Money Follows the Person Demonstration Grant
Operational Protocol
DRAFT

Operational Protocol

A. Project Goals and Benchmarks

Introduction/Goals

1. Case Study

2. Benchmarks

a. Projected number of eligible individuals in each target group to be assisted in transitioning
b. Qualified expenditures for HCBS during each year of the demonstration program
c.

B. Demonstration Implementation Policies and Procedures

1. Participant Recruitment and Enrollment

The following provides a description of the target Medicaid-enrolled populations within North Carolina that will be transitioned during the duration of the MFP Demonstration Grant project, as well as the recruitment processes utilized for those target populations.

As noted in the grant proposal, the target Medicaid-enrolled populations selected for transition include aging individuals with care needs and/or disabilities who have been residing in nursing facilities for a minimum of six months; individuals who have been diagnosed with a mental illness and who have resided in nursing facilities or special care units for a minimum of six months; individuals who have been residing in private ICF-MR facilities or public ICF-MR facilities (developmental centers) for a minimum of six months; and individuals with mental illness who have been treated in a state or private psychiatric facility for a minimum of six months.

A detailed person-centered plan including a transition plan is required to be completed for each individual who qualifies for transition through the MFP Demonstration Grant project. Factors to be considered in the transition plan will include:

- medical issues and resources to meet the identified needs
- behavioral challenges and resources to address the needs including development of a behavior support plan with ongoing oversight and training by a licensed psychologist
- a clear and well documented crisis plan that addresses not only intervention techniques but prevention processes
- residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members and informal supports

a. Selection Process

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

To qualify for transition, individuals must be eligible for Medicaid and have resided in the facility for a minimum of six months. The target region for this population is the entire state.

Individuals expressing a desire and interest to transition out of a nursing facility will review and discuss with the transition coordinator, the information from the Resident Assessment Instrument or any other assessment tool used by the facility to determine the medical support, personal care, and other supports available to the meet the individual's needs for transitioning to a qualified residence. The transition coordinator will also discuss the information with guardians of individuals including parents of children and with families if the individuals give permission to do so.

Nursing home transition coordinators will facilitate the process of identification through contact with specific nursing homes within their geographical region and with the Regional Long Term Care Ombudsmen. The transition coordinators will provide information to consumers to ensure an understanding of the MFP Demonstration Grant project and the target population focus. This information will be provided both in written as well as verbal processes and will include information regarding the project itself, community residential options to nursing home placement, as well as support services available to maintain the individual within the community. Any assessments are person centered and will accurately reflect the individual's desires with input from the individual's guardian, when applicable. Input from the individual's family will be considered if the individual has provided permission for the family to be involved.

Individuals Who Are Residing in Private ICF-MR Facilities or State-operated ICF-MR Facilities (Developmental Centers)

During the first year of the demonstration, individuals residing in the state-operated developmental centers and private ICF-MR facilities who have indicated through a survey or at the individual's annual person-centered planning meeting an interest in community living will be contacted along and informed about the MFP Demonstration Grant project, along with the individual's guardian, when applicable, and the individual's family if the individual has provided permission for the family to be involved. For state-operated developmental centers, the survey (see Attachment A) will be administered by developmental center staff. The transition coordinator will provide information to individuals surveyed regarding the MFP Demonstration Grant project and their choice of community placement. This information will be provided both in written as well as verbal process and will include information regarding the project itself and community residential options to institutionalization, as well as services and supports available in the

community that can be used so that the individuals is able to remain within the community. Those individuals and their guardians or family members with permission who express an interest and desire to transition to the community will be the focus of the transition process during the first year of the demonstration.

Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

Primary participants from state-operated psychiatric hospitals will be children and adolescents ages 6 through 17 who are being treated for a duration of six months or longer. Social workers at each hospital (Cherry, Broughton, Dorothea Dix/John Umstead/Central Regional hospitals) will identify individuals who meet the following criteria:

- Ages 6 through 17
- Hospitalized for 6 months or more
- Medicaid eligible
- Residents of North Carolina
- Ready for discharge

The psychosocial assessment completed by the social worker and the discharge plan developed by the treatment team, in conjunction with family/guardian and community representatives, will be used to identify the most appropriate level of services and supports that the individual needs to transition to the community.

Hospital social workers will have received information from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) about MFP and will share the information with the child/adolescent and his/her family/guardian. During the development of the discharge plan, the child/adolescent, treatment team, family/guardian, and community representatives will determine if the individual will be a participant in the MFP Demonstration Grant project.

b. Qualified Institutional Settings

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

Qualified institutional settings include skilled nursing facilities throughout the State.

Individuals Who Are Residing in Private ICF-MR Facilities or State-operated ICF-MR Facilities (Developmental Centers)

Qualified institutional settings include private ICF-MR facilities and state-operated facilities (developmental centers) throughout the State as well as the O'Berry Neuro-Medical Treatment Center.

Note: The short-term specialty programs at the developmental centers are exempt from the MFP Demonstration Grant project.

Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital
Children/adolescents at each of the state-operated hospitals (Cherry, Broughton, Dorothea Dix/John Umstead/Central Regional hospitals) will be eligible. Each of the hospitals is certified as an Institution for Mental Disease (IMD).

c. Residency Requirements

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility
The transition coordinator will be responsible for ensuring, through contact with the administrator and staff of the facility that the individual assessed for transition to the community has been residing in the nursing facility for at least six months. This will be documented via an admission summary.

Individuals Who Are Residing in Private ICF-MR Facilities or State-operated ICF-MR Facilities (Developmental Centers)
For state-operated developmental centers, the transition coordinator will be responsible for ensuring through the director and staff of the facility that the individual assessed to transition to the community has been residing in the developmental center for at least six months. This will be documented via an admission summary.

Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital
Children and adolescents must be hospitalized for a minimum of six months to be eligible participation in the MFP Demonstration Grant project.

d. Process for Assuring Medicaid Eligibility

The transition coordinator will be responsible for ensuring that the individual who will be participating in the MFP Demonstration Grant project continues to be eligible for Medicaid upon discharge from the facility. As applicable, hospital social workers, the developmental center's or ICF-MR facility's reimbursement office and nursing facility discharge planners work in collaboration with the individual's local department of social services (DSS) in the specific county in which the individual resides to obtain documentation verifying Medicaid eligibility.

e. Re-enrollment Policy

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility
Individuals who have been identified for transition to the community who subsequently are re-admitted to the nursing facility after the 12-month demonstration period may be a candidate for another 12 months of demonstration services (or the number of months left until the demonstration cut-off date of June 30, 2011 if less than 12 months remain) if the reason for re-entry was related to medical issues requiring

skilled nursing care for at least six months or longer. In order to ensure success in the community, an assessment must be completed to determine if adequate community resources are available to meet the medical needs of the individual. This will include verification by the transition coordinator of ongoing access to medical care specific to the needs of the individual.

