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Money Follows the Person Demonstration Grants: Summary of State MFP Program Applications

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SUMMARY AND INITIAL ASSESSMENT OF STATE MFP GRANT PROGRAM APPLICATIONS

INTRODUCTION

The Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) made several changes to Medicaid policies governing state financing and provision of long-term care services. Among its other provisions, it created the Money Follows the Person (MFP) Demonstration program under Section 6071 which authorized $1.75 billion to support state efforts to move people currently residing in institutions back into their communities and to rebalance their long-term care systems to emphasize home and community-based services (HCBS) rather than institutional placement.

The MFP program, administered by the federal Centers for Medicare and Medicaid Services (CMS), is the largest demonstration program of its kind in the history of Medicaid. CMS has awarded MFP grants to 30 states and the District of Columbia, committing over $1.4 billion so far (See Table 1). The program's objectives are to:

- **Rebalance** — Increase the use of home and community-based, rather than institutional, long-term care services.
- **Ensure Money Follows the Person** — Eliminate barriers or mechanisms, whether in the state law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.
- **Assure Continuity of Service** — Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.
- **Quality Assurance and Quality Improvement** — Ensure that procedures are in place (at least comparable to those used in the qualified home and community-based program[1]) to assure the quality of home and community-based services provided to MFP participants and continuously improve the quality of such services.

Purpose and Organization of this Report

This document presents an initial assessment of the MFP programs proposed by the 30 states and the District of Columbia that were awarded MFP Demonstration grants, based on their applications to CMS. The MFP grantees begin the demonstration program at different starting points. Tables 2 through 7 provide the most recent data for each grantee state on current long-term care resources, use of institutional and HCBS services, and recent trends in Medicaid spending on long-term care in each setting.

Part I then presents summaries for each grantee's proposed MFP program, organized in the same format to make it easy to compare MFP programs across states. For each state, the summary describes:

[1] This refers to the Medicaid programs, such as HCBS waiver programs and State Plan services, that serve MFP demonstration participants during the one-year transition period and which must be available to continue serving them at the end of that time.

1) **MFP program goals, benchmarks, and target groups.** These include specific state goals related to the statute's objectives such as rebalancing, flexible budgeting, continuity of service, and quality assurance and improvement. Also included are the state's proposed annual transition targets by year and target population. Some states have already modified their annual transition targets from those proposed in their applications; these changes are reflected in the summaries.

2) **Proposed services/programs for transitioned individuals in each target group.** These include how eligible participants will be identified and screened, how their needs will be assessed, in which Medicaid home and community-based service programs they will be enrolled and which services they will be offered during the one-year demonstration period following their discharge from an institution, and the opportunities they have to self-direct their own services. Also included are the states' proposed strategies to increase the availability of appropriate, affordable housing options for transitioning participants and to ensure an adequate supply of direct care workers.

3) **Challenges to rebalancing the long-term care system and expanding home and community-based services.** This section includes state-specific issues identified in the MFP application that will prove to be challenging when working towards a rebalanced long-term care system.

4) **Quality management strategy.** This contains state plans for assuring quality of services to MFP Demonstration participants and assuring their health and welfare.

5) **Administration, oversight, and evaluation.** Included in this section are state mechanisms for managing MFP programs across state agencies; for assuring consumer, provider, and other stakeholders' input into MFP program design and implementation; and for conducting their own evaluations of program impact.

Part II contains three tables (Table 8-10) summarizing for each state: 1) transition targets, 2) program goals, 3) Medicaid program options available to MFP participants, and 4) policy changes required to serve MFP demonstration participants during the one-year transition period.

The information in these summaries is subject to change. States receiving MFP grants are required to prepare an Operational Protocol within one year of receiving the MFP grant award. These Operational Protocols must contain measurable benchmarks of state progress towards program goals, and provide a step-by-step guide to program implementation. Hence, state MFP program features could change as the projects develop specific plans for transitioning individuals from institutions to qualified homes or other community-based residences, and for rebalancing long-term care systems to enhance the ability of people with disabilities to receive services and support in the setting of their choice. These summaries will be updated in the future to reflect state MFP programs as described in their final Operational Protocols.

TABLE 1

LIST OF STATES THAT RECEIVED MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION GRANTS

State	Group	Number of Transitions Proposed[a]	Year One Award Amount	Five Year Commitment
Arkansas	I	305	$139,519	$20,923,775
California	I	2,000	$90,000	$130,387,500
Connecticut	I	700	$1,313,823	$24,207,383
Delaware	II	100	$132,537	$5,372,007
District of Columbia	II	1,110	$2,546,569	$26,377,620
Georgia	II	1,312	$480,193	$34,091,671
Hawaii	II	415	$231,250	$10,263,736
Illinois	II	3,357	$6,879,166	$55,703,078
Indiana	I	1,031	$860,514	$21,047,402
Iowa	I	528	$307,933	$50,965,815
Kansas	II	934	$102,483	$36,787,453
Kentucky	II	546	$4,973,118	$49,831,580
Louisiana	II	760	$524,000	$30,963,664
Maryland	I	2,413	$1,000,000	$67,155,856
Michigan	I	3,100	$2,034,732	$67,834,348
Missouri	I	250	$3,398,225	$17,692,006
Nebraska	I	900	$202,500	$27,538,984
New Hampshire	I	370	$297,671	$11,406,499
New Jersey	II	590	$230,000	$30,300,000
New York	I	2,800	$192,981	$82,636,864
North Carolina	II	1,045	$16,055	$16,897,391
North Dakota	II	110	$18,089	$8,945,209
Ohio	I	2,231	$2,079,488	$100,645,125
Oklahoma	I	2,075	$3,526,428	$41,805,358
Oregon	II	780	$80,785	$114,727,864
Pennsylvania	II	2,490	$130,609	$98,196,439
South Carolina	I	192	$34,789	$5,768,496
Texas	I	2,616	$143,401	$142,700,353
Virginia	II	1,041	$13,793	$28,626,136
Washington	I	660	$108,500	$19,626,869
Wisconsin	I	1,262	$8,020,388	$56,282,998
Totals	I = 17 II = 14	38,023	$40,109,539	$1,435,709,479

Note: Group I grants were awarded in January 2007 and Group II grants were awarded in April 2007. States must submit an operational protocol within one year of the grant award. Wisconsin is expected to start enrollment as early as Fall 2007, but some states may not begin enrolling people until mid 2008.

[a] The number of proposed transitions has been modified in some cases to reflect changes and inconsistencies identified during MPR's review of the initial state applications. This information is correct based on information received from states on or around August 31, 2007.

TABLE 2

DISTRIBUTION OF CERTIFIED NURSING FACILITY RESIDENTS BY PRIMARY PAYER SOURCE, 2006

	Medicare	Medicaid	Private/Other
Arkansas	10.7	70.3	19.0
California	12.6	65.7	21.7
Connecticut	16.4	66.0	17.7
Delaware	17.3	58.4	24.3
District of Columbia	10.0	77.5	12.4
Georgia	11.2	74.7	14.1
Hawaii	9.1	72.3	18.6
Illinois	13.1	62.5	24.4
Indiana	15.1	62.6	22.3
Iowa	6.2	49.3	44.5
Kansas	8.9	53.2	38.0
Kentucky	14.6	66.6	18.8
Louisiana	10.4	75.3	14.3
Maryland	13.2	66.0	20.8
Michigan	16.8	65.4	17.8
Missouri	11.7	62.7	25.5
Nebraska	10.1	52.5	37.4
New Hampshire	13.1	66.0	20.9
New Jersey	16.7	63.6	19.7
New York	12.5	72.4	15.2
North Carolina	15.5	68.9	15.6
North Dakota	7.3	55.4	37.3
Ohio	13.4	63.9	22.8
Oklahoma	10.3	66.2	23.5
Oregon	13.5	60.6	26.0
Pennsylvania	11.4	64.2	24.4
South Carolina	16.4	67.3	16.3
Texas	13.3	66.6	20.2
Virginia	15.9	62.3	21.8
Washington	14.9	62.2	22.9
Wisconsin	12.2	63.0	24.9
United States	13.3	65.0	21.8

Note: 1) Data are for calendar year 2006. These data include the number of nursing facility residents in certified nursing facilities that were surveyed in each state during calendar year 2006. Not all facilities are surveyed by state agenices during each calendar year. These data exclude residents in uncertified beds.

2) Rows total to 100%.

Source: http://www.ahca.org/research/oscar/rpt_payer_200706.pdf

TABLE 3

INSTITUTIONAL RESOURCES AND UTILIZATION IN MFP GRANTEE STATES:
NURSING FACILITY POPULATION

State	Nursing Facility Beds, 2006	Nursing Facility Occupancy Rate, 2006	Pop 65+, 2006	Nursing Facility Beds per 1,000 age 65+, 2006	Nursing Facility Residents as a Percent of People age 65+, 2006
Arkansas	24,684	72.9	390,421	63.2	6.3
California	124,438	86.0	3,931,514	31.7	3.2
Connecticut	30,041	92.1	470,443	63.9	6.4
Delaware	4,754	86.1	114,574	41.5	4.1
District of Columbia	2,988	92.4	71,331	41.9	4.2
Georgia	39,920	89.6	912,874	43.7	4.4
Hawaii	4,127	94.9	179,370	23.0	2.3
Illinois	102,941	79.3	1,534,476	67.1	6.7
Indiana	56,948	81.6	784,219	72.6	7.3
Iowa	39,319	81.6	435,657	90.3	9.0
Kansas	25,908	84.9	357,709	72.4	7.2
Kentucky	26,041	91.2	537,294	48.5	4.8
Louisiana	36,160	76.4	523,346	69.1	6.9
Maryland	29,020	87.1	650,568	44.6	4.5
Michigan	47,370	88.7	1,260,864	37.6	3.8
Missouri	54,541	74.8	778,891	70.0	7.0
Nebraska	16,258	84.2	234,655	69.3	6.9
New Hampshire	7,829	90.2	162,629	48.1	4.8
New Jersey	52,126	88.1	1,127,742	46.2	4.6
New York	120,850	92.8	2,522,686	47.9	4.8
North Carolina	43,768	89.0	1,076,951	40.6	4.1
North Dakota	6,502	91.8	92,874	70.0	7.0
Ohio	93,146	88.2	1,531,994	60.8	6.1
Oklahoma	30,776	66.3	473,545	65.0	6.5
Oregon	12,573	64.5	478,180	26.3	2.6
Pennsylvania	88,560	91.2	1,885,323	47.0	4.7
South Carolina	18,415	92.7	553,396	33.3	3.3
Texas	124,491	75.3	2,334,459	53.3	5.3
Virginia	31,830	91.1	887,768	35.9	3.6
Washington	22,486	86.9	738,369	30.5	3.0
Wisconsin	38,408	88.3	724,034	53.0	5.3
US	1,719,114	85.4	37,260,352	46.1	4.6

Sources: 1) Nursing Facility Beds by Certification Type CMS OSCAR Data Current Surveys, December 2006 http://www.ahca.org/research/oscar/rpt_certified_beds_200612.pdf;

2) http://www.census.gov/popest/states/asrh/tables/SC-EST2006-01.xls

TABLE 4

INSTITUTIONAL RESOURCES AND UTILIZATION IN MFP GRANTEE STATES: MR/DD POPULATION

State	Total MR/DD Service Recipients, 2006	Public ICFs/MR Residents, 2006	Private ICFs/MR Residents, 2006	Total ICFs/MR Residents, 2006	ICFs/MR residents as a percent of total MR/DD Service Recipients, 2006	Nursing Home Residents with MR/DD, 2006
Arkansas	5,108	1,070	505	1,575	30.8%	1,376[1]
California	206,621	2,934	6,930	9,864	4.8%	6,799
Connecticut	13,823	816	383	1,199	8.7%	434
Delaware	2,751	88	66	154	5.6%	71
District of Columbia	1,791	0	677	677	37.8%	7
Georgia	10,634	975	110	1,085	10.2%	1,620
Hawaii	3,269	0	79	79	2.4%	103
Illinois	31,849	2,695	6,707	9,402	29.5%	622
Indiana	17,171	336	3,871	4,207	24.5%	1,699
Iowa	13,210	737	1,581	2,318	17.5%	808[3]
Kansas	7,361	363	261	624	8.5%	0
Kentucky	5,996	448	208	656	10.9%	450
Louisiana	13,747	1,576	4,027	5,603	40.8%	684
Maryland	8,995	365	0	365	4.1%	843[3]
Michigan	36,482	127	0	127	0.3%	451
Missouri	13,890	977	77	1,054	7.6%	878[3]
Nebraska	3,686	365	237	602	16.3%	271[2]
New Hampshire	2,211	0	25	25	1.1%	96
New Jersey	35,134	2,946	74	3,020	8.6%	741
New York	124,172	2,259	5,865	8,124	6.5%	1,215[3]
North Carolina	28,219	1,598	2,493	4,091	14.5%	532
North Dakota	2,604	131	461	592	22.7%	113
Ohio	27,301	1,566	5,090	6,656	24.4%	2,429[3]
Oklahoma	8,626	335	1,253	1,588	18.4%	560
Oregon	10,164	41	0	41	0.4%	70
Pennsylvania	48,244	1,380	2,363	3,743	7.8%	1,604[3]
South Carolina	16,989	893	717	1,610	9.5%	238
Texas	25,615	4,934	6,682	11,616	45.3%	2074[2]
Virginia	7,890	1,421	321	1,742	22.1%	899
Washington	21,444	723	56	779	3.6%	389[3]
Wisconsin	20,704	519	827	1,346	6.5%	82
US	944,263	38,815	59,729	98,544	10.4%	33,227[2]

[1] includes 331 dual diagnosis

[2] estimate

[3] FY2004

Source: Prouty, R. Smith, G. and Lakin, K.C. "Residential Services for People with Developmental Disabilities: Status and Trends Through 2006,"Research and Training Center on Community Living, Institute on Community Integration/UCEDD, University of Minnesota, 2007.

TABLE 5

HOME AND COMMUNITY-BASED RESOURCES AND UTILIZATION IN MFP GRANTEE STATES

State	Assisted Living and Residential Care Beds, 2004	Assisted Living and Residential Care Beds per 1,000 age 65+, 2004	All Medicaid HCBS Participants per 1,000 state residents, 2003	Aged & Disabled HCBS Waiver Participants per 1,000 state residents, 2003	MR/DD HCBS Waiver Participants per 1,000 state residents, 2003
Arkansas	4,644	12	12.3	3.2	0.9
California	154,830	41	12.1	0.4	1.4
Connecticut	2,753	6	7.4	3.1	1.7
Delaware	1,738	16	4.3	1.6	0.8
District of Columbia	1,866	28	9.0	0.5	0.6
Georgia	25,434	30	4.1	1.8	1.0
Hawaii	3,890	23	5.0	1.4	1.4
Illinois	14,406	9	8.8	3.7	0.8
Indiana	11,767	15	3.2	0.6	1.2
Iowa	5,220	12	12.6	2.5	2.9
Kansas	7,971	22	7.8	3.8	2.3
Kentucky	7,389	14	10.3	3.8	0.5
Louisiana	4,443	8	3.9	0.5	0.9
Maryland	17,148	27	3.6	0.6	1.4
Michigan	47,503	38	7.0	0.9	0.8
Missouri	21,797	28	13.8	4.2	1.4
Nebraska	9,187	39	9.6	2.8	3.0
New Hampshire	4,013	25	6.3	2.0	2.3
New Jersey	16,084	14	5.0	1.0	0.6
New York	43,601	17	13.3	1.1	2.7
North Carolina	39,942	39	10.0	1.3	0.7
North Dakota	2,851	31	6.3	0.8	3.6
Ohio	41,921	28	11.7	2.8	1.1
Oklahoma	9,666	21	8.2	4.1	1.2
Oregon	21,070	46	12.5	8.9	2.2
Pennsylvania	76,385	40	6.2	1.2	2.0
South Carolina	16,641	32	7.5	3.3	1.1
Texas	42,245	19	13.9	1.8	0.6
Virginia	34,598	41	2.7	1.4	0.8
Washington	24,498	35	10.4	4.9	1.4
Wisconsin	27,375	38	9.0	3.7	2.2
US	937,601	26	8.8	1.9	1.4

Sources: Data on assisted living and residential care bed in 2004 taken from AARP calculations using data from Robert Mollica and Health Johnson-Lamarche "State Residential Care and Assisted Living Policy: 2004," National Academy for State Health Policy, 2005 and AARP calculations using data from the U.S. Census Bureau, Population Division, "State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2005-RESIDENT"

Data on HCBS waiver participants taken from The Kaiser Commission on Medicaid and the Uninsured (KCMU) and The University of California at San Francisco's (UCSF) analysis based on The Centers for Medicare & Medicaid Services (CMS) Form 372, December 2006, Table 4. "Medicaid 1915(c) Home and Community-Based Service Programs: Data Update" available at http://www.kff.org/medicaid/7575.cfm.

TABLE 6

TRENDS IN MEDICAID HCBS AND TOTAL LONG-TERM CARE SPENDING IN MFP GRANTEE STATES

State	HCBS Spending on Waiver Services, 2001	HCBS Spending on Waiver Services, 2006	HCBS Spending on Waiver Services Per Capita, 2006	HCBS Waiver Spending Percent Change, 2001 to 2006	Total Medicaid LTC Spending Per Capita, 2006	Total Medicaid LTC Spending Percent Change, 2001 to 2006	HCBS Spending as a Percent of Total Medicaid LTC Spending, 2001	HCBS Spending as a Percent of Total Medicaid LTC Spending, 2006	HCBS Spending as a Percent of Total Medicaid LTC Spending Percent Change, 2001 to 2006
Arkansas	$96,409,032	$160,297,080	$57.02	66.3%	$332.42	44.4%	28.0%	29.7%	6.1%
California	$822,498,910	$1,446,460,202	$39.67	75.9%	$255.86	60.3%	48.1%	52.1%	8.3%
Connecticut	$432,286,550	$560,875,836	$160.02	29.7%	$647.17	23.2%	31.9%	33.3%	4.4%
Delaware	$47,845,395	$86,289,243	$101.16	80.4%	$324.00	41.4%	27.7%	33.9%	22.5%
District of Columbia	$1,473,296	$35,059,246	$60.24	2279.6%	$574.58	32.2%	6.4%	24.5%	280.4%
Georgia	$178,743,578	$402,099,710	$42.94	125.0%	$202.55	72.5%	20.6%	26.3%	27.3%
Hawaii	$51,668,108	$119,772,223	$93.21	131.8%	$251.92	54.0%	25.7%	37.2%	45.1%
Illinois	$396,845,838	$843,616,568	$65.74	112.6%	$241.38	20.0%	16.0%	28.4%	77.9%
Indiana	$140,458,805	$421,900,273	$66.82	200.4%	$375.95	81.7%	14.7%	21.2%	44.3%
Iowa	$131,120,508	$327,083,595	$109.69	149.5%	$373.05	47.3%	23.7%	36.6%	54.5%
Kansas	$302,415,773	$414,944,423	$150.12	37.2%	$302.07	-5.8%	38.2%	53.7%	40.7%
Kentucky	$158,305,707	$242,615,095	$57.68	53.3%	$289.91	30.4%	29.5%	29.2%	-0.8%
Louisiana	$139,988,426	$289,412,902	$67.49	106.7%	$339.96	-13.1%	9.7%	27.1%	178.1%
Maryland	$214,451,789	$583,767,676	$103.95	172.2%	$299.29	58.4%	28.8%	40.4%	40.2%
Michigan	$412,131,932	$476,140,475	$47.16	15.5%	$211.62	-10.4%	25.6%	31.9%	24.6%
Missouri	$296,480,274	$412,451,381	$70.59	39.1%	$281.41	-2.0%	26.9%	39.2%	45.4%
Nebraska	$135,133,825	$192,536,647	$108.90	42.5%	$358.32	9.6%	27.7%	35.7%	28.9%
New Hampshire	$137,743,635	$182,072,669	$138.46	32.2%	$370.91	36.1%	40.9%	39.8%	-2.7%
New Jersey	$325,946,398	$914,601,981	$104.83	180.6%	$421.44	15.2%	18.1%	34.1%	88.7%
New York	$2,097,855,335	$3,923,739,760	$203.24	87.0%	$914.74	30.3%	36.9%	44.3%	19.9%
North Carolina	$454,909,887	$637,602,808	$71.99	40.2%	$311.61	35.5%	37.3%	43.8%	17.4%
North Dakota	$48,449,331	$65,035,188	$102.26	34.2%	$477.94	21.3%	20.4%	24.2%	18.4%
Ohio	$479,576,793	$1,200,569,069	$104.60	150.3%	$416.08	31.1%	14.9%	28.9%	94.1%
Oklahoma	$231,755,026	$382,762,263	$106.95	65.2%	$276.41	22.0%	33.4%	41.4%	23.9%
Oregon	$484,208,026	$654,831,729	$176.93	35.2%	$267.06	-7.7%	48.3%	71.6%	48.4%
Pennsylvania	$900,429,816	$1,604,800,733	$128.99	78.2%	$491.16	19.0%	18.8%	27.7%	47.4%
South Carolina	$223,962,532	$293,291,404	$67.88	31.0%	$216.40	18.6%	31.2%	33.2%	6.6%
Texas	$692,308,591	$992,102,973	$42.20	43.3%	$199.47	35.9%	32.5%	43.5%	33.7%
Virginia	$288,912,992	$528,847,320	$69.19	83.0%	$193.73	46.7%	29.1%	36.0%	23.8%
Washington	$515,347,723	$747,677,974	$116.90	45.1%	$271.33	21.7%	47.8%	60.6%	26.8%
Wisconsin	$487,837,652	$666,804,970	$119.99	36.7%	$348.70	6.9%	35.7%	46.0%	29.0%
US	$14,806,943,081	$25,620,630,665	$85.57	73.0%	$331.69	30.1%	25.8%	39.4%	52.7%

Sources: a) Brian Burwell, Becky Selig and Steve Eiken. Medicaid HCBS Waiver Expenditures, FY 2001 through FY 2006. Accessed at www.hcbs.org.

b) Eiken, S. and Burwell, B. Medicaid HCBS Waiver Expenditures, FY 2001 through FY 2006 Thomson Healthcare: August 2007. Institutional services include nursing homes services and ICF/MR services. Total HCBS spending include HCBS waiver services, personal care, home health, HCBS authorized under Section 1115 waivers, and HCBS authorized under Section 1929. Institutional data for several states include expenditures for Medicaid Upper Payment Limit programs. Data do not include most expenditures for managed care programs that provide long-term care. California's reported expenditures will likely increase as the state submits prior period adjustments. New York's reported expenditures will likely increase as the state submits prior period adjustments.

TABLE 7

TRENDS IN MEDICAID HCBS AND TOTAL LONG-TERM CARE SPENDING IN MFP GRANTEE STATES: MR/DD POPULATION

State	HCBS MR/DD Spending on Waiver Services, 2001	HCBS MR/DD Spending on Waiver Services, 2006	HCBS MR/DD Waiver Spending Percent Change, 2001 to 2006	Annual HCBS Waiver Spending per State Resident, 2006	ICF/MR Spending, 2001	ICF/MR Spending, 2006	ICF/MR Spending Percent Change, 2001 to 2006	HCBS MR/DD Spending on Waivers as a Percent of MR/DD Medicaid LTC Spending, 2001	HCBS MR/DD Waiver Spending as a Percent of MR/DD Medicaid LTC Spending Percent Change, 2001 to 2006
Arkansas	$47,104,650	$94,603,828	100.8%	$33.65	$96,255,399	$134,527,835	40%	32.9%	41.3%
California	$717,820,018	$1,331,641,909	85.5%	$36.53	$419,725,174	$706,596,048	68%	63.1%	65.3%
Connecticut	$358,856,015	$423,938,646	18.1%	$120.95	$230,489,160	$288,306,732	25%	60.9%	59.5%
Delaware	$35,709,014	$66,500,922	86.2%	$77.96	$30,869,844	$22,750,881	-26%	53.6%	74.5%
District of Columbia	$403,180	$17,532,617	4248.6%	$30.12	$77,914,495	$79,031,189	1%	0.5%	18.2%
Georgia	$83,494,732	$241,150,306	188.8%	$25.75	$111,980,166	$111,653,954	0%	42.7%	68.4%
Hawaii	$28,646,412	$78,031,211	172.4%	$60.72	$8,000,357	$7,707,296	-4%	78.2%	91.0%
Illinois	$211,829,431	$428,628,987	102.3%	$33.40	$668,984,334	$714,280,782	7%	24.0%	37.5%
Indiana	$120,013,602	$385,790,262	221.5%	$61.10	$296,849,846	$580,564,862	96%	28.8%	39.9%
Iowa	$105,048,019	$251,604,688	139.5%	$84.37	$202,856,281	$264,363,121	30%	34.1%	48.8%
Kansas	$179,905,423	$232,355,740	29.2%	$84.07	$68,926,147	$65,014,487	-6%	72.3%	78.1%
Kentucky	$81,496,823	$173,639,033	113.1%	$41.28	$94,311,899	$128,758,532	37%	46.4%	57.4%
Louisiana	$130,421,971	$171,573,568	31.6%	$40.01	$355,268,229	$426,075,633	20%	26.9%	28.7%
Maryland	$207,008,326	$492,312,790	137.8%	$87.66	$58,419,284	$61,676,235	6%	78.0%	88.9%
Michigan	$226,803,347	$405,915,883	79.0%	$40.21	$31,213,716	$7,669,886	-75%	87.9%	98.1%
Missouri	$218,352,774	$318,979,970	46.1%	$54.59	$184,558,123	$237,511,700	29%	54.2%	57.3%
Nebraska	$104,705,444	$137,765,902	31.6%	$77.92	$47,765,756	$60,368,305	26%	68.7%	69.5%
New Hampshire	$114,267,785	$137,761,312	20.6%	$104.76	$2,146,938	$2,483,541	16%	98.2%	98.2%
New Jersey	$234,531,851	$770,986,102	228.7%	$88.37	$421,459,378	$644,230,654	53%	35.8%	54.5%
New York	$2,070,062,559	$3,888,993,984	87.9%	$201.44	$2,159,385,111	$2,893,576,049	34%	48.9%	57.3%
North Carolina	$235,232,775	$338,890,756	44.1%	$38.26	$400,129,463	$442,437,262	11%	37.0%	43.4%
North Dakota	$43,368,700	$62,596,495	44.3%	$98.42	$48,134,972	$62,935,692	31%	47.4%	49.9%
Ohio	$198,375,602	$668,738,099	237.1%	$58.26	$787,065,753	$741,765,139	-6%	20.1%	47.4%
Oklahoma	$195,054,643	$243,783,214	25.0%	$68.11	$114,123,962	$125,060,741	10%	63.1%	66.1%
Oregon	$261,545,752	$366,483,571	40.1%	$99.02	$11,216,811	$0	-100%	95.9%	100.0%
Pennsylvania	$800,525,109	$1,152,338,340	43.9%	$92.62	$486,148,847	$555,407,634	14%	62.2%	67.5%
South Carolina	$127,639,870	$190,216,315	49.0%	$44.02	$169,106,488	$161,278,523	-5%	43.0%	54.1%
Texas	$276,766,910	$481,462,704	74.0%	$20.48	$724,584,981	$817,810,892	13%	27.6%	37.1%
Virginia	$181,522,927	$320,190,342	76.4%	$41.89	$187,411,959	$237,898,977	27%	49.2%	57.4%
Washington	$227,279,626	$379,908,440	67.2%	$59.40	$130,662,490	$125,984,331	-4%	63.5%	75.1%
Wisconsin	$294,630,485	$482,169,343	63.7%	$86.77	$205,681,098	$170,088,819	-17%	58.9%	73.9%
US	$10,886,782,380	$19,252,895,260	76.8%	$64.30	$10,351,051,240	$12,469,822,317	20%	51.3%	75.2%

Table 7 *(continued)*

Sources: a) Brian Burwell, Becky Selig and Steve Eiken. Medicaid HCBS Waiver Expenditures, FY 2001 through FY 2006. Accessed at www.hcbs.org.

b) Eiken, S. and Burwell, B. Medicaid HCBS Waiver Expenditures, FY 2001 through FY 2006 Thomson Healthcare: August 2007.

ICF/MR Notes: Data for several states include expenditures for Medicaid Upper Payment Limit programs.
California's reported FY2006 expenditures will likely increase as the state submits more prior period adjustments.
Michigan's reported FY 2006 expenditures are lower than state data, which indicates $28.3 million in FY 2006.
New York's reported FY2006 expenditures will likely increase as the state submits more prior period adjustments.
Data do not include most expenditures for managed care programs that provide long-term care.

MR/DD Waiver Notes: Louisiana reported a significant portion of FY2006 HCBS waiver expenditures under 1115 waivers for Hurricane Katrina evacuees. CMS 64 reports for the 1115 waivers did not include target population information.
California's reported FY2006 expenditures will likely increase as the state submits more prior period adjustments.
New York's reported FY2006 expenditures will likely increase as the state submits more prior period adjustments.
Data do not include most expenditures for managed care programs that provide long-term care.

Total Expenditures Notes: Vermont shows zero reported expenditures because all long-term supports are provided in managed care programs.
Louisiana reported some HCBS waiver spending under 1115 waivers. These reports did not specify target population.
California's reported expenditures will likely increase as the state submits prior period adjustments. For FY2002 through FY2005, adjustments increased community services expenditures by $200 - $500 million and ICF/MR spending by $100 - $135 million.
New York's reported expenditures will likely increase as the state submits prior period adjustments. For FY2002 through FY2005, adjustments increased community services spending by $60 - $120 million and ICF/MR spending by $140 - $270 million.

PART I

STATE SUMMARIES

ARKANSAS MFP GRANT PROGRAM SUMMARY

Grantee Agency: Arkansas Department of Health and Human Services (ADHHS), Division of Aging and Adult Services (DAAS). The application was submitted in partnership with the Division of Medical Services (the State Medicaid agency), Behavioral Health Services (DBHS) and Developmental Disabilities Services (DDS), all of which are part of ADHHS.

Total Award: $20,923,775

Overview: The state will build on infrastructure from Passages, a prior Nursing Home Transition program; existing and planned 1915c waiver services; an 1115 Demonstration "cash and counseling" waiver; State Plan services; and a Real Choice Systems Change/Systems Transformation Grant to transition a total of 305 individuals to the community during the Demonstration period.

Transition Target Groups: Elderly; individuals with developmental disabilities or mental retardation living in ICFs/MR; individuals with mental illness; adults age 19 to 64 with physical disabilities, or traumatic brain injury residing in nursing facilities for at least six months.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The state plans to add 240 slots in its developmental disabilities waiver by requesting $1,788,201 in state general revenue funds in 2007. It also plans to add a 1915c waiver program for people with traumatic brain injury (TBI). All other Medicaid waivers are fully funded for the next two years. The state will expand existing waiver capacity to enable people in institutions to transition to home or community-based settings, and emphasize the expansion of self-directed options within each of its waiver programs.
- **Money Follows the Person/Flexible Budgeting Goals:** DHHS can transfer funds from institutional settings to home and community-based services with the approval of the legislature, but HCBS waiver slots are limited.
- **Continuity of Service to Transitioned Individuals:** Not mentioned.
- **Quality Assurance and Improvement:** The state will develop a quality management strategy for MFP to measure outcomes and provide meaningful feedback from participants.
- **Other State Goals:** None mentioned.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	12	15	15	1	0	43
FY 2009	19	28	15	1	0	63
FY 2010	28	47	15	3	0	93
FY 2011	33	56	15	2	0	106
TOTAL	92	146	60	7	0	305

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

Transition coordinators will create an informational program about opportunities to return to the community, which will be shared with nursing facility family councils, health and social service professionals, Arkansas Advocates for Nursing Home Residents, and nursing home ombudsmen. The state will use a social marketing campaign to inform providers and consumers about the opportunity to participate in ARHome, a new 1915c HCBS waiver to support transitions. In addition, Area Agencies on Aging (AAAs) and the four Centers for Independent Living (CILS) will identify individuals appropriate for transition.

B. Eligibility Criteria, Screening, and Assessment Methods and Tools

ADHHS plans to use the Minimum Data Set (MDS) to identify individuals to similar those transitioned under the state's previous nursing home transition grant, Passages. Those designated as potential transitions or who express a desire to live in the community (as captured in Section Q of the MDS) will be contacted. Individuals in intermediate care facilities for the mentally retarded (ICFs/MR) will discuss transitioning during the annual review of their Individual Program Plan. Interested parties will be visited and assessed by DAAS nurses. DBHS has already identified a number of individuals with mental illness who have expressed interest in moving to the community but need more services than current waivers provide.

C. Demonstration Services

The majority of the nearly 300 individuals who will transition from institutions to qualified residences during the MFP Demonstration project will be enrolled in a new HCBS 1915c waiver program, ARHome, which is an outgrowth of the state's Cash and Counseling/1115 waiver program. The state plans to submit the waiver proposal for ARHome to CMS in early 2007. Individuals enrolled in ARHome will be able to direct their own care, receive care from agencies, or access a combination of the two. The state will also propose a new waiver to serve people with traumatic brain injury.

- **Qualified Home and Community-Based Services:** In addition to the new ARHome waiver program, MFP participants will be served through the Medicaid State Plan and other existing waivers, but these waivers will be amended to ensure that people are supported in transitioning to the community by (1) modifying eligibility rules, such as adding a Medicaid Buy-In option for the working disabled earning up to $4,000/month; (2) adding services, such as adult companion services,

transitional costs and home modifications in the ElderChoices waiver program and full-time case management and agency attendant care for physically disabled adults who do not wish to self-direct services; and (3) adding slots for people with MR/DD in the Alternative Community Services waiver. Personal care, an optional benefit under the Medicaid State Plan, will be available to all MFP participants.

Those in the ARHome waiver choosing to self-direct services will be referred to a pre-paid Ambulatory Health Plan (PAHP) in their area to help them develop individualized budgets and purchase services, supports, equipment and supplies. Those who do not wish to direct their own budgets will be entitled to enhanced service coordination. PAHPs will coordinate community transitional services and, as a Medicaid provider, contract with other providers and directly hired workers.

- **Home and Community-Based Demonstration Services:** This includes telemedicine to monitor and collect clinical information, a 24-hour help line, intensive transition assistance, and attendants to accompany people when using the state's medical transportation system.
- **Supplemental Demonstration Services:** None mentioned.

D. Self-Direction Options for MFP Demonstration Participants

Independent Choices is the self-direction waiver for adults 18 years of age or older. Participants may receive a direct cash allowance to hire friends, relatives and neighbors and/or to purchase other services and items related to the general category of personal care. Alternatives, another 1915c waiver, offers consumer-directed services for adults with physical disabilities to choose attendants and environmental modifications. The ARHome waiver will also allow for self-direction, as described above.

E. Home and Community-Based Housing Options and Strategies

The Tenant-Based Bridge Rental Assistance (TBRA)—developed by the Arkansas Development Finance Authority (ADFA) using HOME funds—provides rental assistance for up to two years for individuals transitioning from an institution.

Using money from a Systems Change Grant for Integrating Long-Term Supports with Affordable housing, the DAAS has established a Housing Work Group to identify housing needs and develop a 10-year plan to address them. An initiative is underway to address the housing needs of those in rural areas by developing Adult Family Homes. In addition, Arkansas is working with the U.S. Department of Housing and Urban Development (HUD), the Centers for Medicare & Medicaid Services (CMS), NCB Capital Impact, and the Little Rock Housing Authority to convert part or all of an 11-story HUD 202 project into additional affordable assisted living.

F. Workforce Strategies

None mentioned.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- To remain eligible for 1915c waivers, individuals with functional impairments must severely limit their earnings and savings, making it difficult to start working and participate in a waiver program. Individuals with a Traumatic Brain Injury (TBI) often do not qualify for services under existing waivers.
- The supply of affordable and accessible housing is inadequate and there are often waiting lists for facilities in the Coming Home program, which offers affordable assisted-living housing.

- The waiver for individuals with developmental disabilities has reached its cap, and additional slots are needed to serve this population.
- Waiver services do not always provide the necessary services for transition. For example, individuals without a caregiver cannot take advantage of Respite Care, even though it is a service currently offered through ElderChoices, a 1915c waiver. Although it is currently a service in ElderChoices, the state does not have a viable reimbursement system for Adult Foster Care, so there are no participating providers. Home modifications are not covered under ElderChoices, and there is no money readily available to cover transition costs such as security and rental deposits.
- Arkansas does not have a "presumptive eligibility" process, so that consumers waiting for home and community-based services may wait 45 days or longer.
- Arkansas does not have a tele-health or a tele-medicine system in place to serve consumers in their homes remotely. It also lacks an escort assistance service for individuals requiring transportation for medical care, and after-hours support for consumers or families in non-emergency situations.

IV. QUALITY MANAGEMENT STRATEGY

Arkansas is using a Systems Change Grant to implement a new Comprehensive Quality Management System, which will be based on the CMS HCBS Quality Framework and Procedural Guidance. This revised system will add program staff to the Quality Management (QM) Unit and add capacity to the system to evaluate and disseminate reports about all waiver programs. The grant will also be used to write an Advanced Planning Document to enhance funding for the Medicaid Management Information System (MMIS) in order to automate solutions.

Arkansas' planned QM strategy for MFP will use survey data to measure outcomes and provide meaningful feedback on the program's efficiency. A consumer survey will be designed to collect data on participants' satisfaction with the quality of service and the quality of life in the community as compared to the nursing home. In addition, Arkansas is also considering modifying a 90-day follow-up survey that was previously sent to individuals who transitioned to the community under Passages.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The executive management team for the MFP grant will comprise the Division Directors of DMS, DAAS, DDS, and DBHS, which are all under the umbrella of ADHHS and report to the same deputy director.

B. MFP Program Oversight/Key Stakeholder Involvement

The Governor's Integrated Services Taskforce (GIST) was appointed in 2001 to implement the State's Olmstead plan, and remains involved in recommending and informing DHHS on long-term care services and support policy. GIST members provided input to the MFP proposal and subsequently set up subcommittees (by disability group) to make further recommendations. GIST will remain involved in providing input on the design, development and evaluation of the MFP project.

C. IT System Developments or Enhancements

Arkansas will use the MMIS to determine the Medicaid eligibility for individuals to participate in MFP and can use the Decision Support System (DSS) to monitor Medicaid expenditures. For Passages, Arkansas developed a database that records demographics and expenditures for each individual who was transitioned to the community; this database can be modified to keep data for MFP on a monthly basis.

D. Independent State Evaluation

The state will contract with the University of Arkansas Medical Sciences (UAMS) College of Public Health for consumer satisfaction and safety outcome data.

CALIFORNIA MFP GRANT PROGRAM SUMMARY

Grantee Agency: California Department of Health Care Services (DHCS)

Total Award: $130,387,500

Overview: A California MFP program, California Community Transitions (CCT), aims to transition 2,000 individuals from institutional to community-based settings in up to 10 regions within the state. CCT will employ the uniform assessment instrument developed in California Pathways (the MFP pilot funded by the Real Choice Systems Change Grant for Community Living) and will coordinate with California Community Choices, which is California's 2006 Real Choice Systems Transformation Grant. Through CCT, the state will provide home and community-based services with a focus on consumer control and self-direction, and seeks to expand services through existing waivers and programs under Medi-Cal, the state Medicaid program.

Transition Target Groups: The program targets elders, residents of institutions of mental disease (IMDs) under the age of 21 and over the age of 65, and persons of any age who have mental retardation/developmental disability (MR/DD), a physical disability, a mental illness, or a dual diagnosis of chronic medical and mental illness. To participate in the MFP program, these individuals must also have been enrolled in the Medi-Cal program for at least 30 days, and have resided in a health care facility (or combination of health care facilities) for six months or longer.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** California is committed to moving toward a system focused on home and community-based services, using existing programs and waivers that are currently under the authority of DHCS. Pending legislative approval, DHCS will increase home and community-based waiver services and program capacity. This does not necessarily require additional resources, but rather, better resource allocation, flexible budgeting, and a modified reimbursement system.
- **Money Follows the Person/Flexible Budgeting Goals:** The state will use lessons learned about budget restructuring and funding management reforms from the Real Choices Systems Transformation grant that is funding an MFP project, California Community Choices.
- **Continuity of Service to Transitioned Individuals:** Following an individual's discharge to community living, the state will ensure the provision of ongoing health management and service coordination.
- **Quality Assurance and Improvement:** The state will use the existing quality assurance and monitoring systems for Medi-Cal HCBS waivers, which includes Quality Management Units (QMUs) to oversee performance across multiple DHCS waivers and/or programs.
- **Other State Goals:** The state plans to develop community-level transition teams and to conduct intensive outreach to providers, consumers, and caregivers to facilitate transitions.

B. Annual Transition Targets[2]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other*	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	20	45	15	10	10	100
FY 2009	100	225	75	50	50	500
FY 2010	130	292	98	65	65	650
FY 2011	150	337	143	60	60	750
TOTAL	400	899	331	200	200	2,000

*"Other" includes those with dual diagnoses and those with co-occurring chronic medical and mental illness.

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

Recruitment will consist of two primary activities: (1) education and outreach and (2) preference assessment. Education and outreach will inform providers and consumers about community-based alternatives, using culturally appropriate materials. To identify residents who wish to transition to the community, CCT will also use the California Preference Survey Tool, which was developed in partnership with the California Department of Rehabilitation (DOR) under the California Pathways project.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The selection of the number of individuals to be served will be based on the number of local service areas in the Demonstration, the number of staffed Community Transition Teams (CTT) in each service area, and the number of participating facilities as well as a census of partner facilities, the percentage of facility residents who are Medi-Cal eligible, the share who have been in the facility for six or more months, and the percentage of people who express desire to transition to community living.

C. Demonstration Services

In partnership with stakeholders, DHCS will select CTTs using a competitive selection process. These teams will be in up to 10 different regions within the state, to be determined through the selection process, and will represent a rural/urban mix spread across the state. The transition coordinator of each CCT will act as a service coordinator and will work with the consumer to develop a culturally competent transition plan using appropriate home and community-based and other services.

- **Qualified Home and Community-based Services:** California's Medicaid service package that comprises 1915c and/or State Plan services. To the extent that additional waiver slots are needed to meet the demand of the target population, DHCS will submit waiver amendments to CMS and seek approval from other appropriate state and federal agencies. Depending on eligibility, Demonstration

[2] Initial state application showed 2,030 total transitions, with 15 more each in the 'MI' and 'other' categories in Year 5.

participants may also access California's non-Medicaid funded home and community-based services, including DOR Olmstead initiatives and organizations that serve specific disability populations (but these services would not be eligible for federal fund matching). Current 1915c waivers include: AIDS, assisted living waiver pilot project (ALWPP), developmentally disabled, multipurpose senior services program (MSSP), and in-home operations (IHO) waivers. Optional Medi-Cal State Plan services include in-home supportive services (IHSS),[3] home health agency services (HHA), adult day health care (ADHC), and targeted case management.

