SOUTH CAROLINA Healthy Connections MEDICAID

Home Again Program

Division of Long Term Living

December 6, 2017

Topics

- Program Overview
- Program Process
- Program Statistics
- Home Again and Prime
- Waiver Amendments

Program Background

- National grant name is “Money Follows the Person (MFP) Rebalancing Demonstration”
- Helps States rebalance their long-term care systems to transition people with Medicaid from institutions to the community.
- The Deficit Reduction Act of 2005 established $2 billion in funding
  - January 2007, 17 states received demonstration awards
  - As of November 2017, 43 states and the District of Columbia are implementing MFP programs.
- From Spring 2008 through fall 2017, over 75,000 people have transitioned back into the community through MFP Programs

Program Goals

- Increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services
- Eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
- Put procedures in place to provide quality assurance and improvement of HCBS

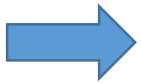
Why Home Again?

- Most desired site of care
- Bypass waiver waiting list
- Address Housing needs
- Rate Comparison
  - Average NF Daily Rate: $171
  - Average HA Daily Rate: $62

Why Home Again?

- Cost Savings
  - SC Nursing Facility Average Daily Rate: $171
  - Home Again Average Daily Rate: $62

$171 X 365 days X 97 individuals = $6,054,255



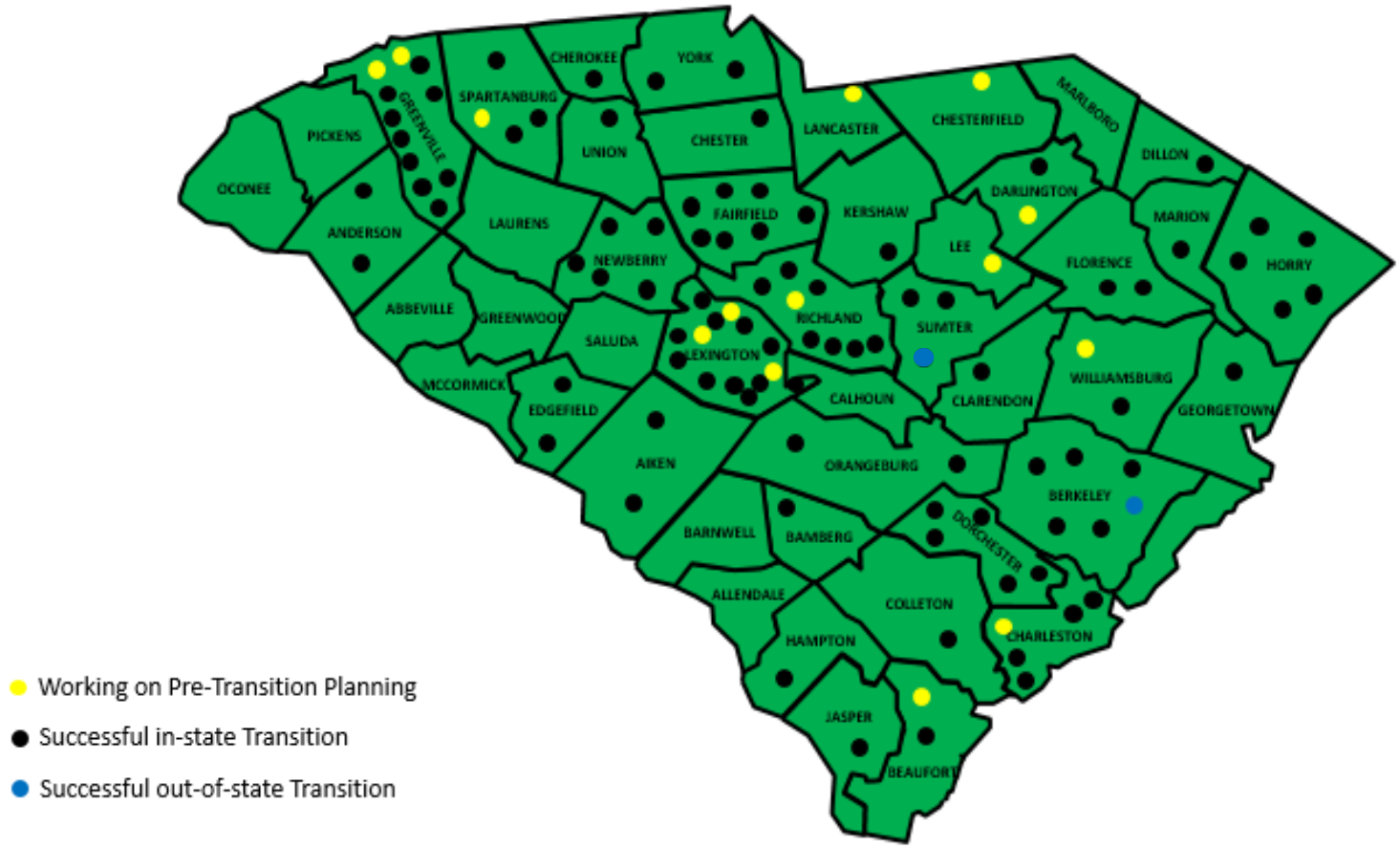
$62 X 365 days X 97 individuals = $2,195,110

