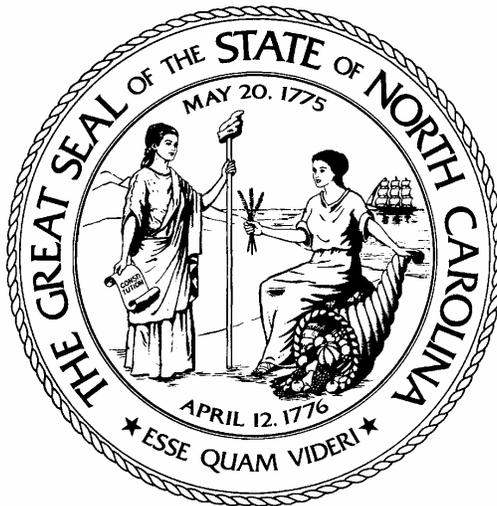


# **Money Follows the Person Rebalancing Demonstration Grant**

## **Operational Protocol 2007–2015**



**State of North Carolina  
Department of Health and Human Services**

**Grant No. 1LICMS030170**

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**North Carolina Department of Health and Human Services**

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## Project Introduction

In May 2007, the Center for Medicare and Medicaid Services (CMS) awarded North Carolina a grant through Money Follows the Person Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. Services under this demonstration grant will end September 2011. North Carolina intends to use the funds to develop a roadmap for rebalancing Medicaid long-term care delivery system. Staff from state agencies, providers, advocates and consumers have worked together to create this road map for operations – the Money Follows the Person Operational Protocol.

The goal is to move forward with a long term care system that provides an even greater array of home and community-based services and supports designed to promote choice and independence for individuals who are aging with care needs, and/or have physical, mental, or developmental disabilities. The State intends to use Money Follows the Person funding to promote a long term care system in which individuals transitioning from qualified inpatient facilities have access to assistive technology, to increase the awareness and use of home and community based services through educational programs, and to offer more transitional services for individuals wishing to move back into the community.

Participants for Money Follows the Person are those who have lived in a state or private Intermediate Care Facility for people with developmental disabilities (“ICF-MR”) or other inpatient facilities for at least three months (and within the eligibility parameters set forth in the *Affordable Care Act*); meet Medicaid eligibility criteria; and meet the criteria for enrollment in one of the Community Alternatives Programs (CAP) waivers (CAP/MR-DD Comprehensive, CAP/Choice, and CAP/DA) or in the Program of All-Inclusive Care for the Elderly (PACE). CAP/Choice is currently being piloted in four counties (Cabarrus, Duplin, Forsyth, and Surry), therefore, when CAP/DA is referenced in this document it is understood that CAP/Choice applies as well. The State intends to transition 304 individuals for the identified population groups. Recipients will be enrolled in a CAP waiver or the Program of All-Inclusive Care for the Elderly (PACE) on day one of the move into the community. Participants will have a full array of services and supports for successful community living.

Money Follows the Person demonstration project will be available statewide. The Division of Medical Assistance has a 1915(c) waiver, Innovations, that operates concurrently with a 1915(b) waiver program, known as the Piedmont Cardinal Health Plan in Cabarrus, Davidson, Rowan, Stanley and Union counties. All Medicaid covered behavioral health and substance abuse services as well as Innovations waiver services for the MR/DD population are provided through the Piedmont plan.

As North Carolina progresses through the demonstration project, the following objectives will be met.

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*Objective 1: Increase the use of home and community-based, rather than institutional, long-term care services.*

In 2004, the State Legislature passed House Bill 1414, section 10.12(a) mandating the Department of Health and Human Services, Division of Medial Assistance to develop a pilot program to implement the Program of All-Inclusive Care for the Elderly. This is a community based program that provides unique managed care benefits for the frail elderly. The program operates an adult day health center and:

- Provides a comprehensive array of medical and social services at the center
- Arranges for all in-home and referral services that may be required by each enrollee, and
- Uses an interdisciplinary team to manage care and services for each enrollee.

The first PACE site was opened in Wilmington, North Carolina in February 2008. Currently there are four enrolled participants with an anticipated enrollment of four participants per month. Two future sites are planned for Burlington (Piedmont) and Fayetteville. The Piedmont location has completed and submitted an application to CMS and is in the process of applying for Adult Day Health Care certification. The Fayetteville site has received approval from the programs' Board of Directors to pursue developing the program. Both future sites are expected to enroll an average of four participants per month. To assist in increasing the use of home and community-based, long-term care services, PACE participants are eligible to be enrolled as Money Follows the Person participants.

Slots have been reserved in the CAP waivers (CAP/DA, CAP/MR-DD, and CAP/Choice) and the Program of All-Inclusive Care for the Elderly for Money Follows the Person participants. Plans are under way to increase services and supports for continued success in the effort to rebalance long-term care and supports in North Carolina via waiver amendments and renewals. In addition to traditional CAP services, participants will have the opportunity to self-direct their own services and supports through a relatively new current waiver – CAP/Choice.

*Objective 2: Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, which 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.*

North Carolina has worked in several areas to promote increased access to home and community based services. These include changes in services, additional waiver slots, partnerships with other agencies, service rate increases, inpatient facility transition efforts and program expansions.

In addition to services already offered under the three North Carolina's 1915(c) waivers (CAP/DA, CAP/MR-DD, and CAP/Choice) and the Program of All-Inclusive Care for the Elderly, Money Follows the Person will make services available to ease the transition when individuals move back into the community. Some of these are one-time occurrences, such as security deposits or home furnishings; the use of assistive technology has been expanded to

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include security devices and reminder systems and devices; and increased awareness and use of home and community based services through education programs to the state's medical community.

North Carolina legislature has proposed in their fiscal year 2009 budget the allocation of additional funding to the Area Resource Center of North Carolina to provide housing to individuals with developmental disabilities. Also, additional targeted rental units, within the Housing Credit properties and smaller scale supportive housing developments are becoming available to assist Money Follows the Person participants who can live independently and/or with in-home assistance transition into independent rental housing.

*Objective 3: 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 institution to a community setting.*

North Carolina has experienced success with transitioning individuals from nursing facilities. In September of 2002, CMS awarded North Carolina Division of Medical Assistance a three-year grant of \$600,000 to develop and conduct a **North Carolina Nursing Facility Transitions Program** in collaboration with North Carolina Division of Vocational Rehabilitation Services Independent Living Rehabilitation Program. In July of 2005, CMS approved a six-month no cost extension that extended grant-funded activities through March 29, 2006. By March 2006 (end of program), 134 individuals have been fully transitioned from nursing facilities to community living as a direct result of intervention managed, coordinated, and funded under this grant. The average length of time transitioned individuals remained in the community was 287 days at the time program evaluation data was reported.

The grant enabled North Carolina to demonstrate a successful collaboration between state agencies, regional non-profit organizations, and local agencies and groups. In particular, the North Carolina Division of Vocational Rehabilitation's Independent Living Rehabilitation Program and the Centers for Independent Living played key roles in identifying individuals for transition. Long-term care ombudsmen were also effective in identifying and referring nursing home residents interested in transitioning to community care. The agencies and organizations are committed to participating in these transition activities under the Money Follows the Person Demonstration.

North Carolina Nursing Facility Transitions Program Participant Task Force made recommendations—through lessons learned—to the Assistant Secretary of Office of Long Term Care at the conclusion of the grant project.

- Sustaining the transition process. Generally, it was recommended to make nursing facility transitions a priority via funding avenues which would produce supports needed to consumers for successful community living.
- Eliminate Intuitional bias. This would involve education of stakeholders, increase education and outreach to hospitals, doctors, and the medical community about long term care community options, and implement Money Follows the Person grant. Additionally, it was recommended that the Governor of North Carolina reinstate the Protection Advocacy Agency as a private, non-profit entity, separate from the state government

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structure. This occurred through the organization of Disability Rights NC, a private non-profit organization working to improve the lives of people with disabilities by protecting their rights.

- Improve affordable, accessible, integrated housing. The highlights of the recommendations were to support the CMS housing grant, seek ongoing funding for the Key Program, and increased publicity of the Low Income Housing Tax Credit and the State Housing Tax Credit.

*Objective 4: Ensure strategies and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long term care services and to provide for continuous quality improvement in such services.*

Since Money Follows the Person will be implemented parallel with the 1915c waivers and the Program of All-Inclusive Care for the Elderly (PACE), quality assurance protocols developed for each of the waivers will be the basis for the required quality assurance strategy. At this current time, two of the waivers are either being submitted as new waivers or renewals. CAP/MR-DD Comprehensive is a new waiver and is being submitted by July 2008. CAP/DA is a renewal waiver and is being submitted by September 2008. CAP/Choice is an approved waiver using 3.5 version and meets all CMS assurances. The PACE program is a three-way agreement between the program, the State, and CMS and is an approved program using the 3.4 version. Each new waiver or renewal is using the required 3.5 version and will include all assurances, risk management, 24-hour back up, and critical incident as required by Money Follows the Person.

While in the demonstration, and continuing after the demonstration, participants will have access to consumer supports, such as a Personal Emergency Response system, to reduce their risk of incidents and ensure their community living is one of success. The quality of services and supports will be monitored through a newly designed Quality Management Strategy. Standardizing quality measures across programs and populations is anticipated to strengthen service delivery and improve outcomes for consumers.

Through the above four objectives and benchmarks established specifically for North Carolina, the State will continue to increase and expand home and community-based service over institutionally-based services.

## Case Studies

The following case studies are intended to show how North Carolina's Money Follows the Person demonstration program will work from the consumer's point of view.

### Case Study for a Person with Developmental Disabilities

#### The Key Players:

Caroline: person using services

#### Caroline's Family:

1. Frank: Caroline's father
2. Bill: Caroline's brother
3. Wendy: Bill's wife

#### Transition Team:

1. Tammy: transition coordinator
2. Sara: developmental center staff member – Qualified Developmental Disabilities Professional
3. Sam: joint surveyor/self-advocate
4. Donna: Caroline's key direct support staff person in the developmental center
5. Allison: staff member from the local advocacy group that is working with Tammy to coordinate Caroline's transition process
6. Chris: Caroline's new case manager/support broker in Greenville
7. Marissa: manager at Caroline's new support agency in Greenville

Caroline, who is 40 years old, loves people, big dogs, and the East Carolina University Pirates. Her affiliation with the Pirate Nation runs deep; she grew up in Greenville, where ECU is located. As a little girl, she attended the local school during the week, went to Pirates football games on Saturdays, and attended First Baptist church on Sundays. Caroline's family still lives in Greenville.

Although Caroline has cerebral palsy, uses a wheelchair, and requires total physical assistance, she had a fairly typical life experience until her mother died in 1980, when Caroline was 12. Her father, Frank, tried to piece together support for Caroline so he could continue work at a boat production factory, but he still had to miss work (and lose income) regularly when assistants weren't available.

In 1980, the only state-funded support option available to Caroline and her family was institutional care at the Caswell Developmental Center, a state-run intermediate care facility for the mentally retarded, in Kinston, about one hour away from Greenville. As a result, Caroline's family doesn't get to visit her much. She has two younger brothers she was close to growing up,

but she doesn't get to see them much anymore, and they miss her. Caroline has a baby niece she's never met, and she hasn't gone tailgating at a Pirates football game in over 27 years.

Like everyone, Caroline needs some support to think through major life decisions, but can largely make decisions on her own and communicates these decisions verbally. Because she has spent most of her life in the developmental center, Caroline sometimes needs "community" concepts explained to her. She is her own guardian and the people who know her best don't think she needs anyone else in that role.

### **Participant Identification**

**Caroline learns about Money Follows the Person:** Sara, Caroline's Qualified Developmental Disabilities Professional at the Caswell Developmental Center, and Sam, from the North Carolina Association of Self Advocates, had a joint conversation about Money Follows the Person with every person on Carolina's caseload, including Caroline and her guardian. Together, Sara and Sam told each person about this opportunity for people to receive supports in their hometowns, to reconnect with their families, to possibly get jobs, and to do the things they enjoyed (like going to Pirate football games!). Sara and Sam were sure to tell people that the transition wouldn't always be easy, and community-based supports would pose some new challenges, but that this project gave people in developmental centers more choices about where they lived.

Caroline's guardian had indicated an interest in community living for Caroline on a Community Options Interest Survey and had discussed this with Caroline. Caroline was thrilled about the chance to go back home to Greenville and reconnect with her family and childhood friends. Sara and Sam spent a couple of hours talking with Caroline about the Money Follows the Person project; they asked her if she wanted to participate. Caroline was thrilled about the chance to go back home to Greenville and reconnect with her family and childhood friends. After Sara and Sam spent a couple of hours talking with Caroline about the Money Follows the Person project, they asked her if she wanted to participate. The East Carolina Behavioral Health would determine if Caroline was eligible to participate in Money Follows the Person project. If deemed eligible, she would have a level of care review conducted by clinical staff of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and then receive a CAP/MR-DD waiver slot.

Caroline's father loved his daughter and trusted Sara and the other staff at the developmental center. After all, they had taken care of his daughter for almost 30 years. Yet, he was a little anxious about what it meant for Caroline to move back to Greenville. Would he be expected to make sure Caroline had the supports she needed by himself? He was 65 years old and was still working. Sara acknowledged his concern and noted that the community resources and supports available to Caroline in Greenville were significantly more available and stable than they had been in 1980. Sara and Caroline ended the conversation with Frank by reassuring him that his involvement in the process did not obligate him to anything and that he would be supporting his daughter's dream by participating in the planning process.

### **Prior to Transition**

A critical person in the State's MFP Project was Tammy, the Project's Program Specialist. Tammy was a state employee whose primary office was in Raleigh. Tammy worked with transition coordinators from local advocacy groups to ensure each person's transition was successful. Tammy found it helpful to have up to 180 days of transition coordination – a supplemental service under Money Follows the Person – for clients Tammy was deeply invested in the idea of people living in their home communities. She viewed her role as helping to ensure local transition coordinators effectively guided Caroline and her family through the transition process and served as matchmakers to the community-based services available, including case management services. She also understood that her first commitment was to Caroline and others transitioning under the Project and she would do everything she could to ensure people and their families received the information and support they needed throughout the transition process.

While her role in Caroline's life was temporary, Tammy understood how critically important it was. There are so many details and logistics associated with successfully transitioning people. Tammy also understood that a key part of her role was to build positive relationships with everyone involved. She understood that the success and stability of a person's community living experience largely rested on everyone's ability to work together and to trust each other. Tammy was well networked among the state's advocacy groups. Transition coordinators from these groups would manage the day-to-day logistics of transitioning Caroline and others out of the developmental centers. Though transition coordinators from these groups would work in tandem with Tammy, Tammy was ultimately responsible for the transition's success.

In Caroline's case, Allison from Family Advocacy—a local advocacy group in Greenville—would serve as Caroline's transition coordinator. Family Advocacy had significant experience in helping people with developmental disabilities transition out of developmental centers and back into local communities. In addition to coordinating the logistics of the transition, Allison would work with others in Caroline's life to ensure Caroline understood what was happening at every step and would take the lead on communicating information about the Project to her.

Tammy and Allison scheduled a Saturday visit at Caswell Developmental Center with Caroline and her family (father Frank and brother Bill—at Caroline's request) together. Tammy knew that she would not be directly participating in all of the logistics and meetings about Caroline's transition. However, because she was ultimately responsible for the transition's success, she felt it was really important to attend every person's first meeting. After the first meeting, Allison would take the lead on the coordination and logistical details and would talk with Tammy regularly to keep her updated on the progress of Caroline's transition.

This first meeting was critical as it gave everyone involved an opportunity to talk about some of the basic living arrangements Caroline wanted in Greenville and some of the supports she would require. Tammy and Allison understood that the state's service delivery system was complex and often confusing to service users and their families. At this first meeting, they all talked informally about Caroline's coming back to Greenville, where she might enjoy living, the kinds of supports she would need, what activities she would enjoy, and the potential timeline for making the transition. While additional people (like provider agency staff) would need to be

brought in to fine tune the details of Caroline's support structure, it was important for Tammy and Allison to have a broad understanding of Caroline's support interests and needs to ensure that the transition process honored her basic preferences.

### **The First Meeting of Caroline's Crew**

At the end of the meeting, Tammy and Allison asked Caroline if she wanted to move forward with the process. Caroline eagerly said yes. With the others as witnesses, Allison assisted Caroline and her guardian in reviewing and signing the Informed Consent form. Tammy and Allison asked Caroline and others who else should be a part of the process. Caroline asked if Bill's wife, Wendy, could become part of her crew. Wendy had always talked "girl talk" with Caroline during their visits and Caroline trusted her. Bill agreed to ask Wendy to come to the next meeting.

At the end of the meeting, Tammy and Allison provided Caroline, Frank, and Bill with their contact information and with individual packets of information about the Money Follows the Person demonstration project. Allison also promised to send them a written summary of the meeting they just finished.

### **Connecting Caroline with Service Coordination/Case Management Services**

After getting to know Caroline and her family a bit, Tammy and Allison knew their first priority was supporting Caroline through the process of selecting a long-term, community-based service coordination service. There were three qualified coordination services in the Greenville area.

While ideally, representatives of each agency and Caroline would visit individually, it sometimes was logistically difficult to make this happen. East Carolina Behavioral Health had recognized the logistical hurdle and organized a service coordination provider fair two times each month. This provided an opportunity for people coming into services for the first time, either through the Money Follows the Person demonstration project or other channels, to learn about the different service coordination agencies in order to make a more informed decision. Allison knew the dates of these fairs and worked with Sara to secure developmental center transportation to bring Caroline and a few others who were transitioning back to the East Carolina Behavioral Health region.

At the Service Coordination fair, Allison and Caroline listened to the presentations and asked questions that had emerged from their day-long conversation on Saturday. Allison was careful to ask questions she knew would be important to Caroline and Frank based on the comments from their meeting so that Caroline could make a fully informed decision.

After the fair, Allison, Caroline, and Donna (Caroline's direct support staff from the developmental center) talked over lunch about which agency Caroline preferred. Caroline really liked "Your Best Life" agency because the staff knew a lot about the local housing market and how to help consumers get their own homes. Allison assisted Caroline in completing a freedom of choice form and then submitted it on Caroline's behalf. A few days later, a representative from Your Best Life called Allison to confirm their services and to introduce Allison to Caroline's new service coordinator, Chris, pending Caroline's final approval, of course.

While Chris was now involved and assisting in the transition process, everyone was clear that for as long as Caroline was in the developmental center, Allison remained the point person for the transition process, and Tammy continued to assume ultimate responsibility for the transition's success. It was discussed that transition coordination could begin no sooner than 60 days prior to Caroline's anticipated move date – her first day in the community.

By working through joint phone calls and e-mails, Allison, Chris, and Sara arranged the next group conversation about Caroline's supports. Allison, Chris, and Caroline's family would spend another Saturday on the road to visit Caroline and her staff at the developmental center.

This day-long Saturday conversation covered a lot:

- Caroline and her family got to know Chris, Caroline's service coordinator.
- Allison facilitated a personal futures planning session that gave Caroline the opportunity to think about what she wanted in her life and be more specific about what kind of supports she would need. This session wasn't really about services, specifically, but rather a chance for everyone to understand what Caroline hoped to get out of her life.
- Chris facilitated the group's development of a preliminary service plan based on Caroline's life goals and service support needs. Chris was responsible for making sure this plan of care met all of the relevant system requirements and for submitting the plan to East Carolina Behavioral Health. Chris provided information about the different providers that could meet Caroline's support needs.
- They discussed which providers Caroline would like to interview and she decided that she wanted Chris, Donna, Allison, Frank, and Wendy to be there to interview the providers as well if they could.
- Allison made sure Caroline received information on abuse/neglect policies, cost-sharing requirements, her other personal responsibilities, the state's complaint process, and other materials. Sara agreed to assist Caroline in processing the documentation more thoughtfully after the meeting.
- Chris and Allison explained that once Caroline received CAP/MR-DD funding, her level of care would be re-evaluated annually, at least two months before the current year's service eligibility expired and future determinations would occur during her birth month.
- They also discussed what would happen if Caroline needed to re-enter the intermediate care facility for the mentally retarded for an unforeseen reason over the next year. Caroline understood that if she remained in the intermediate care facility for the mentally retarded for more than 6 months, she would have to go through the Money Follows the Person assessment and eligibility determination for community-based supports process again. She also understood that should she remain institutionalized for 31 days or longer, was able to return to the community under Money Follows the Person demonstration funding, she would not receive again the transitions services she first received to set up her house (such as couch, chair, etc.).

Through this conversation, it became evident what services and supports provided by the Project Caroline would need her first year. Because Caroline had lived in the developmental center most of her life, she had no furniture of her own. While her family was able to contribute a dining room table and a dresser, they were unable to provide anything else. Caroline and her crew decided to use transition services funds (covered as a demonstration service with a limit of \$3000) to purchase a bed that would elevate at the head and foot to meet Caroline's circulatory needs; a second bed for her staff to use; an inexpensive couch and living room chair, some basic kitchen utensils and some dishware. They understood that this "start up" funding would not be available after Caroline's first year in the Project.

They also knew they would likely need to access environmental modification funding under the waiver to ensure any apartment Caroline rented would have a roll-in shower that she required. They knew that community apartments often supported modifications beyond what was required by the Americans for Disabilities Act so long as someone else paid for them. By using waiver dollars to modify her rental unit, Caroline and her crew were also inadvertently expanding the accessible housing capacity in Greenville. Caroline would also be provided a personal care assistant for four hours daily to assist with daily activities such related to lack of mobility (example: showering, dressing, moving into and out of the wheelchair).

### **Identifying a Provider**

Chris was able to assist Caroline in narrowing down the possible provider agencies to two that were able to meet her support interests and needs. Through joint conference calls and e-mails that Allison arranged, Chris organized an opportunity for Caroline, her family, and the others she had identified to meet with the two provider candidates.

Sara arranged transportation for Caroline and her staff to visit Greenville and meet with potential providers. Bill (Caroline's brother) was able to join Caroline, her staff, Tammy, and Chris in meeting with the two providers. Both providers were very aware of the Money Follows the Person demonstration project through provider networks and the state-published information they received in the mail and on the Web. During the visit with each provider, Caroline and her crew got to talk to members of the provider's management team and direct support staff and were able to visit others served by the organization.

Caroline's crew and the two organizations discussed the kind of living options each could provide based on Caroline's preferences. One organization, Community Support Options ("Options"), indicated they fully supported Caroline to live in her own home and would help her secure community-based accessible housing—but to make the money work, she would likely need a live-in companion or a roommate.

After the full day, Caroline decided she really liked Options because of the level of flexibility they would provide her in creating her own supports. Tammy, Chris, and the provider staff all talked to Caroline and her family about how sometimes funding limits service options, but Caroline really liked that Options made a commitment to "figure out good solutions" and supported Caroline's dream of living in her own home.

## **Transition to Community Life**

**Making the Transition:** When Caroline selected Options, the organization's management team created budgets for several different support scenarios that would meet Caroline's needs and be financially viable. The Options manager, Marissa, met and became part of Caroline's crew, making several trips to visit Caroline at the center. Through these visits, Marissa was able to get to know Caroline and observe firsthand what kind of supports she needed and what worked for her. Marissa took extensive notes.

Through regular conference calls and face-to-face meetings, Caroline and her crew began to shape the structure of her supports in Greenville. Topics discussed included

- Caroline's new home (a handicapped accessible apartment in a local complex);
- her potential roommate (another Options consumer whom Caroline met and liked);
- her staffing pattern, based on her scheduling preferences and personal interests (24/7 support, with Bill and Wendy helping Caroline go to church on Sundays, a volunteer job with dogs);
- her transportation (a wheelchair-accessible van); and
- her transition of her medical and financial services to Greenville

ECU's last home game was scheduled for the Saturday of Thanksgiving weekend. The apartment was ready. Caroline's staff was trained. And even though it was slightly ahead of schedule, Caroline's crew decided to do whatever it took to formalize the transition in time for the holiday and the last Pirates game of the season. The apartment manager agreed to prorate her living expenses for November. Caroline's family agreed that if Options could ensure that Caroline's overnight staff was available Thanksgiving night, Caroline would spend Thanksgiving with her family without paid support during the day.

On the Monday before Thanksgiving, Caroline's crew met one last time at the developmental center. The center had been her home for nearly 30 years and it was important to Caroline to stay in touch with some of the other residents and staff to whom she had been close. The center staff threw Caroline a party, and Tammy made sure that everyone had Caroline's new contact information and that Caroline had the contact information for those people she cared about.

Caroline's crew met for a final meeting with everyone: Sara, Donna, Allison, Tammy, Marissa, Caroline's family, and (of course) Caroline herself. They went through the final checklist that outlined the numerous details—both anticipated and unexpected—that had to be addressed before the transition could be complete. They tied up loose ends and officially transferred lead coordinator responsibilities from Tammy to Chris. Caroline's crew helped load up Caroline's things and, in an accessible van that Options had made available, brought Caroline home.

Caroline enjoyed her first home-cooked Thanksgiving meal in nearly 30 years and cheered her Pirates to victory in their final game of the season!

### **Fully Transitioned into a Home and Community-Based Program**

Thanks to the hard work and continued involvement of Caroline's crew, she is thriving in her new life. While there have been some bumps in the road (one of Caroline's staff accepted a new position three weeks after Caroline moved back to Greenville!), Options has remained responsive to meeting Caroline's needs. Marissa arranged coverage, with Caroline's remaining staff pitching in, until she could identify a new candidate. Caroline met and approved the candidate and now Candace is a valued part of Caroline's staff.

For two months after Caroline moved back, Tammy and Allison continued to check in with Caroline about how things were going. Tammy, Allison and Chris worked together to make sure all of the loose ends around the transition were tied up before Tammy turned over responsibility to Chris. Chris is now Caroline's point person and visits her at least once a month. Since her services are still new, Chris works hard to visit Caroline a few times a month until she is fully settled.

Caroline and her Greenville crew meet every few months to debrief on what's working and to work on how to address challenges that have emerged. Chris organizes these meetings around Caroline's volunteer job at the Humane Society.

Caroline's staff also attends professional development opportunities that focus on the emerging needs of people who have transitioned back into their communities. These trainings are funded by the Money Follows the Person demonstration project. Community-building remains a key topic. While Caroline's transition process revealed a rich network of natural supports, it was recognized that many people transitioning back into their communities would need staff assistance to develop and sustain unpaid relationships.

All in all, Caroline's transition process back to her hometown was a success and can serve as an example to others of what is possible under the Money Follows the Person demonstration project.

## Case Study for an Individual with a Physical Disability

### The Key Players:

Greg: person using services

### Caroline's Family:

1. Sharon: Greg's wife
2. Shawn: Greg's son

### Transition Team:

1. Jose: transition specialist from Center for Independent Living
2. Edward: Money Follows the Person Program Specialist
3. Peter: Shady Lawn Social Worker
4. Sally: CAP case manager

## Background

Greg is 30 years old and has been living at the Shady Lawn Nursing Home since February 2007. In October 2006 Greg was involved in a car accident and sustained a C-6 level spinal cord injury. Prior to the car accident Greg was living with his wife Sharon and son Shawn in their home in Durham, North Carolina. Greg worked as an electrical engineer for Duke Power. Following the accident his wife Sharon was not able to provide the level of support that Greg needed to live in their home.

Greg was transferred to the Shady Lawn Nursing home in February of 2007 after he was discharged from an inpatient rehabilitation program. Greg continued to receive outpatient physical and occupational therapy while living at Shady Lawn. Staff from Shady Lawn provided transportation to his appointments. Although Greg made a lot of progress in rehabilitation and regained much of his upper body strength, he had very limited use of his hands and was unable to transfer himself in and out of his wheelchair upon entering Shady Lawn. He also needed some level of assistance with most daily living skills.

## Process of participant identification

In February of 2009 Greg had been living at Shady Lawn for 2 years. Although Sharon and Shawn consistently came by for visits weekly, he missed seeing them on a regular basis and felt he was missing major milestones in his son's life. Greg located the number to his local Center for Independent Living (CIL) while doing research online. Greg called the Alliance of Disability Advocates Center for Independent Living and spoke with the transitions specialist, Jose, on staff.

Jose met with Greg at the Shady Lawn Nursing Home. The transition specialist spoke with Greg and briefly assessed the supports that Greg currently had available to him and the supports that would need to be arranged in order for him to live with his family in the community. During their visit, Jose transition specialist told Greg about a new program called Money Follows the Person and explained how the project could help Greg transition to the community. Jose gave Greg some printed information about the Money Follows the Person project. He told Greg to share the information with his family and to decide if he and his family were ready to start thinking about creating a transition plan.

A week later Greg called Jose and indicated that he and his wife were ready to begin discussing a transition plan. Jose arranged a meeting with Greg, Sharon, Edward (Money Follows the Person Program Specialist), and Peter, a social worker from Shady Lawn.

### **Processes prior to the transition**

At the meeting Edward explained the Money Follows the Person project to Greg and Sharon in more detail. Edward explained what service options could be available to Greg once he moved out of the nursing facility. The program specialist explained that the Community Alternative Program for Disabled Adults (CAP/DA) was a waiver program that allows people who are eligible for nursing facility care to receive supports in their home. It would be the best suited service package for Greg. The program specialist explained what services could be available through CAP/DA. The program specialist explained that some additional supports, such as one time transitions services, could be available to Greg through the Money Follows the Person demonstration grant. This would most likely be in the form of one time funding to help Greg secure needed items/support during the transition process. Greg expressed interest in moving forward in the transition process and creating a person centered plan and transition plan. The group scheduled another meeting to develop a person centered plan and transition plan for Greg.

Greg, Sharon, Jose, and Peter met two weeks later to assess discuss Greg's needs and give a clear picture of what Greg would need for successful living in his own home. They talked about the process Greg would go through: level of care assessment, needs assessment, person centered plan, and a transition plan. The group brainstormed a more thorough 'relocation' assessment to determine all of the supports that would be needed in order for Greg to successfully transition to living in the community:

- Personal data
- Professional care needs such as the continued need for physical therapy and occupational therapy
- Health care needs
- Mental health/counseling needs
- Housing preferences and any needed home modifications
- Family supports
- Available social networks
- Transportation needs
- Public and private supports needed
- Assistive technology needs

- What is important to Greg
- Greg's self-identified goals and plans for the future

The group also discussed that Greg would have a crisis plan as part of his community living. The plan would outline the need for back up staffing in the event that Greg's primary support staff is not available. It also included protocol for a variety of emergency situations.

Greg stated that he would like to move into the house that he and Sharon own once he left the nursing home. His home would need to be modified to make it wheelchair accessible. Greg said he thought he would need personal attendant services 3 hours each morning and evening to assist him with bathing, dressing, and other personal care tasks. Since Sharon currently works from home she would be available to help him prepare meals during the day. Edward assisted Greg in setting up an appointment with a CAP case manager at the Department of Social Services in Durham County.

Jose gave Greg contact information for accessible public transportation in Durham County. Since Greg's family does not currently own a wheelchair accessible vehicle he would need to utilize Durham Regional Transit Specialized Services to secure accessible transportation to his medical appointments. Greg and Sharon expressed interest in purchasing a wheelchair accessible van in the future but would need to save money in order to make such a purchase. Jose also put Greg in contact with another individual whom the Center had previously helped successfully transition out of a nursing facility. That individual was able to let Greg know exactly what the transition process would be like and provide peer support.

### **Processes during the actual transition into community life**

Greg met with his new CAP case manager, Sally. Sally determined that Greg would be eligible for CAP/DA supports. Greg's doctor had completed an FL2 form indicating that Greg meets the requirement of needing nursing facility level of care. Sally indicated there would be no waiting period for a waiver slot. It was explained that the home modifications identified and written in his plan could be taken care of before he moved in. During this time period, Jose and Sally worked with Greg to ensure his house would be ready for him to move in and to set up all of the necessary supports discussed in his transition plan. Jose worked with Greg to utilize the waiver funds to contract with a builder to construct a ramp leading to the front of Greg's house and to widen some of the doorways. The CAP/DA waiver services the team had a spending limit of \$1,500/year. The transition specialist was able to locate a builder the Center had contracted with on other projects. He was able to provide services at a reduced rate. With help from his family and friends Greg was able to raise money to install a wheel-in shower in his downstairs bathroom. Greg's case manager worked to secure needed equipment such as a shower chair and hospital bed utilizing Medicaid funding.

Sally put Greg in contact with several agencies that provide CAP/DA services in Durham County. After Greg and Sharon called several agencies they picked the one that seemed to be the most receptive and reliable. This particular provider agency had a very detailed protocol for providing back up staffing in the event that a primary support staff was unavailable. The

coordinator at the provider agency brought several potential support staff to Shady Lawn for Greg and Sharon to interview.

After two months Greg's CAP/DA services were in place, his primary support staff was selected, and his house modifications were completed. Greg, his wife, the Center for Independent Living transition specialist, the Money follows the Person program specialist, his case manager, the coordinator from the provider agency, and the nursing home social worker all worked together to ensure a seamless transition as outlined in Greg's transition plan.

CAP/DA services provided in-home aide 4 hours a day for Greg. Greg also requested a personal emergency response system through CAP/DA so that he would be able to quickly call for help in the event of an emergency or if his staff did not show up for his shift.

### **Processes when the individual has been transitioned into a home and community based program**

Edward, Jose, Sally, and the coordinator from the provider agency met with Greg a week after his move to his house to ensure that the needed supports including his attendant services were in place and consistent.

Everyone from Greg's group continued to follow up with Greg after his transition to the community. They all remained in contact with Greg in various ways (phone, in-person, email) in some way on a month basis for six months following his transition. Edward and Jose would also check in with Greg and Sally over the phone regularly. They agreed that everyone would check in with Greg and one another over the phone and report updates to each other. The team worked together to address challenges that would come up as Greg adjusted to living at home.

Five months after Greg had transitioned to his house an incident occurred. Greg's wheelchair tipped over while he was at home alone. Luckily Greg had his personal emergency response system alert button around his neck. The emergency response center contacted Sally, Sharon, and the paramedics according to the protocol in Greg's crisis plan. By the time Greg's wife and case manager had arrived the paramedics were already there. Greg was taken to the hospital and it was determined that he had a broken arm. Due to the level of support Greg needed, it was decided by his team to have Greg enter the nursing home again, hopefully for less than 30 days. However, he had to stay 45 days in order to heal and receive physical therapy. Fortunately, he was able to re-enter Money Follows the Person project – all he needed to do was be determined that he meet CAP waiver requirements and he did. He was re-evaluated and his plan of care was updated. He had no changes in services and supports needed so he was able to continue on with the supports he had before the incident.

As it came near to the end of Greg's 365 days of demonstration services his team met again to look at the steps necessary to determine CAP eligibility so that his services would continue with no lapse. Greg's team worked together to ensure the assessments were completed prior to day 365.

Money Follows the Person Operational Protocol  
N.C. Department of Health and Human Services

Jose continued to remain in contact with Greg and his family following the 356 day period and provided independent living assistance as needed. When Greg expressed a desire to start working part time hours the Center for Independent Living transition specialist helped Greg contact Vocational Rehabilitation to begin receiving vocational services. The transition specialist also put Greg in touch with the North Carolina Assistive Technology Center so that he could be assessed for voice input systems for his computer. Eventually Greg joined a support group of others in his area that had transitioned from an inpatient facility to the community. With the group, Greg began to provide peer support to others that were going through the transition process.

## Case Study for an Elderly Person

### The Key Players:

Mrs. Sergor: person using services

### Mrs. Sergor's Family:

Howard: Mrs. Sergor's husband

### Transition Team:

1. Tommy: Regional Long-Term Care Ombudsman
2. Edward: Money Follows the Person Program Specialist
3. Patti: Transition Coordinator – Division of Vocational Rehabilitation
4. George: Nursing facility social worker
5. Michelle: CAP case manager

## Background

Mrs. Sergor, age 65, has been residing in a New Hanover County nursing home for the past 10 months. Mrs. Sergor and her husband Howard moved to the coast of North Carolina from Charlotte when her husband retired eight years ago. Howard died suddenly a year and a half ago. She has no relatives living in North Carolina, but she has several friends from church who visit often. Due to her rheumatoid arthritis, Mrs. Sergor had a hip replacement at a Wilmington hospital and transferred to the nursing home for the expected two-week rehabilitation after her surgery. While she was there, she suffered a stroke, leaving her paralyzed on her left side. Mrs. Sergor received extensive rehabilitation and improved, but still needs assistance in bathing, dressing, and getting in and out of a bed or chair. Mrs. Sergor continues to need skilled-level care, but feels she is too young to be in a nursing facility. She was determined to be eligible for Medicaid three months ago.