- **Home and Community-Based Demonstration Services:** Services that will be considered include personal care services that exceed the state statutory limit of 283 hours per month, respite for caregivers, and family training.
- **Supplemental Demonstration Services:** Services will be identified through stakeholder input during pre-implementation, and may include outreach and education for HCBS providers, nursing facility staff, hospital discharge planners, consumers, and their families. A flexible one-time funding for home set-up may also be included.

D. Self-Direction Options for MFP Demonstration Participants

Participants will be actively involved in determining how, when, and in what manner services will be provided, and will be able to choose whether they want to maintain the responsibility for hiring, training, and supervising personal care providers (similar to California's IHSS program).

E. Home and Community-Based Housing Options and Strategies

State oversight efforts will strive to ensure that qualified residences that meet MFP specifications are available. The Housing and Emergency Shelter Trust Fund Act of 2006, which was adopted in November 2006, may help to increase housing options because it authorized the state to sell $2.85 billion in bonds to finance construction or acquisition and rehabilitation of additional rental housing. Rental assistance, however, cannot be funded through bonds.

F. Workforce Strategies

The state will select a county or multi-county region that has an identified lead organization with proven competency to organize and implement an effective CTT, and the personnel with the knowledge, skills, and abilities to administer the California Preference Survey Tool.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- There is fragmentation because multiple state departments administer long-term care services and there are numerous funding streams, different assessment procedures, and a lack of coordination between medical and social care systems.
- There is a lack of transitions infrastructure, including scant awareness about community living options, no systematic way to identify individuals who wish to transition, a lack of trained coordinators to assist with transition, and a lack of community organizations and HCBS waivers to provide for temporary and long-term transition needs.
- In California, there is a lack of access to affordable, accessible housing. At the same time, many funding streams carry incentives to maintain high nursing home residency.

[3] IHSS is the state's personal care category.

- There is a lack of access to personal care services and service coordination in counties due to system fragmentation.
- Long waiting lists limit the capacity of programs to serve participants.
- There is a lack of flexibility in state budgeting: resources cannot easily be transferred to areas of need. In addition, there is no global long-term care budget system.

IV. QUALITY MANAGEMENT STRATEGY

The MFP Quality Management Strategy will mirror that used in California's nursing facility A/H waiver program—which comprises three restructured IHO programs—to ensure that the state conducts level of care need determinations, plans of care are responsive to participant needs, qualified providers serve participants, and the health and welfare of participants is maintained. DHCS retains administrative authority over the program, the state provides financial accountability. DHCS will also measure quality and outcomes specific to the Demonstration, which will require a Quality Improvement Strategy to feed back into the Quality Assurance Program.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

CCT will rely on a collaborative partnership between state and local-level partners, led by the DHCS under the auspices of the California Health and Human Services Agency (CHHSA). DHCS works collaboratively with many other state departments: DOR, the Department of Development Services (DDS), Department of Social Services (DSS), Department of Aging (CDA), and the Department of Mental Health (DMH). The CCT Advisory Committee will convene regular meetings with those departments, the CHHSA and its committees, and other agencies to address barriers, implementation issues, and solutions. The CHHSA will work closely with cross-agency partners such as the Department of Housing and Community Development (HCD), the Housing Finance Agency (CalHFA), and the Department of Transportation (Caltrans) to address housing and transportation barriers.

B. MFP Program Oversight/Key Stakeholder Involvement

DHCS will convene a CCT Advisory Committee to obtain input from community stakeholders and the California Olmstead Advisory Committee (OAC) will provide feedback during the term of the project. The OAC advises the CHHSA on matters related to the avoidance of institutionalization and support of seniors and persons with disabilities in the community.

C. IT System Developments or Enhancements

No modifications are proposed due to an existing comprehensive IT system, including the DHCS Management Information System/Decision Support System (MIS/DSS), the Medi-Cal Eligibility Data System (MEDS), and the Case Management Information System (CMIS). A key component of the California Community Choices project includes a client-centered, integrated system via the CalCareNet portal.

D. Independent State Evaluation

None mentioned.

CONNECTICUT MFP GRANT PROGRAM SUMMARY

Grantee Agency: Connecticut Department of Social Services (DSS)

Total Award: $24,207,383

Overview: The proposal builds on Choices are for Everyone, a prior Nursing Facility Transition Program (NFTP) funded by a Real Choice Systems Change Grant in 2001. The state has a goal of transitioning 700 individuals from nursing facilities and other institutions to home and community-based settings by 2010. Six support staff and 15 to 25 transition and housing coordinators will guide the transition process. Targeted priority areas include the provision of rental assistance to 60 percent of those transitioning, in addition to accessibility modifications; increased access to and utilization of appropriate technology; the addition of personal care assistance as an optional Medicaid benefit through a State Plan Amendment; and strengthening of the quality management system for people living in home and community-based settings.

Transition Target Groups: Individuals with mental illness, physical disabilities, mental retardation, and multiple disabilities.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Increased use of and spending on home and community-based services so that 58 percent of people receiving long-term care are served in home and community-based settings by 2011, and 75 percent by 2025, compared to 50 percent in 2006. The state recommends 2007 legislation to increase home and community-based services waiver capacity to support all Demonstration participants and to increase the capacity of existing waivers by 2011, based on demand.
- **Money Follows the Person/Flexible Budgeting Goals:** Continue to utilize the current system, which operates under a pooled budget approach and allows funds to be transferred from institutional care to home and community-based services. However, legislative caps on HCBS waiver programs limit the number of people who can be served by these programs; legislation has been introduced to increase the capacity of waivers to serve Demonstration participants as well as others. Ultimately, the state would like to develop a "single cross-disability waiver or State Plan amendment based on functional need," possibly through a Section 1115 waiver.
- **Continuity of Service to Transitioned Individuals:** The state plans to use existing waivers and/or a new waiver or State Plan amendment to increase HCBS waiver capacity as needed to serve MFP Demonstration participants after the transition period.
- **Quality Assurance and Improvement:** The state will implement a coordinated effort to ensure that necessary information about quality management is shared across departments/divisions focusing on improvements made to the delivery of services.
- **Other State Goals:** (1) increase access to affordable housing, (2) increase information for conservators and attorneys about self-direction and choice, (3) increase successful integration of assistive technology (AT) post transition, (4) modify waivers or make State Plan changes to qualify

for services based on functional limitation rather than diagnosis, and (5) add personal care assistance to the State Medicaid plan via a State Plan amendment.

B. ANNUAL TRANSITION TARGETS

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other*	TOTAL
FY 2007	20	10	5	10	5	50
FY 2008	40	20	10	20	10	100
FY 2009	60	30	15	30	15	150
FY 2010	80	40	20	40	20	200
FY 2011	80	40	20	40	20	200
TOTAL	280	140	70	140	70	700

*"Other" includes individuals with physical disability/mental illness.

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

Independent Living Centers (ILCs) and Area Agencies on Aging (AAAs) will be entry points to MFP, charged with screening and enrolling residents who have resided in institutions for longer than six months. The Long-Term Care Ombudsman will also make referrals to the program, as will nursing facilities, family members, and individuals. Referrals may also come from a recently launched website that offers information about long-term care options.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The state will use its existing preadmission screening program designed to offer home care as an alternative to institutional care. Offering home care as an alternative to an institution is now linked with the preadmission screening and resident review (PASARR) for individuals with mental illness and mental retardation. In addition, the project will use the instruments developed and utilized by the NFTP including: transition guide, self-assessment tool, housing resources manual, quality management strategies, satisfaction instrument, and a "Common Sense Fund" for one time transitional expenses.

C. Demonstration Services

MFP participants will be offered all Medicaid State Plan optional benefits, and may be enrolled in any of the state's six 1915c waivers: (1) Home Care Program for Elders Waiver, (2) Personal Care Assistance (PCA) Waiver, (3) Acquired Brain Injury Waiver, (4) Mental Retardation Individual and Family Support Waiver, (5) Mental Retardation Comprehensive Waiver, and (6) a Katie Beckett Model Waiver. Three of these waiver programs may require expanded capacity and additional funds, which must be authorized by the Centers for Medicare & Medicaid Services (CMS), the governor and the state General Assembly. If existing waivers are not utilized to sustain MFP services, then a new waiver and/or State Plan amendment will be developed.

DSS will contract with the five AAAs and ILCs to provide transition services to institutionalized individuals eligible for MFP, building on the procedures of the NFTP. AAAs will be added to this system for the MFP program.

- **Qualified Home and Community-Based Services:** These services include the following Medicaid State Plan option benefits: skilled nursing, physical therapy, speech therapy, homemaker/home health aide services, occupational therapy, medical social services, durable medical equipment, and a rehabilitation option for individuals with mental illness. It also includes services available under each of the home and community-based services waivers described above. Personal care assistance is only available under a waiver program. A single cross-disability wavier or State Plan amendment is envisioned based on functional need.
- **Home and Community-Based Demonstration Services:** This category will include services not currently available under either Medicaid State Plan optional benefits or HCBS waivers. At the time of the proposal, the state believed this would primarily be 24-hour live-in support. Starting in the third year of the MFP program, the services needed by MFP participants not covered under the qualified home and community-based services program will become part of a Section 1115 waiver to address gaps in services encountered by those transitioning from institutions. Post transition services for up to twelve months will also be part of the Demonstration.
- **Supplemental Demonstration Services:** These services include the addition of five housing coordinators to assist in the housing search. A team of researchers who have experience with the Nursing Facility Transition Project will conduct a state-level evaluation. One-time transitional costs will be provided to individuals who have a demonstrated need. The MFP project will coordinate with the State's Assistive Technology (AT) equipment loan programs. The AT needs of participants will be identified, equipment loans arranged for a trial period, and data collected relative to utilization of technology. Successful trial periods will be followed by the purchase of appropriate technology within Medicaid-allowable rates. Individuals who require accessibility modifications will be eligible for services

D. Self-Direction Options for MFP Demonstration Participants

All of the proposed pilots include self-directed options for home and community-based services and supports. PCA and ABI waivers allow participants to hire and manage their own PCA staff with a fiscal intermediary. Home Care Program for Elder Participants enter the program through an assessment conducted by an experienced professional to identify unmet needs and recommended supports. Older adults are empowered to make adjustments in the frequency, duration and intensity of services without prior approval. A limited number of slots in the elder waiver allow consumers to self-direct using the PCA model. DMR waiver recipients are allowed to hire people directly for many services, including but not limited to supported living, supported employment, respite, and personal support. Participants are provided a fiscal budget limit within which they can choose services in their package of support.

E. Home and Community-Based Housing Options and Strategies

The state plans to increase the amount available in its rental assistance program to provide state-funded housing subsidies to an estimated 60 to 70 percent of transitioned MFP participants. Housing modification funds from the Department of Economic and Community Development (DECD)—which manages the state's housing rental assistance program and accessibility modification program—are estimated at $1 million under MFP. The MFP Demonstration will hire five full-time housing coordinators, and will work with DECD to build the latter's newly developed housing registry of affordable, accessible housing.

F. Workforce Strategies

None mentioned.

III. Challenges to Rebalancing the Long-term Care System and Expanding Home and Community-Based Services

- Current funding mechanisms in the long-term care system are varied, with Medicaid as the primary payer for services. Within each line item of the budget, legislative caps on HCBS waiver programs limit the number of people who can receive services. Each program is funded separately with different numbers of community slots, which cannot be transferred or reallocated beyond the cap to any other program without legislative approval.
- Additional challenges include: lack of affordable, accessible housing, lack of information for conservators and attorneys, lack of integration of assistive technology, and lack of access to information about community-based options.
- Connecticut does not cover personal care as an optional Medicaid service; the only way to provide these services is through waiver programs.
- Connecticut has waiting lists for the PCA waiver and both MR waivers.
- Connecticut is one of only three states with no program for adults with developmental disabilities who are not mentally retarded.
- The state does not have an Aging and Disability Resource Center.

IV. Quality Management Strategy

Connecticut intends to use the guidance provided under its 1915c applications as the basis for its quality management system; it will design a system that largely reflects the current waiver quality management systems. DSS has a comprehensive quality improvement plan reflecting CMS' Quality Framework and is currently evaluating the quality framework for each Medicaid waiver. Each of the state's home and community-based services waiver programs has a quality management component in place, but there is no mechanism in place for formally sharing information. The state will try to better coordinate its quality monitoring activities to ensure necessary information is shared across departments/divisions focusing on improvements made to the delivery of service to consumers; this will be done by a Quality Management/Quality Coordinating Committee established for the MFP program that will meet every two months to share information.

V. Administration, Oversight, and Evaluation

A. Role and Involvement of Other State Agencies

The Division of Medical Care Administration will be the lead division within DSS to administer the project in collaboration with various state agencies and community partners. State agencies include among others: the Department of Mental Retardation, which operates waiver programs and the quality framework; Department of Mental Health and Addiction Services, which operates local Mental Health Authorities providing support in the community for persons with substance abuse or mental illness; Department of Economic and Community Development, which coordinates the housing rental assistance program and an accessibility modification program and maintains a housing registry of affordable, accessible housing. The Board of Education Services for the Blind provides access to specialized supports for individuals with blindness or low vision. The Office of Long Term Care Ombudsman serves as an advocacy organization for nursing facility residents; the University of Connecticut Health Center is responsible for the overall MFP evaluation.

B. MFP Program Oversight/Key Stakeholder Involvement

The project will be governed by a steering committee that is currently performing this function for the Nursing Facility Transition Project initiated under the Real Choice Systems Change Grant in 2001. All aspects of the MFP Demonstration will be designed, developed, implemented and evaluated by work groups. Status updates will be presented to the steering committee on a monthly basis. The 25-member steering committee will develop, implement and monitor policies guiding the project. Fifty-one percent of the members are consumers including persons with disabilities, older adults and family members; state agencies, nursing facility administrators, and providers comprise the other 49 percent. Active collaboration will also come from community stakeholders—including the State Independent Living Centers, Connecticut Association of Centers for Independent Living, Area Agencies on Aging, Council on Developmental Disabilities, Association for Retarded Citizens and many others

C. IT System Developments or Enhancements

Currently, the state has the capacity to report on MFP participants using the existing Data Warehouse, Medicaid Management Information System (MMIS), and other quality indicator systems. However, the state needs to develop a system for capturing and reporting data on MFP participation, expenditures, and quality separate from those of other Medicaid beneficiaries. It also needs to link the ILCs and AAAs to the state DSS system. An electronic database system, which has been converted to a Web-based system, will be used for intake, planning and evaluation purposes. It includes 171 variables that range in content from demographics to transition barriers. The state plans to automate MFP reporting by adding additional fields to the MMIS.

D. Independent State Evaluation

The state plans to contract with the University of Connecticut Center on Aging to assess the impact of the Assistive Technology program on MFP participants' level of independence, enhanced self-direction, consumer satisfaction, cost of care, community participation, and connections to employment, among other outcome variables. The state will also use the research team to collect information on consumer satisfaction and other quality indicators to support the Quality Management System. In addition, the state plans to enter data about MFP participants into an existing database designed for its Nursing Facility Transition Project to assess quality of care.

DISTRICT OF COLUMBIA MFP GRANT PROGRAM SUMMARY

Grantee Agency: The DC Department of Health, Medical Assistance Administration (MAA), in collaboration with the Department of Mental Health (DMH), the Mental Retardation and Developmental Disabilities Administration (MRDDA, housed within the Department of Human Services), the DC Housing Authority, and the DC Office of Aging.

Total Award: $26,377,620

Overview: The District's MFP program takes a two-part approach to serve several distinct populations. One approach, led by MAA, builds on two home and community-based services (HCBS) waivers already in place, and another, led by DMH, serves the mentally ill population through mental rehabilitation services available under the State Plan. The transition model will emphasize placement in a residence rather than in group homes or intermediate care facilities. Current residents of St. Elizabeths Hospital, the District's primary long-term care facility for the mentally ill, are specifically targeted for transition, due to a planned reduction in the number of beds.

Transition Target Groups: Elderly, individuals with physical disabilities, individuals with mental retardation or developmental disabilities (MR/DD), and individuals whose primary diagnosis is severe mental illness.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The District will increase enrollment in its Elderly and Persons with Physical Disabilities (EPD) and Mental Retardation and Developmental Disabilities (MR/DD) waivers by 10 percent each year during the MFP Demonstration. The District anticipates that home and community-based services, as a percentage of total long-term care spending, will increase from 16.4 percent to 23.4 percent during the Demonstration.
- **Money Follows the Person/Flexible Budgeting Goals:** MAA will use the same Medicaid funds for the nursing home, EPD, and MR/DD Waiver populations. MAA will develop an internal MFP Financing Committee, which will meet on an as-needed basis to remove or reduce identified financial barriers. The committee will explore a possible State Plan amendment to address barriers to purchasing medical equipment for MFP participants prior to their transition.
- **Continuity of Service to Transitioned Individuals:** To ensure continuity of services for transitioned individuals, the District plans to amend its State Plan to offer waiver services across all disability types. DMH will enhance community crisis and psychiatric emergency services, and develop "comprehensive services" for those leaving St. Elizabeths Hospital.
- **Quality Assurance and Improvement:** Current quality management systems at MAA will be utilized and enhanced. The MFP Advisory Commission will review the data collection instruments currently being used, and will devise additional items for monitoring quality of care, operational processes, and administrative systems for MFP participants. DMH will continue to develop its quality improvement program.

- **Other State Goals:** MAA plans to remove barriers that constrain its ability to recruit and retain providers for the MR/DD waiver. In collaboration with the District Housing Authority and private developers, DMH will develop 300 additional affordable housing units for its consumers over the next three years. DMH will also develop incentives for providers to encourage the successful transition of consumers with serious mental illness and multiple needs. Other goals include the enhancement of community crisis and psychiatric emergency services, the development of support alternatives for individuals with mental illness, and the addition of three Assertive Community Treatment (ACT) teams.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	25	75	0	20	0	120
FY 2008	35	105	15	20	0	175
FY 2009	45	135	30	20	0	230
FY 2010	50	150	45	20	0	265
FY 2011	60	180	60	20	0	320
TOTAL	215	645	150	100	0	1,110

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

EPD & MR/DD Populations: All skilled nursing facilities from the eight District wards will be asked to participate, and efforts will be made to bring DC residents back to the District when possible. MAA has requested that several organizations, including DMH, the Mental Retardation and Developmental Disabilities Administration (MRDDA), the District's Senior Network, Adult Protective Services, the Long Term Care Ombudsmen, and the District's Housing Authority, make referrals to the MFP program. MAA will also devise a dataset that identifies individuals currently within institutional settings who might be interested in or eligible for transition. Finally, MAA will encourage community advocates to include MFP in their discussions of alternatives to nursing home placement.

Mental Illness Population: The target group will be people leaving St. Elizabeths Hospital who have a primary diagnosis of a serious mental illness. St. Elizabeths Hospital is developing a list of MFP-eligible consumers and identifying barriers to those leaving the hospital. MAA has also requested that nursing homes develop lists of MFP-eligible individuals with mental health issues who are ready to return to the community. In future Demonstration years, improvements in the DMH information technology system will enable the identification of MFP-eligible consumers. In addition, the Consumer Action Network will provide outreach and education to targeted individuals with mental illness.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

EPD & MR/DD Populations: The District's Aging and Disabilities Resource Center (ADRC) will conduct pre-eligibility screening. MAA's quality improvement organization (QIO) will conduct level-of-care assessments using existing tools, and also has plans to develop an electronic assessment tool.

Mental Illness Population: DMH and MAA will develop a process for pre-screening consumers identified by nursing homes as eligible for transition. A protocol will be developed to determine their mental illness diagnosis.

C. Demonstration Services

EPD & MR/DD Populations: MFP participants will be served by existing 1915c waiver programs, as well as services offered under the Medicaid State Plan. Existing HCBS waiver programs include the EPD and MR/DD Waivers. The EPD waiver has been renewed through 2012, and a renewal application for the MR/DD waiver, which expires in November 2007, was recently submitted. MAA anticipates that waiver capacity will be reached in 2009, and plans to develop a State Plan amendment at that time; this will expand waiver services across all disability types. MAA is also exploring a possible State Plan amendment to address the acquisition of durable medical equipment for all MFP participants. MRDDA is developing a pilot program to provide additional assistance to consumers with developmental disabilities who are living in the community. As part of this program, regulations for MR/DD services (attendant care, residential habilitation, individual habilitation, skilled nursing care, and respite care) have been rewritten, and a State Plan Amendment for both individual and residential habilitation was recently approved by the DC Council.

Mental Illness Population: DMH does not have a qualified HCBS program; however, under a Medicaid State Plan amendment, Mental Health Rehabilitation Services (MHRS) are available. The District is also considering legislation that would amend the State Plan to allow for community-based psychotherapy. Expanded waiver services are available for persons who are dually diagnosed with mental retardation and mental illness.

- **Qualified Home and Community-Based Services**: The District plans to provide home and community-based services under existing EDP and MR/DD 1915c waivers and the Medicaid State Plan; the mental illness population that does not have co-occurring MR/DD will be served exclusively through MHRS in the State Plan.
- **Home and Community-Based Demonstration Services:** None mentioned.
- **Supplemental Demonstration Services**: The District plans to provide transitional assistance of $300 per person for one-time moving costs.

D. Self-Direction Options for MFP Demonstration Participants

EPD & MR/DD Populations: Although the renewed EPD waiver does not contain provisions for consumer direction, an amended application that would provide for this has been submitted to the Centers for Medicare & Medicaid Services (CMS). The program would include a personal broker to help consumers oversee their care needs, and a fiscal intermediary that would assist with payroll requirements. MAA is also developing a training curriculum for consumers to assist them in selecting personal care assistants and home health aides. Currently, there are no established programs for people with MR/DD to self-direct their services.

Mental Illness Population: DMH offers Long-Term Support grants that allow consumers access to housing of their choice, and transitional supports to help maintain those choices. Targeted groups for this program are consumers who are dually diagnosed with mental retardation and mental illness, as well as youth with mental illness who are transitioning into adulthood.

E. Home and Community-Based Housing Options and Strategies

The District aims to transition MFP participants back into a residence, rather than a group home or intermediate care facility. MAA's Office on Disabilities and Aging (ODA) will consult with the DC

Housing Authority during the development of the operational protocol to identify housing infrastructure changes needed for MFP participants.

EPD & MR/DD Populations: The DC Housing Authority has agreed to act as the leader in coordinating all housing options for MFP participants, and will identify necessary housing infrastructure changes. MAA will research whether City Council approval is necessary to establish priority for access to housing choice vouchers for people with disabilities seeking to transition from nursing homes, intermediate care facilities for the mentally retarded (ICFs/MR), and St. Elizabeths Hospital.

Mental Illness Population: In collaboration with the DC Housing Authority and private developers, DMH has developed a Housing Business Plan to construct 300 new sustainable affordable housing units over the next three years, with guarantees that they will be available to DMH consumers for 25 years.

F. Workforce Strategies

To assist the recruitment and retention of qualified staff, MAA recently increased the minimum hourly wage rate to $16.30 for personal care services and $17.30 for home health aides. MAA anticipates that its MR/DD waiver renewal will remove multiple barriers to the delivery of residential supportive services, allowing the District to attract significant numbers of new home and community-based service providers. A task force is working on the development of a registry of available personal care assistants; placement on the registry is optional, but will include data on several characteristics (such as smoker/non-smoker, years of experience, education) that consumers may find helpful in selecting a caregiver.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- The District's ADRC, which will conduct pre-eligibility screening of MFP participants entering the EPD and MR/DD waivers services and assist residents who choose to transition, was closed in June 2006. The District plans to re-establish its ADRC in fiscal year 2008, and has secured budget authority, although staffing, partnership, and location issues are still being resolved.
- Several issues related to the consumer-directed services component of the EPD waiver have not been resolved. For example, the District has not determined how formal delegation of some nursing tasks, such as bladder and bowel care, will occur.
- Services under the MR/DD waiver are limited, due to a significant lack of providers with proven track records of supporting people with medical and psychiatric issues or developmental disabilities. This situation is due in part to funding ceilings and low reimbursement rates that have deterred potential providers.
- For MR/DD consumers with significant medical support needs, better health care coordination and case management are needed.
- There are several barriers that prevent the flexible use of funds to develop individually tailored care plans for beneficiaries. For example, transportation services are provided only when beneficiaries access State Plan services and, for patients with mental illness, rehabilitation and residential services cannot be billed on the same day.
- The District faces a lack of affordable housing that meets the unique needs of MFP participants, such as wheelchair accessibility.
- Several challenges at St. Elizabeths Hospital have slowed the transition of its consumers back to the community. These include insufficient "comprehensive adult services" for people leaving the hospital, insufficient incentives for providers to encourage the successful transition of consumers, and insufficient residential and housing resources. DMH's current information technology system also does not permit tracking of client outcomes or movement across service systems.

- There is a need for increased capacity for crisis services through Medicaid for people with co-occurring mental retardation and mental health issues to facilitate their safe transition into the community.
- MR/DD consumers and those with mental illness have few opportunities for individualized consumer-driven care. Consumers also have limited access to clear and concise information about mental health and related services.

IV. QUALITY MANAGEMENT STRATEGY

The District's Health Regulatory Administration, located within the Department of Health, is responsible for licensing and certification of institutional facilities, as well as community-based residential facilities and home and community-based service providers.

EPD & MR/DD Populations: MFP participants will be accommodated within existing waivers, and the quality management strategy used in those programs will be extended to include MFP participants. In addition, the MFP Advisory Commission will review the data collection instruments used in each waiver program, and will devise additional items for monitoring quality of care, operational processes, and the administrative systems for the MFP participants.

Mental Illness Population: For people with mental illness, consumer satisfaction surveys, site visits, and in-depth interviewing are used to measure quality assurance, consumer satisfaction, and program efficacy. DMH's quality improvement (QI) program continues to develop. The system-wide QI committee began meeting monthly in February 2005, and has formed two subcommittees to look at outcomes and utilization. DMH certifies all community-based MHRS providers.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The lead agency for the MFP program is the Medical Assistance Administration within the Department of Health, which is the sole state Medicaid agency for the District. There are four major partner agencies within the District government, including the Department of Mental Health, the Mental Retardation and Developmental Disabilities Administration (housed within the Department of Human Services), the DC Housing Authority, and the DC Office on Aging.

B. MFP Program Oversight/Key Stakeholder Involvement

The MFP Advisory Commission will consist of fourteen members, including four representatives from the provider community, four community advocate representatives, four consumer representatives, and two government representatives. Several community partners will be working with the Department of Health to implement the MFP program. Community-based partners include: The Arc of DC the Consumer Action Network, the Quality Trust for Individuals with Disabilities, DIRECT Action, University Legal Services—Protection & Advocacy, Legal Aid Society, AARP Long-term Care Ombudsman Program, the DC Long-Term Care Coalition, the DC Coalition for Community Services, the DC Primary Care Association, and Help-Yourself, Inc.

C. IT System Developments or Enhancements

ODA will work with MAA's fiscal intermediary and pharmacy benefits manager to devise a dataset for identifying pre-transition individuals in institutions, and a separate dataset to monitor and assess individuals post-transition.

EPD& MR/DD Populations: For the EPD and MR/DD waivers, a dataset has been established within MMIS to capture utilization and expenditures for these populations. Additional codes will be added when the consumer-directed services provided through the EPD waiver are finalized. MAA is also planning to move to an electronic case management system that will assist with post-transition monitoring of the population, and an electronic service verification system that will track workers going to and from Medicaid consumers and coordinate multiple Medicaid workers.

Mental Illness Population: DMH is implementing a contract management system to track and pay providers based upon services rendered, and to coordinate Medicaid reimbursement to DMH. The DMH information system will be able to capture demographic information that will allow the identification of MFP-eligible consumers.

D. Independent State Evaluation

The District will hire an external evaluator to evaluate the MFP Demonstration, using both quantitative and qualitative methods. The evaluation will include an assessment of processes, outcomes, infrastructure barriers, and participant and provider satisfaction.

DELAWARE MFP GRANT PROGRAM SUMMARY

Grantee Agency: Division of Medicaid and Medical Assistance (DMMA) within the Department of Health and Social Services (DHSS)

Total Award: $5,372,007

Overview: Delaware's program, "Finding a Way Home," builds on infrastructure and processes developed through its recent CMS Systems Change Grant, "Delaware Passports to Independence." The state will continue to develop processes to strengthen and expand a program of self-directed care for clients with mental retardation or developmental disabilities (MR/DD) that uses individual flexible budgets.

Transition Target Groups: Elderly, individuals with physical disabilities, individuals with MR/DD, and individuals with mental illness.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Delaware will establish consistent and effective policies and practices that eventually can be used, beyond the scope of the grant period, across Delaware's long-term care system to maximize the ability of people to transition out of long-term care facilities quickly.
- **Money Follows the Person/Flexible Budgeting Goals:** The state will continue to use a single Medicaid budget that combines State Plan and HCBS waiver funds. DMMA has the flexibility to allocate funding between state agencies to support and finance transition programs.
- **Continuity of Service to Transitioned Individuals:** Delaware will continue to serve eligible individuals through its existing HCBS waivers after the MFP Demonstration concludes.
- **Quality Assurance and Improvement:** The Division of Developmental Disabilities Services (DDDS) will continue work on protocol revisions to measure outcomes for service recipients. Quality management systems will be expanded to include regular monitoring of MFP participants who have transitioned to the community.
- **Other State Goals:** None mentioned.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	8	7	5	5	0	25
FY 2009	8	7	5	5	0	25
FY 2010	8	7	5	5	0	25
FY 2011	8	7	5	5	0	25
TOTAL	32	28	20	20	0	100

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

Recruitment efforts will be modeled on the successful outreach and recruitment methods of Delaware's Passports to Independence (DPI) program. Delaware's Minimum Data Set (MDS) and an integrated case management system (once developed) will be used to identify transition candidates. Case managers also will conduct brief screenings as part of their regular case review activities with institutionalized clients, and information on the MFP Demonstration project will be posted on a central state Website. Delaware is particularly interested in transitioning clients residing in one of five state-run long-term care facilities.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The Centers for Independent Living (CIL) will be involved in the initial screening process. Staff affiliated with the MFP program will conduct follow-up assessments using an existing universal form.

C. Demonstration Services

MFP participants will be served through two existing HCBS waivers. As a transition coordination service, consumers will be able to participate in workshops that build skills for independent living. The workshops will be modeled after DPI's successful "On My Own" workshops. Additionally, the state is in the process of submitting an Independence Plus Waiver for Consumer-Directed Attendant Services and an Independence Plus Family Support Waiver. If the waivers are approved, DHSS will need to introduce legislation to secure matching state funds and enable self-direction. The state also is considering applying for a State Plan option to provide services for mentally ill clients; Delaware currently does not have an HCBS waiver for the mentally ill.

- **Qualified Home and Community-Based Services**: The two HCBS waivers serving MFP participants are the elderly and disabled (E/D) waiver and the MR/DD waiver. Mentally ill clients will receive case management and pre-vocational training.
- **Home and Community-Based Demonstration Services**: Physically disabled clients will have access to case management. Physically disabled, elderly, and MR/DD clients will have access to home accessibility adaptations, assistive technology, habilitation services, training and counseling services for unpaid caregivers, and community transition and personal assistance services. Mentally

ill clients will have access to community transition services, day treatment, and mental health services.

- **Supplemental Demonstration Services:** None mentioned.

D. Self-Direction Options for MFP Demonstration Participants

As part of a self-determination pilot program for three individuals with MR/DD, the state has completed work on a standardized rate system that creates individual budgets for consumers based on an objective assessment. The MFP Demonstration will develop procedures to build on and expand this pilot program.

E. Home and Community-Based Housing Options and Strategies

The state will continue to work with Delaware Housing Authorities to increase the availability of affordable, accessible, and integrated housing options.

F. Workforce Strategies

The state will work with the University of Delaware to enhance the community-based workforce.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- The state was approved for an Independence Plus 1915c waiver for consumer-directed attendant services, but funding to support state implementation is not available.
- The state does not have adequate accessible housing to meet the needs of its disabled and aging population.
- With the exception of the MR/DD waiver, HCBS waivers currently do not provide environmental modification services, even though these investments might enable a consumer to remain in the community.
- The state lacks a single outreach and information dissemination mechanism to reach all targeted long-term care groups.
- The state has limited home and community-based service capacity, especially in terms of respite care and attendant services.
- Transportation through Delaware's Paratransit System has limited the independence of people with disabilities because of issues with its reliability, quality, and weekend availability.

IV. Quality Management Strategy

A 2003 Systems Change Grant will be used to continue the work of DDDS on protocol revisions to measure outcomes for service recipients. The results will be shared with other divisions within DHSS to enhance quality assurance procedures across long-term care programs. In addition, MFP participants will be monitored regularly for a period of at least six months after transition to the community.

V. Administration, Oversight, and Evaluation

A. Role and Involvement of Other State Agencies

The Division of Medicaid and Medical Assistance (DMAA) within the Department of Health and Social Services (DHSS) is the lead agency for the MFP Demonstration. Four additional divisions within

DHSS will participate in the MFP program. These Divisions, Services for Aging and Adults with Physical Disabilities (DSAAPD), Developmental Disabilities Services (DDDS), Substance Abuse and Mental Health (DSAMH), and Public Health (DPH), administer and coordinate long-term care services, including the HCBS waivers. These Divisions will develop Memoranda of Understanding to guide their efforts on behalf of the MFP program and reduce administrative fragmentation.

B. MFP Program Oversight/Key Stakeholder Involvement

The MFP Coalition, which includes 14 consumers or consumer-representatives, as well as provider groups and formal advocacy groups, will continue to advise DHSS during the Demonstration.

C. IT System Developments or Enhancements

Delaware will continue to develop its plans to construct an integrated case management database, which may be used to help identify candidates for transition.

D. Independent State Evaluation

The state has budgeted to complete a mid-term evaluation.

GEORGIA MFP GRANT PROGRAM SUMMARY

Grantee Agency: Georgia Department of Community Health (DCH), in collaboration with the Departments of Human Resources (DHR), Labor (DoL), and Community Affairs (DCA)

Total Award: $34,091,671

Overview: Georgia's MFP Demonstration, which emphasizes consumer self-direction, will build on five existing waiver programs and will utilize Transition Coordinators stationed in three Area Agencies on Aging (AAAs), as well as Peer Counselors, to assist consumers transitioning to the community. The state also plans a 70 percent reduction in the number of beds in state Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) by the end of the Demonstration.

Transition Target Groups: Demonstration funds will be used to transition the elderly, individuals with mental retardation or developmental disabilities (MR/DD), and persons with physical disabilities and traumatic brain injury (TBI).

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Georgia will increase the dollar amount and percentage of expenditures for home and community-based services (HCBS) as a percentage of total long-term care spending. The state also will achieve a 70 percent reduction in the number of state-owned and operated ICFs/MR beds by closing and decertifying the beds as consumers transition to the community.
- **Money Follows the Person/Flexible Budgeting Goals:** Georgia will develop methodologies to eliminate barriers to the flexible use of Medicaid funds if any are discovered during the pre-implementation phase of the Demonstration.
- **Continuity of Service to Transitioned Individuals:** The state will expand the number of slots in existing waiver programs to ensure that individuals will have access to home and community-based services after the Demonstration. The state also will evaluate whether its HCBS waivers should be modified to include ongoing transitional services.
- **Quality Assurance and Improvement:** Georgia will expand the current quality management plan to include activities specific to supporting and monitoring consumers who have transitioned. The state proposes that the Long-Term Care Ombudsman service follow the person to the community when transitioning occurs, a service that currently is available only in institutions.
- **Other State Goals:** The state will increase the availability of community housing and will assess how it can augment existing systems of self-direction. Apart from the MFP Demonstration, Georgia will use state funds to transition 35 individuals with mental illness out of state mental institutions.

B. Annual Transition Targets[4]

	Elderly	Individuals with Physical Disabilities*	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	50	50	75	0	0	175
FY 2009	100	100	150	0	0	350
FY 2010	100	100	150	0	0	350
FY 2011	125	125	187	0	0	437
TOTAL	375	375	562	0	0	1,312

*Note: Includes individuals with traumatic brain injury (TBI).

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

Georgia will implement the Demonstration statewide for consumers with physical disabilities and those with MR/DD. The state will target elderly consumers residing in three multi-county regions served by AAAs: Atlanta, Augusta, and Rome/Northwest GA. For all three populations, DCH will analyze the Minimum Data Set (MDS) provided by nursing facilities and hospitals to identify potential "transition consumers." DCH will forward its list of candidates to transition coordinators (TCs), who will interview candidates to discuss their preferences for transitioning to the community; TCs also will meet with consumers referred by Aging and Disability Resource Connections (ADRCs) located in the AAAs, long-term care Ombudsmen, institutional staff, and family members. All consumers with MR/DD residing in state hospitals will be offered the opportunity to transition to the community.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

TCs will use a standardized assessment tool that will be developed for the MFP Demonstration. Then they will link participants to the appropriate HCBS waiver intake unit, where each consumer will be matched with the appropriate waiver services and other community supports needed for transitioning.

C. Demonstration Services

MFP participants will be served through one of four existing 1915c waiver programs. Annual budget allocations which require legislative approval are planned to add the necessary slots for MFP participants to each waiver. Also, three waivers (two for MR/DD and one for the Community Care Services Program (CCSP) for the elderly and physically disabled) have been revised to include additional opportunities for self-direction. CCSP consumers also receive State Plan enhanced primary care case management through the Service Options Using Resources in a Community Environment (SOURCE)

[4] The Centers for Medicare & Medicaid Services (CMS) award announcement of May 14, 2007 lists a target of 1,347 slots for Georgia, a total that includes 35 individuals with mental illness who will be transitioned solely at state expense. Because no federal funds will be expended for this population, these 35 individuals are not included in the annual transitions target table.

program. TCs will work with all consumers to ensure a smooth transition to the community, and the state will consider modifying HCBS programs to include ongoing transitional services. Additionally, MR/DD consumers will receive support coordination services for up to six months prior to transition to allow sufficient time for service planning.

Finally, no Medicaid funds currently are used for consumers with mental health disorders in Georgia's long-term care state-administered mental health institutions. All persons in need of mental health services who are served through the Demonstration will receive a set of core and specialty services.

- **Qualified Home and Community-Based Services**: CCSP/SOURCE, the Independent Care Waiver Program for Physical Disabilities and Traumatic Brain Injury (ICWP), the Mental Retardation Waiver Program (MRWP) [to be replaced with the New Options Waiver (NOW)], and Community Habilitation Support Services (CHSS) [to be replaced with the Comprehensive Supports Waiver, (COMP)].
- **Home and Community-Based Demonstration Services**: The elderly population will have access to specialized geriatric mental health services and skilled respite care beds. Consumers with physical disabilities will have access to peer counseling and mental health supports. Consumers with MR/DD will have access to mental health services, peer supports, dual diagnosis crisis management, and sustaining behavioral supports.
- **Supplemental Demonstration Services**: Services for the elderly include rent and utility deposits, vehicle adaptation and repairs, financial counseling, training of family caregivers, non-medical transportation, roommate match services, the long-term care Ombudsman program, and technology options. Services for consumers with physical disabilities include rent deposits, moving expenses, assistive technology, household goods, non-medical transportation, and other one-time supports. Services for consumers with MR/DD include non-medical transportation.

D. Self-Direction Options for MFP Demonstration Participants

Enrollees in the ICWP and CCSP waivers may self-direct personal support services. MRWP waiver consumers currently may act as the employer of their personal support and/or respite providers. The revised MRWP and CHSS waivers (COMP and NOW) allow for individually developed budgets and the ability to self-direct virtually all services under the waivers. Self-directed services give consumers in rural areas the opportunity to hire relatives, neighbors, or friends, which minimizes the problems associated with limited availability of providers in those communities.

E. Home and Community-Based Housing Options and Strategies

Georgia will appoint a housing coalition that will focus on short- and long-term housing solutions, such as expanding existing housemate/roommate match programs, home modification through the use of flexible funds, and prioritized waiting lists for the elderly and people with disabilities. Current regulations regarding Certificates of Need (CON) and/or limits on the number of beds in Medicaid-supported living will be reviewed to ensure that they do not create barriers to increasing available housing.

F. Workforce Strategies

None mentioned.

III. CHALLENGES TO REBALANCING THE LONG-TERM CARE SYSTEM AND EXPANDING HOME AND COMMUNITY-BASED SERVICES

- The state lacks adequate non-Medicaid transportation options to help the transitioning consumer can seek out housing and other community resources before discharge from the institution.
- There is a lack of adequate, affordable housing for consumers with limited incomes.
- Consumers cannot "fast track" restoration of Supplemental Security Income (SSI) cash benefits to assure that they have income available on the day they leave the institution.
- Georgia lacks a coordinated information and referral system for all HCBS waivers, so that consumers can be linked to all of the resources needed for transition.
- The state lacks a formal system for coordinating planning and service delivery among the key federal, state, and local entities.
- Community service providers and residential funding options must be developed to assist consumers with mental illness in transitioning to the community.
- The state faces difficulties in attracting and maintaining a well-trained direct-care workforce.
- Physical and mental health services are not well integrated into the delivery of individual long-term care waiver services.
- Two HCBS waivers have extensive waiting lists: MRWP (7,102) and CCSP (2,289).

IV. QUALITY MANAGEMENT STRATEGY

Georgia will add activities specific to MFP participants to its existing Quality Management Strategy (QMS). For consumers with MR/DD, support coordinators will report monthly on each participant's status, using a standardized rating methodology. At intervals of one, six, and twelve months following transition, MFP participants of all disability types will meet with an long-term care Ombudsman, who will review the quality of services, monitor satisfaction, help ensure safety and consumer choice, and protect consumer rights.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

As the single state Medicaid agency, DCH is the lead agency for the Demonstration, and also directly manages the ICWP waiver and SOURCE programs. DCH will work with DHR, which manages the MRWP, as well as the CCSP waivers and contracts with state AAAs for coordination of home and community-based services. In addition, DCA will help to develop more housing options and DoL will address employment and work-force issues.

B. MFP Program Oversight/Key Stakeholder Involvement

Georgia will appoint an MFP Advisory Council with representatives from a broad range of advocacy and provider groups, including consumers who have made a transition and those currently residing in a facility.

C. IT System Developments or Enhancements

The state will alter its current IT systems to identify potential MFP participants, track financial information separately for MFP services, and monitor the quality of services provided to MFP consumers. The state's QMS will be supported by a Web-based management system with the ability to incorporate

monitoring and feedback tools in a systematic manner. The system will capture data from case managers, claims, surveys, and other sources.

D. Independent State Evaluation

During the pre-implementation phase, Georgia will develop an appropriate evaluation and continuous improvement methodology through work with an outside vendor. The implementation of evaluation procedures will occur during all years of the demonstration.

HAWAII MFP GRANT PROGRAM SUMMARY

Grantee Agency: Hawaii Department of Human Services (DHS), in collaboration with the Developmental Disabilities Division of the Department of Health (DoH-DDD)

Total Award: $10,263,736

Overview: Hawaii's MFP Program, called "Going Home Plus," will expand existing Medicaid waiver programs—in particular, the Residential Alternatives Community Care Program (RACCP) and Nursing Home without Walls (NHWW). Community Care Foster Family Homes for these waiver programs will be supported by transition coordinators, as well as virtual care teams of medical staff (physicians, nurses, and specialists) accessible through a video support system installed in the home. Hawaii is particularly interested in transitioning individuals with complex medical issues who are residing in acute hospital beds for extended periods of time (>6 months) because appropriate community placements cannot be found.

