Welcome! I'm Scott Trudo. Today we'll be reviewing New Hampshire's Plan for Supporting Individuals to Live in Home and Community Based Settings. More specifically we'll be looking at how NH is implementing the Community Passport sustainability plan.

I'd like to begin with a brief review of the history of the MFP program here in NH.

Money Follows the Person (MFP) was made possible through a Grant from the Centers for Medicare and Medicaid Services (CMS), which began in 2007. NH's MFP program implementation was named Community Passport.

Under CPP, over 300 elders and people with disabilities were assisted in transitioning from living in institutional settings to community based settings. With MFP funding scheduled to conclude, NH developed a sustainability plan, to ensure that safe and successful community transitions continue. This presentation will review elements of the plan.

Final CPP transitions were completed on March 31, 2016. Under CPP, individuals who transitioned continued to be followed for 1 year. As part of that follow up, Quality of Life Surveys were taken at the time of discharge and 1 year later.

Over the past year we've been working with the department to operationalize the CPP sustainability plan.

Our **Goals** have been to:

Continue to support safe and successful community transitions:

We're pleased to report that working with facility staff, case mgt. and other service providers, and more, the department has supported 16 community transitions between 4/1/2016 and 4/1/2017.

Another goal has been to Prevent Reinstitutionalization. We did that by revealing existing protocols and procedures and identifying gaps and barriers that existed in the current system.

We refined the framework that was built to support the CPP.

During MFP, the CPP Transition Coordinator worked closely with social workers across facilities using a consistent process. With CPP no longer in place, the framework had to be refined to define new pathways and processes.

Over the past few months we've been presenting this information at stakeholder groups, conducting webinars, virtual meetings and onsite visits to ensure that as many stakeholders as possible receive the information they need to assist in safe and successful community transitions.

Today we'll review a number of processes that are in place to support individuals returning to the community. We'll compare these new processes to the processes that were in place under CPP.

We'll look at:

1. The process used to make referrals
2. The process used to determine eligibility under NH's 4 HCBS waivers
3. The processes related to providing Transitional Services

4. The processes related to service authorizations and claiming

The graphic on this slide identifies a number of possible referral sources. Section Q of the Minimal Data Set (commonly referred to as MDS) is a primary source of referrals because it's designed to identify people who have expressed an interest in transitioning from a nursing facility back into the community. But it's not the only source. Referrals can come from a number of sources such as family members, the LTC Ombudsman's office, hospitals or others who believe the individual has an interest in transition.

NH's ServiceLink Resource Centers (SLRC) are the state's Aging and Disability Resource Centers and the designated referral agency for all Section Q referrals . They are also the full service access point within the No Wrong Door system, providing information and referral (I&R) and Options Counseling to all populations, including individuals living in nursing facilities. Referrals are redirected to SLRCs for initial screening part of the MDS Section Q protocol established in 2010.

Once a referral is made to SLRC, follow-up is made with the facility and the individual to provide Options Counseling. If an individual continues to express interest in pursuing community living, SLRC staff may provide continued Options Counseling regardless of eligibility for waivered services.

If the individual appears likely to qualify for Medicaid waivered services, SLRC staff shares this information with NF staff who initiates a referral to start the process of determining waiver eligibility. As the graphic illustrates, the SLRC staff may make a referral to GSIL as appropriate for transition services they provide. We'll look at this in more detail in just a moment.

The graphic on this page illustrates the process flow identifying the tasks performed by SLRC and those performed by the NF staff. Earlier we mentioned Options Counseling. If you are not familiar, Options Counseling is a service that helps individuals assess what's important to them and for them, and to assist them in making informed decisions about appropriate long-term services and supports. OC may also include helping individuals develop person centered plans and arranging for the delivery of services and supports. Once ServiceLink has determined which waiver the individual is most likely for, they share that information with the nursing facility staff. At that point, the nursing facility staff begin the process of applying for the appropriate waiver. In the case of an acquired brain disorder, developmental disability, or in-home supports waiver, they contact the local area agency to begin the process. In the case of CFI, they upload the various documents, which we'll talk about in just a moment, through the NH Easy system to the long term care unit for the application eligibility and determination process for CFI.

Each of the ServiceLinks have a standardized protocol that they follow when receiving a MDS Section Q. referral. Each of the red boxes on the screen represents a piece of the work flow and many have specific timelines associated. Take a minute and review the information on the screen before moving forward.

Now we'll take a look at referrals that flow to and from GSIL. GSIL is a center for independent living. Centers for Independent Living are community-based, cross-disability, non-profit organizations that are designed and operated by people with disabilities. They operate according to a strict philosophy of

consumer control (empowerment). CILs are governed by the Administration on Disabilities (AOD).