Individuals Who Are Residing in Private ICF-MR Facilities or State-operated ICF-MR Facilities (Developmental Centers)
and
Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

Individuals who have been identified for transition to the community who subsequently are re-admitted to the developmental center, ICF-MR group home, or state-operated psychiatric hospital after the 12-month demonstration period may be a candidate for another 12 months of demonstration services (or the number of months left until the demonstration cut-off date of June 30, 2011 if less than 12 months remain) if the reason for re-entry was related to lack of adequate resources in the community to ensure the health and safety of the individual. In order to be a candidate for a second 12-month demonstration period, a detailed person-centered plan including a transition plan is required to be completed by a team of individuals consisting of developmental center staff, Local Management Entity (LME) staff, and community providers with specific processes to ensure community sustainability. (Person centered planning tools such as Essential Lifestyle Planning or MAPS may be used.) Factors to be considered in the transition plan will include:

- medical issues and resources to meet the identified needs
- behavioral challenges and resources to address the needs including development of a behavior support plan with ongoing oversight and training by a licensed psychologist
- a clear and well documented crisis plan that addresses not only intervention techniques but prevention processes
- residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members and informal supports

f. Informed Choice Assurance

All individuals who wish to participate in the MFP Demonstration Grant project will be asked to sign a consent form (see **Attachment B**) indicating that they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights and responsibilities as participants. Additionally, participants will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents.

i. Training and Information

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

Each individual identified for transition to the community will be provided with information regarding protection from abuse, neglect, and exploitation and the process for notifying the appropriate authorities if the participant is subject to abuse, neglect or exploitation. This information will be given by the transition coordinator to the individual as well as to other identified family members, legal guardians, etc. during the person-centered planning process.

Individuals Who Are Residing in Private ICF-MR Facilities or State-operated ICF-MR Facilities (Developmental Centers)
and
Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

Each individual identified for transition to the community and, where applicable, his/her guardian, will be provided with the following information regarding protection from abuse, neglect, and exploitation in the community and how to notify the appropriate authorities if the participant is subjected to abuse, neglect or exploitation. The information will be reviewed with the individual and his/her guardian by the individual's treatment team during the person-centered planning process.

Processes for ensuring protection from abuse, neglect, and exploitation include the following. Transition coordinators in collaboration with the LME will be responsible for training the individual and legal guardians in this system of responding and reporting of critical incidents and other processes.

- The North Carolina Administrative Code requires all LMEs and provider agencies to participate in a DMH/DD/SAS-coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and consumer behavior issues.
- Service providers are required to respond to all incidents by:
  - ensuring the safety of consumers and others,
  - documenting the incident and steps taken to remedy the situation, and
  - analyzing incident trends as part of the agency's quality improvement process.

- Incidents are divided into three levels of severity, which determines the intensity and breadth of the response:
  - level I: includes incidents that are already being addressed clinically and/or have limited immediate adverse consequences as isolated events, but that can signal the potential for more serious future problems if not addressed.
  - level II: includes incidents with immediate or potentially serious adverse consequences to the consumer or others, including such events as injuries, abuse allegations, and use of restrictive interventions
  - level III: includes incidents with the most severe and permanent consequences-death or permanent impairment. In addition to the steps taken for all levels, providers must convene a team within 24 hours to address immediate needs regarding their safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer's guardian and the LME of steps taken.
- Provider agencies handle level I incidents internally and report aggregate numbers of level I incidents, identified trends, and activities being undertaken to address identified problems to the LME quarterly.
- Provider agencies report level II incidents to the LME within 72 hours. The LME reviews these incidents to ensure that the provider is taking the necessary actions to keep consumers and others safe, to minimize the reoccurrence of the incident in the future, and to make the required reports to other authorities.
- When there is reason to believe that an adult or child may be abused, neglected or exploited and in need of protective services, the incident is also reported to the local DSS and to the State Health Care Personnel Registry for investigation. Criminal acts are also reported to legal authorities for investigation.
- Provider agencies report level III incidents to both the LME and the DMH/DD/SAS within 72 hours (or immediately if a death occurred within 7 days of seclusion or restraint of the individual).
- LMEs report information on level II and III incidents to the DMH/DD/SAS quarterly, including aggregate numbers of types of incident, local trends identified in the LME's analysis and actions they have taken to prevent future incidents.

- The DMH/DD/SAS assures that individuals receive support to exercise their right and voice complaints. The LME is the local hub for receiving complaints about service provision.
- In addition, per administrative rule, each area board for MH/DD/SAS or LME services is required to operate at least one Client Rights Committee, and require contracted providers to operate a Client Rights Committee as well.
- N.C. General Statute 122C-64 states that the Client Rights Committee is responsible for protection of client rights and includes provisions regarding confidentiality, right to treatment and consent to treatment, use of corporal punishment, use of physical restraints or seclusion, and protection from abuse and exploitation.
- The LME Client Rights Committee reviews incidents and consumer complaints, including alleged violations of the rights of individuals or groups, cases of alleged abuse, neglect or exploitation, concerns regarding the use of restrictive procedures, and failure to provide needed services that are available. The Committee reviews incidents occurring within a contract agency after the governing body of the agency has reviewed the incident and has had opportunity to take action.
- The Committee makes recommendations to the local LME board and may make report to local DSS and other applicable licensing agencies such as the Division of Health Services Regulation and the Division of Public Health.
- The Community Services Customer Rights (CSCR) team tracks and analyzes all complaints that come to the Division. Data collected on complaints include complainant and consumer information, the type of complaint, results of attempts to resolve the complaint, and the number of contacts.
- Locally mortality reviews are conducted by the Quality Improvement Committee of the LME.
- The Performance Contract with LMEs requires that LMEs produce reports and use for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends. Trends related to consumers include incidents, and client rights. LMEs must report quarterly all incidents and deaths as well as complaints as part of the Performance Contract with DMH/DD/SAS.

ii. Responsible Entities

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

The transition coordinators in collaboration with the local DSS adult protective service worker will be responsible for providing the individual and legal guardians with local information regarding who to contact and how to report suspected abuse, neglect, or exploitation and the process for reporting critical incidents.

Individuals Who Are Residing in Private ICF-MR Facilities or State-operated ICF-MR Facilities (Developmental Centers)
and
Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

Transition coordinators in collaboration with the LME will be responsible for providing the individual and legal guardians with local information regarding who to contact and how to report suspected abuse, neglect, or exploitation and the process for reporting critical incidents.

2. Informed Consent and Guardianship

a. Informed Consent

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

Informed consent for participation in the MFP Demonstration Grant project may be provided by the adult participant, emancipated minors, the parents of minors or the legal representative or surrogate decision makers who have responsibility for individual's living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent named in a health care power of attorney. In cases where there is a legal representative or surrogate decision maker, the transition coordinator will review appropriate legal documentation to ensure that the individual possesses the legal authority to make decisions dealing specifically with a participant's living arrangement and receipt of services/treatment.

Individuals Who Are Residing in Private ICF-MR Facilities or State-operated ICF-MR Facilities (Developmental Centers)

Informed consent must be provided by the participant, unless that participant has been adjudicated as unable to make major life decisions in which case informed consent must be provided by the court-appointed guardian.

Children and Adolescents Who Are Residing in a State-operated Psychiatric Hospital

The only individuals who can provide consent to participate in the MFP Demonstration Grant project is the child/adolescent's legal guardian. Legal guardians will be provided with information during the person-centered planning process about the transition process and the services that will be provided to the participant by the primary community provider in conjunction with the LME.

b. Guardianship

Chapter 35A of the North Carolina General Statutes contains the state's laws dealing with guardianship. In North Carolina, each of the state's 100 counties has a clerk of superior court who determines the appropriateness of guardianship and appoints a guardian if needed. Guardians are considered surrogate decision makers for individuals who are no longer capable of making and communicating decisions about themselves and/or their assets. The guardian's duty is to advocate for and assist the ward in exercising his/her rights.

