OPERATIONAL PROTOCOL

Going Home Plus

Money Follows the Person Rebalancing Demonstration Project

A. Project Introduction

“Going Home Plus,” Hawai`i’s Money Follows the Person (MFP) Rebalancing Demonstration Project, is a collaborative effort between the Hawai‘i State Department of Human Services (DHS) and all of its community partners to engage in a joint effort to discharge individuals from nursing home, ICF-MR and hospital institutions into community settings. The project will target individuals currently institutionalized, for at least six continuous months, including the elderly, persons with physical disabilities, and persons with developmental disabilities who express a choice for community living.

Going Home Plus builds on the ‘Going Home’ project that the DHS implemented in July 2003. The original ‘Going Home’ project targeted Hawaii’s acute care bed shortage in hospitals and successfully transitioned 838 Medicaid beneficiaries from acute waitlisted hospital beds to alternative residential settings in expanded-care ARCH (E-ARCH) homes and foster family homes between July 2003 and December 2007. Most ‘Going Home’ patients were able to successfully move to Medicaid waiver foster homes and E-ARCHs within 30 days after payment was converted to the lower nursing home reimbursement. ‘Going Home’ has been saving state taxpayers about $70,000 per year per patient. The success of that project in making “the money follow the person” resulted in this expansion to *Going Home Plus* which will also be transitioning individuals out of the hospital setting, but also expand to nursing home and ICF-MR settings. *Going Home Plus* will use community settings in all the 1915c home and community based waiver programs and Hawai’i’s new Quest Expanded Access QExA Medicaid managed care program for the Aged Blind and Disabled. The lessons learned from ‘Going Home’ are incorporated into *Going Home Plus* as the three demonstration pilot services.

The mission of the DHS motivated the submission of the application for this demonstration project. That mission is as follows.

> *“Our committed staff strive, day-in and day-out, to provide timely, efficient, and effective programs, services, and benefits, for the purpose of achieving the outcome of empowering those who are the most vulnerable in our State to expand their capacity for self-sufficiency, self-determination, independence, healthy choices, quality of life, and personal dignity.”*

As a result of this mission, the DHS has embraced the following values regarding community-based services that will drive the implementation of *Going Home Plus.*

- Full implementation of the Olmstead Implementation Plan for Hawai‘i.
- Consumer choice and self-direction.
- Improved quality of life for Medicaid users of long-term care.
- Redistribution of funds from institutional care to community-based services.

This Operational Protocol (OP) is intended to provide a "roadmap" for state agencies, stakeholders, providers, and consumers of how Hawai‘i intends to implement *Going Home Plus* successfully. The OP provides a framework for describing the processes, options, and services that will be available to potential clients of the program.

- Information will be targeted to institutional residents to inform them about *Going Home Plus.*
- Eligible individuals will learn how they can be supported if they desire to move back into the community.
- Housing options and opportunities will be discussed.
- Potential participants will be fully informed of the opportunities and the limitations inherent in the demonstration project.

In developing the OP, the Project Director and Management Team intend to assure that residents of long-term care facilities have opportunities to make informed decisions about where they want to live and receive services. The demonstration project intends to supplement existing services with previously unavailable supports to make successful transitions a reality. The participant's network of support, that may include family, friends, neighbors, religious connections, and providers, will be engaged to encourage the use of natural supports to achieve this reality.

Going Home Plus will seek to test the utility of the following pilot projects in creating successful transitions from institutional to community-based care.

- Transition coordinators
- A virtual care office utilizing telemedicine technology
- A Training Institute

These pilot projects will be discussed in detail later in the OP.

The recent approval and planned implementation of Hawai`i's new Quest Expanded Access (QExA) 1115 Demonstration Project are closely aligned with the stated goals of the MFP. In October 2008, the State will enroll approximately 37,250 Medicaid beneficiaries, the entire group of Fee for Service (FFS) Aged Blind and Disabled (ABD) Medicaid population, into the QExA program. Hawai'i's QExA program will provide acute and primary care as well as home and community based services (HCBS) and institutional long–term care services in a mandatory managed care delivery system that is intended to improve access to home and community-based services for the state's most vulnerable populations. When this occurs, the QExA health plans will have the increased flexibility to develop a customized service plan to meet the varied needs of each participant. (See Table B.5.3., Table B.5.4. and Appendix E-3)

