North Carolina MFP Rebalancing Demonstration Proposal
Additional Information as Requested by CMS

Introduction

In November of 2006, the North Carolina Division of Medical Assistance (the State Medicaid Agency), in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS), submitted a Proposal to CMS for funding under the *Money Follows the Person Rebalancing Demonstration*.

This document is North Carolina's response to CMS's Request for Additional Information. The following information is provided:

- Section I: Budget Verification (attached);
- Section II: Rebalancing Benchmarks with Supporting Information; and
- Section III: Responses to State-Specific Questions.

The State is requesting approval to receive "enhanced FMAP" match for transitioning qualified individuals from qualified institutions to qualified residences in the community. The following population groups are addressed:

- Individuals who are elderly and disabled and are residing in nursing homes;
- Individuals who have been diagnosed with mental illness, who are residing in nursing facilities and special care units, both public and private.
- Individuals who are developmentally disabled (DD) and residing in State DD Centers and Intermediate Care Facilities for the Mentally Retarded (ICFsMR); and
- Individuals with mental illness being treated in state and private psychiatric facilities.

North Carolina requests continuation of consideration for MFP Demonstration funding, based on the information provided below.

Section II: Required Benchmarks

1. Projected number of eligible individuals in each target group to be assisted in transitioning from an inpatient facility to a qualified residence

Federal Fiscal Yr[1]	Elderly	MR/DD	Phy Disabled	Mental Illness	Dual Dx[2]	Total
2008	1	6	8	2	4	21
2009	5	25	51	6	16	103
2010	7	61	61	15	41	185
2011	9	80	82	19	53	243
2012	8	73	68	16	48	213
Total	30	245	270	58	162	765

Notes: [1]Based on a proposed start date of July 1, 2007
[2]Estimated 35 % of MR/DD/MI population will have dual diagnosis

2. Qualified expenditures for HCBS during each year of the demonstration project

Federal Fiscal Year	Qualified HCBS Expenditures	Increase in Expenditures	Percent Increase from Previous Year
2008	$108,891		
2009	$2,415,755	$2,306,764	2116.5%
2010	$5,246,328	$2,830,573	117.2%
2011	$8,839,079	$3,592,751	68.5%
2012	$9,965,952	$1,126,873	12.7%
Total	$26,576,105		

Optional Benchmarks (State must select three)

1. Establishing a trusted, visible, and reliable system for accessing information and services by a date certain (i.e., the establishment or expansion of one-stop shops).

Benchmark	Federal Fiscal Year				
	2007	2008	2009	2010	Total
Number of ADRCs in North Carolina	3	4	5	6	6
Number of individuals served by Aging and Disability Resource Centers (ADRCs)	8,200	10,200	12,200	14,000	44,600

Supporting Information

The North Carolina Department of Health and Human Services (DHHS), Division of Aging and Adult Services, received an $800,000 three-year grant to develop two Aging and Disability Resource Center (ADRC) pilot sites in 2004. These two pilot sites are located in Forsyth and Surry counties. The purpose of these ADRCs is to provide information on the full-range of long-term care (LTC) options and to streamline access to LTC services and supports at a single point of entry.

In October of 2006, North Carolina DHHS, Office of Long-Term Care and Supports, received a Systems Transformation Grant from CMS. One of three selected goals is "Improved access to long term care support services: Development of a one-stop system." Funds were provided under this grant to expand ADRCs. These centers will be the principle "one-stop shops" in North Carolina.

At this time, there are two operational ADRCs that served 6,254 individuals last year. The benchmarks provided in the table above summarize the expected expansion of ADRCs and the increase in the number of individuals served by these centers.

North Carolina is also in the final phase of developing a web-based information and referral system called CareLink. This system includes information about services and supports available statewide and will be utilized in all the state's ADRCs to assist individuals to identify LTC services and programs in their part of the state.

ADRCs will also have a qualified screener who can utilize the web-based Medicaid Uniform Screening Program to assist individuals in determining what Medicaid LTC services and supports may be available. This uniform screening program is described below.

2. Establishing processes for screening, identifying, and assessing persons who are candidates for transitioning to the community that are put into use in the general Medicaid program beyond recruitment for the MFP demonstration.

The Divisions of Medical Assistance and Mental Health, Developmental Disabilities will employ a variety of methods to identify individuals in various treatment settings, who would like to transition to community care. These methods are summarized by population group and facility setting below.