Transition Target Groups: Individuals of all disability types in nursing homes and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), and those with complex medical needs who have been residing in acute hospitals for six months or longer.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Hawaii will increase the percentage of long-term care (LTC) expenditures that are represented by home and community-based services (HCBS) in each year of the Demonstration. In July 2007, the state fully transitioned from a cost-based to an acuity-based reimbursement system for nursing facilities and acute hospitals.
- **Money Follows the Person/Flexible Budgeting Goals:** DHS combined the State Plan budget, managed by its Med-QUEST Division (MQD), and the HCBS waiver program budget, managed by its Social Services Division (SSD), into one Medicaid budget, effective July 1, 2007. To align organizational with budgetary structure, DHS also will consider transferring administration of the HCBS waivers to MQD.
- **Continuity of Service to Transitioned Individuals:** Individuals who have remained in the community for one year will be transitioned to one of Hawaii's HCBS waiver programs.
- **Quality Assurance and Improvement:** The state's ongoing monitoring system, Quality Management Improvement (QM&I), will be expanded to include MFP participants.
- **Other State Goals:** Hawaii will seek to maintain 90 percent of its MFP participants in the community for one year or more. DHS will expand available housing resources by recruiting homeowners to provide community foster homes for MFP participants, and will develop a plan for constructing new housing facilities. To address the nursing shortage, the state will evaluate the potential for delegating some tasks to unlicensed caregivers.

B. Annual Transition Targets[5]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	30	30	0	0	0	60
FY 2009	45	40	0	0	0	85
FY 2010	55	55	10	0	0	120
FY 2010	55	55	40	0	0	150
TOTAL	185	180	50	0	0	415

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

B. Participant Recruitment and Education

During the first two years of the Demonstration, Hawaii will target potential participants on the island of Oahu before expanding statewide in later years. To identify participants, the state will query its existing information system to identify individuals whose level of care assessment score has been stable or improved since entry into the nursing facility. The state will use this information to initiate conversations with nursing facilities, and will work directly with ICFs/MR and hospitals to identify individuals with complex medical needs who potentially could be transitioned to the community.

C. Eligibility Criteria, Screening and Assessment Methods and Tools

Currently, the level of care determination and authorization of specific services are separate processes. The level of care determination form will be revised to combine needs identification and authorization of services prior to transitioning consumers. A workgroup also will design a tool to assist in matching participants with community caregivers. This tool will build on one currently used by the Med-QUEST Division (MQD).

D. Demonstration Services

Hawaii will serve MFP participants through one of five Medicaid waiver programs listed below, although the state anticipates that the majority will receive services through RACCP or NHWW. The state believes that the current service packages in its HCBS programs are adequate to sustain individuals in the community, although it does propose to increase the number of individuals served, using new grant waiver services. DoH is evaluating whether Hawaii should pursue an additional waiver for persons with serious mental illness, and the Centers for Medicare & Medicaid Services (CMS) currently is reviewing an amendment to the state's 1115 demonstration waiver, which would include HCBS for neurotrauma survivors.

[5] Hawaii plans to transition 365 individuals from nursing facilities and acute care hospitals, but officials are unsure as to what proportion will be elderly and what proportion will be individuals with physical disabilities each year. For purposes of this table, the annual transition target totals were divided roughly equally between the two populations.

Transition coordinators will oversee the acquisition of housing, services, supplies, and equipment for nursing home residents. Once the Demonstration ends in 2011, the state will consider amending its 1115 waivers to include transition coordinators. Hospital discharge planners will assume responsibility for the transition of clients residing in hospitals. Medically fragile and hospitalized children and youth have access to case management under the State Plan to assist with the transition process.

- **Qualified Home and Community-Based Services**: HCBS waivers include: the Residential Alternatives Community Care Program (RACCP), Nursing Home without Walls (NHWW), HIV Community Care Program (HCCP), Medically Fragile Community Care (MFCC), and MR/DD HCBS.
- **Home and Community-based Demonstration Services**: Education/training of caregivers to support MFP participants, installation of a "virtual care team" video support system, and transition coordinator services. Transition coordination services are available only to participants transitioning from nursing facilities.
- **Supplemental Demonstration Services**: One-time security deposits, utility set-up fees, and home furnishings.

E. Self-Direction Options for MFP Demonstration Participants

Consumer-directed services that allow clients to hire their own providers are available through most of Hawaii's HCBS waivers. Some waivers include consumer-directed respite and individual budgeting**.**

F. Home and Community-Based Housing Options and Strategies

Hawaii will establish a public/private partnership to expand the supply of affordable, accessible housing. The partnership will focus on finding ways to utilize existing housing supports, such as vouchers, to enable individuals to transition to their own homes. Grant funds will be used to expand the number of certified RACCP homes by encouraging qualified homeowners and renters (nurse aides, LPNs, and RNs who have at least one year of nursing experience in a home setting and who satisfy other training and background search requirements) to become certified RACCP homes. These homes allow up to two nursing facility level of care residents at one time. A longer term objective will be to develop more accessible housing units. For ambulatory nursing home patients with dementia, the state is considering transitioning individuals to "community memory centers" in assisted living facilities.

G. Workforce Strategies

To address the shortage of qualified home and community-based services workers on the neighboring islands, Hawaii will develop a formal specialized training curriculum for Community Care Family Foster Home caregivers and licensed community home operators. To support this training, a video support system will be installed for up to six months to link caregivers in homes with nurses, physicians, and other specialists via telemedicine. The state also will review the Nurse Delegation Act and existing administrative rules to identify duties that can be delegated to community providers.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- Hawaii faces a nursing shortage, which makes it difficult to procure skilled nursing services in the community on a regular basis.
- There is an extreme shortage of affordable and accessible homes for individuals at a nursing facility level of care. The City and County of Honolulu have stopped taking applications for Section 8

vouchers, because current voucher holders cannot find rentals within the established program guidelines.

- The state has a large number of patients who are residing in hospitals for extended periods of time, because appropriate community placements cannot be located.
- Individuals with complex medical needs are difficult to transition, because community caregivers may be reluctant to assume the responsibility for their care.

IV. QUALITY MANAGEMENT STRATEGY

The University of Hawaii Center for Disability Studies will develop a Quality Management Improvement (QM&I) program for the MFP grant participants. The state will utilize transition coordinators to determine whether services are meeting clients' needs and to evaluate services provided by unlicensed personnel under the self-direction provisions of the waiver programs. For medically fragile children, case managers will maintain weekly, and later monthly, contact. The state intends to collect additional information related to MFP participant satisfaction at six months and one year following the transition.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The Department of Human Services, the single state Medicaid Agency, is the lead agency for the MFP program. Within DHS, MQD is responsible for the operation and administration of State Plan services, and SSD currently administers all of the Medicaid waiver programs, except for the MR/DD HCBS waiver program, which is administered by DOH-DDD. This division will assist with the identification and transition of MR/DD individuals for the MFP Demonstration. The Adult Mental Health Division of the Department of Health also will provide input for the development of tools for matching clients with community homes.

B. MFP Program Oversight/Key Stakeholder Involvement

Community participants will form a Planning Group; its membership will include hospitals, nursing facilities, the Healthcare Association of Hawaii (representing hospitals and nursing homes), the Hawaii Long-Term Care Association, the University of Hawaii Center on Disability Studies, Family Voices, and the Hawaii Centers for Independent Living.

C. IT System Developments or Enhancements

Hawaii will identify MFP participants as a different eligibility group in its Medicaid Management Information System (MMIS). The new eligibility group will enable the state to process claims for services, prepare separate financial reports of expenditures, and easily extract claims of services for review and analysis. The state also will utilize its MMIS to examine quality of care at the system level.

D. Independent State Evaluation

The University of Hawaii at Manoa—Center on Disability Studies will develop and test the MFP beneficiary satisfaction survey instrument.

ILLINOIS MFP GRANT PROGRAM SUMMARY

Grantee Agency: The Department of Healthcare and Family Services (HFS), in collaboration with the Department on Aging (DoA), three divisions of the Department of Human Services ([DHS]; Divisions of Rehabilitation Services, Developmental Disabilities, and Mental Health), and the Illinois Housing Development Authority (IHDA)

Total Award: $55,703,078

Overview: Illinois' MFP Demonstration expands three existing transition programs, adds a transition program for consumers with mental illness, and increases coordination among these programs. The state also seeks to rebalance its long-term care system by improving screening and review processes, housing availability and access, and incentives for facility bed closure and conversion. Legislation will be introduced to remove barriers that prevent flexible use of Medicaid funds.

Transition Target Groups: Elderly, individuals with physical disabilities (including brain injury and HIV/AIDS), individuals with developmental disabilities (DD), and individuals with mental illness.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Illinois will reduce the census in state-operated developmental centers (SODC), private intermediate care facilities for the mentally retarded (ICFs/MR), and nursing facilities. By the end of the Demonstration, the state will achieve a shift in long-term care spending on home and community-based services from 28.5 to 37 percent.
- **Money Follows the Person/Flexible Budgeting Goals:** HFS will introduce legislation to establish an MFP transition budget mechanism to allow for more flexible utilization of appropriated long-term care funds. Based on transitions that occur each year, funding will be realigned from institutional care to the appropriate agency for home and community-based services appropriation.
- **Continuity of Service to Transitioned Individuals:** MFP participants will continue to receive services through HCBS waiver programs after the Demonstration has concluded.
- **Quality Assurance and Improvement:** MFP participants will be monitored under existing and enhanced quality management strategies. The state will develop follow-up protocols to identify individuals at risk of poor outcomes, and triggers for further review and intervention. In addition, the DHS Division of Mental Health (DMH) will develop an outcome monitoring protocol to evaluate the effectiveness of its service package in supporting transitioned individuals with mental illness in the community.
- **Other State Goals:** The state will increase housing opportunities for MFP participants.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	237	200	5	20	0	462
FY 2008	320	200	25	50	0	595
FY 2009	320	200	25	175	0	720
FY 2010	320	200	25	220	0	765
FY 2011	320	200	25	270	0	815
TOTAL	1,517	1,000	105	735	0	3,357

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

HFS will evaluate the use of the minimum data set (MDS) to generate lists of transition candidates. Transition coordinators for each of Illinois' four long-term care support systems (DoA, DHS Division of Mental Health [DMH], DHS Division of Developmental Disabilities [DDD], and DHS Division of Rehabilitation Services [DRS]) will contact potential participants to discuss MFP, conduct transition assessments, and enroll MFP participants. Current methods of outreach by Centers for Independent Living (CIL), LTC Ombudsmen, and case coordination units will continue as well. Consumer, family, and provider outreach education will be coordinated across long-term care service systems.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

A transition assessment tool will be developed that includes some common elements across the long-term care groups. DMH also will develop additional assessment components to add to the mental health pre-admission screening and resident review (MH PASARR) tool.

C. Demonstration Services

Each long-term care support system (DoA, DMH, DDD, and DRS) has a specific transition project that will serve MFP participants utilizing 1915c waiver programs and State Plan services. DoA plans statewide expansion of its Enhanced Transition/Home Again (ET/HA) program, which utilizes home and community-based services in the Community Care aging waiver. There are no waiting lists for this program.

DMH initially will transition MFP participants with mental illness using State Plan services, including services in the rehabilitation option. During the Demonstration, the state will develop a mental illness HCBS waiver or HCBS State Plan amendment.

DDD will serve MFP participants through its HCBS waiver, which was renewed in July 2007. DRS will utilize the community Home Services Program (HSP) and the Community Reintegration Program (CRP) which is run in partnership with CILs.

- **Qualified Home and Community-Based Services**: Elderly waiver, persons with disabilities waiver, persons diagnosed with HIV/AIDS waiver, persons with brain injury waiver, adults with developmental disabilities waiver, and the supported living program. State plan services including

assertive community treatment (ACT) and/or community support team (CST) services will be available to MFP participants with mental illness, with a planned mental illness HCBS waiver or State Plan HCBS amendment in Demonstration years four and five.

- **Home and Community-Based Demonstration Services**: Elderly: extended homemaker hours, personal assistant services, medication management, caregiver services, and respite care. Physically Disabled: pre/post transition peer training. Mentally Ill: Community living skills training with peer involvement.
- **Supplemental Demonstration Services**: Elderly: up-front transition costs (e.g., security deposits, rent deposit assistance, home modification, and utility deposits), as well as assistive technology, non-medical transportation, and substance abuse treatment. Consumers with mental illness: up-front transition costs. Consumers with physical disabilities: up-front transition costs. Consumers with DD: up-front transition costs.

D. Self-Direction Options for MFP Demonstration Participants

Currently not all of the waivers encompass opportunities for consumer direction. The DoA My Choices (Cash and Counseling Grant) program is piloting consumer direction for older adults. Clients with developmental disabilities have access to the Home-Based Support Services option, which includes individual budgets, consumer development of services plans, and purchase of services from vendors of their choice. DDD has selected vendors to provider fiscal, payroll, and bill payment services for those who hire their own direct support staff. DMH will implement Person Centered Planning and Advance Directives in MFP. Customers in the DRS Home Services Program recruit, hire, supervise, and fire their individual providers independently. Customers can use family, friends, or others as personal assistants or can use individual home health providers. MFP also will explore additional options for consumer control.

E. Home and Community-Based Housing Options and Strategies

- The Illinois Housing Development Authority (IHDA) will help develop a comprehensive housing strategy for MFP, including: creating or improving housing referral networks; developing a comprehensive affordable and accessible housing database; developing more affordable housing; supporting efforts to increase the development capacity of supportive housing providers; continuing a state-funded home modification program; and continuing IHDA incentives for set-asides of units for special needs in non-specialized affordable housing developments.

F. Workforce Strategies

None mentioned.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- Improvements are needed in the functionality and integration of those state information technology systems related to long-term care.
- Illinois lacks sufficient affordable, accessible housing options, particularly for persons with psychiatric disabilities.
- Strategies for the long-term funding of transition costs must be developed; at present, they are mostly state-funded.
- There is a need for provider outreach and education on assessment, discharge planning, and community-based long-term care support services.

- Because the MFP Demonstration targets residents with longer stays than current diversion and transition efforts, the state needs better assessment tools and protocols; the needs of and informal supports for these residents can differ in important ways from those with shorter stays.
- Current provider tax assessment policy poses a fiscal disincentive to downsizing, since providers are levied the full assessment during the fiscal year that they downsize, despite decreased income as residents move out.
- For quality management, the state needs to move from a case-by-case resolution to a more systemic process of identifying and preventing abuse, neglect, and exploitation.

IV. QUALITY MANAGEMENT STRATEGY

In general, MFP participants will be covered under the quality management strategy of their respective HCBS waivers. Three of the waivers operated by DRS are under one quality management plan, and the other waivers have separately operated plans. Each waiver program has a qualified case management staff person, who will be trained specifically on community transition activities, and will closely monitor transitioning individuals before and after transition. The state also will test follow-up protocols to identify individuals at risk of poor outcomes and to trigger further review and intervention. In addition, DMH will develop an outcome monitoring protocol to evaluate the effectiveness of its service package in supporting individuals with mental illness who have transitioned to the community. Finally, HFS has contracted with a quality improvement organization to assist Illinois in improving its quality management strategies across waiver programs. To help improve the system, the vendor will conduct a sample of personal experience surveys with approximately 1,500 individuals across six of the HCBS waivers.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The Department of Healthcare and Family Services (HFS), the single state Medicaid agency, is the lead agency for the MFP Demonstration. HFS will coordinate the MFP Demonstration through the State Leadership Team, which will include project leads from each major partner department: Department of Aging (DoA), three divisions of the Department for Human Services (DHS): the Division of Rehabilitation Services (DRS), the Division of Mental Health (DMH), and the Division of Developmental Disabilities (DDD), as well as the Illinois Housing Development Authority (IHDA).

B. MFP Program Oversight/Key Stakeholder Involvement

Active participation of direct consumers, advocates, and providers will be ensured throughout the Demonstration period. Participation will be accomplished through the two existing long-term care rebalancing bodies, the Older Adult Services Advisory Committee and the Disability Services Advisory Committee. A special consumer advisory group will be added. Broader stakeholder input will be sought through focus groups, surveys, and meetings. The State Leadership Team will also conduct outreach to institutional providers.

C. IT System Developments or Enhancements

The Demonstration will improve data systems to facilitate tracking individuals across service systems and funding streams, and to identify individuals with the potential for transition. Modifications will be necessary to capture required fiscal and program reporting data.

D. Independent State Evaluation

In collaboration with the University of Illinois at Chicago, the Demonstration will conduct surveys of individuals at the point of nursing facility admission to ascertain (1) perceived barriers to remaining in the community, and (2) what individuals believe they would need to be able to return home. A second set of surveys will obtain feedback and recommendations from people who have used one of the current transition pilot programs or MFP Demonstration services.

HFS will evaluate the characteristics of successful vs. non-successful transition clients, the services they utilize, and the relative importance of the services provided in transitioning the clients and sustaining transition over time. DMH will conduct focus groups with current and transitioned residents to identify other groups of residents who have potential for transition, but who would require an expanded service package.

INDIANA MFP GRANT PROGRAM SUMMARY

Grantee Agency: State of Indiana Family and Social Services Administration (FSSA)

Total Award: $21,047,402

Overview: The state's MFP Demonstration program strengthens current long-term care reform initiatives to transition 1,031 individuals statewide who meet the MFP criteria from nursing facilities to the community. To rebalance its long-term care system, the state will continue its use of the nursing facility closure fund to give incentives to providers to reduce the number of institutional beds or close facilities and encourage development of community-based residential options, resulting in a shift of long-term care dollars to the community.

Transition Target Groups: Those residing in institutions for a minimum of six months and who meet nursing facility level of care criteria—specifically, elders and adults with physical disabilities who are eligible for the Aged and Disabled (AD) Waiver, adults with traumatic brain injury (TBI) who are eligible for the TBI or the AD Waiver, and adults with MR/DD who are eligible for the Developmental Disabilities (DD) Waiver or the AD Waiver.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The state plans to increase the proportion of long-term care funds spent on home and community-based services for people who are eligible for nursing facility level of care from 23 percent in 2007 to 27 percent in 2009. It will also increase home and community-based spending from approximately $546 million in 2007 to $858 million in 2011.
- **Money Follows the Person/Flexible Budgeting Goals:** Indiana already utilizes a single-appropriation, global financing model for Medicaid long-term care appropriations. This is how long-term care funds are reported to the legislature, and permits FSSA the flexibility and control to follow individuals leaving nursing facilities into the community. FSSA, internally, is moving towards a quarterly budget analysis . The state intends to reallocate funds saved from planned facility closures to home and community-based services.
- **Continuity of Service to Transitioned Individuals:** Following the one-year Demonstration period, MFP participants will be enrolled into one of three 1915c waiver programs—the AD, TBI, or DD Waiver—based on the need for waiver services, eligibility, and individual choice. The state-funded program, Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE), is not routinely provided along with wavier services however, there may be situations where MFP participants will also continue to receive home and community-based services through the CHOICE program, the Medicaid State Plan, HCBS waivers, and other programs.

- **Quality Assurance and Improvement:** The state will develop a system that can generate home and community-based quality indicators such as incident reporting, mortality review, and provider standards.
- **Other State Goals:** Indiana will track and evaluate outcomes for transitioned individuals and use the data to refine its ongoing transition efforts.

B. ANNUAL TRANSITION TARGETS[6]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	51	17	6	0	0	74
FY 2008	276	88	28	0	0	392
FY 2009	173	51	11	0	0	235
FY 2010	126	45	9	0	0	180
FY 2011	100	42	8	0	0	150
TOTAL	726	243	62	0	0	1,031

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

The state will perform outreach activities such as meeting with and distributing materials to key stakeholders, establishing a toll-free (1-800) phone number for MFP inquiries, and posting materials on the Long-Term Care Options Website. In addition to self-referrals, the state will identify potential Demonstration participants through Minimum Data Set (MDS) data that identifies nursing facility residents who express a desire to return to the community, and family members/others who inquire about transition. Question Q1c of the MDS, which projects the length of stay, will also be used. For individuals residing in nursing facilities with anticipated bed closures, the transition team will identify prospective candidates and provide them with options counseling and assistance with the transition.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

In accordance with state code, all individuals seeking admission to a nursing facility as a "new admission" must participate in the Pre-Admission Screening (PAS) process. The state intends to enhance its existing institutional screening and assessment process through the development of Options Counseling tool. The state is also identifying an assessment instrument, the MDS-Home Care, to assess potential MFP participants who are residents in nursing facilities.

[6] Initial state application appendix showed 1,039 total transitions. The state has adjusted the number of transitions each year, and the transitions now total 1,031.

C. Demonstration Services

MFP participants will be served by existing 1915c HCBS waiver programs (AD waiver, MR/DD waiver, TBI waiver, and DD waiver), Medicaid State Plan services, and the state funded CHOICE program. The state plans to amend the AD Waiver to increase the maximum amount of one-time transition expenses from $1,000 to $1,500 and add post-transition care coordination services to support transitioned individuals. The FSSA Division of Aging will contract with an entity that will provide transition case management teams across the state. These teams will be comprised of a registered nurse and a social worker.

- **Qualified Home and Community-Based Services:** This includes all home and community-based services currently available under existing HCBS waiver programs, services through the state-funded CHOICE program, as well as home health services, DME, TCM, and other services offered under the Medicaid State Plan for which the person is eligible.
- **Home and Community-Based Demonstration Services:** The newly developed post-transition care coordination service will be used for all MFP participants.
- **Supplemental Demonstration Services:** No supplemental services

D. Self-Direction Options Available to MFP Demonstration Participants

Consumers in the CHOICE and HCBS waiver programs can self-direct attendant care services. The state has implemented a consumer-directed personal attendant option for individuals served by the AD waiver.

E. Home and Community-Based Housing Options and Strategies

The state will seek help from the Indiana Housing and Community Development Authority (IHCDA) to identify available housing options for elders and persons with disabilities and to obtain priority access for Demonstration participants. In addition, the Division of Aging is completing an inter-agency agreement with the IHCDA, whereby the former will appropriate $1 million to the IHCDA to implement an Elderly Tenant Buy-down Program. The program will be structured so that rents will be reduced to 50 percent of the level paid by those with Average Median Income (AMI), for those people whose income falls under 60 percent of AMI. This will be done by offering a lump sum buy-down per unit to property owners who meet certain threshold criteria for the program. In tandem with this effort, the Division of Aging will oversee the maintenance of IndianaHousingNow.org. This Website will provide an up-to-date resource for consumers, property owners, and transition teams to locate and research affordable housing choices within their communities.

F. Workforce Strategies

The state increased reimbursement rates in fiscal years 2007 and 2008 for AD and TBI Waiver services such as assisted living, attendant care, homemaker supports, and other services in order to provide incentives for workers in those areas. It is also actively recruiting adult day, assisted living, and adult foster care providers. In addition, the Indiana Division of Aging is collaborating with the Neighborhood Self-Employment Initiative to increase the number of direct personal care attendants. The Division of Disabilities and Rehabilitative Services has been collaborating with Workforce Development to implement a grant that trains caregivers on direct services to enhance the quality of care provided to the MR/DD population and reduce staffing turnover.

III. CHALLENGES TO REBALANCING THE LONG-TERM CARE SYSTEM AND EXPANDING HOME AND COMMUNITY-BASED SERVICES

- The state needs a formal or strengthened system to more proactively identify and assess transition candidates; in the past, candidates have been self-referred.
- There is a need for greater access to critical supports, such as in-home services, nutritious meals, on-demand transportation, and appropriate housing.
- The state needs additional methods to improve the quality of services and help participants achieve desired outcomes, as well as improved clinical oversight during the post-transition period.

IV. QUALITY MANAGEMENT STRATEGY

The state will maintain its current systems and strategies to enhance quality assurance and quality improvement within the Bureau of Quality Improvement Services (BQIS). These existing systems include a risk management program, consumer complaint process, and formal surveys of home and community-based care consumers and providers. In an effort to develop a more robust quality assurance and improvement plan, each division within FSSA responsible for long-term care services will be required to inventory activities related to the data collection (discovery), remediation, and quality improvement efforts currently underway. The inventory will serve to highlight areas that need improvement, lack integration, or are functioning well. To ensure participants' health and welfare, transition teams will maintain contact with individuals for the first four to six weeks post-transition to ensure that they are functioning well in the community. After discharge from the transition team, individuals will receive post-transition care coordination services through a registered nurse or licensed practical nurse. The post-transition care coordinator will be required to provide regular status reports to the Division of Aging. MFP participants will also receive ongoing case management through their Medicaid wavier case managers. Finally, FSSA will expand its existing contract with a vendor that randomly audits 10 percent of providers on an annual basis; this number will increase.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

In addition to the Indiana Housing and Community Development Authority, the state plans to collaborate with the Indiana Department of Transportation to facilitate state funding of additional transportation for elders and individuals with disabilities. The Division of Aging will partner with the Division of Disabilities and Rehabilitative Services (DDRS) to develop a pilot guardianship program. The Division of Aging will also collaborate with Vocational Rehabilitation to require the state-funded Centers for Independent Living to provide support to the transition team through the State Plan.

B. MFP Program Oversight/Key Stakeholder Involvement

FSSA's Division of Aging will have primary responsibility for the MFP Demonstration. To foster stakeholder participation in the implementation of the Demonstration, the Nursing Facility Transition Stakeholder Work Group comprising of consumers, consumer advocates, state officials, home and community-based services and nursing facility providers—will meet regularly throughout the five-year grant period to review MFP participants' health outcomes as well as transition teams' performance outcomes.

C. IT System Developments or Enhancements

The state will upgrade its IT infrastructure and the system enhancements will include (1) an online tracking tool that will enable Ombudsman across the state to enter and immediately access all data in the

repository, (2) an online assessment tool that will assess community-based needs using a real-time assessment instrument, (3) a new case management software suite, and (4) data from satisfaction surveys, audits, dates of hospitalizations and deaths, mortality reviews will be utilized to track quality outcomes of transitioned individuals. The state plans to implement an automated assessment tool (MDS-HC) to identify potential MFP participants and produce data on outcomes and expenditures.

D. Independent State Evaluation

None mentioned.

IOWA MFP GRANT PROGRAM SUMMARY

Grantee Agency: Iowa Department of Human Services (DHS)

Total Award: $50,965,815

Overview: Iowa's Partnership for Community Integration Demonstration builds on the work of the Iowa Department of Human Services and Iowa Medicaid Enterprise (IME)* to address barriers in access, financing mechanisms, and gaps in services and to transition 528 individuals from institutional care facilities for the mentally retarded (ICFs/MR) settings into integrated communities. Funding will be used to expand services under the Mental Retardation (MR) Waiver and to provide one-time transition services to individuals transitioning from ICFs/MR to the community. The initiative is a significant component of the Department's response to its legislative mandate to plan for the reduction in populations served by ICFs/MR and to expand populations served by home and community-based services.

Transition Target Groups: Adults and children with mental retardation and related conditions who reside in an ICF/MR setting (and have done so for at least six months).

*The DHS made the decision in 2003 to separate the State Medicaid System into nine components. All components form the Iowa Medicaid Enterprise (IME) and are housed within DHS.

Source: http://www.hce.org/medicaid/IAmcaid.html.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Increase the total annual qualified home and community-based service expenditures for each fiscal year of the Demonstration; increase the number of eligible individuals with mental retardation or developmental disability (MR/DD) transitioned from ICFs/MR to a qualified residence during each fiscal year of the project (75 people transitioned in Year 2, 113 in Year 3, 151 in Year 4, and 189 in Year 5); and increase home and community-based service expenditures by $61.9 million for those same years.
- **Money Follows the Person/Flexible Budgeting Goals:** Continue to use the authority that DHS already has to transfer funds from the ICF/MR line item to home and community-based services.
- **Continuity of Service to Transitioned Individuals:** At the conclusion of the Demonstration, the state plans for all participants who have transitioned from ICF/MR settings to be served by MR Waiver services. These include but are not limited to adult day care, transportation, nursing, consumer-directed attendant care, day habilitation, home and vehicle modifications, home health aide, and supported employment.
- **Quality Assurance and Improvement:** The state is in the process of developing its quality management system for all home and community-based services and Medicaid State Plan services; these processes will be applied to the MFP Demonstration, with adaptations as appropriate.

Consumer satisfaction will be assessed using the Participant Experience Surveys (PES), and the state review system will include provider oversight.

- **Other State Goals:** The state aims to use a carefully planned and executed social marketing campaign to address the concerns of many parents and guardians about community living for individuals with MR/DD.

B. ANNUAL TRANSITION TARGETS

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	0	0	75	0	0	75
FY 2009	0	0	113	0	0	113
FY 2010	0	0	151	0	0	151
FY 2011	0	0	189	0	0	189
TOTAL	0	0	528	0	0	528

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

The Partners Group—a broad-based stakeholder group that includes consumers, ICFs/MR administrators, community providers and advocates—is developing recommendations on how to target and recruit Demonstration participants. The Partners Group anticipates launching a marketing/public education strategy, possibly before the close of the planning year. Recruitment efforts during at least the first year will be directed to the Resource Centers and the large campus ICFs/MR, as several of the latter have expressed willingness to assist in facilitating community alternatives for their residents. While the initial focus will be on ensuring that all ICF/MR residents and their families/legal guardians know that transition assistance is available, a system for resident assessment and effective reporting on resident preferences will also be explored, which may lead to the development of a targeting and recruitment strategy.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

Under the Demonstration, the state plans to develop transition programs targeted to residents of ICFs/MR that will identify those residents who are interested in transitioning, strengthen the person-centered planning processes, provide transition services and a transition process capable of addressing all foreseeable contingencies, and provide residents with an array of residential options in the community.

C. Demonstration Services

MFP participants will have access to a set of services at least equivalent to Iowa's existing MR Waiver program, as well as Medicaid State Plan services for which the person is eligible. In 2005, transportation, adult day care, and prevocational services were added to the MR Waiver, and the Partners Group will be recommending that additional service options be added to help ensure successful community living. The state will work closely with the counties' "central points of coordination" to make sure that home and community-based services are provided.

To implement the Demonstration, the Medicaid agency will request legislative and Centers for Medicare & Medicaid Services (CMS) approval for amendments to the MR Waiver to include additional slots, to include people with "related disabilities" (including non-MR developmental disabilities) in the target population for the Waiver, and to add services that may have been recommended by the Partners Group. Furthermore, DHS will request legislative authority to increase appropriations for Medicaid over the next five years, so it is sufficiently funded for (1) the expansion of the MR Waiver, (2) the match supporting qualified home and community-based services, and (3) administrative expenses associated with the Demonstration.

Depending upon the recommendations from Partners Group and pending approval by IME (and the state legislature, if required), MFP participants may be entitled to receive the following services:

- **Qualified Home and Community-Based Services:** This includes the state's existing array of services offered under the MR Waiver program plus future enhancements that include home-delivered meals, assistive technology (AT) devices, chore and homemaker services, mental health outreach, behavioral programming, and transition services.
- **Home and Community-Based Demonstration Services:** This includes initial household set-up costs, enhanced supported community living services, and tele-health.
- **Supplemental Demonstration Services:** Durable medical equipment (DME) in excess of current coverage, environmental modifications, counseling, family counseling, substance abuse services, transportation, family support, clothing, service and companion animals, and nutrition services.

D. Self-Direction Options for MFP Demonstration Participants

The state is in the process of implementing self-direction, called the "Consumer Choices Option," in six of its home and community-based services waiver programs that will allow consumers to cash out all unskilled services in their plans and give them control over the use of those resources. Consumers may hire employees to provide personal care, chore services, transportation and other supports, and may also purchase goods and materials needed to maintain independence and productivity. An Independent Support Broker, chosen by the consumer, will provide assistance in developing and implementing his/her own budget. The Consumer Choices Option will be made available to any MFP participant under the qualified home and community-based program.

E. Home and Community-Based Housing Options and Strategies

The Iowa Finance Authority (IFA) will request from the legislature changes in statutory language governing the home and community-based services Waiver Rent Subsidy program to enable preference to be given to MFP participants, or alternatively for an increase in appropriations to ensure timely access to the program for all MFP participants. The Waiver Rent Subsidy program provides temporary rental assistance to people receiving waiver services, until they are able to access Section 8 housing assistance. With funding from Iowa's 2005 Real Choices grant, the IFA is also developing a Web-based Housing Registry to help elders and people with disabilities locate affordable and accessible housing to meet their needs.

F. Workforce Strategies

The Partners Group Workforce Subcommittee is currently reviewing barriers to workforce development in support of community living, including wage differentials in institutional versus home and community-based settings, provider reimbursement issues, and training needs.

III. CHALLENGES TO REBALANCING THE LONG-TERM CARE SYSTEM AND EXPANDING HOME AND COMMUNITY-BASED SERVICES

- Iowa's system has a pervasive attitude that for people with MR/DD, placement in institutions—including large institutions—is the best way to ensure their health and safety. Differential reimbursement for institutional versus community-based services also favors keeping people in institutions.
- The state lacks affordable, accessible transportation.
- Personal care is not covered as an optional benefit under Iowa's Medicaid State Plan.
- The state lacks a policy of presumptive eligibility, meaning that people are not able to secure transportation or housing modifications prior to returning home from hospitals or institutions.
- There is bifurcated state/county responsibility for policies governing disability service provision, creating confusion for providers and consumers. In addition, there are limited resources available for the county-based system.
- The state lacks a robust transition program because it has focused more on keeping people out of institutions than on transitioning people once they get placed in an institution.
- Three primary barriers exist that prevent the flexible use of Medicaid funds: (1) limited access to the MR Waiver by the targeted population as there are only 9,400 budgeted slots under the Waiver, resulting in a waiting list, and it only serves people with an MR diagnosis, (2) underdeveloped network of home and community-based services for the target population due in part to facility-based service providers receiving higher reimbursement rates than community service providers, and (3) skilled services tend to be easier to access in institutional settings.

IV. QUALITY MANAGEMENT STRATEGY

The state is in the process of developing its quality assurance and improvement system for all home and community-based services and Medicaid State Plan services. The state is using the CMS Quality Framework as the basis for its quality management system. Information will be collected and analyzed from such sources as consumers, Medicaid service providers, and county partners. Two primary measures of system integrity will be consumer experience surveys and provider oversight. Demonstration participants will complete the Participant Experience Surveys (PES) to capture information pertaining to transition service quality, whether the consumer was provided meaningful choices with respect to qualified residences, and whether qualified home and community-based services are adequate to sustain the individual in the community. With regard to provider oversight, the state will collect patterns of provider performance using its Provider Oversight and Input System (POVIS), review this data, and develop corrective action plans based upon Iowa-defined thresholds. Providers will be subject to episodic indicator initiated audits as well as a full on-site audit every five years.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The Department of Human Services and the Iowa Finance Authority are collaborating to ensure the availability of meaningful choices in qualified residences for consumers. Intra-departmental coordination between the IME and the new Division of Mental Health and Disability Services within DHS (which oversees the county disability service systems) will be essential.

B. MFP Program Oversight/Key Stakeholder Involvement

The Iowa Department of Human Services, the single state Medicaid agency, will administer and oversee the MFP Demonstration. The primary vehicle through which stakeholder input is being secured is the Partners Group, comprising consumers, consumer advocates, service providers, state agencies and other stakeholders, which is participating in the development of the Operational Protocol. The Partners Group is developing recommendations on (1) how to target and recruit Demonstration participants, (2) the transition process and the role of key entities, (3) services and supports to be available to people who are transitioning, (4) strategies to ensure meaningful choices among qualified residences, and (5) how to address workforce issues.

C. IT System Developments or Enhancements

IME's Individualized Services Information System (ISIS) will be modified to separately track MFP participant utilization of qualified home and community-based services, Demonstration services, and supplemental services. Iowa COMPASS, the state's disability information and referral service Website, is being enhanced through funding from the 2005 Real Choice Systems Transformation grant, and will serve as a resource to help consumers, family members and transition specialists to locate supports tailored to their personal circumstances and locale.

D. Independent State Evaluation

A supplemental assessment will be undertaken of the effectiveness of the transition process and of consumer satisfaction with their transition experience, the services and supports received in the demonstration, and their quality of life.

KANSAS MFP GRANT PROGRAM SUMMARY

Grantee Agency: Kansas Department of Social and Rehabilitation Services (SRS), in partnership with the Kansas Health Policy Authority (KHPA) and the Kansas Department on Aging (KDoA)

Total Award: $36,787,453

Overview: The Kansas Demonstration, "Community Choice," places a priority on consumer self-direction and builds on the success of its Money Follows the Person Project, which began in 2004. The Demonstration will also benefit from system improvements planned as part of 2005 Aging and Disability Resource Center (ADRC) and 2006 Real Choice Systems Transformation (RCST) Grants. The state proposes to achieve rebalancing, measured by a five percentage point increase in long-term care costs spent on home and community-based services (HCBS). Private intermediate care facilities for the mentally retarded (ICFs/MR) will be targeted for closure through a voluntary incentive program. Those residents of state ICFs/MR who have been difficult to transition to the community due to offender behaviors will also be targeted as part of the Demonstration.

Transition Target Groups: Elderly, individuals with physical disabilities (PD), individuals with traumatic brain injuries (TBI), and individuals with mental retardation/developmental disabilities (MR/DD), including those with identified offender behaviors.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Kansas will increase the percentage of total long-term care expenditures dedicated to home and community-based services from 53 percent to 58 percent. The state will reduce the number of private ICFs/MR beds by 70 percent through voluntary closure incentives.
- **Money Follows the Person/Flexible Budgeting Goals:** Kansas will continue its existing MFP project, which allows funding transfers from institutional to home and community-based services budgets on a case-by-case basis.
- **Continuity of Service to Transitioned Individuals:** MFP participants will be enrolled in existing HCBS waivers that will continue to provide services after the Demonstration has ended. Also, SRS and KDoA will amend the current HCBS waivers to include transition services at that point.
- **Quality Assurance and Improvement:** The current Quality Management Strategy will be modified to improve the state's ability to identify trends across its waiver programs.
- **Other State Goals:** None mentioned.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD*	Individuals with Mental Illness	Other**	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	92	185	28 (Private) 5 (State)	0	20	330
FY 2009	50	57	45 (Private) 10 (State)	0	10	172
FY 2010	50	57	59 (Private) 30 (State)	0	10	206
FY 2011	50	57	59 (Private) 50 (State)	0	10	226
TOTAL	242	356	286	0	50	934

*In the category for individuals with MR/DD, 'private' refers to privately run ICFs/MR and 'state' refers to state-run ICFs/MR.

** "Other" includes individuals with traumatic brain injury (TBI).

II. Proposed Services for Transitioned Individuals in Each Target Group

A. Participant Recruitment and Education

In two geographic areas, KDoA will pilot a process that uses data elements from the Minimum Data Set (MDS) for nursing facilities to identify elderly and physically disabled consumers who prefer returning to the community. Potential participants will be contacted by an Area Agency on Aging (AAA) case manager or Center for Independent Living (CIL) counselor, who will notify them of the MFP Demonstration and determine their current potential for discharge. KDoA will evaluate specific outcomes to determine how this potential participant identification process should be implemented statewide.

Several approaches will be used to recruit consumers with MR/DD. All such persons who receive institutional services will be informed about home and community-based services through Community Developmental Disability Organizations (CDDO). In addition, for the MFP Demonstration, Kansas has targeted one large private ICF/MR for closure (60+ clients), and will target all remaining ICFs/MR for voluntary closure through an incentive package. All individuals in State Mental Retardation Hospitals (SMRH) will be notified of the MFP Demonstration and offered the opportunity to receive home and community-based services, including 90 individuals with offender behaviors or other behaviors that have made them difficult to serve in their communities.[7]

B. Eligibility Criteria, Screening and Assessment Methods and Tools

Kansas will develop an MFP qualifying eligibility assessment tool. Screening and assessments will continue to be conducted by the gateway agencies that serve each of the MFP populations: CDDOs serve

[7] Kansas defines "offender behavior" in a broad manner. These behaviors may include sexual offender tendencies; however, such individual has not been charged or adjudicated. The offender behavior may alternatively or additionally be aggressive, violent, or self-destructive.

all individuals seeking MR/DD services; Kansas Independent Living Centers (KILC) serve individuals seeking PD or TBI services; AAAs act as the single point of entry for the elderly in the long-term care system.

C. Demonstration Services

Four 1915c waiver programs will be used to serve MFP participants. Kansas is in the process of responding to questions from the Centers for Medicare & Medicaid Services (CMS) about its State Plan amendment to provide targeted case management (TCM) for the PD waiver; currently, TCM services for the PD population are operational. MR/DD, TBI, and Frail Elderly home and community-based services consumers already receive TCM through the State Plan. Finally, Kansas will explore amending all four waivers to include transition services that will provide allowable costs to establish consumers in the community after they exit institutions.

- **Qualified Home and Community-Based Services**: MFP participants will be served by the following waivers: HCBS-Frail Elderly (FE), HCBS-Physical Disabilities (PD), HCBS-MR/DD, and HCBS-TBI.
- **Home and Community-Based Demonstration Services**: Start-up services, including the payment of one-time non-room and board costs, such as deposits and the costs of setting up a living situation.
- **Supplemental Demonstration Services**: All participants will receive necessary housing modifications. TBI and MR/DD beneficiaries will receive services from the Building Community Bridges program, designed to meet a consumer's needs to live successfully in his/her home community. Participants with offender behavior patterns transitioning from SMRHs will receive support team training and therapeutic supports (technology). Beneficiaries with TBI or PD will have access to one-time adaptive equipment, supplies, and training not otherwise covered, and TBI beneficiaries will have access to staff training for their personal case assistants.

D. Self-Direction Options for MFP Demonstration Participants

All MFP participants will have the opportunity to hire, train, and supervise their own attendants. In addition, a recent MR/DD waiver amendment incorporates increased individual budget control and an increase in the number of services that can be self-directed. All HCBS waivers will utilize the Kansas Personal Assistance Supports and Services (K-PASS) "Self-Direction Tool Kit" as the basic training tool for consumers seeking to self-direct services. The state also plans to use its 2006 RCST Grant to expand options for self-direction. Self-directed services give consumers in rural areas the opportunity to hire relatives, neighbors, or friends, thus minimizing the problems associated with limited availability of providers in those communities.

E. Home and Community-Based Housing Options and Strategies

SRS and KDoA will coordinate with other state agencies, private resources, and advocates to identify housing gaps, barriers, resources, existing model projects, and successes that could be replicated statewide.

F. Workforce Strategies

SRS and KDoA will coordinate with other state agencies, private resources, and advocates to identify education, training, support, pay, and benefits needed to assure a stable direct-care workforce.

