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What is MFP?

- Department of Health and Human Services Demonstration Grant, with transitions through December 2018
- Designed to assist states to balance long-term care systems and help Medicaid enrollees transition from institutions to community
- MFP demonstration services were authorized by Congress in the Deficit Reduction Act of 2005; and extended by the Affordable Care Act of 2010
- Medicaid Solutions Workgroup

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SD MFP Eligibility

- Is a South Dakota resident and 18 years or older;
- Has been residing in a nursing facility, ICF/ID or other qualifying institution for more than 90 consecutive days;
- Meets Medicaid level of care and financial eligibility criteria at least one day prior to transition;
- Will reside in qualified housing upon transition;
- Is willing to enroll in and can be supported in the community through the provision of an existing 1915(c)HCBS waiver; and
- Expresses a desire to live and receive services in a home and community based setting.

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SD MFP Benchmarks

1. Projected number of eligible transitions
2. Increase in Home and Community Based Service expenditures
3. Maintain transitions for at least one year
4. Participants treated how they want to be treated
5. Home and Community Based Services and Long Term Care workforce services receive training

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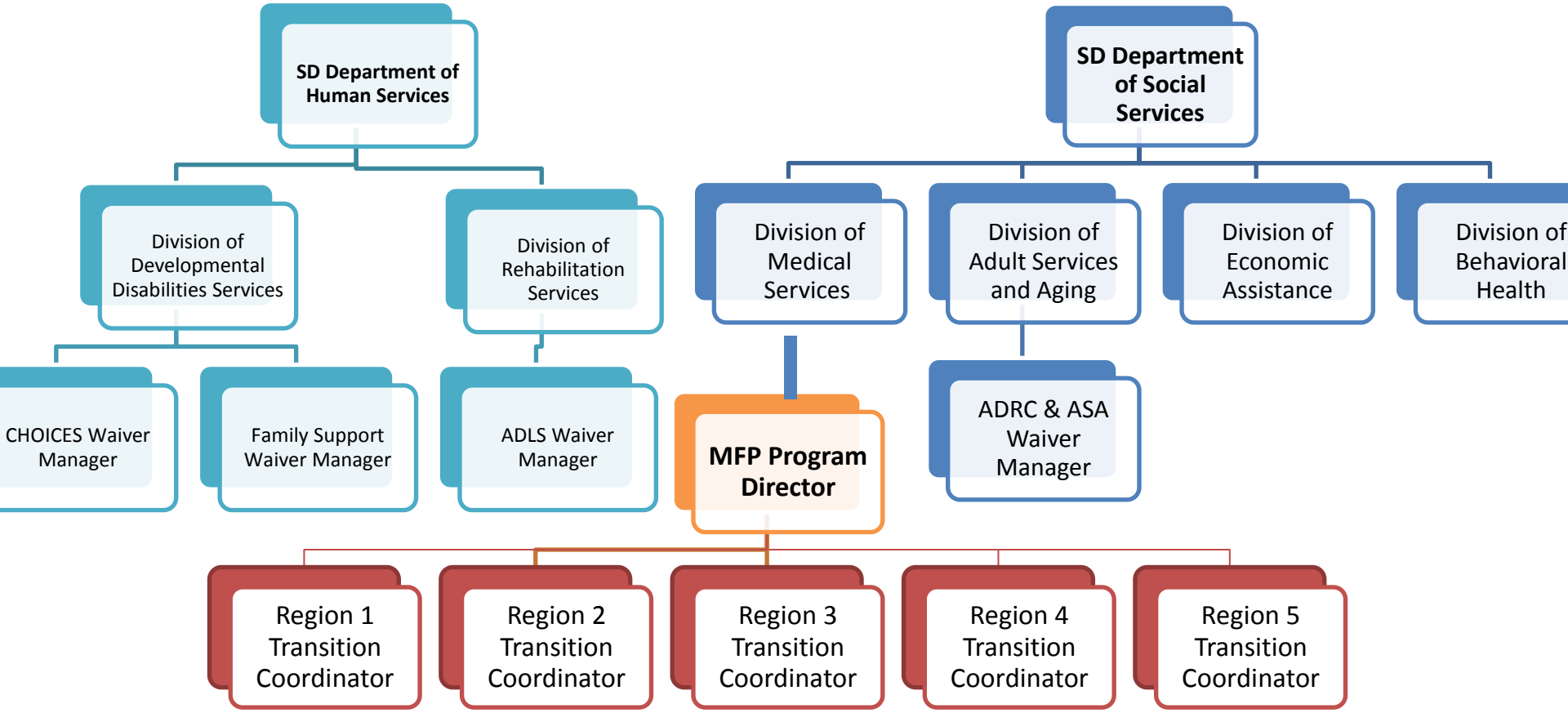
SD MFP Collaboration



MFP Roles

- **MFP Program Coordinator – Sara Spisak**
  - Overall oversight of the MFP Program
- **MFP Transition Coordinator**
  - Point person on transitions
- **MFP Participant**
  - Engaged in every step of the process
- **Transition Team**
  - Group of people who support the participant before, during and after transition

MFP Roles

- **Aging and Disability Resource Connections**
  - Intake and referral
- **HCBS Waiver staff**
  - Crucial part of Transition Team and build continuity of care for post-MFP
- **LTC Ombudsman**
  - Outreach/training to long term care facilities
- **Community Development Specialists**
  - Community based experts engaged to support individual transitions

SD MFP Services

- MFP participant would receive services as authorized by the appropriate HCBS 1915(c) waiver
  - ADLS Waiver
  - ASA Waiver
  - CHOICES Waiver
  - Family Support

- Participant would also be eligible to receive MFP demonstration services as assessed by Transition Team

SD MFP Demonstration Services

- Transition Services
- Non-Medical Transportation
- Assistive Technology
- Consumer Preparation
- Behavior Crisis Intervention

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Transition Stages of SD MFP

1. Assessment Stage
2. Planning Stage
3. Moving Stage
4. At Home Stage

1. Assessment Stage

- Referral

- Initial Interview with Transition Coordinator
  - ✓ Meet eligibility requirements
  - ✓ Interested in transitioning (Wants/Needs and Behavioral Assessments)
  - ✓ Viable transition options

- Informed Consent

- Identify Transition Team members

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2. Planning Stage

- Transition Care Plan
  - ✓ Participant working with Transition Coordinator and Transition Team to develop plan
  - ✓ Identify all needs and the potential risks
- Identify qualified housing
- Create Risk Plan, including 24/7 Back up Plan
- Assess for services needed in the community /providers of services

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3. Moving Stage

- Complete MFP Quality of Life Survey prior to transition
- Discharge plan
- Assure actual transition proceeds smoothly

4. At Home Stage

- Follow up contacts
  - ✓ 2 days, 2 weeks, and 2 months or as needed
- Review care plan and service authorizations to confirm services are meeting recipient's needs
- Quality of Life surveys
  - ✓ Completed again at 11 and 24 months

Questions??

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SD MFP Contact Information

www.dss.sd.gov/mfp

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