## Participant identification

The Regional Long-Term-Care Ombudsman – Tommy – was invited to speak to the resident council at the nursing facility. After the resident council meeting, Mrs. Sergor spoke with the Tommy about her desire to move out of the facility. Tommy had information for her regarding Money Follows the Person demonstration project. Tommy explained how the demonstration project assists individuals in long-term-care facilities to transition out of a nursing home and back into the community. Tommy explained that the funding was provided for 365 for an individual. So that individuals were not left without supports after 365 days, they were enrolled in CAP wavier program with additional supports under Money Follows the Person. Tommy gave Mrs. Sergor the telephone number for the Edward, Money Follows the Person Program Specialist, who is a State employee located in the Division of Medical Assistance in Raleigh.

When Mrs. Sergor called the Edward, she was connected with the agency that serves as the transition coordinator in New Hanover County.

### **Prior to the transition**

The transition coordinator in New Hanover County – Patti, who is with the Division of Vocational Rehabilitation, Independent Living Section – scheduled an appointment to visit with Mrs. Sergor at the nursing facility. Patti explained the program in more detail and how the Money Follows the Person project could assist Mrs. Sergor in transitioning out of the nursing facility into a place of her own. Patti explained the different living arrangements and service options available to her, including the Program of All-inclusive Care for the Elderly (PACE) or the Community Alternative Program for Disabled Adults (CAP/DA).

PACE is a managed care program in New Hanover County that enables elderly individuals who need facility care to live as independently as possible. The PACE service package includes all Medicaid-covered services, as specified in the State's approved Medicaid plan, such as multidisciplinary assessment and treatment planning, social work services, skilled nursing care, primary care physician services, medical specialty services, specialized therapies, recreational therapy, personal care services, nutrition counseling, meals, medical supplies, home mobility aides, transportation, prescriptions, laboratory tests, rays, and other diagnostic procedures, durable medical equipment and corrective vision devices.

CAP/DA also provides services to adults who qualify for facility care so they can remain in their private residences. The services include adult day health care; in-home aide services, level II and level III (includes personal care); supplies such as incontinence supplies, oral nutritional supplements, and medication dispensing boxes; case management, home mobility aids; adaptations to home environments (such as wheelchair ramps, safety rails, grab bars, non-skid surfaces, and so on and with a \$1500/year limit); preparation and delivery of meals; respite care (both in-home and institutional); telephone alerts; and attendant care services. Mrs. Sergor should be able to live independently after the transition with minimal risks if she participates in either the Program of All-Inclusive Care for the Elderly (PACE) or CAP/DA.

With Mrs. Sergor's approval, Patti arranged a meeting with Mrs. Sergor, George, and the director of nursing at the facility to review Mrs. Sergor's information from the Resident Assessment Instrument (RAI). That would help determine the medical support, personal care, and any other current supports needed to assist Mrs. Sergor in the community.

Patti began a detailed person-centered plan with Mrs. Sergor by discussing the roles of friends, housing options, health care, personal assistance, home adaptations or assistive technology, transportation, finances, her social and faith activities, and volunteer or employment options. Patti briefly explained the eligibility requirements for CAP/DA and the Program of All-Inclusive Care for the Elderly (PACE), and assisted Mrs. Sergor in setting up an appointment with the CAP case manager, Michelle, who would provide more detailed information. Michelle would work with Mrs. Sergor and any others Mrs. Sergor desired to develop a plan of care, which would outline the services and supports needed for a successful community living. The plan would include the supports Mrs. Sergor would have in the event of emergencies, such as a fall or

no-show of her personal assistant. Michelle described the process for re-enrollment should Mrs. Sergor have to go back to the inpatient facility. If she were to stay in the facility for longer than 30 days, she would be disenrolled. At the point she was ready for community living, she would be re-evaluated and her plan of care would be updated to reflect the services and supports needed. Though they hoped this would not happen, it was explained to Mrs. Sergor that should she have three incidents of 30 days or longer in the inpatient facility, she would no longer be considered for reentry into the project. With careful planning and strong supports, Mrs. Sergor and her team were planning on successful living and no re-entries into an inpatient facility. Michelle explained to Mrs. Sergor that her supports under Money Follows the Person would continue after day 365, as she was enrolling in waiver services. She would have a redetermination of level of care each year, just before her birthday month. As long as she met the level of care required for waiver services, she would continue in the CAP/DA waiver program. This would mean no lapse of services for Mrs. Sergor after the 365 days of demonstration services.

Mrs. Sergor expressed a desire to move into a housing situation where two meals a day are provided. A senior congregate housing apartment complex in her former neighborhood is close to her church, and a few of her friends from church recently moved there. The rent is based on income so it is an affordable option. The apartment complex regularly transports tenants to the grocery store and shopping malls, and the housing manager would assist in arranging trips for medical appointments. Pattie assisted Mrs. Sergor in contacting the senior housing apartment complex to inquire about the availability of apartments.

### **Transition into community life**

Patti met with Mrs. Sergor, George, and a close friend of Mrs. Sergor's to develop a plan to ensure the success of her transition. George is involved in the planning to ensure that the discharge for Mrs. Sergor is safe and orderly. Mrs. Sergor asked that her close friend sit in on the planning for emotional support.

Mrs. Sergor chose the service package with the CAP/DA. Typically, there is a waiting list for CAP/DA slots in the county; however, a person transitioning out of an inpatient facility who is participating in the Money Follows the Person demonstration is given priority *and existing waiver slots have been reserved for MFP participants*. Mrs. Sergor spoke with the senior housing apartment manager and was informed an apartment would be available in a month. Case management services can be provided for up to 30 days prior to the first day of transition into the community and thirty days after, so this worked well that the apartment would be ready in 30 days. Over the next 30 days, Pattie and Michelle assisted Mrs. Sergor in securing essential furnishings for her new home (provided by demonstration funding), and also provided security deposits and connection fees for utilities through the Money Follows the Person one-time transition expenses. Mrs. Sergor was informed she had a \$3000 limit on transition services, so she carefully considered what supports from this funding was most important to her success. Mrs. Sergor expressed a desire for a motorized wheelchair so she would have more mobility and be able to perform volunteer work at her church, which is across the street from her new home. With Mrs. Sergor's permission, Pattie contacted the Aging and Disability Resource Connection

to obtain information about other community resources available to assist Mrs. Sergor in obtaining a motorized wheelchair.

The day arrived when her senior housing apartment became available and CAP/DA eligibility was approved. Patti worked closely with Mrs. Sergor and the facility George to ensure that her discharge from the inpatient facility progressed in an orderly way. Patti ensured that Mrs. Sergor was able to find a doctor in the community, and that she had a sufficient supply of medications to last before her visit to her new doctor.

### **Transition into a Home- and Community-Based Program**

Patti met Mrs. Sergor when she arrived at her new apartment, where her church had stocked the small kitchen with groceries afforded by the transition services funds from Money Follows the Person. Patti and the home health agency ensured that the in-home aide reported to work at the same time Mrs. Sergor moved into her new place. They gave Mrs. Sergor telephone numbers of Patti and the home health agency to contact directly if she has any problems or questions. Patti also provided Mrs. Sergor with the county department of social services contact information and information on how to report suspected abuse, neglect, or exploitation and reminded her again of the process for reporting critical incidents.

Patti told Mrs. Sergor she would check on her by phone or in person once a week for the next month to see how she was adjusting. The second month, Patti would visit her two times; and the third month, one time. The visits by Patti found Mrs. Sergor happy to be able to visit with her friends and enjoying participation in activities at the senior apartment complex and volunteering at her church.

One day, Mrs. Sergor had a challenge with her in-home aide, who provided her personal care services. The in-home aide failed to show up as scheduled. Mrs. Sergor tried to transfer herself to the wheelchair, but her arms were a little weaker than usual and she panicked. She remembered her emergency response button around her neck and pushed the button. The emergency response system alerted the home health agency and a neighbor who had a key. The neighbor went to the apartment and sat with Mrs. Sergor until the home health agency sent an in-home aide.

## Benchmarks

The North Carolina Money Follows the Person Project measures five benchmarks—two which are required by CMS and three developed by the State. NC MFP’s benchmarks have been revised since the beginning of the Project based on transition experience and stakeholder feedback.

### 1. Transition Benchmarks

By December 31, 2013, NC MFP had facilitated 377 transitions since the beginning of the Project. NC has committed to the following transition benchmarks for CY2014-CY2016. Final transition benchmarks for Calendar Year 2017-2019 will be set in 2016.

<b>NC MFP TRANSITION BENCHMARKS</b>		
<b>Transition YEAR</b>	<b>I/DD</b>	<b>Aging &amp; Physical Disability</b>
CY 2014	30	105
CY 2015	30	125
CY 2016	30	150
Population TOTAL	90	380
<b>TOTAL</b>	<b>470</b>	

### 2. Projected Expenditures for North Carolina Home and Community Based Services

NC MFP has committed to the following projected expenditures for the following home & community-based services. Projections are based on actual financial performance of the prior year and include the following HCBS services: CAP DA/CAP Choice, CAP for Children, Home Health, Personal Care Services, CAP MR/DD/Innovations waiver. PACE is not yet included in forecast because of facility portion of capitation is not extracted for non MFP capitated payments. Additionally, MFP Qualified and Demonstration Services expenses from the “AB” portion of the quarterly MFP ABCD Financial Reports are included.

Because of this forecasting method, this benchmark will be revised annually.

**See Attachment R “Projected Expenditures”**

**3. Continued, increased outreach to *qualified facilities*.**

In partnership with the state’s Local Contact Agency network and behavioral health managed care organizations, MFP will conduct targeted, direct, in-person outreach and in-reach to the following number of qualified facilities.

<b>YEAR</b>	<b>In-Reach and Outreach Events within Nursing Facilities</b>	<b>ICF-IDD/State DD Centers</b>
CY2013	60	10
CY 2014	300	10
CY 2015	350	30
CY 2015	400	40
CY 2016	450	50
Facility Event Totals	1, 560	140
<b>Grand Total</b>	<b>1,700 In-Reach/Outreach Events</b>	

**4. Ninety percent of active, transitioned MFP participants will remain in their communities for at least one year following their transition date.**

North Carolina Money Follows the Person is committed to ensuring MFP participants have the supports needed to remain in their community upon transitioning and will track its recidivism rate to assess its effectiveness in doing so.

This rate will be measured by identifying the cumulative number of individuals who returned to the facility during their MFP participation year that resulted in a discharge from the Program, and dividing that number by the total number of transitions to date.

**5. Twenty percent of MFP Participants who do not have identified housing at the time of the application and desire to live in their own homes (not family's homes) will have housing identified within 6 months of MFP application approval date.**

NC MFP has a desire to support individuals, regardless of age or disability, to live in their own homes (either owned or rented) if they choose to do so. MFP shall work to help create a service delivery system and housing network that makes this option possible within a reasonable period of time. Preliminary MFP data suggest that while most individuals returned to a private home, most of these were likely returning to a family's home.

Therefore, NC MFP shall strive to meet the following benchmark:

<b>Priority: Housing</b>	
Percentage of MFP participants who do not have identified housing at the time of application and desire to live in their own homes (not family's homes) who have housing identified within 6 months of MFP application approval date.	
<b>YEAR</b>	<b>Benchmark Goal</b>
CY 2013	25%
CY 2014	40%
CY 2015	50%
CY 2016	55%

## **Participant Recruitment and Enrollment**

Persons who are eligible for home and community based waiver services (CAP-MR/DD, CAP/DA, CAP/Choice and PACE) and reside in an eligible institution will be eligible to participate in North Carolina's Money Follows the Person Demonstration grant. Individuals will transition into a CAP waiver program on the first day in the community. Slots have been reserved in each waiver program for Money Follows the Person participants. The following provides a description of the target populations within North Carolina that will be transitioned during the duration of the Money Follows the Person Demonstration Grant project, as well as the recruitment processes utilized for those target populations.

The target populations selected for transition include aging individuals with care needs and/or disabilities who have been residing in inpatient facilities for a minimum of three months; individuals who have been diagnosed with a mental illness and who have resided in inpatient facilities or special care units (for Alzheimer's or related disorders) for a minimum of three months and who are eligible for Medicaid 30 days; individuals who have been residing in private Intermediate Care—Mental Retardation facilities or state-operated Intermediate Care Facility-Mental Retardation facilities (developmental centers) for a minimum of three months and who are eligible for Medicaid prior to transition.

Level of Care assessments will be completed on individuals according to the specific policies and procedures of the CAP waiver or Program of All-Inclusive Care for the Elderly (PACE) in which they are enrolling. Additionally, a detailed person-centered plan<sup>1</sup> (which includes a transition plan) is required to be completed for each individual who qualifies for transition through the Money Follows the Person 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, well documented crisis plan that addresses not only intervention techniques but the prevention processes as well
- Residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members/guardians and informal supports.

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<sup>1</sup>The use of person-centered planning principles is being encouraged in all divisions within North Carolina Department of Health and Human Services for their day-to-day operations and use in policy development. Participation of agency's staff in developing these principles has truly been effective in helping the Department of Health and Human Services to make policy changes. This information was distributed in August 2007. It will take time for systems to change where this terminology is used consistently and across the board in all divisions. In the meantime, 'plan of care' will be seen in written documentation until such revisions and/or amendments are made. Specifically, within this document, both phrases will be seen and the reader is advised to understand there will be a gradual, systematic change to the use of 'person-centered planning' and the principles around this important concept.

In all cases, the individual's family will be considered if the individual has provided permission for the family to be involved. Please refer to Marketing, Outreach, and Education section for additional information.

To ensure that the effort can give proper attention to long-term systemic rebalancing initiatives while remaining responsive and thoughtful to the transition needs of MFP participants; the Project will retain an Associate Director. The Associate Director's core functions will be:

- Oversee the transition process of every MFP participant;
- Address challenges and issues related to the transition practices.

Once an individual has been identified as a potential Money Follows the Person participant, the local lead agency or Local Management Entity or PACE organization will be contacted to begin the process of assessing, determining eligibility, and development of the plan of care/person-centered plan. In each community, staff and advocates from Centers for Independent Living, Division of Independent Living Rehabilitation Program, Association of Self Advocates, Real Advocates Now Emerging, and others will also work directly with individuals who express a desire to transition out of a facility.

***Individuals who have Care Needs and/or Disabilities Residing in an Inpatient Facility***

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

Individuals expressing a desire and interest to transition out of an inpatient facility will review and discuss with their families/guardians and the transition coordinator, information from the Minimum Data Set or any other assessment tool used by the facility to determine medical support, personal care, and other supports available to the meet the individual's needs for transitioning to a qualified residence.

Transition coordinators will facilitate the process of identification through contact with the Regional Long Term Care Ombudsmen and/or Centers for Independent Living staff. The agency's transition coordinators will provide information to consumers and their families/guardians/caregivers to ensure an understanding of the Money Follows the Person Demonstration Grant project and the target population focus. This information will be provided in written and verbal form and will include information regarding the project itself, community residential options to inpatient placement, and support services available to maintain the individual within the community.

***Individuals Who Are Residing in State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)***

Guardians of individuals residing in state-operated Intermediate Care–Mental Retardation facilities who previously indicated through a standardized survey (see **Attachment A**) an interest in their family member moving into community living will be provided information on Money Follows the Person Demonstration grant project. For individuals who have not had an opportunity to participate in this survey, community living options will be discussed at the

annual person-centered planning/plan of care meeting. The surveys were administered late 2007/early 2008 by developmental center staff. Throughout the demonstration project (2008-2011), as residents and guardians express a desire for community living, the survey may be administered.

***Individuals Who Are Residing in Private Intermediate Care–Mental Retardation Facilities***

A survey, similar to the one used in state-operated facilities, will be used in private Intermediate Care–Mental Retardation facilities to identify individuals desiring to move into the community from facilities (see **Attachment B**). Disability Rights North Carolina funded a pilot Volunteer Monitoring Project in Durham, North Carolina at which time individuals were identified who wanted to transition to the community. Development of a similar process is underway with the Money Follows the Person Project Director and advocates who administered the above mentioned survey. This process will be used state-wide in private Intermediate Care–Mental Retardation facilities.

Transition coordinators of local provider agencies will provide information to individuals surveyed and their guardians regarding Money Follows the Person Demonstration Grant project and their choice of community placement. This information will be provided in written and verbal form and will include information regarding the project itself and community residential options versus institutionalization, as well as services and supports available in the community that can be used so that the individual 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 (2008).

**Qualified Institutional Settings**

***Individuals who have Care Needs and/or Disabilities Residing in an Inpatient Facility***

An *inpatient facility* means a hospital, nursing facility or intermediate care facility for people with developmental disabilities (“ICF-MR”). It also includes an institution for mental diseases (an “IMD”) but only to the extent medical assistance is available under the State Medicaid plan for services provided by this institution. This means MFP is available to IMD residents who are under 21 years old or over 65 years old and are receiving Medicaid State Plan services and meet other MFP eligibility requirements. Qualified institutional settings also include psychiatric residential treatment facilities (PRTFs). Please reference Attachment S, *North Carolina Money Follows the Person (MFP) in the MCO Landscape* for additional information.

**Residency Requirements**

***Individuals who have Care Needs and/or Disabilities Residing in an Inpatient Facility***

The transition coordinator of local provider agencies 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 inpatient facility for at least three months. This will be documented via an admission summary.

***Individuals Who Are Residing in Private or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers - State-operated)***

The transition coordinator of local provider agencies 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 or intermediate care facility for at least three months. This will be documented via an admission summary.

**Process for Assuring Medicaid Eligibility**

The transition coordinator will be responsible for ensuring that the individual who will be participating in the Money Follows the Person Demonstration Grant project continues to be eligible for Medicaid upon discharge from the facility. As applicable, hospital social workers, the developmental center's or Intermediate Care–Mental Retardation group home's reimbursement office and inpatient facility discharge planners work in collaboration with the individual's local Department of Social Services in the specific county in which the individual resides to obtain documentation verifying Medicaid eligibility.

**Enrollment**

All individuals who wish to participate in the Money Follows the Person Demonstration Grant project, or if appropriate, the individual's legal guardian or representative, will be required to sign an Informed Consent (see **Attachment C**) 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 and/or their family/guardian will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents. A level of care assessment will be conducted and a plan of care/person-centered plan will be developed specific to the needs of each individual following the requirements of the waiver program which they are eligible.

**Re-enrollment Policy**

A Money Follows the Person participant who is re-institutionalized for a period *greater than 30 consecutive days* will be categorized as **disenrolled** from the program. However, a disenrolled individual may re-enroll in the program without re-establishing the three-month institutional residency requirements. As long as a former participant meets Medicaid waiver eligibility criteria, the participant will still be eligible for Money Follows the Person services at the enhanced Federal Medicaid Assistance Percentage match. However, if the former participant remains in the qualified institution beyond six months, the participant will be defined as a "new" Money Follows the Person participant in terms of the Money Follows the Person services and the Federal Medicaid Assistance Percentage.

A former participant may re-enroll in the program after being re-evaluated and after having an updated Plan of Care. Once the individual is assessed to be appropriate for home and community based services, a referral will be made to the case manager for development of the individualized Plan of Care that addresses any change in the status of the Money Follows the Person participant and/or any lack of necessary supports in the community. After three incidences of re-institutionalization of 30 consecutive days or longer, the re-institutionalized

Money Follows the Person participant will not be considered for reentry into the Money Follows the Person project.

***Individuals with Care Needs and/or Disabilities Residing in an Inpatient Facility***

In order to be considered for re-enrollment, 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 Intermediate Care – Mental Retardation Facilities or State-operated Intermediate Care – Mental Retardation Facilities (Developmental Centers)***

In order to be considered for re-enrollment, 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 staff, and community providers with specific processes to ensure community sustainability. [Person-centered planning tools such as Essential Lifestyle Planning or Making Action Plans 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

**Continuity of Care**

Money Follows the Person participants will continue to receive waiver services at the end of the transition period (365 days) as long as they remain eligible for one of the waivers (CAP/DA, CAP/MR-DD, and CAP/Choice). If an individual does not continue to remain eligible for a CAP waiver, all efforts will be made to assist the individual and/or family/guardian in locating community services offered by various organizations and state programs in their local area. This will be explained to all individuals prior to enrollment into the Money Follows program and prior to transitioning out of the Money Follows the Person program.

## **Informed Consent and Guardianship**

All individuals who wish to participate in the Money Follows the Person Demonstration Grant project (or, if appropriate, those individuals' legal guardians) will be required to sign an Informed Consent form (see **Attachment C**) 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 and/or their family members and/or guardians will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents.

### **Informed Consent**

All individuals who want to participate in Money Follows the Person will be required to sign an informed consent stating they understand and agree to program requirements and have been informed of their rights, responsibilities, options and risks. This form will also indicate their willingness to participate in the Quality of Life surveys, which will be given two weeks before discharge, 11 months after discharge, and 24 months after discharge. All participants will acknowledge through the signed informed consent that they understand they will be reassessed for waiver eligibility prior to the end of 365 days. If an individual does not continue to remain eligible for one the CAP waivers (CAP/DA, CAP/MR-DD, and CAP/Choice), all efforts will be made to assist the individual and/or family/guardian in locating community services offered by various organizations and state programs in their local area.

### ***Individuals with Care Needs and/or Disabilities Residing in an Inpatient Facility***

Informed consent for participation in the Money Follows the Person 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 Intermediate Care–Mental Retardation Facilities or State-operated Intermediate Care Facility-Mental Retardation 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 that case, informed consent must be provided by the court-appointed guardian.

### **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 may no longer be

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 or 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 Department of Social Services, Local Management Entity, local health department, or county department on aging) or an adult officer or agent of a state human services agency.

While North Carolina General Statute 35A does not specify the level of interaction between a ward and an individual or corporation serving as guardian, it does speak to the rights of the individual and the guardian/ward. Specifically, North Carolina General Statute 35A-1201(5) reads, "Guardianship should seek to preserve for the incompetent person the opportunity to exercise those rights that are within his comprehension and judgment, allowing for the possibility of error to the same degree as is allowed to persons who are not incompetent. To the maximum extent of his capabilities, an incompetent person should be permitted to participate as fully as possible in all decisions that will affect him." Additionally, North Carolina General Statute 35A-1241, Powers and duties of guardian of the person, (a)(2) states, "The guardian of the person may establish the ward's place of abode within or without this State. In arranging for a place of abode, the guardian of the person shall give preference to places within this State over places not in this State. The guardian also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, the guardian shall give preference to community-based treatment facilities, such as group homes or inpatient facilities, over treatment facilities that are not community-based."

The General Statute 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. Corporations and disinterested public agent guardians submit annual status reports to the clerk of court's office, detailing what has been done for the ward during a specified time period. These reports include the level of interaction between the guardian and the ward.

In regard to the Money Follows the Person 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 appointed by the individual within the project, will be required and agree to have contact with the individual identified for transition within the last six months. Only a court-appointed guardian may act as guardian or other legally appointed representative for the participant. Corporations and legal guardians other than family members will follow their agency (such as local Department of Social Services or Local Management Entity) protocol for ensuring ongoing guardian interaction.

Case managers will work with guardians of Money Follows the Person participants to explain the program, safeguards and operating procedures. They will also work with the guardian and individual during the transition process so they fully understand their rights.

### **Training and Information**

#### ***Individuals with Care Needs and/or Disabilities Residing in an Inpatient 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. For details on abuse, neglect, and exploitation prevention and reporting, please refer to the Quality Management section.

#### ***Individuals Who Are Residing in Private Intermediate Care– Mental Retardation Facilities or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)***

Each individual identified for transition to the community and, where applicable, his or her guardian or legal representative, will be provided with 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 or her guardian and/or legal representative by the individual's planning team during the person-centered planning process and at any time a transition meeting is taking place (should the desire to transition occurs prior to the annual person-centered planning process).

Processes for ensuring protection from abuse, neglect, and exploitation include the following. Transition coordinators, in collaboration with the Local Management Entity, will be responsible for training the individual and legal guardians in this system to respond to and report critical incidents and other processes.

- The North Carolina Administrative Code requires all Local Management Entities and provider agencies to participate in a Division of Mental Health/Developmental Disabilities/Substance Abuse Services coordinated system for responding to and reporting critical incidents and other life-endangering situations. This system addresses deaths, injuries, behavioral interventions (including physical restraints), and 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 include 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, within 24 hours providers must convene a team to address immediate needs regarding the safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer’s guardian and the Local Management Entity of steps taken.
- Provider agencies handle level I incidents internally and make quarterly reports of aggregate numbers of level I incidents, identified trends, and activities being undertaken to address identified problems to the Local Management Entity.
- Provider agencies report level II incidents to the Local Management Entity within 72 hours. The Local Management Entity reviews these incidents to ensure that the provider is taking the necessary actions to keep consumers and others safe, to minimize the recurrence of the incident in the future, and to make the required reports to other authorities.
- When there is reason to believe that an individual has been abused, neglected, or exploited and is in need of protective services, the incident is also reported to the local Department of Social Services 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 Local Management Entity and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services within 72 hours (or immediately if a death occurred within 7 days of seclusion or restraint of the individual).
- Local Management Entities report information on level II and III incidents to the Division of Mental Health/Developmental Disabilities/Substance Abuse Services quarterly, including aggregate numbers of types of incidents, local trends identified in the Local Management Entity’s analysis, and actions they have taken to prevent future incidents.
- The Division of Mental Health/Developmental Disabilities/Substance Abuse Services ensures that individuals receive support to exercise their rights and voice complaints. The Local Management Entity is the local hub for receiving complaints about service provision.
- In addition, per administrative rule, each area board for the Division of Mental Health/Developmental Disabilities/Substance Abuse Services or Local Management Entity services is required to operate at least one Client Rights Committee, and require contracted providers to operate a Client Rights Committee as well.
- North Carolina 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 Local Management Entity 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 Management Entity board and may report to the local Department of Social Services and other applicable licensing agencies, such as the Division of Health Services Regulation and the Division of Public Health.
  - The Community Services Customer Rights team tracks and analyzes all complaints that come to the Division. Data collected on complaints include complainants 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 Local Management Entity.
  - The Performance Contract with Local Management Entities requires that Local Management Entities produce reports and use them for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends. Trends related to consumers include incidents and client rights. Local Management Entities must report quarterly all incidents and deaths as well as complaints as part of the Performance Contract with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services.

### **Responsible Entities**

#### ***Aging Individuals with Care Needs and/or Disabilities Residing in an Inpatient Facility***

The transition coordinators, in collaboration with the local Department of Social Services adult protective service worker, will be responsible for providing the individual (and his or her legal guardian(s), if applicable) with local information regarding whom to contact and how to report suspected abuse, neglect, or exploitation and the process for reporting critical incidents. All Money Follows the Person participants in the CAP/DA and CAP/Choice waivers will receive information regarding protection from abuse, neglect, and exploitation and the process for notifying appropriate authorities when abuse, neglect or exploitation. This information and explanation occurs during the development of the person centered plan. This process is facilitated by the case manager.

#### ***Individuals Who Are Residing in Private Intermediate Care–Mental Retardation Facilities or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)***

Transition coordinators, in collaboration with the Local Management Entity, will be responsible for providing the individual (and his or her legal guardian(s), if applicable) with local information regarding to whom to make protective services reports and the process for reporting critical incidents. All Money Follows the Person participants in the CAP/MR-DD Comprehensive waiver will receive information regarding protection from abuse, neglect, and exploitation and the process for notifying appropriate authorities when abuse, neglect or exploitation occurs. This information and explanation occurs during the development of the person centered plan. This process is facilitated by the case manager.

## **Outreach, Marketing, and Education**

To support the successful implementation of the Money Follows the Person 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 (**Attachment D**) will be available to all audiences. State staff may edit this template for use 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 Money Follows the Person 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. Interest in transitioning would have been gained through the methods noted in Participant Participation and Enrollment. Information is disseminated to participants in several stages: pre-transition, post-transition, and ongoing. During the pre-transition stage, potential participants will be notified about the opportunity to transition to the community. During the three months after the transition and on an ongoing basis, participants will be notified of additional services and supports in the community. Participants, potential participants, and/or guardians will be kept informed of services available through the Money Follows the Person demonstration grant throughout the project.

### **Providers**

Providers in the Money Follows the Person 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 Money Follows the Person Demonstration Grant project. A provider workgroup has been formed; its members have been involved in reviewing the protocol and will continue to be involved through the life of the project. A mass mailing will also be designed for providers to make them aware of the Money Follows the Person Demonstration Grant project and the opportunities for involvement. Examples of service providers across the state are

- Community providers of waiver services
- Professional caregivers
- Inpatient administrators
- Health care workers at agencies providing waiver services
- Community Mental Health Centers
- Centers for Independent Living
- Aging and Disability Resource Connections

During the public forums and stakeholder events being held for CAP waiver renewal information dissemination, the community at large will have the opportunity hear about Money Follows the Person demonstration grant benefits and services. During these meetings, which are planned for May 2008, Money Follows the Person staff will be available to present information and answer questions regarding the demonstration project.

Additionally, as noted in additional Benchmark #4, outreach will be conducted as a means of rebalancing of long term care expenditures. This will be accomplished by a number of different approaches that will take place simultaneously; for example, increased marketing of existing waiver services and conducting educational workshops for physicians and other medical personnel that would promote the use of home and community based services rather than the traditional move to an inpatient or ICF/MR facility. In addition, encouraging and supporting, in collaboration with state healthcare associations and independent providers, the development and provision of training programs that would assist facilities to develop diversified services within their communities. These efforts would directly impact the goal of rebalancing between institutional and home and community based services expenditures as well as having a positive outcome of increased range of services available within the specific community. These programs will be conducted by Money Follows the Person staff and any other staff designated as knowledgeable about such services. A training packet will be developed as part of information dissemination.

### **State Staff**

State staff refers to the employees of the North Carolina Department of Health and Human Services (Department of Health and Human Services) who will be involved in the Money Follows the Person Demonstration Grant project. A wide variety of staff and Department of Health and Human Services divisions are touched by this initiative. Examples of State agency divisions are

- Department of Health and Human Services
- Division of Medical Assistance
- Division of Aging and Adult Services
- Division of Vocational Rehabilitation Services
- Office of Long-Term Services and Supports
- Department of Health and Human Services—Office of Housing
- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

### **Other**

Advocacy groups also serve as important audiences for Money Follows the Person Demonstration Grant project information. The Division of Medical Assistance will design a mass mailing, using postcards, to provide basic information about the Money Follows the Person Demonstration Grant project to various advocacy groups. Examples of advocacy groups across the state are:

- North Carolina Council on Developmental Disabilities
- Centers for Independent Living
- disAbility Rights of North Carolina
- Carolina Legal Association
- Coalition on Aging
- Friends of Residents
- Health Care Facilities Association
- Home Care Association
- Long-Term-Care Regional Ombudsman

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- Mental Health Consumers Association
- National Alliance on Mental Illness
- Real Advocates Now Emerging
- Association of Self Advocates

**Types of Media to be Used**

***Participants***

Participants may receive information on Money Follows the Person demonstration grant services via brochures, broadcast messages (television or radio), in-person-visits to inpatient facilities and institutions, Medicaid card inserts, and the Division of Medical Assistance's Web site at <http://www.ncdhhs.gov/dma/MoneyFollows/>. Information will also be available on tapes, CDs, videos, and other formats. Media press releases may also be used.

***Providers***

Providers may receive information using the following media: Division of Medical Assistance bulletins (e-postings), Money Follows the Person Demonstration Grant project information sheet, Division of Medical Assistance Web site, remittance advice banner messages, verbal recordings that providers hear while on telephone hold with the Division of Medical Assistance, mass mailings (post cards) to provider associations, and inserts in conference "swag bags."

***State Staff***

State staff may receive information via the Division of Medical Assistance Web site, fact sheets, and training sessions.

**Specific Populations to Be Targeted**

***Aging Individuals Who Have Care Needs and/or Disabilities and Who Reside in an Inpatient Facility***

Facilities throughout the state will be targeted through inpatient facility transition coordinators with the Centers for Independent Living and the North Carolina Division of Vocational Rehabilitation Services Independent Living Rehabilitation Program.

***Individuals Who Are Residing in Private or State-Operated Intermediate Care–Mental Retardation Facilities***

Private Intermediate Care–Mental Retardation Facilities and state-operated facilities (developmental centers) throughout the state will be targeted.

**Information Dissemination**

The following resources will be used for information dissemination:

- Aging and Disability Resource Connections
- Various non-profit health care organizations, including
  - National Multiple Sclerosis Society
  - ARC of North Carolina
  - Easter Seals/UCP of North Carolina
  - National Alliance on Mental Illness
  - Mental Health Association

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- Provider associations
- Local management entities (including Community and Family Advisory Committees)
- North Carolina Family Resource Line
- Centers for Independent Living
- Rehabilitation centers
- Inpatient facilities
- North Carolina Division of Vocational Rehabilitation Independent Living program offices
- Senior Health Insurance Information Program/North Carolina Senior Medicare Patrol
- Long-Term-Care Ombudsmen offices
- North Carolina Council on Developmental Disabilities
- Providers of Programs for All-inclusive Care for the Elderly (PACE)
- Lead agencies for the CAP/DA
- disAbility Rights North Carolina
- Local libraries
- Community spaces (example: Parks and Recreation centers)

**Sharing Stories**

The Project recognizes the value of people who have transitioned and their families telling their own stories about the transition experience and community life. The Project will explore opportunities to support people in sharing their own stories through:

- The collection of written stories
- Supporting opportunities for people to speak at conferences and other public forums as they arise
- The development of a documentary
- Using other media (radio, YouTube, etc.) as appropriate.

The Project will follow the relevant ethical guidelines related to testimonials and informed consent when supporting people in telling their stories.

**Staff Training**

Annual training for Money Follows the Person services will be provided for stakeholders. This would include those who assist in transitioning individuals, those working with CAP waiver services and benefits, information technology staff, and staff from agencies providing transition services. This training will be videotaped, and each person who participated in the training will also have a six-month refresher session/video update.

Other options for training include conference calls and Web-based training activities. These will be scheduled regularly and/or as needed.

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

**Bilingual Materials/Interpretation Services**

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

**Informing Eligible Individuals of Cost-Sharing Responsibilities**

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

## Stakeholder Involvement

On September 17, 2007, a Money Follows the Person Project kick-off meeting was held to inform stakeholders and State staff about the project. This meeting gave an overview of the project; described the funders' (CMS) role; and provided information on how the Operational Protocol would be developed. Dates for Town Hall meetings were announced and participants were encouraged to attend to provide input into the development of the Operational Protocol and service delivery.

### Stakeholders

Stakeholder involvement is acquired through various committees and workgroups. The Money Follows the Person Demonstration grant is overseen and administered by the Department of Health and Human Services. Leadership from the Department of Health and Human Services is represented on the **Executive Committee**, which sets policy and resolves issues. The **Stakeholders Advisory Group** helps structure the development and implementation of benefits and service deliveries of the Money Follows the Person Demonstration grant in ways that address the needs of stakeholders. Stakeholders are identified as consumers, families of consumers (which together comprise 60% of the membership), providers, and advocates of services provided through Money Follows the Person grant (which together comprise 40% of the membership). (See Consumer Involvement, below, for more detail.) The **State Workgroup** developed the Operational Protocol, implements the benefit package, and responds to the administrative requirement for the project. The **Demonstration Workgroups** are comprised of providers, consumers, advocates, and staff to provide specifics on system issues facing long-term-care services delivery and needed changes. See **Attachment E**.

The Money Follows the Person Stakeholder Advisory Group was formed in late March and has met two times – 4/2/08; phone conference 4/28/08 – to provide input into the Operational Protocol. It is anticipated this group will meet four to six times per year. Reimbursement is provided to committee members and their travel assistant (if applicable) in attending the meetings. This expense is reflected in the budget.

### Consumer Involvement

Consumers, advocates, and others were invited to participate in six demonstration workgroups as a prerequisite to developing the Operational Protocol for the Money Follows the Person Demonstration Grant project. As the protocol was developed, the workgroups met a total of seven times and was provided with an opportunity to review and comment on the draft Operational Protocol. Group members were kept abreast of changes and developments in the Operational Protocol via email. Members responded with information and/or edits.

- Recruitment/Enrollment, Informed Consent Guardianship Workgroup met 10/9/07;
- Provider Workgroup met 10/12/07; phone conference was held 10/19/07
- Continuity of Care and Quality Workgroup met 10/11/07
- Benefits Workgroup met 10/10/07 and 10/15/07
- Outreach Workgroup met 10/10/07

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Four Town Hall meetings were held across the state to solicit input into the development, implementation, and evaluation of Money Follows the Person.

- Raleigh, North Carolina – 11/29/07
- Wilmington, North Carolina – 12/4/07
- Greenville, North Carolina – 12/5/07
- Hickory, North Carolina – 12/6/07

During the month of May 2008, Money Follows the Person staff participated in five of six Town Hall meetings for waiver renewals and presented information and received feedback on Money Follows the Person demonstration services:

- Goldsboro, North Carolina – 5/6/08
- Asheville, North Carolina – 5/7/08
- Wilmington, North Carolina – 5/9/08
- Winston Salem, North Carolina 5/9/08
- Morganton, North Carolina – 5/14/08

The meetings were advertised with letters sent to long-term-care services consumers, consumer advocates, Local Management Entities, County Department of Social Service Directors, and long-term-care services providers. The letters asked recipients to share the invitation with other stakeholders they knew. From these meetings, information was compiled and integrated into the Operational Protocol and will be considered as services are implemented.