Population Group: Individuals who are elderly and disabled who have resided in a nursing facility for at least six months.

Benchmarks

Federal Fiscal Year	Individuals identified by:				
	Uniform Screening	Centers for Independent Living	Long-Term Care Ombudsmen	Voc Rehab ILRP	Total
2008	0	5	2	2	9
2009	2	28	14	12	56
2010	3	34	17	14	68
2011	5	46	23	17	91
2012	4	38	19	15	76
Total	14	151	75	60	300

Supporting Information

In August of 2006, the North Carolina Division of Medical Assistance entered into a two-year agreement with EDS to develop and implement a web-based Uniform Screening Program for Medicaid long-term care programs, services, and supports.

This screening tool provides a comprehensive screening of individuals applying for Medicaid LTC services that includes evaluation data elements relating to medical conditions and needs, prescription drugs, functional limitations, socio-demographics, MI/MR/RC issues and needs (i.e., PASARR Screening and Level II Evaluations),

cognitive status, mood and behavior, orientation and interpersonal functioning, home environment and caregivers to name some of the most relevant. The Uniform Screening Program, through programmed internal logic, will select three Medicaid programs that are the best fit for the individual and recommend one program as being the best of the identified options.

The Uniform Screening Program incorporates level of care (LOC) reviews and pre-admission screening (as required under the federally-mandated PASARR regulations) for mental illness, mental retardation, and related conditions. Screened individuals who appear to have treatment needs relating to these conditions are referred for a full Level II MI/MR/RC evaluation.

The North Carolina Medicaid Uniform Screening tool will support nursing facility and special care unit transitions in five ways. Specific elements within the screening domains will:

1. Record the applicant's preference to receive services in a facility, or in the home/community setting;
2. Evaluate the applicant's home environment and availability of capable and willing caregivers;
3. Provide information about whether the applicant can live safely in the community;
4. Determine if the individual has the requisite cognitive capacities, orientation, and interpersonal functioning capabilities for self-directed and chronic disease self-management programs; and
5. Provide the applicant a choice of program and service options based on the level of care required, preferences, and available programs, services, and supports.

The screening tool will also help to determine if a nursing home confinement is likely to be short or long term. Individuals requiring only short-term stays in nursing homes will be contacted by a professional or volunteer associated with one of the MFP participating agencies/organizations when the individual has been in the nursing home the requisite six months. Transition plans will be developed for those that want to return home and receive home and community-based services (HCBS).

During the period September 2002 to July of 2005 North Carolina conducted a successful Nursing Facility Transition Program under a CMS grant. The grant enabled the state to demonstrate a successful collaboration between state agencies, regional non-profit organizations, and local agencies and groups. In particular, the North Carolina Division of Vocational Rehabilitation's Independent Living Rehabilitation Program (ILRP) and the regional Centers for Independent Living (CILs) played key roles in identifying individuals for transition. Long-term care ombudsmen were also very effective in identifying and referring nursing home residents interested in transitioning to community care.

All of these agencies and organizations are committed to participating in these transition activities under the MFP Demonstration.

All individuals in this population group will receive an independent living evaluation before a transition plan is developed and implemented.

Population: Individuals with skill nursing requirements and mental illness who have resided in nursing homes for at least six months.

Benchmarks

Federal Fiscal Year	Individuals identified through:		
	PASARR Screening	Through CILs, ILRPs, and Ombudsmen	Total
2008	1	1	2
2009	7	2	9
2010	18	5	23
2011	23	6	29
2012	20	5	25
Total	69	19	88

Supporting Information

Federal regulations require that all individuals requesting admission to a nursing facility be screened for mental illness, mental retardation, and related conditions. This process will be included in the North Carolina Medicaid Uniform Screening Program, once implemented. Currently, the PASARR contractor maintains records of all previous screenings and follow-up Level II MI/MR/RC assessments. PASARR screening will be the principle source of information to identify individuals residing in nursing facilities with mental health diagnoses. Other individuals may be identified by agencies and organizations involved in monitoring LTC services (i.e., Ombudsmen) and providing transition-related services (i.e., centers for independent living and Vocational Rehabilitation's Independent Living Rehabilitation Program).

All individuals in this population group will receive an independent living evaluation before a transition plan is developed and implemented.

Population Group: Individuals with developmental disabilities who have resided in state DD centers and public and private ICFsMR for at least six months and individuals who have resided in state and private psychiatric facilities for at least six months.