A guardian may be an individual, such as a family member or friend; a corporation chartered to serve as guardian; or a disinterested public agent guardian. A disinterested public agent guardian may be the director or assistant director of a local human services agency (local DSS, LME, local health department or county department on aging) or an adult officer or agent of a state human services agency.

NCGS 35A does not specify the level of interaction between a ward and an individual or corporation serving as guardian. It also does not address how frequently a guardian must visit with a ward. Disinterested public agent guardians are required by North Carolina Administrative Code to have contact related to the ward no less than once every 90 days. General Statute 35A requires corporations and disinterested public agent guardians to submit annual status reports with the clerk of court's office detailing what has been done for the ward during a specified time period. These reports may include the level of interaction between the guardian and the ward.

Guardian involvement should be individualized to the participant and his/her person-centered plan. The guardian, participant, and others (such as a case manager) will decide the guardian's involvement and ongoing interaction based on person centered plan.

In regard to the MFP Demonstration Grant project, legal representatives or surrogate decision makers who have responsibility for individual's living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent named in a health care power of attorney appointed by the court for individuals within the project will be required to have contact with the individual identified for transition within the last six months.

Only a court appointed guardian may act as guardian for the participant. Legal guardians other than family members will follow the agency protocol for ensuring ongoing guardian interaction.

Because children and adolescents are eligible to participate in MFP, only the parent or court appointed guardian may act as the guardian for the participant. Legal guardians other than family members will follow their agency protocol for ensuring on-going guardian interaction.

3. Outreach, Marketing, and Education

a. Information to Be Provided

To support the successful implementation of the MFP Demonstration Grant project, generic outreach and marketing materials will be developed to be used across a wide range of audiences and locations. A general information sheet template (see **Attachment C**) will be available to all audiences. This template may be edited for use state staff with specific audiences. Additionally, a flow chart template will be developed to explain the transition process. This template may also be edited to suit various audiences.

Participants

Participants in the MFP Demonstration Grant project are those who have expressed an interest in transitioning and who wish to live and receive supports and services in the community of their choosing. There are several stages of information dissemination with regards to participants. These stages include pre-transition, post-transition and ongoing. During the pre-transition stage, potential participants will be notified about the opportunity to transition to the community and surveyed to determine their interest. During the post-transition (the three months after the transition) and ongoing stages, participants will be notified of additional services and supports in the community. Guardians and others identified by the participants (e.g., family members) will also receive information at the various stages.

Providers

Providers in the MFP Demonstration Grant project are those public, private, and community organizations that will provide services and supports to the participants so that they are able to successfully transition to and remain in the community. There are a wide variety of providers with multiple interests. Many providers have already been notified of the MFP Demonstration Grant project. There is a "provider workgroup" that has been formed and members of this group have been involved in reviewing this protocol and will continue to be involved through the life of the project. A mass mailing will also be designed for providers to ensure that a wide variety of providers is aware the MFP Demonstration Grant project and the opportunities for involvement.

State Staff
State staff refers to the employees of the N.C. Department of Health and Humans Services (DHHS) who will be involved in the MFP Demonstration Grant project. There are a wide variety of staff and many DHHS divisions will be touched by this initiative.

Other
Advocacy groups also serve as important audiences for MFP Demonstration Grant project information. DMA will design a mass mailing (using postcards) for various advocacy groups. The postcards used in the mass mailing will provide basic information about the MFP Demonstration Grant project.

b. Types of Media to be Used

Participants
Participants may receive information using brochures, broadcast messages (on television or radio, during in-person-visits to nursing homes/institutions to discuss the MFP Demonstration Grant project, via Medicaid card inserts and through the Division of Medical Assistance's (DMA) website at http://www.ncdhhs.gov/dma/MoneyFollows/MoneyFollowsPerson.html.

Providers
Providers may receive information using the following media: DMA bulletins (e-postings), MFP Demonstration Grant project information sheet, DMA's website, remittance advice (RA) banners, verbal recordings for providers to hear while "on hold" (on the phone) with DMA, mass mailings (post cards) to provider associations and via inserts in conference "goodie bags".

State Staff
State staff may receive information via DMA's website, fact sheets and through trainings.

c. Specific Areas to be Targeted

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility
Facilities throughout the state will be targeted through Nursing Home Transition coordinators with the Centers for Independent Living and the N.C. Division of Vocational Rehabilitation Independent Living Services.

Individuals Who Are Residing in Private ICF-MR Facilities or State-operated ICF-MR Facilities (Developmental Centers)
Private ICF-MR facilities and state-operated facilities (developmental centers) throughout the State along with the O'Berry Neuro-Medical Treatment Center will be targeted.

Individuals Who Are Residing in a State-operated Psychiatric Hospital

- Cherry Hospital
- Broughton Hospital
- Dorothea Dix/John Umstead/Central Regional hospitals

d. Information Dissemination

The following resources will be used for information dissemination:

- Aging and Disability Resource Centers (ADRCs)
- Various non-profit health care organizations, including:
  - National Multiple Sclerosis Society
  - ARC of NC
  - Easter Seals/UCP of N.C.
  - NAMI
  - Mental Health Association
  - Provider associations
- Local management entities (LMEs)
- N.C. Family Resource Line
- Centers for Independent Living (CILs)
- Rehabilitation centers
- Nursing facilities
- N.C. Division of Vocational Rehabilitation Independent Living program offices
- Senior Health Insurance Information Program/N.C. Senior Medicare Patrol
- Long Term Care Ombudsmen offices
- N.C. Council on Developmental Disabilities
- Providers of Programs for All-inclusive Care for the Elderly (PACE)
- Lead agencies for the Community Alternative Program for Disabled Adults
- Disability Rights North Carolina (formally known as Carolina Legal Assistance

e. Staff Training

There will be mandatory, annual staff training. This training will be video taped. Each person who participated in the training will also have a six-month “refresher” session/video update.

Other options for trainings include conference calls and web based trainings.

Continuing Education Units (CEUs) should be offered to nursing facility staff, referring agencies and others. This was demonstrated to be a successful technique during North Carolina’s Nursing Home Transition grant.

f. Bilingual Materials/Interpretation Services and Services for Individuals with Special Needs

Materials will be available in English and Spanish, and, upon request, in Braille and large print. Electronic materials will be accessible to those who use screen readers.

g. Informing Eligible Individuals of Cost Sharing Responsibilities

All materials intended for use by participants, their family, friends and guardians will include language that indicates the responsibility of the individual to participate in cost-sharing.

4. Stakeholder Involvement

a. Stakeholder Chart

See **Attachment D**.

b. Consumer Involvement

Consumers, advocates and others were invited to participate in six demonstration workgroups as a prerequisite to developing the operational protocol for the MFP Demonstration Grant project. As the protocol was developed, this group was consulted and was provided with an opportunity to review and comment on the draft.

Additionally, consumers and advocates were asked to participate in an application/nomination process for participation in ongoing Stakeholder Advisory meetings.

c. Institutional Providers Involvement

Institutional providers were invited to participate in provider issues workgroups. These providers will also be asked to participate in ongoing Stakeholder Advisory meetings.

d. Roles and Responsibilities

The stakeholders will be responsible for providing input to the six workgroup focus areas as well as to provider issues.

e. Operational Activities

Each year, DMA will coordinate four state forums that will be held in conjunction with the Quarterly Stakeholder Advisory meetings; these meetings will rotate to locations around the state. These forums will be open to the pubic and efforts will be made to invite a wide range of potential participants, their families, friends and guardians, providers, state staff and other important community stakeholders.