Centers for Independent Living Provide 5 Core Services

1. Information and Referral
2. Individual and Systems Advocacy
3. Peer Support and Mentoring
4. Independent Living Skills Training
5. Full range of transitional services

So with that in mind, GSIL works closely with the ServiceLinks in terms of providing referrals to ServiceLink for the process outlined earlier as well as ServiceLink providing referrals to GSIL for work with individuals who might fall outside of Medicaid waiver programs or need additional information GSIL can provide.

Eligibility determination for Long Term Supports and Services contains two parts; State Medicaid and Waiver services. State Medicaid has a financial and medical component, each determined by the Division of Client Services. The Choices for Independence (CFI) waiver is determined by the Long Term Care Unit within Client Services. Eligibility for the remaining three waivers; Developmental Disabilities (DD), Acquired Brain Disorder (ABD) and In Home Supports (IHS) is determined by the Bureau of Developmental Services (BDS).

Eligibility determination requires that many tasks be completed concurrently, not always ending simultaneously. Medical and functional assessments, consents, change of service and release forms are just a few of the documents needed to make a LTC waiver determination. Significant differences exist between CFI and the other three waivers regarding how eligibility is determined. One difference is that the three waivers governed by BDS have a standardized process that is initiated and managed by an Area Agency. Intake Coordinators are involved from time a referral is received through eligibility determination. Their involvement reduces reliance on a MFP Transition Coordinator. The framework surrounding CFI is different. Many of the system gaps identified are associated with the CFI eligibility determination process. An Eligibility Coordinator position was created as part of New Hampshire's No Wrong Door system, to help people navigate the Medicaid LTSS application and eligibility determination process. This position can play an important role in community transitions.

This slide points out the eligibility determination process under the CFI waiver.

So as the slide illustrates, the facility uploads through the New Hampshire easy system a change of status along with PHI release, combined release and a completed MEA to the long-term care unit. Next, the long-term care unit nurse reviews the MEA, which is scored and eligibility is determined. If the MEA indicates that the person is eligible, the case management agency is notified and transitional services continue. If the individual is determined to not be eligible a couple of things may then happen: the long-term care unit may request additional information and reconsider the decision and or the individual may appeal the decision.

As I mentioned earlier at the time the long-term care unit receives the COS, they assign a case management agency to provide transitional case management and services. This is the point where transitional planning and services begin.

A couple of key points to keep in mind: the COS is the mechanism that triggers the entire process and if the MEA was not included, long-term care unit will automatically assign a contracted nurse to complete it.

The details of transition planning may vary depending on:

- The nature of the transition in terms of services needed
- The waiver that the person is receiving services through
- The system supporting the person in transition - whether it is the organized services under the area agency system, or the Independent case management and provider network for CFI.

And while those services may differ, there are also a number of common elements of transition planning. These include:

- The communication takes place between the Case Manager or Service Coordinator and the nursing facility to create a discharge plan and date of the discharge.
- Meetings between the Case Manager or Service Coordinator and the person transitioning back to the community to develop a service plan.
- Requests for authorizations to provide services allowing the provider to claim and receive payment.

The graphic on this slide illustrates the process flow and milestones associated with Transitional Services. Note that there are essentially two phases of service delivery; before and after housing has been secured. The initial services begin just after the LTC unit has received the COS and an agency has been assigned. Initial services include meeting with the individual and facility staff, possibly the family, the guardian or others.

Initial services also include a conducting a housing assessment and assessing the individual's risks for living in the community. If, after completing these assessments, the individual and the Case Mgr. still feel that a safe and successful move can take place, the housing search begins. This is also the time that the process of determining CFI eligibility is taking place.

<u>A note about housing:</u>

Because the timeframe for locating and securing suitable housing can vary, it is possible that the individual could be determined eligible for CFI before housing has been found. The CFI approval will remain valid for 90 days. After 90 days a new MEA and other documentation may be required. It's also possible that housing is located prior to CFI having been approved. Because of this it's important that the TCM maintain communication with the LTC unit. An EC may be helpful in these cases.

Once housing has been located and CFI has been approved, additional Transitional Services begin. The graphic identifies some of the key services.

It's important to note that Transitional Services include the one-time-set-up expenses for an individual who transitions from an institution to his/her own home or apartment in the community. Expenses must be reasonable and necessary for an individual to establish his/her own living arrangement. Expenses may include the security deposit required to obtain a lease, deposits to ensure utility access, essential furnishings such as bedding, pots and pans, dishes, or one time cleaning costs prior to occupancy. Services must be prior authorized and are limited to $1,000. This service does not include payment for rent.