Additionally, consumers, families of consumers, providers, and advocates were asked to participate in an application/nomination process for participation in ongoing Stakeholder Advisory Group meetings (see above). Members are defined as consumers and/or family members of consumers who receive publicly financed long-term-care services; agencies or providers; or representatives of people who are aging with care needs, have an intellectual or other developmental disability, have a physical disability, have a mental illness, or have a dual (or multiple) diagnosis.

### **Provider Involvement**

Institutional providers, consumers, advocates, and State staff were invited to participate in provider issues workgroups. These providers will also be asked to participate in ongoing Stakeholder Advisory Group meetings.

### **Roles and Responsibilities**

The stakeholders will be responsible for providing input to the six workgroup focus areas as well as to provider issues. An orientation to Money Follows the Person project components and deliverables was provided at the initial meeting of each workgroups and stakeholder group. At least one meeting was held for each workgroup focus area during development of the Money Follows the Person Operational Protocol; many groups met several times, and information was obtained through e-mails and telephone calls as well. During the implementation phase of the demonstration project, stakeholders at all levels will be responsible for providing input to the six

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workgroup focus areas and workgroups will meet on as needed. The six workgroup focus areas are

- Participant Recruitment/Enrollment/Informed Consent/Guardianship
- Housing
- Outreach, Marketing, and Education
- Provider Issues
- Benefits/Services/Consumer Supports/Self-Direction
- Quality Assurance/Continuity of Care

**Operational Activities**

Each year, the Division of Medical Assistance will coordinate four state forums to 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 public 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.

Stakeholder involvement will continue to ensure successful implementation of Money Follows the Person demonstration. These meetings will be instrumental in moving forward with a long-term care system that provides an array of home and community-based services and supports designed to promote choice and independence. It is anticipated that these groups will continue to provide input into the implementation of the demonstration project through face-to-face meetings (four to six), emails, and conference calls.

In order to have thoughtful, effective dialogue about how to effectively develop and implement the Project's long-term vision and objectives, the Project will retain formal facilitation services to facilitate quarterly stakeholder meetings and other workgroups and forums as needed.

## Benefits and Services

### Service Delivery Systems

In North Carolina, the Money Follows the Person 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 Money Follows the Person Demonstration Grant project. Money Follows the Person participants will be enrolled in CAP waiver services or in the Program of All-Inclusive Care for the Elderly (PACE) the first day they transition into a community setting. These slots have been reserved in the waiver programs for Money Follows the Person demonstration participants. After 365 days of demonstration services, individuals will continue in the same 1915(c) waiver program or the Program of All-Inclusive Care for the Elderly (PACE) 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 an inpatient 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 Intermediate Care Facility-Mental Retardation or a state-operated Intermediate Care Facility-Mental Retardation (developmental center): *NC Innovations*. This waiver is part of a larger 1915 (b)(c) behavioral health waiver, managed by a network of managed care organizations, *MCOs*.

Referrals to CAP/DA and CAP/Choice come from hospitals, Department of Social Services, provider agencies, advocacy groups, friends, family, inpatient facilities, senior centers, Area Agency on Aging, and other sources. The majority of referrals come from Department of Social Services and hospitals. Upon referral, eligibility is determined and if eligible, a program assessment is performed and a plan of care/person-centered plan is developed.

The chart below describes the services currently covered under existing CAP and Innovations waiver programs. The target population consists of North Carolina individuals who are currently residing in institutional care for a period of three months or more from one of the following categories: developmental disabilities, elderly and chronically ill, mental retardation, and physical disabilities.

### Service Package

	Currently Covered Services		
	NC INNOVATIONS	CAP/DA	CAP/Choice
Adult Day Health Care	YES [Day Support]	YES [Adult Day Health]	YES [Adult Day Health]
Augmentative Communications	YES [Assistive Technology Equipment and Supplies]	NO YES? [See Assistive Technology]	NO YES? [See Assistive Technology]

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	Currently Covered Services		
	NC INNOVATIONS	CAP/DA	CAP/Choice
Case Management	Case management functions performed by MCO as care coordination and Community Guide service	YES [Case Management]	NO [See Care Advisor below]
Consumer-directed Goods and Services (equipment and services not covered through State Plan that are needed to increase ability to complete activities of daily living and instrumental activities of daily living and to decrease dependence on aide services)	NO	NO	YES \$600/year limit
Crisis Services	YES	NO	NO
Day Supports	YES [Community Guide, Community Networking, Day Supports]	NO	NO
Employment Support	YES [Supported Employment Services]	NO	NO
Enhanced Respite Care	YES [Respite]	NO	NO
Financial Management	YES [Financial Support Services]	NO	YES [Financial Management Services]
Home and Community Supports	YES [In Home Skill Building; In Home Intensive Supports;]	NO	NO
Home Modifications/Home Mobility Aids	YES [Home Modifications]	YES	YES [Home Accessibility and Adaptation] \$
Individual/Caregiver Orientation/Training/Education	YES [Natural Supports Education]	YES [Training/Education and Consultative Services]	YES [Training/Education and Consultative Services]
Institutional Respite Care	YES [Respite]	YES [Institutional Respite Services]	YES [Institutional Respite Services]
Non-institutional Respite Care	YES [Respite]	YES [Non institutional Respite]	YES [Non Institutional Respite]
Personal Care Services/In-home Aide Services	YES [Personal Care Services]	YES [Personal Care Aide]	YES [Personal Assistance Services]
Personal Emergency Response Services/Telephone Alert	YES [ See Assistive Technology Equipment and Supplies]	YES [Personal Emergency Response Services]	YES [Personal Emergency Response Services]

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	Currently Covered Services		
	NC INNOVATIONS	CAP/DA	CAP/Choice
Preparation and delivery of meals (Meals on Wheels)	NO	YES [Meal Preparation and Delivery]	YES [Meal Preparation and Delivery]
Residential Supports (Group Homes)	YES [Residential Supports]	NO	NO
Respite Care (In Home)	YES	YES [See Noninstitutional Respite]	YES [See Noninstitutional Respite]
Specialized Consultative Services (psych counseling, therapy counseling, nutrition counseling, etc.)	YES [Specialized Consultation Services]	NO	NO
Specialized Equipment	YES [See Assistive Technology Equipment and Supplies]	NO	NO
Transportation - Non-medical	YES	NO	NO
Vehicle modifications	YES [Vehicle Modifications] <del>\$15,000 limit over waiver duration (3 year period)</del>	NO	NO
Waiver Supplies	NO	YES [Specialized Medical Equipment and Supplies]	YES [Specialized Medical Equipment and Supplies]
Community Transition	YES	YES	YES
Individual Goods and Services	YES [Individual Goods and Services]	YES [Participant Goods and Services]	YES [Participant Goods and Services]
Consumer-directed Care Advisor	NO	NO	YES [Care Advisor]
Assistive Technology	YES [see other service definitions]	YES	YES

***Program of All-Inclusive Care for the Elderly (PACE)***

PACE is a managed care program that enables elderly individuals who are certified to need inpatient facility care to live as independently as possible. The PACE provider receives monthly Medicare and/or Medicaid capitation payments for each eligible enrollee. The PACE provider assumes full financial risk for participants' care without limits on amount, duration, or scope of services.

Effective February 1, 2008, to enroll in this program, an individual must be Medicaid eligible and;

- Be 55 years of age or older
- Certified by the State to require inpatient facility level of care
- Able to live safely in the community at the time of enrollment, and
- Reside in the service area of the PACE organization.

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Services provided by the Program of All-Inclusive Care for the Elderly (PACE) include, but are not limited to:

- All Medicaid-covered services, as specified in the State’s approved Medicaid plan
- Multidisciplinary assessment and treatment planning
- Social work services
- Skilled nursing care
- Primary care physician services
- Medical specialty services
- Specialized therapies
- Recreational therapy
- Personal care services
- Nutrition counseling
- Meals
- Medical Supplies
- Home Mobility Aides
- Transportation
- Prescriptions
- Laboratory tests, X-rays, and other diagnostic procedures
- Prosthetics, orthotics, durable medical equipment and corrective vision devices

***State Plan Services***

In addition to the waiver program services, all Money Follows the Person participants will be eligible for Medicaid State Plan Services.

***Home and Community Based Demonstration Services***

Under the demonstration grant, demonstration services will be provided and reimbursed with demonstration funds when not covered under current waiver services and benefits. The chart below shows the demonstration services.

<b>Demonstration Service</b>	<b>Applicable Waivers/Programs</b>
Transition Year Stability Resources/Staff and Clinical Capacity Building	CAP/DA; CAP/Choice; Innovations; PACE
Transition Coordination	CAP/DA; CAP/Choice
PreTransition Case Management	CAP/DA; CAP/Choice
Supplemental Environmental Accessibility Support Service	Available to eligible MFP participants through Division of Vocational Rehabilitation—Independent Living Program

***Home and Community Based Supplemental Services***

At this point, North Carolina does not intend to offer supplemental services.

### **Transition Year Stability Resources Demonstration Service**

Ensuring that a person has a stable and well-planned transition is a priority for the Project. If an MFP participant cannot safely and adequately meet his/her transition-related expenses within the individual service definitions and/or budget cap under the current waiver, the person will have access to “Transition Year Stability Resources.” This funding is only available during a person’s transition year and must not be needed as part of a person’s ongoing support plan.

This demonstration service will provide up to \$3,000.00 for one-time start-up costs such as:

- utility and rent deposits
- appliances
- essential furnishings
- one-time home preparation: pest eradication, cleaning, allergen control;
- for waiver items, supports and services that cannot be adequately covered in a person’s transition year waiver budget because of the waiver's individual service cap;
- for items, supports and services that are allowed by CMS but not currently available through the waiver chosen by the MFP participant.

### **PreTransition Staffing and Consultation**

MFP recognizes that strong staff training and clinical consultation are often the most critical “start up” needs a person may have. MFP encourages individuals and their transition teams to consider utilizing TYSR funds for this purpose as appropriate. MFP shall reimburse for direct support staff training at a rate of \$21.40 per hour and clinical consultation at the applicable billing rate.

This funding is intended to be flexible to adequately meet a person’s specific living needs. If a participant has a specific transition need that is not clearly outlined above, the participant is encouraged to ask for clarification.

This funding may not be used to cover:

- ongoing living expenses (such as rent, bill payment);
- entertainment items such as televisions, stereos, etc.

Additionally, since Transition Year Stability Resources are not available after the first year, there has to be clear evidence that the participant's ongoing support needs will be met within the individual service cap and existing scope of approved waiver services after the first year of living in the community.

All tangible items (furnishings, etc.) acquired using this funding become the personal property of the MFP participant.

All requests for Transition Year Stability Resources must be approved by the Project Director.

The Transition Year Stability Funding may be accessed up to 60 days prior to the transition or up to 365 days after the transition.

## **Pre-Transition Case Management and Transition Coordination**

### **Pre-Transition Case Management**

The case management services that occur prior to a person transitioning are called “pre-transition case management.” Effective August, 2012, MFP shall fund up to eight hours of pre-transition case management for up to 60 days prior to the transition date as a *demonstration service* under CAP-DA and CAP/Choice. This timeframe for CAP DA/CAP CHOICE pre-transition case management begins on the FL-2 approval date and expires 60 days after this date.

### **Transition Coordination Services**

The Project may fund transition coordination services that are separate and distinct from case management services. The Transition Coordination service is a demonstration service and only available to individuals who have received transition coordination training by MFP staff. The role of the transition coordinator is to support the MFP participant through the transition process.

Under this service, transition coordinators shall follow applicable transition protocols, which include but are not limited to:

- Having ongoing, respectful communication with the MFP participant, his/her supports, facility and community provider staff throughout the transition process;
- Coordinate and conduct at least two face-to-face planning meetings with the participant and transition planning team members.
- Working with the participant and the participant’s family and supports to develop a thoughtful, organized transition plan that addresses his/her community-based support needs;
- Coordinating with the participant, his/her family and supports to identify and secure the community resources necessary to transition. This includes but is not limited to: housing, medical care, financial management (setting up a bank account, etc), and other community supports that are needed for community living;
- Coordinating *Transition Year Stability Resource* requests;
- Maintaining regular follow up with the MFP participant according to the Follow Along Contact Schedule, included in Attachment T, *Supporting People to Thrive: MFP Follow Along Practices*.
- Working with the participant’s case manager, notifying the Project of any critical incidents impacting the MFP participant.

Transition coordination services provided by CAP DA case managers are reimbursed at a flat rate of \$2000.00 per successful transition. Reimbursement for transition coordination services that do not result in a participant transitioning may be reimbursed on a pro-rated basis up to \$1000.00.

Transition coordination services may be performed by a case manager but are separate and distinct services from case management. These transition coordination services are distinct from

other one-time services allowed under TYSR and must be billed separately. Examples of other one-time services allowed under TYSR include but are not limited to: behavior support consultation and individualized staff training.

### **Partnership with Division of Vocational Rehabilitation's Independent Living Program**

#### **Transition Coordination Services**

NC MFP and the Division of Vocational Rehabilitation's Independent Living Program have partnered together to provide transition coordination for MFP participants who have physical disabilities and are 65 or under and meet DVR-IL eligibility criteria. Under this partnership, DVR-IL shall provide transition coordination services, following MFP's established transition coordination practices as outlined in Supporting the Return to Home and Community: North Carolina's Money Follows the Person Transition Coordination Handbook. Available at: [www.mfp.ncdhhs.gov](http://www.mfp.ncdhhs.gov).

#### **MFP's Expansion to Partner with Centers for Independent Living**

In collaboration with DVR-IL, NC MFP will contract with three identified Centers for Independent Living to expand its transition coordination capacities. DVR-IL and CILs shall collaborate to support MFP in meeting its transition benchmarks for people with physical disabilities.

#### **Supplemental Environmental Accessibility Support Service**

Because individuals with significant physical disabilities often have accessibility needs that exceed the existing MFP Transition Year Stability Resource allocation, DVR-IL has committed additional resources to meet one-time, time-limited start up transition needs. Up to an additional \$5,000.00 per MFP/DVR-IL participant may be authorized for transition needs related to assistive technology, accessibility modifications to their home or vehicle, adaptive equipment or tele-support needs not otherwise available under current Medicaid services.

This Supplemental Environmental Accessibility Service is only available to MFP participants who are under the auspices of DVR-IL, either directly or through contract. The DVR-IL Housing and Transition Specialist shall review and authorize all requests to access Supplemental Environmental Accessibility Support services. Supplemental Environmental Accessibility funds may only be used to fund goods and services recommended through DVR's assistive technology assessment or DVR IL home assessment process.

#### **MFP Activity within DHHS Behavioral Health Managed Care Organizations (MCOs)**

MCOs are responsible for providing transition supports to MFP participants with intellectual and/or developmental disabilities and may play a key role in ensuring MFP participant's mental health needs are effectively addressed. For specific guidance on how the MFP Demonstration Projects interface with MCO functions, please review Attachment S, *North Carolina Money Follows the Person (MFP) in an MCO Landscape*,

### **Transition Services to Qualified Individuals Who Do Not Require Waiver Services**

For MFP participants who receive MFP-funded transition coordination services through one of the Centers for Independent Living and whose support needs do not necessitate CAP DA waiver-level services and the transition planning team has determined that their needs could be easily met through other similar state or county funded services or state plan services, MFP Transition Coordination Services will be provided for the entire 365 days of a participant's MFP eligibility. These transition practices are referenced as "SubCAP" Transitions, as transitioning participants do not require CAP DA level of service.

The Transition Coordinator and the MFP participant who is not utilizing waiver services shall engage in a more vigorous risk mitigation planning and post-transition oversight practice that ensures HCBS quality assurances and MFP-specific Quality Assurance measures are met. During the course of the MFP year, the participant and the transition coordinator will continue ongoing review of support needs and consider additional services through a wavier service if needed. The transition coordinator shall facilitate a Level of Care review and waiver assessment as needed to access waiver service and at minimum during the eleventh month of the participant's MFP participation. If the MFP participant's needs increase during the demonstration period, an MFP-reserved waiver slot shall be available.

The Transition Coordinator works in cooperation with the Home and Community Based Wavier Case Managers located in each county to assist the MFP participant in arranging the necessary supports throughout the 365 days of MFP eligibility and with services post MFP eligibly to assure continued successful community living and continuity of care to prevent re-institutionalization.

### **Transitions Services to High Engagement MFP Participants**

MFP is committed to supporting individuals who may demonstrate a higher level of complexity or require more intensive engagement due to their individual circumstances to safely transition and remain in their communities. These populations are referred to as *high engagement* populations and include:

1. Individuals transitioning out of Developmental Center Specialty Units; Psychiatric Residential Treatment Facilities, State Psychiatric Facilities
2. Individuals transitioning without waiver-level services (SUB CAP)
3. Other specific transitions that the transition coordinator determines is eligible.

MFP requires additional activity or oversight of individuals deemed to require high engagement as outlined in Attachment T, and as outlined in transition coordinator training protocols.

### **Wait List**

Individuals will transition into a CAP waiver or PACE on the first day in the community. Slots have been reserved in each waiver program (CAP/DA, ~~CAP/MR-DD~~ Innovations, and CAP/Choice) and PACE for Money Follows the Person participants. Currently, North Carolina

gives priority to individuals transitioning out of inpatient facilities, skilled nursing facilities and intermediate care facilities for individuals with intellectual/developmental disabilities-(state and private). Slots will be available to meet North Carolina's stated transition benchmarks. *Innovations* waiver slots for MFP participants are managed by the DHHS MCO network. *Innovations* slot allocation procedures are outlined in Attachment S.

### **Disenrollment/Re-enrollment**

A Money Follows the Person participant who is re-institutionalized for a period *greater than 30 days* will be categorized as **disenrolled** from the program. However, a disenrolled individual may re-enroll in the program without re-establishing the three-month institutional residency requirements. As long as a former participant meets Medicaid waiver eligibility criteria, the participant will still be eligible for Money Follows the Person services at the enhanced Federal Medicaid Assistance Percentage match. However, if the former participant remains in the qualified institution beyond six months, the participant will be defined as a "new" Money Follows the Person participant in terms of the Money Follows the Person services and the Federal Medicaid Assistance Percentage.

A former participant may re-enroll in the program after being re-evaluated and after having an updated plan of care/person-centered plan. Once the individual is assessed to be appropriate for home and community based services, a referral will be made to the case manager for development of the individualized plan of care/person-centered plan that addresses any change(s) in the status of the Money Follows the Person participant and/or any lack of necessary supports in the community. After three incidences of re-institutionalization of 30 consecutive days or longer, the re-institutionalized Money Follows the Person participant will not be considered for reentry into the Money Follows the Person project.

### **Follow Along Practices**

In order to effectively support an individual after the transition occurs, MFP requires that participating transition coordination, care management or case management service entities comply with the Project's Follow Along requirements. These requirements are outlined in Attachment T, Supporting People to Thrive: MFP Follow Along Practices

### **Denial or Termination from the Project**

MFP is a time-limited project only available to eligible Medicaid beneficiaries. A beneficiary is considered an MFP participant once an MFP application has been approved. If an MFP participant transitions into an eligible home and community-based setting, the beneficiary is considered enrolled in MFP for the first 365 days after the transition date, unless the beneficiary's participation is terminated for one of the reasons outlined below.

If a Medicaid beneficiary is denied or terminated from the NC MFP Demonstration Project, the beneficiary will not have continued access to the NC MFP service package which includes: priority access to services outlined in the Benefits and Services section of this Operational Protocol.

Denial or termination from the MFP Project does not necessarily restrict the individual's ability to transition. Further, a transitioned beneficiary's disenrollment in MFP does not necessarily impact the beneficiary's access to existing Medicaid services.

### **Denial of MFP Application**

An MFP applicant will be denied enrollment into NC MFP if the NC MFP staff determine the applicant is ineligible for the program. NC MFP's eligibility requirements are outlined in applicable federal law and further clarified by the NC MFP project. To be eligible for NC MFP, an applicant must meet the criteria outlined in the Participant Recruitment and Enrollment section of this Operational Protocol, specifically:

1. Currently resides in a *qualified facility*;
2. Has resided in the qualified facility for at least 90 consecutive days, excluding days reimbursed under Medicare Part A;
3. Receives Medicaid benefits from this facility for at least one day prior to transition; and
4. Continues to meet federal and state program level of care requirements.

### **Discontinuing MFP Participation: Pre-Transition**

In NC, MFP participants must also meet the eligibility requirements of the home and community-based service (HCBS) programs utilized by NC MFP. These are: Innovations (c) waiver; Community Alternatives Program from Disabled Adults (CAP-DA) or the self-directed CAP DA Program, CAP CHOICE; PACE or in designated areas, meet the criteria for Sub CAP program.

### **MFP staff may disenroll an MFP Participant from the Program prior to transitioning for the following reasons:**

1. MFP participant does not meet the criteria for the applicable HCBS program outlined above. Appeal rights for Innovations, CAP DA/CHOICE and PACE are managed according to the guidelines of the specific program.
2. Unable or unwilling to move into a "qualified residence" that is both authorized under federal law and supported by the applicable NC waiver program.
3. Failure to honor transition-related commitments as outlined in the NC MFP Informed Consent document.
4. Voluntarily withdrawing from the Program.

### **Discontinuing Participation: Post Transition**

An MFP participant retains MFP participant status for one year after the participant's transition date. After 365 days, the participant is automatically disenrolled from the MFP Program. During this 365 day period, a beneficiary's MFP participation can be terminated for one or more of the following reasons:

1. Beneficiary's circumstances no longer meet criteria of applicable HCBS program;
2. Beneficiary is reinstitutionalized for more than 30 days;
3. Beneficiary transitions to a residence that does not meet MFP federal criteria or does not meet applicable home and community-based program criteria;

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4. Beneficiary no longer receives Medicaid;
5. Beneficiary refuses to comply with agreements as outlined in the Informed Consent, Plan of Care or Risk Mitigation agreements; or
6. Beneficiary no longer meets relevant level of care criteria.

**Transition at termination**

The 1915(c) waivers and the Medicaid State Plan Services will continue to provide services at the termination of the Money Follows the Person project. Program participants will also be assisted to access other community-based services for which they may qualify. At the end of demonstration services, CAP waiver services and benefits for which an individual qualifies will support continued community and home based living. This will result in no loss of services and supports to individuals who transitioned under demonstration services.

## Consumer Supports

### Educational Materials

Division of Medical Assistance will develop informational brochures that outline the services provided through Money Follows the Person. Current consumer information will be updated to include information about the Money Follows the Person Demonstration Grant project. The systems listed in this section are various ways for Money Follows the Person participants to access consumer supports when needed (such as in a non-911 emergency). Specifically, each participant's plan of care/person-centered plan will have concise methods to address the individual's needs in regards to supports, services and back up plans. For specifics on risk management, critical incident, and 24-hour back up, refer to the Quality section.

### Back-up Systems

**CARE-LINE.** The North Carolina Department of Health and Human Services toll-free information and referral telephone service, CARE-LINE [1-800-662-7030; local calls: 855-4400 or 919-733-4851 (TTY)], 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. The CARE-LINE is available 24 hours, 7 days a week. Consumers, their families/guardians, and other customers have a service to call which provides information and referrals on a wide array of human services any time of the day or night.

**NCcareLINK.** North Carolina maintains a comprehensive health and human services Web site called NCcareLINK (<http://www.nccarelink.org>). It is a collaborative effort of the North Carolina Department of Health and Human Services and many other government and non-profit information and referral stakeholders across North Carolina. This Web site provides up-to-date information about programs and services across North Carolina for families/guardians, seniors, youths and everyone in-between (see Attachment F).

NCcareLINK system:

- Provides current consumers with local resources
- Introduces potential consumers to local resources
- Outlines services for persons moving to North Carolina
- Provides a marketing opportunity for local providers
- Helps Local Management Entity staff make appropriate referrals to provider agencies.

NCcareLINK has been designed with the end-user in mind. Partnering agencies—through a Memorandum of Understanding with the Office of Citizen Services—provide six month updates to the system on all of the Providers in their region. Partnering agencies are:

- non-profit entities that offer health and human service programs
- Government agencies (local/state/deferral)
- Self-help/support groups
- Faith-based organizations that offer specific health and human services program(s) to the community
- Civic/social groups that offer specific health and human services programs(s) to the community

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- For-profit agencies that offer a sliding scale payment plan or accept governmental funds or offer unique services that meet health and human services needs at the community level
- An organization must be in business providing specific service(s) for a minimum of six consecutive months, have an established physical address and contact telephone number, and have a license to provide services.

Individuals may also access 911, the statewide suicide hotline at 1-800-273-8255, and/or visit the emergency room at a local hospital.

**Personal Emergency Response System (PERS).** Personal Emergency Response System is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals from the company ADT Security Services. Personal Emergency Response System services are limited to those individuals who live alone, or who are alone for significant parts of the day, who are alone for any period of time and have a written plan for increasing the duration of time spent alone as a means of gaining a greater level of independence, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

The Personal Emergency Response System may be helpful in the following situations:

- A fall has occurred and the individual cannot get up without assistance. The attendant on the other end of the response system would obtain the information regarding the emergency and respond according to the nature of the emergency.
- A personal care attendant does not show up. The individual would make a call using the Personal Emergency Response System and appropriate action would be taken.

### **24 Hour Back up**

#### **PACE**

In each participant's service plan a back up plan for needed care coverage that includes formal and informal supports is included. However, there are times when the most comprehensive plans can be insufficient. For this reason, each PACE center is required to have a 24/7 on-call staff person who is able to assist any PACE participant who is in a crisis or emergency who needs to obtain access to critical medical supports. The PACE participant, their legal guardian (as applicable) and family members are informed of how to access the 24/7 on-call system during the intake and assessment process, and in their service plan. This information is reviewed on an annual basis and as needed with each participant. The on-call person is either a physician or registered nurse. PACE on-call staff documents all calls taken during the center's non-operational hours and the action taken to address the participant's issue or problem. The call and resulting action is also documented in the participant's record. It is the responsibility of the PACE Program Manager to monitor the PACE Center to ensure the 24/7 system is working and that 24/7 coverage needs are identified and addressed adequately and in a timely manner. The Division of Medical Assistance PACE Program Manager reviews monthly reports of calls to the

center's 24/7 system and provides feedback as necessary related to any improvements in the handling of calls to this system.

### ***CAP/DA and CAP/Choice***

In each participant's service plan a back up plan for needed care coverage that includes formal and informal supports is included. However, there are times when the most comprehensive plans can be insufficient.\*\* For participants with diagnoses that require rapid access to Emergency Medical Services CAP/DA provides for the use of telephone response systems. The CAP/DA case manager checks this system on a monthly basis to ensure it works properly and reviews any reports from the Emergency Response System Provider. This case management activity is documented in the client's case notes.

For other non-emergency but critical support needs, the CAP/DA Case Manager is available to assist the participant during the agency's normal business hours. Information regarding these interactions is available to Division of Medical Assistance staff during participant record reviews during lead agency site audits. In addition, the case manager is required to perform a monthly review of the provision of services with both the client and the agency providing the services. Any deviation in waiver service provision is to be documented in case manager's notes and a detailed description of how the client's needs were met are included. Division of Medical Assistance staff provides feedback regarding any deficiencies noted during the review including inadequate actions and issues not handled in a timely manner.

After hours, North Carolina's **CareLine**, a toll-free hotline designed to assist North Carolina citizens in need of supports and services, has live operators 24 hours a day, seven days a week. The **CareLine** operator is able to assess a participant who is in a crisis or emergency and can coordinate access to critical medical supports. **CareLine** staff logs and tracks each call and compiles reports and recommendations for each encounter. The Division of Medical Assistance recognizes the importance of evaluating this data and will work collaboratively with the **CareLine** program to develop regular reporting and a method for evaluating and using this information to improve the quality of CAP/DA. The volume and types/categories of calls (e.g. – absence of personal care attendant, failure of durable medical equipment, etc.) and whether the responses were adequate and timely will be evaluated and addressed as a part of this process. MFP clients will be flagged in the system and a report will be generated specifically on these clients.

The CAP/DA participant, their legal guardian (as applicable) and family members are informed of how to access all aspects of 24 hour back up by the case manager during the intake and assessment process, and in their service plan. This information is reviewed monthly by the case manager as a part of their monthly monitoring requirements, assessed on an annual basis during the continued need review and as needed with each participant.

\* CAP/CHOICE is administered by the CAP/DA Lead Agencies; therefore, when CAP/DA is referenced in this document it is understood that CAP/Choice applies as well.

\*\* 24 Hour Care Coverage Plans are completed for only those participants identified as needing around the clock care supports critical for his/her health and welfare. For the purposes of the

Money Follows the Person Project all participants designated for MFP are required to have a 24 hour coverage plan, regardless of the need for 24 hour care coverage.

### ***CAP/MR-DD***

The CAP/MR-DD waiver guidelines require all providers to have a process for ensuring 24 hour back-up (24/7/365) availability, so that a live person is accessible when needed. All participants of CAP/MR-DD waiver services are informed of and provided with information related to back-up staff at the time of identification of provider and during the person centered plan/plan of care planning process.

Providers of 24 hour services and Targeted Case Management services act as the First Responders if and when the participant or a member of their support system initiates contact for assistance in the case of an emergency. The provider is required to notify the participant and his or her support system of the process for accessing emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at the initial contact. The notification includes contact information for an alternate source of assistance in the eventuality that the provider is not available.

The person centered plan/plan of care is expected to address how the provider will ensure back-up staff is available, if the staff regularly assigned to provide services are unavailable. The back-up staff must be trained to meet the specific needs of the participant, as detailed in the person centered plan/plan of care, including health, mobility, communication, risks behavioral issues, and skill training.

Each provider will be required to document and track receipt of calls and requests for back-up staff and staff unavailability. This report will be submitted to the Local Management Entity on a monthly basis for tracking and analysis.

## **Critical Incident Management**

### **Reporting Abuse, Neglect and/or Exploitation**

North Carolina General Statute 108A, Article 6 mandates the protection of vulnerable and elderly adults who have been abused neglected, or exploited. The statute authorizes County departments of social services to provide protective services which include receiving, screening, and evaluating reports that adults with disabilities are in need of protective services. Adult Protective Services also makes referrals to law enforcement, the district attorney and other enforcement and regulatory agencies.

According to the statute a disabled adult is “any person 18 years or over or any lawfully emancipated minor present in the state of North Carolina and who is physically or mentally incapacitated due to mental retardation, cerebral palsy, epilepsy or autism; organic brain damage caused by advanced age or other physical degeneration in connection therewith; or due to conditions incurred at any age which are the result of accident, organic consumption or absorption of substances.”

Adult Protective Services is a state supervised, county administered program. Each county in the state has an Adult Protective Services unit. Statute requires that any person having reasonable

cause to believe that a disabled adult is in need of protective services shall report such information. For MFP participants, this includes but is not limited to: MFP staff or contracted designees, MFP transition coordinators, or CAP case managers. Reports alleging abuse, neglect, or exploitation of a disabled adult should be reported to the county DSS where the adult resides. The report may be made orally or in writing and it should include:

- The name and address of the disabled adult
- The name and address of the disabled adult's caretaker (if known)
- The age of the disabled adult
- The nature and extent of the disabled adult's injury or condition resulting from abuse, neglect or exploitation.

### ***PACE***

The state, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. All incident reports are provided to the PACE Program Manager for review, including critical incident reporting. Reports are reviewed to ensure that appropriate action was taken at the time of the incident, whether further investigation is needed, or if further action or training may be required to ameliorate and/or prevent any recurrence of the incident. Each PACE Center is required by CMS to report all critical incidents to CMS. All information provided to CMS is also submitted to the North Carolina *PACE* Program Manager for review.

### ***CAP/DA and CAP/Choice***

The State, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. Case managers will be required to report monthly on substantiations of abuse and neglect for Money Follows the Person participants.

Additional critical incidents for the aged and disabled population include falls, unplanned weight loss and unplanned hospitalizations. These are reported during the initial assessment, at annual continued need review and as needed in change of status assessment. Data is collected and accessed through Automated Quality and Utilization Improvement Program. Reports are run quarterly are reviewed to ensure that appropriate action was taken at the time of the incident. Reports are provided to the lead agencies and Division of Medical Assistance staff.

### ***CAP/MR-DD Comprehensive***

North Carolina Administrative Code 10A NCAC 12G.0603 requires all Local Management Entities and agencies providing mental health, developmental disabilities or substance abuse services to any person receiving public funds to participate in the Division of Mental Health/Developmental Disabilities/Substance Abuse Services-coordinated system for responding to and reporting critical incidents and other life endangering situations. This will include the Money Follows the Person participants. Critical Incidents are defined as any happening which is not consistent with routine operation of a facility or service in the routine care of participant and that is likely to lead to adverse effects upon the consumer. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues.

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Providers are responsible for responding to all incidents and submitting to the Local Management Entities reports on all Level II incidents (e.g., incidents where police are involved, injuries requiring medical treatment). Providers submit to both the LME and to Division of Mental Health/Developmental Disabilities/Substance Abuse Services reports on all Level III incidents (e.g., incidents that cause permanent injury or death). Providers also report quarterly aggregate information to the Local Management Entities on a Level I incidents (e.g., injuries that do not require hospitalization or medical treatment other than first aid).

Local Management Entities are responsible for ensuring that providers submit incident reports as required and respond appropriately to minimize harm from the incident and the likelihood of future incidents.

Local Management Entities must report to Division of Mental Health/Developmental Disabilities/Substance Abuse Services quarterly on their analysis and response to trends on all incidents and deaths as part of the Performance Contract with the Department of Health and Human Services. The Division of Mental Health/Developmental Disabilities/Substance Abuse Services Quality Management and Customer Services Community Rights Teams provide oversight and technical assistance to the Local Management Entities to ensure that Level III incidents are fully addressed by providers.

The Division of Mental Health/Developmental Disabilities/Substance Abuse Services Quality Management (QM) Team maintains an internal database on reported Level III incidents. From this data and the Quarterly Incident Reports submitted by the Local Management Entities, quarterly and annual trend analysis reports are created and reviewed by the team for comparison on a Local Management Entities level. The Quality Management Team reviews the reports to identify trends that may need to be responded to by remediation and improvement activities to assure that the underlying philosophy and assurances of the CAP-MR/DD waiver are maintained. The Internal Quality Management Review Committee (See Section IV of Quality Management Plan) will also review these reports to identify trends and issues that may need remediation and improvement activities

## **Risk Management**

### ***PACE***

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each PACE participant are identified during an on-going interdisciplinary assessment process that is very thorough and comprehensive. Each risk identified by the assessment process must be addressed in the individual's service plan. For example, an individual identified with a fall risk may need to have assistance while ambulating through the use of gait belt, or, an individual with a history of bowel obstructions may require a more thorough monitoring of bowel movements and/or a specialized diet to help prevent hospitalizations. Since PACE Centers serve a significant number of individuals with cognitive impairments and/or dementia, wandering and elopement is often an issue. Any individual identified with a dementia-like diagnosis is monitored using a Wander-guard system. The North Carolina PACE Program Manager will monitor Service Plans with special consideration given to diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately. Any service plan that is deficient in this regard must be amended before approval. Additionally, any interventions designed to minimize risk will be assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

### ***CAP/DA and CAP/Choice***

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each CAP/DA and CAP/CHOICE participant is identified as part of the intake and assessment process. These items are entered into the Automated Quality and Utilization Improvement Program assessment tool along with the Service Plan which is completed using the Automated Quality and Utilization Improvement Program Plan of Care Tool. The Automated Quality and Utilization Improvement Program system has the capacity to compare identified risk factors with elements of the plan to ensure these risks are adequately addressed for all CAP/DA and CAP/CHOICE participants. Each risk identified by the assessment process must be addressed in the individual's service plan.

Some example scenarios where service plans should address risk factors identified in the assessment process include:

- a) An individual identified with a fall risk may need to have assistance while ambulating through the use of gait belt
- b) An individual with diabetes requires continuous monitoring of blood glucose levels (AC1s), specialized diet and physical activity.
- c) An individual with a history of decubitus ulcers requires regular and continuing monitoring of skin to detect and prevent skin breakdowns
- d) An individual with hypertension will require regular and continuing monitors of blood pressure

Additionally, case managers monitor service plans with special consideration given to diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately on at least a monthly basis. Assessments are completed at intake, during continued need reviews, or as needed, when the health of the participant changes. Every time the assessment (initial,

CNR, or a change in status) is completed, a plan of care is completed or amended based upon the most current assessment.