5. Benefits and Services

a. Service Delivery Systems

In North Carolina, the MFP Demonstration Grant project will be used to transition individuals into existing 1915(c) home and community based waiver programs. A separate demonstration 1915(c) waiver will not be created for the ongoing services provided through the MFP Demonstration Grant project. After the 12-month demonstration period, individuals will continue in the same 1915(c) waiver program as long as they meet the eligibility requirements of the program.

North Carolina currently operates two 1915(c) waivers that target individuals who are aging and/or have disabilities as an alternative to residing in a nursing facility: CAP/DA and CAP/Choice. North Carolina also operates a 1915(c) waiver that targets individuals with intellectual or developmental disabilities as an alternative to residing in a private ICF-MR or a state-operated ICF-MR (developmental center): CAP/MR-DD.

DMA also operates a 1915(b) and (c) waiver, Piedmont Behavioral Health Plan, which provides behavioral health and substance abuse services as the Piedmont Cardinal Health Plan, as well as services to individuals who have intellectual/developmental disabilities as the Piedmont Innovations Program. This waiver is provided to recipients in Cabarrus, Davidson, Rowan, Stanly, and Union counties.

b. Service Package

CAP/DA

The Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults (age 18 and older) who qualify for nursing facility care to remain in their private residences. The current CAP/DA waiver provides services and supports to individuals who meet the nursing facility level of care who can be safely and effectively served in the community. Services include:

- Adult day health care
- Home modifications
- Incontinence supplies
- In-home aide services, level II and level III
- Personal emergency response service
- Preparation and delivery of meals
- Respite care, in-home
- Respite care, institutional
- Specialized equipment and supplies
- Specialized supplies
- Case management

CAP/Choice

The Community Alternatives Program Choice (CAP/Choice) is a program of consumer-designated care for aging and disabled adults (age 18 and older) who qualify for nursing facility care to remain in their private residences. CAP/Choice provides the individuals with increased control over their services and supports and provides the ability to more fully direct their care. CAP/Choice provides the individuals with more flexibility in tailoring their plans of care to their home care requirements. In addition to the services provided through the CAP/DA waiver, CAP/Choice participants have access to:

- Consumer-directed care advisor
- Consumer-directed financial management
- Consumer-directed goods and services (equipment and services not covered through the State Plan that are needed to increase the individual's ability to complete activities of daily living and to decrease dependence on aide services)

Note: Because CAP/Choice provides consumer-directed care advisors, case management is not a direct service component of the waiver.

CAP/MR-DD

The Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities (CAP-MR/DD) provides community services to individuals of any age who qualify for care in an intermediate care facility for individuals who have intellectual disabilities (mental retardation) (ICF-MR). Services include:

- Adult day health care
- Augmentative communications (purchase and repairs/service)
- Crisis services
- Day supports (group or individual)
- Enhanced personal care
- Enhanced respite care
- Home and community support (group or individual)
- Home modifications
- In-home aide services, level II and level III
- Individual caregiver training and education
- Non-medical transportation
- Personal emergency response service
- Respite care, enhanced
- Respite care, institutional
- Respite care, non-institutional (group or individual)
- Respite care, nursing level LPN
- Respite care, nursing level RN
- Residential supports (levels 1 through 4)
- Specialized consultative services
- Specialized equipment and supplies)

- Supported employment (group or individual)
- Transportation, non-medical
- Vehicle adaptations

Piedmont Cardinal Health Plan/Piedmont Innovations
PCHP is a prepaid managed care plan administered by Piedmont Behavioral Healthcare, a public mental health, developmental disabilities, and substance abuse services organization. PCHP includes all Medicaid-covered mental health and substance abuse services as well as the new Piedmont Innovations waiver program, which replaces CAP/MR-DD in the five-county area. PCHP also includes intermediate care facilities for the individuals who have intellectual disabilities and psychiatric inpatient hospitalizations.

Transition Services
One-time set-up transition expenses for individuals who are transitioning from a nursing facility, a state-operated developmental center or private ICF-MR group home, or a state-operated psychiatric hospital to a community setting or another living arrangement where the person is directly responsible for his/her own living expenses include the following:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, bed/bath linens;
- Set-up fees or deposits for utility or service access including telephone, electricity, heating and water; and
- Service necessary for the individual's health and safety such as pest eradication and one-time clearing prior to occupancy.

Transition services are furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. Transition services do not include monthly rental or mortgage expenses; regular utility charges; and/or household appliance or diversional/recreational items such televisions, VCRs, and DVDs. These services may be provided only once and may not be accessed for any subsequent moves within the community.

State Plan Services
In addition to the waiver program services, all MFP participants will be eligible for State Plan Services.

6. Consumer Supports

a. Educational Materials

DMA will develop informational brochures that outline the services provided through MFP. Current consumer information will be updated to include information about the MFP Demonstration Grant project.

b. Back-up Systems

The North Carolina Department of Health and Human Services toll-free information and referral telephone service, CARE-LINE, is available to provide information and referrals regarding human services in government and non-profit agencies. A database of over 10,000 agencies across North Carolina is available to staff who are assisting callers. In addition, residents and professional can access program information via the N.C. careLINK (http://www.nccarelink.org). The CARE-LINE is available Monday through Friday, except state holidays, by calling 1-800-662-7030 (English/Spanish), 1-877-452-2514 (TTY) or 919-855-4400.

c. Consumer Complaints

The DHHS Ombudsman Program was created to address inquiries and complaints that consumers have regarding services that DHHS oversees or administers. Through this service, Office of Citizen Services staff serves as the central point of contact for the DHHS Secretary's Office, Governor's Office, other elected and appointed officials, department personnel, all government agencies, non-profit and private agencies, advocates and residents of the state.

Constituents who contact their governmental representatives or any human service professional with complaints concerning DHHS or who are in need of human service programs are referred to the DHHS Ombudsman Program. When a complaint is received, OCS staff serves as a liaison between the resident and the DHHS program specialist. OCS staff ensures that complaints are thoroughly examined and investigated. Staff determines the most appropriate parties to contact and work with to resolve the situation. Feedback is provided to elected officials regarding their constituents' concerns. Ensuring that consumers have the proper channel for addressing their concerns is the key to this program. If a person's complaint is valid, steps are taken to rectify the situation. If the complaint is not valid, time is spent with the resident to educate them on the process and help them understand why the situation was handled in a certain manner. In addition, staff relies on an extensive statewide database to give additional referrals that may be of assistance.

The Regional Long Term Care Ombudsmen program can also be accessed through the CARE-LINE and is available Monday through Friday, except state holidays, by calling 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (TTY).

7. Self-direction

North Carolina's MFP Demonstration Grant project includes the same services as the CAP/Choice waiver with regard to self-direction and ensures compliance with the Freedom of Choice requirement. Participants may choose any willing and qualified provider; receive information about providers; select whom to interview; and meet, interview and select the provider of their choice. Consumer directed options are currently available through the Piedmont Innovations waiver serving individuals with intellectual and developmental disabilities in the Piedmont catchment area. As new waivers are developed for this population over the next year consumer directed options will be made available to include the rest of the state.

8. Quality Management

a. Quality Assurance for Integrating Services into New or Existing 1915(c) Waivers

Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility

North Carolina intends to integrate the MFP Demonstration Grant services into an existing 1915(c) waiver for individuals who require the level of care provided by a nursing facility transitioning to the community. The same level of quality that applies to the CAP/DA waiver will apply to those individuals during the transition and during the demonstration.