Savings for serving individuals in the community rather than in NF = **$3,859,145** per year

Why Home Again?

- Home Again program participants stay, on average, 704 days in a Skilled Nursing Facility prior to transitioning to the community
- The longest stay in a Skilled Nursing Facility was 6,475 days or 17.7 years among Home Again participants
- With the longest stay of 17.7 years, the program could have saved $796,099 for the individual

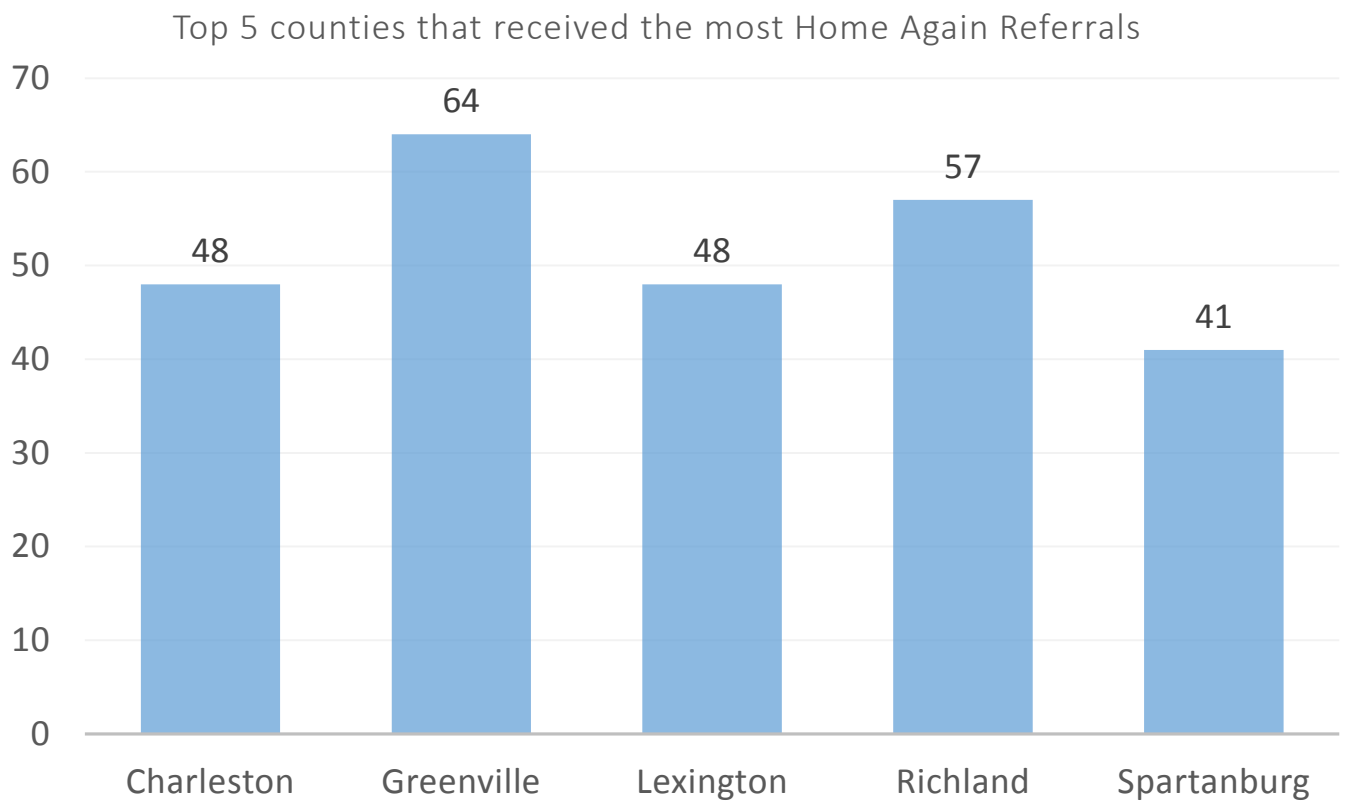
Home Again Map as of November 2017



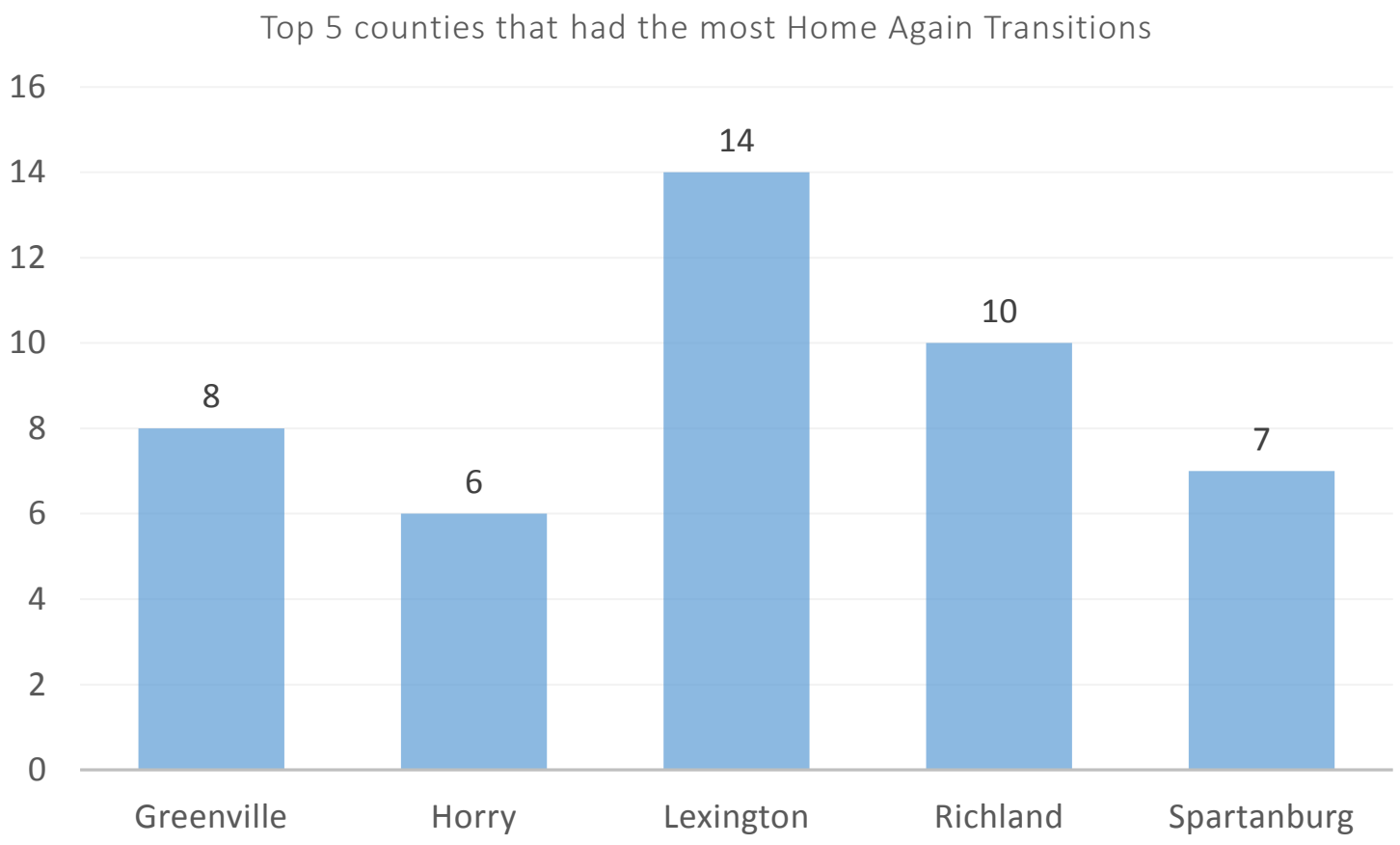
Home Again Statistics

- 685 Home Again Referrals from Sep. 2012 to Nov. 2017
- 97 individuals transitioned to the community (14%)
- 28 individuals transitioned to the community in 2017
- 330 assessments were completed
- Main Reasons for termination after assessment
  - Lack of family support
  - Difficulty in finding housing
  - Deteriorating health conditions
  - Lack of community resources to meet the medical needs

Referrals by County



Transitions by County



Program Eligibility

To be eligible for the program, a person must:

- ❑ Currently reside in a qualified institution (Nursing Facility or Hospital)
- ❑ Have been in the institutional setting for at least ***90 consecutive days****
- ❑ Be on South Carolina Medicaid payment for at least one day before transitioning
- ❑ Meet skilled or intermediate Level of Care

* A person ***cannot*** count Skilled Rehabilitation Services via their Medicare Part A benefit as part of the 90 day requirement. The person ***can*** count hospital stays as part of the 90 days but the person needs to be admitted into the nursing facility at the time of transition (for at least one day).