Automated Quality and Utilization Improvement Program generates reports of service plans that do not address risk factors identified in the assessment. These reports are reviewed by CAP/DA staff and feedback is provided to the specific CAP/DA lead agency where the assessment and service plan were completed. The interventions, as set forth in the individual's service plan, designed to minimize risk will be assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

### ***CAP/MR-DD Comprehensive***

As a preliminary step, the MR2 assessment form which documents Intermediate Care Facility for the Mentally Retarded level of care, along with the North Carolina-Service Needs Assessment Profile (NC-SNAP), will be used to identify potential risks to the participant. A Crisis Prevention Plan is incorporated within the person centered plan/plan of care. The Crisis Prevention Plan includes supports/interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive). The proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to address them. The reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond. The planning team are to consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably.

Other assessment tools will be utilized to identify potential risks for all Money Follows the Person participants. The Risk Assessment tool identifies potential risk, such as but not limited to, situational, environmental, behavioral, medical, and financial risks. If a risk is identified and the planning team concurs, the risk identified will be documented within the Crisis Prevention Plan of the Person Centered Plan. The Supports Intensity Scale (SIS) is an assessment tool that measures practical support requirements of a person with an intellectual disability. Unlike traditional assessments, the SIS focuses on what daily supports a participant needs to live as independently as possible within their community. A major strength of the Supports Intensity Scale is that it identifies supports that are needed to help a participant be successful in a variety of life domains. As such, during the person centered plan/plan of care planning meeting, as needs are identified, corresponding supports should also be identified to assist the consumer in meeting those needs. The person centered plan/plan of care will identify and document strategies to address risks identified in the Risk Assessment Tool and the Supports Intensity Scale. The Risk Assessment Tool and the Supports Intensity Scale can be used independently or in collaboration to identify potential risk to the participant.

### **Consumer Complaints**

The Department of Health and Human Services Ombudsman Program was created to address inquiries and complaints that consumers and their legal/guardians have regarding services that Department of Health and Human Services oversees or administers. Through this service, Office of Citizen Services staff serves as the central point of contact for the Department of Health and Human Services Secretary's Office, Governor's Office, other elected and appointed officials,

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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 Department of Health and Human Services or who are in need of human service programs are referred to the Department of Health and Human Services Ombudsman Program. When a complaint is received, Office of Citizen Services staff serves as a liaison between the resident and the Department of Health and Human Services program specialist. Office of Citizen Services' 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 him/her on the process and help the person 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 24 hours a day/7 days a week, by calling 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (TTY).

## Self-Direction

Self direction is an *option* currently afforded to individuals under CAP/Choice waiver program. CAP/Choice is a program of participant-directed care those who are elderly and/or have a disability, and/or their family/guardian, who wish to remain at home and have increased control over their services and supports. CAP/Choice reflects North Carolina's health reform policy objectives of promoting consumer choice and decision-making, reducing health-care costs, and identifying key stakeholders, especially consumers in its approach to reform the delivery of services. North Carolina's Division of Medical Assistance is committed to expanding the CAP/Choice program statewide. The services under CAP/Choice are currently offered in four North Carolina counties: Cabarrus, Duplin, Forsyth, and Surry. The waiver was approved March 31, 2008 with a retroactive date for services of January 1, 2008. A systematic roll-out to all of North Carolina's remaining counties will begin January 1, 2009. CAP/Choice services will become an option under the traditional CAP/DA waiver program, which is already implemented statewide. Training specific to CAP/Choice will be provided to the CAP/DA lead agencies not already providing CAP/Choice services.

North Carolina's Money Follows the Person Demonstration Grant project includes the same services as the CAP/Choice waiver with regard to compliance with the Freedom of Choice requirement. Participants and/or their family/guardian 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. CAP/ Choice participants have the opportunity to hire a personal assistant who is a family member, friend, or neighbor. Any individual hired by the CAP/Choice participant is not required to be an employee of a provider agency.

Under CAP/Choice, participants will be able to:

- Choose (hire) the Personal Assistant who will provide their care support
- Train, supervise and evaluate the worker
- Negotiate the rate of pay and other benefits
- Terminate the worker should this become necessary
- Select individual providers and direct reimbursement for specified waiver services
- Engage in a cooperative working arrangement with a financial manager (FM) who will pay the participant's worker, handle federal/state taxes and other payroll/benefit functions related to the employment of the worker, and reimburse service providers under the direction of the participant.

Self-Direction Support Provisions: Self-Directed Services is an option afforded the individual (or in the case of children, their parents or other legally responsible relatives) and others that the individual asks to assist him/her to direct some or all of the services and supports in their person-centered plan. Self-directed means that the individual or the family (in the case of minors) hires and directs the provider of services and directly authorizes the financial management services provider to make payment on the participant's behalf for a goods or service included in the person-centered plan.

Care advisors will inform individuals and/or families/guardians of the option to direct services and supports during the assessment and person-centered planning process. Each plan of care will include a risk assessment and identify appropriate risk management strategies. The individual who desires to direct his/her services will be assessed to determine if the individual is able to independently direct services. If the individual has a court appointed guardian, is a minor, or is assessed as needing assistance to direct services, a representative will be required for the individual to participate in Self-Directed Supports Option. The representative may be a family member, friend, legal guardian, other legally appointed representative, or income payee. A person who provides services to the individual may not be the representative. This includes any employee of a licensed facility where the individual lives or any member of an Alternative Family Living or foster home where the individual resides. The representative must:

- Demonstrate knowledge and understanding of the individual's needs and preferences
- Agree to a predetermined level of contact with the individual
- Be willing and able to comply with program requirements
- Be at least 18 years of age
- Be approved by the individual and/or his/her legal representative to act in this capacity.

Care advisors will be responsible for identifying the need for a representative for the individual and assuring that the representative meets established criteria.

Individuals who are considering the Self-Directed Supports Option will be provided educational opportunities and materials. They will have further educational opportunities through individual training and education services. The individual and/or their guardian, in conjunction with the planning team, will assess the need for Supports Brokerage and the specific activities to be performed for CAP/Choice participants. Care advisors will also be responsible for ensuring that the person-centered plan identifies how emergency back-up services will be furnished for workers employed by the individual and/or their guardian. As an added safeguard, provision may be made via on-call service agreements with licensed home health agencies to provide staff in the event that emergency back-up strategies, identified in the person-centered plan, cannot be implemented and there is the potential that the person's health and welfare would be jeopardized. The individual's care advisor will authorize the provision of these on-call emergency back-up services.

Refer to Attachment G for further details regarding self-direction as an option for individuals under CAP/Choice services. Note: Section III.n. (which indicates # of participants) is only a **goal** (a CMS required component of the waiver development) for North Carolina and is not an indication of the exact number of projected participants. Everyone enrolled in CAP/Choice will be afforded this option.

Self Direction is not available for individuals enrolling in CAP/MR-DD waiver program. North Carolina will submit to CMS on August 1, 2008 two new CAP-MR/DD waivers. These waivers will include a Supports waiver and a Comprehensive waiver, both to be implemented November 1, 2008 (per CMS approval) when the current Comprehensive waiver expires. The Supports Waiver will have the option to self-direct services including budget authority as well as employer authority. It should be noted that individuals served under the Supports waiver are individuals with more limited intensity of support needs who are currently reside in the state developmental centers. These individuals will have self-direction available to them. Individuals participating in

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Money Follows the Person would need more intensive services than the Supports waiver will provide and will therefore be enrolled in the Comprehensive waiver. These individuals will not have self-direction available to them.

## Quality

The purpose of the Quality Management Strategy is to ensure that discovery processes and systems for remediation and quality improvement take into consideration the specific and unique needs of individuals with developmental disabilities, mental retardation, physical disabilities and the elderly when they leaving public institutions and Private Intermediate Care Facilities-mental retardation. The quality management plan includes oversight of the success of the transition process, successes and barriers experiences in community living, effectiveness of back-up systems, and risks that might lead to re-institutionalization.

North Carolina is aware that the Money Follows the Person demonstration grant occurs within the State's overarching Quality Management Strategy for home and community based waiver services. To the degree possible it will enable the State to collect data across all waivers and all waiver participants and compare data between Money Follows the Person and non- Money Follows the Person waiver participants.

The North Carolina Quality Management Strategy is designed to capture data and address issues at every level – individual, provider, local management entity and lead agencies, and state. The assurances (level of care, service plan, qualified providers, health and welfare, and administrative authority) are addressed. Additionally, each waiver will address risk management, 24-hour back up, and critical incidents are required for Money Follows the Person participants.

CAP/DA and CAP/Choice waivers are currently in renewal and/or new submission status. It is anticipated that CAP/DA will be approved by CMS September 2008 and CAP/MR-DD November 2008. Each waiver will incorporate the required 3.5 version and will include all assurances, risk management, 24-hour back up, and critical incident as required for Money Follows the Person participants. Attachments H, H1 and I describe each waiver's Quality Management Strategy:

- Attachments H: CAP/DA and CAP/Choice.
- Attachments H1: CAP/MR-DD.
- Attachment I: PACE. PACE is a three-way agreement between the program, the State, and CMS and is an approved waiver using the 3.4 version.

## Housing

**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, the Secretary of the Department of Health and Human Services established the position of Housing Coordinator within this office. The Department of Health and Human Services Housing Work Group (HWG), with representatives of all Department of Health and Human Services service divisions, was 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 Department of Health and Human Services constituents.**

### **Ensuring Sufficient Qualified Residences**

As a result of this department-level commitment, the North Carolina Housing Finance Agency has partnered with the Department of Health and Human Services 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 the North Carolina Housing Finance Agency and the Department of Health and Human Services, is also available to Housing Credit properties funded since 2004 to ensure that 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 Department of Health and Human Services and the North Carolina Housing Finance Agency, 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.

The Department of Health and Human Services 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 Housing 400 Initiative, the Department of Health and Human Services–Housing Finance Agency partnership in addressing the housing needs of extremely low income persons with disabilities. In total, \$18.4 million of capital funding to the North Carolina 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 Money Follows the Person participants will be challenged to locate safe, decent, accessible, and affordable housing in communities of their choice. Participants 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 Web site of the North Carolina Housing Coalition. North Carolina has also implemented an online housing search tool, <http://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 Money Follows the Person participants will be invited to join one of 30 Housing Support Committees organized across the state. Access to the Housing Credit and Housing 400 Initiative units is managed at the local level by the Housing Support Committee, a collaborative of human service providers who have come together to make referrals to these new housing opportunities and ensure that tenants have access to the ongoing supportive services 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 Housing Support Committee in dealing with property management. Members of the Housing Support Committee make referrals to the property owner and the Local Lead Agency maintains a waiting list, in the event of turnover, once the specified number of targeted units is occupied. The Housing Support Committee members are 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, public housing agencies have been approached by the disability community, through the Housing Support Committee 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 public housing agencies are responding to pressure on their budgets to direct assistance to higher income levels. Efforts to engage public housing agencies for the benefit of the Money Follows the Person target populations will continue.

Although sometimes a challenge, individuals with developmental disabilities have a variety of options available for housing in the community. Supported living arrangements are available

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also using state funds in conjunction with waiver funding. These settings support individuals to live in their own apartment or in settings of one to three. Many individuals served through the CAP-MR/DD waiver are housed in alternative family living arrangements with families using waiver funding. In addition, the NC legislature has proposed in their fiscal year 2009 budget the allocation of additional funding to the Area Resource Center of North Carolina to provide housing to individuals with developmental disabilities.

Access to other qualified residences—community-based settings housing no more than four individuals—will likely require providers who are willing to re-tool existing residential settings licensed under North Carolina facility rules. Supervised Living settings are licensed under Mental Health, Developmental Disabilities and Substance Abuse rules; Family Care Homes are smaller board-and-care facilities. Both may serve as few as two individuals, but 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).

With additional targeted rental units, within both Housing Credit properties and smaller scale supportive housing developments, now continuously coming on line, Money Follows the Person participants who can live independently, and/or with in home assistance, will transition to independent rental housing. Many of these apartments are being constructed to provide a high degree of accessibility, bathrooms designed to allow full toilet transfers and curbless showers, features that will support a high degree of independence for persons with mobility impairments. For persons being transitioned who need a higher level of care or supervision, North Carolina anticipates their transition to small, 4 or less person, licensed shared living arrangements.

Qualified Residences

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

## **Continuity of Care Post Demonstration**

The State's efforts to rebalance long-term care support programs and meet demonstration objectives include continuity of care post demonstration. Money Follows the Person participants will be accessing existing 1915(c) waivers (CAP/DA, CAP/MR-DD Comprehensive, CAP/Choice) and Program of All-Inclusive Care for the Elderly (PACE). Participants will continue to be served through these waivers in the post-demonstration period as long as they continue to meet the eligibility criteria. Therefore, there will not be a lapse in services for Money Follows the Person demonstration participants and a transition plan is not required.

For those participants who do not meet waiver qualifications after 365 days of demonstration services, a transition service plan will be developed and assistance with referrals to supportive programs will be provided. Referrals may include connecting participants to local Councils on Aging and/or Departments on Aging, which coordinates aging services that provide transportation, personal care, chore services, adult day care, information and referral, outreach, and case management. For people with physical disabilities, a referral to the regional Center for Independent Living for assistance with services as well as a referral to the Department of Social Services for assessment of appropriate services will be made. For individuals needing personal care assistance, the State Medicaid Plan can be accessed.

Referrals will also be made to regional Aging and Disability Resource Connections. The Aging and Disability Resource Connections are an important community resource that can provide support to Money Follows the Person participants who are elderly and/or with disabilities regarding such services as insurance counseling, information referral and assistance, emergency rent assistance, and caregiver support. Aging and Disability Resource Connections staff will also assist consumers with evaluating all services for which they may qualify and provide assistance with applying for those services.

## Organization and Administration

### Organizational Structure

The North Carolina Money Follows the Person demonstration grant will be managed by the Department of Health and Human Services. This structure will provide great coordination of services across programs as well as high-level support within the Department of Health and Human Services. The Division of Medical Assistance will have oversight responsibilities for the grant.

**Attachment E** is an organizational chart for the Money Follows the Person demonstration grant.

### Staffing Plan

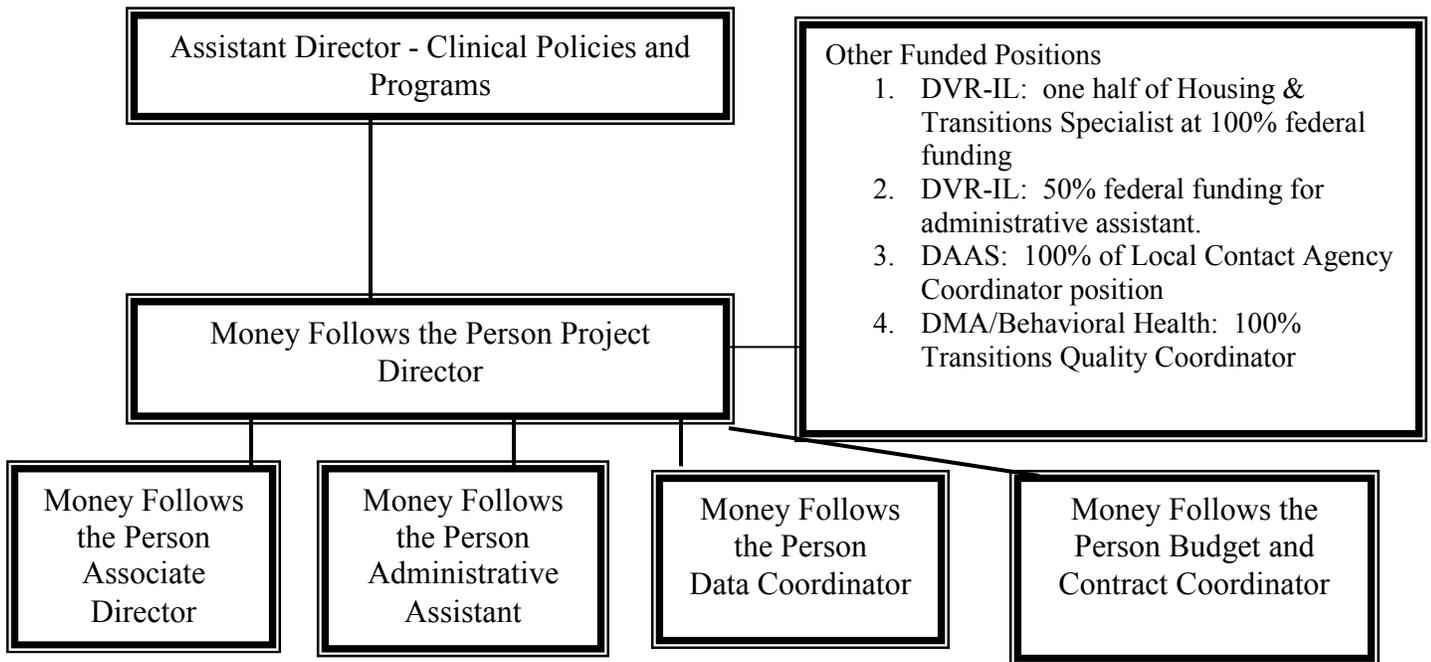
Project staff for the North Carolina Money Follows the Person demonstration grant will include:

- a. **Project Director:** A Project Director, hired to provide direct management of the project, started in the position on February 28, 2008. The project director will be responsible for the project management, policy development, outreach development, budget management, supervision of project staff, and training and program analysis. Program Specialist
- b. **Associate Director:** To ensure that the effort can give proper attention to long-term systemic rebalancing initiatives while remaining responsive and thoughtful to the transition needs of MFP participants; the Project will retain an Associate Director. The Associate Director's core functions will be:
  - Oversee the transition process of every MFP participant;
  - Address challenges and issues related to the transition practices;
  - Oversee Transition Coordination contract;
  - Assist with outreach efforts about the Project.
- c. **Data Coordinator:** The Data Coordinator develops, implements and maintains automated systems for data collection and analysis to ensure the efficiency and integrity of MFP data reporting. The Data Coordinator is responsible for managing accurate data related to:
  - Manage Project data sets related to transition benchmarks;
  - Manage Project data reporting requirements such as quarterly "data set" reports and bi-annual reports;
  - In collaboration with other MFP staff, organize information for the Project's financial reporting requirements.
  - Quality of Life surveys
  - Other Project information as needed.

The Data Coordinator will evaluate the need for new data elements and systems and incorporate with the approval of the MFP Project Director. The Data Coordinator assists the Project Director in data analysis; prepares reports for the MFP Project; coordinates with other entities to meet the Project's data collection needs and provides guidance to MFP Program staff in the development and integration of new methods and procedures associated with the information systems and data required for advancing the organization's performance improvement efforts.

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- d. Administrative Coordinator  
 This person will assist the Project Director and Program Specialist in administrative duties and office functions.
- e. Budget and Contracts Coordinator  
 Effective July, 2012, MFP will hire a Budget and Contracts coordinator to coordinate with the Project Director to manage the Project's budget and financial management functions and to assist in the development and monitoring of the Project's expanding number of contracts and formal partnerships with sister agencies and private, community contractors.



### **Billing and Reimbursement Procedures**

The Medicaid Program's fiscal agent, Electronic Data Systems Corporation, is responsible for ensuring that CAP/DA, CAP/Choice, and CAP/MR-DD claims are paid correctly through a contract with the Division of Medical Assistance. Electronic Data Systems Corporation has established edits and audits in the claims payment system to ensure that payment is made in accordance with the approved methodology. Division of Medical Assistance provides oversight to the contract work performed by Electronic Data Systems Corporation.

The Program Integrity section in the Division of Medical Assistance conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid, identifies and collects provider and recipient overpayments, educates providers and recipients when errors or abuse is detected, ensures that recipients' rights are protected, and identifies needs for policy and procedure definitions or clarifications.

Post-payment reviews by the Division of Medical Assistance look at the complete audit trail: the approval of the person-centered plan, the case manager's authorization to the provider to render approved services, service provision, service documentation, and the case manager's authorization for claims submission and actual claims data.

CAP/Choice participant files are monitored as submitted and/or changed by the Division of Medical Assistance quality assurance contractor, The Carolinas Center for Medical Excellence. Quality assurance reviews determine that participants are classified correctly at either the intermediate-care or skilled-nursing level of inpatient facility care. Results of monthly monitoring are reviewed by Division of Medical Assistance CAP consultants and shared with the agencies that have been reviewed. The findings enable the agencies to improve the manner in which CAP/Choice is operated. The quality assurance review process is not a negative process, but one that leads to the strengthening of program. Additionally, The Carolinas Center for Medical Excellence looks at claims data for possible inappropriate payment of services and monthly budget monitoring.

The Resource/Regulatory Team of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services 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. These data provide the ability to view services paid per individual consumer, as well as per individual Local Management Entity or provider, and may be used in the event that there is a concern or complaint received regarding a specific consumer or provider. The Division of Mental Health/Developmental Disabilities/Substance Abuse Services Accountability Team and the Division of Medical Assistance Behavioral Health Unit routinely conduct a Medicaid Compliance Audit that includes the waiver services. Auditors review Medicaid-billed events for a sample of individual directly enrolled providers. This review includes monitoring of both Division of Medical Assistance/Waiver and Division of Mental Health/Developmental Disabilities/Substance Abuse Services requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocols. These reviews ensure that documentation and other requirements are followed for services providers bill to Medicaid and for which they are paid.

## **Evaluation**

Evaluation is not a required component of the Money Follows the Person Operational Protocol. Although states may propose to evaluate unique design elements from their proposed Money Follows the Person programs, the state of North Carolina has opted not to include its own evaluation. The State will utilize data collected by the national evaluator (Mathematica, Inc.) for the Money Follows the Person evaluation as indicators of the project's effectiveness.

## Final Project Budget

### **Budget Presentation and Narrative**

North Carolina's budget projections for this grant are based on the anticipated enrollment of 304 individuals for the 2007-2011 project periods. The State utilized existing data and experience gained from its earlier nursing home transition grant and from its Case Management System to estimate the number of individuals that would likely be eligible under the terms of the grant. The State based its cost allocations on the uniform transition of the 304 individuals over each month of the implementation grant.

### Medicaid Administrative Costs

The State has hired a full time Grant Project Director who is responsible for grant's operations. The State projects hiring a Project Program Specialist with a base salary of approximately \$57,979 and the Administrative Assistant with a base salary of approximately \$26,825. The two salaries include related fringe benefits of 33% for each position. In addition, the State is projecting ancillary expenditures including travel, equipment, supplies, brochures, and postage to be approximately \$60,000 over the life of the grant. The State projects the total administrative expenditures to be approximately \$720,161 over the life of the grant.

### Qualified Home and Community-Based Services

The State also projected the 304 individuals would need to utilize more qualified Home and Community-based services due to these individuals having previously resided in a qualified inpatient facility for at least a three-month period. It has been the States experience that one of the larger impediments to transitioning to the community has been a lack of community support. In response to this the state has budgeted for a larger percentage of services being utilized.

### Home and Community-based Demonstration Services

The State is up-dating all CAP waivers to incorporate the new demonstration services that will be used to support individuals in their efforts to access services in the community. These services are mandated to be imposed no later than March 2010. The CAP/DA services will be bundled, which are projected to be utilized by more than 50% of the Money Follows the Person target population, and will address an important gap in the State's long term system. CAP/MRDD services will be utilized by the state and non-state ran ICFR facilities. Based on previous experience with the nursing home transition grant it is the State's experience that this service will be a resource for community services and assist with education and training of the individual community supports for those choosing to transition from the institutional setting.

### Supplemental Demonstration Services

The state is projecting that a less than 10% of the individuals to be served through the Money Follows the Person grant will utilize the State's supplemental demonstration service of adaptive devices. From previous experience the State has determined a need for adaptive devices including lift chairs, automatic door openers and other electronic assistive devices.

### **Money Follows the Person Budget Forms**

See Attachments N, N1, N2.

## Attachment A

### Community Options Interest Survey: CAP/MR-DD

Guardian: \_\_\_\_\_ Resident: \_\_\_\_\_

Surveyor: \_\_\_\_\_ Date of Survey: \_\_\_\_\_

Hello. My name is \_\_\_\_\_ and I am a \_\_\_\_\_ at the \_\_\_\_\_ Center. We are calling all of the residents [**or the legal 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 exploring opportunities for individuals to live in community homes with the supports they need to be safe, happy, and healthy. We want input from you as a resident [**or as \_\_\_\_\_'s legal guardian**] on your interest in community living.

If there were an option for you [**or for the individual in your guardianship**] to relocate to a community living arrangement, what circumstances or conditions would you [**or for the individual in your guardianship**] need to consider before making a decision to live in the community?

**a. The location of the community arrangement**

Community located close to family \_\_\_ Yes \_\_\_ No  
A particular region in the state \_\_\_\_\_  
A particular county in the state \_\_\_\_\_

**b. The type of living arrangement**

Home owned or leased by you or a family member \_\_\_ Yes \_\_\_ No  
Apartment leased by you or a family member \_\_\_ Yes \_\_\_ No  
Public housing \_\_\_ Yes \_\_\_ No  
Assisted living with individual living, sleeping, bathing, and cooking areas \_\_\_ Yes \_\_\_ No  
Community-based residence with fewer than four unrelated individuals \_\_\_ Yes \_\_\_ No

**c. Services and supports**

Personal emergency response services \_\_\_ Yes \_\_\_ No  
Respite care \_\_\_ Yes \_\_\_ No  
In-home aide services \_\_\_ Yes \_\_\_ No  
Preparation and delivery of meals \_\_\_ Yes \_\_\_ No  
Specialized equipment or supplies \_\_\_ Yes \_\_\_ No  
Consumer-directed care advisory \_\_\_ Yes \_\_\_ No  
Consumer-directed financial management \_\_\_ Yes \_\_\_ No  
Augmentative communications \_\_\_ Yes \_\_\_ No  
Home modifications \_\_\_ Yes \_\_\_ No  
Non-medical transportation \_\_\_ Yes \_\_\_ No  
Specialized consultative services \_\_\_ Yes \_\_\_ No  
Home modifications \_\_\_ Yes \_\_\_ No  
Vehicle adaptations \_\_\_ Yes \_\_\_ No  
Transition expenses \_\_\_ Yes \_\_\_ No

Money Follows the Person Operational Protocol  
N.C. Department of Health and Human Services

- d. Need immediate and consistent access to quality healthcare?  Yes  No
- e. Behavioral supports and crisis services that meet your needs?  Yes  No

Surveyor's Comments:

## Attachment B

### DRAFT CHOOSING WHERE YOU LIVE North Carolina Money Follows the Person Demonstration Grant

Name of Resident \_\_\_\_\_

Name of Resident's Guardian (if applicable) \_\_\_\_\_

This a Full Guardianship\_\_ Partial Guardianship\_\_

Name of Surveyor: \_\_\_\_\_

Date of Survey: \_\_\_\_\_

Where Survey Conversation Occurred \_\_\_\_\_

Survey Conducted with \_\_Resident \_\_Guardian \_\_Both



#### DID YOU KNOW YOU CAN CHOOSE WHERE YOU LIVE?

There are lots of different places you can live.

With the right kind of supports, you can live in your own place, like in a house or an apartment (sometimes with another person). You can also live in a “group home” with a few other people who use services. Living in your own home or in a group home is usually called “living in the community.”

You can stay here in the \_\_\_\_\_ [name of ICF-MR] but you do not have to.

We know that deciding where you live is a really big decision. No matter where you live, there will be challenges. But we think it is important for YOU to decide where you live and we want to make sure you are comfortable with whatever decision you make.

Right now, we just want you to know there are different options out there.

**CHOOSING WHERE YOU LIVE SURVEY**

**Page 2**

**Where I Live (check one):**

I really want to live in my own home or a group home. I do not want to live here anymore.

If possible, I would really like to live in: \_\_\_\_\_ [name of town or area of state].

I'm not sure I know what part of the state I want to live in.

I am really happy here and do not want to move right now.

I am not sure where I want to live. I want to learn more about the different places I could live and think more about it.

**How I Would Like to Learn More (check as many as you want):**

I want to talk to people who live in their own homes or group homes.

I want to see pictures or watch movies about people who live in their own homes or group homes.

I want to visit people living in their own homes or group homes.

I really want \_\_\_\_\_ [person's name] to talk with me about this.

Other Ways:

**Questions I Have Right Now** [Surveyor will assist in securing answers]:

**Surveyor Comments:**

## Attachment C

### NC MFP Informed Consent and Authorization to Share Information



Hello!

We are so glad that the North Carolina Money Follows the Person Demonstration Project (NC MFP) may be able to assist you in returning to your home and community. Thank you for taking the time to read this information. We want to make sure you have a clear understanding of the NC MFP Project and its transition process. **We know there is a lot of information here, so please don't hesitate to ask questions and get assistance. We're happy to help.** Thanks for Your Interest in NC MFP!

The NC MFP Staff  
1-855-761-9030

#### To Complete this Form, Think "Inside the Box"



Throughout this document there are places to check a box. By checking the box, you are showing that you have read and understand the material in that particular section of this Informed Consent Form.

#### Information about Who Qualifies For NC MFP:

Money Follows the Person (MFP) is a demonstration project that assists individuals in North Carolina to move from qualified institutions back into their own communities. To be eligible for MFP, a person must:

- Currently reside in an institution for intellectual and/or developmental disabilities (private or state-operated ICF-MR facility) or currently placed at a skilled nursing facility for three months or longer.
  - The eligibility timeframe may be impacted if facility services have been

paid for with Medicare Part A funding.

- Be eligible for Medicaid prior to transitioning back into the community.
- Move into a qualified community residence which includes the following: a home owned or leased by the individual or that individual's family member, an apartment with a monthly lease including lockable access along with living, sleeping, bathing, and cooking areas which the individual or their family have domain over, or a residence in a community-based setting with no more than four unrelated individuals reside.
- Meet the eligibility requirements/criteria of the waiver or PACE program that s/he intends on using upon transition.

**YES, I have read this section and understand what it means.**

### **Your Responsibilities In the Transition Process:**

The success of a transition relies on collaborative work by the participant, family, guardian, friends, community based programs, case manager, transition coordinator, and MFP staff.

- To the extent possible, the MFP participant will guide his/her own transition process and assume responsibilities in ensuring the transition occurs (i.e. calling possible housing options, identifying a bank, etc.)
  - Along with their families as appropriate, MFP participants agree to help develop their Transition Plan, including goals designed to make community based living reasonable and accessible resources outlined.
  - Along with their families as appropriate, work with the entities that are making community based living an option by achieving set goals within set time frames (like not cancelling meetings at the last minute, following up on my “to do list” as appropriate, returning calls promptly, etc.)
- YES, I have read this Section and agree to do my part to make sure my transition is organized and well-planned.**

### **Transition Year Stability Resource Funding**

- Depending on the community services you need, NC MFP participants may have access to up to \$3,000.00 of “start up” funds to help cover the cost of the one-time expenses associated with transitioning that cannot be accommodated in the waiver budget.
  - Examples include: housing and utility deposits, deposits on personal emergency response systems, home modifications and household supplies.
  - These funds are available up to 365 days AFTER you transition.
  - Funding requests are submitted by the CAP or PACE Lead Agency and must be authorized by MFP staff.
- YES, I have read this Section and understand the “basics” of the Transition Year Stability Resource Fund**

### **MFP Quality of Life Survey**

- Each MFP participant can help ensure that NC and Medicaid have good data in order to improve the services needed by transitioning individuals by participating the Quality of Life survey effort.
- I understand that I will be asked to participate in a Quality of Life Survey three times: before I transition, about one year after I transition and two years after I transition.
- I understand that participation in this survey process is voluntary, confidential and will not impact my ability to transition.
- Participation in the survey will help MFP build services and supports that better support people to return to and remain in their own homes and communities.

- MFP staff or Quality of Life Surveyors designated by MFP staff will be contacting you to participate in these surveys.
- YES, I have read this Section and understand I will be asked to participate in the MFP Quality of Life Survey three times: once before I transition and twice after I transition.**

### **Continuation of Care**

Upon the 365<sup>th</sup> day of participating in the MFP Demonstration Project, you may continue with wavier services if you continue to meet the wavier program's level of care and other requirements.

- YES, I understand that if my circumstances don't change, my services should continue after my MFP participation ends.**

### **Enrollment, Disenrollment and Re-enrollment**

#### **Important Information about Discharging from the Facility and MFP Enrollment:**

It's important that you coordinate your discharge date with your MFP transition team. If you transition without having an approved MFP application and without MFP staff knowledge, **you may lose your MFP status**. This means you will not be eligible for MFP's "start up" funds or have priority status for CAP services.

- YES, I understand that I may not be eligible for MFP services if I discharge without coordinating with MFP staff.**

#### **Important Information about MFP Re-Enrollment Once You Transition Into the Community**

Any MFP participant that is re-institutionalized for a period longer than 30 consecutive days will be considered **disenrolled** from the program. However the individual is eligible for re-enrollment without re-establishing the three month institutionalization requirements, as long as the individual meets Medicaid wavier eligibility criteria. The participant then will be eligible for MFP services at the enhanced Federal Medicaid Assistance Percentage match. Any participant having 3 incidences of re-institutionalization of 30 consecutive days or longer will not be considered for reentry into the MFP Project.

Any former participant may re-enroll after being re-evaluated and with an updated plan of care in place. Once the individual is found eligible for community based services the updated plan of care addressing any change in the status of the MFP participant and/or any concerns with lack of necessary community supports will be submitted to MFP staff for review. If a former participant reenters a qualified institution for 6 months or longer then the participant will be defined as a "new" MFP participant if they wish to consider transitioning again.

- YES, I understand this Enrollment and Re-Enrollment Policy.**

### **Withdrawal**

Since the MFP Demonstration Project is voluntary, a participant is able to withdraw at any point by making the request in writing to the Project at any time. MFP participants also have the right to appeal under the CAP wavier or PACE program, depending on which he/she is enrolled.

- YES, I understand I can withdraw from the MFP Program at any time by letting the Project Staff know in writing.**

**Complaints**

MFP staff strives to be responsive to concerns and issues that you may have. We encourage you to contact us directly if you have concerns about the quality of service you are receiving. We may be able to help you resolve your concerns and encourage you to call our toll-free number at: 1-855-761-9030. If we have not been able to resolve your concerns or you would prefer to not discuss your issue with MFP staff, the Department of Health and Human Services (DHHS) Ombudsman Program was created to address inquiries and complaints that consumers and their legal guardians have regarding services that DHHS oversees or administers. The Regional Long Term Care Ombudsman program can also be accessed through the CARE-LINE 24 hours a day, 7 days a week, by calling 1-800-662-7030 (English or Spanish) or 1-877-452-2514 (TTY).

- YES, I understand the different ways to make a complaint about the services I receive through NC MFP.**

**Giving my Consent**

- By checking here and signing below, I am letting MFP staff know that I understand the information contained in this MFP Informed Consent document.
  - By checking here and signing below, I am letting MFP staff know that I have asked any questions I have at this point and understand I may ask additional questions at any time.
  - By checking here and signing below, I understand I can get a copy of this document any time I want one.
  - By checking here and signing below, I understand that I can change my mind about these agreements at any time, but changing my mind may impact my ability to participate in the MFP Project.
  - By checking here and signing below, this document is valid for one year after the date of my transition or earlier, if I decide to revoke it.
- YES, I would like to become a North Carolina Money Follows the Person participant.**

**SIGNATURES:**

\_\_\_\_\_ Name of MFP Applicant (please print)

\_\_\_\_\_ Signature of MFP Applicant

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Guardian or Authorized Representative (if applicable)

\_\_\_\_\_ Date

**MFP APPLICATION:  
 AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**  
**Please complete this document as part of your MFP Application**



MFP Applicant Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 MFP Applicant Medicaid Identification  
 Number: \_\_\_\_\_

To ensure a coordinated and organized transition to a new place of residence, I \_\_\_\_\_ (MFP Applicant or Authorized Representative) hereby authorize NC Money Follows the Person Staff and Transition Coordinators to disclose my/the MFP Applicant's name, location and health information related to the transition process to the following agencies:

Description of Agency	Reason for Contacting	Notes
The facility in which you currently live (for example, the social worker and billing specialist there).	To begin transition coordination process To ensure your eligibility for this Project	
The Medicaid entity that oversees case management services in your area.	To ensure they can participate in the planning process.	Examples include: Local CAP DA Lead Agency or Local Management Entity
The Division of Vocational Rehabilitation's Independent Living Office	To help coordinate the transition process (if applicable) To access supports around home modifications and assistive technology (as applicable)	This may not be necessary for every MFP participant
The local Department of Social Services (DSS) (for example, the Medicaid Representative)	To help clarify questions about your Medicaid enrollment or possible deductible status.	
The local agency that will be doing our follow up Quality of Life Surveys and may provide benefits counseling.	To help identify local resources that may be helpful in transitioning and to conduct MFP Quality of Life Surveys.	These are agencies under contract with DHHS to provide options counseling or other services. These agencies are usually local nonprofit organizations and are under the same privacy requirements as

		MFP.
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**IMPORTANT**

**If you have concerns about MFP staff and transition coordinators contacting any of the entities listed above, please explain here:**

**ADDITIONAL INFORMATION ABOUT SHARING HEALTH INFORMATION AND YOUR PRIVACY**

\* MFP Project Staff is happy to provide additional explanation if you have any questions about information below.