Individuals Who Are Residing in Private ICF-MR Facilities or State-operated ICF-MR Facilities (Developmental Centers)

North Carolina intends to integrate the MFP Demonstration Grant services into an existing 1915(c) waiver for individuals with developmental disabilities transitioning from a state-operated developmental center or private ICF-MR facilities. The same level of quality that applies to the CAP/MR-DD waiver will apply to those individuals during the transition and during the demonstration.

b. Quality Assurance for State Plan Services

c. Waiver Assurances

CAP/DA and CAP/Choice

CAP/MR-DD

Attached to this document is North Carolina's Quality Management plan for the current 1915(c) Home and Community Based Waiver for individuals with developmental disabilities. This plan reflects processes for assuring that the MFP Demonstration Grant project will reflect the same level of quality assurance and improvement activities required under Appendix H of the Home and Community Based Waiver application for those individuals transitioned to the community into an HCBS waiver during the demonstration.

i. Level of Care Determinations

CAP/DA and CAP/Choice

Local lead agencies are responsible for coordinating with case managers in the assessment of the individual's strengths and needs in six basic areas of functioning to determine individuals who are potentially eligible for waiver services, assuming funding availability and that the individual meets the nursing facility level of care.

A continued need review (CNR) is completed annually for all participants. The statewide utilization review vendor reviews CNRs including the FL2 reflecting the nursing facility level of care.

The instruments and process for determining level of care are the same as those described in the approved waiver. Nursing facility level of care criteria are applied to determine eligibility for the waiver. Documentation of nursing facility level of care is provided using the FL2.

CAP/MR-DD

LMEs are required through Performance Measures in the LME Performance Contract to provide a system of screening, triage and referral to services in a prompt, user-friendly manner. This includes individuals who are potentially eligible for waiver services, assuming funding availability and that the individual meets the ICF-MR level of care. Individuals referred for waiver funding have their level of care assessed by a psychologist or physician. Clinical staff employed by DMH/DD/SAS make the final determination of level of care.

A continued need review (CNR) is completed annually for all participants by a Qualified Professional in the field of developmental disabilities. The LME is responsible for signing the MR2 reflecting ICF-MR level of care at the annual CNR. The statewide utilization review vendor reviews CNRs including the MR2 reflecting the ICF-MR level of care.

The instruments and process for determining level of care are the same as those described in the approved waiver. ICF-MR level of care criteria are applied to determine eligibility for the waiver. Documentation of ICF-MR level of care is provided using the MR2.

Clinical staff employed by DMH/DD/SAS through the Murdoch Developmental Center maintain a spreadsheet to record timeliness of level of care reviews. The DMA audits a random sample of 15 records monthly, which includes a review of the level of care determination.

ii. Service Plan Development

CAP/DA and CAP/Choice

Case managers employed by individual provider agencies are responsible for developing each person-centered plan to address the services that are needed to maintain the individual's health, safety, functions, and independence.

Case managers revise the person-centered plan as needed. DMA contracts with a statewide vendor to monitor person-centered plans to assure that:

- participants continue to meet the criteria for nursing facility level of care;
- re-evaluations are conducted annually;
- participants are provided with the option for institutional care; and
- services are delivered as approved.

CAP/MR-DD

Case managers employed by individual provider agencies through a contract with the LME develop an individual person-centered plan for each applicant/participant and 100% of these plans are submitted for review and approval through a statewide utilization review vendor.

Case managers revise Plans of Care as needed. Revised plans must be approved by the statewide utilization review vendor.

Case managers monitor Plans of Care to determine whether services are delivered as approved. LMEs monitor service provision through review of paid claims data reflecting the amount and frequency of services billed for specific consumers on an as-needed-basis, as well as through post-payment reviews. The State audits a random sample of 15 records monthly through DMA's Behavioral Health Unit, Quality Assurance Reviews, which includes a review of encounter data/paid claims. In addition, DMH/DD/SAS Program Accountability Team and DMA's Behavioral Health Unit conducts a Medicaid Compliance Audit that includes waiver services

Case managers monitor appropriateness of service delivery in light of any changes in the consumer's needs. Monthly face-to-face monitoring is required. LMEs have responsibility through the Performance Contract with the DMH/DD/SAS to produce reports and use for planning and improvement. These include provider trends such as assessment of provider quality, results of audits and monitoring activities, technical assistance, and trainings. The reports analyze and summarize patterns and trends related to providers. All initial person-centered plans,

revisions to the person-centered plans, and CNRs are reviewed and approved by a statewide utilization review vendor. The State audits a random sample of records monthly through DMA's Behavioral Health Unit, Quality Assurance Reviews, which includes a review of encounter data/paid claims. DMH/DD/SAS Program Accountability Team and DMA's Behavioral Health Unit conducts a Medicaid Compliance Audit that includes waiver services.

iii. Identification of Qualified HCBS Providers for those Participants Being Transitioned

CAP/DA and CAP/Choice

Participants are offered choices of waivers versus institutional care and between/among providers. Choice must be documented in the person-centered plan.

The local lead agencies are responsible for verifying that providers within their catchment areas meet all the requirements to provide CAP/DA services. The DMA Provider Enrollment Unit is responsible for enrolling all CAP/DA providers based on meeting endorsement criteria.

CAP/MR-DD

Participants are offered choices of waivers versus institutional care and between/among providers. Choice must be documented in the person-centered plan.

The LME is responsible for verifying that providers within its catchment area meet all the requirements to provide CAP/MR-DD services through the endorsement process. The LME is responsible for performing provider endorsement activities in accordance with the policies, processes, and timeframes outlined in the DHHS Provider Endorsement policy. The Division of Health Service Regulation is responsible for licensure of all healthcare facilities in which CAP/MR-DD waiver recipients may reside. The DMA Provider Enrollment Unit is responsible for enrolling all CAP/MR-DD providers based on meeting endorsement criteria.

LMEs maintain responsibility through the Performance Contract with the DMH/DD/SAS to provide ongoing monitoring of providers within their catchment areas. In addition, if through the monitoring process it is determined that the provider no longer meets the requirements of endorsement to provide a specific CAP/MR-DD service, the LME may withdraw endorsement resulting in withdrawal of to provide and bill for the specific service. The State provides monitoring of providers as well through annual DMH/DD/SAS and DMA Medicaid Compliance Audits. DMH/DD/SAS has in place a protocol for

summary suspension and revocation of authorization to receive public funding for providing MH/DD/SAS services.

Enrolled providers are required to ensure that all direct care staff receive required training as outlined in Appendix B-2 of the CAP/MR-DD waiver, Provider Qualifications. LMEs maintain responsibility through the Performance Contract with the DMH/DD/SAS to provide ongoing monitoring of providers within their catchment area. LMEs have responsibility through the Performance Contract with the DMH/DD/SAS to produce reports and use for planning and improvement. These include provider trends such as assessment of provider quality, results of audits and monitoring activities, technical assistance, and trainings. The reports analyze and summarize patterns and trends related to providers. The state provides monitoring of providers as well through annual DMH/DD/SAS and DMA Medicaid Compliance Audits.

iv. Health and Welfare

CAP/DA and CAP/Choice

Case managers maintain responsibility for monitoring each waiver participant's changing needs, situation or condition. The case manager monitors the services to the participant through direct observation, including a monthly face-to-face visit, participant report, and review of provider documentation. Case managers are responsible for reporting any abuse, neglect, or exploitation to the county DSS as well as the provider agency.

