated Caregiving
CAP In-Home Aide: • CNAI or CNAII • 18 years and older Pediatric Nurse Aide: CNAII 18 years old and older Congregate Care • CNAI or CNAII • 18 years old and older Respite services • 18 years old and older • Not a primary caregiver or live-in relative	CAP In-Home Aide Pediatric Nurse Aide Congregate Care: • Meet competency assessment requirements • 18 years and older • Pass background check Attendant Nurse Care: • RN • LPN supervised by RN • 18 years old and older • Pass background check Respite services • 18 years old and older • Not a primary caregiver or live-in relative • Pass a background check	CAP In-Home Aide Pediatric Nurse Aide Congregate care Attendant Nurse Care: • 18 years old and older • Live in the same home Respite services • 18 years old and older • Not a primary caregiver or live-in relative

Legally responsible person wanting to be the paid caregiver must meet the extraordinary criteria outlined in clinical coverage policy 3k-1

Provider Qualifications

Hands-on Service Options & Standard Minimum Qualifications	Consumer-Directed Qualifications	Coordinated Caregiving
• CAP In-Home Aide/Congregate Care - CNA I	• Competency evaluation • Completion of background check (criminal and registry) • CPR certification, when applicable	• Must be at least 18 years of age • Must pass criminal and registry background check • Competency evaluation • CPR certified, when applicable
• Pediatric Nurse Aide/Congregate Care – CNA II or + four competencies	• Competency evaluation • Completion of background check (criminal and registry) • CPR certification, when applicable	• Must be at least 18 years of age • Must pass criminal and registry background check • Competency evaluation • CPR certified, when applicable
• Attendant Nurse Care - RN or LPN	• Competency evaluation • RN or LPN • Hours/experience in area of medical need • Completion of background check (criminal registry) • CPR/BLS	• Must be at least 18 years of age • Must pass criminal and registry background check • Competency evaluation • CPR/BLS certified, when applicable

Individual Qualifications

- Legally responsible person can become a paid caregiver when the following conditions are met:
  - There are no available certified nursing assistants (CNAs) or personal care assistants in the CAP participant's county or adjunct counties through a Home Health Agency, In-Home Aide Agency or under consumer direction due to the impact of infectious viruses, and the CAP participant needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.
  - The CAP participant requires short-term isolation, 90-days or less, due to experiencing symptoms of infectious viruses extensive to maximal assistance with bathing, dressing, toileting and eating, and the CAP participant chooses to receive care in his or her home instead of an institution.
  - The CAP participant requires physician-ordered 24-hour direct observation and, or supervision specifically related to symptoms of infectious viruses and the legally responsible person is not able to maintain full or part-time employment due to multiple absences from work to monitor or supervise the CAP participant; regular interruption at work to assist with the management of the CAP participant's monitoring or supervision needs; or an employment termination.
  - The CAP participant has specialized health care needs specific to infectious viruses that can be only provided by the legally responsible person, as indicated by medical documentation, and these health care needs require extensive to maximal assistance with bathing, dressing, toileting and eating to assure the health and welfare of the participant and avoid institutionalization.
  - Other documented extraordinary circumstances not previously mentioned that places the CAP participant's health, safety and well-being are in jeopardy resulting in an institutional placement directly related to infectious viruses.

Person-Centered Choices

Differences between the Service Options

Provider-Led	Consumer-Directed	Coordinated Caregiving
• Provider agency such as an In-Home or Home Health agency takes lead in advertising, recruiting, interviewing, hiring and supervising worker • Provider agency takes lead in bringing awareness to poor performance of the worker • Provider agency sets the pay and pays the worker • Provider agency finds a replacement when worker can't come to waiver participant's home • Provider agency's RN provides quarterly monitoring of the worker to ensure care plan needs are being implemented • Provider agency brings awareness of health care needs to the case manager or physician for follow up • Provider agency reports and tracks critical incidents of the waiver participant • Provider agency (closely) ensures compliance with fraud, waste and abuse	• Parent/representative create job descriptions, advertise, recruit, interview, and hire employees • Parent/representative evaluates skills and experience to ensure interested worker can carryout the medical needs of the waiver participant • Parent/representative set a wage for employees that aligns with skills and experience within the Medicaid limits and authorize payroll for the employee(s) • Parent/representative manages employees and ensures that employees are following work plan and program rules • Parent/representative is aware of fraud, waste and abuse and report any occurrences to FMS or CM • Parent/representative meets monthly with the CM to keep case manager aware of changing needs and progression of waiver participant • Parent/representative keeps in close contact with medical professionals to ensure medical needs of child are being met and addressed • Parent/representative reports and tracks critical incidents of the waiver participant	• Provider agency supports the live-in caregiver through: ➢ coaching ➢ supervision • Provider agency is available 24/7 to provide needed support • Provider agency brings awareness of healthcare needs to the case manager or physician for follow up • Provider agency sends a professional to the home to assist live-in caregiver with managing a new medical condition or other changing needs • Provider agency reports and tracks critical incidents of the waiver participant