I understand that this authorization will expire on the following date, event or condition:

One year after I transition under MFP or if I decide to leave the MFP program

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

(Signature of Client)	(Date)	(Witness-If Required)
(Signature of Personal Representative)	(Date)	(Personal Representative Relationship/Authority)

\*\*\*\*\*

NOTE: This Authorization was revoked on \_\_\_\_\_

(Date)

(Signature of Staff)

## Attachment D

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

#### ***The Money Follows the Person 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 an inpatient facility 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 inpatient facilities 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 inpatient facility 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 Money Follows the Person Demonstration Grant in May 2007.

#### **What is the purpose of North Carolina’s Money Follows the Person 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 304 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 Money Follows the Person Demonstration Grant project?**

During the course of the Project, North Carolina wants to support **at least** 304 people who are currently in inpatient facilities 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.

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**How long will Money Follows the Person Demonstration Grant project last?**

Until September 30, 2011.

**What happens when the Money Follows the Person 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 an inpatient facility or institution to receive those same services in their homes and communities.

**How is Money Follows the Person Demonstration Grant project different from other Money Follows the Person advocacy efforts in North Carolina?**

In addition to North Carolina's Money Follows the Person 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 an inpatient facility or institution to receive those same services in their homes and communities. The Money Follows the Person Demonstration Grant project (*a federally funded initiative*) targets 304 people in North Carolina, 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 Money Follows the Person Demonstration Grant project?**

Trish Farnham, Project Director

[Trish.farnham@dhhs.nc.gov](mailto:Trish.farnham@dhhs.nc.gov)

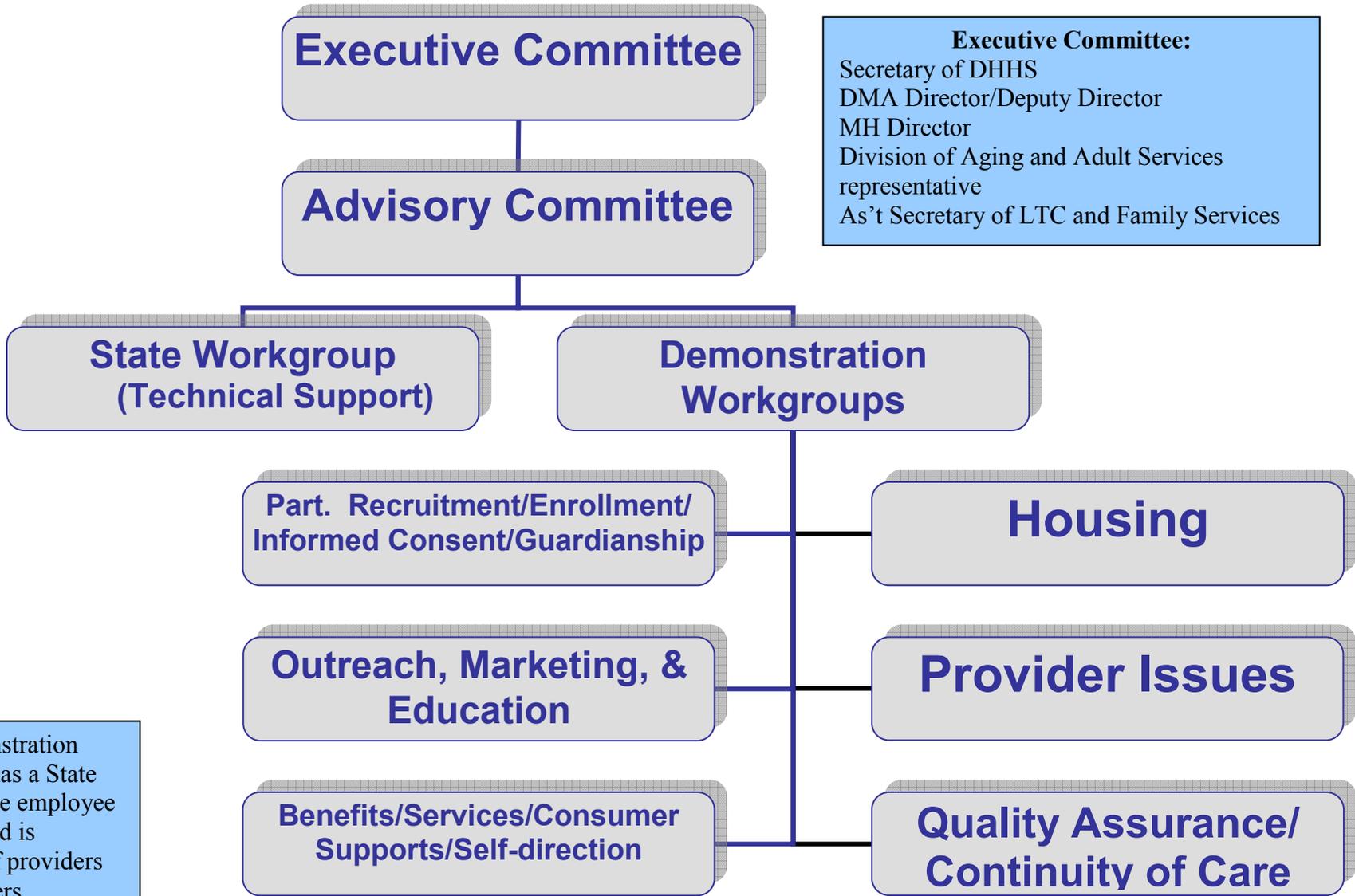
919-855-4274

**Is there a Web site where I can learn more about North Carolina's Money Follows the Person Demonstration Grant project?**

North Carolina Division of Medical Assistance has created a site for the Money Follows the Person Demonstration Grant project. Please visit <http://www.ncmfp.com>.

The North Carolina Disability Action Network (NCDAN) is following the Money Follows the Person Demonstration Grant project's progress and has lots of useful information including a link to the site above. NCDAN's Web site: <http://www.ncdan.com>

**Attachment E**



Each Demonstration workgroup has a State and non-State employee facilitator and is composed of providers and consumers.

## Attachment F

(Opening page of NCcareLINK Web site)

- 
- Text Size:
- [Help](#)
- [Contact Us](#)



- [Home](#)
- [Search By Keyword](#)
- [Search By Topics](#)
- [My NCcareLINK](#)

## Welcome to North Carolina's careLINK

A comprehensive health and human services Web site.

This Web site provides up-to-date information about programs and services across North Carolina for families, seniors, youths and everyone in-between. It is a collaborative effort of the North Carolina Department of Health and Human Services and many other government and non-profit information and referral stakeholders across North Carolina. Click the Start a Search button to get started.

### Neighborhoods



#### [Services for Veterans](#)

The Veterans and their Families Resources Neighborhood is a statewide link to assist veterans and their families find a variety of programs. This section can assist the veteran in finding services including Veterans Benefits Assistance, Financial Assistance, Hospital and Medical Services, Counseling Services and other veteran related services.



#### [Family and Children Resources](#)

The Family and Children Resources Neighborhood is a statewide link to help you meet the wide spectrum of needs of your children or family. This section of NCcareLINK will help you connect to resources that will allow you and your family to achieve self sufficiency. You will be able to link to a variety of services including resources for day care, medical care, education, child support, adoption and foster care, assistance with food and clothing needs and much more.



#### [Services for Older Adults](#)

The Services for Older Adults Neighborhood of NCcareLINK will help seniors, their families, and caregivers focus on finding the help they need. This is your direct link to a variety of services including: adult day care programs and inpatient facility, employment, family and caregiver support programs, health, housing and long term care options.



[People with Disabilities Connection](#)

The People with Disabilities Connection Neighborhood is a statewide link to resources and services. This is your connection to a variety of resources that will help you in achieving equal access, effective communication and a better quality of life. Some services include supports for living independently, residential care, communication and technology, community advocacy and employment.

## Take Me To . . .

[Find My Vet Center](#)

Vet Centers provide readjustment counseling and outreach services to all veterans who served in any combat zone. Services are also available for their family members for military related issues. Veterans have earned these benefits through their service and all are provided at no cost to the veteran or family.

[Provider Portal](#)

The provider portal section allows resource providers access to their existing information for updating purposes. The provider portal also allows new resource providers to add their information and to become an essential resource to the community. Click on the "Provider Portal" link above to go there.

[Partners Page](#)

NCcareLINK is a collaboration of partners throughout North Carolina that provide the most current resource information. [Click to visit the NCcareLINK partner's page.](#)



## Sign In to Save Resources

If you are already a registered user, sign in below. If you'd like to register, go to the [registration page](#).

Note: User ID and Password are case-sensitive.

User ID  Password    Remember Me

[Forgot Your Password?](#)

[Forgot Your User ID?](#)

[Need to Register?](#)

[How We Protect Your Privacy](#)

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**Opening page for link to People with Disabilities Connection  
on NCcareLINK resource Web site**



- [Home](#)
- [Search By Keyword](#)
- [Search By Topics](#)
- [My NCcareLINK](#)

## People with Disabilities Connection

The People with Disabilities Connection Neighborhood is a statewide link to resources and services. This is your connection to a variety of resources that will help you in achieving equal access, effective communication and a better quality of life. Some services include supports for living independently, residential care, communication and technology, community advocacy and employment.

## Popular Search Topics

- [Caregiver Supports](#)
- [Chemical & Mental Health](#)
- [Communications](#)
- [Education](#)
- [Employment](#)
- [Financial](#)
- [Food](#)
- [Health Services & Equipment](#)
- [Home and Community Living](#)
- [Housing](#)
- [Legal & Advocacy](#)
- [Leisure](#)
- [Long Term Care Ombudsman](#)
- [Public Benefits](#)
- [Technology & Modifications](#)
- [Transportation & Driving](#)

## Take Me To . . .

### [NCcareLINK Main Page](#)

Online access to statewide community resources.

### [Find My Vet Center](#)

Vet Centers provide readjustment counseling and outreach services to all veterans who served in any combat zone. Services are also available for their family members for military related issues. Veterans have earned these benefits through their service and all are provided at no cost to the veteran or family.

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Note: User ID and Password are case-sensitive.

User ID  Password    Remember Me

[Forgot Your Password?](#)

[Forgot Your User ID?](#)

[Need to Register?](#)

[How We Protect Your Privacy](#)

- [Legal](#)
- [Privacy](#)
- [Disclaimer](#)
- [Accessibility Policy](#)
- [Accessibility Tips](#)
- [Technical Problems](#)
- [General Info](#)
- [Satisfaction Survey](#)

## Attachment G Self-Direction

### I. Participant Centered Service Plan Development

a. **Responsibility for Service Plan Development.** Specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

X	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
X	Case Manager. <i>Specify qualifications:</i>
X	Social Worker. <i>Specify qualifications:</i> Social Worker I or higher as specified by the North Carolina Office of State Personnel. Social Worker I requires a bachelor's degree in a human services field from an accredited college or university; bachelor's degree from an accredited college or university and one year directly related experience.
<input type="checkbox"/>	Other ( <i>specify the individuals and their qualifications</i> ):

b. **Service Plan Development Safeguards.** *Select one:*

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other services to the participant.
X	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i> All lead agencies have a freedom of choice policy and freedom of choice documents that are required to be signed by participants after plan of care development is completed. These documents explain the participant's choice to choose from any qualified provider for their traditional services at any time, upon request. Additionally, participants in this waiver have the extra responsibility of choosing and directing other specific waiver services (e.g. personal assistant, respite, supplies, etc.). A backup plan is developed to assure that the needed assistance will be provided if any key supports identified in the plan are temporarily unavailable. Participants are also informed of due process rights if they disagree with any decisions made by the care advisor. Consultants from Division of Medical Assistance conduct agency reviews and review plans. Additional monitoring of services is given in situations where the entity providing care advisement also provides another waiver service. This occurs sometimes in more rural regions of North Carolina.

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The care advisor assists the participant in assessing individual needs and developing a plan of care including a participant-directed budget. The care advisor provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate. The care advisor monitors the provision of care and expenditures and maintains contact with the participant to assure the needed care is being provided. The care advisor is also responsible for identifying the need for a representative and assuring that representatives are capable of meeting the needs of the participant.

The role of participants is greater in CAP/Choice than in the traditional program CAP/DA. In CAP/CHOICE participants have more control over resources. With this increased control comes increased responsibility. The key responsibilities of the participant or designated representative are:

- Develop a plan of care with assistance/support from the care advisor;
- Recruit, hire, and manage personal assistant and other individual providers of participant-directed services;
- Prepare an outline of duties and work schedule for personal assistant;
- Negotiate salary and benefits with the assistant;
- Notify assistant of any changes in schedule in a timely manner;
- Train and evaluate personal assistant;
- Negotiate reimbursement or payment rates with individual providers;
- Develop a back-up/emergency plan (alternative caregivers);
- Serve as employer of record for personal assistant;
- Verify accuracy of documentation or provide documentation, as appropriate, to financial manager regarding services provided;
- Report concerns to care advisor about service delivery or representative that affect health and well-being; and,
- Uphold all program agreements as written.

- d. Service Plan Development Process** In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The following individuals are responsible for the preparation of the plans of care:  
The Participant and the care advisor.

(b) A registered nurse and social worker team meet with the applicant/significant others to conduct an assessment and determine the need for a representative.

(c) During the intake process, a care advisor or case manager knowledgeable of participant-directed care provides information on both the traditional and participant-directed care program and the applicant decides which program he/she wishes to pursue.

(d) The plan of care and supporting documents are reviewed by and approved by someone at the lead agency other than the care advisor, after agreement and signature by the participant and/or representative and care advisor. Focus is on the ability to meet the identified needs of the participant within the budget limitations whilst maintaining the participant's health, safety and well-being.

The contracted Quality Assurance/Quality Improvement agency, as well as Division of Medical Assistance consultants, is able to perform ongoing review of plans of care as well as more in-depth reviews on site monitoring visits.

(e) The care advisor assists the applicant in developing a plan of care including both unpaid and paid services, and calculates the participant budget according to state requirements.

(f) The care advisor will assist with development of plan of care and emergency/back-up plan; provide information and skills training to participant/participant's representative; provide worker orientation to participant-directed care; monitor plan of care for quality assurance purposes. Also, waiver program consultants from the State Medicaid agency conduct annual, on-site program reviews and assist/advise with local operation of the waiver program as needed.

(g) Plans of care are updated as many times as warranted by a change in health status, need, etc. However, re-evaluations of the level of care are required at least annually or sooner if there are indications that the participant's condition/level of care has changed. A new assessment and plan of care are required at the same time as the annual level of care re-evaluation.

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The state has procedures to promote family or individual preferences and selections. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

Participants and/or designated representative will be fully involved in the needs assessment process and will select personal assistants based on their (vs. agency) preferences. The participant will train the assistant and determine whether task competencies are met. In assuming these responsibilities, the participant necessarily takes on risk that was previously assumed by provider agencies and program managers. Participants who participate in this program will therefore enter into agreements with the lead agencies which outline rights, risk and responsibilities.

A back-up plan is also developed to assure that the needed assistance will be provided if any key supports identified in the Plan are temporarily unavailable. The Care Advisor provides the information and skills training needed to manage one's own care in the areas of rights and responsibilities of both the Consumer and Worker; recruiting and hiring workers; developing schedules and outlining duties; supervising and evaluating workers; reporting on personal assistance expenditures; and other relevant information and training.

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

The care advisor is available to the participant throughout the planning and service delivery process to provide skills training and information relevant to home care, worker employment, etc. The amount of assistance from the advisor will vary from participant to participant depending upon need. Care advisors are to make available to the participant a comprehensive list of qualified providers in, or having the ability to provide services in the applicable service area. This list will be made available upon the participant's or the representative's request.

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

The same basic care planning process currently used in the elderly/disabled Home and Community Based Services waiver, CAP/DA, will apply to CAP/Choice with the addition that the process will be guided by principles of participant-directed care. Currently the steps in the entry process are:

1. During the intake process, a care advisor or case manager knowledgeable of participant-directed care provides information on both the traditional and participant-directed care program and the applicant decides which program he/she wishes to pursue;
2. A health care professional along with the planning team meet with the applicant/significant others to conduct an assessment and determine the need for a representative;
3. The care advisor assists the applicant in developing a plan of care including both unpaid and paid services, and calculates the participant budget;
4. The care advisor submits the plan to the designated position in the lead agency for approval.
5. Once approval is obtained, services are implemented by the care advisor or participant, as specified in the plan; and,
6. Post-approval reviews by Carolinas Center for Medicaid Excellence quality assurance processes and Division of Medical Assistance consultants are conducted as requested or Plan is sent to Division of Medical Assistance.

- h. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other ( <i>specify</i> ):
	Lead agencies in each county. Note: due to the current use of the AQUIP, an automated assessment and plan of care system, the Division of Medical Assistance has access to electronic records via a secured Web site at any time.

**II. Service Plan Implementation and Monitoring**

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) Care advisors and CAP/Choice program consultants ensure that waiver services are furnished in accordance with the plan of care by maintaining regular contact with the participant and/or designated representative. Monthly contact is required via telephone and/or home visit. Home visits are required a minimum of quarterly.

(b) & (c) Method and Frequency of Oversight/Monitoring: Waiver program consultants from the State Medicaid agency conduct annual, on-site program reviews and assist/advise with local operation of the waiver program as needed. These visits occur every 12-18 months.

**b. Monitoring Safeguards. Select one:**

<input type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input checked="" type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>
	<p>(a) Adequate standards for all types of providers that furnish services under the waiver.</p> <p>(b) Assurance that applicable state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements will be met on the date that the services are furnished.</p> <p>(c) Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities. Participants are provided the freedom of choice amongst providers and are educated on all due process rights. Division of Medical Assistance consultants provide technical assistance and review this information on request and/or at program site visits.</p>

**III. Overview of Self-Direction**

**a. Description of Self-Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration’s approach to participant direction.

(a) Under CAP/Choice, participants will be able to:

- Choose (hire) the personal assistant who will provide their care;
- Train, supervise and evaluate the worker;
- Negotiate the rate of pay and other benefits;
- Release the worker should this become necessary;
- Select individual providers and direct reimbursement for several other waiver services (identified previously in Appendix C-1/C-3 of the waiver amendment); and,
- Engage in a cooperative working arrangement with a financial manager who will pay the client's worker, handle federal/state taxes and other payroll or benefits related to the employment of the worker, and reimburse other service providers under the direction of the participant.

(b) The program affords increased participant choice and independence in meeting home care needs and increasing satisfaction with long term supports. To be eligible for CAP/Choice an individual must:

- Live in the geographic areas where CAP/Choice is available;
- Meet basic criteria to be assessed for home and community based services waiver participation e.g., at risk of institutional care;
- Be eligible for Medicaid; and,
- Understand the rights and responsibilities of directing one's own plan of care and be willing and able to self-direct or select a representative who is willing and capable of assuming this responsibility

(c) Division of Medical Assistance, Local Lead Agencies, Financial Management Agencies, Waiver Service Providers and other providers interacting with and participating in the participant's plan of care.

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the demonstration. *Select one:*

<input type="radio"/>	<b>Participant—Employer Authority.</b> As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant's representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	<b>Participant—Budget Authority.</b> As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant's representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="radio"/>	<b>Both Authorities.</b> The demonstration provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
<input type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
<input type="checkbox"/>	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

<input checked="" type="radio"/>	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

<p>(a) Under CAP/Choice, participants will be able to:</p> <ul style="list-style-type: none"> <li>• Choose (hire) the personal assistant who will provide their care</li> <li>• Train, supervise and evaluate the worker</li> <li>• Negotiate the rate of pay and other benefits</li> <li>• Release the worker should this become necessary</li> <li>• Select individual providers and direct reimbursement for several other waiver services</li> <li>• Engage in a cooperative working arrangement with a financial manager who will pay the client's worker; handle federal/state taxes and other payroll or benefits related to the employment of the worker; and reimburse other service providers under the direction of the participant</li> </ul> <p>(b) The lead agency will give each Home and Community Based Services waiver applicant a choice between the traditional program and the new participant-directed model. In making this decision a participant/representative will be educated on the benefits and responsibilities of the participant-directed model.</p> <p>(c) The care advisor provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate prior to implementation of participant-directed services. The advisor monitors the provision of care and expenditures and maintains contact with the participant to assure that the needed care is being provided on a continuing basis. Care Advisors will participate in training and have access to materials with a participant-directed focus.</p>
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**f. Participant Direction by a Representative.** Specify the State’s policy concerning the direction of demonstration services by a representative (*select one*):

○	The State does not provide for the direction of demonstration services by a representative.
X	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: ( <i>check each that applies</i> ):
X	Demonstration services may be directed by a legal representative of the participant.
X	<p>Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:</p> <p>The representative may NOT also be the paid caregiver (i.e. personal assistant) for the participant. The representative cannot be paid for the service and must meet the following requirements:</p> <ul style="list-style-type: none"> <li>• demonstrate knowledge and understanding of the participant’s needs and preferences;</li> <li>• agree to a predetermined level of contact with the participant;</li> <li>• be willing to comply with program requirements;</li> <li>• be at least 18 years of age; and,</li> <li>• be approved by the participant to act in this capacity.</li> </ul> <p>The Care Advisor plays a significant role in identifying the need for a representative and assuring that the representative meets the criteria outlined above. Additionally, the care advisor, as part of ongoing monitoring activities, assures that the representative continues to act in the best interest of the participant.</p>

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each demonstration service. (*Check the opportunity or opportunities available for each service*):

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Respite Services (In-Home)	X	X
Financial Management Services	X	X
Home Modifications and Mobility Aids	X	X
Consumer-Directed Goods and Services	X	X
Personal Assistant Services	X	X
Waiver Supplies	X	X

**h. Financial Management Services.** Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. *Select one*:

X	<b>Yes.</b> Financial Management Services are furnished through a third party entity. ( <i>Complete item E-1-i</i> ). Specify whether governmental and/or private entities furnish these services. <i>Check each that applies</i> :
X	Governmental entities
X	Private entities

<input type="radio"/>	<b>No.</b> Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>
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**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. *Select one:*

<input checked="" type="checkbox"/>	FMS are covered as a Demonstration service	Fill out i. through iv. below:
<input type="checkbox"/>	FMS are provided as an administrative activity. Fill out i. through iv. below:	
<b>i.</b>	<b>Types of Entities:</b> Specify the types of entities that furnish FMS and the method of procuring these services: Fiscal Employer Agency	
<b>ii.</b>	<b>Payment for FMS.</b> Specify how FMS entities are compensated for the activities that they perform: FM is billed in units of 15 minutes. FM is allowed to bill up to 6 units for the startup month and up to 4 units per month thereafter. Total units in a year cannot exceed 50.	
<b>iii.</b>	<b>Scope of FMS.</b> Specify the scope of the supports that FMS entities provide ( <i>check each that applies</i> ): <i>Supports furnished when the participant is the employer of direct support workers:</i>	
<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status	
<input checked="" type="checkbox"/>	Collect and process timesheets of support workers	
<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance	
<input checked="" type="checkbox"/>	<b>Other (specify):</b> Financial Management Services are provided to assure that participant-directed funds outlined in individual plans of care are managed and distributed as intended. The Financial Manager files claims through the MMIS for participant-directed goods and services and reimburses individual providers. The FM deducts all required federal, state and local taxes, including unemployment fees, prior to issuing reimbursement or paychecks. The Financial Manager entity is responsible for maintaining separate accounts on each participant's services funds and producing expenditure reports as required by the State Medicaid agency. The Financial Manager also provides reports on at least a monthly basis to the participant. The Financial Manager conducts criminal background checks and age verification on personal assistants as requested by the participant.	

<i>Supports furnished when the participant exercises budget authority:</i>		
<input checked="" type="checkbox"/>	Maintain a separate account for each participant's self-directed budget	
<input checked="" type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds	
<input checked="" type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan	
<input checked="" type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the self-directed budget	

	<input type="checkbox"/>	Other services and supports ( <i>specify</i> ):
	<i>Additional functions/activities:</i>	
	<input checked="" type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	<input type="checkbox"/>	Other ( <i>specify</i> ):
<b>iv.</b>	<b>Oversight of FMS Entities.</b> Specify the methods that are employed to: (a) monitor and assess the performance of Financial Manager Services entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input type="checkbox"/>	<b>Case Management Activity.</b> Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:</i>
<input checked="" type="checkbox"/>	<b>Demonstration Service Coverage.</b> Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled: <b>Care Advisory, Financial Management Services</b>

<input type="checkbox"/>	<b>Administrative Activity.</b> Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i>

**k. Independent Advocacy** (*select one*).

<input checked="" type="checkbox"/>	<b>Yes.</b> Independent advocacy is available to participants who direct their services. <i>Describe the</i>
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<p><i>nature of this independent advocacy and how participants may access this advocacy:</i></p> <p>1) North Carolina's Long Term Care Ombudsman Program consists of state and regional ombudsmen who help residents of long-term-care facilities to exercise their rights. In addition to being an advocate for residents, they educate the public and facility staff about rights and help resolve grievances between residents/families and facilities. The regional ombudsmen, who are located within Area Agencies on Aging, also help support the efforts of Adult Care Home and Nursing Home Community Advisory Committees (N.C.G.S. 131E-128 and 131D-3). These local committees, which are composed of volunteers appointed by county commissioners, routinely visit facilities, serve as advocates for residents, help ensure that the intent of the resident's bill of rights is maintained, and work to increase community involvement in long-term-care facilities. There are over 1,100 such volunteers statewide, with committees in each county. The services provided by the Ombudsman Program include:</p> <p>A. Answering questions and giving guidance about the long term care system. An ombudsman will:</p> <ul style="list-style-type: none"><li>• explain long term care options.</li><li>• give pointers on how to select a long-term-care facility provide information on specific facilities (such as the latest and past certification reports and complaint information).</li><li>• explain residents' rights and other federal and state laws and regulations affecting long-term-care facilities and residents.</li><li>• give guidance on the Medicaid and Medicare programs--specifically qualification criteria, application procedures and what services these programs cover.</li><li>• give guidance on such matters such as powers of attorney, living wills and guardianship.</li></ul> <p>B. Educating community groups and long term care providers on various topics such as residents' rights, restraint use, care planning, activities and new laws.</p>
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<p>C. Investigating and assessing matters to help families, residents and families resolve concerns and problems. Common areas of complaints include:</p> <ul style="list-style-type: none"><li>• medical and personal services being provided to residents such as problems with medication, nutrition and hygiene.</li><li>• financial concerns such as handling of residents' funds, Medicare, Medicaid, and Social Security.</li><li>• rights of residents, such as the right to be treated with courtesy and to have individual requests and preferences respected.</li><li>• nursing home administrative decisions, such as admission to or discharge from a facility.</li></ul> <p>D. Working with appropriate regulatory agencies and referring individuals to such agencies when resolutions of issues are not possible through the Ombudsman Program alone.</p> <p>E. Raising long term care issues of concern to policymakers.</p> <p>2) County Adult Protective Service programs are required to investigate and act upon any</p>
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	allegations of abuse, neglect, and exploitation of the participant.  3) The participant has the opportunity to self-advocate through participation in local non-profit advocacy groups, such as Centers for Independent Living, the Participant Task Forces of various state programs and initiatives (e.g. - Rebalancing Grant, Money Follows the Person Demonstration, Systems Transformation Grant, etc), and input into the State Independent Living Council.
<input type="radio"/>	<b>No.</b> Arrangements have not been made for independent advocacy.

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A Care advisor works with the participant to transfer to an alternate waiver or other state plan service(s) and monitors health and safety until the new service is fully implemented.

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Plans of care and service provision will be continually monitored by the care advisor to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified, the care advisor will work with the participant to resolve them. If they cannot be resolved, the participant will be removed from the program and assessed for the traditional home and community based services program, CAP/DA. Care advisors/lead agencies will consult with Division of Medical Assistance program consultants prior to taking any action.

Participants who demonstrate the inability to self-direct waiver services, whether due to misuse of funds, consistent non-adherence to program rules, or an ongoing health and safety risk, will be required to select a representative to assist them with the responsibilities of self-direction. If a participant refuses to select a representative or if participant loses a representative and cannot locate a replacement, they will be required to transfer to another waiver program that has traditional agency oversight. Care advisors will assist the participant in the transition. Participants are given due process rights for any changes in service and/or termination/removal of a service/program.

Note: Participants may also voluntarily terminate participant direction in favor of returning to CAP/DA.

**n. Goals for Participant Direction.** In the following table, provide the State’s goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

<b>Table E-1-n</b>		
	<b>Employer Authority Only</b>	<b>Budget Authority Only or Budget Authority in Combination with Employer Authority</b>
<b>Demonstration Year</b>	<b>Number of Participants</b>	<b>Number of Participants</b>
<b>Year 1 (2008)</b>		0

<b>Year 2 (2009)</b>		2
<b>Year 3 (2010)</b>		2
<b>Year 4 (2011)</b>		1
<b>Year 5</b>		N/A

**Participant Employer**

a. **Participant—Employer Authority** (Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)

i. **Participant Employer Status.** Specify the participant’s employer status under the demonstration. *Check each that applies:*

<input type="checkbox"/>	<b>Participant/Co-Employer.</b> The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</i>
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<input checked="" type="checkbox"/>	<b>Participant/Common Law Employer.</b> The participant (or the participant’s representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
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ii. **Participant Decision Making Authority.** The participant (or the participant’s representative) has decision making authority over workers who provide demonstration services. *Check the decision making authorities that participants exercise:*

<input checked="" type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input checked="" type="checkbox"/>	Hire staff (common law employer)
<input checked="" type="checkbox"/>	Verify staff qualifications
<input checked="" type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated: The financial manager does this upon request of the participant. The cost is incorporated into the financial management reimbursement.
<input checked="" type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications
<input checked="" type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input checked="" type="checkbox"/>	Schedule staff

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<input checked="" type="checkbox"/>	Orient and instruct-staff in duties
<input checked="" type="checkbox"/>	Supervise staff
<input checked="" type="checkbox"/>	Evaluate staff performance
<input checked="" type="checkbox"/>	Verify time worked by staff and approve time sheets
<input checked="" type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other ( <i>specify</i> ):

**b. Participant—Budget Authority** (*Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b*)

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input checked="" type="checkbox"/>	Reallocate funds among services included in the budget
<input checked="" type="checkbox"/>	Determine the amount paid for services within the State’s established limits
<input checked="" type="checkbox"/>	Substitute service providers
<input checked="" type="checkbox"/>	Schedule the provision of services
<input checked="" type="checkbox"/>	Specify additional service provider qualifications
<input checked="" type="checkbox"/>	Specify how services are provided,
<input type="checkbox"/>	Identify service providers and refer for provider enrollment
<input checked="" type="checkbox"/>	Authorize payment for demonstration goods and services
<input checked="" type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other ( <i>specify</i> ):

**ii. Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Methodology for Calculation of Individual/Participant-Directed Budget:

Budgets will be calculated based on the methodology in place for the CAP/DA waiver currently serving the elderly/disabled. The process involves an assessment to identify needs; development of goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. The estimated monthly cost of each service is calculated. The cost of all services cannot exceed the average per capita cost to Medicaid of nursing facility care. Additionally, there is monthly individual budget limit, designated by level of care that cannot be exceeded.

The budget will contain both agency and participant-directed services, as outlined below. Those designated as participant-directed will constitute the individual budget to be directed by the participant.

Agency-Directed:  
Adult Day Health Care  
Care Advice  
Financial Management  
In-Home Aide  
Institutional Respite  
Preparation & Delivery of Meals  
Telephone Alert

Participant-Directed:  
Participant-Designated Goods & Services (additional limit of \$600/year)  
Home Modifications and Mobility Aids\* (additional limit of \$1500/year)  
Personal Assistant  
Respite (In-Home)  
Waiver Supplies\*

\*Indicates service may be either participant or agency directed

It is recognized that actual utilization of services authorized does not equate to 100%—for example, participants are hospitalized, aides miss visits and substitutes are not available. (\*North Carolina Division of Medical Assistance requires a minimum of monthly monitoring of all waiver services, including the participant's emergency back-up plan. If it is determined the participant's needs are not being met the plan of care is modified to address these needs. New supports and services are identified and put in place to meet these needs. If these needs continue to go unmet or the participant's health and well-being are at risk other programs may be identified that better serve the participant.) Based on findings of the National Cash & Counseling Demonstration, at least 10 to 20% of personal care services authorized in the traditional delivery system is not used. In addition, many of the indirect costs which are built into the payment rates such as professional supervision and training of workers, office space, equipment, supplies, etc., are not applicable to the participant-directed model. Therefore, the maximum hourly rate for personal assistant services will be 10 to 20 percent lower than the current Medicaid personal care rate. Individuals may negotiate personal assistant payment rates lower than the maximum, thereby enabling them to set aside a portion of their budget for other services such as participant-designated goods and services which would increase independence.

Participants will have considerable flexibility in using funds designated as participant-directed. They will be able to substitute services and/or reschedule services within the budget without agency approval in certain cases.

The methodology will be explained to the participant/representative by the care advisor. The care advisor will point out both the added responsibilities if this model is selected and its benefits. The Individual/Participant-Directed Budget will be re-determined at least annually and more frequently depending on changes in the Participant's situation. The methodology will be published in the operations manual for this program. All Medicaid policy and program manuals are available for public inspection.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant must be informed of the amount of the individual budget during and after the service plan development process. Participants may inquire about the balance of their account throughout waiver enrollment from his/her care advisor in addition to an annual evaluation.

iv. **Participant Exercise of Budget Flexibility.** *Select one:*

<input checked="" type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
	Participants have the authority to modify the timing of service delivery (ex. personal assistant hours). Otherwise, modifications to the participant-directed budget must be preceded by a change in the service plan after discussion with the care advisor.
<input type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

At the local level plans of care and service provision will be continually monitored by the care advisor to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified the care advisor will work with the participant to resolve them. If the problem(s) is not resolved, care advisors/local lead agencies will consult with Division of Medical Assistance program consultants prior to taking any adverse action towards a participant.

Additionally, post-approval and post-payment reviews are conducted by Carolinas Center for Medicaid Excellence and Division of Medical Assistance consultants.

## **Attachment H**

### **North Carolina Division of Medical Assistance Quality Management Strategy for Money Follows the Person For Persons Enrolled in CAP/DA and CAP/CHOICE Waiver Programs**

**June 12, 2008**

#### **I. Introduction and Purpose**

The North Carolina Community Alternatives Program for Disabled Adults (CAP/DA) is a home and community-based 1915(c) waiver program managed by the Facility and Community Care Section of the North Carolina Division of Medical Assistance (DMA). The CAP/DA Program provides a package of services and supports that allows adults who are elderly or disabled and who qualify for inpatient facility care to remain in their private residences. Services include:

- Case management;
- Adult Day Health;
- In-home personal care aide services;
- Home mobility aids;
- In-home and institutional respite care;
- Preparation and delivery of meals;
- Waiver supplies, such as nutritional supplements and incontinence supplies; and
- Telephone response system.

CAP/DA participants can also receive regular Medicaid services, such as hospital care, physician services, home health care, DME, hospice, home infusion therapy, and private duty nursing. These services are provided under program guidelines to ensure there is no duplication of care and services. In State Fiscal Year 2007, the CAP/DA Program served 14,485 non-duplicated Medicaid recipients in all 100 North Carolina counties. On a monthly basis, CAP/DA served an average of 11,512 individuals who require long-term care services and supports to remain in their homes and communities. The CAP/DA Program is the major source of Medicaid assistance for individuals transitioning out of inpatient facilities into community care. Plans are being made to redesign this program to provide a broader range of services and supports to support the Money Follows the Person Demonstration Project, including paying for one-time transition expenses.

The overall purpose of the Quality Improvement Strategy (QIS) for CAP/DA is to design, develop, implement, and manage a Quality Assessment and Quality Improvement Program for CAP/DA that:

1. Ensures that the Division of Medical Assistance meets the Centers for Medicare and Medicaid Services' (CMS) assurances for the Money Follows the Person Rebalancing Demonstration and the CAP/DA waiver renewal;
2. Implements the CMS Quality Framework in a manner that will meet all CMS requirements and assurances for waiver services;
3. Establishes a systematic approach to monitor, evaluate, and continuously improve the quality of CAP/DA services;
4. Identifies and sets appropriate performance and outcome measures to evaluate CAP/DA services; and

5. Implements a Quality Management (QM) Program for CAP/DA that focuses on participant-centered outcomes related to:
  - a. Participant access;
  - b. Participant-centered services planning and delivery;
  - c. Provider capacities and capabilities;
  - d. Participant safeguards;
  - e. Participant rights and responsibilities;
  - f. Participant outcomes and satisfaction; and
  - g. System performance.