CAP/MR-DD

Case managers maintain responsibility for monitoring waiver participant's changing needs, situation or condition, including a monthly face-to-face visit. Case managers are responsible for reporting any abuse, neglect, or exploitation to the county DSS as well as the provider agency. The N.C. Administrative Code requires all LMEs and provider agencies to participate in a DMH/DD/SAS-coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and consumer behavior issues. In addition, per administrative rule, each area board for MH/DD/SAS services is required to operate at least one Client Rights Committee, and require contracted providers to operate a Client Rights Committee as well. Local mortality reviews are conducted by the Quality Improvement Committee of the LME. The Community Services Customer Rights (CSCR) Team tracks and analyzes all complaints that come to the Division. Data collected on complaints include complainant and consumer

information, the type of complaint, results of attempts to resolve the complaint, and the number of contacts.

v. Administrative Authority for the Waiver

CAP/DA and CAP/Choice

DMA is responsible for monitoring program administration for the CAP/DA waiver. DMA provides information and guidance to counties that have CAP/DA programs and conducts annual on-site visits to review program operations and the provision of technical assistance to facilitate management of the program.

CAP/MR-DD

DMH/DD/SAS and DMA are responsible for monitoring program administration. DMH/DD/SAS is the lead agency for statewide operations of the CAP/MR-DD waiver and DMA oversees the overall operation of the waiver according to federal and state guidelines. These divisions cooperate in the operation of the waiver under a Memorandum of Understanding that delineates each division's responsibilities. LMEs are monitored through the Performance Contract for processes related to basic lead agency functions. DMA audits a random sample of records monthly to determine whether services are being provided appropriately to CAP/MR-DD waiver recipients. Annually the DMH/DD/SAS Program Accountability Team and DMA's Behavioral Health Unit conducts a Medicaid Compliance Audit that includes waiver services.

vi. Financial Accountability

CAP/DA and CAP/Choice

The Medicaid Program's fiscal agent (EDS) is responsible for ensuring that CAP/DA claims are paid correctly through a contract with DMA. EDS has established edits and audits in the claims payment system to ensure payment is made in accordance with the approved methodology.

DMA Program Integrity conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid; identify and collect provider and recipient overpayments, educate providers and recipients when errors or abuse is detected, ensure that recipients' rights are protected, and identify needs for policy and procedure definitions or clarifications.

CAP/MR-DD

The Medicaid Program's fiscal agent (EDS) is responsible for ensuring that CAP/MR-DD claims are paid correctly through a contract with DMA. EDS has established edits and audits in the claims payment system to ensure payment is made in accordance with the approved methodology. The Resource/Regulatory Team of the DMH/DD/SAS also develops a monthly report that

describes the services paid for waiver recipients, the number of units billed, the cost and the number of consumers receiving each service. This data provides the ability to view services paid per individual consumer, as well as per individual LME or provider. This data may be used in the event that there is a concern or complaint received regarding a specific consumer or provider. The DMH/DD/SAS Accountability Team and DMA's Behavioral Health Unit routinely conduct a Medicaid Compliance Audit that includes the waiver services. Auditors review Medicaid-billed events per a sample of individual directly enrolled providers. This review includes monitoring of both DMA/Waiver and DMH/DD/SAS requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocol. These reviews assure that documentation and other requirements were followed for services that providers billed to Medicaid and for which they were paid. DMA Program Integrity conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid; identify and collect provider and recipient overpayments, educate providers and recipients when errors or abuse is detected, ensure that recipients' rights are protected, and identify needs for policy and procedure definitions or clarifications.

9. Housing

a. Qualified Residences

Refer to **Attachment E** for a list of defined qualified residences.

b. Assuring Sufficient Qualified Residences

The lack of affordable and accessible housing in North Carolina remains a significant barrier to meeting the needs of extremely low income households, the elderly, and persons with disabilities, in their communities. However, North Carolina has made significant, if limited, progress in this area over the past five years. In May of 2002, DHHS Secretary Carmen Hooker Odom established the position of Housing Coordinator within her office. The DHHS Housing Work Group (HWG), with representatives of all DHHS service divisions, was then formed to implement the broad agenda for this new initiative: reducing fragmentation of housing efforts within the Department; increasing the housing capacity of the State and local agencies to maximize existing housing resources; and more effectively engaging the affordable housing industry to expand supportive housing opportunities for DHHS constituents.

As a result of this department level commitment, the N.C. Housing Finance Agency (NC HFA) has partnered with DHHS since 2002 to facilitate the inclusion of persons with disabilities within Low Income Housing Tax Credit (Housing Credit) properties. All Housing Credit properties funded in North Carolina since 2004 must develop a Targeting Plan that makes 10% of the units available to extremely low income persons with disabilities, including those who are homeless. To date, over 1,175 units of quality, affordable rental housing have been funded. The Key Program, an operating assistance program created by NC HFA and DHHS, is also available to Housing Credit properties funded since 2004 to ensure targeted units are affordable to persons with incomes as low as Supplemental Security Income (SSI). Since 2006, 5% of units in all new Housing Credit properties must meet a higher than legally mandated level of accessibility, including curbless showers and full turn-around bathrooms.

In 2004, the Department's Housing Work Group prepared a successful grant application to CMS for a Real Choice Systems Change Grant: Integrating Long Term Supports with Affordable Housing. The grant, a partnership between the DHHS and the NC HFA, was designed to bring technical assistance to local communities to expand the collective capacity of the human service system to implement the Housing Credit targeting partnership and promote the expansion of affordable community housing opportunities integrated with long term supports.

DHHS is seeing additional tangible results from collective, cross disability housing advocacy. The 2006 and 2007 legislative budgets included substantial increases in funding to expand the DHHS–HFA partnership in addressing the housing needs of extremely low income persons with disabilities, the Housing 400 Initiative. In total, $18.4 million of capital funding to the N.C. Housing Trust Fund and $5.2 million of recurring funds for the Key Program have been appropriated to expand production of a range of independent and supportive housing units targeted to persons with disabilities and incomes as low as SSI.

While these are housing resources that were not available five years ago, the continually shrinking supply of federally subsidized housing resources means that MFP participants will be challenged to locate safe, decent, accessible and affordable housing in communities of their choice. They will, however, be able to avail themselves of significant improvements developed as part of the Real Choice Grant in the available tools and capacity of supportive service providers to assist them in finding and accessing housing resources.

These tools include county specific listings of affordable housing resources for each of North Carolina's 100 counties and an Affordable Housing Primer that gives basic information about navigating the affordable housing system including North Carolina specific contact information for housing programs across the state. These tools are now

posted and updated on the website of the N.C. Housing Coalition. North Carolina has also implemented an online housing search tool, www.NCHousingSearch.org, which is currently operational, and marketing to landlords. Searchable by a number of criteria (location, proximity of transportation, accessibility, etc.), this service is designed to provide real time information, posted by participating landlords, of units available for rent across the state. A statewide inventory of affordable housing resources is in the development stage.

Service providers working with MFP participants will be invited to join one of 30 Housing Support Committees (HSCs) organized across the state. Access to the Housing Credit and Housing 400 Initiative units is managed at the local level by the HSC, a collaborative of human service providers who have come together to make referrals to these new housing opportunities and assure tenants' have access to the ongoing supportive service they may need to live successfully in the community. As each new property is funded, a Local Lead Agency (LLA) is identified who will represent the local HSC in dealing with property management. Members of the HSC make referrals to the property owner and the LLA maintains a waiting list, in the event of turnover, once the specified number of Targeted units is occupied. The HSC is also knowledgeable about other affordable resources, as well as the range of community services and providers available in their community.