Person-Centered Choices

Consumer-Directed Services Requirements

Waiver participant or Representative must:	Waiver participant or Representative must:	Financial Management Agency must:
• Inform CM of desire to self-direct • Participate in consumer-direction training • Complete a self-assessment questionnaire • Collaborate with financial management agency to obtain an EIN & follow guidelines of IRS and Department of Labor Laws • Make decisions about criminal charges found on a background check • Collaborate with FMS to execute an employer & employee agreement • Have a designated representative	• Be willing and qualified to direct care through evidence of a self-assessment questionnaire • Post ads/notification of hire • Validate staff competencies • Hire/manage self-recruited staff • Negotiate wages based on employee's experience background • Train/supervise staff • Collaborate with financial manager to pay employees/resolve payment issues/assure budget management • Adhere to fraud/waste/abuse reporting and compliance requirements	• Train and onboard waiver participant/representative and employee in consumer-direction • Obtain competency validation form • Complete background checks • Validate CPR or BLS certification • Validate whether extraordinary conditions were met • Validate RN or LPN license through BON • Establish the hourly rate based on negotiated wage and associated taxes • Pays employee(s) • Pay employer/employee taxes • Comply with IRS and DOL

Person-Centered Choices

Weighing Decisions about Service Options

Provider-Led	Consumer Direction	Coordinated Caregiving
• Provider agency takes total lead in advertising, recruiting, interviewing and hiring workers • Provider agency takes lead in managing disciplinary actions of hired workers • Provider agency takes lead in soliciting replacement workers • Provider agency manages all payroll processes • Provider agency conducts quarterly monitoring visits to ensure services are meeting waiver participant needs.=	• Parent/representative must be willing and qualified to direct care through evidence of a self-assessment questionnaire • Parent/representative takes total lead in advertising, evaluating, hiring, training and supervising employees • Parent/representative must maintain employment records in their home and fully comply with IRS and Department of Labor laws • Parent/representative takes lead in assuring workers are paid through a financial management entity and assists with resolving payroll issues • Parent/representative takes total lead in negotiating payment issues and paying, out-of-pocket, any amounts over their budget	• Live in the same home of the waiver participant • Willingness to be available for care needs of waiver participant, when needed (stand-by support) • Willingness to accept support and coaching from a supporting entity to meet the needs of the waiver participant • Keeping case manager and supporting entity informed of changing needs of the waiver participant • No requirement of certification of license as required for minimal hiring requirements

Determining What Service Option Works for my Family

- ❑ Do I have the time to manage employees?
- ❑ Do I have people I know to be my workers?
- ❑ Do I know how to detect FWA?
- ❑ Do I know how to find resources I need?
- ❑ Do I know how to manage a budget?
- ❑ I prefer someone else to take lead in finding/hiring my workers?
- ❑ I don’t know people in my community who can work for me
- ❑ I have stand-by ability to take care of my child
- ❑ I know how to develop a care plan
- ❑ I prefer someone to find a replacement worker if my worker is absent
- ❑ I feel comfortable talking with healthcare professionals

Program Assurances

- Respite services can not be provided by the paid caregiver or a live-in caregiver
- Respite hours can not be used to offset hour overage; respite needs must be identified at least 12 hours prior to use
- A legally responsible person or a close kinship live-in relative can not exceed more than 40 paid work hours per week
- Transitioning to CAP service options must be planned and coordinated to include training and assurances of no gaps in services or payment.