## **II. Quality Management Strategy**

The CAP/DA Quality Management Strategy is based in part on the CMS Quality Framework and CMS Regional Waiver Review Protocol. Major components include Design, Discovery and Data Sources, Remediation, and Continuous Improvement. Each is described below:

### **Design**

Program design sets the stage for achieving the desired outcomes for the CAP/DA Program for CAP/DA enrolled participants. Design features include:

- a. Identifying indicators and standards against which performance is measured;
- b. Developing an approach to collect, synthesize, and share performance information; and
- c. Develop a cohesive work plan that directs time, effort, and resources into the process.

CAP/DA's program design, as outlined in this Quality Management Strategy, addresses such topics as level of care determinations, service planning, provider qualifications, monitoring participant health and welfare, administrative authority of the program, and financial accountability.

### **Discovery Sources and Data Sources**

In this process, CAP/DA data and direct participant experiences are collected to assess the ongoing implementation of the program and identify strengths and opportunities for improvement. Discovery methods should ensure that staff, processes, data systems, and reporting mechanisms are working as intended to meet minimum standards and/or desired outcomes. CAP/DA draws from several data sources to monitor CAP/DA program performance, including:

1. The AQUIP system (described below);
2. On-site audits and reviews;
3. Desktop audits and reviews
4. The Medicaid Fiscal Agent's MMIS;
5. NC Division of Health Services Regulation for licensure/certification records; and
6. DMA Program Integrity Unit for audits, reviews, and investigations.

### **Remediation**

Remediation is the actions taken to remedy specific problems or concerns that arise. As a first step, identified areas of weak performance are brought up to minimum standards through an understanding of the problem. Subsequently, correction or remedial action should be taken to correct the root causes of the problem to improve performance in the weak area to prevent similar problems in the future.

## Continuous Improvement

Finally, the CAP/DA Quality Management Strategy determines how improvements in skill levels, processes, and systems can be established to initiate and sustain higher levels of performance. The changes should, at a minimum, improve system design flaws that allowed for weak performance, but more importantly map out how both existing and improved data and quality information can lead to continuous improvement in the waiver program.

## III. Roles and Responsibilities for Oversight and Quality Improvement

The North Carolina Division of Medical Assistance (DMA) is the state Medicaid agency responsible for the administration of the CAP/DA Program. Services are delivered through a network of county agencies called CAP/DA Lead Agencies (lead agencies). There are 96 lead agencies, as described below. In all, five agencies play key roles in the CAP/DA service delivery system, as summarized below.

1. The Medicaid CAP/DA Unit – The CAP/DA unit is one of ten long-term care programs in DMA’s Facility and Community Care Section. The primary responsibilities of the CAP/DA Unit include providing overall management oversight of the program, developing and implementing program policies and procedures, conducting the CAP/DA quality management program, setting the county slot allocations, and providing training, consultation, and technical assistance to the lead agencies and CAP/DA providers.
2. The Local CAP/DA Lead Agency – Local CAP/DA lead agencies are selected in each county by the county commissioners and may be a department of social services (DSS), local health department, area agency for the aged, or a hospital. CAP/DA lead agencies perform the following duties:
  - a. Process referrals,
  - b. Assess applicants for the program,
  - c. Provide case management,
  - d. Provide home mobility aids and waiver supplies,
  - e. Manage caseloads, including DMA’s recommendations and putting into writing or policy caseload limits,
  - f. Set up and operate an advisory committee,
  - g. Develop and approve Plans of Care (POC),
  - h. Ensure quality services,
  - i. Ensure client freedom of choice, and
  - j. Cooperate with monitoring and reporting activities.
3. The Medicaid Fiscal Agent – The Medicaid Fiscal Agent, Electronic Data Systems (EDS), provides the prior approval review for CAP/DA participants, processes and pays provider claims, and provides training related to these activities to provider organizations.
4. CAP/DA Provider Organizations – Provider organizations are enrolled with Medicaid to provide certain defined services, as specified in their enrollment contracts. Provider qualifications are specified in the CAP/DA Clinical Coverage Policy and Provider Handbook.
5. Carolinas Center for Medical Excellence – Carolinas Center for Medical Excellence (CCME) is the federally-designated Quality Improvement Organization for Medicare for North and South Carolina.

CCME, under contract to DMA, conducts a comprehensive Internet-based quality management program for the CAP/DA Program called AQUIP. This automated quality management system is described below.

### **Automated Quality Utilization and Improvement Program (AQUIP) System Description**

The Automated Quality Utilization and Improvement Program (AQUIP) is a Web-based, automated system used by all 100 counties (which consist of 96 lead agencies) throughout the state to help support the NC Medicaid CAP/DA program. The system helps to identify opportunities for improvement by looking at patterns and trends in individual care. AQUIP is used to:

1. Identify opportunities for CAP/DA systems improvements that will benefit all enrolled participants while assuring the quality of services to each enrollee, and
2. Meet waiver requirements for assurances and quality improvement systems.

The review system captures and assesses data in three areas to assure each individual client receives quality health care that is delivered cost effectively and in the appropriate setting:

1. **Level of Care:** Are enrollees categorized properly, and can this be compared across lead agencies?
2. **Cost:** Are we staying within the cost limits, both at the individual level and at the county and state levels?
3. **Quality:** Are there opportunities for systems improvement? Are there variations between counties that can help us identify ways to more effectively provide services? Are there individuals who need immediate attention?

AQUIP provides an automated assessment and plan of care tool that captures data on all CAP/DA and CAP/CHOICE clients. The client data and resource utilization group scores (RUGs) are analyzed and combined with claims data to help assure all clients receive quality healthcare that is delivered cost effectively, in the appropriate setting. RUGs are used to classify inpatient facility residents into groups. Classification is based on a person's physical functioning, disease diagnoses, health conditions, and treatments received. In addition to providing the automated assessment and plan of care tool, CCME provides the following services:

1. Help Desk Calls (clinical and technical questions)
2. Clinical staff support;
3. Web-based, HIPAA compliant, searchable database that contains data on all CAP/DA and Choice clients;
4. 24/7 secure fax access and data entry support;
5. Automated system that accepts claims data from DMA and matches it to client data and RUG scores;
6. Accepts claims and links them to the client by preparing cost summary reports for use by DMA in monitoring expenditures per client;
7. Assist DMA in implementing a quality measurement and improvement system which can identify both individual and systematic quality issues;
8. Provide training sessions on a quarterly basis for new users;
9. Establish, maintain, and monitor a standardized Waiting List;
10. Development of training videos;

CCME provides a variety of standard reports including:

1. Program applicants by LOC and RUG scores
2. Data Entry Report by County
3. Discharges
4. Inappropriate Services
5. LOC Review Results
6. New CAP/DA Clients
7. QI Maps
8. QI Rank
9. QI Rank All, or by County
10. QI Rank Quarterly
11. RUG Assignments
12. RUG Assignments by County by Category
13. RUG Assignments by County Detail
14. RUG Assignments by County with MID
15. RUG Assignments for CAP CHOICE
16. Summary of County Enrollment
17. Transfers
18. Types of Assessments

#### **IV. CMS Assurances**

This Section describes the process and methods the State of North Carolina utilizes to ensure that the HCBS assurances are met in the CAP/DA Program. This section also describes the procedures that will be used to carry out specific oversight of individuals being transitioned from inpatient facilities to CAP/DA as part of the MFP Rebalancing Demonstration

**Please note that the North Carolina CAP/DA Program is in the process of preparing its first waiver renewal under the Version 3.5 requirements. This renewal is due September 30, 2008.**

CAP/DA staff conducted several “town-hall” meetings across the state in May 2008 to obtain input from key stakeholders about the CAP/DA Program, including successes and challenges, and to solicit suggestions for the future direction of the program. CAP/DA staff is currently orienting themselves to Version 3.5 and is in the process of revising the program’s Quality Management Strategy to meet the new requirements for state assurances and quality improvement. Again, please note that this document is submitted during the application renewal process and not all planned changes have been implemented. Information provided in boxes is planned changes that have not been implemented.

#### **Level of Care**

Sub Assurances 1

***An individual evaluation of LOC is provided for all applicants for whom there is a reasonable indication that services may be needed in the future.***

North Carolina Medicaid requires that a level of care (LOC) determination be made on all recipients seeking home and community based services, including CAP/DA, by using a standardized prior approval tool (currently

the FL-2 form) for determining inpatient facility Level of care. The FL-2 is completed by the applicant's physician and initiates the CAP/DA admission process. Procedures are in place to assure that individuals meet inpatient facility LOC after a complete assessment has been performed.

Each time a CAP/DA applicant assessment is completed in AQUIP, certain information fields are incorporated into calculating a Resource Utilization Group (RUG) score that is assigned to the applicant. RUG categories were developed by national researchers to classify individuals in inpatient facilities into groups that utilize similar types and amounts of staffing resources. Over one hundred (100) data elements are used to determine the RUG classification. Since CAP/DA recipients must qualify for inpatient facility level of care, the RUG score determined by AQUIP incorporates the same data elements as the national system. A review of level of care and a recertification of Medicaid-funded services are required for each CAP/DA participant on an annual basis.

When an applicant does **not** meet inpatient facility level of care requirements after review of the FL-2 and automated assessment this is noted in the "action required" section of the AQUIP report. Each case manager must then submit supporting evidence to document that the applicant is at risk for institutionalization without CAP/DA services and a plan of action. A CAPDA consultant reviews the documentation, logs in the information, and contacts the case manager to review the case. A final determination is made at this time.

Planned performance measures include:

- Number and percent of LOC determinations made on State-approved form
- Number and percent of LOC determinations that require retro approval
- Number and percent of initial LOC determinations made within ten working days of receipt of request for CAP/DA

### **Remediation**

The AQUIP provides an automated assessment and plan of care tool that captures data on all CAP/DA and CAP/CHOICE clients. The tool reviews 100 percent of level of care determinations. DMA will provide feedback to the lead agencies and, when necessary, establish a corrective action plan to ensure that these requirements are met in all cases.

### **Sub Assurance 2**

***The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver***

Every 12 months, the case manager is required to complete a Continued Need Review (CNR) to determine if the enrolled participant continues to meet CAP/DA LOC requirements. The CNR must be completed during the month of the initial CAP/DA effective date. The lead agency's authorized approval agent must approve and sign the plan by the 5<sup>th</sup> of the following month. This recertification process requires the case manager to do the following:

1. Obtain a new FL-2 (assessment form) signed by the client's physician with LOC recommendation(no earlier than 30 days prior to the CNR month);
2. Complete a new assessment by RN and social worker; and
3. Complete a new service plan.

AQUIP's LOC review allows categorization of each CAP/DA participant by intensity of services. This data can be compared across lead agencies and other long-term care populations. Portions of the Minimum Data Set

(MDS), used in inpatient facilities, are included in the AQUIP assessment tool that is completed by lead agency case managers. This information is used to calculate a score for each individual that is compared to the inpatient facility level of care.

A performance measure for this assurance is currently in place as part of the AQUIP system.

- Number and percent of participants who received an annual reevaluation within twelve months of initial or previous evaluation (AQUIP-generated report)

### **Remediation**

DMA will provide feedback to the lead agencies and, when necessary, establish a corrective action plan to ensure that these requirements are met in all cases.

#### Sub Assurance 3

##### ***The processes and instruments described in the approved waiver are applied to LOC determination***

All LOC determinations are monitored by CCME and CAP/DA and reviewed again by EDS as part of the prior approval process. The CAP/DA Unit is responsible for assuring that this process is conducted in accordance with the approved waiver assurances.

Planned performance measures include:

- Number and percentage of LOC evaluations completed using approved processes and instrument
- Number and percentage of LOC determinations monitored by CCME

### **Remediation**

On-site reviews and AQUIP reports can be used to determine if the LOC process is being completed correctly and if the required tools are used correctly. Remediation will include feedback to the lead agencies, technical assistance, and training.

If, at the time of the CNR, the FL-2 is not called into EDS for approval or the CAP DA Unit questions the validity of the form, the unit will request a new FL2 be obtained and called into EDS.

### **Service Plans**

#### Sub Assurance 1

##### ***Service Plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means***

In North Carolina CAP/DA Program, the local lead agency assures that comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan. Local lead agencies assure that plans of care address all assessed needs and personal goals, either by waiver services or other means. Below is a list of assurances local lead agencies provide to ensure Service Plans address participants needs:

1. Assure that participants are afforded choice among service providers.
2. Participants and/or their legal responsible party actively participate in the plan of care development, and that plans of care are updated or revised when warranted by changes in the waiver participant's needs.
3. Federal Financial Participation (FFP) cannot be claimed for waiver services furnished prior to the development of the plan of care or for services that are not included in the individual written plan of care.

4. All services must be furnished pursuant to the plan of care. If they are not provided per the service plan, the case manager must document who the client's needs are met.
5. The plan of care describes the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each.
6. The plan of care addresses how potential emergency needs of the individual will be met.

For Medicaid audit purposes, a valid plan must:

1. Have the required signatures on or before services begin;
2. Cover the dates of service;
3. Identify the services billed and the amount being billed;
4. Have measurable goals and appropriate interventions;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems; and
7. Include a 24 hour schedule of coverage if warranted.

A majority of these quality indicators look at plan of care development to assure that CAP/DA is meeting the participants' assessed needs.

Planned performance measures include:

- Number and percent of POCs reviewed that meet all requirements
- Number and percent of POCs that is adequate and appropriate to the waiver participant's needs, as identified in the assessment.

### **Remediation**

CCME reviews cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided. These reviews also determine deficiencies that result from failure to complete the care planning assessment tool accurately.

The CAP Case Managers received deviations from the providers and review provision of services monthly. If there are consistent deviations and the service is authorized on the POC, the case manager must review these with the client and discuss a possible change in providers. If the client can be maintained at the deviated service(s), a POC revision must be completed.

Each county lead agency has access to the QI reports and often contacts CCME or the CAP DA Unit for clarification of the score and to verify the accuracy of the assessment question/answer. The case managers can also access the Q and A section of the AQUIP system.

Sub Assurance 2

***The state monitors Person Centered Plan development in accordance with its policies and procedures.***

In addition to the activities described above for Sub Assurance 1, CAP/DA staff utilizes desktop reviews and on-site reviews (audits), AQUIP reports, and special reviews to assure program accountability for POC development and implementation. Approximately 48 on-site reviews per year are conducted by CAP/DA staff.

The Case Manager establishes the POC in collaboration with the applicant's primary care or attending physician, the applicant, and the applicant's formal/informal caregivers. The case manager is responsible for providing, at a minimum, the following monitoring requirements for waiver services:

1. Adult Day Health, In-Home Aide and Respite Services:
  - a. Review the provision of services with the client or responsible party and the provider agency at least monthly;
  - b. Observe hands-on service being provided at least every 90-days;

- c. Review supporting documentation for claims at least every 90 days;
  - d. Review provider claims prior to filing for payment from Medicaid to monitor for compliance with services in approved Plan of Care.
2. Meals and Personal Emergency Response Systems:
    - a. Review the provision of services with the client or responsible party and the provider agency at least monthly; and
    - b. Review the provider claims prior to filing for payment from Medicaid to monitor for compliance with approved Plan of Care.
  3. Waiver/Medical Supplies - Confirm after initial delivery and at least quarterly if supplies are appropriate for client's needs and use.
  4. Home mobility aids - Confirm after delivery/installation and at least quarterly if items are appropriate for client's needs and use.
  5. Home Health Nursing visits - Review results of home health agency's nurse visit(s) with nurse once a month if applicable.
  6. Home mobility aids - Visit all clients, at a minimum, every 90 days.
  7. Case management notes - All activities listed above must be documented in case notes as they occur (dated, time in minutes, appropriately signed, multiple entries totaled).

Planned performance measures include:

- Number and percent of POCs that meet all the requirements specified in the CAP/DA clinical coverage policy
- Percent of waiver participants whose Service Plan included a risk factor assessment
- Number of waiver participants whose Service Plan was based upon a completed uniform needs assessment/instrument (CAP/DA Assessment form)

### **Remediation**

If it is discovered during the monthly monitoring that services are not being delivered in accordance with the Person Centered Plan, the case manager will address the issue with the provider and work to resolve the issue. If the provider fails to adequately address the issue, the case manager may address the issue with the participant and suggest a change of provider. The provider can be reported to DMA's Program Integrity Unit for auditing if warranted, and the lead agency can subsequently revoke the provider's endorsement.

Sub Assurance 3

***Person Centered Plans are updated/revised at least annually or when warranted when there are changes in the participants needs***

The Case Manager revises the POC as the client's needs change (either improves or deteriorates). The assessment will identify ADL deficits and the linked home management tasks.

The status of the CAP/DA enrolled participant is monitored by the case manager, the lead agency authority, and reviewed on an on-going basis by CAP/DA and CCME. POCs are changed when on-going monitoring reveals a change in the participant's needs, situation, or condition to reflect these changes. POCs are also changed as a result of annual reviews.

Planned performance measures include:

- Number and percent of POCs that are updated on or by the person's annual renewal date
- Number and percent of waiver participants whose POC was revised, as needed, to address changing needs.

### **Remediation**

Remediation efforts for this sub assurance are underway. CAP/DA staff will consider a chart audit that will enable DMA to review case notes. The reviewer will look to see if the person's needs changed commensurate with a needed change in the POC and whether or not the POC was actually revised to meet the changing need.

Sub Assurance 4

***Services are delivered in accordance with the Person Centered Plan, including the types, scope, amount, duration, and frequency specified in the Person Centered Plan.***

The AQUIP system is linked to NC Medicaid's MMIS (claims payment system) and compares paid claims data to the participant's POC. CCME compares the service plan to the paid claims data to ensure that billed services corresponded to the POC.

- Planned performance measures include:
- Percent of participants reviewed who have claims for services not authorized on the POC.
- Establish an indicator that will measure underutilization or whether or not the person received all waiver services in the POC.

### **Remediation**

Provide feedback to lead agencies to make the necessary adjustments in service delivery to correspond with the plan of care. Cases of apparent fraud will be referred to Medicaid Program Integrity.

Sub Assurance 5

***Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers.***

All individuals enrolled in CAP/DA sign a POC statement that confirms that he/she was provided a choice between CAP/DA and institutional care. In addition, CAP/DA participants sign a Freedom of Choice form that verifies that they had a choice among waiver services and providers available through NC Medicaid list of providers authorized to provide that service. The Freedom of Choice form is updated annually, or as warranted by client needs.

Planned performance measures:

- Number and percent of waiver participants whose records contained a completed and signed POC that specifies choice was offered between institutional care and waiver services
- Number and percent of waiver participants whose records contain a completed and signed Freedom of Choice form that specifies choice offered among waiver services and providers

### **Remediation**

Remediation will include feedback to the lead agencies, corrective action plan, technical assistance, or training as appropriate.

## **Qualified Providers**

### Sub Assurances 1

***The state verifies that providers, initially and continually, meet required licensing and/or certification standards prior to their furnishing waiver services***

DMA verifies that all Medicaid providers be licensed or certified, as required, and properly enrolled as a Medicaid provider by DMA Provider Enrollment Services for each type of service furnished. Through these rigorous state licensure/certification standards providers must demonstrate competency to perform services. In addition to DMA's requirement for providers to be enrolled through DMA Provider Enrollment Services, these providers must be authorized by the CAP/DA lead agency for each county where services are provided. The provider must receive an authorization notice initially, re-issued annually at continued need review and updated as needed. Medicaid recipients have the freedom to choose to receive services from any licensed home care agency that serves their county and they may switch agencies without any restrictions. A provider must document the provision of services before seeking Medicaid payment and this record must provide an audit trail for services billed to Medicaid.

Licensed home care agencies are required to perform the following activities to comply with state laws:

1. Complete background checks on all employees
2. Conduct in-home aide competency evaluations and trainings
3. Monitor quality of care
4. Handle Workers' Compensation
5. Manage the payment of income and Social Security taxes
6. Ensure that in-home aides work under the supervision of a Registered Nurse

Plan performance measures include:

- The number and percent of providers who meet licensure/certification requirements (100% for NC)
- The number and percent of new provider applications for which appropriate background and registry checks, as required by the State, were conducted
- The number and percent of agency providers whose direct support staff had timely criminal background and registry checks (future provider performance survey under consideration)

### **Remediation**

Planning is underway for local lead agencies to provide stronger provider oversight. DMA staff is considering the following actions as the waiver renewal process is underway. If the local lead agency or DMA staff finds the provider out of compliance they may require a corrective action plan. The local lead agencies, through DMA oversight involvement, will then conduct a follow up review to determine if the provider has corrected the issues. If subsequent corrective actions are required, DMA may exercise the right to revoke the provider's endorsement. The Division of Health Service Regulation may also require a corrective action plan, fine the provider or revoke the provider's license for violations discovered.

### Sub Assurance 2

***The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements***

This sub assurance is not applicable to NC Medicaid. North Carolina does not permit non-licensed or non-certified providers to furnish services to Medicaid recipients.

### Sub Assurance 3

***The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver***

CCME, under its contract with NC DMA, provides quarterly regional training programs throughout the year to newly enrolled providers. In addition, the NC Association for Home and Hospice Care sponsors an annual CAP/DA conference. CAP/DA staff provides ongoing technical assistance and consultations by telephone and on-site when needed.

Planned performance measures include:

- Number and percent of providers, by provider type, meeting provider training requirements
- Number and percent of participating providers represented at training programs calculated annually

### **Remediation**

DMA will ensure that provider training is conducted in accordance with state licensure/certification requirements, DMA clinical policy, and waiver requirements. DMA accepts DHSR's licensure of home care agencies and if any continuing education is required, DHSR conducts supplemental training. CAP/DA staff review CCME's training course materials and verifies that provider training programs meet the state administrative requirements, program policy, and waiver requirements.

### **Health and Welfare**

*Sub Assurance:*

***The state, on an ongoing basis, identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation***

Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence and safety with the informed involvement of the participant. Local lead agencies assure that services and supports are included in the POC to address risk and safety issues identified in the assessment. Case managers monitor specific triggers in the assessment that should have corresponding POC inclusions, including medication confirmation, fall risk, need for assistive devices, and need for Personal Emergency Response System (PERS).

The NC Division of Health Services Regulation (HSR), the State's provider licensing agency, houses a Complaint Intake Unit which investigates complaints regarding the care and services provided to patients/residents/consumers by health care facilities, provider agencies, and group homes. Complaints may be shared with the Unit by telephone, by facsimile or by postal mail. The Unit is able to investigate complaints regarding incidents that have occurred in the past year and issues that are regulated by federal regulations or state statutes (see below for a list of common non-regulatory issues). A Complaint Form is available for written complaints but is not required to be used. Each complaint is prioritized for investigation according to the seriousness of the situation. Complaints are investigated by the appropriate licensing Section within the Division. Investigations are unannounced to the facilities/agencies/homes, and complainant identifying information is not shared with the facilities/agencies/homes. Complaints received by our Complaint Intake Unit for Adult Care Homes are forwarded to the local Department of Social Services for investigation.

In addition, DMA has mandatory reporting requirements for all providers. North Carolina statutes require any person having reasonable cause to believe that a disabled adult is in need of protective services shall report (either orally or in writing) such information to the director of the county Department of Social Services.

County Departments of Social Services must accept all reports alleging an abused, neglected or exploited disabled adult is in need of protective services. County Departments of Social Services report to the State department of Social Services.

In addition to reports of abuse, neglect or exploitation, there are also systematic safeguards in place to protect participants from critical incidents and other life-endangering situation. DMA requires that critical events or incidents be reported for review and follow-up action. Critical events include decline in mental or physical health and/ or loss of informal support that affect the ability of the participant to self direct. If this occurs, care advisors reassess the participant's situation to determine whether the participant-directed option continues to be appropriate for the individual. Personal assistants and other direct workers who are in touch with the participant on a regular basis are instructed to report problems to the care advisor. After hours, North Carolina's *CareLine*, a toll-free hotline designed to assist North Carolina citizens in need of supports and services, has live operators 24 hours a day, seven days a week. See section V. (24 hour back up) for more information describing NC's 24-hour *CARELINE*.

Planned performance measures include:

- Number and percent of medication errors (AQUIP, I, 6)
- Fall risk score (AQUIP, H, 4)
- Need for assistive devices (N, 3)
- Need for PERS (AQUIP, H, 1 and 4)
- Number and percent of cases appropriately reported and investigated where notes in case files indicate abuse, neglect, or exploitation.
- Number and percent of reportable critical incidents, by type
- Number and percent of reportable critical incidents being investigated, by type
- Number and percent of critical incidents for which corrective actions were verified within required time frame.

### **Remediation**

The case manager must ensure that the POC is kept current with the participant's changing needs. When the case manager discovers that a participant is at risk s/he must address the issue immediately or in a timely fashion as required. This may include anything from calling a team meeting to address the issue to getting medical advice for the participant to seeing that the participant is removed immediately from the environment that has him or her at risk. If the case manager discovers that the participant has had multiple incident reports submitted for the same or different incidents, s/he must address this with the team or in whatever manner is necessitated by the severity of the incident. The case manager must ensure that the POC is updated on a continuous basis as the participant's needs change.

As part of the CAP/DA waiver renewal, DMA will set more rigorous requirements to ensure local lead agencies and providers report all complaints, specified types of incidents, and any observed or suspected participant abuse, neglect or exploitation.

## **Administrative Authority**

### *Sub Assurance:*

***The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of the waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

DMA is responsible for all Medicaid programs including CAP/DA and as the state operating agency maintains authority and oversight responsibilities for all entities participating in this program and entities providing services to program participants. Specifically, CAP/DA staff conducts on-site compliance reviews annually to ensure local lead agencies follow waiver policies and procedures are implemented. DMA also oversees CCME who performs ongoing quality assurance and utilization management functions. CAP/DA unit has “real time” access to assessments, plans of care and quality indicators.

Any policy and/or regulation changes which impact waiver operations must follow the agency’s approval process. Final decision-making rests with the DMA and recommendations made by a Physicians Advisory Group (PAG). This process ensures Division of Medical Assistance authority.

Planned performance measures include:

- Number and percent of lead agencies audited that have a passing score for compliance with waiver requirements

## **Remediation**

CAP DA staff in DMA must review all waiver policies, rules, procedures, rates and service definitions prior to their final approval. If DMA has an issue with any item reviewed, they will notify the appropriate stakeholders (e.g. local lead agencies, providers, etc.) to correct the issue. In addition, if a lead agency is found to be out of compliance they can be terminated or local approval can be removed for a period of time during remediation, training, or technical assistance provided by CAP/DA staff.

In conjunction with CAP/DA’s waiver renewal (9/30/08), planning is underway to write administrative rules for CAP/DA to give the state greater authority to set statewide standards, criteria, and administrative requirements. The clinical coverage policy will also be revised to strengthen greater state control over local lead agencies.

## **Financial Oversight**

### *Sub Assurance:*

***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.***

The Medicaid Fiscal Agent – EDS - is responsible for ensuring that CAP/DA claims are paid correctly. All services are appropriately coded and audits and edits within the system ensure that claims are paid correctly.

CCME monitors paid claims to ensure that they are coded and paid correctly and that they correspond to the approved services in each participant’s POC. The Medicaid CAP/DA Unit monitors expenditures to ensure that monthly benefit limits are not exceeded and the program stays within its approved budget.

Planned performance measures include:

- Number and percent of claims reviewed that are coded and paid correctly (financial audit)

- Number and percent of claims adhering to reimbursement methodology in the waiver application
- Number and percent of claims reviewed where the claims paid are only for services specified in the participant's POC.
- Number and percent of participants reviewed that are within their monthly benefit limit

### **Remediation**

In conjunction with CAP/DA's waiver renewal (9/30/08), planning is underway to change payment methodology from monthly limits to aggregate funding. CAP/DA staff will work with the DMA Budget Office and CCME to develop methodology to track aggregate funding against the approved CAP/DA budget.

### **V. Critical Incident Reporting**

The State, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. Case managers will be required to report monthly on substantiations of abuse and neglect for Money Follows the Person participants.

Additional critical incidents for the aged and disabled population include falls, unplanned weight loss and unplanned hospitalizations. These are reported during the initial assessment, at annual continued need review and as needed in change of status assessment. Data is collected and accessed through AQUIP. Reports are run quarterly are reviewed to ensure that appropriate action was taken at the time of the incident. Reports are provided to the lead agencies and Division of Medical Assistance staff.

### **VI. Risk Management**

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each CAP/DA and CAP/CHOICE participant is identified as part of the intake and assessment process. These items are entered into the AQUIP assessment tool along with the Service Plan which is completed using the AQUIP Plan of Care Tool. The AQUIP system has the capacity to compare identified risk factors with elements of the plan to ensure these risks are adequately addressed for all CAP/DA and CAP/CHOICE participants. Each risk identified by the assessment process must be addressed in the individual's service plan.

Some example scenarios where service plans should address risk factors identified in the assessment process include:

1. An individual identified with a fall risk may need to have assistance while ambulating through the use of gait belt;
2. An individual with diabetes requires continuous monitoring of blood glucose levels (AC1s), specialized diet and physical activity;
3. An individual with a history of decubitus ulcers requires regular and continuing monitoring of skin to detect and prevent skin breakdowns; and
4. An individual with hypertension will require regular and continuing monitors of blood pressure.

Additionally, case managers monitor service plans with special consideration given to diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately on at least a monthly basis. Assessments are completed at intake, during continued need reviews, or as needed, when the health of the participant changes. Every time the assessment (initial, CNR, or a change in status) is completed, a plan of care is completed or amended based upon the most current assessment.

AQUIP generates reports of service plans that do not address risk factors identified in the assessment. These reports are reviewed by CAP/DA staff and feedback is provided to the specific CAP/DA lead agency where the assessment and service plan were completed. The interventions, as set forth in the individual's service plan, designed to minimize risk will be assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

## **VII. CAP/DA and CAP/CHOICE – 24-Hour Back Up**

While the need for 24/7 care coverage is assessed and addressed in each CAP/DA participant's service plan, including a back up plan for needed care coverage that includes formal and informal supports, there are times when the most comprehensive service plans can be insufficient.\* For participants with diagnoses that require rapid access to EMS CAP/DA provides for the use of telephone response systems. The CAP/DA case manager checks this system on a monthly basis to ensure it works properly and reviews any reports from the Emergency Response System Provider. This case management activity is documented in the client's case notes.

For other non-emergency but critical support needs, the CAP/DA Case Manager is available to assist the participant during the agency's normal business hours. Information regarding these interactions is available to Division of Medical Assistance staff during participant record reviews during lead agency site audits. In addition, the case manager is required to perform a monthly review of the provision of services with both the client and the agency providing the services. Any deviation in waiver service provision is to be documented in case manager's notes and a detailed description of how the client's needs were met are included. Division of Medical Assistance staff provides feedback regarding any deficiencies noted during the review including inadequate actions and issues not handled in a timely manner.

After hours, North Carolina's *CareLine*, a toll-free hotline designed to assist North Carolina citizens in need of supports and services, has live operators 24 hours a day, seven days a week. The *CareLine* operator is able to assess a participant who is in a crisis or emergency and can coordinate access to critical medical supports. *CareLine* staff logs and tracks each call and compiles reports and recommendations for each encounter. The Division of Medical Assistance recognizes the importance of evaluating this data and will work collaboratively with the *CareLine* program to develop regular reporting and a method for evaluating and using this information to improve the quality of CAP/DA. MFP clients will be flagged in the system and report will be generated specifically on these clients.

\* 24 Hour Care Coverage Plans are completed for only those participants identified as needing around the clock care supports critical for his/her health and welfare. For the purposes of the Money Follows the Person Project all participants designated for MFP are required to have a 24 hour coverage plan, regardless of the need for 24 hour care coverage.

## **VIII. Evaluation of Quality Management**

The Facility and Community Care (FCC) Section of the North Carolina Division of Medical Assistance (DMA) is responsible for managing ten Medicaid long-term care programs and services, including three home and community-based (HCBS) 1915c waiver programs – CAP/DA, CAP/CHOICE, and CAP/Children. These HCBS waiver and Medicaid state plan services are provided in facility, assisted living, and home and community-based settings. FCC staff has been developing a section-wide Quality Management Program to improve the overall quality of long-term care services provided to Medicaid recipients. The overarching

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purpose of the Quality Management Program is to develop, implement and continuously improve a quality management system that incorporates the strategies and related activities documented in the Quality Management Work Plan. The HCBS Quality Framework and HCBS waiver assurances work together as the blueprint for the FCC Quality Management Plan.

For the HCBS waiver programs, including CAP/DA and CAP/CHOICE, FCC will employ a Quality Improvement Strategy Plan based on the assurances in Version 3.5 HCBS Waiver Application. This document begins a dialogue of how FCC is conducting an evaluation of quality management systems for its HCBS waiver programs and state plan services.

## **Attachment H1**

**North Carolina  
DMH/DD/SAS  
Quality Management Strategy for Money Follows the Person (MFP)  
For Persons with Mental Retardation/Developmental Disabilities  
June 14, 2008**

### **Introduction and Purpose**

The purpose of the Quality Management plan is to ensure that discovery processes and systems for remediation and quality improvement take into consideration the specific and unique needs of individuals with developmental disabilities leaving public institutions and private ICFs. Components of the plan include oversight and evaluation of the transition process, the successes and barriers to success in community living, the effectiveness of back-up systems, and the risks that might lead to harm and/or re-institutionalization.

North Carolina is aware that this MFP initiative occurs within the state's overarching Quality Management System for HCB waiver services. To the degree possible it will enable the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) to collect data across all CAP-MR/DD waiver participants and compare data between Money Follows the Person (MFP) and non-MFP waiver participants.

The North Carolina Quality Management System (QMS) is designed to capture data and address issues at every level--individual, provider, local management entity (LME), and state. Section I includes a description of each level's roles and responsibilities to ensure quality. Section II describes the various discovery processes/data sources that are employed to measure quality across all the CMS assurances generally and the quality of services and supports to MFP participants specifically. Section III aligns the discovery processes and responsibilities with all the CMS assurances. Section IV describes how data from the various monitoring processes are used to develop improvement strategies. Section V describes how the QMS is evaluated to ensure that it continues to generate valid, reliable and actionable data.

### **I. Roles and Responsibilities for Oversight and Quality Improvement**

Each level of the system has well-defined roles and responsibilities to ensure the quality of the services and supports. While this is important for all individuals with developmental disabilities receiving CAP-MR/DD waiver services, it is even more critical for individuals transitioning from institutions who, in all likelihood have intensive support needs. Following is a description of specific roles and responsibilities beginning with monitoring at the most important level--- the individual.

#### **• Individual Level**

- **Transition coordinators** identify needed and preferred services with the individual and family. Transition coordinators ensure that the transition plan addresses any risks that might be a barrier to a successful transition to community life.
- **Case managers** are responsible for facilitating the development of the Person-Centered Plan/Plan of Care (PCP/POC) and ensuring that it includes all needed services and supports. The case manager ensures that the PCP/POC includes an updated risk assessment and any services/supports necessary to

mitigate risk over time. As well, the case manager has a key role in the development of a viable back-up plan. The case manager has primary oversight responsibility for monitoring the implementation of the PCP/POC to determine whether identified services and supports are being delivered and if the individuals' needs change, that the plan is revised. Case managers conduct monthly visits to oversee PCP/POC implementation, ensure health and safety, identify any additional risk factors and determine whether the back-up plan remains effective. Monitoring will be governed through use of a standardized monitoring tool.

- **Provider Level** quality management responsibilities are as follows:
  - Implement the PCP/POC, including risk mitigation strategies and the back-up plan.
  - Address Level I incidents (e.g., injuries that do not require hospitalization or medical treatment other than first aid).
  - Report quarterly aggregate information to the LME on a Level I incidents.
  - Report Level II incidents to the LME (e.g., incidents where police are involved, injuries requiring medical treatment).
  - Report Level III incidents to the LME and DMH/DD/SAS (e.g., incidents that cause permanent injury or death).
  - Develop and implement an internal quality improvement plan.
  - Develop and convene an internal client rights committee.
  
- **Local Management Entity (LME)** quality management responsibilities are as follows:
  - Serve as the single portal for HCB services eligibility.
  - Provide or arrange for 24/7/365 crisis response system.
  - Conduct the endorsement process for providers.
  - Conduct ongoing monitoring of endorsed providers based on a standardized monitoring protocol and scheduled based on a confidence level calculation.
  - Provide technical assistance to providers.
  - Oversee and provide follow-up of to ensure implementation of plans of correction.
  - Implement a quality improvement system that includes an incident review committee, external consumer/family advisory committee (CFAC), quality improvement committee, and client rights committee.
  - Receive, track and respond to participant complaints and appeals.
  - Receive, track and respond to incident reports from providers; prepare incident trend reports for DMH/DD/SAS.
  - Assess community service needs and develop provider capacity.
  - Monitor and oversee the transition process for individuals returning to the catchment area from a state institution.
  - Monitor and oversee case managers working with individuals leaving state facilities to ensure they are monitoring health and safety and implementation of the PCP.
  