HCBS Qualified Services

- Qualified HCBS Services can be overlapped with Home Again Program
- Qualified HCBS Services are:
  - Community Choices Waiver
  - HIV/AIDS Waiver
  - Mechanical Ventilator Waiver
  - Dual Eligible Program (HCBS portion only)

We are working to add HASCI Waiver as one of the qualified HCBS services

Home Again Services

- Home Again Services
  - Transition Coordination
  - Expanded Goods and Services
    - Furniture up
    - Appliances
    - Initial Groceries
    - Security Deposits
    - Utility Deposits
    - Household items
    - Other non-covered items

Home Again program is assisting with housing and other issues in order to make successful transitions as well.

Transition Coordination

- Definition

  Transition coordinator is responsible for providing service counseling and assisting participants in coping with changing needs. The transition coordinator will also assist the participant with decisions regarding a successful transition into the community. The transition coordinator will also ensure continued access to appropriate and available services for participants.

Transition Coordination Qualification

- Qualifications
  - Registered Nurse (RN), or individuals with a Bachelor's degree in a health or human services field
  - 2 years case management experiences with at least one of the program target populations

Transition Coordination Service

- Responsibilities (including but not limited to):
  - Obtain informed consent from participant and/or his/her legal representative if participant has been determined incompetent
  - Assess participants medical, financial, and housing situation
  - Assist to develop a service plan with the participant
  - Conduct Risk Assessment and Mitigation Plan
  - Determine whether the participant is moving into a “qualified residence”
  - Maintain a 24/7 backup plan for critical services (as is requirement to be a provider)
  - Conduct psychosocial assessments of the participant
  - Evaluate Durable Medical Equipment (DME) needs of the participant
  - Assist Transition Coordinator Manager to create referrals and authorizations that’s addressed on Service Plan
  - Provide individual health education training for the participant and caregivers

Transition Coordination Service

- Responsibilities (including but not limited to):
  - Conduct home visits of the participant
  - Monitor transition and medical needs of the participant
  - Facilitate transition meetings for the participant
  - Explain to the participant the types of community long term services and supports
  - Assist the participant with housing needs
  - Build and maintain good working relationships with waiver staff, Nursing Facility staff, service providers, clients, caregivers and etc.
  - Keep Quality Assurance personnel closely updated on transition activities on a monthly basis
  - Complete Transition and Discharge Checklists for participant
  - Any additional work required by waiver and Home Again staff