Rollout/Implementation Plan



Appendix K Flexibilities

Eligible beneficiaries may begin transitioning to newly approved service options by July 2023 with full transition by Nov. 11, 2023

Supporting Waiver Participant to Transfer to CAP Service Options

- The PHE expired on May 11, 2023; Appendix K extends six months after the expiration of the PHE (Nov. 11, 2023).
- CM will begin transition planning with waiver participant in May 2023 during the waiver participant's annual reassessment.
- Discussion will assist in evaluating health and well-being that leads to a plan of care and appropriateness to enroll in new service option.
- Transition from Appendix K to new service options may occur when there are no gaps in service provision or pay and when qualifying conditions are met for a legally responsible person to be the paid caregiver.
- The CM will assist with assuring a smooth and efficient transition from Appendix K to renewed CAP waiver.

Appendix K Transition

May 15

- Beneficiary transition planning starts
- Planning occurs at annual evaluation or established month (an assessment of need is evaluated) by CM

Jul. – Oct.

- Referrals to service providers from assessment of need evaluation to assist impacted beneficiary's transition from Appendix K to CAP new service options
- Service to start on planned effective date of POC

Nov. 11

- All impacted waiver participants transition from Appendix K flexibilities by 11/1 not later than 11/11
- All Appendix K flexibilities pay/close out by Nov. 12

CD Lite to CD Transition

May 15

- Beneficiary transition planning starts
- Planning occurs at annual evaluation by CM

Jul. – Oct.

- Referrals to FMS from CM to transition qualified beneficiaries from CD Lite to CD
- FMS will validate CD enrollment, per slide 10

Nov. 11

- All eligible waiver participants in CD Lite are transitioned to CD with effective date of 11/1
- All CD Lite services/pay close out by Nov. 12

CAP Services by Categories

Hands-on	Supportive Services	Modification Services
Personal care type services: • *Attendant Nurse Care • CAP In-Home Aide • Congregate Care • *Coordinated Caregiving • Pediatric Nurse Aide • Respite services	• Care management/care coordination • Community transition • *Community integration • Financial management services • *Individual/participant goods and services • Non-medical transportation • Nutritional supplements • Pest eradication • Specialized medical equipment and supplies • Training, Educational and Consultative services	• Assistive Technology • Home accessibility and adaptive services • Vehicle modification Service requests for new budgets are being processed

The CM must authorize the service through a POC-I or revision based on a justification of need evaluation (initial or annual assessment) through collaborative input of the multidisciplinary team, before the FMS can seek reimbursement.

Supporting Waiver Participant to Hire Qualified Employees

- EOR bring awareness of training needs as result of competency validation (employee isn't hired until competency is checked off)
  - CM in collaboration of the FMS completes a plan of care to include training before the hiring of the employee
  - FMS submits the claim to NCTracks for payment and issue payment
- EOR bring awareness the employee does not have CPR certification and can't afford the training prior to employment
  - CM collaborates with the FMS and EOR to create an IRA to address HSW concerns while the EOR and employee work to save money to pay for the CPR training (employee isn't hired until an IRA is in place and fully addresses HSW)
- EOR hires an LPN (employee isn't hired until RN is confirmed, per slide 8)
  - FMS confirms the name of RN and obtain hiring documents (IRS forms, etc.)
  - FMS checks BON for RN listing
  - FMS adds RN as an employee, similar to how respite employees are added



All questions will be compiled and addressed in a FAQ document.
Please type your questions in the chat or raise your hand to state a question.

Virtual Training Schedule

- Virtual training schedule for Providers, CMEs and FMS:
  - For **all provider** - Willing and Qualified provider of Hands-on services; April 28 at 3 pm
  - Registration link: https://attendee.gotowebinar.com/register/3757656185287168342
  - For **CMEs only** – What I need to know as a CAP Case Manager; May 8 at 10 am
  - Registration link: https://attendee.gotowebinar.com/register/5813287208516562 82
  - **For Financial Management Agencies only;** May 11 at 1-2:30 pm - Assisting families to direct their care through consumer-directed services
  - Registration link: https://attendee.gotowebinar.com/register/1127663431599798 66

Virtual Training Schedule

- Virtual training schedule for **beneficiaries/families only**:
  - Becoming a paid caregiver for **In-Home and Pediatric Nurse Aide services**; May 17 at 9 am and 12 pm
  - Registration links: https://attendee.gotowebinar.com/rt/5797663148286321 56
  - **Attendant Nurse Care**, hiring my own nurse; May 22 at 9 am and 12 pm
  - Registration links: https://attendee.gotowebinar.com/rt/1494903036766167388
  - What is **Coordinated Caregiving** and how does it work? May 24 at 9 am and 12 pm
  - Registration links: https://attendee.gotowebinar.com/rt/6874293362474229086







NC Department of Health and Human Services

Transitions of Care Coordination Program Introduction

Renee Stapleton,

LTSS Service Operations Manager

May 19, 2023

Agenda

- Managed Care Background
- Transitions of Care Coordination Overview
- LTSS Disenrollment Form
- Local Contact Agency Overview

Managed Care Background

Within NC Medicaid, there are multiple payor sources for individuals eligible for NC Medicaid

- There are five STANDARD PLANS that launched July 1, 2021.