III. CHALLENGES TO REBALANCING THE LONG-TERM CARE SYSTEM AND EXPANDING HOME AND COMMUNITY-BASED SERVICES

- Kansas lacks sufficient affordable, safe, and accessible housing for transitioning consumers.
- The state faces challenges in recruiting and training direct-care staff.
- Transportation options for transitioning consumers are inadequate.
- Consumers who could transition to the community often lack the basic necessities to set up an apartment or home, including rental deposits, household items, and utility fees.
- Community providers have found it difficult to provide services to some MR/DD consumers with offender behavior patterns who are currently housed in SMRHs.
- Some potential transition consumers are unaware of the necessary life skills needed to live, work, and pursue leisure activities successfully in their home communities. This is particularly true of consumers with TBI and MR/DD.

IV. QUALITY MANAGEMENT STRATEGY

Kansas plans to strengthen the cross-waiver components of its Quality Management Strategy, using funds from its 2006 RCST Grant. The state will work with stakeholder groups to develop and implement quality assurance and performance reporting tools, enabling it to identify trends across waivers. In addition, the MFP Demonstration Steering Committee will develop an addendum to the current quality assurance monitoring tool to provide non-intrusive assurance that identified needs are met and all required supports are in place for MFP participants.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

SRS is the lead agency for this Demonstration, and operates three of the four waivers (MR/DD, PD, and TBI) through which MFP participants will receive services. KDoA administers the fourth waiver, HCBS/FE. KHPA is the single State Medicaid Agency, and will collaborate closely with KDoA and SRS on the MFP Demonstration.

B. MFP Program Oversight/Key Stakeholder Involvement

At least 51 percent of the membership of the MFP Steering Committee for Community Choice will be comprised of consumers. Other members will include advocacy organizations across all disabilities, community service providers, provider organizations, and state agencies. Fourteen consumer and advocacy groups assisted with the development of the MFP application, and will continue to collaborate with the state during implementation.

C. IT System Developments or Enhancements

SRS already has a website that includes a self assessment tool to help users determine benefits and services for which they may be eligible, as well as an online application tool. The 2005 ADRC and 2006 RCST Grants will fund enhancements to the state's existing IT system that will benefit the MFP Demonstration. Specifically, Kansas will develop a virtual resource center to streamline access consumer information. Also, KDoA, KHPA, and SRS will work to integrate their IT systems. While their systems currently communicate, a more integrated system will enhance data collection, analysis, trending, and comparisons on the quality and outcomes of services rendered in community-based settings.

D. Independent State Evaluation

No additional evaluation funds are requested for the MFP Demonstration. However, evaluation activities planned as part of the 2006 RCST Grant will include elements relevant for the Demonstration, such as the development of structures to ensure an effective cross-disability-system ongoing evaluation and improvement process.

KENTUCKY MFP GRANT PROGRAM SUMMARY

Grantee Agency: Department for Medicaid Services (DMS)

Total Award: $49,831,580

Overview: The Kentucky MFP Demonstration, which will provide self-direction opportunities to all participants, will build on resources and processes developed during its nursing facility transition pilot project, which was funded by a 2001 Real Choice Systems Change Grant. The Demonstration seeks to close some of the system gaps identified during the transition pilot and address some of the unique challenges faced by clients residing in rural areas.

Transition Target Groups: Residents of nursing homes (both elderly and physically disabled), individuals with mental retardation or developmental disabilities (MR/DD), and individuals with acquired brain injuries.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Kentucky will increase the number of individuals receiving home and community-based services.
- **Money Follows the Person/Flexible Budgeting Goals:** For each MFP participant, DMS will transfer a percentage of the annual cost of facility-based care to the appropriate home and community-based services (HCBS) waiver program.
- **Continuity of Service to Transitioned Individuals:** Kentucky's HCBS waiver programs will continue to be available to MFP participants after the Demonstration.
- **Quality Assurance and Improvement:** Kentucky will expand its current quality management strategy to include periodic monitoring of transitioned MFP participants.
- **Other State Goals:** Kentucky will seek to eliminate the transportation gap in rural areas of the state and develop additional housing opportunities for MFP participants. All transitioning consumers will have the choice of self-directing non-medical waiver services.

B. Annual Transition Targets[8]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	30	11	29	0	0	70
FY 2008	47	30	42	0	0	119
FY 2009	47	30	42	0	0	119
FY 2010	47	30	42	0	0	119
FY 2011	47	30	42	0	0	119
TOTAL	218	131	197	0	0	546

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

The Demonstration first will target residents of intermediate care facilities for the mentally retarded (ICFs/MR) and nursing facilities. During the second year of the program, the state will begin targeting individuals with brain injuries. DMS is identifying resources to assist in outreach and education to facility residents, and to identify and assist facility residents choosing to transition.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

DMS is reviewing and revising screening and assessment tools developed under Kentucky's Real Choices grant, along with tools already being utilized for the state's HCBS waivers.

C. Demonstration Services

MFP participants will be served through one of three HCBS 1915c waivers. DMS will review the current waivers and program regulations for any additional services that will be required for individual target populations, and will submit waiver and regulation amendments as necessary. MFP participants wishing to access the Support for Community Living (SCL) and Acquired Brain Injury (ABI) waivers will be able to bypass the waiting list requirements. The Home and Community-Based Waiver (HCB) does not have a waiting list.

- **Qualified Home and Community-Based Services**: the HCB waiver for the elderly and physically disabled, the SCL waiver for individuals with MR/DD, and the ABI waiver.
- **Home and Community-Based Demonstration Services:** None mentioned.
- **Supplemental Demonstration Services**: Supplemental services include assistive technology, transition specialists, home modifications and electronic aids to daily living (EADL), and housing-related transition costs (one-time transition costs, including security deposits, basic furnishings, food, household items and goods, and utility deposits, up to $2,000). DMS also has identified additional

[8] The state has revised its transition targets since the grant award, from a total of 431 to the new total of 546. This increased number of transitions also reflects the state's decision not to transition any individuals with acquired brain injuries during the first year of the Demonstration.

transition services, which include medication reminders, medication administration, and Personal Emergency Response Systems (PERS).

D. Self-Direction Options for MFP Demonstration Participants

All MFP participants will have access to a consumer-directed waiver option that allows members to self-direct non-medical services, such as respite, personal care, and companion services. The consumer-directed option for all three waiver programs will be coordinated through regional Area Agencies on Aging (AAAs).

E. Home and Community-Based Housing Options and Strategies

The Kentucky Housing Corporation (KHC) will create a strategy that provides access to housing for MFP participants through Section 8 housing vouchers, vacant project-based housing units, and tenant-based rental assistance funded by the HOME Investment Partnerships Program. KHC also is financing the development of four rental housing projects to serve participants with MR/DD. The Kentucky Assistive Technology Load Corporation (KATLC) provides low 5.5 percent interest loans to qualified applicants with disabilities for purchase of assistive technology, home modifications, or EADLs. DMS also will engage in negotiations with other housing authorities to address the lack of affordable and accessible housing.

F. Workforce Strategies

None mentioned.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- Two HCBS waivers have significant waiting lists: ABI (117 for a program with 135 total slots), and SCL (2,806 for a program with 3,201 total slots).
- There are gaps in existing community resources that make it difficult to transition individuals with ABI back into the community successfully.
- Community waiver providers cannot complete their assessments until an individual has already transitioned to the community, resulting in a delay in services of up to eight weeks.
- Community waiver providers are unable to provide services seven days a week, making transition impossible for individuals requiring that level of service.
- Many communities do not have any waiver service providers, limiting clients' choices of where to locate.
- A lack of specialized or public transportation in rural areas may result in a participant becoming isolated after transitioning to the community.
- Kentucky lacks sufficient affordable and accessible housing for transitioning consumers.
- Inadequate reimbursement has made hiring and retaining direct-care staff difficult.
- Current funding is based on a medical model, rather than individualized community supports, resulting in reduced flexibility to serve clients.
- Facilities need education in community alternatives and how to assist consumers wishing to transition. For example, there is a lack of awareness about the benefits and availability of assistive technology.

IV. QUALITY MANAGEMENT STRATEGY

In addition to the Quality Management Strategy followed for traditional waiver members, MFP participants will receive on-site reviews of their plans of care and current support systems three, six, nine, and twelve months after transition. Member outcomes and satisfaction will be monitored through client satisfaction surveys distributed during on-site monitoring visits.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

DMS will be responsible for managing the MFP Demonstration, and will work closely with the Department of Aging and Independent Living, the Department of Mental Health and Mental Retardation, and KHC. Other state agencies, including the Department of Transportation, also are assisting in the development of the Demonstration.

B. MFP Program Oversight/Key Stakeholder Involvement

A statewide MFP Steering Committee will act as an advisory committee to address issues and concerns related to development of the Demonstration. The committee is made up of partnering agencies, Medicaid recipients and their representatives, advocacy groups, and providers.

C. IT System Developments or Enhancements

The current Medicaid Management Information System (MMIS) will need modifications to enable it to track and identify clients who have transitioned to the community, and to establish the financing structure for transferring funds from facilities to community resources.

D. Independent State Evaluation

None mentioned.

LOUISIANA MFP GRANT PROGRAM SUMMARY

Grantee Agency: Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), in collaboration with the Offices for Citizens with Developmental Disabilities (OCDD) and Aging and Adults Services (OAAS)

Total Award: $30,963,664

Overview: Louisiana's MFP program will utilize three existing home and community-based services (HCBS) waivers, two new waivers—one for developmental disabilities and one for adults and elders, as well as State Plan services. The program will attempt to fill gaps in access to HCBS, to assist the state in accomplishing existing plans for rebalancing the long-term care system, and to address housing and workforce challenges exacerbated by Hurricanes Katrina and Rita. Several CMS Systems Change and Transformation Grants have supported the development of assessment tools, information technology, and quality management infrastructure that will contribute to the success of MFP.

Transition Target Groups: Elderly, adults with physical disabilities, and individuals (elders, adults and children) with developmental disabilities.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Louisiana will increase spending on home and community-based services as a proportion of total long-term care spending by at least 1 percent annually throughout the Demonstration. The state will increase the number of people served in home and community-based settings and decrease the number served in institutions. The state will reduce bed capacity at intermediate care facilities for the developmentally disabled (ICFs/DD) and provide supports to downsize ICFs/DD with 16+ consumers to smaller-sized facilities or group homes.
- **Money Follows the Person/Flexible Budgeting Goals:** The state will continue using a single Medicaid appropriation for payment of private facility and home and community-based service providers, and has legislative authority to provide funding to move consumers in state-run ICFs/DD to community placements.
- **Continuity of Service to Transitioned Individuals:** Ongoing home and community-based services will remain consistent with that offered during the Demonstration. When children who are participating in the DD Children's Choice Waiver turn 19, they will receive a targeted slot in the DD New Opportunities Waiver, a comprehensive waiver for adults with DD.
- **Quality Assurance and Improvement:** Louisiana will develop a unified and IT-supported quality management system that crosses long-term care programs and services.
- **Other State Goals:** The state will expand self-direction options, increase the number of accessible housing units available to consumers with disabilities, and address the shortage of direct-care service workers.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	53	12	108	0	0	173
FY 2009	60	10	90	0	0	160
FY 2010	66	14	62	0	0	142
FY 2011	185	40	60	0	0	285
TOTAL	364	76	320	0	0	760

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

DHH will target private ICFs/DD who have indicated their willingness to voluntarily close beds vacated by Demonstration participants. Ombudsmen from the Community Living Ombudsman Program, who visit all private ICFs/DD on a quarterly basis, also will identify potential participants. All residents of state-run ICFs/DD will be offered the option to participate in the Demonstration. Children with DD will be identified via the Medicaid Management Information Systems (MMIS) database.

Current HCBS waiting lists will be used to identify adults with physical disabilities and the elderly in nursing homes. OAAS will target individuals who entered nursing facilities as a result of Hurricanes Katrina or Rita and also will compile a list of residents who indicated their preference to transition to the community in the nursing facility minimum data set (MDS). The LTC Ombudsman program will contact people identified by OAAS and respond to those who self-identify.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The Supports Intensity Scale (SIS) and accompanying Louisiana Plus (LA Plus) assessment will be used for comprehensive assessment of clients with MR/DD. For the elderly and physically disabled, the MDS-based Level of Care Eligibility Tool (LOCET) will be used, along with the MDS-Home Care (HC) assessment and functional-eligibility determination tools.

C. Demonstration Services

MFP participants will be served through one of three existing waivers (the Adult Day Health Care Waiver, DD Children's Choice Waiver, and Elderly and Disabled Adult Waiver), as well as two proposed 1915c waiver programs. The two proposed waivers submitted to the Centers for Medicare & Medicaid Services (CMS) are the Adult Residential Care Program Waiver, which follows an assisted living model, and the DD Residential Options Waiver (ROW), which increases the array of services available to support people transitioning from ICFs/DD. ROW offers living options in individual or family housing, with a live-in caregiver (one or two people), or with shared living supports (three or four people, or up to six, in special circumstances). All ROW services will be available to MFP participants, except the six-person shared living situation, which is not a qualified residence. To ensure that MFP participants have access to existing waiver programs despite long waiting lists, the state will target slots for MFP/institutional transition; new waivers will include MFP in their targeting criteria. Youths who age out of eligibility for

the Children's Choice Waiver will have access to Louisiana's New Opportunities Waiver (NOW). The state already has targeted NOW opportunities for Children's Choice participants.

BHSF also will need to secure State Plan amendments to include case management for individuals transitioning from nursing homes, and will pursue an amendment to facilitate the acquisition of durable medical equipment prior to transition. The Program of All-Inclusive Care for the Elderly (PACE) has recently been introduced as a State Plan option, and will be available to MFP participants in selected geographic areas. Long-Term Personal Care Services (LTPCS), which provides up to 56 hours a week of personal attendant services, also will be available to MFP participants.

- **Qualified Home and Community-Based Services**: DD Residential Options Waiver (proposed), Adult Residential Care Program Waiver (proposed), Adult Day Health Care Waiver, DD Children's Choice Waiver (with access to the DD New Opportunities Waiver at age 19), Elderly and Disabled Adult Waiver, PACE program (State Plan), Case Management (State Plan), Long-Term Personal Care Service (State Plan)
- **Home and Community-Based Demonstration Services:** None mentioned.
- **Supplemental Demonstration Services:** None mentioned.

D. Self-Direction Options for MFP Demonstration Participants

Self-direction components are planned for the Residential Options Waiver in 2008. Beginning in 2008, Louisiana will pilot a self-direction option in its LTPCS program. Further expansion of its self-direction options will be assessed during MFP.

E. Home and Community-Based Housing Options and Strategies

Federal funds for post-Katrina housing recovery in Louisiana will be used to build 3,000 units of Permanent Supportive Housing (PSH) for people with disabilities. Community Development Block Grants will be used to rebuild small rental properties damaged or destroyed by the hurricanes; incentives to create additional PSH will be incorporated into this program. Finally, housing authorities are developing a statewide Web-accessible affordable housing database and locator service that includes detailed information about accessibility features.

F. Workforce Strategies

Louisiana was granted a 2006 National Direct Support Workforce (DSW) Resource Center Intensive Technical Assistance award that will examine possible wage and benefits enhancements, develop recruitment programs, expand utilization of "Career Pathways" (a paraprofessional program), and identify short-term interventions to address the immediate shortage of DSW services in areas impacted by Hurricane Katrina.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- Community advocates have had difficulty in securing legislative and political support for measures that would fully consolidate budgeting of long-term care services. Proposals for the closure of public nursing facilities and ICFs/DD have met with consistent opposition from interest groups who have been successful in lobbying against closure.
- Louisiana has extensive waiting lists for its HCBS programs. The waiting list for the Elderly and Disabled and Adult Day Health Care waivers was 7,419 as of August 2006, and 14,786 were on waiting lists for DD waivers as of December 2005.

- The state lacks a comprehensive and coordinated approach to quality management that cuts across long-term care programs and services, and also lacks the information technology to support such an approach. Most data is currently collected on paper.
- The challenge of providing affordable housing for people with disabilities has intensified as a result of Hurricane Katrina. Public Housing Authorities in Louisiana have long waiting lists for Section 8 housing, and have little data regarding people with disabilities on the lists.
- DHH does not have the legislative authority to remove beds from private ownership in either nursing facilities or ICFs/DD, resulting in the maintenance of excess bed capacity. In addition, Louisiana levies provider fees on these facilities, but is prohibited from levying provider fees on home and community-based services. Therefore, the loss of a bed in the institutional system through MFP lowers state revenue and reduces the cost-effectiveness of the move.

IV. QUALITY MANAGEMENT STRATEGY

Supported by a Systems Transformation Grant, Louisiana is developing a quality management system (QMS) that crosses long-term care programs and services. This QMS will be expanded to include elements specific to the Demonstration. OCDD is piloting a quality management process to track people with DD transitioning from ICFs/DD. The process includes the pre-transition collection of individual baseline data, as well as face-to-face followups starting at 30 days post-move and continuing at intervals for two years. Elements of this pilot may be appropriate for implementation in the Demonstration program. The state proposes ongoing tracking of data elements related to (1) reasons why people do not complete the transition process, (2) barriers that present delays to participants' transition, (3) reasons for readmission into an institution, and (4) challenges participants experience when moving to home and community-based settings.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The Bureau of Health Services Financing (BHSF) within the Department of Health and Hospitals (DHH) is the state Medicaid office and will be the lead agency for the MFP Demonstration. BHSF will partner with the Office for Citizens with Developmental Disabilities (OCDD) and the Office of Aging and Adults Services (OAAS), also located within DHH. OCDD has administrative and budgetary responsibility for all DD waivers and public and private ICFs/DD. OAAS has administrative and budgetary responsibility for aging/adult waivers, State Plan personal care, and the nursing home program.

B. MFP Program Oversight/Key Stakeholder Involvement

Consumers, family members, ICF/DD providers, nursing facility providers, direct support staff, home and community-based service providers, support coordinators, advocates, ombudsmen, and mental health advocates were involved in developing the MFP application through regularly scheduled meetings, focus groups, stakeholder listening sessions, and a public Website. All of these groups also are part of a standing committee that exists to provide guidance for the Louisiana Department of Health and Hospitals' Systems Transformation initiative. The group meets quarterly and will be used on an ongoing basis during the Demonstration.

C. IT System Developments or Enhancements

The SIS/LA Plus assessment tool has been automated to provide summaries and checklists of identified needs for waiver participants with DD. In 2008, OAAS will implement a standardized automatic care planning software tool designed to integrate the MDS-HC assessment instrument and the MDS-based LOCET. Louisiana also is developing a unified and IT-supported quality management

system that crosses long-term care programs and services. The state proposes to develop a method of flagging Demonstration participants to enable efficient fiscal management.

D. Independent State Evaluation

None mentioned.

MARYLAND MFP GRANT PROGRAM SUMMARY

Grantee Agency: Maryland Department of Health and Mental Hygiene (DHMH)

Total Award: $67,155,856

Overview: The state proposes to build on the existing state "Money Follows the Individual" policy and other state long-term care initiatives to transition (statewide over five years) 2,413 residents of six months or more in nursing homes and other institutions to home and community-based settings. Demonstration participants will have a full range of qualified home and community-based services (HCBS), Demonstration, and supplemental services and will work with peer mentors to successfully transition.

Transition Target Groups: Those residing for six months or longer in nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) who are Medicaid-eligible for 30 days at the time they become participants in the Demonstration. Participants must continue to require an institutional level of care to remain in the Demonstration.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals[9]

- **Rebalancing Goals:** The state intends to transition numerous individuals from institutions to community settings, while developing a broad strategy for long-term care reform.
- **Money Follows the Person/Flexible Budgeting Goals:** None mentioned.
- **Continuity of Service to Transitioned Individuals:** The state asserts that no Demonstration participant will experience a diminished set of program services at the end of the 12-month Demonstration period; the only changes will be in response to shifts in participants' needs.
- **Quality Assurance and Improvement:** The state is now improving its existing comprehensive quality management system for home and community-based services (HCBS) using the Centers for Medicare & Medicaid Services (CMS) Quality Framework as the basis for program evaluation.
- **Other State Goals:** Develop and implement an improved, expanded, accelerated transition assistance process to more effectively and rapidly bridge the gap between institutional and community living. Work closely with Maryland Access Point (MAP), the state's Aging and Disability Resource Center (ADRC), to implement a statewide single point-of-entry system.

[9] The original state application included features of an 1115 waiver called "Community Choices" as part of its proposed MFP plan. However, the state withdrew the 1115 application and therefore this summary reflects the application without Community Choices content.

B. ANNUAL TRANSITION TARGETS[10]

MFP transition participants must reside in an eligible institution for at least six months and be Medicaid-eligible for 30 days on the first day of their participation in the Demonstration.

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
SFY 2008*	144	61	25	0	0	230
SFY 2009	312	163	50	0	0	525
SFY 2010	362	184	50	0	0	596
SFY 2011	411	217	50	0	0	678
SFY 2012	238	121	25	0	0	384
TOTAL	1,467	746	200	0	0	2,413

*Maryland's fiscal year begins July 1 and state fiscal year 2012 includes transitions through December 31, 2011.

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

The state plans to perform aggressive outreach to advise potential participants about community living opportunities, introduce them to peer mentors who have successfully transitioned to home and community-based settings, and educate potential participants to make an informed decision regarding the available options and services. Maryland law requires that nursing home providers inform new residents of community-based service options. The state will use existing eligibility, claims, and encounter data along with the Minimum Data Set (MDS) data to identify and target potential participants. Additionally, the state will employ transition teams to identify priority areas and meet with residents and consumer advocates in those areas to inform them about the Demonstration and transitioning opportunities. The state will develop a mechanism to train volunteer peer mentors to visit institutions and assist those interested in applying for appropriate waiver services.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The state plans to strengthen and streamline the process by which individuals are determined to be eligible for community-based services.

C. Demonstration Services

MFP participants will be served by existing home and community-based waiver programs and Medicaid State Plan services for which the person is eligible, including personal care, adult medical day care, occupational therapy, physical therapy, and durable medical equipment (DME). Maryland has

[10] Initial state application showed 3,106 total transitions, but numbers were modified once the state withdrew its waiver application for managed long-term care. The transition targets differ from those captured in the state's original MFP application in part because the state modified its targets since the MFP planning period was extended to a full year, as recommended by CMS.

seven existing HCBS waiver programs, among them the Older Adult Waiver, Living at Home Waiver, Community Pathways Waiver (DD), and the New Directions Waiver (self-directed model for DD services). The state will consider amending the Older Adult and Living at Home Waivers to align the service packages.

- **Qualified Home and Community-Based Services:** This encompasses the state's existing array of HCBS Waiver services as well as optional Medicaid State Plan services for which the individual is eligible. The waivers and the State Plan include transportation services to assist individuals to get to medical appointments and subsidized transportation for those with disabilities.
- **Home and Community-Based Demonstration Services:** The state is exploring the possibility of making more widely available some waiver services that are currently only available to certain waiver populations.
- **Supplemental Demonstration Services:** The state is considering offering a housing cost subsidy for 12 months post-transition, pantry set-up, and transportation cost assistance for 3 months post-transition.

D. Self-Direction Options for MFP Demonstration Participants

A large percentage of personal care in the state is currently provided by independent, non-agency providers. The Living at Home Waiver for young adults with disabilities allows consumers to manage their personal care services. The New Directions Developmental Disabilities Waiver allows consumers to use fiscal intermediaries and have control over individualized budgets. To support the movement towards self-direction, the state is funding a project called *My Life: Going Far* that aims to foster personal and collective empowerment of individuals and family members in the State. The state plans to continue to use consumer-directed models under the MFP Demonstration.

E. Home and Community-Based Housing Options and Strategies

The state provides several housing programs and initiatives to assist individuals in locating and securing affordable housing. For example, the Maryland Department of Housing and Community Development (DHCD) administers the Homeownership Program for Individuals with Disabilities, which provides below market rate financing and exceptions to individuals who have poor credit due to medical expenses, and the More House 4 Less program, which provides competitive financing and closing cost assistance. Through these programs, the DHCD will explore the possibility of providing closing cost assistance in the form of a one-time down payment sum to match contributions from MFP Demonstration participants. The Bridge Subsidy Program, which provides short-term rental assistance to Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) beneficiaries, will be expanded and will target Demonstration participants. DHCD has also created an online searchable database of affordable rental housing. In addition to these initiatives, the state plans to expand housing transition services and make available to those targeted for the Demonstration a one-time expenditure for setting up housekeeping.

F. Workforce Strategies

None mentioned.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

The state conducted six focus groups in nursing facilities and held two meetings to solicit stakeholder input on the perceived gaps in existing home and community-based services. Challenges identified by the state and stakeholders include the following:

- Maryland lacks of mental health/substance abuse services for both institutional and community-dwelling older adults and persons with disabilities.
- The state has a fragmented budget for long-term care Medicaid services. Institutional care is funded under the Medicaid State Plan without operational caps. However, each HCBS waiver is funded by a separate State appropriation that is subject to enrollment caps based on budgetary constraints.
- There is a scarcity of affordable and accessible housing, as well as inadequate supports to assist in locating housing in the community.
- Unreliable transportation services and difficulty obtaining transportation services that cross county lines are challenges for participants.
- There is a current lack of peer mentoring for individuals in institutionalized settings.
- Maryland lacks a single point of entry to access accurate and timely information and counseling on community care options.
- The lengthy eligibility process impedes the transitioning process.
- There are inconsistent services across HCBS waivers.

IV. QUALITY MANAGEMENT STRATEGY

The state is in the process of improving its existing comprehensive quality management system for home and community-based services and is using the CMS Quality Framework as the basis for program evaluation. During the pre-implementation period and the first year of the Demonstration, the state will work in partnership with consumer and provider stakeholders to develop and implement improvements to its existing quality management system for community-based services. It will also explore the potential for developing quality indicators and performance measures directly tied to the Demonstration. The state will also consider using information technology (IT) more effectively as a monitoring mechanism for quality assurance purposes.

V. ADMINISTRATION, EVALUATION, AND OVERSIGHT

A. Role and Involvement of Other State Agencies

The state will continue to foster cross-agency collaboration—among for example, the Departments of Health and Mental Hygiene, Aging, Disabilities, Human Resources, and Housing and Community Development—to ensure success of the MFP Demonstration. The Demonstration is one part of a larger statewide cross-agency effort to increase and improve the services, choices and self-direction opportunities for Maryland's residents who rely on Medicaid and state programs for their long-term care needs.

B. MFP Program Oversight/Key Stakeholder Involvement

The Department of Health and Mental Hygiene, the single state Medicaid agency, will administer the MFP Demonstration. The state will continue to engage stakeholders in both the pre- and post-implementation phases of the Demonstration to gather and share information, obtain community feedback, and obtain decision-making recommendations.

C. IT System Developments or Enhancements

The state will identify ways in which it can use its current IT resources to identify each Demonstration participant and their start and end date of their enhanced match period. In addition, it will develop and test data reporting and coding to capture performance measurement and other Demonstration

data, enabling the evaluation and quality management components of the Demonstration to operate with real data on all participants. The Aging and Disability Resource Center, known as Maryland Access Point (MAP), will develop a statewide Web-based searchable database to provide quick access to long-term care provider and program information. MAP is also planning to implement an application tracking system and an integrated Web-based application process that enables simultaneous application to different programs.

D. Independent State Evaluation

None mentioned.

MICHIGAN MFP GRANT PROGRAM SUMMARY

Grantee Agency: Jointly operated by the Medical Services Administration (MSA), which operates the state Medicaid program, and the Office of Long-Term Care Supports and Services, within the Michigan Department of Community Health (MDCH).

Total Award: $67,834,348

Overview: The program builds on current long-term care initiatives to transition at least 3,100 individuals (statewide over five years) from nursing facilities or hospitals to homes or qualified community residences. Current initiatives include the MI Choice waiver program for elderly and people with disabilities, the Home Help State Plan personal care program, the 2006 initiation of a Single Point of Entry Program, and the development of a demonstration program for a prepaid, capitated model of long-term care services.

Transition Target Groups: The elderly and adults with physical disabilities—the same populations served by MI Choice waiver for elderly and disabled—who have resided in an institution or hospital for at least six months and who receive Medicaid services for the 30 days prior to transition. In the third year of the Demonstration, state intends to make MI Choice waiver services available in licensed residential settings in order to create an alternative for individuals with dementia but minimal nursing needs.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Increase the percent of long-term care spending represented by home and community-based services by 3 percent by 2011, increase annual MI Choice waiver spending by $30 million by 2011, and increase the number of people serviced by the state Home Help program by 500 over five years.
- **Money Follows the Person/Flexible Budgeting Goals:** The current legislative appropriation for long-term care services is divided into separate lines for nursing facilities, the MI Choice waiver and other services. The department will work with the legislature to roll those lines into a single long-term care line for fiscal year 2008, creating greater flexibility for responsive financing. The state will use its Systems Transformation Grant to develop a 1915b/c waiver to pilot a prepaid, capitated long-term care model.
- **Continuity of Service to Transitioned Individuals:** Individuals transitioned will continue as participants of either the MI Choice waiver or the Home Help Program.
- **Quality Assurance and Improvement:** Integrate the state's data warehouse of Medicaid claims records, the University of Michigan Institute of Gerontology's store of the long-term care Minimum Data Set (MDS), and the MDS-Home Care for the MI Choice waiver assessments. Further, Michigan is developing and will revise a Participant Outcomes and Status Measures (POSM) instrument.

- **Other State Goals:** Develop and provide housing coordination services to individuals transitioning to the community; develop within the MI Choice waiver for elderly and disabled the option of receiving services in licensed settings, allowing for the transition of at least 600 individuals (of the total 3,100) to qualified residential setting.

B. Annual Transition Targets[11]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	60	40	0	0	0	100
FY 2008	240	160	0	0	0	400
FY 2009	360	240	0	0	0	600
FY 2010	540	360	0	0	0	900
FY 2011	660	440	0	0	0	1,100
TOTAL	1,860	1,240	0	0	0	3,100

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

The state will implement a Single Point of Entry system statewide by 2009; this system will have the responsibility to educate the community about long-term care and to support families and caregivers in their roles. Recruiting strategies will build upon those developed during Michigan's 2001 transition grant and subsequent efforts, including (1) marketing to nursing facility staff, residents and family members through presentations, letters and former nursing facility residents, (2) marketing to secondary audiences, including senior groups and places of worship, (3) referrals from nursing facilities, residents, families, long-term care ombudsmen and others who have direct contact with residents, and (4) contact with consumers and families made through the Single Point of Entry agencies. Marketing and outreach materials and presentations will emphasize community-based options, consumer rights, person-centered planning and self-determination options. Concentrated, targeted outreach will occur when a nursing facility is closing or at risk of closing.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The same populations served in Michigan's MI Choice waiver for elderly and disabled will be eligible for the MFP. Specifically, individuals living in nursing facilities or hospitals for at least six months and receiving Medicaid services for the 30 days prior to transition are eligible. The project plans to service broadly and avoid targeting subgroups of residents.

The MI Choice waiver agencies have broad responsibilities for screening and referrals to service programs. The Single Point of Entry demonstration sites will use a single electronic record for each

[11] Initial state application appendix showed 2,440 total transitions, but state clarified that there will be 3,100 transitions (as listed in the main body of the application).

transitioning individual in which standardized assessments will be available along with user-defined assessments. Centers for Independent Living also participate in the process.

C. Demonstration Services

Transition services will be available through Michigan's Single Point of Entry programs; where these are not available (as noted above, the programs will expanding statewide by 2009), participants can access services through the MI Choice waiver agencies and Centers for Independent Living (CILs). The state anticipates submitting waiver amendments to increase the number of people served by the existing waiver, as well as an amendment to serve those in licensed residential settings, which the state hopes to use to stimulate the availability of small residential facilities as alternatives to nursing facilities.

- **Qualified Home and Community-Based Services**: Services currently available through the MI Choice waiver program will be covered—including support coordination for up to six months prior to the transition for the purpose of developing a transition plan and making the necessary arrangements, and coverage for transition expenses, such as housing deposits. In addition, the MI Choice waiver recently added self-direction for certain services, and the Home Help Program provides State Plan personal care services.
- **Home and Community-Based Demonstration Services**: The project will include housing coordinators located within Single Point of Entry agencies. During the person-centered planning process, these coordinators will work with individuals who are transitioning.
- **Supplemental Demonstration Services:** None mentioned.

D. Self-Direction Options for MFP Demonstration Participants

Since 2006, the amended MI Choice waiver has provided self-directed options. The Home Help program is the other option for community-based services, and it has a long history of providing self-directed services through which consumers can select supervise, and fire their personal care workers. The Single Point of Entry program will use person-centered planning and self-direction as standard operating procedures.

E. Home and Community-Based Housing Options and Strategies

The project proposes to fund housing coordinators in the Single Point of Entry programs. The Michigan State Housing Development Authority's set-aside for people with disabilities in its Qualified Allocation Plan provides tax credits for the development of suitable housing and incentives for a lottery for housing developers. These result in the creation of approximately 100 new affordable, accessible housing units in the state each year.

F. Workforce Strategies

Michigan's legislature recently authorized a $20 million increase in wages for Home Help program workers, which will give each worker an additional $0.50 to $2.00 per hour. The state believes this will make it easier to hire and retain qualified personal care workers for the MFP program. Additionally, the Michigan Quality Community Care Council provides a worker registry, and screening and training for Home Help workers.

III. CHALLENGES TO REBALANCING THE LONG-TERM CARE SYSTEM AND EXPANDING HOME AND COMMUNITY-BASED SERVICES

- Long-term care funding is split into separate line items, and moving funding across program areas requires legislative approval. Furthermore, funding for the MI Choice waiver is capped at $100 million per year, which limits its growth; changing this requires legislative action.
- Low overall state spending on long-term care constrains how much can be budgeted for all Medicaid programs, resulting in a general resistance to new initiatives.
- Daily MI Choice Waiver rates are not sufficient to support individuals with high needs transitioning from nursing facilities. The project budget includes a $10 per day increase in the per diem (the daily rate is currently $41, plus $9 for case management and administration).
- There are two barriers that limit the availability of affordable, accessible housing: (1) the need for more housing coordinators, and (2) MI Choice wavier services are not currently available in licensed settings.

IV. QUALITY MANAGEMENT STRATEGY

Overall, Michigan does not have a comprehensive quality system for long-term care. Each program has a quality management practices, but an integrated system is needed. The state quality plan is based on the Michigan Department of Community Health (MDCH) quality assurance reviews, monitoring, and incident reporting that is provided by MDCH staff and/or the University of Michigan School of Nursing. The use of MDS-based assessments in nursing facilities and the MI Choice waiver provide a basis for an integrated system.

Michigan's MI Choice quality management plan is built on the Centers for Medicare & Medicaid Services (CMS) Review Protocols and Quality Framework, and uses a statewide strategy to assess and improve the quality of MI Choice Waiver services. It supports more than twenty-one local waiver agency quality management plans. Procedures include reviewing: level of care, individual care plans, qualified providers, and reporting of suspected abuse, neglect, and exploitation.

V. ADMINISTRATION, OVERSIGHT AND EVALUATION

A. Role and Involvement of Other State Agencies

The MFP program will be supported by inter- and intra-agency collaboration with the Medical Services Administration, the Office of Long-Term Care Supports and Services, the Office of Services to the Aging, the Michigan State Housing Development Authority, the Commission on Long-Term Care Supports and Services, and the Consumer Task Force. As per the Governor's 2005 Long-Term Care Task Force, a system with a Single Point of Entry program will be implemented statewide by 2009.

B. MFP Program Oversight/Key Stakeholder Involvement

MDCH has established an inter-and intra-agency committee to oversee the work of the Office of Long-Term Care Supports and Services.

The Commission on Long-Term Care Supports and Services (from the Governor's Task Force) is a forum for deliberation among stakeholder groups and for input from the public. It advises the department and Office of Long-Term Care on issues related to the Task Force's recommendations.

C. IT System Developments or Enhancements

The state will develop an innovative Web-based information system, called Service Point, which will consist of a single electronic record that will be shared among all Single Points of Entry and contain standardized and user-defined assessments. A Housing Locator will be acquired, configured and installed by April 2007. The state also plans to integrate two existing data sources, the Data Warehouse and the Minimum Data Set (see the Quality Management Strategy section, above).

D. Independent State Evaluation

None mentioned.

MISSOURI MFP GRANT PROGRAM SUMMARY

Grantee Agency: Missouri Department of Social Services (DSS), Division of Medical Services (DMS)

Total Award: $17,692,006

Overview: The goal of the Demonstration is to transition a minimum of 250 individuals over five years from state habilitation centers and nursing facilities to home and community-based care settings. This will be accomplished by the enhancement of existing efforts to transform the long-term support system consisting of 1915c waivers and a 1992 legislative initiative, Missouri Care Options (MCO). The existing system is being revised based on recommendations from a 2005 Medicaid Reform Commission, a Centers for Medicare & Medicaid Services (CMS) Systems Transformation grant, a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to create a comprehensive state mental health plan, and other systems changes.

Transition Target Groups: Those who have received institutional care for a minimum of six months including the elderly (age 60 and older) and disabled individuals (ages 18 to 59) residing in nursing facilities, individuals with developmental disabilities, and those with co-occurring developmental disabilities and mental health disabilities residing in state habilitation centers.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The state aims to 1) increase Medicaid funding directed to community-based services during each year of the Demonstration, 2) eliminate barriers that prevent individuals currently residing in institutions from accessing needed long-term community supports, and 3) assist 50 eligible individuals to transition to qualified residences during each year of the Demonstration.
- **Money Follows the Person/Flexible Budgeting Goals:** The state will proactively work to implement provisions of House Bill 10, which provides for flexible funding for money to follow residents of intermediate care facilities for the mentally retarded (ICFs/MR) and House Bill 11, which includes funding for other long-term care services for nursing facility residents.[12]
- **Continuity of Service to Transitioned Individuals:** The state aims to improve the ability of the Missouri Medicaid program to continue provision of home and community-based services to individuals who choose to transition from institutional to community settings following the MFP Demonstration.

[12] Note: The House Bill referenced in the MFP application stated HB1011, but should have read HB 11, the appropriation bill for DSS. In addition, it should also have stated Section 11.470 instead of 11.485. Both of these bills have been passed by the legislature and are awaiting the governor's signature.

- **Quality Assurance and Improvement:** The state plans to maintain current quality management systems in existing programs and evaluate consumer satisfaction outcomes for Demonstration participants using the Participant Experience Survey (PES) that will be completed by participants 6 and 12 months post-transition.
- **Other State Goals:** The state has set a goal of having 85 percent of those who transition each year express satisfaction with services, supports and quality of life. To meet this goal, the state will ensure that procedures are in place to provide for continuous quality improvement in long-term care services.

B. Annual Transition Targets[13]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other*	TOTAL
FY 2007	4	4	25	0	5	38
FY 2008	11	12	25	0	5	53
FY 2009	11	12	25	0	5	53
FY 2010	11	12	25	0	5	53
FY 2011	11	12	25	0	5	53
TOTAL	48	52	125	0	25	250

*"Other" includes those with a dual diagnosis of mental retardation or developmental disability (MR/DD) and mental illness.

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Participant Education

Lead transition coordinators will be involved in person-centered transition planning. For each target group, they will assure that individuals have informed consent and choice.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The state will employ existing screening and assessment tools to screen Demonstration participants. To identify MR/DD individuals eligible to participate in the MFP Demonstration, the state will use existing information technology (IT) systems to verify individuals who have been eligible for Medicaid ICF/MR services in a habilitation center for a minimum of six months. Individuals with co-occurring mental illness as well as MR/DD will be identified by a search of individuals who reside in habilitation centers and diagnostic demographic information. The state will rely upon the Centers for Independent Living, ombudsman, family or other sources to identify disabled and elderly individuals who reside in nursing facilities as potential MFP participants. The state will check the state Medicaid eligibility system to verify that potential participants have resided in a Nursing Facility for at least six months. The participant must have been Medicaid-eligible for at least one month prior to participation.

[13] While the total number of transitions has stayed constant at 250 over 5 years, the state has decreased the number of transitions in its first year since the initial application (from 50 to 38), and increased the number in each subsequent year by 3 annually (from 50 to 53).

C. Demonstration Services

MFP participants will be served by existing 1915c waiver programs as well as those services offered under the Medicaid State Plan. The state is planning for a new waiver, the HCB 1115 Waiver, that will divert some of the disproportionate share funds generated by inpatient facilities to enhance home and community-based service capacity for those with co-occurring developmental and mental health disabilities. The following services will be made available to Demonstration participants:

- **Qualified Home and Community-Based Services/Programs:** The state plans to provide home and community-based services offered under existing 1915c waivers and the Medicaid State Plan for which individuals qualify. These services include the comprehensive waiver, community support waiver, targeted case management, and State Plan personal care. Individuals with dual diagnoses of mental retardation and mental illness will receive mental health rehabilitation services provided under the Medicaid State Plan.
- **HCB Demonstration Services:** MFP participants can receive all services currently available through existing 1915c waiver programs.
- **Supplemental Demonstration Services:** For elderly and disabled individuals transitioning from nursing facilities, the state will provide one time supplemental housing services during the Demonstration period if necessary. These funds will assist with transition services such as helping to furnish the home, assisting with payment of a security deposit, and cleaning prior to occupancy.

D. Self-Direction Options Available to MFP Demonstration Participants

Qualified individuals with disabilities can take advantage of self-directed options offered through the Division of Mental Retardation/Developmental Disabilities (MRDD) and DHSS—including choosing a personal assistant, support brokers, and other services. An individual can choose a personal assistant employed by an agency, or independent assistance; in the latter case, the Division of MRDD will contract with a fiscal management provider for payroll services. Under the state Medicaid program, individuals with physical disabilities are offered consumer-directed personal care services.

E. Home and Community-Based Housing Options and Strategies

Transition coordinators will assist individuals in applying for housing assistance and supports such as Section 8 vouchers. They will also provide assistance with, for example, identifying available community living options, arranging for appropriate community psychiatric rehabilitation services, and exploring residential support options for elderly individuals. Demonstration participants will be eligible for housing units set aside by public housing agencies for elderly and citizens with disabilities. For participants who are mental health service consumers, rental assistance and other housing services will be provided by a Housing Team that is part of the Missouri Department of Mental Health (DMH). In addition to these options, the state has a Mental Health Housing Trust Fund where proceeds from the sale of surplus property used by the DMH are paid into this fund and used to finance the rental, purchase, construction, or rehabilitation of community-based housing for individuals served by the DMH. The Missouri Planning Council will partner with the state to increase accessible and affordable housing options and the Missouri Personal Independence Commission (PIC) will be used to foster partnership across state agencies.

F. Workforce Strategies

The Missouri College of Direct Support—a program to train and credential direct support professionals to ensure the quality of the direct care workforce—has been created under a statewide partnership.