Transition Coordination Service

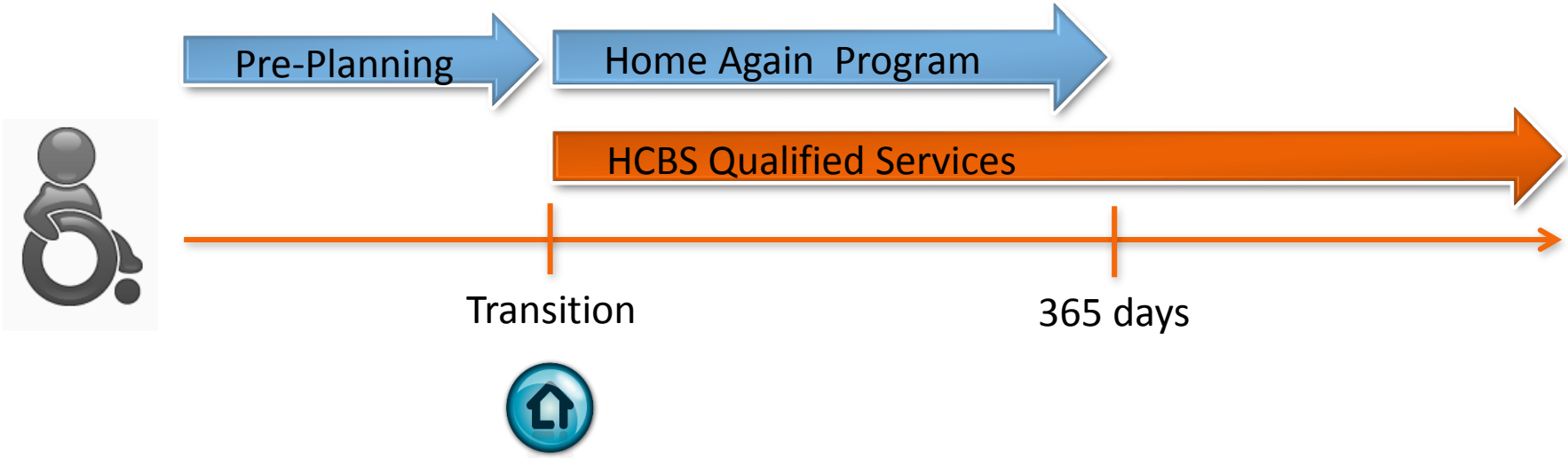
- Visitation Schedule
  - During the first two (2) months, there must be two (2) face-to-face visits and two (2) telephone calls per month.
  - During months 3-12, the Providers will perform one (1) face-to-face visit every other month and one (1) monthly telephone call.