- **State Operating Agency – Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)**

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- Assist in the identification of individuals choosing the option to return to community living through implementation of a standardized Community Options Interest Survey
  - Collect, aggregate and analyze statewide and sub-state incident and complaint data
  - Develop expectations through the promulgation of performance contracts with LMEs
  - Routinely monitor the performance of LMEs
  - Conduct yearly accountability audits of the LMEs and providers, including a targeted review of all participants in MFP, using a standardized review instrument
  - Conduct surveys of individual and family outcomes
  - Conduct reviews of high cost PCPs (over \$85,000) and all PCPs of individuals participating in MFP regardless of cost, using a standardized survey instrument
- **Single State Agency - Division of Medical Assistance (DMA)**
    - Conduct monthly audits of a sample of LOC/PCPs for waiver participants.
    - Conduct fiscal audits of the waiver programs.
    - Review data/evidence from DMH/DD/SAS on the waiver program.
    - Require remediation by DMH/DD/SAS for any identified issues and conduct ad hoc reviews of the waiver program.
    - Meet with DMH/DD/SAS on at least a quarterly basis to review trends and to communicate information on any new CMS policies and procedures.
    - Enroll qualified providers.
    - Oversee the performance of the Utilization Review vendor (UR vendor).

## II. Money follows the Person Discovery Processes/Data Sources

- **Pre-Transition**

Individuals (and their families/guardians), who currently reside in State Developmental Centers or community ICF MR living arrangements, will at least on an annual basis:

- Complete a Community Interest Survey with their family and or guardians.
  - Be given the information on what an HCB waiver is; what the advantages of participating in the HCB waiver are; and be given the opportunity to learn more about the HCB waiver at their annual review meeting.
  - Be allowed to express an interest in participating in the HCB waiver program. If a request for participation is made, the DD Center staff will be responsible for assisting the individual and their team in the next steps for community living.
- **Case Management Monitoring Protocol**

In the service array for participants in the MFP project, case management plays a crucial role. The case manager's most important task is to meet with the participant at least monthly to monitor and determine if all services in the PCP/POC are being provided according to the plan, if the back-up is being implemented as written, if the participant is satisfied with services and if the participant's service/support needs or preferences have changed. There are other tasks conducted during the face to face meeting, but the most important is the evaluation of the participant's health, safety and welfare and the timely and appropriate action taken if a risk to the health, safety or welfare is discovered. A Case Management monitoring tool is

being developed specifically for use by the case manager to assess the MFP participant and the delivery of the services and supports identified on the PCP/POC, during the face to face meeting. The monitoring tool will address health changes, back-up plan, risk factors such as injuries, incidents, needs changes, etc.

- **Backup Plan**

The CAP-MR/DD waiver guidelines require all providers to have a process for ensuring 24 hour back-up (24/7/365) availability, so that a live person is accessible when needed. All participants of CAP-MR/DD waiver services are informed of and provided with information related to back-up staff at the time of identification of provider and during the PCP/POC planning process.

Providers of 24 hour services and Targeted Case Management services act as the First Responders if and when the participant or a member of their support system initiates contact for assistance in the case of an emergency. The provider is required to notify the participant and his or her support system of the process for accessing emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at the initial contact. The notification includes contact information for an alternate source of assistance in the eventuality that the provider is not available.

The PCP/POC is expected to address how the provider will ensure back-up staff are available, if the staff regularly assigned to provide services are unavailable. The back-up staff must be trained to meet the specific needs of the participant, as detailed in the PCP/POC, including health, mobility, communication, risks behavioral issues, and skill training.

Each provider will be required to document and track receipt of calls and requests for back-up staff and staff unavailability. This report will be submitted to the LME on a monthly basis for tracking and analysis.

- **Utilization Review (UR) Process**

The CAP-MR/DD case manager annually reassesses the participant's need for CAP-MR/DD funding by completing a Continued Need Review (CNR). The case manager completes a CNR to determine if the person continues to meet criteria for ICF-MR LOC and remains appropriate for CAPMR/DD funding. The CNR is completed during the birth month of the individual. The NC-SNAP must also be updated during this time. If the CNR is not completed and submitted within the local approval timelines, the person must be terminated from CAP-MR/DD services. Claims for services provided after the CNR month will be denied and may not be recouped.

The Case Manager (CM) is responsible for submission of all CNR(s) to the state-contracted UR vendor in a timely manner to ensure continued service. The LME is responsible for monitoring CM agencies to ensure compliance to CAP-MR/DD waiver requirements.

1. Each CM agency will provide the LME a monthly *Caseload Report* listing all CNRs due that month. The report includes the participant's name, address, provider(s), date of birth, date of last CNR, MR 2 reviewed by the LME, and CM agency name and point person. The LME will be responsible for forwarding the *Caseload Report*, per CM agency, to the UR vendor monthly. The UR vendor will develop and implement a database to track the CNR(s) received or missing. This information will be updated at least annually or as necessary.
2. The CM will develop a tickler system indicating PCP/POC due dates for each participant on their case load to serve as a management tool to ensure the completion of PCP/POC(s) in a timely manner.
3. The LME review will note the date of receipt of the MR2 on the noted list.

4. The CM will submit the PCP/POC information to the UR vendor prior to the birth month for review.
5. The UR vendor will report to the LME (using the information from their tracking database) by the first day of each month the names of participants and the assigned CM agency for which they have not received a completed PCP/POC.
6. The LME will be responsible for contacting the CM agency by the 5<sup>th</sup> business day of the month to determine the reason for the lapse of the PCP/POC and take the necessary corrective action.
7. The CM agency will submit to the LME and UR vendor a completed PCP/POC within 5 days of the notice from the LME of the lapsed PCP/POC.
8. The LME will supply to the DMH/DD/SAS Best Practice Team a ***PCP/POC Timely Submission Report***, by the 15<sup>th</sup> of the month, indicating the names of the CM agencies that have submitted PCP/POC(s) beyond required timelines, including the specific Case Manager(s) and the corrective action implemented.
9. The DMH/DD/SAS Best Practice Team will follow-up with LME(s) regarding the ***PCP/POC Timely Submission Report*** to ensure appropriate corrective actions are implemented and systems are in place to ensure timely submission of PCP/POC(s).

The DMH/DD/SAS Best Practice Team will conduct a clinical and technical review of the PCP/POC of participants of MFP to determine whether they comport with the waiver policy and procedure, state's policies and procedures including any required assessments, timelines, crisis plans, risk assessments, etc. This review includes assuring that issues identified in risk assessment, assessments, and evaluations have been addressed; that identified needs of the individual are addressed and appropriate providers have been identified. The Best Practice Team also reviews the plan to assure consumer rights has been protected through the individual's involvement in the planning process, consent for services and external reviews such as Human Rights Committees as appropriate. The review includes assuring that items identified in the risk assessment are addressed and protections of rights have been included. PCP/POCs not meeting guidelines will be reviewed with the UR vendor and/or the CM and corrections will be made to bring the plan in compliance prior to the approval of the plan.

The Behavioral Health Unit of DMA and the UR vendor conduct quality assurance reviews monthly that include a review of the PCP/POC for individual waiver participants. Each month DMA selects a random sample of 15 PCPs/POCs that were active on the last day of the review month. The state contracted Utilization Review vendor conducts a monthly audit of 25 randomly selected PCP/POCs to supplement the DMA audit.

Reviews occur either on site or the records are sent by the provider to DMA and the UR vendor for a desk review. The reviewer looks for a current MR2, documentation that the participant is at risk of institutionalization or was de-institutionalized, where the participant resides while on the program, and a current, approved PCP/POC to insure that services are appropriate to the needs of the participant. The PCP/POC is further reviewed to insure that services and supports provide for the participant's health, safety and well being and that services were provided according to the approved PCP/POC during the review month.

- **LME Endorsement of Qualified Providers**

The LME(s) are required to complete the Provider Endorsement process per request by providers seeking to become directly enrolled Medicaid providers. Provider Endorsement is a verification and quality assurance

process using statewide criteria and procedures. Provider Endorsement is a prerequisite for direct enrollment with the DMA and consists of two parts: business verification and site/service approval. An endorsed provider must be directly enrolled by DMA prior to delivering and billing covered Medicaid services.

In order to ensure providers continue to meet established quality standards LME(s) conduct re-endorsement of providers three years after the initial endorsement. This process includes verification of the National Accreditation status of the provider and a letter of attestation, using return receipt/certified mail, that includes the current business information (name, business status, and address), and any dissolutions, revocations, or revenue suspensions that have occurred over the past 3 years. The LME retains the right to conduct an onsite review based on the information contained in the letter of attestation. If the information submitted meets endorsement requirements the LME renews the Provider endorsement for three more years. If at any time the provider organization's National Accreditation status lapses or is withdrawn, the provider organization must notify the LME.

- **LME Monitoring of Providers**

The LME(s) have responsibility through the Performance Contract with the DHHS (See next section) for Provider Monitoring. Such monitoring does not duplicate regulatory authority or functions of agencies of the DHHS. It includes first responder capacity and quality, consumer rights protection, and compliance with documentation requirements. In addition, a function of the LME is to assure to the DHHS that providers in the LME catchment area are in substantial compliance with requirements of the service for which the LME has endorsed the provider. The LME must evaluate its level of confidence in at least one fourth of the endorsed and/or contracted providers in its catchment area each quarter, and monitor 100% of providers rated in the lowest category of confidence every quarter.

LME monitoring of providers includes determining providers' progress in achieving national accreditation, first responder capacity and quality, compliance with data submission requirements, consumer rights protection, incident reporting requirements, meeting defined quality criteria, adherence to evidence-based practices in the delivery of services and compliance with DHHS documentation requirements. (Although there is currently not a specific measure in place related to 24-hour back-up requests, it is clearly a function of the LME monitoring processes and will be incorporated into the Performance Contract within two years of the waiver implementation.) The Frequency and Extent Monitoring (FEM) tool to determine confidence levels and standardized monitoring tools are being implemented statewide to ensure that providers remain in compliance with the aforementioned criteria.

- **DHHS Monitoring of LMEs**

The DHHS has a contractual relationship with the LMEs. Annually the DHHS and each LME sign a LME Performance Contract indicating the specific roles and functions of the LME, including specific performance indicators. The DMH/DD/SAS has a variety of methods for monitoring the LMEs' performance regarding the DHHS LME contract. The DMH/DD/SAS LME Systems Performance Team (LME Team) has direct responsibility for monitoring the performance of the LMEs based on the DHHS LME Performance Contract. The DMH/DD/SAS monitors the LMEs for compliance with the terms of this Contract and publishes individual and comparative reports regarding the LME's performance under this contract. The LME Team works with the LMEs providing technical assistance regarding the findings of the reports.

DMH is developing a comprehensive systematic monitoring process to address the nine functions indicated in the DHHS LME Performance Contract.

- **DHHS Monitoring of Providers**

Annually the Accountability Team and the DMA Behavioral Health Unit conduct a Medicaid Compliance Audit that includes CAP-MR/DD waiver services. Auditors review directly enrolled Medicaid providers using a two stage simple random sample. The first stage of the sample is of directly-enrolled providers of CAP-MR/DD services distributed across the state. The second stage is a sample within each provider agency of claims paid for services provided during a specific time period. This review includes monitoring of requirements that address staff qualifications, service authorizations, PCP/POC, service documentation, and billing protocol.

- **Complaint Review**

The DMH/DD/SAS Accountability Team and the DMA Behavioral Health Unit conduct on site reviews of all LME and provider responses to reported complaints. The DHHS Performance Contract with the LMEs requires that the LME report quarterly on complaints and use complaint data for planning, decision making, and improvement. The reports analyze and summarize patterns and trends related to consumers, including incidents and client rights issues, as well as complaints. Maintenance of a fully functioning Client Rights Committee is a requirement of the LME in the Performance Contract between DHHS and the LMEs. This is monitored through the DMH/DD/SAS Customer Services Community Rights (CSCR) Team' analysis of data on complaints that come to the state, as well as annual Client Rights Committee reports that are submitted by the LMEs to its Area Board.

- **National Core Indicators**

DMH/DD/SAS will collect information on individuals involved in the MFP program and their families through the National Core Indicators (NCI) surveys, a joint project between the National Association of State Directors of Developmental Disabilities Services (NASDDD) and the Human Services Research Institute (HSRI). Face-to-face interviews will be conducted on a random sample of about 1,200 individuals with developmental disabilities who received services other than case management in the survey year. In addition, surveys will be mailed to the family members or legal guardians of the individuals in the random sample eligible for the mailed survey. The surveys provide data on a variety of domains that include individual outcomes and satisfaction with the services and supports that the individual receives from developmental disabilities services. DMH/DD/SAS will review the survey questions and if needed, add specific questions relevant to the MFP program.

- **Risk Management/Mitigation**

As a preliminary step, the MR2 assessment form which documents ICF-MR level of care, along with the NC-Service Needs Assessment Profile (NC-SNAP), will be used to identify potential risks to the participant. A Crisis Prevention Plan is incorporated within the PCP/POC. The Crisis Prevention Plan includes supports/interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive). The proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to address them. The reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond. The planning team are to consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably.

Other assessment tools will be utilized to identify potential risks for all MFP participants. The Risk Assessment tool identifies potential risk, such as but not limited to, situational, environmental, behavioral, medical, and financial risks. If a risk is identified and the planning team concurs, the risk identified will be

documented within the Crisis Prevention Plan of the Person Centered Plan. The Supports Intensity Scale (SIS) is an assessment tool that measures practical support requirements of a person with an intellectual disability. Unlike traditional assessments, the SIS focuses on what daily supports a participant needs to live as independently as possible within their community. A major strength of the SIS is that it identifies supports that are needed to help a participant be successful in a variety of life domains. As such, during the PCP/POC planning meeting, as needs are identified, corresponding supports should also be identified to assist the consumer in meeting those needs. The PCP/POC will identify and document strategies to address risks identified in the Risk Assessment Tool and the SIS. The Risk Assessment Tool and the SIS can be used independently or in collaboration to identify potential risk to the participant.

- **Incident Management System**

North Carolina Administrative Code 10A NCAC 12G.0603 requires all LMEs and agencies providing mental health, developmental disabilities or substance abuse services to any person receiving public funds to participate in the DMH/DD/SAS-coordinated system for responding to and reporting critical incidents and other life endangering situations. This will include the MFP participants. Critical Incidents are defined as any happening which is not consistent with routine operation of a facility or service in the routine care of participant and that is likely to lead to adverse effects upon the consumer. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and participant behavior issues.

Providers are responsible for responding to all incidents and submitting to the LME reports on all Level II incidents (e.g., incidents where police are involved, injuries requiring medical treatment). Providers submit to both the LME and to DMH/DD/SAS reports on all Level III incidents (e.g., incidents that cause permanent injury or death). Providers also report quarterly aggregate information to the LME on a Level I incidents (e.g., injuries that do not require hospitalization or medical treatment other than first aid).

LMEs are responsible for ensuring that providers submit incident reports as required and respond appropriately to minimize harm from the incident and the likelihood of future incidents.

LME's must report to DMH/DD/SAS quarterly on their analysis and response to trends on all incidents and deaths as part of the Performance Contract with the DHHS. The DMH/DD/SAS Quality Management and CSCR Teams provide oversight and technical assistance to the LMEs to ensure that Level III incidents are fully addressed by providers.

The DMH/DD/SAS Quality Management (QM) Team maintains an internal database on reported Level III incidents. From this data and the Quarterly Incident Reports submitted by the LMEs, quarterly and annual trend analysis reports are created and reviewed by the team for comparison on an LME level. The QM Team reviews the reports to identify trends that may need to be responded to by remediation and improvement activities to assure that the underlying philosophy and assurances of the CAP-MR/DD waiver are maintained. The Internal QM Review Committee (See Section IV) will also review these reports to identify trends and issues that may need remediation and improvement activities

### **III. CMS Assurances**

The following describes the ways in which the State of North Carolina ensures that the HCBS assurances are met. This section also describes the additional ways in which the state will carry out specific oversight of individuals leaving public institutions within each assurance.

- **Level of Care**

***An individual evaluation of LOC is provided for all applicants for whom there is a reasonable indication that services may be needed in the future.***

Currently the LME prioritizes applicants using a standardized Prioritization process. The MFP participants will be considered top priority for CAP-MR/DD waiver funding. CAP-MR/DD slots will be available for the MFP participants. All applicants, including MFP applicants, must have an approved LOC evaluation to determine if the applicant meets ICF-MR/DD level of care criteria before CAP-MR/DD waiver services may be implemented.

The case manager submits the required LOC documents (MR-2 and a diagnostic assessment by a psychologist) to Murdoch Center (a DMH/DD/SAS Developmental Disability Center). The Murdoch Center LOC staff reviews the documents using the processes and instruments described in the approved CAP-MR/DD waiver to make a LOC determination. If the documents indicate the applicant meets the criteria for CAP-MR/DD waiver services, the LOC is approved.

The approved initial LOC documents are compared to the names of the prioritized applicants to make sure all prioritized applicants receive an LOC evaluation. The LOC reviewer maintains a database of reviewed, denied and approved applicants, their case managers and LMEs. A monthly report is generated as well as an annual aggregate report.

### **Remediation**

If it is discovered that an applicant for whom a slot has been identified has had no initial LOC application, the LME contacts the case manager to have the initial LOC evaluation started.

If the review process indicates the initial LOC evaluations are incomplete or need additional information, the Murdoch reviewer returns the documents to the LME who returns the documents to the case manager along with a request to amend the documents so that the review may be completed. The case manager has fifteen (15) days to return the amended documents to the reviewer. The reviewer has five (5) days to complete the review process. Murdoch maintains a database of these LOC evaluations, issues encountered and timeliness of submission and resubmission. The database also reflects the case managers and LMEs who serve the applicant. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team. A CAP-MR/DD Waiver Database is being developed to maintain the data from all waiver-related reviews. This database will facilitate the aggregation and analysis of the data.

***The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver.***

The PCP/POC must be updated annually for all enrolled CAP-MR-DD waiver participants, including the MFP participants. The annually updated PCP/POC is referred to as the Continued Need Review (CNR). The case manager submits the CNR to the UR vendor who is responsible for its review and approval. The UR vendor compares the list of participants who require a Continued Need Review (CNR) each month and the participants who have had the CNR completed by their birthday month. Using the same process as the UR vendor, the DMH/DD/SAS reviews all PCP/POCs for the MFP participants and all plans over \$85,000. The UR vendor and DMH/DD/SAS have ten (10) days to complete the reviews. Data will be generated by

the UR vendor with DMA on the CNRs due each month, CNRs approved/denied, and CNRs not submitted according to the waiver timeline, grouped by case manager and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH QM Team.

### **Remediation**

If the UR vendor or DMH/DD/SAS reviewers find issues with the CNR, they contact the case manager and request that corrective action be taken. The case manager has five (5) days to re-submit the CNR. DMA and the UR vendor conduct approximately 40 quality assurance reviews of PCPs/POCs each month. This review involves the evaluation of the participant's need for waiver services.

If issues are identified, the reviewer alerts DMH/DD/SAS, which contacts the case manager to request corrections. Both agencies maintain a database of the results of these PCP/POC evaluations, including issues encountered and timeliness of submission and resubmission. The databases also reflect the case managers and LMEs who serve the applicant. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

If it is discovered that a participant does not meet LOC definitions, the DMA notifies the DMH/DD/SAS, which contacts the LME who contacts the case manager to re-submit an updated LOC packet, so that eligibility may be re-evaluated. If it is ascertained that the participant does not meet eligibility requirements, his/her services will be suspended and non-waiver services will be pursued by the case manager. The case manager informs the participant of their appeal rights included in the DHHS appeals process.

If it is discovered that a participant does not meet LOC definitions, the DMA will also provide technical assistance to the LOC reviewer to prevent other non-eligible persons from being approved for waiver services in the future.

### ***The processes and instruments described in the approved waiver are applied to LOC determination***

The DMA, the UR vendor, and DMH/DD/SAS conduct a monthly review of PCP/POCs that includes a review of the participant's need for waiver services and evidence in the PCP/POC that services and supports provide for the participant's health, safety and well being (e.g. risk assessment, crisis plan, backup plan). The plans must include current MR-2s and diagnostic assessments.

### **Remediation**

If it is discovered that an applicant for whom a slot has been identified has had no initial LOC application, the LME contacts the case manager to have the initial LOC evaluation started.

If it is discovered that a participant has no CNR by their birth month, the UR vendor notifies the LME and the LME contacts the case manager to have the CNR completed. In order to continue provision of services, the case manager must request and receive approval from the UR vendor, for services to continue until the CNR is completed.

If it is discovered that an LOC initial packet is incomplete, the UR vendor returns the LOC initial packet to the LME. The LME contacts the case manager who must submit a complete LOC initial packet.

If it is discovered that a participant does not meet ICF-MR/DD LOC criteria, the DMA notifies the DMH/DD/SAS who contacts the LME who contacts the case manager to re-submit an updated LOC packet,

so that eligibility may be re-evaluated. If it is ascertained that the participant does not meet eligibility requirements, his/her services will be suspended and non-waiver services will be pursued by the case manager. The participant may choose to initiate the DHHS appeals process.

If it is discovered that a participant does not meet ICF-MR/DD LOC criteria, the DMA will also provide technical assistance to the LOC reviewer to prevent other non-eligible persons from being approved for waiver services in the future.

- **Service Plans**

***SPs address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means***

In order to ensure that all PCP/POCs address the assessed needs and goals of individual participants, the state uses a variety of methods, including the utilization review of all PCPs/POCs by the UR vendor and a review of a random sample of PCP/POCs by the DMA. DMH/DD/SAS reviews all plans over \$85,000, and a conducts a focused review of the transition plans and PCP/POC for all MFP participants. PCP/POC development will be reviewed during the ongoing monitoring process, including determining whether assessments are conducted as required, strategies in the plan address assessed needs, services are being implemented and the case manager is monitoring the plan. Monthly reports will be written by the reviewing agencies.

National Core Indicator data will be collected annually on participant/guardian opinions regarding their satisfaction with the way the PCP/POC meets the needs of the participant. These data, along with data generated by the reviewing agencies, will be aggregated, analyzed and reported by the DMH/DD/SAS QM Team.

**Remediation**

If the PCP/POC of an MFP participant is found by the DMH/DD/SAS to be out of compliance, the reviewer will notify the UR Vendor and/ or case manager. The UR Vendor will contact the case manager and request that the issue(s) be corrected. The case manager has five (5) days to submit the corrections to the UR vendor. The UR Vendor tracks whether the plan is revised in an adequate fashion. DMH/DD/SAS will follow up with the UR Vendor and the case manager to ensure that changes have been made.

The DMH/DD/SAS will review aggregate data on POC compliance to determine to determine any systematic issues and trends. The Division will do a targeted review of aggregate information for people being discharged from state facilities.

***The state monitors Person Centered Plan development in accordance with its policies and procedures***

The DMH/DD/SAS reviews all MFP participants' PCPs/POCs as well as those plans over \$85,000 and the UR vendor reviews all other PCPs/POCs. These reviews determine whether they comport with the state's policies and procedures including any required assessments, timelines, crisis plans, risk assessments, etc. The DMA also conducts monthly reviews of a sample of PCP/POCs. For individuals enrolled in MFP, DMH/DD/SAS staff will review each plan to determine that policies and procedures are honored. In addition, the DMH/DD/SAS Accountability Team reviews PCP/POCs as part of their annual provider reviews to determine whether or not plans meet state guidelines. As part of the LME monitoring of providers, a sample of plans is reviewed during regular monitoring of case management agencies.

Data will be generated by the reviewers based on findings and including the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH QM Team.

### **Remediation**

If a state reviewer discovers a plan out of compliance, a plan of correction will be required. The case manager has 5 days to submit the correction. The DMH/DD/SAS or DMA reviewer follows up to ensure the issue was resolved in accordance with the standardized PCP/POC policy.

If the LME finds a plan out of compliance during the provider review, the LME will require a plan of correction and will follow up to ensure that issue is rectified. If the problem persists, the LME can remove the provider's endorsement.

### ***Person Centered Plans are updated/revised at least annually or when warranted when there are changes in the participants needs***

The case manager notifies the LME 30 days before the expiration of the PCP/POCs. The UR vendor generates a monthly list of PCP/POCs that were renewed annually and plans that were not updated in a timely fashion. In addition, the DMA monthly review of plans, the LME review of case management agencies, and the DMH/DD/SAS review of providers will also assess whether plans are renewed in a timely fashion and whether plans changed as individual needs changed. For MFP participants, the state will develop a standardized case management tool to canvass any changes in needs during the year. Data will be generated by the reviewers based on findings and grouped by the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

### **Remediation**

When the DMH/DD/SAS identifies a participant who's PCP/POC has not been renewed, staff will contact the LME who will in turn contact the participants' case manager and ask for a plan of correction. Further, if the DMH/DD/SAS Accountability Team, DMA, or LME provider monitoring uncovers individuals whose needs have changed without the appropriate plan revision, the LME will ask for a plan of correction and follow-up would be carried out.

### ***Services are delivered in accordance with the Person Centered Plan, including the types, scope, amount, duration, and frequency specified in the Person Centered Plan.***

To ensure that services are delivered as included in the plan, the case manager will use a standardized case management checklist during each monthly face to face interview with the consumer. The checklist will facilitate the case manager's conducting a consistent review on a continuous basis to assure that services are delivered as specified in the PCP/POC. The review includes monitoring provider services, data and time sheets, as well as monitoring the billing. The LME will conduct a review of the case manager's process that will include an annual review of all MFP providers. Data will be generated by the reviewers based on findings and grouped by the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH QM Team.

### **Remediation**

If it is discovered that services are not being delivered in accordance with the PCP/POC, the case manager or LME addresses the issue(s) with the provider and works with the provider to resolve the issue. If the provider fails to resolve the issue adequately, the case manager may address the issue with the participant and suggest a change of provider. The provider can be reported to DMA's Program Integrity unit for auditing if warranted. The LME can also revoke the provider's endorsement.

***Participants are afforded choice between [CAP-MR/DD] waiver services and institutional care, and between/among waiver services and providers.***

The PCP/POC for each participant will include statements attesting that the participant/guardian has been notified of the choice of CAP-MR/DD waiver or institutional care and the choice of CAP-MR/DD waiver services and providers. The participant must sign the statements in order for them to be valid. The PCP/POC cannot be approved without this evidence. The UR vendor and the DMH/DD/SAS reviewer will contact the case manager to request the signed documents. The DMH/DD/SAS reviewer may contact the UR vendor and ask them to request the signed documents for the PCPs/POCs over \$85,000. Data will be generated by the reviewers based on findings and including the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

### **Remediation**

If the UR vendor reviewer finds the signature(s) to be missing, the reviewer contacts the LME who contacts the case manager. The DMH/DD/SAS reviewer may contact the UR vendor or the case manager directly and request the appropriate signatures be obtained. The case manager has 5 days to submit the requested documents.

- **Qualified Providers**

***The state verifies that providers, initially and continually, meet required licensing and/or certification standards prior to their furnishing waiver services.***

The LME initially endorses all providers prior to service provision, but cannot endorse if the provider is found to be out of compliance with any licensing or certification standard. The Division of Health Services Regulations (DHSR) licenses the provider agency, if it meets all licensing requirements. The LME and DMH/DD/SAS Accountability Team monitor the providers on a scheduled basis. Their monitoring includes reviewing the provider's documentation and observing service provision, both of which may indicate whether licensing and/or certification requirements have/are being met. DHSR monitors each licensed provider annually to see if all licensing requirements are being met. Data will be generated by the all reviewers based on findings and including the case management agency and LME. The annual reports will be written by the reviewing agency. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

### **Remediation**

If the LME or DMH/DD/SAS Accountability Team finds an endorsed provider out of compliance with any certification standard, they may require a Plan of Correction (unless the compliance issue may or is endangering participants, in which case the endorsement could be immediately revoked). The same is true if DHSR finds a licensing issue. The provider has 15 days to submit the plan of correction.

DHSR also conducts an investigation of a licensed provider against whom a complaint has been lodged. Results of the investigation will be shared with DMH/DD/SAS and the person who submitted the complaint.

When DHSR finds a licensing compliance issue, they may require a plan of correction, fine the provider, or revoke the provider's license. If a provider's license is revoked, their endorsement to provide services is immediately revoked as well.

After an agency submits a Plan of Correction, the LME or Accountability Team will conduct a follow up review to determine if the provider has corrected the issues. If not, the LME or Accountability Team may require another Plan of Correction. The LME may revoke the provider's endorsement, if the issues are still not corrected. The Accountability Team can also require the provider to reimburse the DMH/DD/SAS and/or Medicaid, if the discovered issues warrant such action.

***The state monitors non-licensed/non-certified providers to assure adherence to [CAP-MR/DD] waiver requirements***

For non-licensed, non-certified providers, the LME reviews the provider's qualification documents and endorses the provider if all qualifications are met. The LME monitors the provider on an ongoing basis, as does the DMH/DD/SAS Accountability Team. DMH/DD/SAS reviews all MFP participants' PCPs/POCs as well as those plans over \$85,000 and the UR vendor reviews all other PCP/POCs. These reviews determine whether plans comport with the state's policies and procedures, including any required assessments, timelines, crisis plans, risk assessments, etc. DMA also conducts monthly reviews of a sample of POCs. In addition, the DMH/DD/SAS Accountability Team reviews PCP/POCs as part of their annual provider reviews to determine whether or not plans meet state guidelines. As part of the LME monitoring of providers, a sample of plans is reviewed as part of the review of case management agencies.

Data will be generated by the reviewers based on findings and including the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH QM Team.

**Remediation**

If the LME or Accountability Team finds the provider out of compliance, they require a Plan of Correction. The LME or Accountability Team will then conduct a targeted monitoring review to determine if the provider has corrected the issues. If not the LME or Accountability Team may require another Plan of Correction. The LME may revoke the provider's endorsement, if the issues are still not corrected. The Accountability Team can also require the provider to reimburse the DMH/DD/SAS and/or Medicaid, if the discovered issues warrant such action.

***The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver***

The LME is responsible for monitoring the provider to ensure the provider has documentation to prove all training has been conducted in accordance with state requirements and the approved CAP-MR/DD waiver. This includes, but is not limited to, reviewing First Aid, CPR and medication administration training, as well as training specific to caring for individual participants. This will be vital for the success and safety of the MFP participants. The Accountability Team also reviews for the training documentation.

Data will be generated by the reviewers based on findings and grouped by the case management agency and LME. Monthly reports will be written by the reviewing agencies. The annual aggregate data will be analyzed and reported by the DMH/DD/SAS QM Team.

**Remediation**

If the LME or Accountability Team finds the provider out of compliance they may require a Plan of Correction. The LME or Accountability Team will then conduct a follow up review to determine if the provider has corrected the issues. If not the LME or Accountability Team may require another Plan of Correction. The LME may revoke the provider's endorsement, if the issues are still not corrected. The Accountability Team can also require the provider to reimburse the DMH/DD/SAS and/or Medicaid, if the discovered issues warrant such action.

- **Health and Welfare**

*The state, on an ongoing basis, identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation*

The case management monitoring protocol requires that the case manager must conduct a monthly face to face meeting with the participant to discover if all services in the PCP/POC that address health, safety and welfare are being provided according to the plan. The case management monitoring protocol also requires oversight of the participant's health, welfare and safety, including any injuries or other unusual incidents that may have occurred. Prior to or during the PCP/POC meeting, the team, along with the participant/guardian, conducts a risk assessment which is incorporated into the PCP/POC. The PCP/POC must address the identified risks in order that the consumer's risks may be minimized. The PCP/POC must also contain a Crisis Plan, as well as a behavioral plan as needed. The providers must participate in the DHHS incident reporting system. (See Section III.)

Health data from the National Core Indicators surveys is analyzed to ascertain what proportion of participants are receiving adequate health monitoring by doctors and dentists.

**Remediation**

The case manager must ensure that the Person Centered Plan is kept current with the participant's changing needs. When the case manager discovers that a participant is at risk, s/he must address the issue immediately or in a timely fashion as required. This may include anything from calling a team meeting to address the issue to getting medical care for the participant to seeing that the participant is removed immediately from the environment that has put him or her at risk. If the case manager discovers that the participant has had multiple incident reports submitted for the same or different incidents, s/he must address this with the team or in whatever manner is necessitated by the severity of the incident. The case manager must ensure that the crisis plan and behavioral plans are updated on a continuous basis as the participant's needs change.

The DMH/DD/SAS QM Team will aggregate and review complaint data, incident data, and National Core Indicators data – particularly those questions directed at whether individuals feel safe in their neighborhoods and homes – to examine any trends that suggest health and safety vulnerabilities of CAP-MR/DD waiver participants generally and MFP participants specifically. Troublesome trends will be reported to the LMEs for action and followed up by the DMH/DD/SAS.

- **Administrative Authority**

*The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of the waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

DMA's responsibilities include review of reports generated by DMH/DD/SAS and LMEs and review of all policies and procedures and information governing the CAP-MR/DD waiver. The DMA ensures that CAP-

MR/DD waiver slot allocations do not exceed approved limits and CAP-MR/DD waiver costs do not exceed estimated costs. DMA reviews participant PCP/POCs to ensure all CAP-MR/DD waiver requirements are met and ensures that CAP-MR/DD waiver services have prior authorization. DMA sets the standards for and oversees the provider enrollment process and all Medicaid provider agreements. With reference to MFP specifically, DMA will communicate any information regarding CMS policies, procedures, and technical assistance opportunities.

### **Remediation**

DMA must review all CAP-MR/DD waiver policies, rules, procedures, rates and service definitions prior to their final approval. If DMA has an issue with any item reviewed, they will notify DMH/DD/SAS to correct the issue. If DMA finds an issue with any report they review, they will return it to DMH/DD/SAS and ask for corrections, amendments, more analysis, etc. DMH/DD/SAS will correct the report to DMA's satisfaction. DMA may then opt to conduct a validation review.

## **IV. Quality Improvement**

Development of a quality improvement strategy for the CAP-MR/DD waiver and the developmental disabilities service system as a whole is one of the fundamental building blocks of Mental Health/Developmental Disabilities and Substance Abuse Services transformation in North Carolina. Quality improvement for the MFP participant services will be incorporated into the overall CAP-MR/DD QM system. This quality management system is built around a coordinated approach that defines, assigns and interprets quality related activities across various entities in the system. According to federal and state guidelines the DMA has responsibility for the overall operation of the CAP-MR/DD waiver. The DMH/DD/SAS is the lead agency overseeing the daily operations of the CAP-MR/DD waiver. The two Divisions cooperate in the operation of the CAP-MR/DD waiver program under a memorandum of understanding that delineates each division's responsibilities

The quality improvement strategy for the CAP-MR/DD waiver includes identification and regular reporting on performance measures that are accepted by the program managers and stakeholders, several committees responsible for reviewing patterns and trends to identify and build on successes and to address problems as they emerge, and processes for developing and implementing plans for improvement of service quality. Evaluation of the QI strategy will be done through self accountability, oversight by the DMH/DD/SAS and DMA leadership and through communication to and feedback from key stakeholders.

### **Quality Improvement Committees**

The State MH/DD/SAS has developed a quality management plan that integrates and analyses information from multiple sources and functions within the state system. The plan brings together partners and stakeholders, including consumers/families, provider agencies, LME representatives and representatives from the different parts of the State system. Following is a description of the major oversight/quality improvement committees:

- **Internal Quality Management Committee (IQMC)**

DMH/DD/SAS and DMA will establish the IQMC comprised of the members of the DMH/DD/SAS QM Team and other DMH/DD/SAS teams, and representatives from the DMA. The IQMC will be convened quarterly as part of the QM plan.

This committee will work to support and encourage systematic quality management systems and consistent expectations for all MH/DD/SAS consumers, including the MFP participants. The responsibilities of the IQMC include:

- Review QA/QI system data received from the responsible entities/agencies. The committee shall review the data at a minimum quarterly. Meetings shall be scheduled one time per calendar quarter. Meeting minutes shall be kept at all workgroup meetings.
  - Analyze data to determine patterns, trends, problems, and issues in service delivery of waiver services.
  - Make recommendations to the CAP-MR/DD Waiver program managers for changes in policy based on analysis of compiled QA/QI data.
  - Direct LMEs to provide training, technical assistance, or other activity, based on analysis of QA/QI data. Monitor the activity to assure consistent implementation statewide.
  - Continue to develop and refine the QA/QI quality indicators to be monitored.
  - Review and make changes to the QA/QI plan as needed to assure that the data gathered is generating useful information to improve quality of service delivery. At a minimum the plan shall be reviewed annually.
  - Review and modify the QA/QI policies and procedures as needed. At a minimum this shall occur annually
  - Disseminate information compiled from analysis of QA/QI data to appropriate stakeholders, including consumers, family members and system advocates.
- **Consumer and Family Advisory Committees**

Each LME is required by legislation to establish a Consumer and Family Advisory Committee (CFAC) made up of adult consumers and family members of consumers. Local CFACs are self-governing and self-directing bodies that advise the LME on the planning and management of the local public MH/DD/SAS system. Local CFACs undertake the following:

- Review, comment on, and monitor the implementation of the LME's local business plan.
- Identify service gaps and underserved populations.
- Make recommendations regarding the service array and monitor the development of additional services.
- Review and comment on the LME program budget.
- Participate in all quality improvement measures and performance indicators.
- Submit to the State CFAC findings and recommendations regarding ways to improve the delivery of MH/DD/SA services.