III. CHALLENGES TO REBALANCING THE LONG-TERM CARE SYSTEM AND EXPANDING HOME AND COMMUNITY-BASED SERVICES

The program faces the following challenges:

- The state lacks the financial flexibility to transfer money from the long-term budget to the home and community-based budget to support nursing facility transitions.
- The community long-term support system lacks the capacity to respond effectively to crisis situations among those with DD. There is also a lack of access to transition funds and affordable housing to transition the elderly.
- The state's IT infrastructure is not capable of supporting trending, reporting, and sharing information with multiple stakeholders.
- It is difficult to find, recruit, and retain qualified direct support professionals to assist people with developmental disabilities in the community. In rural areas, there are too few personal care attendants to serve elderly and disabled individuals.
- There is a lack of cross-training among community providers.
- There are separate funding streams for Division of Comprehensive Psychiatric Services (CPS) and Division of Mental Retardation and Developmental Disabilities (MR/DD) that make it difficult to support individuals with dual diagnoses.
- Limited opportunities exist for individuals to self-direct services, and certain skilled services are not covered under the consumer-directed model.
- Public administrators of individuals living in state habilitation centers are reluctant to permit individuals with dual diagnosis to transition to the community.
- For individuals in nursing facilities, accessing transition services depends heavily on assistance from facility staff, volunteers, and family members.

IV. QUALITY MANAGEMENT STRATEGY

The state's quality management strategy is based upon quality management systems that are in place to ensure that 1915c waiver programs meet CMS-required quality assurances. Case managers, employed by the Division of MR/DD, will assure the health and safety of Demonstration participants by determining waiver eligibility, facilitating person-centered planning, authorizing the necessary services, and performing frontline monitoring. Furthermore, the Division of Senior and Disability Services provides oversight to programs and services for seniors and adults with disabilities, and investigates and intervenes in cases of adult abuse, neglect or financial exploitation. Expanding upon an existing DHSS initiative, the state will assess consumer satisfaction and evaluate consumer satisfaction outcomes for Demonstration participants using the Participant Experience Survey (PES) that will be completed by participants 6 and 12 months post-transition.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

DSS, the single state Medicaid agency, will be the lead organization for the Missouri MFP Initiative and will work in partnership with the DMH and the Missouri Department of Health and Senior Services (DHSS). DMH is responsible for the transition of individuals with MR/DD (including those with MI diagnosis) from state habilitation centers; DHSS is responsible for the transition of individuals with physical disabilities or illnesses from nursing facilities.

B. MFP Program Oversight/Key Stakeholder Involvement

The state plans to engage project stakeholders in an inclusive operational protocol development process. Through the PIC, DSS will support the ongoing collaboration and participation of multiple stakeholders that include consumer advocates, individuals with disabilities and their families, state agencies, legislators, and the University of Missouri. The PIC is charged with advising the governor on necessary policy/programmatic changes to assure that Missourians of all ages have access to needed community support services.

C. IT System Developments or Enhancements

The state will determine whether the Medicaid eligibility system can be modified to add a new level of care indicator to identify MFP participants, which would allow all paid Medicaid claims to be tracked for each Demonstration participant. If this is not possible, participants will be identified quarterly and a search of the Missouri MMIS paid claims files for MFP-covered services will be conducted to identify expenditures that are eligible for reimbursement under the MFP program.

D. Independent State Evaluation

The University of Missouri Kansas City Institute for Human Development (UMKC-IHD) will undertake process and outcome evaluations of the MFP Demonstration.

NEBRASKA MFP GRANT PROGRAM SUMMARY

Grantee Agency: Nebraska Department of Health and Human Services (HHSS), Department of Finance and Support.

Total Award: $27,538,984

Overview: Building on the state's Medicaid Reform Initiative that is designed to enhance access to an array of long-term care service options in the community, the MFP program aims to transition 900 more individuals from nursing homes and intermediate care facilities for the mentally retarded (ICFs/MR) to home and community-based settings. The state will employ a two-phased approach and will use the first year of the Demonstration to plan for implementation. During this 12-month pre-implementation phase, the state plans to fast track transition for individuals who can thrive with existing support services. The state will enhance its community service system in year one to support the second wave of individuals as they transition into the community. To rebalance the long-term care system, the state will use MFP Demonstration funding to increase home and community-based services through seeking approval from the Centers for Medicare & Medicaid Services (CMS) for the renewal of the Aged and Disabled Adults/Children (A&D) Waiver and Adults with Developmental Disabilities (DD) Waiver programs.

Transition Target Groups: Elderly, physically disabled, developmentally disabled, or individuals with traumatic brain injury.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. A. Program Goals

- **Rebalancing Goals:** The state aims to increase home and community-based services by increasing the number of persons served by 49 percent in the A&D Waiver program and by 23 percent in the Developmental Disability (DD) Waiver program.
- **Money Follows the Person/Flexible Budgeting Goals:** In response to passage of Legislative Bill 994, which consolidated the Home and Community Service Division into the single state Medicaid agency, both institutional and home and community-based services are in a single Medicaid budget allowing money to follow transitioned persons into the community. Previous efforts to encourage nursing facility conversion have also made funds to support home and community-based care more flexible.
- **Continuity of Service to Transitioned Individuals:** The state is fully committed to maintaining the service system in place after termination of the Demonstration.
- **Quality Assurance and Improvement:** Current quality assurance measures will be utilized and enhanced. The state will rely on its Quality Councils that are charged with reviewing the outcomes of transitioned consumers on an ongoing basis and making recommendations for quality improvement.

- **Other State Goals:** Increase capacity for supports and services, increase access to behavioral health supports in the community, invest in "transition planning" capability, design a "rural solution" to support the choice of people who seek to live in rural or frontier communities, develop a "no wrong door" access portal, and invest in remote technology to support assessments, interventions, and monitoring.

B. ANNUAL TRANSITION TARGETS[14]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other*	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	133	66	66	0	33	298
FY 2009	133	67	67	0	33	300
FY 2010	134	67	67	0	34	302
FY 2011	0	0	0	0	0	0
TOTAL	400	200	200	0	100	900

*"Other" includes those with traumatic brain injury (TBI).

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

To target and recruit potential Demonstration participants, the state will perform outreach activities that will include a public relations campaign, one-on-one interviews with potential candidates, activities at institutions, and mailings to consumers, families, guardians, and providers. During the pre-implementation phase, the state will work with consumers, families, Area Agencies on Aging (AAAs), Independent Living Centers (ILCs), intermediate care facilities for the mentally retarded (ICFs/MR) and nursing homes to screen, identify and assess potential transitions. Project teams will also encourage case managers and discharge planners within ICFs/MR to routinely provide informational brochures and discuss community services as an option to residents, families, guardians, and others.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

During the pre-implementation phase, the state will work with stakeholders to design a process for screening, identifying, and assessing consumers who are candidates for transition. The state intends to revise existing assessment tools so that they are strength-based, person-centered, and focused on the individual's preferences, needs, and capacities. The state will continue to expand access to its Web-based system for providers and consumers, which provides information on assessments and eligibility determinations. It will also use Demonstration funding to develop a Web-based self-assessment tool to identify willingness to transition into the community. The state will also explore using Minimum Data Set (MDS) data to identify candidates and/or prioritize which individuals are approached first.

[14] Initial application table indicated 898 due to arithmetic error.

C. Demonstration Services

MFP participants will be served by existing 1915c home and community-based (HCBS) waiver programs and Medicaid State Plan services for which the person is eligible. Existing HCBS waiver programs include the Aged and Disabled Adults/Children (A&D) Waiver, the Adults with Developmental Disabilities (DD) Waiver, Children with Developmental Disabilities Waiver, Early Intervention Waiver, Katie Beckett Plan Amendment, and the Traumatic Brain Injury (TBI) Waiver. The state has requested to expand the number of waiver slots for the A&D Waiver and to amend the TBI Waiver to increase the number of slots from 48 to 98 and to expand the definition of TBI to cover people with acquired brain injuries. The DD service list will also be expanded to include the Home Again transition service to cover consumers' expenses related to transitioning to the community. The state plans to request legislative approval to transfer state matching funds from the Medicaid budget to the DD budget to fund 200 additional waiver slots. MFP participants will be entitled to receive the following services:

- **Qualified Home and Community-Based Services:** The state's existing A&D Waiver, DD State Plan and Waiver services, and added community services to the TBI Waiver. All HCBS waivers will be amended to include technology that supports in-home monitoring, assessments and interventions, and a new level of targeted case management will be developed to cover transition coordinators. The state will also explore the addition of behavioral health services to the TBI waiver.
- **Home and Community-Based Demonstration Services:** None mentioned.
- **Supplemental Demonstration Services:** None mentioned.

D. Self-Direction Options for MFP Demonstration Participants

Waivers for the aged and disabled, developmentally disabled, those with traumatic brain injury, and for early intervention incorporate aspects of client direction in the use of non-traditional providers and arrangements with clients where the department acts as their employer of agent. All target populations included in the Demonstration will have Personal Assistance Services (PAS) based on need through which individuals can recruit, hire, and supervise individuals who furnish supports. Current grant programs and initiatives also support self-direction: the Real Choice for Nebraskans developed PAS regulations and the "Home Again" initiative provided $1,500 for a Home Again Advocate to secure necessary items for establishing a household.

E. Home and Community-Based Housing Options and Strategies

The MFP Demonstration will build upon the results of the Behavioral Health Housing Assessment, completed in 2004, to address the housing needs of MFP participants. Furthermore, HHSS' Medicaid Reform Rural Advisory Committee has begun to address housing needs in rural and frontier communities. The state will also engage the agencies and organizations that were involved in the development of the housing.ne.gov Website to make recommendations on housing needs and strategies.

F. Workforce Strategies

The state anticipates using Demonstration funds to foster a "paradigm shift" and to develop an increased workforce to meet the needs of transitioned individuals. This will include a major marketing campaign to inform providers about the benefits of diversifying their services to include home and community-based care. The state also anticipates that the increased demand will be met by private providers (community and family members who are selected by the consumer).

III. CHALLENGES TO REBALANCING THE LONG-TERM CARE SYSTEM AND EXPANDING HOME AND COMMUNITY-BASED SERVICES

Through its Medicaid Reform Initiative, the state engaged stakeholders to identify specific challenges facing individuals wishing to transition from institutions to home and community-based settings. These include:

- Existing bias towards institutions rather than home and community-based living options, including existing incentives for physicians to refer individuals to institutional settings.
- Lack of capacity of the long-term care network—particularly in rural areas..
- Lack of knowledge about available supports and service delivery options.
- Limited access to needed support services in rural areas.
- Inadequate transportation options, limited housing options, and lack of behavioral health supports
- Inadequate employment opportunities and programs for individuals transitioning to community residential settings.
- Inadequate training opportunities for direct care staff.
- Inadequate integration of auxiliary services.

IV. QUALITY MANAGEMENT STRATEGY

Each waiver program has a Quality Council to advise the state on strategies to strengthen waiver quality management with an emphasis on service plan development, consumer health and welfare, and the new Incidence Management System, which ensures that incidents of consumer abuse, neglect and/or exploitation are recorded and reported. The state also requires annual reviews of at least 10 to 100 percent of home and community-based services cases; these include a review of level of care determinations, the plan of services and support, client choice, qualified providers, health and welfare, and financial accountability. The state will continue to conduct the Participant Experience Survey (PES), the Family Experience Survey, and the Quality of Life Survey to assess consumer satisfaction with the services rendered.

Throughout the Demonstration, the state will work with its Quality Council to identify the most appropriate and effective benchmarks needed to track quality-related outcomes. Examples of proposed benchmarks include the percentage of individuals who were transitioned out of nursing homes and intermediate care facilities for the mentally retarded (ICFs/MR) who have re-entered institutions, the number of days of hospitalization for transitioned individuals verses institutionalized individuals, and length of stay in institutions verses home and community-based services.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The state will develop cross-agency collaboration among state programs within HHSS—such as the State Unit on Aging and the Nebraska Council on Developmental Disabilities—to ensure the success of the MFP Demonstration. The state will also collaborate with AAAs, ILCs, vocational rehabilitation centers, and local public housing authorities to ensure that transitioned individuals have adequate supports in the community.

B. MFP Program Oversight/Key Stakeholder Involvement

The state's Home and Community Services Division (HCSD) will administer and oversee the MFP Demonstration. The MFP project director will develop a tactical plan specifying the tasks, coordinated schedule for completion, and timeframes necessary to achieve the outcomes of the Demonstration. The tactical plan will be developed in collaboration with the MFP Advisory Panel, which comprises consumers, family members, providers, and state agencies. During the pre-implementation phase of the Demonstration, the state will partner with stakeholders to design a process for screening, identifying, and assessing consumers who are candidates for transitioning to the community.

C. IT System Developments or Enhancements

Nebraska will use both the state Senior Care Options process on the Department's CONNECT integrated database, the long-term care Minimum Data Set (MDS), the Medicaid Management Information Systems (MMIS) data warehouse to monitor eligibility and follow those who transition. Using Geographic Information Systems (GIS) software, the state will map current information on A&D Waiver providers to identify statewide gaps in coverage for resource development purposes.

D. Independent State Evaluation

The state plans to procure a contractor to conduct an independent state evaluation of the Demonstration project.

NEW HAMPSHIRE MFP GRANT PROGRAM SUMMARY

Grantee Agency: New Hampshire Department of Health and Human Services (DHHS)

Total Award: $11,406,499

Overview: The state's MFP Demonstration builds on previous Medicaid long-term care reform initiatives, including: the two previous nursing home transition grants, the Aging and Disabilities Resource Center Grants, the Long-Term Care Systems Transformation Grant and the other Real Choice Grants awarded to New Hampshire. The MFP program aims to expand Medicaid home and community-based services options to transition 370 eligible residents of six months or more in qualified institutions to community-based settings over a five-year period. New Hampshire will use the Demonstration funding to rebalance the long-term care system, reducing its historical reliance on institutional care as the primary provider of long term care while developing community-based alternatives.

Transition Target Groups: While all persons who meet the criteria described above are eligible to participate in MFP, the Demonstration will target two high priority populations: those eligible for the state's elderly and chronically ill 1915c waiver and those who qualify for the acquired brain disorder waiver.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The state intends to (1) increase the number of individuals in home and community-based services by 10 percent per year, (2) decrease bed day utilization in nursing homes by 5 percent per year, (3) increase Medicaid expenditures for home and community-based services by 10 percent per year while keeping Medicaid expenditures for nursing homes flat, (4) keep 90 percent of individuals transitioned to the community in those settings after the first year, (5) increase the proportion of Medicaid funds spent on home and community-based services (total and per capita) relative to institutional care, and (6) increase in rate of change for Medicaid long-term care spending on home and community-based services as compared to the national average.
- **Money Follows the Person/Flexible Budgeting Goals:** The state plans to make flexible funds available to support participants during the transition period.
- **Continuity of Service to Transitioned Individuals:** Following the one-year Demonstration period, MFP participants will be eligible for all home and community-based services provided under the 1915c waivers, as well as the Medicaid State Plan personal care services. The state will ensure adequate funding for home and community-based services to maintain participants in the community.
- **Quality Assurance and Improvement:** The state will maintain current quality management systems in existing programs and develop a participant survey instrument and other mechanisms to obtain feedback from participants receiving home and community-based services.

- **Other State Goals:** The state aims to implement a system that provides person-centered, appropriate, needs-based, quality services and supports that ensure a high level of access and quality in both home and community based settings as well as institutions.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	10	0	0	0	0	10
FY 2008	75	15	0	0	0	90
FY 2009	75	15	0	0	0	90
FY 2010	75	15	0	0	0	90
FY 2011	90	0	0	0	0	90
TOTAL	325	45	0	0	0	370

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

Participants will be recruited in two phases: in the first two years from the more populated Southern region of the state (Merrimack and Hillsborough counties), and in the remaining three Demonstration years from less populated regions. The state will employ five main strategies to recruit and educate eligible individuals: (1) collaborate with stakeholders, (2) publicize the project to nursing homes and local media, emphasizing the importance of consumer choice and independence, (3) initiate direct contact with nursing home residents, (4) perform outreach to communities, families, and facilities and (5) employ five transition coordinators who will identify key nursing home staff and discharge planners at acute care facilities and educate them about transition activities. In addition, information captured in the Minimum Data Set database and the state's eligibility database, New HEIGHTS, will be used to identify potential MFP participants.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The state intends to employ five outreach/transition coordinators who will identify participants for transition and work with them to develop, coordinate, and implement transition plans. The state will create a protocol to guide these activities as well as to ensure that participants make an informed choice about participation. Transition coordinators will also build relationships with hospital discharge planners to review patients who are being referred to nursing homes and/or those who express an interest in returning to the community.

C. Demonstration Services

MFP participants will be served by existing 1915c waivers as well as by services offered under the Medicaid State Plan. There are four HCBS waivers: the Elderly and Chronically Ill (HCBC-ECI), the Developmentally Disabled (HCBC-DD), the Acquired Brain Disorder (HCBC-ABD), and the In-Home Supports (IHS) Waiver, which serves children with severe developmental disabilities who require in-home assistance. The state plans to amend each 1915c waiver to include a variety of transition and Demonstration services, and is considering modifying the HCBC-ECI waiver to increase consumer direction and expand the availability of service options. The current Medicaid State Plan personal care

attendant (PCA) program targets those who can self-direct and are wheelchair bound. The state also plans to pursue the HCBS State Plan Option (under Section 6086 of the DRA) to provide home and community-based services to individuals with emotional/behavioral/functional needs. MFP participants will be entitled to receive the following services:

- **Qualified Home and Community-Based Services:** This includes all home and community-based services currently available under existing 1915c waiver programs as well as personal care services offered under the Medicaid State Plan for which the person is eligible. The state will make every effort to provide the level of service to maintain the participant in the community, but the participant will have the option to return to the institution if they so choose.
- **Home and Community-Based Demonstration Services:** The state will modify existing home and community-based care waivers to include Demonstration services such as health and safety assurances, home technology, independent living skills, vehicle modifications, telehealth monitoring equipment, health and personal hygiene products, and service animals.
- **Supplemental Demonstration Services:** This includes supportive transition services, home cleaning, pest eradication, security deposits, utility hookups, necessary home purchases, overnight visits to a new home, and a medication bridge to avoid interruption of medication.

D. Self-Direction Options for MFP Demonstration Participants

All state 1915c waivers provide options for consumer-directed services. Under the HCBC-DD, HCBC-ABD, and the Independence Plus Waiver (which serves families who have children with significant disabilities), consumers are given an individualized budget and the choice to self-direct their services. Under the HCBC-ECI, consumers of personal care services (PCS) are allowed to develop their service plan, select their providers, and set the terms and conditions of the work to be provided. Consumers are also afforded fiscal intermediary services to help them direct their own care more effectively. Persons served in developmental services system have the choice to self-direct to the extent they desire through an "Agency with Choice" model, which provides person-centered planning, individual budgeting, fiscal intermediary services, service brokerage, and quality oversight.

E. Home and Community-Based Housing Options and Strategies

The state will expand residential care home options by implementing the adult family care model statewide and increasing the availability of housing with supportive services. The state is developing an agreement with the housing authority to give priority to MFP participants for ACCESS vouchers and other subsidy programs.

F. Workforce Strategies

The utilization of a consumer-directed personal care model is anticipated to create more flexibility in working hours and conditions for direct care provider staff.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- There are restrictions on transportation services.
- The state faces a scarcity of affordable and accessible housing and rental units.
- The state lacks adequate flexible funds to purchase non-medical goods and services during the transition period, and gaps in medications supplied during the transition period.
- There is a lack of coordinated transition to community-based primary care providers.

- There is limited mid-level care availability, especially for the memory-impaired.
- There is a lack of connection between services offered and those paid.
- Administrative restrictions on service utilization such as short-term nursing home stays complicate efforts to provide long-term home and community-based care.
- State budget mechanisms limit the transfer of funds from nursing homes to home and community-based care. Statutory caps limit aggregate spending on the HCBC-ECI 1915c waiver.
- Long time period needed to complete 1915c eligibility determinations.
- There is a bias towards institutional care with differential treatment of room and board.
- The state faces direct care workforce shortages.
- Respite care needs of home and community-based workers.
- Nurse practice limits on the administration of medications.

IV. QUALITY MANAGEMENT STRATEGY

The DHHS is currently redesigning the quality management system for the HCBC-ECI 1915c waiver program. The redesign will be replicated in all 1915c state waiver programs. Early emphasis was placed on risk management and as a result, operating procedures have been strengthened, consumer access has been improved through a reduction in the cycle time from application to service delivery, and activity tracking has been instituted to provide better data for analysis and evaluation. The Bureau of Elderly and Adult Services (BEAS) is responsible for assuring quality in the ECI waiver and its work groups are addressing specific issues—for example, incident review protocols, case management, and clinical practice guidelines—with a focus on developing a standardized clinical assessment instrument. In addition to these strategies, DHHS is developing a participant survey instrument and process to gather feedback from participants receiving a variety of services in the full array of community settings.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

During a recent DHHS reorganization, the Bureaus of Behavioral Health, Developmental Services, and Elderly and Adult Services were merged into the Division of Community-Based Care Services (DCBCS) to facilitate the movement to a single-point of entry model for target populations and to emphasize a common mission: to promote maximum personal independence in the most integrated setting. Collaboration with other departments such as housing, transportation, labor, employment, and health and human services is also anticipated.

B. MFP Program Oversight/Key Stakeholder Involvement

DCBCS will manage the MFP initiative. A work group comprised of consumers, consumer advocates, housing agencies, county commissioners, and various Bureaus within DHHS will participate in the development of the operational protocol.

C. IT System Developments or Enhancements

The state has initiated IT enhancements to simplify the identification of MFP participants. The state's level of care determination process for nursing home and home and community based waiver services is being transitioned to an automated clinical assessment and management system.

D. Independent State Evaluation

None mentioned.

NEW JERSEY MFP GRANT PROGRAM SUMMARY

Grantee Agency: New Jersey Department of Human Services (DHS)

Total Award: $30,300,000

Overview: New Jersey will build on its 1915c Home and Community-Based Services (HCBS) waivers, its Real Choice Change Grants, and the recent award of the Independence, Dignity and Choice in Long-Term Care Act (the Act) to rebalance its long-term care system.

Transition Target Groups: Older adults, persons with developmental disabilities, and physically disabled individuals from nursing home facilities and state developmental centers to the community.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** MFP Demonstration benchmarks for assessing progress include: (1) an annual increase in service expenditures of approximately 5 percent, and (2) an annual increase in the number of MFP-transitioned individuals of 5 percent relative to the baseline of 48 percent.
- **Money Follows the Person/Flexible Budgeting Goals:** Under the Independence, Dignity and Choice in Long-Term Care Act (the Act), New Jersey proposes that funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care shall be reallocated to home and community-based services through a global budget, and will be expended solely for home care.
- **Continuity of Service to Transitioned Individuals:** The state plans to continue to make all waiver and Medicaid State Plan Services available to eligible individuals after the Demonstration period.
- **Quality Assurance and Improvement:** The state plans to incorporate self-correcting feedback loops with providers, consumers, and family caregivers to continue strengthening its quality improvement system.
- **Other State Goals:** New Jersey proposes to expand affordable and cost-effective options for receiving home and community-based services; streamline its eligibility processes; improve access for individuals from all cultural and disability groups; and expand transition services to aid in finding housing and services to improve quality of life. In addition, the state hopes to include greater opportunities for self-advocacy and participation of consumers at all levels of decision making related to the long-term care system, design, implementation, monitoring, and evaluation.

B. Annual Transition Targets[15]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	12	20	37	0	0	69
FY 2009	51	20	84	0	0	155
FY 2010	54	23	97	0	0	174
FY 2011	57	24	111	0	0	192
TOTAL	174	87	329	0	0	590

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

Through the completion of a comprehensive assessment by staff working in institutions, New Jersey already has identified individuals living in institutions who want to reside in the community. Further, the Division of Aging and Community Services (DACS) currently employs 60 Community Choice Counselors (CCC) to transition individuals from nursing facilities to the community. Each of the state's facilities is assigned a CCC.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

An independent Support Coordinator will create and implement an Essential Life Style Plan based on the individual's needs and desires for a successful transition. All MFP participants will have the opportunity to choose a self-directed or provider-managed approach. Individuals being admitted to an nursing facility, as well as those currently residing in such a facility, will receive a pre-admission screen (PAS) to identify their potential for transitioning from the NF. The state plans to identify and counsel individuals at risk of being placed or remaining in a nursing home to help them understand the full range of available home and community-based services.

C. Demonstration Services

The state has implemented numerous long-term care efforts, including six waivers, State Plan services, and other state-funded services that make up New Jersey's Home and Community-Based Services System. With the passage in 2006 of the Act, no additional major legislative changes will be needed to implement the MFP Demonstration.

The state's Division of Developmental Disabilities (DDD) intends to submit amendments to its existing HCBS waivers. The proposed amendments will not have an impact on the implementation of MFP. DACS also plans to consolidate its three current waivers into one Global Options for Long-Term

[15] The state has modified its transition targets from its initial application, where 734 total transitions were proposed. The number of transitions in each category are different from the initial application and the state has also changed the time units from the state fiscal year to the federal fiscal year, so that the transitions per year by category are different.

Care (GO for LTC) Waiver that will allow for greater funding flexibility and streamlined processes for delivering all current waiver and State Plan services. The expected implementation date is January 1, 2008.

- **Qualified Home and Community-Based Services**: All Medicaid State Plan Services will be available to eligible individuals.
- **Home and Community-Based Demonstration Services**: Global Options for Long-Term Care (GO for LTC) is being pilot tested statewide for individuals transitioning from nursing facilities to the community. GO for LTC provides participant-centered service planning processes and individualized budgets based upon level-of-care needs.
- **Supplemental Demonstration Services**: Persons with MR/DD who transition will receive community services, which can include security deposits, utility set-up/installation, furnishings, moving expenses, one-time cleaning, medical equipment, and clothing. Individuals with physical disabilities (PD) may receive medical equipment.

D. Self-Direction Options for MFP Demonstration Participants

New Jersey's Medicaid Program currently includes an 1115 waiver, Personal Preference (Cash and Counseling) that allows Medicaid recipients to self-direct Personal Care Assistant services. The Division of Disability Services (DDS) plans to move this option into the State Plan via the section 1915j option, which will facilitate access for all recipients. In addition, the Community Care Waiver was amended to provide a Self-Determination/Real Life Choices option allowing individuals to establish a budget for HCBS services and self-direct the budget through a fiscal intermediary. The state also has two initiatives directed at seniors. One established the Participant-Employed-Providers (PEP) option that allows participants to direct their own care by hiring qualified family members, friends, and neighbors. The second initiative, the Statewide Respite Care Program (SRCP), enables caregivers to be reimbursed for a wide variety of services and supplies. Finally, the state's new GO for LTC option provides participant-centered service planning processes and individualized budgets.

E. Home and Community-Based Housing Options and Strategies

To develop affordable housing options, in 2005, the state established a $200 million Special Needs Housing Trust Fund to provide alternative housing options for its aging and disabled community. In addition, the state's 2001 Real Choice Systems Change Grant provides a centralized registry of affordable and accessible rental housing by county for persons with disabilities. Also, a housing initiative, "Moving On," connects residential providers with individuals currently living in group homes who want to move into independent living with supports.

F. Workforce Strategies

The Medicaid Long-Term Care Funding Advisory Council, established under the Act, is responsible for developing recommendations for the recruitment and training of a stable workforce of home care providers.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- There is a need for training of nursing facility (NF) staff to understand people with disabilities and how they can live independently in the community, so that the staff can facilitate the transitioning process.

- There is a lack of advocates to help individuals transition from nursing facilities/developmental centers to the community, and to coordinate home and community-based services.
- Transitioned individuals need a broader array of support services, including more vehicles and staff for transportation; social activities; equipment; support with finances, bill paying, or budgeting; medical supports, including medication management; and housing options.
- Support services need to be provided in a timely manner and made more flexible, such as giving Medicaid nurses the ability to visit transitioned individuals in the community, even though technically they are not considered "housebound."
- Medicaid rules and eligibility requirements including asset rules, access limitations due to a lack of a spend-down provision in the medically needy program, and rules restricting the setting for certain services make transition more difficult for some individuals.

IV. QUALITY MANAGEMENT STRATEGY

The state will continue the Quality Management strategy it developed under previous waivers and grants. Committees within each division will continue to meet so as to provide a venue for input. Consumers and families also will be able to provide feedback to improve quality continuously in home and community-based services. In addition, a Quality Management Steering Committee, involving all key stakeholders, is designing IT applications to collect key data and to collect, track, aggregate, and analyze information to monitor process compliance and outcomes for Quality Assurance.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies.

The State Management Team will oversee the MFP Demonstration. This team consists of high-level management from the Division of Medical Assistance and Health Services (DMAHS), the Division of Aging and Community Services (DACS) in the Department of Health and Senior Services (DHSS), and the Divisions of Disability Services (DDS) and Developmental Disabilities (DDD) in the DHS. The charge of the RCSC Systems Change Council will be expanded to include MFP oversight. Additional work groups include: (1) DDD's Quality Management Steering Committee (QMSC) and Advocate Panels; (2) the Medicaid Long-Term Care Funding Advisory Council, which will focus on rebalancing and workforce issues; (3) an IT Work Group that will develop an integrated IT system; and (4) an STG Eligibility Work Team, which will focus on standardizing screening processes, clinical assessments, eligibility processes, and computer systems across all divisions to serve all Medicaid and MFP participants.

The State Management Team was originally developed to oversee the ADRC grant and will also be overseeing the System Transformation Grant, which will foster improved coordination and service delivery for Medicaid waiver programs across DACS, DDS, and DDD. Administrative and fiscal oversight of MFP is delegated by DHS to DMAHS.

B. MFP Program Oversight/Key Stakeholder Involvement

A consumer representative will be added to the State Management Team. The Real Choice Systems Change Grant had a Council composed of 50 percent consumers and advocates. This was expanded to oversee ADRC development, and now will be enhanced to include MFP oversight.

C. IT System Developments or Enhancements

New Jersey plans to enhance its current Medicaid claims system to identify Medicaid and MFP participation prior to transition, and to track services eligible for the enhanced Federal Medicaid

Assistance Percentages (FMAP). In addition, the state has developed and begun to implement an IT Strategic Plan aimed at more efficiently and effectively collecting, aggregating, and analyzing the data needed to monitor the quality of its program services, and to plan for future program needs. The partnering Divisions (DDD, DACS, and DDS) plan to collaborate in the development of IT infrastructure to share the data collected.

D. Independent State Evaluation

The state will develop an evaluation plan, but no details were included in the application.

NEW YORK MFP GRANT PROGRAM SUMMARY

Grantee Agency: The single state Medicaid agency, the New York State Department of Health (NYS-DOH), oversees the MFP grant program, and has delegated management responsibility to the Office of Long Term Care (OLTC).

Total Award: $82,636,864

Overview: The state plans to transition 2,800 individuals over the five-year demonstration period and use the savings from the enhanced Federal Medical Assistance Percentage (FMAP) for qualified home and community-based services to fund various long-term care rebalancing activities, including (1) contracts with the Centers for Independent Living to conduct outreach to potential transition candidates, (2) informational materials aimed at diverting hospitals from unwanted nursing home admission, (3) strategies to increase the availability of affordable, accessible and integrated housing, and (4) increases in assistive technology funds and equipment loans.

Transition Target Groups: Individuals with disabilities ages 18 and older, seniors, and individuals with mental retardation and developmental disabilities, and mental health disabilities.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** In addition to transitioning individuals from nursing homes who want to live in the community, the state aims to increase the dollar amount and percentage of expenditures for home and community-based services. It expects to increase spending on Medicaid home and community-based services every year of the Demonstration—by $68.7 million in 2008, $114 million in 2009, $162 million in 2010, and $91 million in 2011. Although these increases will not significantly change the balance of spending on home and community-based services (in fiscal year 2005, the state's expenditure on community-based long-term care services was over $7 billion), the state is expected to save about $27 million from enhanced FMAP for qualified home and community-based services. This savings will be used to fund long-term care rebalancing activities, including: outreach to potential transition candidates; informational materials aimed at diverting hospital patients from unwanted nursing home admission; strategies to increase affordable, accessible and integrated housing options; and increases in assistive technology funds and equipment loans.
- **Money Follows the Person/Flexible Budgeting Goals:** NYS-DOH already has authority to transfer funds between institutional and home and community-based services care in its budget.
- **Continuity of Service to Transitioned Individuals:** Services provided through a new 1915c Nursing Home Transition and Diversion (NHTD) waiver, and certain Medicaid State Plan home and community-based services, would continue for MFP participants after the one-year transition period.
- **Quality Assurance and Improvement:** The state plans to develop a Quality Management Program for the Nursing Home Transition and Diversion 1915c waiver program, which will serve most MFP participants, based on the Centers for Medicare & Medicaid Services (CMS) Quality Framework.

- **Other State Goals:** None mentioned.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	159	159	19	38	0	375
FY 2009	265	266	32	62	0	625
FY 2010	383	383	44	90	0	900
FY 2011	383	382	45	90	0	900
TOTAL	1,190	1,190	140	280	0	2,800

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

Regional Resource Development Centers (RRDC), which are planned to implement the Nursing Home Transition and Diversion waiver program, will recruit individuals for both the NHTD Waiver and MFP programs. RRDC specialists will conduct outreach to eligible individuals in nursing facilities and establish relationships with the nursing facility staff, including discharge planners, to generate referrals. They will also present information about the MFP program to nursing home resident councils and long-term care ombudsmen. Independent Living Centers will also conduct outreach and recruit individuals for the MFP program. The state will publicize the MFP program to the DOH Discharge Planning Group. The single Points of Entry around the state may also make referrals to the program.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The state plans to request permission from CMS to release Minimum Data Set (MDS) data to RRDCs and to Independent Living Centers in order to identify nursing residents wishing to return to the community (Question Q1a). The state expects to secure this agreement by October 2007. Prior to enrollment in MFP, the state would verify through the Medicaid Management Information Systems (eMedNY) that the individual meets eligibility requirements.

C. Demonstration Services

The state plans to enroll MFP demonstration participants into the Nursing Home Transition and Diversion (NHTD) 1915c waiver program. The state expected this program to be approved by April 2007.[16] RRDC specialists located in nine state-contracted Regional Resource Development Centers would determine program eligibility, review and approve service plans, assure regional cost neutrality, and develop local resources. MFP participants would select service coordinators to assist them in the development of service plans and in the transition from nursing homes.

[16] The State has requested an expedited approval date of August 1, 2007 from CMS.

- **Qualified Home and Community-Based Services**: All services in the proposed NHTD waiver would be available to MFP participants, in addition to certain home and community-based services covered by the Medicaid State Plan—for example, personal care services, consumer-directed personal assistance program services, private duty nursing, DME, adult day health, personal emergency response system, and certified home health agency services. Community Transition Services funds may be used for moving expenses, security deposits and other one-time costs associated with the transition. Environmental Modifications Services provide funds for home modifications to allow people to function with greater independence. Additional funds to pay for devices and equipment loans—provided through the state's TRAID program—will also be covered under this category.
- **Home and Community-based Demonstration Services:** None mentioned.
- **Supplemental Demonstration Services:** None mentioned.

D. Self-Direction Options for MFP Demonstration Participants

The state Nursing Home Transition and Diversion Advisory Group would be charged with exploring opportunities for waiver participants to self-direct services. In addition, MFP demonstration participants can utilize consumer-directed personal assistance services.

E. Home and Community-Based Housing Options and Strategies

The state plans to establish the MFP Demonstration Housing Task Force comprising various stakeholders and state agency representatives; the task force will develop strategies to increase affordable and accessible housing options. The state will contract with an expert in affordable, accessible and integrated housing for seniors and people with disabilities to help the Task Force conduct a needs assessment for the MFP target populations, develop recommendations and strategies, and draft a comprehensive report by July 2007. Using funds from the enhanced FMAP, the state will contract with Independent Living Centers to implement a statewide housing education and advocacy campaign aimed at large Public Housing Authorities to promote expanded housing options for people with disabilities. It may also pursue other strategies, such as setting aside Section 8 vouchers, giving preference to people transitioning from nursing homes to the community, and developing a Housing Subsidy Fund to provide rental subsidies for people transitioning from institutions.

F. Workforce Strategies

The state's Health Care Workforce Recruitment and Retention Act (HCWRRA), passed in 2000, provides funds to increase wages for health care workers, including those in long-term care, and for training and other projects to improve their skills and stability. The MFP application did not explain whether this resource would contribute to the MFP program.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- There is a need for comprehensive information about home and community-based services and supports to individuals needing long-term care who are in nursing homes or who are hospitalized for longer than six months, which was an impetus for the state's submittal of a Nursing Facility Transition and Diversion waiver application.
- The state needs more affordable, accessible, and integrated housing, and wider marketing of the state's "Housing AccessAbility" registry of affordable or market-rate housing, maintained by the Center for the Independence of the Disabled. In many urban areas, an individual's entire

Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefit is less than the monthly rent of a modest one-bedroom apartment.

- There are often delays in receiving durable medical equipment while an individual resides in a nursing facility. The state's Technology-Related Assistance for Individuals with Disabilities (TRIAD) program also lacks the capacity to provide equipment loans to all individuals in nursing homes who need them.

IV. QUALITY MANAGEMENT STRATEGY

The NYS-DOH Office of Health Systems Management (OHSM) conducts all surveillance activities for providers of Medicaid-funded long-term care services, both institutional and home and community-based; it uses Outcome Based Quality Improvement, Quality Management, and Adverse Event Reports to monitor various quality outcomes. DOH maintains a toll-free hotline to report complaints, which it investigates and remedies. For 1915c waivers overseen by DOH, OHSM monitors and addresses QA deficiencies through provider surveys, provider incident reports, complaint hotlines, and participant satisfaction surveys. For the MR/DD waiver program, the Office of MRDD Division of Quality Assurance surveys programs, tracks outcomes and consumer satisfaction, provides training and technical assistance, and takes action against substandard providers.

For the MFP program, quality assurance would be performed by quality management specialists assigned to the NHTD waiver. The proposed NHTD Quality Management Program is based on CMS' Quality Framework and uses a five-level approach to identify problems, implement solutions, and change program policies Annual Participant Satisfaction Surveys, among other avenues, will ensure participants play a role in identifying problems; surveys will be tracked through IT. DOH would meet quarterly with RRDC specialists and QMS agencies to assess problems and develop solutions, and will create a Quality Advisory Board to keep stakeholders involved in quality improvement efforts. DOH will also conduct retrospective annual reviews of a random sample of MFP Service Plans to assure RRDC quality performance.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

NYS-DOH' Office of Long Term Care (OLTC) will manage the MFP program, in coordination with the other 1915c programs it administers. OLTC will involve several other sister agencies in MFP program implementation, including the Office of Mental Retardation and Development Disabilities (OMRDD), the Office of Mental Health (OMH), the New York State Office on Aging (SOFA), and the Division of Housing and Community Renewal. The state will work with Public Housing Authorities at the state and local level.

B. MFP Program Oversight/Key Stakeholder Involvement

The state's Most Integrated Setting Coordinating Council (MISCC) oversees the implementation of Olmstead decision and makes recommendations to ensure that people with disabilities receive services in the most integrated settings appropriate to their needs; this includes addressing gaps that the MFP program should tackle. NYS-DOH organized an MFP work group, comprising advocates, consumer organizations, state agencies and others to provide input to the MFP demonstration. This workgroup will continue to provide input to the development of the Operational Protocol. Members will seek the cooperation of institutional and community-based provider associations, and encourage local government and private sector organizations to work together toward MFP goals.

C. IT System Developments or Enhancements

To identify MFP participants and services eligible for the enhanced FMAP, the state will develop a process to track participants and expenditures. The state would need to develop a separate database to track NHTD waiver participants, including those in the MFP demonstration, to measure quality, participant satisfaction and outcomes.

D. Independent State Evaluation

None mentioned.

NORTH CAROLINA MFP GRANT PROGRAM SUMMARY

Grantee Agency: North Carolina Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA)

Total Award: $16,897,391

Overview: The North Carolina MFP program will develop community alternatives to institutional care and provide a greater array of home and community-based services and supports. The state will create regional case management teams to identify and coordinate a broad range of services and supports.

Transition Target Groups: Persons residing in nursing facilities, state psychiatric institutions, group homes, intermediate care facilities, and state centers for the developmentally disabled.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The state plans to transition 5 percent of individuals currently residing in ICFs/MR and all children with mental illness residing in group homes. For those leaving nursing facilities, beds will not be backfilled with a person with a disability.
- **Money Follows the Person/Flexible Budgeting Goals:** North Carolina (NC) plans to implement a flexible funding arrangement for long-term care that enables funds to move along with the individual to the most appropriate and preferred settings. For the provision of waiver services, the state will transfer savings from the ICF/MR line item in Medicaid to the Community Alternatives Program for persons with MR/DD.[17]
- **Continuity of Service to Transitioned Individuals:** After the Demonstration, the state will allow home and community-based services to be available through (1) increased state appropriations for HCBS, (2) the development of HCBS waiver amendments and new waiver programs, and (3) the elimination of institutional biases and the development of flexible financing for long-term care.
- **Quality Assurance and Improvement:** The state intends to implement a quality management (QM) system that is both preventive and responsive in nature. A cross-disability quality assessment also will be employed.
- **Other State Goals:** North Carolina will submit a new waiver, "New Focus," that will include self-directed support options for individuals with developmental disabilities. Other goals include the development of an Internet-based assessment and plan-of-care tools, chronic disease self-management programs, and interactive case management systems.

[17] Unable to verify if this transfer occurred.

B. Annual Transition Targets[18]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	25	25	40	130	0	221
FY 2009	35	30	50	130	0	247
FY 2010	45	40	60	130	0	278
FY 2011	50	50	75	130	0	309
TOTAL	155	145	225	520	0	1,045

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

The state's approach will include: (1) referrals by residents, family members, guardians, and advocates; (2) referrals by hospital discharge planners, facility staff, case managers, and transition coordinators for facilities and programs; (3) nursing facility visits by regional nursing facility ombudsmen and Centers for Independent Living (CIL) staff; (4) use of the Minimum Data Set (MDS); (5) referrals by community organizations, provider organizations, and related stakeholders; and (6) access via the NC Care Link and NC Self Care Web systems, which help families and individuals make decisions about transitioning and managing their own illnesses/care at home. In addition, the state will meet with advocacy groups and interested families and individuals to share transition success stories.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The state will use assessment instruments, such as the Supports Intensity Scale (SIS), to measure the level of need of potential participants. (The SIS will be adapted for all disability groups and elderly individuals.) The state's Medicaid Uniform Screening Program will be designed to identify options for each recipient requiring a nursing facility level of care, including home and community-based care. The state proposes to develop and conduct strengths-based needs assessments and connect these to budgetary allocations.

C. Demonstration Services[19]

North Carolina has six waiver programs providing home and community-based services. They are: Community Alternatives Program for Disabled Adults (CAP/DA), CAP/Choice, CAP/Children, CAP/MRDD, CAP/AIDS, and the Piedmont combination (b)(c) behavioral health waiver. In addition,

[18] Row and column totals due not sum to the same number of annual transitions. Unable to verify correct transition targets with North Carolina. The state did not specify how the transitions would be divided between the elderly and people with disabilities. We assumed a roughly even split between the two groups, and the sum of the two groups shown in this table sums to the total across both groups listed in the state application (i.e. this summary shows 150 in each group, and the total in the state application was 300 in both groups).

[19] Unable to verify which waiver programs have waiting lists.