Transition Process

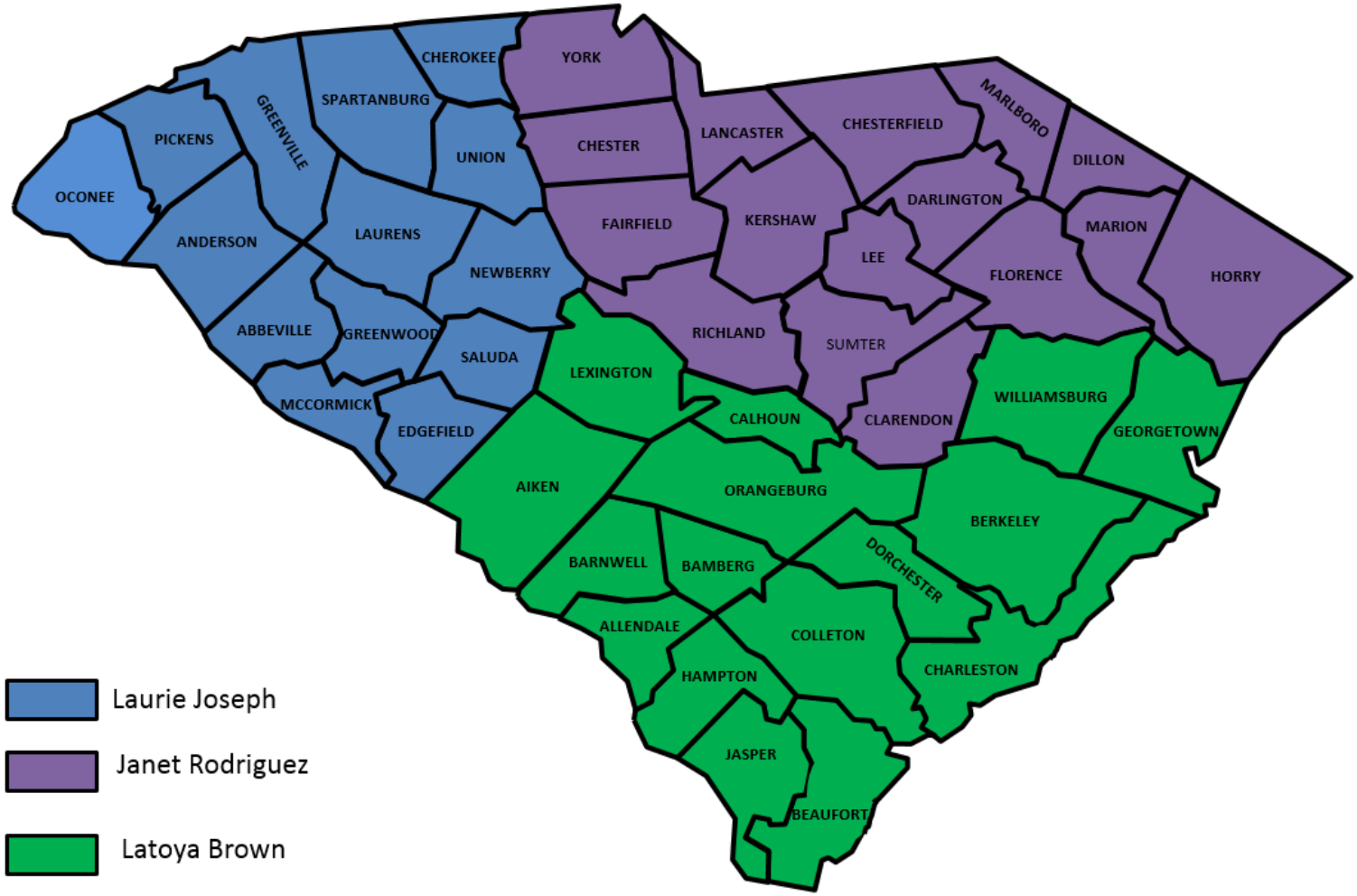
1. Home Again Referral is made
2. Centralized Intake processes the referral
3. Home Again team contacts NF to receive Eligibility Packet
4. Home Again Transition Coordinator Manager visits the NF to conduct initial assessment
5. Case transferred to Area Office and the assigned NC completes LOC
6. TC Manager obtains TC provider choice and completes TC referrals/authorization
7. Case transferred to CM II and CM II completes Service Plan when notified
8. TC Manager creates referrals and authorizations for Home Again demonstration services and Waiver services
9. The participant transitions to the community
10. CM II obtains CM provider choices and create CM referrals/authorization upon enrollment

Note: Case Managers working with Home Again participants should not complete the waiver re-evaluation showing in Phoenix

Home Again Timeframe



Transition Coordination Map



Expanded Goods and Services

- Participants are eligible for all waiver services including environmental modifications as part of waiver services.

- Expanded Goods and Services may cover items such as:
  - Furniture
  - Appliances
  - Initial Groceries
  - Security Deposits
  - Household items
  - DME deemed necessary and not covered by either Medicare or Medicaid DME

Housing Coordinator Roles

- Primary focus to identify and expand the pool of affordable and accessible housing opportunities for Home Again applicants and participants statewide.

- Responsible for outreach to the network of housing entities, including public housing authorities and private landlords, in an effort to better serve individuals needing long term care that will allow them to receive services in their community rather than in a long-term facility.

- Responsible for networking and building a collaborative relationship with local housing authorities, community development corporations, developers, and other housing related entities to promote the development and identification of affordable and accessible housing opportunities that meet the requirements of the Centers for Medicare and Medicaid Services.

Qualified Residence

- A home owned or leased by the individual or the individual's family member; the lease/deed must be held by the individual or the individual’s family member

- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control

- A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside
  - A residence in which no more than 4 unrelated individuals reside and that is part of a larger congregate care setting (campus) separated from typical community dwellings would not be considered a qualified residence.

Transitions by Housing Type

- Home Owned by Participant or Family Member: 70
- Leased Apartment: 26
- Community Based Residential Setting: 0

HUD Affordability Standard

- The HUD affordability standard suggests that a tenant pay no more than 30 percent of his or her income for rent and utilities (not including telephone or cable). The Home Again program has adopted this standard to determine affordability for individuals requesting housing assistance.