North Carolina has 131 public housing agencies (PHAs) or Housing Choice Voucher administering agents. The availability and quality of public housing units varies across locations. The availability of Housing Choice Vouchers is more limited, with many locations having closed waiting lists or waits up to two and three years. Over the past few years, most, if not all, PHAs have been approached by the disability community, through the HSC or other efforts, about re-establishing a preference for persons with disabilities. While this has been successful in some areas, in others it has not, where PHAs are responding to pressure on their budgets to direct assistance to higher income levels. Efforts to engage PHA's for the benefit of the MFP target populations will continue.

Access to other qualified residences, community based settings housing no more than four individuals, will likely require providers who are willing to re-tool exiting residential settings licensed under North Carolina facility rules. While both Supervised Living, licensed under mental health, developmental disabilities and substance abuse rules, and Family Care Homes, North Carolina's smaller board and care facilities, may serve as few as two individuals, the majority of these settings are currently serving the maximum number allowed by the rules, six persons in Supervised Living and seven in Family Care.

10. Continuity of Care Post Demonstration

The following will be used to promote the effective outcomes of the demonstration and to ensure continuity of care.

a. Managed Care/Freedom of Choice (Section 1915 b)

Evidence for each participant will be the written documentation of choice of receiving services within an ICF/MR facility or receiving home and community based services. Documentation will be included prior to transition to the community and will be maintained within the participant record as part of the certification process to the Waiver program. Within the choice document, it will provide a clear and informed choice for the consumer and or legal guardian. Fair Hearing documentation will also be included upon the beneficiary choice and informed consent determination. Review of record will occur by the Local Management Entity within the first three months of community living

b. Home and Community Based (Section 1915 C)

In the waiver for individuals who have eligibility for the CAP/MR-DD, there will be a specified number of slots assigned to eligible participants to the MFP Demonstration Grant project. These slots will be managed by the Waiver Program Manager at DMH/DD/SAS; be used for those who are currently are in either a State Developmental Disabilities Center or a Community ICF-MR and be used only for participants who have their own guardianship and request community placement or those whose legal guardians have requested community placement.

c. Research and Demonstration (Section 1115)

Not applicable.

d. State Plan and Plan Amendments

C. Organization and Administration

1. Organizational Structure
2. Staffing Plan
3. Billing and Reimbursement Procedures

D. Evaluation (not required)

1. Evaluator
2. Evaluation Design

E. Final Project Budget

1. MFP Budget Forms
2. Budget Presentation and Narrative
3. OMB Forms and Assurances

Money Follows the Person Demonstration Grant
Operational Protocol
DRAFT

Attachment A

Community Options Interest Survey

Guardian: _____ Resident: _____

Surveyor: _____ Date of Survey: _____

Hello. My name is _____ and I am a _____ at the _____ Center. We are calling all guardians to gather information for the Center for planning purposes. It will only take a few minutes to complete the survey. Is this a convenient time for you or would it be better to arrange another time to call back? **If yes, proceed with survey. If no, schedule a date and time to call again.**

The _____ Center is committed to always exploring opportunities for individuals from the Center to live in community homes with the supports they need to be safe, happy and healthy. We want input from you as _____'s guardian on your interest in community living.

1. If an appropriate community living arrangement that you and your team endorses became available in the near future (for example, in the next month), would you consider it? ____ yes ____ no

   Note to surveyor: If response is no, proceed to question 2. If response is yes, skip to question 3.

2. We respect your decision. We are also interested in your reasons for choosing not to pursue community living. Which, if any of the following circumstances would change your mind about considering a community living arrangement in the near future?

   Note to surveyor: Obtain a yes or no response for each of the items below. Enter Y or N.

   a) Community arrangement located within a certain distance from my or other family members' homes ___Yes ___No
   b) Better monitoring and oversight ___Yes ___No
   c) Immediate access to quality healthcare ___Yes ___No
   d) Appropriate behavioral supports and crisis services ___Yes ___No
   e) Availability of day/work programs ___Yes ___No
   f) More stable workforce ___Yes ___No
   g) More stable provider agencies ___Yes ___No
   h) Other (specify)_____

   We appreciate your taking time to respond to this survey and look forward to your continued input at the annual Person Centered Planning meeting. **End survey here.**

3. Which parts of the state would you consider a community living arrangement?

   Note to surveyor: Mark as many choices as the guardian indicates interest in.

   a) ___ East
   b) ___ Central
   c) ___ West
   d) ___ County Preferences (specify)_____

4. There are three main types of community living arrangements for individuals moving from the developmental centers to the community. In each of these settings, individuals could have the opportunity to participate in recreational, social and some type of day programming.

   Would you consider a group home that has 5 or 6 individuals living together with staff that is awake throughout the night? (ICF-MR group home) ___Yes ___No

   Would you consider a group home that between 4 to 6 individuals living together with staff that can sleep at night after the individuals go to bed but are responsible for getting up during the night to help anyone who needs it? (Supervised Living group home) ___Yes ___No

   Would you consider a living arrangement where the individual lives in the home of a person who is paid to provide their care? (Alternative Family Living) ___Yes ___No

Thank you for your participation in this survey. Your input is very valuable to us. Your team will contact you as potential community living arrangements become available. If you have questions, please feel free to contact me or a member of your family member's team. Have a nice day.

Surveyor's Comments:

Attachment B

Contract of Responsibility

I, _____(name) understand that I am being served

by Transition specialist, _____ (name) from the

_____ (organization).

In receiving services from this organization, I will develop an independent living plan. The plan will include my goals and steps for reaching my goals. The plan will be based on my goals and choices, an independent living evaluation and other pertinent information. Furthermore, I will work in partnership with the organization to achieve my goals in the manner and time agreed upon by the staff person and me. Anytime I choose to end this relationship, I may do so by notifying the staff member of my decision in writing or another alternative format. Failure to meet my responsibilities in the plan shall be cause for the organization either to revise the plan or terminate the contract.

I understand that the organization and its employees, working to achieve the objectives of the plan, are not themselves making medical decisions or making decisions about the transition process for me. The organization and its employees are not responsible for any consequences to my health resulting from a transition to community-based care and/or a residential setting.

The risks of transitioning to the community have been explained to me.

Furthermore, I understand that the _____ staff person is obligated in aiding the transition from the initial planning stage through the actual transition and follow up (can be up to one year) but is not going to act as my permanent case manager.

I authorize the _____staff person to share information that is reasonably necessary to assist me in achieving my goals with members of the transition team. I can revoke this consent at any time.

Consumer signature _____Date_____

Witness signature _____Date_____

Family member _____Date_____

Attachment C

The North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA) Introduces…

The *Money Follows the Person (MFP) Demonstration Grant project*!

What does "Money Follows the Person" mean?

When people who are elderly or have disabilities need personal assistance, they often have to go to a nursing home or an institution in order for Medicaid to pay for it. However, many folks would prefer to receive these services in their own homes and in their own communities.

Money Follows the Person is the term describing the practice of Medicaid allowing these same people to move *out* of nursing homes and institutions and receive the assistance they need to live in their homes and communities. Thus, the **money** for the assistance **follows** the **person** out of the nursing home or institution and into their homes and communities.

Why is this called a "Demonstration Project?"