The graphic on this slide illustrates the process flow and milestones associated with transitional services. Note that there are essentially two phases of service delivery; before and after housing has been secured. The initial services begin just after the LTC unit has received the COS and an agency has been assigned. Initial services include meeting with the individual and facility staff, possibly the family, the guardian, or others. Initial services also include conducting a housing assessment and assessing the individual's risks for living in the community. If after completing these assessments, the individual and the case manager still feel that a safe and successful move can take place, the housing search begins. This is also the time that determining CFI eligibility is taking place. Quick note about housing. Because the timeframe for locating and securing suitable housing can vary, it is possible that the individual could be determined eligible for CFI, before housing has been found. CFI approval will remain valid for 90 days. After the 90 days, a new MEA and/or other documentation may be required. It's also possible that housing is located prior to CFI having been approved. Because of this, it is important that the case manager maintain communication with the LTC unit. This is also where an eligibility coordinator may be of great help in these kinds of cases. Now once housing has been located and CFI has been approved, additional transitional services begin. The graphic on this page identifies some of the key services. Transitional services include the one time set-up expenses for an individual to set-up his or her own apartment in the community. These expenses must be reasonable for an individual to establish his or her own living arrangements. Expenses may include security deposit required to obtain a lease, deposits to ensure utility access, essential furnishings. Services must be pre-authorized and are limited to a cap of $1000. Services do not include payment for rent or for food.

The graphic on this slide illustrates the process for the preauthorization and billing of Transitional Case Management services:

- When TCM agency is assigned, a service authorization for up to 5 units of services is entered into the MMIS system (billing code T1017).
- Once the services have been delivered, the CM agency enters the service delivery information into the MMIS system.
- The CM agency invoices for services delivered.

Note: TCM Services (billing code T1017) is used to bill for the Case Manager's time. Items purchased for set-up/furnishing the apartment are reimbursed under "Community Transition" (T2038 HC), which is a CFI billing code that allows for the reimbursement of purchases; furniture, home set-up items and security deposit. Prior authorization is entered into Options and billed against. Receipts are sent in to LTC unit after the transition once CFI has been turned on.

The process for the preauthorization and billing of Community Transition (T2038 HC):

- At the time CFI eligibility has been determined the LTC unit enters into Options a preauthorization for Community Transition Service (T2038 HC).
- Once CFI has been "turned on" the CM agency invoices for reimbursement of home set-up expenses. A copy of receipts must be included.

Once the individual has been approved for CFI and a discharge date has been set, the LTC unit assigns Targeted Case Management (T1016), to provide ongoing case management after the transition has taken place. Billing is entered directly into the MMIS system, no prior authorization is needed.

Additional supports and resources have been put in place to support transitions from the Glencliff Home.

In these cases, Glencliff staff identify those residents that meet the target population as defined by Community Mental Health Agreement (CMHA) and have a desire to transition into the community.

They then identify a provider to support the transition and ongoing community living including but not limited to housing, medical and behavioral service access, budgeting, community integration, socialization, public assistance, transportation, education, employment, recreation, independent living skills, legal/advocacy and faith based services.

The community provider must be enrolled with Xerox, the Medicaid Managed Care Information System (MMIS) as a Medicaid Provider

The community provider works with the Glencliff Home to complete their comprehensive assessment and intake and the Department of Health and Human Services (DHHS) Glencliff Transition of Care Community Living Plan. The Individual Service Plan (ISP), the Community Living Plan and Service Authorization (SA) Request along with the budget must also be completed. All documents listed in this procedure must be submitted to the Director at Bureau of Mental Health for approval.

Once the request is approved by the Director of the Bureau of Mental Health, the Service Authorization is forwarded to the Office of Medicaid Services, Medical Services Unit for data entry into the MMIS system.

The Medical Services Unit faxes the Service Authorization number to the community provider for billing purposes and to the Bureau of Mental Health for their file.

The community provider electronically submits CMS 1500 Form to Xerox for payment.

The community provider may request an upfront payment of no more than a quarter of the annual approved budget in order to begin work on the transition

The annual budget will be authorized in equal quarterly increments. Continued authorization will be tied to concurrent review and progress achieved

As we conclude today's training, I'd like to draw your attention to an additional training that is available. It's also part of the sustainability plan for the community passport program. The training covers information and resources available to help you secure affordable housing and other community supports. The items on the screen are some of the topics covered in this training. And finally, we've

provided you with a list of the definitions of the abbreviations that were used in this presentation. And once again, thank you for taking the time out of your day to learn about NH's plan for supporting individuals to live in home and community based settings.