- In 2016, a person living on Supplemental Security Income (SSI) in Columbia only receives $733.00 a month. This means that SSI beneficiaries are living at 30% below the federal poverty level or at the extremely low income end. With this money they must pay rent, transportation, groceries, utilities, and when possible other miscellaneous items.

Bridge Rental Subsidy

- There are multiple ways to fund affordable housing.
- One way SCDHHS has attempted to address this need is through the Bridge Rental Subsidy program.
- SCDHHS has a contract with State Housing to administer this program.
- The main objective of this program is to provide rental assistance for our extremely low income Home Again participants for up to 24 months, while on the waiting list for Housing Choice Voucher, Public Housing and Project Based apartments.
- Participants must show proof that they have been placed on at least three (3) waiting list.

Challenges

- The following challenges can prolong the transition to affordable housing:
  - Outstanding Utility Bills
  - Prior Evictions or unpaid rent balances
  - Poor Credit History
  - Prior Criminal History
  - Missing birth certificate and/or SC photo ID and/or Social Security Card
  - Obtaining a current Social Security benefit letter
  - Lack of family support

Client Satisfaction Survey

- **Satisfaction & Experience Study Overview:**

  The study aimed to identify strengths of the Home Again program and areas for improvement by examining programmatic areas including interactions with the Transition Coordinator, participant self-direction, and satisfaction.

- **Program Satisfaction:**

  Almost all survey respondents were ‘extremely’ satisfied with the Home Again program and the CLTC Community Choices Waiver program, the program to which most are transitioning.

Client Satisfaction Survey

- **Transition Coordination:**

  Overall, Transition Coordinators are rated highly by program participants. Transition Coordinators seem to be doing an outstanding job of building professional and respectful relationships with Home Again participants and caregivers. Survey respondents reported high satisfaction with Transition Coordinators and rated response times well indicating that when they needed to talk outside of normal visits that they could reach Transition Coordinators immediately.

- **Person Centered Planning:**

  Most respondents felt that they had choices, and most thought that the Transition Coordinators explained how they could be involved in making choices. However, ratings dropped slightly when asked if they had a say 'all of the time.' While most believed that they could include their personal goals during planning, only half of the respondents said that they could include ways to achieve their personal goals 'all of the time.'

Quality Of Life Data Analysis

- **QoL Data Analysis Overview:**

  In addition to the Satisfaction & Experience study, secondary data analysis was conducted on the Quality of Life (QOL) data which is collected by the Home Again staff at three program intervals, pre-transition, 11 months post-transition, and 2 years post-transition.

- **Living Arrangements, Choice, and Control:**

  Fewer than half of participants reported that they liked where they lived pre-transition, while most reported that they liked where they lived post-transition. For the most part, choice and control seemed to increase as length of time transitioned into the community increased. Choice and control increased from the baseline measure to the first survey post-transition.

- **Access to Personal Care:**

  The overwhelming majority of participants indicated that they needed some type of assistance with activities of daily living (ADLs), and most of the people providing the care were paid. The number of informal care hours provided by friends and family declined by 4 hours from 11 months post transition to 2 years post transition. Approximately one-quarter of participants who are at the two year mark for post-transition report that they need more help with personal care than they are currently receiving. This could be indicative of a need for more caregiver support so that informal caregivers can continue to support those who have transitioned successfully.

Quality of Life Data Analysis

- **Community Integration & Inclusion:**

  At each QOL survey administration, most people reported being able to get places that they needed to go. They also reported being able to see family and friends when they wanted. Few report needing more help to get around the community; however, around half of participants said that they would like to do more activities outside of their facility/home.

- **Participant Well-being:**

  Around one-third of participants reported having symptoms of depression, such as feeling sad and/or irritable at the first and second surveys. This pattern decreased some at the second survey, but irritability decreased significantly by the third survey. These patterns suggest that some aspects of participant wellbeing increase the longer that they remain in the community.