The federal government is awarding extra funding and assistance to states wishing to **demonstrate** how state Medicaid agencies can effectively develop "Money Follows the Person" practices. This funding is time-limited and each state must agree to move people from institutional settings to home and community-based settings.

North Carolina was awarded its MFP Demonstration Grant in May 2007.

What is the purpose of North Carolina's MFP Demonstration Grant Project?

Reorganizing Medicaid services to enable **money** to **follow** people out of institutions is a very complex process. It involves shifting state policies, rules and regulations, adjusting Medicaid funding streams, and supporting local communities so people who are elderly or have disabilities can come home.

The purpose of the Money Follows the Person Demonstration Grant is to provide the state with additional funding and support so it can assist 552 people to move from institutional settings to home and community-based settings and also ensure this continues after the grant ends.

Who will benefit from the MFP Demonstration Grant project?

During the course of the Project, NC wants to support **at least** 552 people who are currently in nursing homes or institutions to move from institutional care to home and community-based services. These people will be made up of senior citizens, people with developmental disabilities, people with physical disabilities and people with mental illness.

How long will the MFP Demonstration Grant project last?

Until September 30, 2011.

What happens when the MFP Demonstration Grant project is over?

Hopefully, the state will have the structures and supports in place to begin supporting **anyone** who is eligible to receive services in a nursing home or institution to receive those same services in their homes and communities.

How is the MFP Demonstration Grant project different from other MFP advocacy efforts in NC?

In addition to NC's MFP Demonstration Grant project, there is also a Money Follows the Person grass-roots advocacy effort. This grass-roots advocacy effort is promoting *state legislation* that will allow anyone who is eligible to receive personal care in a nursing home or institution to receive those same services in their homes and communities. The MFP Demonstration Grant project *(a federally funded initiative)* targets 552 people in NC, while the Money Follows the Person grassroots effort is advocating for everyone to have this option.

The two efforts have the same goal: to support people to live in their homes and communities.

Who do I contact if I want more information on the MFP Demonstration Grant project?

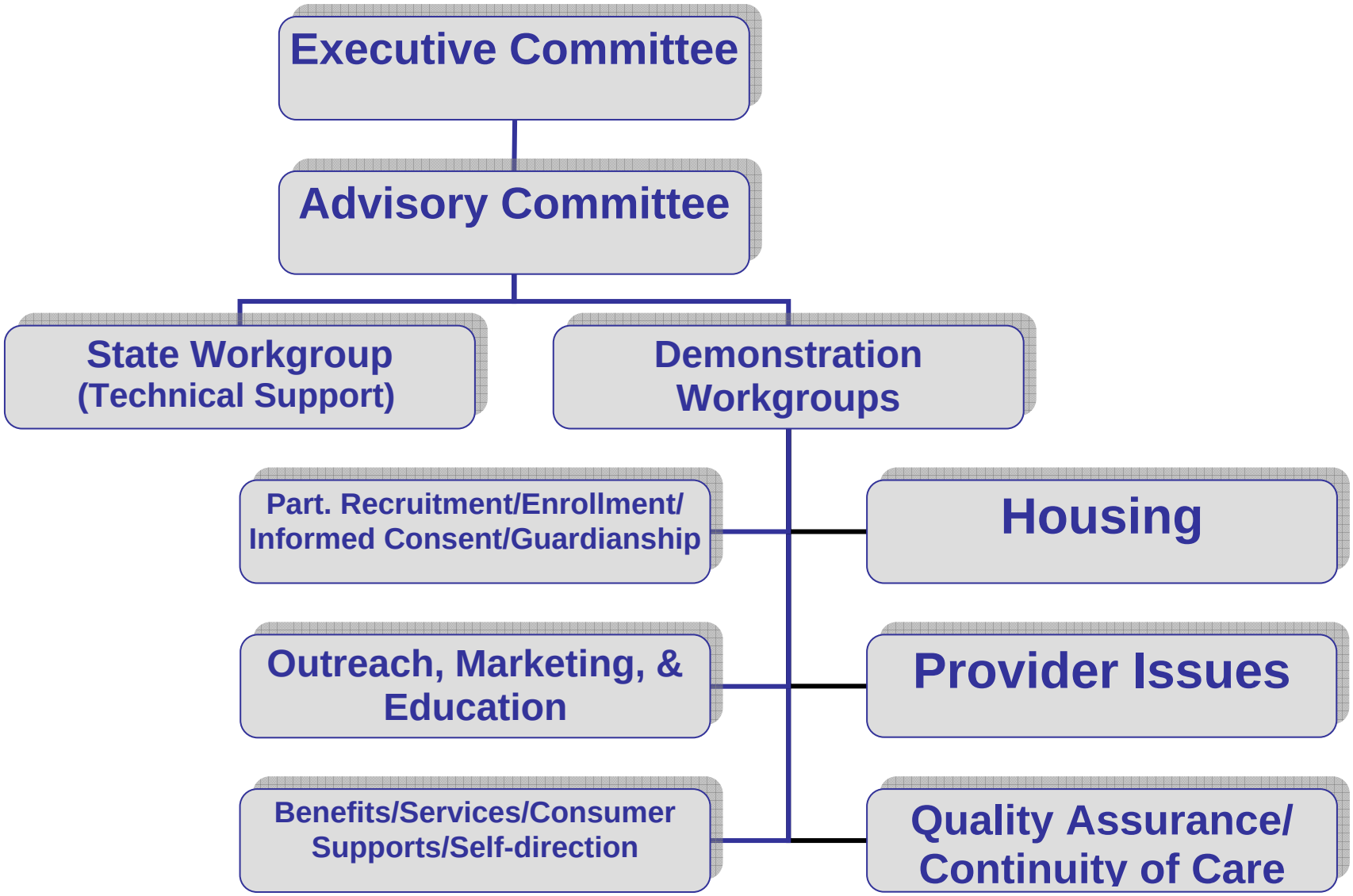
Lorie Williams, Project Supervisor
919-855-4260 or lorie.williams@ncmail.net

Is there a website where I can learn more about North Carolina's MFP Demonstration Grant project?

The NC Division of Medical Assistance has created a site for the MFP Demonstration Grant project. Please visit
http://www.dhhs.state.nc.us/dma/MoneyFollows/MoneyFollowsPerson.html.

The North Carolina Disability Action Network (NCDAN) is following the MFP Demonstration Grant project's progress and has lots of useful information including a link to the site above. NCDAN's website: www.ncdan.com

Attachment D



Money Follows the Person Demonstration Grant
Operational Protocol
DRAFT

Attachment E

Qualified Residences where NC MFP Participants are Living				
Type of Qualified Residence	**Number of Each Type of Qualified Residences***	**State of Definition Housing Settings & Number of Each**	**Number of Each Settings***	**How Regulated**
Home owned or leased by individual's family member		• Home leased by individual or family • Home owned by individual • Home owned by family		• Lease with landlord • N/A • N/A
Apartment with an individual lease, lockable access & egress, & which includes living, sleeping, bathing, & cooking areas over which the individual or the individual's family has domain & control.		• Apartment building • Assisted living: multi-unit assisted housing with services • Public housing units • Rural Development Apartment • Housing Credit unit • Supportive housing unit		• Lease with private landlord • Lease with private landlord and HC Voucher • Lease with Public Housing Agency • Lease with RD • Lease with landlord w/HC Voucher • Lease with landlord and Key assistance • Lease with landlord
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside (Non-ICF-MR facility).		• Supervised Living • Alternative Family Living • Family Care Home		• State122C licensing regs • 131D licensing regs