February 1, 2009 is the effective QExA start date. For continuing 1915c waiver participants, roll-over of currently authorized HCB services to the QExA health plans should be seamless. The QExA health plans will continue providing each member with all the HCB services they had

been receiving prior to enrollment in the health plan. Within 90 days from February 1, 2009, the health plan is required to reassess all active HCBS members and update their service plans. The *Going Home Plus* project will be just getting underway when the QExA opens. It is anticipated that the QExA rollover and reassessment requirements will affect less than 25 *Going Home Plus* participants. All participants enrolled in the *Going Home Plus* project after February 1 will be on schedule with QExA HCBS implementation.

Two (2) QExA health plans have been contracted to provide the medical, institutional and HCB services for Medicaid ABD enrollees statewide. Under the 1115(a) demonstration authority, four (4) of Hawai'i's five (5) existing 1915(c) HCBS waivers service packages have been combined to create one comprehensive home and community-based long term care benefit package. The four (4) 1915c waivers in QExA are the Nursing Home Without Walls Program (NHWW-Waiver ID #0057), Residential Alternatives Community Care Program (RACCP-Waiver ID #0014), Medically Fragile Community Care Program (MFCCP- Waiver ID #40195), and HIV Community Care Program (HCCP- Waiver ID #00182). Since approval of the Standard Terms and Conditions for Hawaii's QExA program in February 2008, all waiver participants have been receiving services through exact replicas of the HCBS programs listed above until the QExA program is in operation. The QExA Demonstration is approved through June 30, 2013.

Waiver participants in Hawaii's fifth 1915c Medicaid waiver program, the Home and Community Based Services for the Developmentally Disabled and Mentally Retarded (DD/MR) (#0013), will be enrolled in the Section 1115 QExA managed care program to receive their state plan acute and primary care services. However the home and community-based waiver benefits for the DD/MR population are carved out; DD/MR HCBS will continue to be provided under the 1915c authority (Waiver ID# 0013).

The transition to QExA will be seamless for *Going Home Plus* participants. *Going Home Plus* intends to admit MFP participants directly into QExA HCBS services or the DD/MR 1915c waiver program upon discharge from the institution in order to avoid multiple case management transitions and duplication of case management services. For QExA members, the *Going Home Plus* case manager will be the health plan service coordinator.

Table A.1. illustrates how the goals of the *Going Home Plus* (MFP) project are consistent and complementary with the QExA program objectives.

Table A.1. Comparison of MFP Goals and QExA Objectives.

Rebalancing
MFP 1: Increase use of home and community based, rather than, institutional services
QExA: (a) Expanding access to home and community-based service for the State's most vulnerable populations is a primary objective of the QExA program. (b) Emphasis is on services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible.

Flexible Funding
MFP 2: Eliminate barriers or mechanisms (state law/budget/state plan) that prevent or restrict the flexible use of Medicaid funds
QExA: a) Beginning July 2007, the state created one Medicaid budget by combining the budgets of the Medicaid 1915c waiver programs and the Medicaid State plan services (b) The HCBS QExA capitation is structured to incentive health plans to maintain members in the community based setting versus institutional placement. (In most cases, the health plans capitation payment will be reimbursed at the HCBS rate for the first 12 months a member is receiving services in an institution.)
Sustainability
MFP 3: Increase the ability of the state Medicaid program to assure continued provision of community-based services
QExA: Home and community based services will continue to be available to MFP participants after the demonstration period. A key objective of the QExA program is to develop capacity within the community so that all members can be served in the most appropriate, least restrictive cost-effective setting.
Quality
MFP 4: Ensure quality assurance strategies and procedures are in place
QExA: Strategies are to: (a) improve access to medical and long term care services; (b) improve health outcomes and reduce inappropriate utilization; (c) improve the overall health of Hawai’i’s most vulnerable citizens under a coordinated care-management environment; (d) ensure participation by qualified and properly licensed service providers and health plans (e) deliver enhanced quality healthcare services

In summary, *Going Home Plus* intends over the four years of the project implementation period to demonstrate an increased number of persons with long-term care needs living in the community, an improved quality of life for community-based individuals, increased provider capacity to manage complex care in the community, and continued reduced average annual cost from institutional to community-based services.