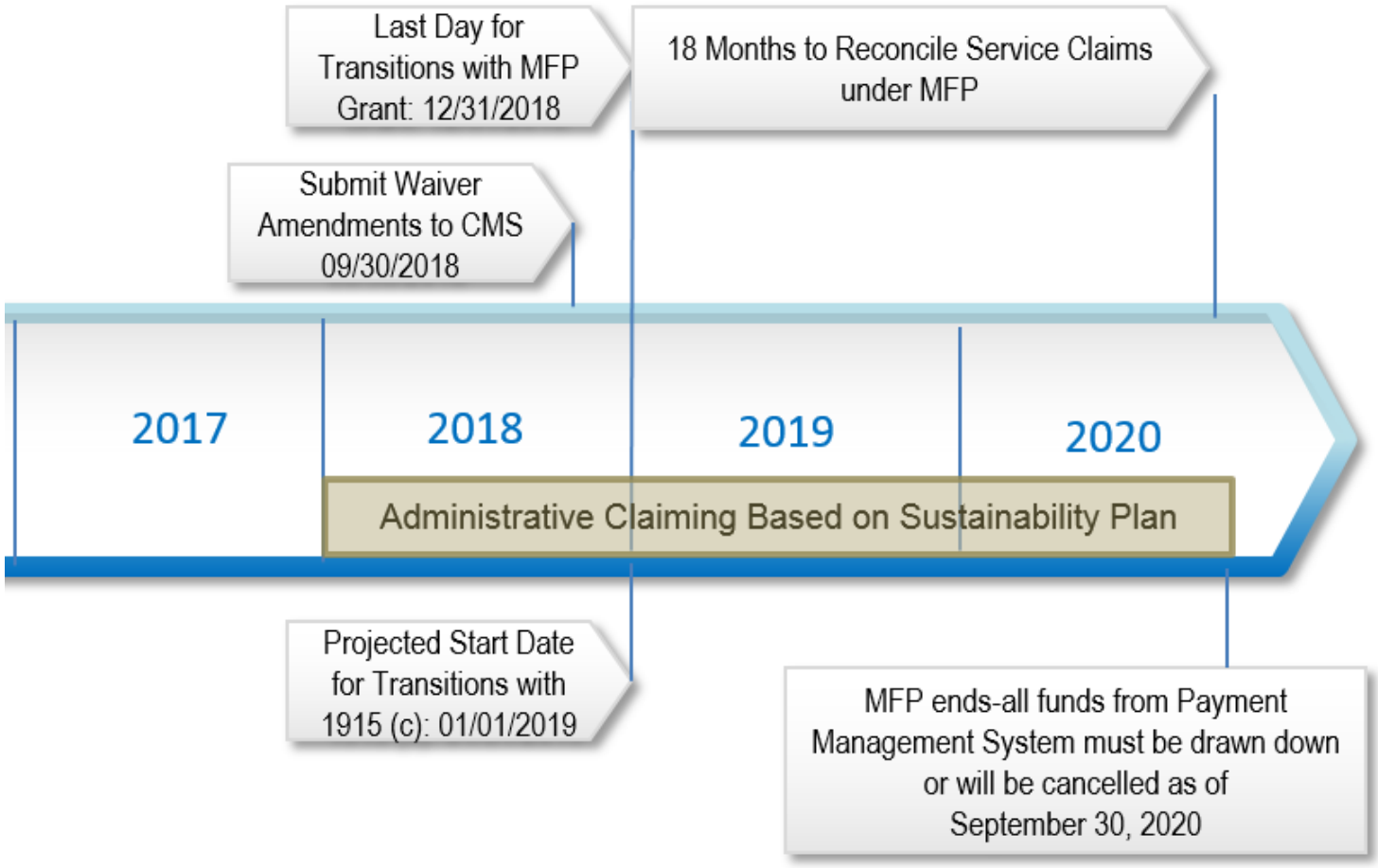
Prime and Home Again

- Transition Coordination vs Care Coordinator
- Focus on on-going monitoring for safety, welfare and etc.
- Emphasize Person-centered approach
- Common goal: Supporting individuals to sustain in the community

Waiver Amendments

- SCDHHS is proposing to maintain the Home Again program under the 1915 (c) Medicaid authority.
- Planning to retain the Home Again program and the two demonstration services through three existing 1915 (c) waiver amendments (Community Choices, Mechanical Ventilator, and HIV/AIDS).
- Will maintain the target population, the eligibility requirements and the qualified institutions for transition activities.

Proposed Timelines for Waiver Amendments



Home Again Success Story

Questions

Contact us

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