Benchmarks

Federal Fiscal Year	Identified via Annual Person-Centered Planning Meetings
2008	11
2009	42
2010	105
2011	137
2012	124
Total	419

Supporting Information

Each year, individuals receiving Medicaid and state-funded services for developmental disabilities and mental illness, with their families or guardians, participate in an annual "Person-Centered Planning Meeting." If the resident or resident's family or guardian indicates that they are "in favor of," or "not opposed to" community living, the resident is put on a list and, transitioned when housing and services become available.

3. Expanding and improving health information technology (i.e., progress directed by the state to build systems that accommodate the business needs of multiple organizations that serve populations).

Benchmark	Federal Fiscal Year					
	2008	**2009**	**2010**	**2011**	**2012**	**Total**
Number of individuals screened through Uniform Screening Program[1]	26,500	106,000	114,500	123,600	100,125	470,725
Number of individuals served through the web-based case management system, including automated assessments and plans of care[2]	650	25,650	42,150	75,000	90,000	233,450
Number of "hits" on NC CareLink	12,000	15,000	20,000	27,000	37,000	64,000

Notes:
[1]Based on historical data
[2]Based on adding LTC programs sequentially, including PDN, waiver programs, nursing facility, adult care home, and personal care services

Supporting Information

The North Carolina Division of Medical Assistance has planned for and is in the processing of developing two web-based automated LTC program management tools.

The first is the automated uniform screening tool, described above, that will make it faster and easier for individuals to be approved for Medicaid LTC services and supports. This system will also support facility transitions, consumer self-directed programs, and chronic disease self-management programs. Since this tool is Internet-based, multiple

organizations will have access to data and information required to fulfill their roles in the Medicaid LTC program admission process.

The next step in LTC automation will involve the development of a multi-faceted, automated, web-based care management tool that will provide tools and resources for:

- Professional care managers to assist individuals participating in HCBS;
- Individuals participating in consumer self-directed programs that link them to care managers, providers, consumer supports, information, and available resources;
- Individuals participating in chronic disease self-management programs that link them to care managers, providers, information, and resources; and
- Family members and informal caregivers to provide better care to individuals with disabling conditions and keep "distant" family involved with and informed about their disabled family member.

Plans call for the web site to have three portals and provide the tools, information, and resources summarized in the table below.

Web Portal	**Examples of tools, information, and resources available**
Professional	• Communicate with consumers • Communicate with providers • Monitor consumers via telemonitoring peripherals • Monitor prescription drug use • Implement interventions • Access and update plan of care • Track recipient outcomes • Manage program waitlists • Provide calendar and schedule reminders • Provide reports and profiles
Consumer	• Provide access to care manager • Provide access to providers • Provide self-assessment tools • Assist in medication management • Provide information on chat rooms and support groups • Provide video conferences with care managers and providers • Provide Webcasts on relevant topics • Provide resource library and Internet links
Family/ Caregiver	• Provide access to key information (based on consumer consent) • Provide information on the goals, tasks, and events related to the consumer's care • Communicate with care manager and providers • Communicate with consumer (distant caregivers) • Provide education and training on caregiver tasks • Provide resource library and Internet links

Section 3: State-Specific Questions

Q1: Please describe how you will address the Medicaid financial eligibility criteria so that money can follow the person in your MFP program?

A1: The North Carolina Division Medical Assistance plans to implement a LTC case-mix reimbursement system to compensate HCBS providers in the same way as nursing facilities. Reimbursement will be based on medical and technology needs, functional performance (level of assistance required for ADLs and IADLs), mental/cognitive functioning, self-management capacities, and home environment, as measured by the North Carolina Medicaid Uniform Screening Tool.

At the present time, DMA does not have the comprehensive automated screening and assessment tools required to determine the level of functioning and care and treatment needs to generate appropriate reimbursement levels. Therefore, the Division is waiting to fully implement the automated web-based screening and assessment tools described in Section II.

Other MFP approaches are being reviewed and discussed, include: (1) the various cash and carry funding mechanisms; (2) the use of Medicaid Community Care Networks to manage long-term care services; and (3) capitated approaches.

Q2: Much of your MFP program hinges on legislation approval. If the legislature does not come through with all that is planned, what are your contingency plans for implementation of your MFP program?

A2: Over the last four years, the North Carolina General Assembly has approved a series of statute amendments and mandates that favor and promote the expansion of home and community-based services. Some examples are provided in the table below.