  AmeriHealth, Carolina Complete Health, Healthy Blue, United HealthCare and WellCare

- NC Medicaid Managed Care also includes six TAILORED PLANS launching Oct 1, 2023.

  Alliance, EastPoint, Partners, Sandhills, Trillium and Vaya

- NC Medicaid Direct continues to provide services to individuals who are otherwise not eligible for managed care health plans.

Transitions of Care

- The Centers for Medicare & Medicaid Services (CMS) defines a transition of care as the movement of a patient from one setting of care to another.
- Transitions increase the risk of adverse events due to the potential for miscommunication as responsibility is given to new parties.
- Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication

TCC Overview

What is Transitions of Care Coordination in NC Medicaid?

- Transition of Care Coordination (TCC) is the process of oversight when a Member transitions between payment delivery systems, including transitions that result in the disenrollment from managed care back to NC Medicaid Direct.
- TCC objective is to ensure beneficiary continuity of care, minimize provider abrasion and provide beneficiaries with information to make informed decisions about the least restrictive appropriate settings for their care.
- All individuals receiving Long Term Services and Supports (LTSS) who are transitioning to NC Medicaid Direct receive TCC oversight.

TCC Overview

The TCC objectives are met in the following manner:

- Evaluation of continuity of care.
  - Health Plans notify the TCC unit of pending disenrollment for individuals receiving LTSS services
  - TCC Unit notifies current providers of the transition
- Review options counseling for nursing facility residents and managed care members.
- Screening to evaluate transitional needs for community living, making referrals to appropriate NC Medicaid Direct programs and services.

Disenrollment Notification

Health Plans submit LTSS Disenrollment Form

- Completed by Health Plans
- Completed for members in managed care who are disenrolling from the plan and
  - Are actively receiving Long Term Services and Supports services

Personal Care Services	**Hospice**
Home Health Services	**Private Duty Nursing**
Home Infusion Therapy	**Nursing Facility Services**

  - Or are enrolling in NC Medicaid CAP Waiver Services

NC MEDICAID
Long Term Services and Supports (LTSS)
MANAGED CARE DISENROLLMENT FORM

DISENROLLMENT / RETURNING TO MEDICAID DIRECT REASON: (select one)	DISENROLLMENT DATE ON THE 834 or if due to CAP, POC Date:
☐ Becoming Dually Eligible ☐ Extended Nursing Home Stay ☐ CAP Enrollment (CAP/DA or CAP/C) ☐ Other: _____	____/____/____

If selecting other as the Disenrollment Reason, please attach information to explain the reason in detail.

SECTION A. MEMBER DEMOGRAPHICS

Member's Name: First: _____ MI: _____ Last: _____ **DOB:** ____/____/____

Medicaid ID#: _____ **Medicare ID#:** _____

PASRR#: _____ **PASRR Start Date:** ____/____/____ **PASRR Expiration Date if applicable:** ___/___/____

RS-ID# (ACH Only) : _____ **RS-ID Date:** ____/____/____

Gender: ☐ Male ☐ Female **Language:** ☐ English ☐ Spanish ☐ Other _____

Address: _____ **City:** _____

County: _____ **Zip:** _____ **Phone:** (___) _____

Plan Name (Select One): ☐ AmeriHealth Caritas ☐ Carolina Complete Health ☐ BCBS – Healthy Blue

☐ United Health Group ☐ WellCare ☐ Alliance Health ☐ Sandhills Center

☐ Eastpointe ☐ Vaya Health ☐ Trillium ☐ Partners Health Management

Enrollment Date: ____/____/____ Disenrollment Effective Date: ____/____/____

Member currently resides: ☐ Private Residence ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility

☐ Group Home ☐ Family Care Home ☐ Special Care Unit (ACH/SCU) ☐ Other _____

SECTION B. MEMBER'S CURRENT SERVICE PROFILE – LTSS Disenrollment forms are required for members currently receiving LTSS services in Managed Care, or members disenrolling from Managed Care due to CAP/DA or CAP/C enrollment. If neither scenario applies, a LTSS Disenrollment form is not required.