DHHS is implementing a Centers for Medicare & Medicaid Services (CMS) Rebalancing Initiative Grant to prevent the inappropriate or undesired placement of adults with significant physical disabilities in nursing facilities.

- **Qualified Home and Community-Based Services:** None mentioned.
- **Home and Community-Based Demonstration Services**: A number of new services will enhance the HCBS waiver packages and provide additional services under the State Plan. These services include: enhanced case management services during the transition period, one-time transition costs, peer mentoring, rehabilitation engineering, crisis management, and respite care.
- **Supplemental Demonstration Services**: North Carolina will create the Specialized Service and Support Development Committee to review the development of flexible, wraparound supports that include housing, transition services, and transportation; self-directed services; guardianship and legal services; provider capacity and community building; and HCBS waiver services and additional needed services and supports.

D. Self-Direction Options for MFP Demonstration Participants

In 2005, the state implemented the Piedmont 1915(b)(c) waiver, which informs the state about implementation of self-directed supports for persons with behavioral health issues under a prepaid managed care plan. The state's Systems Transformation Grant will be used to assess and modify person-centered planning for aging persons. Other recent efforts include a DMA-piloted program, "CAP/Choice," in two locations, to incorporate consumer self-direction and supports into the CAP/DA program. The "New Focus" Waiver, with self-directed options for individuals with MR/DD, will be submitted to CMS for approval.

E. Home and Community-Based Housing Options and Strategies

Houses constructed under HUD programs and the QAP Program, as well as housing programs developed by local hospitals, rehabilitation centers, and other community programs, will be utilized where available.

F. Workforce Strategies

North Carolina's Demonstration will establish a Community Workforce Development Committee that will address: provider agency and personnel needs; incentives to attract and retain competent personnel; transitional staffing from institutional facilities; provider training needs; training needs of family and paid care givers of participant-directed services; variation of needs among rural, urban, and limited English proficiency direct-support professionals; human resource contingency plans; utilization of unpaid support personnel; and legislative actions needed to ensure that human service resource needs can be met in these community transitions.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- HCBS waiver enrollment caps limit the number of individuals who can access care in the community.
- Budget caps limit access to CAP/DA for individuals with the greatest (i.e., most expensive) service needs.
- The current system allocates County CAP/DA slots, which means an individual can be on a long waiting list in one county, while other counties have unused slots.

- The approval process often delays appropriate care in the community.
- There are significant shortages of new, well-trained personnel to provide quality services, including direct-support workers and informal caregivers.
- Various system gaps include: (1) lack of collaboration and coordination at the state and local levels; (2) lack of safe, affordable, and accessible housing options; (3) lack of waiver services; (4) lack of effective methods to identify individuals in nursing facilities who desire to transition to community care; (5) limited community support services, including those for children with significant mental health needs; (6) limited reporting mechanisms for nursing facility transitions and mechanisms for quality monitoring and evaluation; and (7) lack of education and information sessions for hospital discharge planners, nursing facility staff, local health and human service agency staff, and health care providers.

IV. QUALITY MANAGEMENT STRATEGY

Health and safety issues will be addressed under the Demonstration Quality Assurance program, including new strategies designed to monitor, evaluate, and continuously improve participant access, participant-centered service planning and delivery, provider capacities and capabilities, participant safeguards, and participant outcomes at the individual and system levels. The state plans to conduct a cross-disability quality assessment of Demonstration participants at least annually. Feedback also will be routinely sought from participants, participant-selected representatives, and providers of services to help determine if a successful transition has been made.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The State of North Carolina Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) and its three partnering divisions, Aging and Adult Services, Vocational Rehabilitation, and Mental Health, Developmental Disabilities and Substance Abuse Services, will oversee implementation of the MFP Demonstration.

B. MFP Program Oversight/Key Stakeholder Involvement

For this Demonstration, DHHS and its relevant Divisions will collaborate with several groups, including several state agencies, consumer advocate groups, and ad hoc groups. Collaborations with both faith-based and governmental organizations will be continued and expanded during the pre-implementation phase. Further, Regional Area Agencies on Aging (AAAs); Lead Regional Organizations (which administer CAP/DA); and local agencies involved in housing, transportation, and social services will be included in this collaboration, in addition to individual ICF/MR providers and formally constituted provider organizations.

C. IT System Developments or Enhancements

The Project Director will appoint an MFP Health Information Technology (HIT) Committee to analyze system needs and make recommendations to DMA, especially as they relate to current HIT grants and transformation efforts.

D. Independent State Evaluation

None mentioned.

NORTH DAKOTA MFP GRANT PROGRAM SUMMARY

Grantee Agency: North Dakota Department of Human Services, Medical Services Division

Total Award: $8,945,209

Overview: North Dakota (ND) will build on its current 1915c waiver programs, a 2004 Real Choice Systems Change Rebalancing Grant, and the state's experience in serving those with developmental disabilities in the community to transition 110 people over the five-year Demonstration period. The state will develop a nursing facility case management transition coordinator (NFTC) service to act as a single access point, and streamline current sources of information and referrals for individuals transitioning from a nursing facility to the community. In addition, North Dakota will continue to work closely with Tribal Communities to support culturally appropriate services and pilot new efforts on the five ND Indian Reservations.

Transition Target Groups: ND's Demonstration will target: (1) elderly individuals, or those with physical disabilities who are residing in nursing facilities; and (2) individuals in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** North Dakota plans to increase access and use of home and community-based services across the state and in the Tribal Communities to allow seniors and persons with disabilities to remain in the community when appropriate and desired. The state projects an overall net decrease of 30 ICFs/MR beds over the course of the five-year Demonstration; five beds in the first year, eight beds in the second and third years, five beds in the fourth year, and four beds in the fifth year.
- **Money Follows the Person/Flexible Budgeting Goals:** The Department currently has the flexibility to transfer appropriated funding between line items, with the approval of the Executive Director. ICFs/MR and HCBS funds are managed by the Disability Services Division, Developmental Disabilities Unit (with support provided by the Medical Services Division). The state plans to eliminate barriers that restrict the use of Medicaid so as to enable people to receive support for long-term care services in a setting of their choice and increase the Medicaid program's ability to support home and community-based services.
- **Continuity of Service to Transitioned Individuals:** Individuals will have access to HCBS and State Plan services after the Demonstration period ends. Nursing Facility Transition Coordinators (NFTCs) will develop a long-term support system plan for individuals transitioning from nursing facilities, which may include identifying a team to continue supporting the individuals after the 12-month transition period ends.
- **Quality Assurance and Improvement:** ND will enhance its existing quality assurance program to collect specific data on individuals transitioned from nursing facilities, including measures of satisfaction, quality of service provision, length of time in the community, and cost effectiveness.
- **Other State Goals:** None mentioned.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	12	13	5	0	0	30
FY 2009	12	13	8	0	0	33
FY 2010	11	4	8	0	0	23
FY 2011	11	4	9	0	0	24
TOTAL	46	34	30	0	0	110

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

NFTCs will develop a media and educational plan to inform traditional referral agencies about the program. Individuals in nursing facilities meeting eligibility criteria will be informed of the demonstration project, either by letter, county eligibility, or nursing home staff.

Individuals in ICFs/MR will be identified using the existing referral process, whereby consumers and their families work with a case manager from Development Disabilities Case Management (DDCM) to make decisions about where and how services will be provided, including possible community placements. Individuals in small, community-based ICFs/MR are given opportunities to work with their families and developmental disabilities (DD) case manager to make informed decisions regarding the provision of services and supports.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

North Dakota plans to access information contained in the Minimum Data Set (MDS) to identify nursing facility residents who would like to be served in an alternative setting. The most recent MDS will be used to identify those who have resided in a facility for six months, desire to live in the community, and are not severely cognitively impaired. An NFTC will conduct a face-to-face interview with referred individuals to determine if transitioning is desired, which residents are most likely to be successful in transitioning, and the availability of resources in the community.

C. Demonstration Services

North Dakota currently offers home and community-based services through a variety of programs that include state-funded services, Medicaid 1915c waivers, and additional pilot projects and demonstration grants that serve the elderly, disabled, individuals with traumatic brain injury, and individuals with developmental disabilities. Additional waiver slots equal to the number of individuals transitioned during the demonstration will be added if existing slots are exceeded.

For the nursing facility group, the NFTCs will serve as a single access point and operate out of Centers for Independent Living (CIL) that currently serve 12 counties in North Dakota and will expand statewide during year two of the demonstration. ND expects to request a waiver of the income and resource eligibility requirements to allow the application of the institutional eligibility rules (specifically the spousal impoverishment provision) for individuals transitioning from a nursing facility who meet the

level of care criteria, receive no waivered services, but receive State Plan services identified as qualified HCB expenditures.

The demonstration for those leaving ICFs/MR will be statewide. ND does not anticipate requests for additional waivers, modifications to existing waivers, or State Plan amendments necessary to operate its program for the population transitioning from ICFs/MR.

- **Qualified Home and Community-Based Services**: Transitioned individuals will have access to all current HCBS waiver and State Plan services.
- **Home and Community-Based Demonstration Services**: People transitioned from nursing facilities will be assigned to a NFTC for enhanced case management, a demonstration service. The NFTC will assess transition needs, help with transition planning, and assist with housing options, provider selection, referrals, and service monitoring for an individual prior to discharge from a nursing facility. In addition, the NFTC will conduct ongoing evaluations to ensure that an individual's needs are being met in the community and to assess and identify problems the individual may encounter that could put him/her at risk in the community. Individuals who are MR/DD will not receive any additional services as part of the demonstration.
- **Supplemental Demonstration Services**: People transitioning from nursing facilities will have access to security and utility deposits, home furnishings, assistive technology devices, and one-time modification for a vehicle owned by the individual. People transitioning from ICFs/MR will receive accessibility equipment and modifications, health and safety technology, apartment furnishings, security deposits, utility set-up fees, home modifications and/or retrofitting to address accessibility, adaptive equipment and/or assistive technology, and one-time vehicle modifications.

D. Self-Direction Options for MFP Demonstration Participants

ND has two Independence Plus self-directed support waivers for children and adults with mental retardation and developmental disabilities. ND has submitted a waiver to the Centers for Medicare & Medicaid Services (CMS) that would provide in-home services to those children with extraordinary medical needs who otherwise would require hospitalization or nursing facility care. The state legislature has approved a program manager position in anticipation of the waiver being implemented by November 2007.

E. Home and Community-Based Housing Options and Strategies

Due to the state's shortage of available housing, the NFTCs are responsible for networking with housing agencies to increase possible options. NFTCs will develop a plan to improve knowledge of available and accessible housing, and will work with agencies having grants available to make a residence accessible. Potential stakeholders and partners include the U.S. Department of Housing and Urban Development (HUD), the North Dakota Housing Finance Agency (NDHFA), Rebuilding Together, local housing authorities, and Community Action.

F. Workforce Strategies

The state has a system that allows individuals and agencies to register as Qualified Service Providers (QSPs) to provide competent home and community-based services. Rates paid to QSPs were raised in 2005 and 2007.

III. CHALLENGES TO REBALANCING THE LONG-TERM CARE SYSTEM AND EXPANDING HOME AND COMMUNITY-BASED SERVICES

- Payment for community-based services, such as planning, securing housing, deposits, training staff, equipment purchase, and other services, cannot be made if an individual still is in an institution. Further, provider costs after an individual is transitioned from an institution of mental disease (IMD) or other institution cannot be reimbursed.
- The long-term care system is extremely complex and cumbersome, limiting the state's ability to provide a comprehensive and flexible long-term delivery system.
- The greatest barrier to self-directed supports is an inadequate payment system for individual and agency QSPs, although the most recent increase in QSP rates by the 2007 legislature have improved this situation.
- ND lacks sufficient and affordable housing, especially for low-income groups. In addition, there is a lack of available funding for modifications to meet the needs of people with disabilities.
- Although the state has been successful in increasing funding and services for community-based long-term care services in recent years, the gap between the amount of funding directed to long-term care services and the demand for these services has widened faster than the state's ability to secure additional funding.
- There is a lack of capacity to meet the current and projected needs of MR/DD individuals in the community.

IV. QUALITY MANAGEMENT STRATEGY

The state's existing quality assurance program is based on the CMS Quality Framework. Individuals transitioned from nursing homes will be included in this program. The Department's Research Division will develop a survey to analyze client satisfaction, as well as ongoing needs among those transitioned from nursing homes.

For ICFs/MR services, the state's overall quality management system builds on the Quality Framework, and encompasses certification and inspection of care facilities, licensing of program services, provider accreditation, policies for reporting abuse, staff training programs, monitoring, and coordination with the North Dakota Protection and Advocacy Program and corporate guardians.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The Medical Services Division will coordinate with the other agencies involved to oversee MFP participants. Transition services for nursing facility residents will be coordinated between Medical Services and four CIL across the state. Transition services for ICFs/MR residents involve Medical Services and three additional entities: The Developmental Disabilities Division within the Department, which provides support of MR/DD waiver and ICFs/MR field operations; Developmental Disabilities Case Management (DDCM), which provides case management services; and the North Dakota Developmental Center (NDDC), which operates institutional ICFs/MR services. The state also plans to target HUD, NDFHA, Rebuilding Together, local housing authorities, and Community Action as potential partners in this implementation. The state incorporated input from several other agencies in developing the implementation plan, and expects to continue this collaboration during the demonstration.

B. MFP Program Oversight/Key Stakeholder Involvement

In 2008, the state will create a stakeholder committee led by the MFP project manager to assist in rebalancing ND's long-term care system. The committee will be comprised of individuals representing the Governor's Olmstead Commission, Home Health, NDFHA, CIL, Public Health, Senior Centers, Older American Act Providers, County Social Service Board Directors, Long Term Care Association, North Dakota Center for Persons with Disabilities, licensed DD community providers, and other interested parties. The committee's purpose will be to educate consumers about rebalancing efforts, provide information to the Aging and Disability Resource Center Program (ADRC) on available resources, and identify activities and services that communities lack.

C. IT System Developments or Enhancements

For individuals in nursing facilities, North Dakota will use the MDS database to track MFP participants in the claims payment system. This will allow for payment, reporting, and tracking of qualified HCBS, Demonstration, and supplemental demonstration services. In addition, the state will be able to collect specific data about transitioned individuals (e.g., length of time institutionalized, length of time in community living, and costs of transition plan) to analyze the transition process.

For the ICFs/MR group, North Dakota will use its existing IT system, Achieving Support System Integration through Services and Technology (ASSIST), to identify MFP participant information and track case management.

D. Independent State Evaluation

None mentioned.

OHIO MFP GRANT PROGRAM SUMMARY

Grantee Agency: Ohio Department of Job and Family Services (ODJFS)

Total Award: $100,645,125

Overview: The program builds on existing 1915c waiver programs and Access Success, a prior Nursing Facility Transition Grant program, in order to transition 2,231 residents (statewide) who have resided for six months or more in nursing facilities and other institutions to home and community-based settings. To rebalance the long-term care system, the state aims to consolidate and computerize the pre-admission assessment system across four state departments to support tracking and monitoring of all institutional placements, and will develop mechanisms to limit "back-filling" of institutional beds vacated by MFP transitioned individuals.

Transition Target Groups: The project targets the elderly, physically disabled adults (age 59 and younger) and medically fragile children (including those with traumatic brain injury), individuals with mental retardation or developmental disabilities, and mentally ill individuals residing in nursing facilities.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The state seeks to (1) increase the number of individuals in Medicaid HCBS waivers, (2) increase beyond predicted normal program growth total Medicaid spending for waiver and State Plan services, especially for MFP participants, (3) decrease the number of Medicaid enrollees residing in nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) and the number of Medicaid-funded "bed days" in each, (4) increase the number of nursing facility or ICF/MR beds that are closed to new Medicaid residents, and (5) enact and implement statutory or administrative rule changes in support of rebalancing efforts.

  In addition, the state plans to redesign its nursing facility and ICF/MR assessment and entry process and transform it from a paper-based to an electronic system that better supports referrals to and monitoring of the long-term care delivery systems that serve different populations.

- **Money Follows the Person/Flexible Budgeting Goals:** The state plans to use MFP as an opportunity to spur debate on how current resources spent on institutional care can follow MFP participants as they transition back to the community.

- **Continuity of Service:** Qualified home and community-based services will continue, as medically necessary, for all eligible individuals during and after the conclusion of the MFP Demonstration period.

- **Quality Assurance and Improvement:** The state aims to maintain continuous quality improvement (CQI) in existing programs to promote participant choic and increase program effectiveness.

- **Other State Goals:** The state will engage key stakeholders on how best to recruit MFP participants, develop affordable housing, implement supported employment programs, and approach the subject of institutional bed closure.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	260	17	112	8	0	397
FY 2009	380	32	164	12	0	588
FY 2010	388	45	148	17	0	985
FY 2010	400	64	160	24	0	648
TOTAL	1,428	158	584	61	0	2,231

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

The state will identify potential MFP participants based on the nursing facility Minimum Data Set (MDS) questions regarding residents' desire to leave, the availability of family/guardian to support them, and an estimated length of stay. It will also use Medicaid claims data from Ohio's existing Data Warehouse and Medicaid Decision Support System (DSS) to identify residents of more than six months, and accept referrals from a wide range of people and organizations that may know of potential MFP participants, including the state aging network, long-term care ombudsmen, and others.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The MFP project will develop a centralized "hub" for identification, tracking, and referral of MFP participants to ensure individual needs are met. In its fiscal year 2008 and 2009 budgets, the state will propose funds for Medicaid nurses to perform on-site reviews to locate nursing facility residents with mental illness who could benefit from a transition to a community setting.

C. Demonstration Services

The state plans to contract with non-governmental organizations experienced in transition planning to conduct individualized person-centered planning and risk management for MFP participants. Medicaid programs to be made available to MFP participants include existing 1915c waivers, which require expanded capacity ("slots") and new funds for an additional 1500 MR/DD slots authorized by the governor and the general assembly.

- **Qualified Home and Community-Based Services:** Community transition services will be added to all 1915c waiver programs currently lacking this category. The state will submit amendments to existing waivers to provide these services, but will cover these as Demonstration services until waiver amendments are approved.
- **Home and Community-Based Demonstration Services:** MFP participants can receive all services currently available through existing 1915c waiver programs, and four additional sets of services provided via contract with a limited network of venders: (1) independent living skills, (2) peer/caregiver support, (3) benefits coordination, and (4) housing location services, which are capped at $1,000/person. The state proposes to add selected services to all HCBS waiver programs: day habilitation, supported employment, respite care, social work and counseling, nutrition consultation

and extended private duty nursing. These services will be phased out as people can be sustained through an HCBS waiver, Medicaid State Plan, or other non-Medicaid services.

- **Supplemental Demonstration Services:** These include service animals and adapted home computers; others may be added during operational protocol planning period.

D. Self-Direction Options for MFP Demonstration Participants

The state will make available to MFP participants all existing or new self-directed options planned to be offered in each of the 1915c waiver programs. Existing self-directed options will also be expanded as part of the MFP Demonstration. The state plans to hire a fiscal intermediary to perform fiscal management tasks for MFP participants who wish to self-direct their care.

E. Home and Community-Based Housing Options and Strategies

State agencies are currently adding a "housing annex" with an online directory of affordable and accessible housing to ConnectMeOhio.org, which is a Web portal for Ohioans with disabilities and their caregivers. The state plans to create a "bridge" rent subsidy with non-MFP funds to fill the gap for MFP participants while they are on waiting lists for Section 8 or other publicly subsidized housing programs. It will also encourage local public housing authorities to give MFP participants preferential status on wait lists. MFP funding will be used to make home modifications and also to create a comprehensive resource guide to public housing assistance.

F. Workforce Strategies

The state plans to allow family members or non-certified home care workers to provide Medicaid-covered personal care services to MFP participants as part of self-directed service options, primarily under existing 1915c waiver programs.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- The state's nursing facility occupancy rate fell from 92 percent to 87 percent between 1993 to 2003; this left 13,000 empty beds, but no mechanism to permanently close them.
- Ohio lacks a state-funded in-home services program for non-Medicaid eligible individuals to promote the use of community-based services among those most likely to qualify for Medicaid soon after entering a nursing home (by using up their resources). In addition, as a "209b" state, Ohio has more restrictive Medicaid financial eligibility requirements for aged, blind and disabled individuals than many other states.
- Ohio does not cover personal care as an optional Medicaid service, so the only way to provide these services is through waiver programs.
- The state has a long waiting list for HCBS waiver services; recently it reached 25,000, with about 22,000 of those being individuals with MR/DD.
- The growth in home and community-based care in the past six years is due to a large infusion of new local, state and federal funds, rather than a decrease in Medicaid spending on institutional care. Further growth in spending on home and community-based services depends upon reducing Medicaid funds for institutional care, particularly since a recent state law limits the growth of state general fund expenditures to 3.5 percent in any single fiscal year.
- Ohio does not have a single "point of entry" for long-term care services, and delegation of responsibility for pre-admission screening is divided among four state agencies and the single state

Medicaid agency lacks the tools to monitor admissions, lengths of stay, and utilization rates across all long-term care populations.

IV. QUALITY MANAGEMENT STRATEGY

The state plans to build on its existing quality assurance and improvement processes for home and community-based services and programs to guide the MFP quality management system. In the spring of 2006, the state created an Home and Community-Based Services Quality Steering Committee to facilitate quality improvement in 1915c waiver programs. The committee is charged with identifying core performance measures, examining the performance of HCBS waiver services, and using performance data to ensure quality improvement. The Committee will (1) inventory existing home and community-based system processes for assessment, discovery, remediation and improvement, (2) identify best practices or gaps in the system, (3) identify quality indicators relevant to MFP services, and (4) incorporate mechanisms to measure the quality of all other Medicaid State Plan services provided to MFP participants. Since 2003, the state has used Participant Experience Surveys to monitor satisfaction among HCBS waiver clients and will continue to do so for MFP participants.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

ODJFS (the single-state Medicaid agency) will convene an Interagency Steering Committee to coordinate MFP activities among those agencies involved in MFP planning and implementation, including: the Department of Aging (ODA), the Department of Alcohol and Drug Addiction Services (ODADAS), the Department of Health (ODH), the Department of Mental Health (ODMH), the Department of Mental Retardation and Developmental Disabilities (ODMR/DD), and the Office of Budget and Management. Partnerships among agencies and stakeholders were solidified through the Governor's 2001 *Ohio Access for People with Disabilities*, which set the state for systems-level long-term care change.

B. MFP Program Oversight/Key Stakeholder Involvement

The state plans to convene the MFP Planning and Advisory Committee, which will bring together key stakeholders to advise and guide the program's planning and implementation. The Committee will involve consumers and advocates, including such organizations as AARP, the Arc of Ohio, and Centers for Independent Living, among others. It will also have representation from nursing facility and ICF/MR provider associations, and home and community-based service providers, whether part of an agency or independent. The state's Olmstead Task Force also will be represented, as it was instrumental in developing the state's MFP grant proposal, and provides ongoing oversight and policy recommendations to Ohio's long-term services and support. The MFP Planning and Advisory Committee will create several work groups to develop specific aspects of the program, including: housing, workforce development, long-term are pre-admission screening, education/training, informed consent, information technology (IT), payment, and rebalancing.

C. IT System Developments or Enhancements

MFP will hire a fiscal intermediary to identify and track MFP participants and convert claims data into formats needed for billing and other purposes. The existing Data Warehouse and Medicaid DSS will be expanded to incorporate data sources from multiple delivery systems. In the first year of the MFP program, the Medicaid agency will implement Medicaid IT changes to identify potential MFP participants, and track those enrolled by attaching an MFP marker to Medicaid recipient master files. Over the long term, Ohio plans to integrate MFP participant tracking into its new Medicaid IT system.

D. Independent State Evaluation

None mentioned.

OKLAHOMA MFP GRANT PROGRAM SUMMARY

Grantee Agency: Oklahoma Health Care Authority (OHCA), the single State Medicaid Agency will serve as the lead agency in partnership with the Developmental Disability Services Division (DDSD) of the Department of Human Services, the Long-Term Care Authority (LTCA), and Progressive Independence (PI).

Total Award: $41,805,358

Overview: OHCA and its partners will build on policies and procedures developed for transition pilots that were initiated using a Real Choice Systems Change grant. The three agencies working with OHCA will each focus on different populations to transition a total of 2,075 individuals over the Demonstration period. Using the state's Community Waiver, DDSD will work to transition 200 of the 452 group home residents in the state. The LTCA proposes to transition 1,575 residents classified as frail elderly using the state's ADvantage Waiver. PI proposes to transition 300 clients who are not directly served by DDSD and LTCA—50 from institutions, and 250 from nursing facilities.

Transition Target Groups: Developmentally disabled, frail and elderly, disabled adults in institutions and facilities not targeted by the other agencies.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Reduce the size of public intermediate care facilities for the mentally retarded (ICFs/MR) from 452 to 152 beds over five years by transitioning residents using the Community Waiver program.
- **Money Follows the Person/Flexible Budgeting Goals:** Oklahoma will work to implement the recommendations from its 2002 Real Choice Systems Change grant that long-term care funds be appropriated as a single line item. For each person who transitions from a facility, a bed will be closed and the funding for those beds will be transferred to waiver program funding.
- **Continuity of Service to Transitioned Individuals:** None mentioned.
- **Quality Assurance and Improvement:** DDSD, LTCA and PI will use the procedures already in place within the waiver programs to provide quality assurance for individuals receiving home and community-based care services, and provide for continuous quality improvement service delivery. During pre-implementation, the ADvantage waiver Quality Management Strategy will be updated to include monitoring and measures specific to institutional transition. As the long-term care system evolves, the state anticipates making additional, multi-program statewide enhancements to integrate the quality management system.
- **Other State Goals:** Oklahoma will implement a comprehensive entry point, a One-Stop Resource Center, that will begin operation in fall 2007 (in addition to the five Centers for Independent Living already in place).

B. Annual Transition Targets[20]

	Elderly	Individuals with Physically Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	75	60	32	0	0	167
FY 2008	200	60	72	0	0	332
FY 2009	350	60	72	0	0	482
FY 2010	450	60	24	0	0	534
FY 2011	500	60	0	0	0	560
TOTAL	1,575	300	200	0	0	2,075

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

DDSD will target group homes in the Northern Oklahoma Resource Center Enid (NORCE) and in the Southern Oklahoma Resource Center (SORC). LTCA will have a phased transition scheme, starting in Tulsa and Oklahoma counties in the first year, expanding to the metropolitan area in the second year, and transitioning people statewide by the fifth year.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

Processes, procedures, assessment tools, outreach material and staff training developed in two pilot programs will be used to identify, assess and successfully transition persons from institutions. Transition coordinators will work with the individual and family to develop a comprehensive service plan.

C. Demonstration Services

DDSD and ASD operate five waivers including the Community Waiver (to support individuals with mental retardation and related conditions), ADvantage Waiver (to serve the frail elderly ages 65 and older), Homeward Bound Waiver (part of a class action settlement), In-Home Supports Waiver for Adults (to remove those with mental retardation from other waiver waiting lists) and In-Home Supports Waiver for children. Waiver services include: case management, skilled nursing, personal care, respite, adult day care, home-delivered meals, advanced supportive/restorative assistance, specialized medical equipment and supplies, personal emergency response system, case management for institutional transitions, and consumer-directed personal assistance and supports.

Transition coordinators from each program will use an agreed-upon process to assist the individual and family members to complete the entire transition process. Oklahoma's Medicaid Waiver and State Plan Personal Care programs provide the majority of supportive services used by people transitioning from institutional settings.

[20] Initial state application showed 2,100 total transitions due to arithmetic error.

- **Qualified Home and Community-Based Services**: This will cover services currently available through waiver programs, including the Community and the ADvantage Waivers; the state plans to amend the latter to include coverage for assisted living and adult foster care.
- **Home and Community-Based Demonstration Services**: This includes institutional Transition Services related to establishing residence in the community and assisted living. Also, services that are provided as part of the Demonstration but are not "qualified home and community-based services" will be included in this category until they are approved.
- **Supplemental Demonstration Services**: This category includes nutritional, substance abuse, and family services (for elderly transitions).

D. Self-Direction Options for MFP Demonstration Participants

Plans are in place to expand the Oklahoma Self-Directed Care Pilot Program statewide (originally included in the Oklahoma Self-Directed Care Act of 2005). This pilot program allows the consumer to hire and fire the staff who provide in-home support services; purchase basic and ancillary services, medical supplies, day care, and home modifications and assistive devices; and set the rate of pay for staff in the home (within the established Medicaid rates). Oklahoma will also continue to develop LTCA's Person-Centered Planning (PCP) approach for statewide replication. Expansion of the PCP will be combined with Consumer-Directed Personal Services and Supports (CD-PASS), which was added as a benefit option within the ADvantage waiver under the 2001 Real Choice Systems Change grant.

E. Home and Community-Based Housing Options and Strategies:

The state's Centers for Independent Living (CILs) provide non-residential, community-based advocacy, information, referral, peer support and independent living skills training. These CILs will be intricately involved in defining and developing housing alternatives.

Progressive Independence (PI) has two rental assistance programs: Shelter+Care and the Mainstream Voucher program. PI has applied for a small grant from the Sarkey Foundation to bridge transition gaps to cover the initial cost of application fees, first month's rent, deposits, food, furniture and supplies. PI is also negotiating to broaden their partnership with the Housing Authority to develop independent living housing communities on donated land.

F. Workforce Strategies

DDSD currently monitors staff turnover on a monthly basis using Web reporting and helps provider agencies, LTCA and OHCA monitor direct care staff turnover. In 2005, OHCA partnered with other state agencies to develop a pilot program to improve training using a broadened curriculum and career ladder paradigm. The state has other pilot programs for direct care workers also, including an expanded CNA program at Oklahoma State University-Oklahoma City.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- Structural budgetary obstacles posed by the segregation of long-term care dollars into line items in separate agency budgets, which lessens the flexible use of such funds for community supports.
- The fragmentation of information about long-term care options and eligibility, and the absence of a Comprehensive Entry Point to the system.
- The service gaps in the current Institutional Transition Services needed to assist people to successfully transition from an institutional environment into the community—for example, long-

term care services are more limited in rural areas than urban ones; people with head injuries have limited options in all areas of the state.

- The need for better assessment tools to identify candidates in institutional settings who prefer to be served in a community setting, and enhanced coordination between institutional centers (hospitals and nursing facilities) and home and community-based programs.
- There is a significant shortage of affordable, safe, and integrated housing and an absence of housing with options for services.

IV. QUALITY MANAGEMENT STRATEGY

Major components of the state's quality management strategy include (1) building quality into the design of the system of services and supports in home and community-based care through checks and balances and fail-safe systems design, (2) employing various methods of obtaining current information about the consumers, providers, stakeholders and service delivery system, (3) using mechanisms to identify and correct deficiencies and prevent future occurrences, and (4) analyzing information to identify patterns and trends in order to proactively address system issues.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

OHCA—Oklahoma's single state Medicaid agency—will serve as the lead agency in partnership with the Aging Services and Developmental Disabilities Services Divisions of the Oklahoma Department of Human Services, the Department of Mental Health and Substance Abuse Services, the Developmental Disabilities Council, the Center for Learning and leadership at the University of Oklahoma Health Sciences Center, the Olmstead Strategic Planning Committee, the Area-wide Aging Agency, and Progressive Independence. OHCA will work closely with: the Public Housing Authorities to find accessible housing, the Centers for Independent Living to address the physical moving process, Department of Human Services on fiscal responsibility and service delivery, Vocational Rehabilitation on educational programs and funding, Aging Services for transportation programs, legal services for safety needs and patient rights, and home health providers for service plans, progress reports, and evaluations.

B. MFP Program Oversight/Key Stakeholder Involvement

OHCA's Opportunities for Living Life (OLL) division is responsible for managing the grant. The OLL participates in the Olmstead Commission, the Long-Term Care Systems Council, the Senior Health Insurance Counseling Program, and other state agencies, and is therefore well connected with the agencies, providers, and other stakeholders.

C. IT System Developments or Enhancements

DDSD will use the technology available in the OHCA Medical Management Information System (MMIS), which is already structured to provide the kind of comprehensive information needed when partnering with multiple agencies.

D. Independent State Evaluation

None mentioned.

OREGON MFP GRANT PROGRAM SUMMARY

Grantee Agency: Oregon Department of Human Services, Division of Seniors and People with Disabilities (SPD)

Total Award: $114,727,864

Overview: For 25 years, Oregon has made great strides in rebalancing its long-term care system, which placed it first among all states and the District of Columbia in the proportion of Medicaid long-term care expenditures made for home care, and last among states and DC in its nursing facility occupancy rate. Although Oregon has transitioned many individuals to community settings, the state proposes to use the MFP project to demonstrate that long-term institutionalized populations of all ages, with complex medical and long-term care needs, can be served in their communities with wraparound packages of support and services. This grant will develop the necessary packages of services for the diverse populations it helps to transition.

Transition Target Groups: Oregon plans to transition 780 individuals from nursing and intermediate care facilities into their communities. In Phase One, the state proposes to transition 40 children with developmental disabilities from pediatric nursing facilities; Phase Two will focus on transitioning 300 seniors with end-stage dementia; Phase Three will focus on 400 adults who live in nursing facilities (300 adults with physical disabilities and 100 adults with developmental disabilities); and Phase Four will target 40 adults with developmental disabilities residing in Oregon's only Intermediate Care Facility for the Mentally Retarded (ICF/MR).

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Building on previous efforts, Oregon plans to extend the option of community-based placements to individuals with complex medical and long-term care needs. The state proposes to transition 780 individuals, or 16.5 percent of the institutionalized Medicaid population.
- **Money Follows the Person/Flexible Budgeting Goals:** Oregon's long-term care expenditures are forecast using global budgeting techniques, encompassing all long-term services under the Seniors and People with Disabilities (SPD) Division. To address issues identified as barriers to flexible use of Medicaid funds, Oregon plans to assess provider capacity, determine if special rates are needed for the identified populations, and develop a model waiver service package as an alternative to nursing home care. In addition, the state plans to design criteria for specialized services needed by individuals, and a system to pay for them; in the past, they have not been accessible using Medicaid funds.
- **Continuity of Service to Transitioned Individuals:** A full package of Medicaid home and community-based services will remain available to participants after the Demonstration program.
- **Quality Assurance and Improvement:** Oregon will continue its current quality assurance system for all individuals served in community settings; this system addresses standards, monitoring, and response activities.

- **Other State Goals:** The state plans to collaborate with other agencies and organizations to increase participants' access to affordable housing, non-medical transportation, and substance abuse services.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	61	0	31	0	0	92
FY 2009	94	83	50	0	0	227
FY 2010	145	218	98	0	0	461
FY 2011	0	0	0	0	0	0
TOTAL	300	301	179	0	0	780

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

For participants in Phases 1-3 of the Demonstration, the state will work closely with families, nursing facilities, foster care homes, state child welfare and local developmental disability agencies, schools, community organizations, Area Agencies on Aging (AAAs), family training and support centers, and community members, to identify possible participants. In addition, Oregon will use the current Medicaid Management Information System (MMIS) and the Minimum Data Set (MDS) to identify potential participants. In Phase 4, the state will work with individuals who live in Oregon's only remaining ICF/MR, as well as their guardians, family members, and Individual Service Plan teams, to identify potential transitions.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

In Phase 1, Oregon plans to transition 40 children under the age of 21 either with developmental disabilities, as evidenced by a preadmission screening and resident review (PASARR), or who do not meet developmental disability criteria, but have complex but stable medical needs that may require registered nurse delegation services and oversight. The department will use its Client Assessment and Planning System (CA/PS) tool to determine the amount and scope of services needed. Transition sites will be located primarily in Oregon's two largest urban areas—Portland and Eugene.

In Phase 2, Oregon plans to transition 300 seniors who have late-stage dementia (as evidenced by dependency in three activities of daily living, one of which is cognition), and who need registered nurse assessment and monitoring at least weekly. Transition sites will be located throughout Oregon, but primarily will be found in the 42 Oregon cities with a population of 10,000 or more.

In Phase 3, the state plans to transition 400 adults—100 adults with developmental disabilities, as evidenced by a PASARR, and an additional 300 adults who have complex but stable medical needs and do not require daily registered nurse services. Transition sites will be located in Oregon's six metropolitan statistical areas (MSAs)—Bend, Corvallis, Eugene, Medford, Portland, and Salem.

In Phase 4, the state plans to focus on transitioning 40 adults with developmental disabilities who live in Oregon's only remaining ICF/MR. Transition sites will be located throughout Oregon, but primarily will be found in the 42 cities with a population of 10,000 or more.

C. Demonstration Services

Oregon's current system of long-term care waivers includes a 1915c nursing facility waiver, two 1915c model waivers for children, two home and community-based services waivers for people with developmental disabilities, and an 1115 Independent Choices Demonstration waiver. The state does not anticipate legislative changes, although they may become necessary to allow the department to implement new service models not currently defined.

- **Qualified Home and Community-Based Services**: For Phase 1 participants (children under the age of 21), the state expects to request a model waiver to allow them to live in their family homes, where maximum self-direction can be exercised. In addition, the state expects that the existing waiver may need amending to allow for the continuation of respite services. At this time, Oregon anticipates that no additional waivers will be necessary to transition Phase 3 or 4 participants.
- **Home and Community-Based Demonstration Services**: To address complex and challenging needs in non-institutional settings, Oregon plans to provide wraparound services, such as 24-hour access to nurse, or other professional consultation, and targeted case management. Case managers will be used to identify possible placements, develop risk mitigation strategies, and coordinate other services, such as housing, equipment, transportation, and access to local and specialized medical services. Specialized nurses will review final transition plans and be actively involved in the process, as well as in ongoing services.
- **Supplemental Demonstration Services**: All Demonstration participants will be provided with access to assistive technology, nutrition services, and housing-related services. In addition, the state plans to provide the elderly and individuals with physical disabilities with access to durable medical equipment and family services. The elderly also will be provided with hospice services, and individuals with physical disabilities will have access to substance abuse services.

D. Self-Direction Options for MFP Demonstration Participants

In-home programs fully utilize self-direction and individual budgets through various services supported by public and private fiscal intermediary services. In Oregon's Home Care Worker program, provided through the Aged and Physically Disabled 1915c waiver, recipients are authorized to hire a home care worker (HCW) to assist them with daily living. The clients direct the HCW in all authorized tasks. In addition, Oregon's 1115 Independent Choices Demonstration waiver provides seniors and people with physical disabilities the authority to manage both the cash benefit and the provision of their home and community-based services. Oregon plans to request that its Independent Choices waiver be converted to a service under Section 1915j of the Social Security Act, and that the program be available statewide. Finally, adults with developmental disabilities can receive in-home services through the Support Services program (authorized under Oregon's 1915c Support Services Waiver), where "support service brokerages" assist clients in decisions related to the development and provision of services.

E. Home and Community-Based Housing Options and Strategies

Affordable housing is limited in Oregon, but the state has a history of supporting a number of efforts to provide community housing in small neighborhood homes for persons with developmental disabilities. The state plans to explore the development of individual apartment settings, in which residents share care services.

F. Workforce Strategies

With an increased focus on foster care homes and smaller, community residential providers for people with developmental or physical disabilities, Oregon plans to support the development and training of a network of medically skilled respite providers and families.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- The state has limited availability of affordable housing options.
- The state has limited availability of non-medical transportation options.
- The lack of respite funds and resources requires a redesign of staffing plans and reimbursement models.
- Provider supports need to be developed to allow very small community providers and families to succeed.
- There is a need for increased coordination among health professionals, more support for providers, and more frequent review of care plans to assure that these clients avoid costly institutionalized care. In addition, the case managers assigned to these clients must have expanded skill sets and low case ratios.
- There are several specialized services (e.g., housing deposits, assistive technology) that are needed by individuals transitioned to the community, but typically are not funded through Medicaid.
- Limited availability of substance abuse services, especially those funded through Medicaid.

IV. QUALITY MANAGEMENT STRATEGY

Oregon already has an extensive quality assurance system in place for all individuals served in community settings, to ensure competent management, program quality, and the cost-effectiveness of community-based services. The basic quality assurance system includes three fundamental elements:

- **Standards.** The state identifies standards for services, including determination of both the specific rules and the underlying values that form the foundation for services. Oregon's licensing and quality of care rules incorporate the values of integration, choice, and independence.
- **Monitoring.** The state monitors all levels of its service system through licensing and certification reviews; reviews of services outcomes; reviews of complaints and serious events; financial audits; and obtaining consumer satisfaction information. Service providers are responsible for monitoring their systems and consumers stay involved by providing input and/or participating in the analysis of information.
- **Response Activities.** These activities are intended to check the status of service delivery and include technical assistance and training to enhance a provider's ability to deliver and administer services, providing in-home nursing supports if needed, working with the client to dismiss HCW's who are not providing quality care and providing emergency supports if needed.

SPD is actively working to build on this system to promote the outcomes of competent management, program quality, and cost-effectiveness. Once implemented, the state's new MMIS will be used in existing Quality Management tools to monitor quality of services post-transition.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The Department of Human Services, Division of Seniors and People with Disabilities will oversee and coordinate the activities involved with this grant.

Oregon's community-based system of care was based on the coordination of several agencies and organizations, including providers, provider associations, local AAAs, local governments, other state agencies, and consumer and advocacy organizations. This Demonstration grant will build on these relationships by increasing the focus on critical areas such as housing, transportation, and mental health and addiction services. Oregon plans to build statewide and local coalitions, in collaboration with the Oregon Housing and Community Services and local housing authorities, to develop effective strategies to address housing barriers. Additionally, Oregon will work with the Oregon Department of Transportation to address concerns regarding non-medical transportation and community involvement. SPD will work within DHS to provide effective and appropriate substance abuse services in partnership with the DHS Addictions and Mental Health Division (AMHD).

B. MFP Program Oversight/Key Stakeholder Involvement

SPD will continue its partnership with nursing facilities, community-based case providers, the provider associations, local governments, the Home Care Commission, Area Agencies on Aging, County Developmental Disabilities Programs, County Mental Health Programs, the Governor's Commission on Senior Services, the Oregon Council on Developmental Disabilities, and other advocacy and consumer-focused organizations, to develop systems and supports to effectively transition the target populations from institutions to the communities.

C. IT System Developments or Enhancements

Oregon is scheduled to implement a new Medicaid Management Information System (MMIS) in the first calendar quarter of State FY 2008. The state will use the current MMIS to identify Medicaid and MFP participation eligibility prior to transition, and the new MMIS to track services eligible for the enhanced Federal Medicaid Assistance Percentage (FMAP).

D. Independent State Evaluation

None mentioned.

PENNSYLVANIA MFP GRANT PROGRAM SUMMARY

Grantee Agency: Pennsylvania (PA) Department of Public Welfare (DPW)

Total Award: $98,196,439

Overview: Pennsylvania has a well-developed system for transitioning individuals from facilities to home and community-based settings. The state's MFP Demonstration will strengthen these efforts and increase the number of individuals who can access home and community-based services.