Session	Bill	Section	Legislation Supporting Rebalancing
2003-2004	HB 1414	Sections 1 through 3	Directed DHHS to commission an independent study to determine whether an institutional bias exists in Medicaid-financed LTC.
			The NC General Assembly increased the number of CAP/DA slots from 10,700 to 13,200.
2005-2006			Directed DHHS to develop recommendations to eliminate the identified institutional biases in the Medicaid Program, including the financial disincentives to use HCBS.
	SL 2005-276	§ 10.20	Directed DHHS to develop a case-mix reimbursement system for community alternative programs similar to the one used with nursing facilities. Payment will be based on level of need regardless of setting.

Session	Bill	Section	Legislation Supporting Rebalancing
		§ 10.24	Directed DHHS to develop a plan to address the services needed at the community level within each Mental Health Lead Management Entity (LME) to ensure adequate levels of community services are adequate to serve the average number of individuals needing these services based on population projections.
		§ 10.28	Directed DHHS to implement a plan for the transition of patients from state psychiatric hospitals to the least restrictive and most appropriate environment.
		§ 10.29	Directed DHHS to downsize state mental retardation centers. Downsizing will be based on the needs of the residents and the availability of community-based services with a targeted goal of four percent each year.
		§ 10.40	Amended Article 6 of North Carolina General Statute Chapter 131E to include a "Home Care Clients' Bill of Rights."
2006-2007	SL 2006-66	§ 10.9C	Directed DHHS to evaluate the use of tele-monitoring equipment in home care services and community-based LTC services.
		§ 10.30	Passed the Independent and Supportive-Living Initiative to provide funds to build affordable housing for persons with disabilities with incomes below the SSI level.

This year the North Carolina Legislative Study Commission on Aging is proposing the following legislation:

- Additional funds to support senior centers;
- Funds to support individuals with dementia and their caregivers;
- Additional funds for the home and community block grant;
- Direct the DHHS to review options for increasing Medicaid medically needy income limits;
- Appropriate funds to increase the availability of housing options for individuals with mental illness; and
- Increase the number of assignments to the State and County Special Assistance In-Home Program.

The North Carolina General Assembly and its Study Commissions on Aging and Mental Health have consistently supported transitioning individuals from facility-based to community-based care and it is expected that a thoughtful and well designed plan for MFP will be favorably received by the legislature.

Q3: Can your current infrastructure successfully implement a MFP program, please explain how?

A3: The current HCBS structure can handle the number of transitions projected in the Demonstration. To assure program accessibility, transitioned individuals will be given priority for placement in the appropriate qualified HCBS program and for additional Medicaid services, when required. In addition, a wide variety of services are available from the North Carolina Division of Vocational Rehabilitation's Independent Living Program. These programs and services are state funded.

Q4: Are Level III group homes qualified institutions for the purposes of the demonstration, state how they meet the definition of "qualified institutions?"

A4: Level III Group Homes are not qualified institutions, as defined in the Money Follows the Person Rebalancing Demonstration Program Announcement and federal regulations. This component of the North Carolina MFP Demonstration is withdrawn.

The state proposes to identify and transition two groups of individuals with mental illness: (1) individuals with mental illness residing in state psychiatric facilities and (2) individuals with mental illness residing in nursing homes.

Q5: Please describe how you will protect the health and welfare of individuals transitioning to the community and ensure that services and supports will be provided during the time of transition and in the first year in the community.

A5: The following measures are in place to ensure the individual's health and welfare in the community;

1. The North Carolina Medicaid Uniform Screening Tool contains items relating to orientation, self-management capabilities, informal caregivers, and safe home environment.
2. All Medicaid individual HCBS program assessments address health and safety issues.
3. A team consisting of a professional social worker and licensed nurse evaluate each individual applying for CAP/DA services (Community Alternatives Program for Disabled Adults), the qualified HCBS waiver program that will be the primary resource for transitioned individuals.
4. Each individual interested in transitioning to community care will receive an independent living assessment by a vocational rehabilitation counselor or trained CIL staff member.
5. Each transitioned individual will be supplied with an emergency response system.

Under the MFP Demonstration, the following additional services will be addressed in the Operational Protocol, should this Demonstration be approved.

1. Enhanced case management services for transitioned individuals during the first six-months of transition.
2. Web-based case management services that will enable the transitioned individual to communicate directly with his/her case manager.
3. The use of home telehealth services, where appropriate.
4. The use of peer counseling and peer mentoring services.