Identify the LTSS services currently received, service provider information and primary diagnosis of current **condition related to the member's need for LTSS**. Complete **ALL** information for each LTSS service received by member.

If member is not returning to Medicaid Direct, or if there are no current LTSS services, a LTSS Disenrollment Form is not necessary.

LTSS State Plan Service List	Provider Name & NPI	Primary Diagnosis ICD-10 Code	Currently Authorized Units (#)	Date of PA Authorization (mm/yyyy)
☐ Home Health	Name: _____ NPI: _____			
☐ Home Infusion Therapy (HIT)	Name: _____ NPI: _____			
☐ Hospice	Name: _____ NPI: _____			
☐ Private Duty Nursing for Members Under 21 Years of Age	Name: _____ NPI: _____			
☐ Private Duty Nursing for Member Aged 21 and Above	Name: _____ NPI: _____			
☐ State Plan Personal Care Services (PCS)	Name: _____ NPI: _____			
☐ Skilled Nursing Facilities	Name: _____ NPI: _____			
☐ Other Value Added or In Lieu Of Services	*List Services:*			

SECTION C. MEMBER'S NURSING HOME ALTERNATIVE CARE SETTING OPTIONS:
This section to be completed for members currently residing in a nursing facility.

Has member received Options Counseling? Yes ☐ **Date:**_____ **(attach summary)**
No ☐ **Reason:**_____

Check programs for which transition options been explored on member's behalf:

Transitions for Community Living (TCLI)	☐	
Money Follows the Person (MFP)	☐	
Transition to Adult Care Homes (ACH)	☐	
Transition to Program for All-Inclusive Care for the Elderly (PACE)	☐	
Community Alternatives Program for Children (CAP/C)	☐	Is member on wait list? Yes ☐ * No ☐
Community Alternatives Program for Disabled Adults (CAP/DA)	☐	Is member on wait list? Yes ☐ * No ☐

* *If Member is on any waitlist, please indicate their place on the list by providing a waitlist number if known:* _____

SECTION D. ATTESTATION

Care Manager Signature AND Credentials: _____ **Date** ___/___/___

Signature stamp not allowed

Printed Name: _____

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

Other comments to share with DHB about this individual:

What is Local Contact Agency (LCA)?

The Local Contact Agency is responsible to:

- work with the resident and Nursing Home Staff
- discuss options for transitioning to the community by
- offer contact information for community-based services that may facilitate transition if a resident indicates interest in learning more about transitioning home during their assessment (MDS 3.0)

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/nursingHomeQualityInits/MDS30RAIManual

What does Local Contact Agency (LCA) do?

- Collaborate with resident and Nursing Facility staff to incorporate Independent Living skills in the resident's care plan
- Shares information and assists resources need for a safe and successful transition
- Provides follow-up with resident and staff on resident's progress leading to the transition

LCA Roles and Responsibilities

- The LCA is responsible for providing accurate and unbiased information to the resident about resources available in the community to facilitate an informed decision-making process and to provide support for a successful and sustainable transition
- The LCA is responsible for making a referral in cooperation with the facility to community agencies who can assist the resident in initiating the transition planning process

Functions of the Local Contact Agency

- NC Medicaid is preparing to onboard a vendor (no award yet made) who will assume the responsibilities for the current LCA activities.
- This vendor will:
  - Establish a formal relationship with Medicaid,
  - Respond to referrals from nursing facility staff or the MDS call center,
  - Provide options counseling and information about transition assistance available in the community.

Functions of the Local Contact Agency

- The vendor managed LCA will establish workflow processes, respond to referrals within a short timeframe (e.g., one week) as specified by the RFP and designate staff to make the visit

Thank you for your time.

Questions?

Discussion

- Based on what you have heard today, what additional information do you need?
  - MFP
  - Supported Living
  - Waiver Update
  - Transition of Care Coordination
- What is the way we need to communicate the information?

Thank You!

http://bit.ly/moneyfollowstheperson

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NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

MFP Roundtable

August 18, 2023
Hampton Inn & Suites Asheville Biltmore Area
835 Brevard Rd.
Asheville, NC 28806