Transition Target Groups: Persons over the age of 65 with mental health diagnoses, persons with cognitive disabilities, and nursing home residents.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The state will expand the number of people transitioned from nursing homes, mental health hospitals, and MR/DD institutions, and increase the amount of funds spent on home and community-based services (HCBS). Five to 10 percent of transitioned individuals will be residents over the age of 65 who have been residing in state mental hospitals for two years or longer. An estimated 10 to 15 percent of transitioned individuals will be residents from state mental retardation centers, and 70 to 80 percent of transitioned individuals will be residents from nursing **facilities throughout the state.**
- **Money Follows the Person/Flexible Budgeting Goals:** None mentioned.
- **Continuity of Service to Transitioned Individuals:** The state will continue to serve MFP clients.
- **Quality Assurance and Improvement:** The state will integrate the Centers for Medicare & Medicaid Services (CMS) HCBS Quality Framework into all of the quality assurance systems for long-term care services, including the Medicaid Management Information System (MMIS). The state also will use Minimum Data Set (MDS) information and consumer surveys to evaluate quality outcomes for MFP participants.
- **Other State Goals:** None mentioned.

B. Annual Transition Targets[21]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007*	0	0	0	0	0	0
FY 2008	112	48	20	61	0	241
FY 2009	280	120	147	96	0	643
FY 2010	490	210	130	26	0	856
FY 2011	435	185	130	0	0	750
TOTAL	1,317	563	427	183	0	2,490

*Note: Fiscal year denotes state fiscal year.

II. Proposed Services for Transitioned Individuals in Each Target Group

A. Participant Recruitment and Education

Individuals and family members will be involved in the planning process to determine if an individual can be transitioned to the community. The state will use the MFP Demonstration as an opportunity to refine the outreach and identification process of potential participants in nursing facilities. Pennsylvania plans to specifically target those individuals who are over age 65, have mental health diagnoses, and have resided in one of seven state-funded hospitals for longer than two years.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The state will use MDS information to identify potential participants. Individuals will participate in medical, family, and social reviews that also include an assessment of available community resources to be included in their service plans.

C. Demonstration Services

Participants being transitioned will work with a team to develop Community Support Plans that help consumers determine a choice of residence, make the move, and ensure the availability of ongoing support following the transition. Each service area will have an MFP Community Resource Team (CRT) to provide this post-transition aid. Transition consultants will work with consumers presenting difficult transition cases to ensure that their needs are being met.

The state does not anticipate requiring any legislative changes as part of its MFP Demonstration, although it is reviewing the need for legislative action for allowing adult foster homes to serve MFP participants. Assisted living licensure legislation was passed in 2007.

- **Qualified Home and Community-Based Services**: Transitioned individuals will be supported by the state's 11 existing waivers and three state-funded programs.
- **Home and Community-Based Demonstration Services:** None mentioned.

[21] The annual transition target has been modified from 2,610 to reflect a new start date.

- **Supplemental Demonstration Services**: Input from stakeholders during the pre-implementation stage will determine what additional supplemental services, such as assistive technology devices, durable medical equipment, and prearrangements for transportation needs, may need to be provided to participants.

D. Self-Direction Options for MFP Demonstration Participants

The state has incorporated consumer-directed principles into several of its waiver services. In addition, it has obtained a Cash and Counseling grant, and is currently developing this service model within two of its Medicaid Waivers.

E. Home and Community-Based Housing Options and Strategies

The state is planning to hire a Statewide Housing Director and five Housing Coordinators to collaborate with state and local groups to increase the availability of affordable, accessible housing. The Statewide Housing Director will build on efforts underway under Pennsylvania's CMS Housing Grant.

F. Workforce Strategies

None mentioned.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- Several current Medicaid policies increase the difficulty of rebalancing. These include the lack of optional Personal Care Medicaid services in Pennsylvania's Medicaid State Plan, the inability to use Medicaid funds to cover services for low-income individuals in personal care homes, and inconsistent oversight and budgetary responsibilities among state agencies.
- The number of potential candidates for transition is limited by the Medicaid eligibility criteria based on age and/or disability. Further, the eligibility process can be cumbersome and lengthy.
- Pennsylvania lacks statewide quality assurance systems.
- The available workforce is inadequate to staff the services needed to support consumers who want HCBS. Also, additional training needs to be provided to facility staff regarding HCBS.
- The limited funding available for home modifications and improvements for people with disabilities makes transition difficult.

IV. Quality Management Strategy

The state has several quality monitoring systems. Using the CMS HCBS Quality Framework, the Waiver Monitoring Unit conducts case reviews and monitors quality across all 11 waivers. In addition, Pennsylvania will use MDS data to look for nursing facility readmissions for MFP Demonstration participants. The state also will administer a consumer satisfaction survey to all individuals receiving HCBS. In addition, it will review the care plans and service notes for a sample of MFP participants to verify that services are being administered in a timely and appropriate manner.

Pennsylvania developed the Independent Monitoring for Quality (IM4Q) quality indicators that allow for the state's results to be compared with outcome results from other states. The state strengthened its discovery and remediation capabilities by developing a Community Incident Management and Report System that is operational. To measure consumer safety, all demographic, diagnostic, and incident information will be available through the state's Home and Community Services Information System (HCSIS).

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The Department of Public Welfare will have oversight of the MFP Demonstration. Oversight will be provided by the Governor's Council for Long-Term Living, which comprises six senior state officials: the Secretary of the Department of Public Welfare; the Budget Secretary; the Secretary of Policy; the Governor's Deputy Chief of Staff; the Director of the Office of Health Care Reform; and the Secretary of the Department of Aging.

B. MFP Program Oversight/Key Stakeholder Involvement

The Intra-Governmental Council on Long-Term Care is a stakeholder council that provides leadership on long-term living issues. The 37-member group consists of the Secretary of Aging, members of the cabinet, four legislators, providers, and consumers. In addition, the MFP Stakeholder Leadership Group will serve in an advisory capacity for the Demonstration. Efforts to expand and strengthen existing housing collaborations and coordination with other consumer advocacy agencies also will be a priority.

C. IT System Developments or Enhancements

The state is integrating the CMS HCBS Quality Framework for participant-centered service planning and provision into all of the quality assurance systems for Pennsylvania's long-term living services and tying it into MMIS.

D. Independent State Evaluation

None mentioned.

SOUTH CAROLINA MFP GRANT PROGRAM SUMMARY

Grantee Agency: South Carolina Department of Health and Human Services (SCDHHS).

Total Award: $5,768,496

Overview: The state will use services that are part of Community Choices, an existing HCBS waiver program, to transition a total of 192 people over the five-year demonstration period. Community Choices was established in 2006 by combining the state's elderly and disabled 1915c HCBS waiver with an Independence Plus waiver to provide more options for consumer-directed services.

Transition Target Groups: The program targets elderly and/or physically disabled adults who currently reside in a licensed Medicaid nursing facility. While Demonstration requirements state that people to be transitioned must have resided in a facility for at least six months, South Carolina has requested that this be changed to allow those who have resided for only 90 days into the demonstration. The 90-day period is the current criteria that the state uses to allow people to bypass waiver waiting lists; the state believes that those who have resided for a shorter period of time may have more community supports in place for a successful transition.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The state aims to build on the Community Choices waiver by increasing service levels and/or expand services.
- **Money Follows the Person/Flexible Budgeting Goals:** The state will create a global funding line for all Medicaid long-term care services so that funds can be put towards home and community-based services. A Blue Ribbon Task Force will be charged with identifying the best ways to establish a single line item for nursing facility care (including swing beds), the Program for All-Inclusive Care of the Elderly (PACE), and the 1915c waivers operated by SCDHHS.
- **Continuity of Service to Transitioned Individuals:** None mentioned.
- **Quality Assurance and Improvement:** The state's comprehensive quality management system will be expanded to accommodate consumers returning to the community.
- **Other State Goals:** The state will enhance its Web-based information and referral system, South Carolina Access, to include information for nursing facilities and advocates to use in identifying potential individuals to transition.

B. Annual Transition Targets[22]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	12	4	0	0	0	16
FY 2009	24	8	0	0	0	32
FY 2010	48	12	0	0	0	60
FY 2011	72	12	0	0	0	84
TOTAL	156	36	0	0	0	192

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

SCDHHS uses 13 regional offices that serve as a single point of entry to assess Medicaid long-term care applicants for both nursing home and home and community-based services. South Carolina Access is a Web-based information and referral system that provides consumers with information about long-term care options. The state will conduct outreach to individuals and families, potentially using resident and family councils that exist within nursing facilities.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

South Carolina has a screening instrument called the Community Long-Term Care Nursing Home Transition Assessment, to be used in conjunction with the level of care assessment forms to determine eligibility and the appropriateness of leaving a facility. The tool will be critically evaluated during the pre-implementation phase of the grant in order to ensure that it remains appropriate. The Minimum Data Set (MDS) might also be used as a potential source for identifying eligible consumers.

C. Demonstration Services

The state will serve those who transition using the existing 1915c waiver for the elderly and people with physical disabilities; services include attendant care services. The State Plan allows for the use of paid family caregivers.

- **Qualified Home and Community-Based Services:** Community Choices participants are eligible for the Nursing Home Transition service, which is a once-in-a-lifetime service that provides a consumer with $1,000 for transition costs within 10 days after a minimum 90-day stay in a nursing facility.
- **Home and Community-Based Demonstration Services:** This includes adult foster care service and transitional nursing services to assist the consumer/family with a variety of medical matters and to provide consumer and family education.

[22] The initial state application reported 300 total transitions. The state modified the annual transition targets to total 192 transitions.

- **Supplemental Demonstration Services:** Participants will be eligible for a one-time equipment and home modifications not covered by existing waiver services.

D. Self-Direction Options for MFP Demonstration Participants

South Carolina will continue to offer a full range of self-directed services. Consumers may exercise budgetary and employer authority to the extent that they desire risk and responsibility. The state's Independence Plus Waiver for the elderly and adults with physical disabilities, South Carolina Choice, allows consumers to assume full budgetary and supervisory authority. This waiver was merged in 2006 with the existing waiver for the elderly and disabled to form Community Choices to provide additional self direction options. Community Choices now includes attendant (hands-on) care and companion (light assistance, not hands-on) services. The State Plan allows for paid family caregivers and financial management services are provided for all levels of consumer direction.

E. Home and Community-Based Housing Options and Strategies

South Carolina will continue its partnership with the South Carolina State Housing Authority to identify and implement appropriate housing options for people who transition, and to expand SCDHHS's ability to perform home modifications.

F. Workforce Strategies

The state increased rates to both individual and agency direct care providers over the past year to improve provider retention and encourage new provider enrollment. The state has also included the use of non-legally responsible family members and self-direction with and without budget authority to increase the pool of viable providers. In addition, the state has received a technical assistance grant to learn from the experiences of other states on methods implemented to sustain direct care workers. Possible initiatives for the Demonstration include (1) recognizing outstanding personal care aids during meetings, and (2) advocating for licensure.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- Nursing facility care is kept in a separate line item than home and community-based services, making it difficult for funds to flow across service areas.
- Housing resources, particularly in rural areas, are often limited.
- There are lengthy waiting lists for waiver programs, which result in delays in getting home and community-based. The Community Choices waiting list is currently 2,472, despite action by the governor in 1998 that removed approximately 4,300 people from this waiting list.
- In order to serve as many consumers in the waiver as possible, the state has elected to provide a less enriched service package
- Turnover over among direct care workers is high, which increases training costs and potentially results in poorly trained workers and a lack of continuity of care.
- While nursing facilities receive rate increases that reflect their costs, there have not been similar increases for waiver programs in recent years.

IV. Quality Management Strategy

SCDHHS has developed quality assurance practices to ensure the standards in HCBS waiver programs are maintained. The state's current quality management strategy involves information transfer

from the regional offices and the CLTC central office to the quality assurance and provider compliance departments. This information includes monthly chart review data, peer review data, annual home visit data, contract case management reports, complaint reports, annual chart review data, provider review data, management reviews, annual consumer survey reports and appeal and disposition information. The quality assurance and provider compliance departments will merge data, conduct compliance reviews, and report as appropriate. These reports could require corrective action from providers and/or regional offices. SCDHHS has also entered into a technical assistance agreement with Medstat to revamp its quality management system to meet the Centers for Medicare & Medicaid Services (CMS) requirements.

The state has an automated case management system and operates Care Call, an automated Voice Response system that allows real-time monitoring of in-home providers by logging the start and end times of services, the type of service, and the provider. Both of these are recognized by CMS as best practices. Case managers are required to review Care Call activity logs, and records are submitted with the Community Long Term Care (CLTC) office's records to the Medicaid Management Information System (MMIS). Together, these systems facilitate quality monitoring by producing reports on a range of subjects.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The state's MFP program will be overseen by a Blue Ribbon Task Force comprising representatives from SCDHHS, the South Carolina Department of Disabilities and Special Needs (SCDHHS), the South Carolina Department of Disabilities and Special Needs (SCDDSN), nursing home representatives, providers of home and community-based services, advocacy groups, consumers of long-term care services, and state policymakers. The state also intends to continue collaborating with state agencies that serve the elderly and people with disabilities, such as the State Unit on Aging or the Office for the Study of Aging at the University of South Carolina.

B. MFP Program Oversight/Key Stakeholder Involvement

The Blue Ribbon Task Force will provide oversight for the grant implementation. It will develop strategies to achieve rebalancing goals, as well as make recommendations for getting SCDHHS the budget authority to manage all long-term care in a single line item, identify best practices in deterring Medicaid recipients from institutional care and deinstitutionalizing those already in institutions, and make recommendations to the state legislature.

C. IT System Developments or Enhancements

South Carolina uses three health information technology (HIT) systems to assist LTC consumers. The automated case management system (CMS) tracks demographic, level of care, and service plans for consumers. The CMS data is uploaded to Care Call, and the information is merged and submitted to MMIS.

D. Independent State Evaluation

None mentioned.

TEXAS MFP GRANT PROGRAM SUMMARY

Grantee Agency: The Health and Human Services Commission (HHSC), which is the single state Medicaid agency and the umbrella agency for four operating agencies: the Department of Aging and Disability Services (DADS), the Department of Family and Protective Services (DFPS), and the Department of Assistive and Rehabilitative Services (DARS), and the Department of State Health Services (DSHS)

Total Award: $142,700,353

Overview: The Demonstration builds on the state's existing MFP and Promoting Independence Priority Population (PIPP) initiatives. It's goal over five years is to transition to home and community-based care (1) 1,400 individuals who are aged, physically disabled or have behavioral health needs and reside in nursing facilities, and (2) 1,216 people with intellectual and developmental disabilities who are currently in institutions. The MFP project will develop new transition mechanisms for individuals in intermediate care facilities for the mentally retarded (ICFs/MR) of nine or more beds, drawn from facilities that choose to voluntarily close. The state will also develop a new pilot focused on transitioning people with complex needs, especially those with behavioral health problems.

Transition Target Groups: Elderly, physically disabled, individuals with mental retardation or developmental disabilities, and individuals with behavior health needs, including mental illness and/or a substance abuse disorder.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** By the end of the grant, Texas plans to use the enhanced matching funds (about $17 million net) to increase the number of persons served in the community by more than 2,000. It also plans to decrease available beds in community-operated ICFs/MR serving nine or more persons by about 400, 20 percent of total beds in non-state facilities.
- **Money Follows the Person/Flexible Budgeting Goals:** The state will study the feasibility of establishing a line item for transitioning people from ICFs/MR, similar to the current line item for transitioning individuals from nursing facilities to the community. (Funding for transition services replaced the state's funding transfer mechanism, in which funds followed the person from the institution to the community). The Department of State Health Services (DSHS) will also request legislative approval for increased funding of community-based crisis mental health services and substance abuse counseling as part of Medicaid State Plan services.
- **Continuity of Service to Transitioned Individuals:** All existing qualified home and community-based service programs will remain in place in the post-grant period, although the state may seek to consolidate waiver services across programs. Future enhancements to waiver services may be made for persons with behavioral health conditions.

- **Quality Assurance and Improvement:** The state may make minor changes to the DADS Quality Management Plan for purposes of tracking pre- and post-transition health and well-being, and MFP participant satisfaction.
- **Other State Goals:** The state may use other benchmarks, including recidivism rates, consumer satisfaction, length of time to complete transitions, use of acute care services, costs of services in the community relative to the institution, and the number of transitioned individuals able to access publicly subsidized housing (compared to the number before the program).

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other*	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	195	105	204	40	10	554
FY 2009	195	105	337	40	10	687
FY 2010	195	105	337	40	10	687
FY 2011	195	105	338	40	10	688
TOTAL	780	420	1,216	160	40	2,616

* "Other" refers to dual diagnoses: mental illness and a co-occurring substance-related disorder.

II. PROPOSED SERVICES/PROGRAMS FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

Relocation specialists will identify eligible individuals in conjunction with Area Agencies on Aging (AAAs), long-term care ombudsmen, and nursing facility social workers. The Community Living Options (CLO) process will be used to inform residents of ICFs/MR about the opportunity to transition. All transitions will be voluntary and with informed consent.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The Preadmission Screening and Resident Review (PASRR) process will be used to identify people with behavioral health needs. Individuals in a managed long-term care plan who are admitted to a nursing facility remain the responsibility of the Managed Care Organization (MCO) for four months, during which time the MCO assists in community relocation. After four months, the individual is disenrolled from the MCO and becomes a "regular" nursing facility resident, eligible for assistance from a relocation specialist.

C. Demonstration Services

Individuals transitioning from nursing facilities will receive transition services from relocation specialists working in six DADS-contracted regional relocation organizations, in cooperation with AAAs, local nursing facility ombudsman, regional MR authorities, and nursing facility discharge social workers. Nursing facility transition teams will assist in pre-transition planning, securing housing, setting up households, and arranging and case-managing the following services:

- **Qualified Home and Community-Based Services:** Those transitioning from nursing facilities will be enrolled in existing 1915c waiver programs, including Community-based Alternatives (CBA), Medically Dependent Children's Program (MDCP), Community Living Assistance and Support Services (CLASS), STAR+ Waiver, and the Integrated Care Model (ICM) Waiver. Those with intellectual or developmental disabilities transitioning as part of PIPP or the bed closure plan will have access to the Community-Based Alternatives (CBA) and Community Living Assistance and Support Services (CLASS) waiver programs. Case management is an important part of the home and community-based services in Texas. No waiver or Medicaid State Plan amendments are anticipated, except to increase the number of persons served in home and community-based settings. Individuals in managed care service areas will be referred to a regional STAR+ Support Unit, operated by DADS, to assist in choosing an MCO and coordinating with the managed care enrollment broker; DADS and relocation specialists will work with MCOs selected by participants. (Note: this includes both STAR+PLUS capitated plans, and the non-capitated managed long-term care model.)
- **Home and Community-Based Demonstration Services:** Relocation specialists will provide pre-transitional services for persons moving out of nursing facilities, as well as extended (minimum seven contacts) home and community-based post-transition services. For persons with behavioral health needs, cognitive adaptive training will be covered as a home and community-based Demonstration service, as well as environmental supports, training, and substance abuse counseling. There are no home and community-based Demonstration services proposed for persons transitioning from ICFs/MR.
- **Supplemental Demonstration Services**: None proposed for any of the target groups.

D. Self-Direction Options for MFP Demonstration Participants

The state currently offers two options for self-direction in its community entitlement and 1915c waiver programs: (1) Consumer Directed Services (CDS), which gives the consumer responsibility for employer functions and budget authority, and (2) Service Responsibility Option (SRO), which allows the consumer some employer functions but no budgetary responsibilities. In addition, a non-Medicaid program, Client Managed Personal Attendant Services, offers self-directed options.

E. Home and Community-Based Housing Options and Strategies

The MFP project director will work with the Texas Department of Housing and Community Affairs and local Public Housing Authorities (PHAs) to locate affordable housing, deal with housing shortages, and identify housing subsidies or other funding mechanisms. It will work with the Texas Housing Voucher Program (HVP) to increase the number of home vouchers for to persons who are transitioning, and will continue efforts to expand affordable and accessible housing across the state.

F. Workforce Strategies

As part of the behavioral health-focused transition pilot, the state will train providers to serve persons with behavioral health disorders.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- Cost-effective mechanisms are not available to support transitions from ICFs/MR without placing an economic burden on ICFs/MR providers with eight beds or fewer.
- It is more costly, on average, to transition an individual from an ICF/MR with nine or more beds or a State Mental Retardation Facility into a 1915c waiver program. (An enhanced Federal Medicaid

Assistance Percentage (FMAP) will enable DADS to finance the higher costs of services for persons transitioned out of ICFs/MR that close).

- It is difficult to transition people with high or complex needs, lack of community supports or both because (1) plans of care in the community may exceed the cost cap (at the nursing facility level of care) and (2) home health agencies are reluctant to accept consumers with such complex needs.
- There is a shortage of dedicated and accessible low-income housing for persons with disabilities and those living on Supplemental Security Income (SSI).
- Post-transitional services must be enhanced and made more consumer-driven, particularly for individuals with complex needs.
- There is a need for increased services to assist persons with behavioral health conditions requiring long-term services and supports.

IV. QUALITY MANAGEMENT STRATEGY

DADS uses a Quality Management Strategy for all of the services it oversees; it ensures quality through licensing and regulatory functions as well as its quality improvement processes. In 2003, the state designed a Quality Assurance and Improvement Data Mart, which produces standardized reports and allows for ad hoc reporting of provider performance and consumer outcomes data. The state also regularly reviews critical incident reports and suspected abuse, neglect, and exploitation, and it maintains an Employee Misconduct Registry. For the MFP project, the state will use the same quality management strategy required for the 1915c waivers. Texas uses the Participant Experience Survey (PES) to assess the satisfaction and quality of life of participants in home and community-based services; it plans to include pre- and post-transition MFP participants in these surveys. The state also joined with the National Core Indicators Project and contracted with an external entity to conduct both face-to-face and mail experience surveys of program participants on an annual basis. Annual MFP quality reports will be generated and shared with stakeholders.

V. ADMINISTRATION, OVERSIGHT AND EVALUATION

A. Role and Involvement of Other State Agencies

HHSC, the single state Medicaid agency, oversees and provides overall policy direction for health and human services, but has delegated lead operational responsibility for the MFP project to DADS. The project director will be located in DADS' Promoting Independence Unit. The project will work with the Department of State Health Services (DSHS), HHSC's Office of Program Coordination for Children and Youth, HHSC's Medicaid Office, and the Texas Department of Housing and Community Affairs (which is outside of the Health and Human Services Enterprise).

B. MFP Program Oversight/Key Stakeholder Involvement

The DADS Stakeholder Relations Unit will ensure input, participation and involvement of all relevant stakeholders in the MFP project. It will develop a plan to use the Promoting Independence Advisory Committee, and a newly established MFP Grant Implementation Task Force. Both will seek to ensure involvement of consumers, families, advocates and providers, who will represent all aging and disability communities and all types of providers. The Task Force will help to design the operational protocol and assist in policy decision-making for the program.

C. IT System Developments or Enhancements

In total, there will be fourteen IT systems impacted by the MFP Demonstration. Texas will use four existing primary automated systems for registering and tracking consumer services: (1) Claims

Management System (CMS), used for all nursing facility and related community services programs, (2) the Service Authorization System (SAS) that is used to authorize all services for nursing facility and related community services programs, (3) the Client Assignment and Registration System (CARE), used for tracking community and institutional services for persons with psychiatric, intellectual and/or developmental disabilities, and (4) the Behavioral Health Integrated Provider System (BHIPS), used for tracking substance abuse services.

D. Independent State Evaluation

None mentioned.

VIRGINIA MFP GRANT PROGRAM SUMMARY

Grantee Agency: Department of Medical Assistance Services (DMAS)

Total Award: $28,626,136

Overview: This grant will complement the efforts of the recently awarded Systems Transformation Grant (2006) that aims to improve the infrastructure for community-based long-term support services. The MFP Demonstration will move the state closer to a rebalanced long-term support system that promotes choice, quality, and flexibility.

Transition Target Groups: Virginia plans to transition individuals from intermediate care facilities for the mentally retarded (ICFs/MR), nursing facilities (NF), and long-stay hospitals (LSH).

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** The state will increase the number of people served in home and community-based services (HCBS) waivers and decrease the use of ICFs/MR.
- **Money Follows the Person/Flexible Budgeting Goals:** None mentioned.
- **Continuity of Service to Transitioned Individuals:** Virginia will increase the ability of the state Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from institutions to community settings. In addition, the provision of these services will be available beyond the one-year Demonstration.
- **Quality Assurance and Improvement:** The state proposes to build a comprehensive quality management strategy across all waiver services, which will encompass HCBS programs for the state's MFP Demonstration. As part of this strategy, the state proposes to track level-of-care determinants, service plans, provider characteristics, the health of participants, administrative processes, and financial activities.
- **Other State Goals:** The state plans to create a consumer-directed (CD) supported employment option for some HCBS waivers, increase the number of housing units available to MFP consumers, and professionalize the role of direct-care service workers.

B. Annual Transition Targets[23]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	25	28	28	0	0	81
FY 2009	100	110	110	0	0	320
FY 2010	100	110	110	0	0	320
FY 2011	100	110	110	0	0	320
TOTAL	325	358	358	0	0	1,041

II. Proposed Services for Transitioned Individuals in Each Target Group

A. Participant Recruitment and Education

Planned outreach efforts include publicizing the initiative on state agency websites; using existing videos about community options; developing marketing materials (such as advertisements and radio spots); meeting with family, advocacy, and support groups statewide; creating a mentor program that matches individuals and families that have supported the transition process with individuals and families who are interested in transition; conducting information sessions for residents and staff; and using existing and newly created Regional Admissions/Discharges and Empowerment Teams to inform individuals and families of community opportunities.

The state will use data from the Minimum Data Set (MDS) and Preadmission Screening and Resident Review (PASARR) to identify potential participants. Additionally, databases from ICFs/MR and long-stay hospitals will be used to identify individuals residing in these facilities.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

Virginia will use transition coordinators and existing long-term care Ombudsmen and case managers for assessment and service planning purposes. The state also will create a process for individuals to self-identify as potential participants, and will review Plans of Care and Support Intensity Scale scores (MR only). The state will use existing assessment and screening tools for the MFP Demonstration.

C. Demonstration Services

Five waiver programs will be used to serve MFP participants. Several modifications to the waivers are in the planning stages, including: providing Personal Emergency Response Systems (PERS) and PERS monitoring to assist with medication management; transition funding up to $5,000; a consumer-directed supported employment option; and assistive technology and environmental modification services. In addition, transition coordination will be added to the EDCD waiver.

[23] State transition targets were originally listed as 1,994 in the application appendix, but have since been modified by the state.

- **Qualified Home and Community-Based Services:** Transitioned individuals will have access to five services, including: Technology Assisted (TECH), HIV/AIDS, Elderly or Disabled with Consumer Direction (EDCD), Mental Retardation (MR), and Individual and Family Developmental Disabilities Support (DD) Waivers. Consumers also will have access to the Medicaid State Plan services.
- **Home and Community-Based Demonstration Services:** None mentioned.
- **Supplemental Demonstration Services:** None mentioned.

D. Self-Direction Options for MFP Demonstration Participants

Individuals have the option of consumer-direction in four of seven HCBS waivers. In 2005, Virginia received a grant to develop a "No Wrong Door" system which creates a sustainable, web-based Community-based Coordinated Services System (CCSS) and informs individuals and family members about service options, including self-directed services. In October 2006, Virginia received a Systems Transformation Grant to develop individualized budgeting options for HCBS waiver recipients, to be implemented by September 2011. The state will explore the option of allowing spouses and the parents of minor children to be compensated for providing consumer-directed services. The state also will add a consumer-directed supported employment option for some HCBS waivers.

E. Home and Community-Based Housing Options and Strategies

The state will explore the possibility of revising legislation to allow DD waiver recipients to share an apartment or single family home with more than two other recipients of waiver services. The Virginia Department of Housing and Community Development (DHCD) will work with the Virginia Housing and Development Authority to support the creation of new housing units designed to be accessible, affordable, and available to persons leaving institutions as part of the MFP Demonstration. DHCD has committed up to $500,000 per year in grant funding for four years to modify housing units for appropriate accessibility for persons leaving institutions.

F. Workforce Strategies

Virginia plans to support the development of a well-trained workforce, including Direct Support Professionals (DSPs) and informal caregivers. The state is working to expand the availability of web-based training to DSPs by the College of Direct Support; the training will be provided through private providers, Community Service Boards, and ICFs/MR. The state also will build upon previous grant-funded direct service workforce initiatives, including the Enhanced Care Attendant Training.

III. Challenges to Rebalancing the Long-Term Care System and Expanding Home and Community-Based Services

- Individuals leaving institutions have limited access to the services needed to integrate successfully into the community. There is a lack of other supports, such as employment services, community living (rental) supplements, and case management services.
- The state's MR and DD waivers have waiting lists for services. Budget requests through the Governor's Office will be submitted annually to account for the new slots needed to transition individuals to the MR and DD waivers.
- A lack of public transportation in many areas of the state precludes some individuals from partaking in community living.
- Affordable, accessible housing is unavailable to many people for a variety of reasons, including insufficient state and federal funding.

- Contrary to national trends, there has been an increase in the number of ICF/MR beds and providers in the state during the last 10 years.

IV. QUALITY MANAGEMENT STRATEGY

Virginia will use its current system of quality management to serve MFP participants in existing waivers and, with the help of Thomson-Medstat, is working to develop a comprehensive quality management strategy across the waivers. As part of Virginia's current system, the state conducts surveys of individuals across all seven HCBS waivers, which allows it to evaluate MFP participant satisfaction on a limited basis.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The Department of Medical Assistance Services, the sole State Medicaid agency, will be responsible for implementation of the Demonstration. The MFP Demonstration will build on current guidance provided by the Community Integration Implementation Team (CIIT) and Stakeholder Advisory Group's (SAG) Strategic Plan to encourage collaboration and coordination across state agencies.

B. MFP Program Oversight/Key Stakeholder Involvement

An MFP Leadership Committee, established and overseen by DMAS, will guide the pre-implementation phase. It will include representation from all project stakeholders. Additionally, an MFP Housing Task Force was created to provide guidance and make recommendations for the community living supplement, home modification eligibility process, involvement of stakeholders in the housing and transportation process, and the development of the annual housing action plan.

C. IT System Developments or Enhancements

The state plans to develop IT to support quality management efforts through a web-based system.

D. Independent State Evaluation

None mentioned.

WASHINGTON MFP GRANT PROGRAM SUMMARY

Grantee Agency: The Aging and Disability Services Administration (ADSA)

Total Award: $19,626,869

Overview: The state's MFP program, called "Roads to Community Living," builds on existing resources already in place (including eight home and community-based services waivers) to transition 660 people to home and community settings over the Demonstration period who have lived in institution settings longer than six months and whose needs cannot be met under existing State Plan or waiver services.

Transition Target Groups: Older adults, individuals with developmental disabilities, individuals with physical disabilities, and individuals with mental illness.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Washington currently has three-quarters of its long-term care services and supports provided in community settings. To further increase the percentage of long-term care spending devoted to home and community-based services, Washington will use its "caseload forecasting," which allows the state to identify and/or project a decrease in institutional care and argue for an increase in community spending each year within the legislative appropriations.
- **Money Follows the Person/Flexible Budgeting Goals:** While barriers exist to flexibility in rebalancing because of categorical funding, the state is able to move money from institution to community by their participation in "caseload forecasting" as described above. In addition, ADSA is piloting chronic care case management in two area agencies. Since the state submitted its application for this pilot, it has expanded the intensive chronic care management program to five Area Agencies on Aging. The state has also added flexibility with the addition of Demonstration integration programs through two contracted managed care plans, Washington Medicaid Integration Partnership (WMIP) and the Medicare/Medicaid Integration Project (MMIP). Washington also plans to remedy limited implementation of budget authority for individuals in home and community-based services programs by offering access to the New Freedom waiver—one of the existing eight waivers that provides full self-direction of home and community-based services—to eligible MFP participants after their first year in the community.
- **Continuity of Service to Transitioned Individuals:** Following the 12-month Demonstration period, the state anticipates that participants will be serviced through a combination of existing waivers and State Plan services. To ensure continuity of care for people after the Demonstration, existing waivers may be amended to increase capacity and allow for additional successful Demonstration services.
- **Quality Assurance and Improvement:** ADSA uses the Centers for Medicare & Medicaid Services (CMS) Quality Framework and will continue to provide quality services for those who are part of the Demonstration project. ASDA will expand and improve on its existing quality management system

by involving participants in identifying measures of success and program satisfaction and by frequently monitoring and communicating with transitioning individuals.

- **Other State Goals:** Other goals include a minimum of 80 percent of transitioning participants reporting satisfaction with their move, community supports, and level of self-direction, and 10 percent of working-age participants employed in the community.

B. Annual Transition Targets

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	0	0	0	0	0	0
FY 2008	34	16	26	20	0	96
FY 2009	145	72	27	20	0	264
FY 2010	169	84	27	20	0	300
FY 2011	0	0	0	0	0	0
TOTAL	348	172	80	60	0	660

II. PROPOSED SERVICES FOR TRANSITIONED INDIVIDUALS IN EACH TARGET GROUP

A. Participant Recruitment and Education

The key components of the state's targeting and recruitment strategies are face-to-face interviews, data analysis, and consultation with clinical, habilitative staff, and technical assistance as needed.

B. Eligibility Criteria, Screening and Assessment Methods and Tools

The ASDA uses the Comprehensive Assessment Reporting and Evaluation (CARE) tool to screen and assess individuals who are transitioning. CARE is based on the Minimum Data set, which the state plans to use this tool in conjunction with the data collected through the nursing home resident assessment instrument and other assessments administered in its institutional settings to identify potential participants. Within nursing facilities for this Demonstration, the state plans to create objective criteria to accurately assess the discharge potential of every Medicaid resident. In state hospitals, potential participants will be identified using census data and by consulting with clinical and habilitation staff. In intermediate care facilities for the mentally retarded (ICFs/MR), yearly individual habilitation planning conferences will be the vehicle for discussing options offered through the Demonstration.

C. Demonstration Services

Participants will be served through a combination of eight existing waivers and State Plan services, which are currently administered by ADSA as well as under the state's waiver for Mental Health services. Personal care has been offered as a State Plan entitlement since 1989 and waiver personal care has been offered since 1983. Other services will include (1) Referral and Workforce Statewide Resource Centers offered by the Home Care Quality Authority (HCQA) that provides a referral registry to connect those needing in-home services with providers and (2) Family Caregiver support, funded under the Older Americans Act and with state funding, that provides respite services and other caregiver supports.

- **Qualified Home and Community-Based Services**: The state has eight waivers to serve individuals who transition, including the recently approved New Freedom/Cash and Counseling waiver. Waivers may be amended to increase capacity and to allow for additional waiver services. The state also has State Plan personal care services and offers its mental health services through a waiver program.
- **Home and Community-Based Demonstration Services**: For the elderly and people with physical disability and mental illness, the state offers habilitation services, supported employment, respite care, vehicle modifications, extended State Plan services, clinical and therapeutic services. For people with developmental disability, the state offers extended State Plan services and crisis management services.
- **Supplemental Demonstration Services**: For the elderly and people with physical disability and mental illness, the state offers assistive technology and durable medical equipment, nutrition services, substance abuse services, housing, service animals, family services, 24/7 problem solving access, and peer education and mentoring. People with developmental disability can access assistive technology and durable medical equipment, nutrition services, substance abuse, housing, service animals, family services, and peer education and mentoring.

D. Self-Direction Options for MFP Demonstration Participants

MFP participants will have access to the Individual Provider program, which includes 26,000 Individual Providers (direct care workers) who are employed directly by consumers to provide their in-home personal care. 60 percent of the workers hired by consumers in this program are family members. Also, the New Freedom Cash and Counseling Waiver offers the option of full self-direction of home and community-based services, including both employer and budget authority.

E. Home and Community-Based Housing Options and Strategies

During the Demonstration, the state will work with local Housing Authorities to develop additional housing resources and small (four people or fewer) community residential support models; the Housing Authorities have indicated a willingness to reserve vouchers for MFP participants. ADSA also has staff dedicated to working with providers to develop community housing and assisted and supportive living opportunities throughout the state, including in rural areas and tribal lands.

F. Workforce Strategies

Individuals who choose not to hire and directly supervise a worker will have access to more than 80 licensed home care agencies that will deploy workers on their behalf. Specialty training is also required for residential providers to serve consumers with mental illness, developmental disability or dementia. Supported living providers for people with developmental disabilities and mental health must provide 30 hours of training tailored to the person being served.

III. Challenges to Rebalancing The Long-Term Care System and Expanding Home and Community-Based Services

- One barrier to flexibility in rebalancing the developmental disabilities and mental health systems is the categorical funding between institutional and community-based services, which would require legislative action for systemic change. The Medicaid payment is tied to rigid service definitions required in HCBS waivers. This interferes with true individual planning for unique one-time needs.
- There are currently waitlists for individuals with developmental disabilities who want to be served in the community rather than in institutions.

- There is also a need to develop decision packages for legislative consideration when additional waiver services are needed for all populations.

IV. QUALITY MANAGEMENT STRATEGY

ADSA will develop a Washington state "Roads to Community Living" quality committee that will take an active role in formally reviewing and providing input on the quality management strategy. ADSA also has a quality improvement strategy in place that utilizes the CMS Quality Framework for home and community-based services that includes the following major components: access, person-centered service planning and delivery, provider capacity and capabilities, safeguards, rights and responsibilities, outcomes and satisfaction and system performance. Changes to the existing quality improvement system will include more frequent monitoring and increased communication with transitioning participants to ensure the health and safety of this high-risk population. Participant feedback will be captured in a variety of ways, including participant and staff surveys and regular meetings with stakeholder groups and participants. Quality assurance staff currently collects outcome and satisfaction measures; they will tailor quality assurance protocols to participants in the Demonstration.

V. ADMINISTRATION, OVERSIGHT AND EVALUATION

A. Role and Involvement of Other State Agencies

The state will create a Roads to Community Living steering committee, called the Collaborative Team. The Team will consist of individuals from each DSHS governmental division including: the Division of Vocational Rehabilitation, Health and Recovery Services Administration, Division of Mental Health, and the Division of Alcohol and Substance Abuse. The committee will also include participants, families, tribal leaders and housing authorities.

B. MFP Program Oversight/Key Stakeholder Involvement

Feedback and recommendations will come from a variety of meetings with different stakeholder groups and program participants including (1) the Governor's Committee on Disability Issues and Employment, (2) the Indian Policy Advisory Committee, and (3) the Washington State Developmental Disabilities Council.

C. IT System Developments or Enhancements

Washington already has in place several IT systems that track demographic, financial, and assessment information and monitor quality of services after transition. These include (1) the CARE comprehensive assessment, a tool that produces information on demographics as well as assessment and care planning, (2) use of satisfaction surveys, service utilization data, and data from CARE reassessment to monitor ongoing quality of services, (3) the Automated Client Eligibility (ACES) system, which tracks Medicaid eligibility, and (4) the Social Service Payment System (SSPS), which is used to track and pay for home and community-based services.

Washington is in the process of developing a new payment system, ProviderOne, that will track all services delivered to a participant. In addition, the Supports Intensity Scale (SIS) was implemented in June 2007; it is used to collect assessment information and establish rates for persons with developmental disabilities who use contracted supported living services. ADSA is also developing a Case Manager Information System, which will include tracking for quality assurance visits with participants (to be implemented in March 2008).

D. Independent State Evaluation

None mentioned.

WISCONSIN MFP GRANT PROGRAM SUMMARY

Grantee Agency: Wisconsin Department of Health and Family Services

Total Award: $56,282,998

Overview: The state's MFP Demonstration program, which builds on previous and current relocation initiatives, plans to transition 1,262 more residents using several existing 1915c waiver programs and the Medicaid State Plan. To rebalance the long-term care system, the state aims to reinvest the savings generated by MFP-enhanced matching funds into other home and community-based services (HCBS), including 1915c waiver programs (reducing waiting lists) and managed long-term care (which the state hopes to make available statewide over the next five years).

Transition Target Groups: Frail elders, individuals of any age with physical or developmental disabilities, and individuals of any age with a dual diagnosis of mental illness or substance abuse issues and a physical disability or age-related infirmity.

I. PROGRAM GOALS, BENCHMARKS, AND TARGET GROUPS

A. Program Goals

- **Rebalancing Goals:** Expand managed long-term care to overcome the current bias toward institutions that results from limited capacity or waiting lists in home and community-based waiver programs and continue current restructuring and relocation efforts to downsize existing institutions.
- **Money Follows the Person/Flexible Budgeting Goals:** Aim to implement managed long-term care statewide over the next five years, eventually replacing the current 1915c waiver programs. Managed long-term care is one mechanism through which to rebalance the long-term care system. Every year, increase the percentage of monetary support for HCBS, the share of long-term care funding used by HCBS, and the percentage of the estimated eligible population served by managed long-term care financing.
- **Continuity of Service:** Participants will be enrolled in the ongoing waiver from the first day on MFP and will continue in that waiver at the end of MFP participation.
- **Quality Assurance and Improvement:** Maintain current quality assurance procedures to ensure that each transitioned individual's care plan is appropriate and effectively addresses his/her health and safety needs.
- **Other State Goals:** Partner with other state, local, and advocacy agencies to increase the availability of affordable and accessible housing to persons trying to transition from institutions.

B. Annual Transition Targets[24]

	Elderly	Individuals with Physical Disabilities	Individuals with MR/DD	Individuals with Mental Illness	Other	TOTAL
FY 2007	41	17	39	15	0	112
FY 2008	123	51	105	45	0	324
FY 2009	123	51	82	45	0	301
FY 2010	123	51	50	45	0	269
FY 2011	123	51	37	45	0	256
TOTAL	533	221	313	195	0	1,262

II. Proposed Services for Transitioned Individuals in Each Target Group

A. Participant Recruitment and Education

The state plans to work closely with the Independent Living Centers and the Ombudsman program to make referrals and advocate for persons in institutions wishing to transition to the community. The Department has already identified all individuals in intermediate care facilities for the mentally retarded (ICFs/MR) and State Centers for persons with developmental disabilities. To recruit elders and persons with physical disabilities, county long-term care agencies will identify individuals from their local 1915c waiting lists, solicit self-referrals and accept referrals from nursing homes and advocacy agencies. To identify individuals in nursing homes who have a serious mental illness, the state will use the Minimum Data Set, which includes diagnosis data, in addition to the Preadmission Screening and Resident Review (PASARR).

B. Eligibility Criteria, Screening and Assessment Methods and Tools

To screen Demonstration participants, the state will use an existing functional screening tool that is used statewide for all HCBS waiver programs. Each HCBS program also employs a consumer-centered, outcome-based assessment that captures the individual's preferences and need for assistance. The state plans to use the existing statewide network of care managers to serve as transition coordinators for MFP participants. To address the capacity needs required to successfully transition people with developmental disabilities from ICFs/MR, an ICF/MR Restructuring Program Coordinator will (1) conduct group training for local care management staff, (2) hold individual person-centered consultations, (3) develop local provider systems, and (4) manage health risks.

C. Demonstration Services

The state plans to use its existing 1915c waivers, Medicaid State Plan, and its existing managed long-term care models to implement the MFP Demonstration. Three managed long-term care programs are in current operation: the Program of All-Inclusive Care for the Elderly (PACE) in one county, the Wisconsin Partnership Program (combined Medicare/Medicaid operating in seven counties), and Family Care (a combined 1915b/1915c Medicaid only long-term care program operating in six counties). The

[24] Initial state application showed 1,322 total transitions. Changes were made to Year 1 targets since that time.

state recently received legislative approval to begin expanding managed long-term care statewide, which will help to reduce waiting lists for HCBS.

- **Qualified Home and Community-Based Services:** All home and community-based services currently covered by the existing state-funded Community Options Program (COP), those available under existing 1915c waivers for which the person is eligible, and case management, home health aide, personal care, DME, supplies and other home care services covered under the Medicaid State Plan, where applicable. As the state transitions to a managed long-term care system, 1915c waiver participants, including MFP participants, will roll over to the new managed care program.
- **Home and Community-Based Demonstration Services:** The state will not be providing these services.
- **Supplemental Demonstration Services:** If it is determined that enhanced match is not available for pre-transition services, certain Qualified HCBS services available to MFP participants will become supplemental services.

D. Self-Direction Options for MFP Demonstration Participants

The state will make available to participants the self-directed options currently available under the state-funded Community Options Program (COP) as well as several 1915c waiver programs that are described below. The statutes that authorize COP and Community Options Program-Waiver (COP-W) require counties to offer fiscal agents so that participants can employ their own staff. The Community Integration Program 1 (CIP 1), a 1915c waiver program for Medicaid-eligible persons with developmental disabilities who meet an ICF/MR level of care, are offered a service called "consumer-directed support." In the one county where this program exists, participating consumers and members of their support network work with a support broker to identify goals and strategies that reflect consumer preferences. The Family Care program provides self-directed supports where participants can choose budget and/or employer authority through a fiscal intermediary. The Medicaid State Plan does not provide an option for self-direction but as the state moves towards a managed long-term care system, self-directed services will be made available under those programs.

E. Home and Community-Based Housing Options and Strategies

To address housing needs related to the MFP Demonstration, the state will work with the Department of Commerce and the Wisconsin Housing for All Advisory Committee, a group developed by housing advocacy and consumer organizations to address housing issues. The state pledges to collaborate with other state and local agencies, advocacy groups and self-advocates to develop strategies to address the scarcity of affordable housing.

F. Workforce Strategies

The state plans to collaborate with the Department of Workforce Development to expand direct care worker cooperatives throughout the state and to streamline the training requirements for direct care workers to reduce duplication and promote "portability" of workers across settings.

III. Challenges to Rebalancing the Long-Term Care System and Rebalancing Home and Community-Based Services

- Federal law does not permit Medicaid funding to be used for room and board in the community in the same way that it is included in the Medicaid rate for institutions.
- Individuals in ICFs/MR have complex needs; capacity building is required to address the special challenges associated with transitioning these individuals to the community.

- Currently, HCBS waiver programs have long waiting lists for services—reaching nearly 12,000 in September 2006—which creates a systematic bias toward institutions.
- Wisconsin has a scarcity of affordable and accessible housing. Communities where housing and housing vouchers may be available often lack other supports needed by people with disabilities, for example service providers or transportation assistance.

IV. QUALITY MANAGEMENT STRATEGY

The state's quality management strategy is based upon current 1915c waiver quality-management requirements as well as those requirements that govern quality management in managed care programs. Quality assurance is essentially built into the system through a required automated long-term care screen that applies consistent logic to eligibility and level of care determinations. For assessments and care plans, quality assurance will be carried out through: (1) random, targeted reviews by state staff, and (2) discovery activities related to appropriateness of services and other performance indicators; staff will perform these activities using encounter data and information from the automated functional screens. Care managers will monitor the health and welfare of the MFP participants, and assess the quality-of-life results of community-based long-term care services using an interview tool designed to discover the participants' desired outcomes in 12 key quality-of-life areas, such as choice of living arrangement and control over daily routine.

V. ADMINISTRATION, OVERSIGHT, AND EVALUATION

A. Role and Involvement of Other State Agencies

The Division of Disability and Elder Services, located within the Wisconsin Department of Health and Family Services (the single-state Medicaid agency), will have primary responsibility for the MFP Demonstration. Most of the programs that are key to the Demonstration are housed within this agency, which facilitates effective coordination—for example, Medicaid State Plan services are administered by the Division of Health Care Financing, which is part of the Department. The Department will collaborate with the state-level housing agencies, which are part of the Department of Commerce and the Wisconsin Housing Authority, and with the Department of Transportation to address issues related to the availability of supports for persons transitioning to the community.

B. MFP Program Oversight/Key Stakeholder Involvement

The state will rely upon the Wisconsin Council on Long-Term Care Reform, its Stakeholder Committee (comprised of consumer advocates and county agency representatives), and various disability-specific state councils—for example, the Wisconsin Council on Developmental Disabilities, Council on Physical Disabilities, and Council on Mental Health—to foster stakeholder participation in the planning and implementation of the Demonstration.

C. IT System Developments or Enhancements

The state has automated systems in place that support the determination of functional and financial eligibility, program enrollment, service and cost information, as well as track and report on individuals who are transitioned from institutions into the community. The state employs a Web-based tool that provides a comprehensive profile of each community and state institution participant, allowing participant information to be shared across case management and provider organizations as people transition between program settings. The state is currently implementing a new Medicaid Management Information System that will be made available for use by local long-term care program providers to support their operation.

D. Independent State Evaluation

None mentioned.

PART II

HIGHLIGHTS OF KEY MFP PROGRAM FEATURES

TABLE 8

MFP TRANSITION GOALS

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Arkansas						
All transitions	0	43	63	93	106	305
Elderly	0	12	19	28	33	92
MR/DD	0	15	15	15	15	60
PD	0	15	28	47	56	146
MI	0	1	1	3	2	7
Other	0	0	0	0	0	0
California						
All transitions[a]	0	100	500	650	750	2,000
Elderly	0	20	100	130	150	400
MR/DD	0	15	75	98	143	331
PD	0	45	225	292	337	899
MI	0	10	50	65	60	200
Other	0	10	50	65	60	200
Connecticut						
All transitions	50	100	150	200	200	700
Elderly	20	40	60	80	80	280
MR/DD	5	10	15	20	20	70
PD	10	20	30	40	40	140
MI	10	20	30	40	40	140
Other	5	10	15	20	20	70
Delaware						
All transitions	0	25	25	25	25	100
Elderly	0	8	8	8	8	32
MR/DD	0	5	5	5	5	20
PD	0	7	7	7	7	28
MI	0	5	5	5	5	20
Other	0	0	0	0	0	0
District of Columbia						
All transitions	120	175	230	265	320	1,110
Elderly	25	35	45	50	60	215
MR/DD	0	15	30	45	60	150
PD	75	105	135	150	180	645
MI	20	20	20	20	20	100
Other	0	0	0	0	0	0
Georgia						
All transitions[b]	0	175	350	350	437	1,312
Elderly	0	50	100	100	125	375
MR/DD	0	75	150	150	187	562
PD	0	50	100	100	125	375
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Hawaii						
All transitions	0	60	85	120	150	415
Elderly[c]	0	30	45	55	55	185
MR/DD	0	0	0	10	40	50
PD[c]	0	30	40	55	55	180
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Illinois						
All transitions	462	595	720	765	815	3,357
Elderly	237	320	320	320	320	1,517
MR/DD	5	25	25	25	25	105
PD	200	200	200	200	200	1,000
MI	20	50	175	220	270	735
Other	0	0	0	0	0	0
Indiana						
All transitions	129	345	234	180	151	1,039
Elderly	88	244	181	139	116	768
MR/DD	9	24	16	12	10	71
PD	32	77	37	29	25	200
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Iowa						
All transitions	0	75	113	151	189	528
Elderly	0	0	0	0	0	0
MR/DD	0	75	113	151	189	528
PD	0	0	0	0	0	0
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Kansas						
All transitions	0	330	172	206	226	934
Elderly	0	92	50	50	50	242
MR/DD[d]	0	33	55	89	109	286
PD	0	185	57	57	57	356
MI	0	0	0	0	0	0
Other	0	20	10	10	10	50
Kentucky						
All transitions	70	119	119	119	119	546
Elderly	30	47	47	47	47	218
MR/DD	29	42	42	42	42	197
PD	11	30	30	30	30	131
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Louisiana						
All transitions	0	173	160	142	285	760
Elderly	0	53	60	66	185	364
MR/DD	0	108	90	62	60	320
PD	0	12	10	14	40	76
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Maryland						
All transitions[f]	230	525	596	678	384	2,413
Elderly	144	312	362	411	238	1,467
MR/DD	25	50	50	50	25	200
PD	61	163	184	217	121	746
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Michigan						
All transitions[g]	100	400	600	900	1,100	3,100
Elderly	60	240	360	540	660	1,860
MR/DD	0	0	0	0	0	0
PD	40	160	240	360	440	1,000
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Missouri						
All transitions[h]	38	53	53	53	53	250
Elderly	4	11	11	11	11	50
MR/DD	25	25	25	25	25	125
PD	4	12	12	12	12	50
MI	0	0	0	0	0	0
Other	5	5	5	5	5	25
Nebraska						
All transitions[i]	0	298	300	302	0	900
Elderly	0	133	133	134	0	400
MR/DD	0	66	67	67	0	199
PD	0	66	67	67	0	199
MI	0	0	0	0	0	0
Other	0	33	33	34	0	100
New Hampshire						
All transitions	10	90	90	90	90	370
Elderly	10	75	75	75	90	325
MR/DD	0	0	0	0	0	0
PD	0	15	15	15	0	45
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
New Jersey						
All transitions	0	69	155	174	192	590
Elderly	0	12	51	54	57	174
MR/DD	0	37	84	97	11	329
PD	0	20	20	23	24	87
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
New York						
All transitions	0	375	625	900	900	2,800
Elderly	0	159	265	383	383	1,190
MR/DD	0	19	32	44	45	140
PD	0	159	266	383	382	1,190
MI	0	38	62	90	90	280
Other	0	0	0	0	0	0
North Carolina						
All transitions[k]	0	221	247	278	309	1,045
Elderly	0	25	35	45	50	150
MR/DD	0	40	50	60	75	225
PD	0	25	30	40	50	150
MI	0	130	130	130	130	520
Other	0	0	0	0	0	0
North Dakota						
All transitions	0	30	33	23	24	110
Elderly	0	12	12	11	11	46
MR/DD	0	5	8	8	9	30
PD	0	13	13	4	4	34
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Ohio						
All transitions	0	397	588	985	648	2,231
Elderly	0	260	380	388	400	1,428
MR/DD	0	112	164	148	160	584
PD	0	17	32	45	64	158
MI	0	8	12	17	24	61
Other	0	0	0	0	0	0

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Oklahoma						
All transitions[l]	189	332	482	537	560	2,075
Elderly	75	200	350	450	500	1,575
MR/DD	32	72	72	24	0	176
PD	60	60	60	60	60	300
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Oregon						
All transitions	0	92	227	461	0	780
Elderly	0	61	94	145	0	300
MR/DD	0	31	50	98	0	179
PD	0	0	83	218	0	301
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Pennsylvania						
All transitions	0	241	643	856	750	2,490
Elderly	0	112	280	490	435	1,317
MR/DD	0	20	147	130	130	427
PD	0	48	120	210	185	563
MI	0	61	96	26	0	183
Other	0	0	0	0	0	0
South Carolina						
All transitions	0	30	60	90	120	300
Elderly	0	24	48	72	96	240
MR/DD	0	0	0	0	0	0
PD	0	6	12	18	24	60
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Texas						
All transitions	0	554	687	687	688	2,616
Elderly	0	195	195	195	195	780
MR/DD	0	204	337	337	338	1,216
PD	0	105	105	105	105	420
MI	0	40	40	40	40	160
Other	0	10	10	10	10	40
Virginia						
All transitions	0	81	320	320	320	1,041
Elderly	0	25	100	100	100	325
MR/DD	0	28	110	110	110	358
PD	0	28	110	110	110	358
MI	0	0	0	0	0	0
Other	0	0	0	0	0	0
Washington						
All transitions	0	96	264	300	0	660
Elderly	0	34	145	169	0	348
MR/DD	0	26	27	27	0	80
PD	0	16	72	84	0	172
MI	0	20	20	20	0	60
Other	0	0	0	0	0	0
Wisconsin						
All transitions[o]	112	324	301	269	256	1,262
Elderly	41	123	123	123	123	533
MR/DD	39	105	82	50	37	313
PD	17	51	51	51	51	221
MI	15	45	45	45	45	195
Other	0	0	0	0	0	0

[a] California initial state application showed 2,030 total transitions, with 15 more each in the 'MI' and 'other' categories in year 5.

[b] The CMS award announcement of May 14, 2007 lists a target of 1,347 slots for Georgia, a total that includes 35 individuals with mental illness who will be transitioned solely at state expense. Because no federal funds will be expended for this population, these 35 individuals are not included in the annual transitions target table.

[c] Hawaii plans to transition 365 individuals from nursing facilities and acute care hospitals, but officials are unsure as to what proportion will be elderly and what proportion will be individuals with physical disabilities each year. For purposes of this table, the annual transition target totals were divided roughly equally between the two populations.

[d] The total in the MR/DD population is divided between those transitioning out of state ICFs/MR and those transitioning out of private facilities. See the Kansas state summary for the proposed breakdown of the number of transitions in each group.

[e] Kentucky has revised its transition targets since the grant award, from a total of 431 to the new total of 546. This increased number of transitions also reflects the state's decision not to transition any individuals with acquired brain injuries during the first year of the Demonstration.

[f] Maryland initial state application showed 3,106 total transitions, but numbers were modified once the state withdrew its waiver application for managed long-term care.

[g] Michigan initial state application appendix showed 2,440 total transitions, but state corrected application to show 3,100 transitions as listed in application main text.

[h] While the total number of transitions in Missouri has stayed constant at 250 over 5 years, the state has decreased the number of transitions in its first year since the initial application (from 50 to 38), and increased the number in each subsequent year by 3 annually (from 50 to 53).

[i] Nebraska initial state application table indicated 898 due to arithmetic error.

[j] New Jersey has modified its transition targets from its initial application, where 734 total transitions were proposed. The number of transitions in each category are different from the initial application and the state has also changed the time units from the state fiscal year to the federal fiscal year, so that the transitions per year by category are different.

[k] Row and column totals due not sum to the same number of annual transitions. Unable to verify correct transition targets with North Carolina. The state did not specify how the transitions would be divided between the elderly and people with disabilities. We assumed a roughly even split between the two groups, and the sum of the two groups shown in this table sums to the total across both groups listed in the state application (i.e. this summary shows 150 in each group, and the total in the state application was 300 in both groups).

[l] Oklahoma initial state application showed 2,100 total transitions due to arithmetic error.

[m] The annual transition target in Pennsylvaniahas been modified from the 2,610 transitions proposed in the initial state application to reflect a new start date.

[n] Virginia's transition targets were originally listed as 1,994 in the application appendix, but have since been modified by the state.

[o] Wisconsin initial state application showed 1,322 total transitions. Changes were made to Year 1 targets since that time.

Note: Unless otherwise indicated, these transition goals were those initially indicated in the state application and therefore may not reflect the states' plans in the Operational Protocol.

Note: The 'other' category may include traumatic brain injury or dual diagnoses such as mental illness and MR/DD, mental illness and substance abuse disorder, or mental illness and a physical disability or chronic condition

Source: State MFP Applications

TABLE 9

MFP REBALANCING AND OTHER GOALS

	Rebalancing Goals	Flexible Spending/Money Follows the Person Goals	Continuity of Service Goals	Other Goals
Arkansas	Add new waiver programs (including a TBI waiver) and expand existing waivers (including 240 additional DD waiver slots) to increase the number of people served through HCBS.	Continue to transfer funds between institutional and HCB settings with the approval of the legislature.	Not mentioned.	None mentioned.
California	Increase waiver services and capacity.	Use budget restructuring lessons learned from an MFP pilot funded by a Real Choices Systems Change grant.	State will ensure the provision of health management and coordination.	Develop community-level transition teams and conduct intensive outreach to facilitate transitions.
Connecticut	Increase use of and spending on HCBS so that 58 percent of people using LTC are served by HCBS in 2011 (75 percent in 2025); 75 percent of Medicaid LTC expenditures on HCBS in 2025 (compared to 31 percent in 2005). Increase existing waiver capacity.	Introduce legislation to remove waiver caps. Develop a "single cross-disability waiver or state plan amendment based on functional need," possibly through an 1115 waiver.	Use existing waivers and expand waiver capacity as needed.	Increase access to affordable housing, increase information for conservators and attorneys about self-direction and choice, increase successful integration of assistive technology post-transition, modify waiver to base eligibility on functional limitation rather than diagnosis, add personal care to State plan via state amendment.
Delaware	Establish consistent and effective policies and practices that can be used beyond the scope of the grant period to maximize the ability of people to transition out of LTC facilities quickly.	Continue to use a single Medicaid budget that combines State Plan and HCBS waiver funds.	Use existing HCBS waivers after the MFP Demonstration concludes.	None mentioned.
District of Columbia	Increase enrollment in the EPD and MR/DD waivers by 10 percent each year during the MFP demonstration. Increase HCBS spending as a percentage of total LTC spending from 16.4 to 23.4 percent.	Develop an internal MFP Financing Committee to work on removing or reducing barriers that are identified.	Amend its State Plan to offer waiver services across all disability types.	Remove barriers that constrain its ability to recruit and retain providers for the MR/DD waiver; develop 300 additional affordable housing units for its consumers and create incentives for providers to encourage successful transition; enhance community crisis and psychiatric emergency services; develop support alternatives for individuals with mental illness; and add three Assertive Community Treatment (ACT) teams.

Table 9 *(continued)*

	Rebalancing Goals	Flexible Spending/Money Follows the Person Goals	Continuity of Service Goals	Other Goals
Georgia	Increase the dollar amount and percentage of expenditures for HCBS as a percentage of total long term care spending. Will strive to achieve a 70 percent reduction in the number of state-owned and operated ICFs/MR beds by closing and decertifying the beds as consumers transition to the community.	Develop methods to eliminate barriers to the flexible use of Medicaid funds if any are discovered during the pre-implementation phase of the Demonstration.	Expand the number of slots in existing waiver programs to ensure that individuals will have access to HCBS after the Demonstration. The state will also evaluate whether its HCBS waivers should be modified to include ongoing transitional services.	Increase the availability of community housing and assess ways to augment existing systems of self-direction. Apart from the MFP Demonstration, use state funds to transition 35 individuals with mental illness out of state mental institutions.
Hawaii	Increase the percentage of LTC expenditures represented by HCBS in each year of the Demonstration.	Medicaid State Plan budget and HCBS waiver program budget were combined into one Medicaid budget effective July 1, 2007. To align organizational with budgetary structure, DHS will also consider transferring administration of the HCBS waivers.	Individuals who have remained in the community for one year will be transitioned to one of the HCBS waiver programs.	Maintain 90 percent of its MFP participants in the community for one year or more; expand available housing resources by recruiting homeowners to serve as community foster homes for MFP participants and develop a plan for constructing new housing facilities. To address the nursing shortage, the state will evaluate the potential for delegating some tasks to unlicensed caregivers.
Illinois	Reduce the census in state-operated developmental centers, private ICFs/MR, and nursing facilities. Also, will achieve a shift in LTC spending from 28.5 percent to 37 percent on HCBS by the end of the demonstration.	Will introduce legislation to establish an MFP transition budget mechanism to allow for more flexible utilization of appropriated long-term care funds.	MFP participants will continue to receive services through HCBS waiver programs after the Demonstration has concluded	Increase availability of housing opportunities for MFP participants.
Indiana	Increase the proportion of LTC funds spent on HCBS from 23 percent in 2007 to 27 percent in 2009 for people eligible for NF level of care. Increase HCBS spending from $546 million in 2007 to $858 million in 2011.	Continue to use single line appropriation to allow money to follow people as they leave facilities; reallocate funds from facility closures to HCBS.	Individuals will be enrolled in the AD waiver, TBI waiver, or DD waiver and will continue to receive services through CHOICE program, Medicaid State plan, HCBS waivers, and other programs.	Track and evaluate outcomes of transitioned individuals and use data to refine efforts.
Iowa	Increase the total annual HCBS expenditures for each fiscal year of the Demonstration. Increase the number of individuals with MR/DD who are transitioned from an ICF/MR. Increase HCBS service expenditures by $61.9 million by coordinating the MFP Demonstration with the Iowa Care Act initiatives.	Continue to use existing authority to transfer funds from ICF/MR line item to HCBS.	All transitioned individuals will continue to be served by MR waiver.	Use social marketing campaign to counteract Iowa's societal bias against community living for individuals with MR/DD.

Table 9 *(continued)*

	Rebalancing Goals	Flexible Spending/Money Follows the Person Goals	Continuity of Service Goals	Other Goals
Kansas	Increase HCBS as a percentage of total LTC expenditures from 53 percent to 58 percent. Reduce the number of private ICF-MR beds by 70 percent through voluntary closure incentives.	Continue its existing MFP project, which allows funding transfers from the institutional to HCBS budgets on a case-by-case basis.	MFP participants will be enrolled in existing HCBS waivers. Current HCBS waivers will be amended to include transition services after the Demonstration has concluded.	None mentioned.
Kentucky	Increase the number of individuals receiving home and community based services.	For each MFP participant, DMS will transfer a percentage of the annual cost of facility-based care to the appropriate HCBS waiver program.	HCBS waiver programs will continue to be available to MFP participants after the Demonstration.	Eliminate the transportation gap in rural areas of the state and develop additional housing opportunities for MFP participants.
Louisiana	Increase spending on HCBS as a proportion of total LTC spending by at least 1 percent annually throughout the Demonstration; increase the number of people served in HCBS and decrease the number served in institutions by a certain percentage; and reduce bed capacity at ICFs-DD and provide supports to downsize ICFs-DD with 16+ consumers to smaller-sized facilities or group homes.	Continue using a single Medicaid appropriation for payment of private facility and HCBS providers and use legislative authority to provide funding for consumers in state-run ICFs-DD to move to community placements	Ongoing HCBS will remain consistent with that offered during the Demonstration. When children who are participating in the DD Children's Choice Waiver turn 19, they will receive a targeted slot in the DD New Opportunities Waiver, a comprehensive waiver for adults with DD.	Expand self-direction options, increase the number of accessible housing units available to consumers with disabilities, and address the shortage of direct care service workers.
Maryland	Transition people to the community while working towards broad-based LTC reforms.	None mentioned.	The only change in services after the Demonstration period will be due to changes in the consumer's needs.	Develop and implement an improved transition assistance process. Implement a single-point-of-entry system statewide.
Michigan	Increase the percent of LTC spending represented by HCBS by 3 percent by 2011, increase annual MI Choice waiver spending by $30 million by 2011, and increase the number of people serviced by the state Home Help program by 500 over 5 years.	Work with the legislature to roll all LTC services into a single line item in FY2008. Use the states Systems Transformation grant to develop a 1915b/c prepaid, capitated long-term care system.	Individuals will continue as participants in either the MI Choice Waiver or Home Help program.	Develop and provide housing coordination services; develop the option to receive services within licensed settings in the MI Choice waiver; allow at least 600 individuals to transfer to qualified residential settings.
Missouri	Increase Medicaid spending on HCBS during each year of the Demonstration; eliminate barriers that prevent access to long-term community supports; assist 50 people per year in their transition to qualified residences.	State will work proactively to implement two House Bills (which have passed and are awaiting the Governor's signature) that increase the flexibility of LTC funds' use.	Improve the ability of the Medicaid program to continue the provision of HCBS after the MFP Demonstration.	Strive for 85 percent of those who transition each year expressing satisfaction with services, supports, and quality of life.

Table 9 *(continued)*

	Rebalancing Goals	Flexible Spending/Money Follows the Person Goals	Continuity of Service Goals	Other Goals
Nebraska	Increase the number of people served in the A&D waiver by 49 percent and the number served in the DD waiver by 23 percent.	Continue to use single line item and nursing home conversion funds to allow transitions to the community.	Maintain the service system in place after the end of the Demonstration.	Increase capacity for supports and services including community-based behavioral supports; invest in transition planning; design a solution for rural residents; develop a "no wrong door" access portal; invest in technology to support assessments, intervention, and monitoring.
New Hampshire	Increase the number of individuals in HCB settings by 10 percent per year; decrease bed day utilization in nursing homes by 5 percent per year; increase Medicaid expenditures for HCBS by 10 percent annually while keeping nursing home expenditures flat; keep 90 percent of transitioned individuals in the community after the first year; increase the proportion of Medicaid funds spent on HCBS (total and per capita) relative to institutions; increase the rate of change for Medicaid LTC on HCBS compared to the national average.	Make flexible funds available to support participants during the transition period.	MFP participants will be eligible for all 1915c waiver services as well as Medicaid State plan personal care services. State will ensure adequate funding for HCBS to maintain community living for those transitioned.	Implement a system that provides person-centered, appropriate, needs based, quality services and supports that ensure a high level of access and quality in both home and community based settings as well as institutions.
New Jersey	Achieve annual increase in service expenditures of approximately 5 percent and an annual increase in the number of MFP transitioned individuals of 5 percent relative to the baseline of 48 percent.	Funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care shall be reallocated to HCBS through a global budget and expended solely for home care.	Continue to make available all waiver and Medicaid State Plan Services to eligible individuals after the demonstration period.	Expand affordable and cost-effective options for receiving HCBS; streamline its eligibility processes; improve access for individuals from all cultural and disability groups; expand transition services to aid in finding housing and services to improve quality of life; include greater opportunities for self-advocacy and participation of consumers at all levels of decision-making related to the LTC system design, implementation, monitoring, and evaluation.
New York	Increase the amount spent on Medicaid HCBS by $68.7 million in 2008, $114 million in 2009, $162 million in 2010, and $91 million in 2011. In addition, state savings of $27 million from the enhanced FMAP for qualified HCBS will be used to fund rebalancing activities.	Continue to use existing budget authority to transfer funds between institutional and HCBS.	Services provided through a new 1915c Nursing Home Transition waiver and certain State plan HCB services would continue after the Demonstration period.	None mentioned.

Table 9 *(continued)*

	Rebalancing Goals	Flexible Spending/Money Follows the Person Goals	Continuity of Service Goals	Other Goals
North Carolina	Transition five percent of individuals currently residing in ICF/MRs and all children with mental illness residing in group homes. For those leaving nursing facilities, beds will not be back-filled with a person with a disability.	Plans to implement a flexible funding arrangement for LTC that enables funds to move with the individual to the most appropriate and preferred settings. Savings will be transferred from the ICF/MR line item in Medicaid to the Community Alternatives Program for persons with MR/DD for the provision of waiver services.	Will allow home and community-based services to be available after the Demonstration using (1) increased state appropriations for HCBS, (2) the development of HCBS waiver amendments and new waiver programs, and (3) the elimination of institutional biases and the development of flexible financing for long-term care.	Submit a new waiver called "New Focus" that will include self-directed support options for individuals with developmental disabilities. Develop Internet based assessment and plan of care tools, chronic disease self-management programs, and interactive case management systems.
North Dakota	Increase access and use of HCBS across the state and in the tribal communities to allow seniors and persons with disabilities to remain in the community when appropriate and desired. The state projects an overall net decrease in 30 ICFs/MR beds over the course of the five-year demonstration; five beds in the first year, eight beds in the second and third years, five beds in the fourth year, and four beds in the fifth year.	Continue to use the existing flexibility to transfer appropriated funding between line items with the approval of the Executive Director. Eliminate barriers that restrict the use of Medicaid to enable people to receive support for long-term care services in a setting of their choice and increase the Medicaid program's ability to support HCBS.	Individuals will have access to HCBS and State Plan services after the demonstration period ends. Nursing Facility Transition Coordinators may identify a team to continue supporting the individuals after the 12 month transition period ends.	None mentioned.
Ohio	Increase the number of individuals in HCBS waivers; increase total Medicaid spending for waiver and state plan services beyond predicted normal program growth (especially for MFP participants); decrease the number of Medicaid enrollees residing in NFs and ICFs/MR and the number of bed days in each; increase the number of NF or ICFs/MR beds that are closed to new Medicaid residents; enact and implement a statutory or administrative rule change in support of rebalancing; move NF and ICF/MR assessment and entry process from a paper to a electronic system.	Use MFP as an opportunity to spur debate about how current resources spent on institutional care can be used to follow the person as they transition back to the community.	Qualified HCBS will be continued for all individuals as medically necessary after the end of the Demonstration period.	Engage key stakeholders about how to best recruit participants; develop affordable housing; implement supported employment programs; approach the subject of institutional bed closure.

Table 9 *(continued)*

	Rebalancing Goals	Flexible Spending/Money Follows the Person Goals	Continuity of Service Goals	Other Goals
Oklahoma	Reduce the size of public ICFs/MR from 452 to 152 beds over 5 years using the Community waiver program.	Work to implement recommendations from a 2002 Real Choice Systems Change grant that LTC funds be appropriated as a single line item. For each person who transitions, a bed will be closed and funding transferred to a waiver program.	None mentioned.	Implement a One-Stop Resource Center as a single point-of-entry in the Fall of 2007.
Oregon	Extend the option of community-based placements to individuals with complex medical and long-term care needs. Transition 780 individuals or 16.5 percent of the institutionalized Medicaid population.	Assess provider capacity, determine if special rates are needed for the identified populations, and develop a model waiver service package as an alternative to nursing home care. Design criteria for specialized services needed by individuals and a system to pay for them as they have not been accessible with Medicaid funds in the past.	A full package of Medicaid home and community-based services will remain available to participants after the demonstration program.	Collaborate with other agencies and organizations to increase participants' access to affordable housing, non-medical transportation, and substance abuse services.
Pennsylvania	Expand the number of people transitioned from nursing homes, mental health hospitals, and MR/DD institutions and increase the amount of funds spent on home and community-based services (HCBS).	None mentioned.	The state will continue to serve MFP clients.	None mentioned
South Carolina	Increase service levels or expand services in the Community Choice waiver.	Establish a Blue Ribbon Task Force charged with creating a single line item for all Medicaid LTC services, including nursing facility, swing beds, PACE, and 1915c waivers.	None mentioned.	Enhance web-based information and referral system to identify potential candidates for transition.
Texas	Use the enhanced matching funds over the course of the grant period (about $17 million net) to increase the number of people served in the community by more than 2,000. Decrease the available beds in community-operated ICFs/MR serving nine or more people by about 400 (20 percent of total beds in non-state facilities).	Assess the feasibility of establishing a line item for those served by ICFs/MR, similar to the line the state currently has for NF transitions. Request legislative approval for increased funding of community-based mental health crisis services and substance abuse counseling as Medicaid State plan services.	All qualified HCBS programs will continue to operate after the Demonstration period, but the state may consolidate services across programs. Potentially enhance waiver services for people with behavioral health conditions.	Establish benchmarks such as recidivism rates, consumer satisfaction, length of time to complete transitions, use of acute care services, costs of community services relative to institutions, and access to publicly subsidized housing.

Table 9 *(continued)*

	Rebalancing Goals	Flexible Spending/Money Follows the Person Goals	Continuity of Service Goals	Other Goals
Virginia	Increase the number of people served in HCBS and decrease the use of ICF/MRs.	None mentioned	Increase the ability of the State Medicaid program to assure continued provision of home and community-based LTC services to eligible individuals who choose to transition from institutions to community settings. Ensure that the provision of these services will be available beyond the one-year demonstration participation.	Create a consumer-directed (CD) supported employment option for some HCBS waivers, increase the number of housing units available to MFP consumers, and promote professionalism in the role of direct care service workers.
Washington	Use "caseload forecasting" to allow the state to identify and project decreases in institutional care to argue for increases in HCBS during legislative appropriations.	Use caseload forecasting; pilot chronic care case management in two area agencies; use existing managed care plans.	Participants will be served by existing waivers and State plan services, including the New Freedom waiver which allows for self-direction of HCBS; existing waivers may be added to increase capacity.	A minimum of 80 percent of transitioning participants will report satisfaction with their move, community supports, and level of self-direction; 10 percent of working-age participants who transition will be employed in the community.
Wisconsin	Expand managed LTC to overcome current bias towards institutions due to limited HCBS capacity; continue current restructuring and relocation efforts to downsize institutions.	Implement managed LTC statewide over five years to eventually replace existing waiver programs. Every year, increase the percentage of LTC funds spent on HCBS and the percentage of the estimated eligible population served by managed LTC financing.	Participants will stay in waiver after MFP Demonstration period ends.	Partner with other state, local, and advocacy agencies to increase the availability of affordable and accessible housing.

Source: State MFP Applications

TABLE 10

PROPOSED POLICY CHANGES TO SUPPORT MFP PARTICIPANTS

	Plans to amend existing HCBS waiver programs or Medicaid State Plan to expand capacity or add services	**Potential new HCBS waiver programs**	**Plans to seek legislative approval for: HCBS waiver or State Plan changes; increased state funds; or authority to combine institutional and HCBS LTC budget lines[a]**
Arkansas	Add 240 slots in its DD waiver. Other waivers may have eligibility rule changes, expanded service capacity, or additional slots to meet MFP participants' needs.	Plan to develop a new 1915c waiver, ARHome, which is an outgrowth of the state's Sec. 1115 Cash and Counseling waiver program. Also intends to add a waiver for people with traumatic brain injury.	Will need legislative approval to add 240 additional DD waiver slots.
California	Increase waiver services and capacity. Additional waiver slots will be added to meet the demands of the target population as necessary.	None proposed	Will need legislative approval for increased waiver services and capacity.
Connecticut	Increase the number of waiver slots in existing waivers to support all Demonstration participants and to meet demand by 2011. If existing waivers are not used to sustain MFP services, a new waiver or State Plan amendment will be developed.	Exploring the possibility of a Section 1115 waiver to address service gaps by creating a single statewide waiver based on functional need.	Will need legislative approval to increase the caps on existing waivers.
Delaware	May apply for a State Plan option to provide services for mentally ill clients since there is not currently a HCBS program for these people.	In the process of submitting an Independence Plus Waiver for Consumer-Directed Attendant Services and an Independence Plus Family Support Waiver.	If new waivers are approved, state will need legislative approval to secure matching state funds and enable self-direction.
District of Columbia	Submitted applications to CMS to renew the MR/DD waiver and amend EPD waiver to include self-direction. Will explore the possibility of a State Plan amendment to address barriers to purchasing medical equipment. An additional State Plan amendment to allow waiver services to be offered across all disability types is anticipated when existing waiver capacity is reached in 2009. Also considering a State Plan amendment to provide community-based psychotherapy.	None proposed	Not mentioned
Georgia	Plans to expand the number of slots in existing waiver programs to ensure that individuals will have access to HCBS after the MFP Demonstration. Will also evaluate whether its HCBS waivers should be modified to include ongoing transitional services after the one-year Demonstration period.	None proposed	Legislative approval needed to add new waiver slots.

Table 10 *(continued)*

	Plans to amend existing HCBS waiver programs or Medicaid State Plan to expand capacity or add services	Potential new HCBS waiver programs	Plans to seek legislative approval for: HCBS waiver or State Plan changes; increased state funds; or authority to combine institutional and HCBS LTC budget lines[a]
Hawaii	Proposes to increase the number of individuals served with new grant waiver services. CMS is currently reviewing an amendment to the State's 1115 demonstration waiver which would include HCBS for neurotrama survivors. After the demonstration ends in 2011, state will consider amending its 1115 waivers to include transition coordinators.	Evaluating whether State should pursue an additional waiver for persons with serious mental illness.	To align organizational with budgetary structure, DHS will consider transferring administration of HCBS waivers to the state's Med-QUEST Division, which manages the State Plan and HCBS waivers as of July 1, 2007.
Illinois	Plans to expand statewide its Enhanced Transition/Home Again (ET/HA) program, which utilizes HCBS in the aging waiver. Will explore a possible new waiver or State Plan amendment to serve those with serious mental illness.	State will explore a possible new waiver (or State Plan amendment) to serve those with serious mental illness.	Will introduce legislation to establish an MFP transition budget mechanism to allow for more flexible utilization of appropriated long-term care funds.
Indiana	Plan to amend the aging and disabled HCBS waiver to increase funds for transition expenses and post-transition care coordination.	None proposed	Not mentioned
Iowa	Plans to add MR waiver slots for people with "related disabilities" including DD. Will also add transition service coordination to the MR waiver or Medicaid State Plan.	None proposed	Will request legislative authority to increase appropriations for Medicaid over the next five years and to expand the number of available slots in the MR waiver.
Kansas	Plans to explore amending all four HCBS waivers to include transition services that will provide allowable costs to establish consumers in the community after they exit institutions. State has submitted a State Plan amendment to CMS for approval to provide targeted case management in the physically disabled waiver.	None proposed	Not mentioned
Kentucky	Plans to review current 1915c waivers and program regulations to determine if additional services will be required for individual target populations and will submit needed waiver and regulation amendments as necessary.	None proposed	Not mentioned
Louisiana	Need to amend State Plan to include case management and durable medical equipment.	Two new proposed 1915c waiver programs have been submitted to CMS: Adult Residential Care Program Waiver and the DD Residential Options Waiver (ROW).	Not mentioned
Maryland	May amend the Older Adult and Living at Home waivers to align the service packages across waivers.	None proposed	Not mentioned

Table 10 *(continued)*

	Plans to amend existing HCBS waiver programs or Medicaid State Plan to expand capacity or add services	Potential new HCBS waiver programs	Plans to seek legislative approval for: HCBS waiver or State Plan changes; increased state funds; or authority to combine institutional and HCBS LTC budget lines[a]
Michigan	Will submit waiver amendment to increase the number of people served under the MI Choice waiver and to serve people in licensed residential settings.	May use the state's Systems Transformation grant to develop a 1915b/c prepaid managed care plan	Medicaid agency will work with the legislature to roll LTC services into a single line item in FY2008
Missouri	Not mentioned	Developing a Sec. 1115 waiver to divert disproportionate share funds generated by inpatient facilities to enhance HCBS for people with co-occurring developmental and mental health disabilities.	Not mentioned
Nebraska	Plans to increase slots in the A&D waiver, the TBI waiver, and possibly the DD waiver (pending legislative approval). Expanded TBI waiver to serve those with acquired brain injury. DD waiver will be amended to include transition service, and all waivers will be expanded to include in-home monitoring technology and targeted case management. May also add behavioral health services to the TBI waiver.	None proposed	Plans to request legislative approval to transfer state matching funds from the Medicaid budget to the DD waiver budget to fund 200 additional slots.
New Hampshire	Intends to modify all waivers to include a variety of transition and Demonstration services, and may modify the waiver serving the elderly and chronically ill (HCBC-ECI) to increase consumer direction and the availability of service options. Plans to pursue the State Plan Option to provide HCBS to those with emotional/behavioral/ functional needs.	None proposed	Not mentioned
New Jersey	Plans to consolidate three current waivers into one Global Options for Long Term Care (GO for LTC) waiver by 2008 that will allow for greater funding flexibility and streamlined processes for delivering services in HCBS and the State Plan. Will propose incorporating the Cash and Counseling program, currently under an Sec. 1115 waiver, into the State Plan using the 1915j option.	GO for LTC is being pilot tested statewide.	Use the Independence, Dignity, and Choice in Long-Term Care Act to reallocate funds not spent on nursing facility care to HCBS through a global budget.
New York	No plans to amend existing waivers, provided CMS approves the pending Nursing Home Transition and Diversion waiver request	New 1915c waiver for Nursing Home Transition and Diversion currently pending CMS approval.	Not mentioned
North Carolina	Expects waiver amendments will be needed to be able to serve MFP participants	Plans to submit a new waiver application, “New Focus,” that will include self-directed support options for individuals with developmental disabilities.	Not mentioned

Table 10 *(continued)*

	Plans to amend existing HCBS waiver programs or Medicaid State Plan to expand capacity or add services	Potential new HCBS waiver programs	Plans to seek legislative approval for: HCBS waiver or State Plan changes; increased state funds; or authority to combine institutional and HCBS LTC budget lines[a]
North Dakota	More waiver slots will be added, equal to the number of Demonstration transitions, if needed.	Expects to request a waiver of the income and resource eligibility requirements to allow the application of the institutional eligibility rules to apply to individuals transitioning from a nursing facility who meet the level of care criteria and receive no waivered services. Has submitted a waiver to CMS that would provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care.	Not mentioned
Ohio	Plans to add 1500 slots to the MR/DD waiver, and add "Community Transition Services" to all 1915c waivers currently lacking such services.	None proposed	Need authorization from the Governor and General Assembly to add more MR/DD slots.
Oklahoma	Plans to amend the ADvantage waiver to include assisted living and adult foster care.	None proposed	Will work to implement a recommendation that came from a Real Choice Systems Change grant to combine institutional and HCBS funding in single line item.
Oregon	May amend existing waiver to add respite services. Plans to request that its Section 1115 Independent Choices waiver be converted to a State Plan option under Section 1915j of the Social Security Act, and that those services be made available statewide.	Expects to request a model waiver to allow participants to live in their family homes where maximum self-direction can be exercised.	Not mentioned
Pennsylvania	Not mentioned	None proposed	Possible need for legislative action allowing adult foster homes to serve MFP participants.
South Carolina	Plans to increase capacity and/or expand services in the Community Choices waiver.	None proposed	A Blue Ribbon Task Force will work to identify best way of creating single budget line item for nursing facilities (including swing beds), PACE, and 1915c HCBS waivers.
Texas	Intends to increase the number served by existing waiver programs, but does not anticipate adding services. Individuals in managed long-term care service areas will be referred to a regional STAR+PLUS Support Unit; as managed LTC expands to additional regions, more MFP participants may be enrolled.	None proposed	Will study the feasibility of creating a single line item for institutions and HCBS. Will request legislative approval for increased funding of community-based crisis mental health services and substance abuse counseling as part of the Medicaid State plan.

Table 10 *(continued)*

	Plans to amend existing HCBS waiver programs or Medicaid State Plan to expand capacity or add services	Potential new HCBS waiver programs	Plans to seek legislative approval for: HCBS waiver or State Plan changes; increased state funds; or authority to combine institutional and HCBS LTC budget lines[a]
Virginia	Planned waiver amendments include: providing Personal Emergency Response Systems (PERS) and PERS monitoring to assist with medication management; transition funding up to $5,000; a consumer directed supported employment option; assistive technology and environmental modification services. Will also add transition coordination services to the EDCD waiver.	None proposed	Not mentioned
Washington	May amend existing waivers, including the Cash and Counseling waiver (New Freedom), to expand capacity or increase services.	None proposed	Not mentioned
Wisconsin	Managed LTC ("Family Care") will be expanded statewide to help reduce waiting lists for HCBS waivers, so does not expect to request expanded waiver capacity.		Not mentioned

a This column only indicates changes the state is planning to make to support MFP. Therefore, states that do not intend to make changes may already have a single line item for institutional and community-based care.

Source: State MFP Applications