In addition, DMH/DD/SAS is required by legislation to establish a state CFAC, comprised of seven appointed members representing each of the three disabilities (21 total members). The State CFAC is a self-governing body that is responsible for carrying out at a statewide level the same activities as the local CFACs. In addition, the State CFAC is responsible for the following:

- Receive the findings and recommendations from local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.
- Submit to the DMH/DD/SAS findings and recommendations regarding ways to improve the delivery of MH/DD/SA services.
- Provide technical assistance to local CFACs in implementing their duties.

○ **MFP Advisory Group**

An MFP advisory group will be formed to review aggregate reports and make recommendations for improvement. This group will be comprised of 60% consumers and/or their families and 40% providers/advocates and other stakeholders. This group will meet at least four to six times per year to review the MFP data and processes and provide remediation suggestions. Recommendations will be reviewed and acted on by the IQMC.

○ **Other DMH/DD/SAS Internal Groups:**

- The **Executive Leadership Team (ELT)** is comprised of the DMH/DD/SAS Directors and Section Chiefs, Personnel Manager, and the representative from the State Attorney General's Office and meets weekly. It is responsible for providing strategic and operational leadership for the service system, setting overall policy direction, and approving all Division policy changes and initiatives.
- The **Clinical Oversight Team (COT)** is comprised of DMH/DD/SAS staff with expertise in the three disability areas (MH, DD and SA) and staff with quality management responsibilities. It meets weekly to review trends in service utilization, consumer safety, and complaints, to address clinical issues arising from the field, and to propose needed clinical policy changes.
- The **Transformation Strategy Group (TSG)** is comprised of mid-level DMH/DD/SAS management staff and meets weekly. It is responsible for responding to legislative mandates, chartering cross-team workgroups to develop and implement initiatives to improve the service system, and ensuring timely completion of assigned initiatives. It monitors progress toward system improvement goals and legislative requirements.

○ **Cross-Division and Stakeholder Groups:**

- The **External Advisory Team (EAT)** is comprised of representatives of LMEs and provider associations for each of the three disabilities and meets monthly. It is charged with advising the DMH/DD/SAS on proposed policy changes and emerging issues regarding the coordination and management of the service system.
- The **Local Management Entity Advisory Group (LAG)** is made up of representatives of the LMEs and meets monthly. It is charged with providing input from the perspective of LMEs on proposed changes in DHHS policies and operations, as they involve local management and oversight of the service system.
- The **Provider Action Agenda Committee (PAAC)** is made up of representatives of service provider agencies across the three disabilities. It meets monthly to discuss statewide issues that affect the provision of services and make recommendations to the DHHS for changes in policies and operations.

- The **Advisory Stakeholder Group (ASG)** is comprised of 60% consumers and/or their families and 40% providers/advocates. This group will meet four to six times per year to discuss and make recommendations on Medicaid policies and operations.
- **Performance Measures and QI Reports**

The CAP-MR/DD waiver includes QA/QI indicators that capture the activities above. Each indicator also includes the type and frequency of activities for gathering data specific to the indicator, the sampling methods for each indicator, how data will be collected, who will collect the data, and acceptable thresholds for each indicator. Through the analysis and review of process indicators, deviations from expected trends will be identified for further analysis and study. If applicable, special studies will be undertaken on prioritized measures to understand changes in trends.

Using the reports on the performance indicators from the CAP-MR/DD waiver and trend analysis of these and other reports, and observations by the CAP-MR/DD waiver team, consumers, families and service providers, the IQMC will set targets for quality and uniform services and develop improvement strategies as needed. There will be alerts set to ascertain when things are going right or wrong. When a problem is identified, the IQMC will facilitate an evaluation to find the source, after which, the CAP-MFP program managers will develop a remediation plan, if needed and assign implementation and follow-up to the appropriate staff.

#### **V. Evaluation of the Quality Management System (QMS)**

The IQMC will evaluate the performance of the QMS annually, including its own performance in achieving the specific responsibilities described above. The evaluation will include a continual review of the quality improvement initiatives implemented by the IQMC. The IQMC will assess the success of the processes undertaken for the monitoring the system. The IQMC process measures would include, but not be limited to, frequency of the meeting, the ability of the group to meet targets of the work plan, and timely review and mitigation of relevant measures. In addition, the IQMC will:

- Gather member input on how well the QMS is functioning and will make ongoing changes to internal processes, as needed to improve the effectiveness of the committee and its initiatives.
- Conduct an annual survey of members, other staff, and partners to gather perceptions of the QA/QI process and possible improvements.
- Review and modify the QA/QI policies and procedures as needed. At a minimum this shall occur annually based on the results of the partners survey and other information which are used to determine 1) adherence to current QA/QI policies and procedures, 4) usefulness of the quality indicators and other data used to monitor service delivery, and 3) effectiveness of the QA/QI process in improving care.

The DMH/DD/SAS Executive Leadership Team will approve the QM Plan and periodically review the status of the performance measures and the corrective processes undertaken by the IQMC.

## Attachment I

### North Carolina Quality Management Strategy for Money Follows the Person *Program of All-inclusive Care for the Elderly (PACE)*

June 10, 2008

#### I. Introduction and Purpose

The purpose of the Quality Management Plan is to ensure discovery processes and systems for remediation and Quality Improvement take into consideration the specific and unique needs of elderly and/or disabled individuals choosing to live in their community and home. This shall include oversight of the success of the transition process, successes and barriers experienced in community living, effectiveness of back-up systems, and risks that might lead to re-institutionalization.

North Carolina is aware that the *Money Follows the Person* initiative occurs within the state's overarching Quality Management System for home and community based waiver services. To the degree possible it will enable data collection across all waiver and *Program of All-inclusive Care for the Elderly* participants and compare data between *Money Follows the Person* and non-*Money Follows the Person* participants. While the *Program of All-Inclusive Care for the Elderly* is a state plan service and not a waiver service, it is just as essential to provide a quality management program that addresses many, if not all of the same aspects as those in the HCBS Waiver Programs.

The *Program of All-inclusive Care for the Elderly* model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

The *Program of All-Inclusive Care for the Elderly* serves individuals who are age 55 or older, determined by the state to need inpatient facility level of care, are able to live safely in the community at the time of enrollment, and live in a *Program of All-Inclusive Care for the Elderly* service area. Even though all *Program of All-Inclusive Care for the Elderly* participants must be determined to need inpatient facility level of care to enroll in *Program of All-Inclusive Care for the Elderly*, only about seven percent of *Program of All-Inclusive Care for the Elderly* participants (nationally) reside in inpatient facilities. If a *Program of All-Inclusive Care for the Elderly* enrollee does need inpatient facility care after enrollment, the *Program of All-Inclusive Care for the Elderly* program pays for it and continues to coordinate the enrollee's care.

Delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. Care and services include but are not limited to:

- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a Program of All-Inclusive Care for the Elderly physician familiar with the history, needs and preferences of each participant
- Home health care and personal care
- All necessary prescription drugs
- Social services

- Medical Specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and inpatient facility care when necessary

North Carolina's first *Program of All-Inclusive Care for the Elderly* is the Elderhaus program. It became operational on February 1, 2008 in Wilmington and has four enrollees at this time. A second *Program of All-Inclusive Care for the Elderly* program run by Piedmont Health Services is scheduled to begin operation this fall in Burlington NC. A third *Program of All-Inclusive Care for the Elderly* program run by St. Joseph of the Pines is developing a *Program of All-Inclusive Care for the Elderly* application for a program in Fayetteville NC with a likely start date of early to mid 2009. North Carolina's *Program of All-Inclusive Care for the Elderly* programs are in their infancy and receive frequent and ongoing monitoring and assistance from the North Carolina Division of Medical Assistance (DMA) and the North Carolina Division of Aging and Adult Services. North Carolina Division of Medical Assistance recognizes the need for continuous monitoring and evaluation of developing and existing *Program of All-Inclusive Care for the Elderly* programs and the need for ongoing and fluid collaboration with the staff of each *Program of All-Inclusive Care for the Elderly* program and the Centers for Medicare and Medicaid Services as these programs continue to develop and evolve. The Division of Medical Assistance has a full-time *Program of All-Inclusive Care for the Elderly* Program Manager to assist with the development and maintenance of all *Program of All-Inclusive Care for the Elderly* programs in North Carolina.

**II. Roles and Responsibilities for Oversight and Quality Improvement \*While the example provided below is specific to the Elderhaus PACE Center, it is expected that all PACE centers will have plans that address the same elements. PACE centers work in collaboration with North Carolina Division of Medical Assistance and Centers for Medicaid staff to ensure the development and implementation of a high quality management program.**

The Quality Assurance Performance Improvement Plan applies to all services provided by medical staff, employees, volunteers, contractors and others affiliated with Elderhaus *Program of all Inclusive Care for the Elderly*.

Responsibility for quality assessment and performance improvement ultimately rests with the organization's governing body, the Board of Directors for Elderhaus, Inc. This governing body has the final authority to commit adequate resources and create a culture to support Quality Assurance Performance Improvement efforts. The governing body will:

1. Activate the organization's mission by continually improving the quality of participant care and services;
2. Incorporate findings from quality assessment and improvement activities in strategic, program, and resource planning;
3. Provide guidance toward continuing education concerning the approach, methods, tools, and application of continuous quality improvement;
4. Establish broad guidelines for quality improvement activities in conjunction with the Elderhaus *Program of all Inclusive Care for the Elderly* Management Team;
5. Guide process analysis and improvement;

6. Provide for and review an annual evaluation of the performance of the Elderhaus *Program of all Inclusive Care for the Elderly* Quality Assurance Performance Improvement Program.

The Elderhaus *Program of all Inclusive Care for the Elderly* Management Team provides oversight of all Elderhaus Program ACE Quality Assurance Performance Improvement activities. The Elderhaus *Program of All inclusive Care for the Elderly Quality Improvement Coordinator* will be responsible for ensuring that quality data are collected from all appropriate sources, that the data are examined and that results are shared with all appropriate staff and/or committee members for follow-up action. The Quality Improvement Coordinator will produce an annual Quality Management Summary to be reviewed with the Management Team and passed up to the Elderhaus *Program of all Inclusive Care for the Elderly* Board of Directors. This report will also be submitted to the Division of Medical Assistance.

The Division of Medical Assistance *Program of All-Inclusive Care for the Elderly* Program Manager provides prior approval through the State's standardized assessment tool (currently the FL-2 form) process. This process includes an initial review of each participant's assessments and service plan. Service plans and related assessments are reviewed annually or as revisions are necessary. The *Program of All-Inclusive Care for the Elderly* Program Manager performs each *Program of All-Inclusive Care for the Elderly* program's site readiness reviews for CMS which includes compliance with local, state, and federal authorities pertaining to the policy and operation of each program. All *Program of All-Inclusive Care for the Elderly* programs are required to have Adult Day Health Care certification which is a provision of the Division of Aging and Adult Services. The Quality Assurance Performance Improvement Plan and the requirements for the "State Administering Agency" (NC DMA) are further detailed in the Three Party Program Agreement between the *Program of All-Inclusive Care for the Elderly* Center, the North Carolina Division of Medical Assistance and the Centers for Medicare and Medicaid Services. (See also Appendices K, Q, R, and S).

### III. CMS Assurances

#### Level of Care

North Carolina Medicaid requires that a level of care determination be made on all participants seeking home and community based services, including the *Program of all Inclusive Care for the Elderly*, by using a standardized screening tool (currently the FL-2 form) for determining nursing facility level of care. Procedures exist to assure that individuals reflect inpatient facility level of care after a complete assessment. Level of care is re-evaluated annually.

#### Service Plan – Plan of Care (includes oversight of back-up plans and risk planning and mitigation)

Service Plans address all participants' assessed needs (including health and safety risk factors) and personal goals that are provided by the *Program of All-Inclusive Care for the Elderly* Center

The state monitors the Service Plan development in accordance with CMS and North Carolina's policies and procedures

The Service Plan is updated / revised at least annually or when warranted when there are changes in the participants needs

Services are delivered in accordance with the Service Plan, including the types, scope, amount, duration, and frequency specified in the Service Plan

Participants are afforded choice between *Program of All-Inclusive Care for the Elderly* services, institutional care, waiver services, and state plan services.

Service Plan assurances are monitored by the *Program of All-Inclusive Care for the Elderly* Program Manager through monthly contacts and site visits which occur at no lesser interval than quarterly.

### **Qualified Providers**

The state verifies that providers, initially and continually, meet required licensing and/or certification standards prior to their furnishing services

The state monitors non-licensed/non-certified providers to assure adherence to Federal *Program of All-Inclusive Care for the Elderly* and North Carolina criteria and requirements.

The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver

### **Health and Welfare**

The state, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. All incident reports are provided to the *Program of All-Inclusive Care for the Elderly* Program Manager for review. This includes reports of critical incidents. Reports are reviewed to ensure that appropriate action was taken at the time of the incident, whether further investigation is needed, and if further action or training may be required to ameliorate and/or prevent any recurrence of the incident.

### **Administrative Authority**

The North Carolina Division of Medical Assistance shares authority and responsibility for the operation of *Program of All-Inclusive Care for the Elderly* programs with the Centers for Medicare and Medicaid Services. North Carolina Division of Medical Assistance exercises oversight over the performance of each *Program of All-Inclusive Care for the Elderly* program. Any deficiencies identified by the State Administering Agency's *Program of All-Inclusive Care for the Elderly* Program Manager are shared with CMS *Program of All-Inclusive Care for the Elderly* staff.

### **Critical Incident**

The state, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. All incident reports are provided to the *Program of All-Inclusive Care for the Elderly* Program Manager for review, including critical incident reporting. Reports are reviewed to ensure that appropriate action was taken at the time of the incident, whether further investigation is needed, or if further action or training may be required to ameliorate and/or prevent any recurrence of the incident.

Each *Program of All-Inclusive Care for the Elderly* Center is required by CMS to report all critical incidents to CMS. All information provided to CMS is also submitted to the North Carolina *Program of All-Inclusive Care for the Elderly* Program Manager for review.

### **Risk Management**

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each *Program of All-Inclusive Care for the Elderly* participant are identified during an on-going interdisciplinary assessment process that is very thorough and comprehensive. Each risk identified by the assessment process must be addressed in the individual's service plan. For example, an individual identified with a fall risk may need to have assistance while ambulating through the use of gait belt, or, an individual with a history of bowel obstructions may require a more thorough monitoring of bowel movements and/or a specialized diet to help prevent hospitalizations. Since *Program of All-Inclusive Care for the Elderly* Centers serve a significant number of individuals with cognitive impairments and/or dementia, wandering and elopement is often an issue. Any individual identified with a dementia-like diagnosis is monitored using a Wander-guard system. The North Carolina *Program of All-Inclusive Care for the Elderly* Program Manager will monitor Service Plans with special consideration given to

diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately. Any service plan that is deficient in this regard must be amended before approval. Additionally, any interventions designed to minimize risk will be assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

### **24 Hour Back Up**

While the need for 24/7 care coverage is assessed and addressed in each participant's service plan, including a back up plan for needed care coverage that includes formal and informal supports, there are times when the most comprehensive plans can be insufficient. For this reason, each *Program of All-Inclusive Care for the Elderly* center is required to have a 24/7 on-call staff person who is able to assist any *Program of All-Inclusive Care for the Elderly* participant who is in a crisis or emergency who needs to obtain access to critical medical supports. The *Program of All-Inclusive Care for the Elderly* participant, their legal (as applicable) and family members are informed of how to access the 24/7 on-call system during intake and assessment, and in their service plan. This information is reviewed on an annual basis and as needed with each participant. The on-call person is either a physician or registered nurse. The *Program of All-Inclusive Care for the Elderly on-call staff* documents all calls taken during the center's non-operational hours and the action taken to address the participant's issue or problem. The call and resulting action is also documented in the participant's record. It is the responsibility of the *Program of All-Inclusive Care for the Elderly* Program Manager to monitor the *Program of All-Inclusive Care for the Elderly* Center to ensure the 24/7 system is working and that 24/7 coverage needs are identified and addressed adequately and in a timely manner. The Division of Medical Assistance *Program of All-Inclusive Care for the Elderly* Program Manager reviews monthly reports of calls to the center's 24/7 system and provides feedback as necessary related to any improvements in the handling of calls to this system.

**IV. Evaluation of the Quality Management - \*While the example provided below is specific to the Elderhaus PACE Center, it is expected that all PACE centers will have plans that address the same elements. PACE centers work in collaboration with North Carolina Division of Medical Assistance and Centers for Medicaid staff to ensure the development and implementation of a high quality management program.**

### **Implementation**

Key to implementing the Quality Assurance Performance Improvement plan is having a system in place to regularly and systematically collect, record, and report data.

- Selected aggregated outcomes data will be reviewed for trends, patterns and opportunities for improvement.
- Variation in outcomes will be evaluated from both the program and the individual participant perspective.
- When practice variations are identified, a plan will be developed and implemented to identify more effective practices whenever possible.
- The Quality Assurance Performance Improvement plan will use standard data measures developed by such organizations as the National *Program of all Inclusive Care for the Elderly* Association whenever possible and those specified by CMS and the State administering agency as specified (in accordance with §460.140). Professional standards of Elderhaus *Program of all Inclusive Care for the Elderly* staff will be measured against those outlined by their respective licensing agency in the state of North Carolina (e.g. The North Carolina Board of Nursing). When published guidelines do not appropriately

address the Elderhaus *Program of all Inclusive Care for the Elderly* population, internal standards inferred by available data may be developed.

- The Elderhaus *Program of all Inclusive Care for the Elderly* Management Team will identify both problems and areas of outstanding performance.
- The organization will monitor staff and contractors to ensure appropriate standards of care are met and appropriate training and credentialing are maintained. Service delivery will be monitored through feedback from staff, participants, and family members during daily staff meetings, care plan reviews, and meetings with families.
- The organization will monitor performance in non-clinical areas. Examples include problems identified during fire drills or problems with timeliness of transportation. All participants will be educated about the grievance process and grievances will be monitored for opportunities to improve future performance.
- Enrollment and disenrollment data, particularly reasons for disenrollment, will be reviewed at least quarterly and compared with benchmarks set against other *Program of all Inclusive Care for the Elderly* programs.
- Monitoring of Occurrences. Review of occurrence reports will be used to monitor possible problems with safe practice, maintaining a safe environment, or protecting participants' rights. Occurrence reports may result from:
  - Abuse or suspected abuse
  - Participant elopement
  - An outbreak of a communicable disease
  - Occurrences involving police or fire department
  - Theft or vandalism of property at Elderhaus *Program of all Inclusive Care for the Elderly* or at contract providers working with Elderhaus *Program of all Inclusive Care for the Elderly*
  - Falls
  - Accidents
  - Potential for injury
  - Medication administration errors or medication adverse reactions
  - Other unusual occurrences
- Prevention of Fraud, Waste, and Abuse: Elderhaus *Program of All-inclusive Care for the Elderly* will participate in the National *Program of All-inclusive Care for the Elderly* Association sponsored evaluation and procedure development being implemented to address monitoring and audit requirements under the new Part-D Medicare regulations. As findings and tools become available, they will be incorporated into the Quality Improvement Performance Improvement process.
- Data Integrity: Elderhaus *Program of all Inclusive Care for the Elderly* will monitor its data collection processes for timeliness, completeness, and accuracy. Tracking and trending may identify problems with data as may periodic spots checks. Identified problems with data collection will be treated as opportunities to improve performance.

## Improvement Process

Corrective actions and outcomes resulting in best practices will be incorporated into Elderhaus *Program of all Inclusive Care for the Elderly* policies and procedures.

- Role of the Quality Improvement Coordinator. The Quality Improvement Coordinator is responsible for assuring that the data collected and reported are accurate, timely and complete. The Quality Improvement Coordinator will assist in performing the appropriate statistical analyses to assure

consistency and ease of presentation and review. The Quality Improvement Coordinator will assist in detecting trends, patterns, and opportunities for improvements as well as potential problems. In addition, the Quality Improvement Coordinator, along with the Intake Coordinator and the Center Manager, submit monthly data to data entry personnel both in manual and electronic format on data collection tools such as the “Inpatient and Emergency Services Utilization” form completed by the Center Manager. Elderhaus *Program of all Inclusive Care for the Elderly* data entry personnel enters HPMS *Program of all Inclusive Care for the Elderly* data electronically no less frequently than quarterly.

- Peer review for clinical staff. Peer review will be conducted under the direction of senior staff. Interdisciplinary team members will not be responsible for reviewing care for which he/she is responsible. When only one discipline representative is on staff, practice will be reviewed within the expertise of the department. In cases where there is no individual with expertise in that field in the organization, provisions will be made to have care evaluated by an outside expert in the discipline.
- Review for non-clinical staff. When outcomes involve non-clinical staff, review will be conducted under the supervision of appropriate supervisory staff. Outcomes identified through quality management projects will be reevaluated as needed to determine if corrective steps improved outcomes.
- Corrective Action Plans. When opportunities for improvement are identified, a corrective plan will be created. Each corrective plan will include: an explanation of the problem, who is responsible for implementing the corrective plan, the time frame for each step of the plan, and an evaluation process to determine effectiveness. The Management Team will develop Corrective Action Plans related to global problems, implement those plans, and evaluate their effectiveness. Corrective Action Plans from contracted providers will be requested by the QIC or other member of Management Team, as appropriate. Internal Action Plans will also be generated by the QI Committee and documented via committee minutes.
- Priority Setting. The Management Team, in consultation with the Elderhaus *Program of all Inclusive Care for the Elderly* Program Director, Quality Improvement Coordinator, staff and participants, determines priorities for performance improvement at least annually. Priority will be based on severity, frequency, prevalence, and relevance to outcomes and feasibility of implementation. Priorities are communicated to the Board of Directors for approval.
- Urgent Corrective Measures. Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the Elderhaus *Program of all Inclusive Care for the Elderly* Director. The appropriate staff and the Quality Improvement Coordinator will consult with relevant Elderhaus *Program of all Inclusive Care for the Elderly* staff and be responsible for developing an appropriate corrective plan within 24 hours. Urgent corrective measures will be discussed during morning meeting and, when appropriate, with participants. Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, or other actions will be implemented immediately. The Quality Assurance Performance Improvement plan and relevant policies and procedures will be amended to ensure the health and safety issues identified have been addressed.
- Orientation of Staff and Contract Providers. All new staff members are introduced to the Quality Assurance Performance Improvement plan and Quality Assurance Performance Improvement concepts during their orientation. Results of Quality Assurance Performance Improvement -identified benchmarks are shared with staff annually. Staff may be surveyed for new areas of improvement and reminded that they can bring issues to the Quality Improvement Committee or Management Team annually.

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- Orientation of New Elderhaus *Program of all Inclusive Care for the Elderly* Participants and their Families. New Elderhaus *Program of all Inclusive Care for the Elderly* participants and their families are informed during the enrollment process of participants' rights, protection of health information, the grievance and appeals processes, and other methods of voicing satisfaction or dissatisfaction with program services. They are encouraged to give both positive and negative feedback to program staff.

## Attachment J

### NORTH CAROLINA RISK ISSUE IDENTIFICATION TOOL

#### I. Identify Risk Issues

Name of Individual:	Date Completed:
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Individual's Support Coordination Agency:
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Name of Person Completing This Form & and Relationship to the Individual
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**Situational** (situations, systemic issues, mental health issues, or circumstances with caregivers, family, friends, or others that create the potential for risk)

✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years
	Loss of caregiver or close family member		
	Loss of someone significant		
	Loss of natural supports		
	Social isolation by caregiver		
	Refusal of critical services (by the individual or the guardian)		
	Unavailable or unreliable staffing		
	Significantly compromised hygiene or appearance (especially if a change from usual)		
	Incapacitated caregiver		
	History of abuse or neglect		
	Pregnancy and parenthood		
	Compromised communication skills		
	Loss of home		
	Eviction		
	Frequent moves for seemingly unjustified reasons		
	Difficulties with relationship with landlord		
	Dangerous or threatening neighbors		

**Environmental** (environmental issues that create the potential for risk)

✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years
	Unsanitary living conditions		
	Home is in significant disrepair		
	Necessary environmental modifications not completed		
	Necessary equipment in disrepair, broken, or is lost		
	Unmet equipment needs		
	Equipment not being available for use		

**Behavioral** (personal behaviors or lifestyle choices that are considered dangerous or potentially dangerous to self or pose a risk to others)

✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years
	Self injury		

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<b>Environmental</b> (environmental issues that create the potential for risk)			
✓	<b>Risk Issue</b>	<b>Why is this issue of particular risk to this person?</b>	
	Aggression or violence towards others		
		Current	Within five (5) Years
	Assault		
	Stealing		
	Excessive self-stimulatory behaviors		
	Making significant threats to the safety of others		
	Destruction of property		
	Refusal of necessary services		
	Poor compliance with treatments or supports		
	Elopement		
	Social isolation		
	Compromised communication skills		
	History of poor decision making despite being well-informed		
	Risky sexual behaviors		
	Predatory behavior		
	Excessive fascination with children or sexual abuse of children		
	History of sexually aggressive or dangerous behaviors		
	Fascination with fire or history of fire setting		
	Frequent job changes		
	Suicidal ideation or attempt		
	Substance abuse		
	Contacts with EMS or law enforcement (i.e. unnecessary calls to or create situations to cause others to call)		
	Criminal justice involvement		
	Multiple requests for crisis services		

<b>Medical</b> (health-related risks)			
✓	<b>Risk Issue</b>	<b>Why is this issue of particular risk to this person?</b>	
		Current	Within five (5) Years
	Multiple medical or psychiatric hospitalizations in a year		
	Multiple visits to the emergency room (whether admitted or not)		
	A person living alone or with little support who takes multiple medications		
	Taking three or more medications for a chronic medical condition, including a psychiatric diagnosis with reduced supports		
	Medical benefit loss		
	Poor follow through on post hospitalization discharge orders		
	Significant change in health or mental status		
	Significant changes in sleeping or eating patterns		
	Significant number of medical visits or a significant increase in medical visits		

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<b>Medical</b> (health-related risks)			
✓	<b>Risk Issue</b>	<b>Why is this issue of particular risk to this person?</b>	
	Unmet medical needs (i.e. appointments not scheduled, follow-up appointments missed)		
		Current	Within five (5) Years
	Information shared with medical personnel by support staff is inadequate (i.e. reason for referral)		
	Poor compliance or non-compliance with medical regime		
	Refusal of services		
	Inability to tolerate a medical examination/procedure		
	Multiple falls/fractures		
	Mobility impairment		
	Significant weight gain or loss		
	Swallowing disorders		
	History of choking and/or aspiration		
	Skin breakdown		
	Obesity		
	Compromised communication skills (especially in relation to being able to indicate physical pain)		
	Pica		
	Lifestyle choices that negatively affect health (i.e. smoking, drinking when contraindicated by medications)		

<b>Financial risks</b> (mismanagement of finances by self or others or loss of income)			
✓	<b>Risk Issue</b>	<b>Why is this issue of particular risk to this person?</b>	
		Current	Within five (5) Years
	Loss of job		
	Loss of benefits or significant reduction in benefits		
	Indebtedness		
	Loaning money to others		
	Excessive gambling		
	Financial exploitation		
	Excessive housing costs		

<b>Other risks</b> (identified risks not otherwise mentioned above)			
✓	<b>What is the Issue?</b>	<b>Why is this issue of particular risk to this person?</b>	
		Current	Within five (5) Years

**II. Summary of Incident Reports**

<b>Reportable Incidents</b> (summarize by type of incident, the number of reportable incidents, or attach other printout summary of reportable incidents)		
<b>Type of Incident</b>	<b>Number of Incidents</b>	<b>Comments</b>



## Attachment K

<b>Qualified Residences for North Carolina Money Follows the Person Participants</b>				
<b>Type of Qualified Residence</b>	<b>Number of Each Type of Qualified Residences*</b>	<b>State of Definition Housing Settings &amp; Number of Each</b>	<b>Number of Each Settings*</b>	<b>How Regulated</b>
Home owned or leased by individual's family member	114	<ul style="list-style-type: none"> <li>• Home leased by individual or family</li> <li>• Home owned by individual</li> <li>• Home owned by family</li> </ul>	<ul style="list-style-type: none"> <li>• 65</li> <li>• 0</li> <li>• 49</li> </ul>	<ul style="list-style-type: none"> <li>• Lease with landlord</li> <li>• N/A</li> <li>• N/A</li> </ul>
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.	177	<ul style="list-style-type: none"> <li>• Apartment building</li> <li>• Assisted living: multi-unit assisted housing with services</li> <li>• Public housing units</li> <li>• Rural Development Apartment</li> <li>• Housing Credit unit</li> <li>• Supportive housing unit</li> </ul>	<ul style="list-style-type: none"> <li>• 0</li> <li>• 55</li> <li>• 10</li> <li>• 12</li> <li>• 75</li> <li>• 25</li> </ul>	<ul style="list-style-type: none"> <li>• Lease with private landlord</li> <li>• Lease with private landlord and HC Voucher</li> <li>• Lease with Public Housing Agency</li> <li>• Lease with RD</li> <li>• Lease with landlord w/HC Voucher</li> <li>• Lease with landlord and Key assistance</li> <li>• Lease with landlord</li> </ul>
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside (Non-Intermediate Care Facility-Mental Retardation facility).	13	<ul style="list-style-type: none"> <li>• Supervised Living</li> <li>• Alternative Family Living</li> <li>• Family Care Home</li> </ul>	<ul style="list-style-type: none"> <li>• 2</li> <li>• 4</li> <li>• 7</li> </ul>	<ul style="list-style-type: none"> <li>• State122C licensing regulations</li> <li>• 131D licensing regulations</li> </ul>

\* NOTE: These are projections only. Projections are based upon limited knowledge of local housing resources and no knowledge of participants' needs or preferences.

## Attachment L

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### PATRICIA (“TRISH”) FARNHAM

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#### EDUCATION

<b>Juris Doctor</b> <i>Georgia State University Atlanta, Georgia</i>	2001
<b>Masters of Public Administration</b> <i>Georgia State University Atlanta, Georgia</i>	2001
<b>Bachelor of Arts</b> <i>Miami University Oxford, Ohio</i> Majors: Geography, American Studies Research Interest: <i>Geographic Barriers to Healthcare in Southeastern Kentucky</i> <i>Union College Barboursville, KY</i> Appalachian Semester Program, Fall 1995	1996

#### PROFESSIONAL EXPERIENCE

**Project Director, *North Carolina Money Follows the Person Demonstration Project*** January, 2010-Present  
*North Carolina Department of Health and Human Services, Division of Medical Assistance*

- **Money Follows the Person is a demonstration project designed to support qualified individuals to transition from inpatient facilities back into their own homes and communities.**
  - **Responsible for both the day-to-day operations and strategic direction of Project, including**
    - Developing and managing transition support structures and practices for MFP participants
    - Budget and grant oversight
    - Contract Management between MFP and sister agencies and/or community partners
    - Strategic thinking related to rebalancing initiatives and state partnerships
    - Outreach

**Project Consultant, *Moving Forward*** September 2007-December, 2009  
*North Carolina Council on Developmental Disabilities*

- *Moving Forward* is an effort of the North Carolina Council on Developmental Disability to provide support to North Carolina’s *Money Follows the Person Demonstration Project* (“MFP Project”) and other “systems change” efforts.
  - Facilitated and provided support to the MFP Project’s Roundtable, an informal group of stakeholders that supports MFP Project Director in idea-sharing on Project activities
  - Supported self-advocates to prepare for and participate in MFP Project Stakeholders’ Advisory Group meetings and at the Looking Forward Summit
  - Organized and facilitated opportunities to develop community-building activities for MFP Project participants

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- Advised Project Director on community building practices and approaches for engaging various stakeholder groups
- In collaboration with Project Director, conducted informational sessions about the MFP Project with various stakeholders
- Assisted in development of NC Council on Developmental Disabilities' *State of the State* report
- Assisted in development of the MFP Project's *Operational Protocol*

**Project Consultant, *Seeing is Believing***

**January 2008-December, 2009**

*North Carolina Council on Developmental Disabilities*

- Seeing is Believing (“SIB”) is an effort of the North Carolina Council on Developmental Disabilities to support people with DD, regardless of disability, to live in their own homes. In partnership with three participating organizations, SIB works to build the capacity of both organizations and state systems to support people to live in homes of their own.
  - Provided support to participating organizations around developing person-centered management practices.
  - Facilitated organizational strategic thinking sessions
  - Researched and analyzed regulations of North Carolina and other states
  - Assisted in organizing and facilitating monthly participant meetings

**Meaningful Day Consultant**

**June 2006-December, 2009**

*State of New Mexico*

- Partnered with people with disabilities, their staff and communities to improve supports and cultivate community-based relationships.
  - Facilitated organizational transition from “facility-based” services to “community-based” supports
  - Provided technical assistance and “brainstorming” on how to expand a person’s life
  - Developed staff curricula and conduct trainings as needed
  - Organized person-centered planning opportunities
  - Facilitated employment opportunities for people with disabilities
- Assisted agencies and State of New Mexico to develop systems/practices that facilitate person-centered outcomes
  - Reviewed/analyzed service standards, individual support plan format, training curricula, contracts, etc.
  - Provided written and verbal feedback and recommendations on current practice
  - Assisted staff by researching and drafting various reports and documents
  - Developed technical assistance “Idea Papers” on various topics. Papers available at: <http://www.health.state.nm.us/ddsd/meaningfulLife/meaningfullife1a.htm>

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**Executive Director**

**July 2001–September 2005**

**Consultant**

**March 2006–March 2008**

*Georgia Options, Inc. Athens, Georgia*

- Directed personalized, in-home supports for 39 people with significant developmental disabilities
- Developed working relationships with persons receiving support and their family members
- Twice led organization to *Three Year Accreditation with Distinction* from international accrediting body
- Managed nine staff members and ensured oversight of 80 direct support employees
- Ensured organizational compliance with state private home care regulations
- Facilitated development and implementation of organization's annual *Quality Improvement Plan*
- Ensured organizational compliance with state service contract requirements
- Developed and managed "person-centered" organizational budget of \$2.3M
- Successfully negotiated with State of Georgia for increased funding in state service contracts
- Developed partnerships with supported employment agencies to expand competitive employment opportunities for people with disabilities
- Consulted with the State of Georgia on how to expand the practice of supported living
- Secured both grant and private funding for special projects and general operations
- Expanded organization's visibility in southeastern US through presentations at various conferences

**Sabbatical**

**November 2005–March, 2006**

- Traveled to New Zealand, Australia, and Thailand
- Partnered with local disability organizations in Melbourne to learn how Australian disability services are structured and to consult on how to structure supported living services
- Researched Australian governmental structures for supporting people with dual diagnoses of mental illness and developmental disability

**Supported Employment Specialist**

**June 1998–June 2001**

*Briggs and Associates Roswell, Georgia*

- Developed sustainable, long-term career options for people with developmental disabilities
- Provided on-going personal and family support
- Developed on-going relationships with current and potential employers
- Monitored legislative activity and coordinated advocacy efforts

**Health Law Research Assistant**

**August 2000–May 2001**

*Georgia State University College of Law Atlanta, Georgia*

- Researched various legal issues relating to health care regulation and health care provision, with particular emphasis on topics of medical errors and informed consent

**Legal Extern, Office of the General Counsel**

**August–December 2000**

*U.S. Department of Health and Human Services Atlanta, Georgia*

- Researched and analyzed federal regulatory standards for long-term health care facilities

**Coordinator of Community Outreach**

May 1996–September 1997

*March of Dimes Charleston, South Carolina*

- Directed volunteer-based program to increase access to adequate prenatal care in under-served communities

**PROFESSIONAL AND ACADEMIC HONORS**

- Led Georgia Options to receive the *Best Practice Award of Excellence* from the Southeastern region of the American Association on Mental Retardation, November 2003
- Led Georgia Options to top accreditation award from *CQL*, 2002 and 2005
- *CALI Award for Academic Excellence in Health Law*, Spring 2000
- *CALI Award for Academic Excellence in Juvenile Justice*, Spring 2000
- Trident Regional Health District's *Community Appreciation Award*, Spring 1997
- *Henry Kendall Memorial Geography Scholarship* recipient, Miami University, 1995-1996
- *Eastern Kentucky Historical Essay Award*, February 1996

**INVITED PROFESSIONAL PRESENTATIONS**

- *The No Frills Slideshow about MFP*
- *Good Day? Good Life: The Role of Microboards in Building Community*
- *Getting to the Heart of It: Creating and Celebrating “Meaningful Communities in New Mexico*
- *Embracing Experience and Supporting the Dignity of Risk*
- *Both/ And: Building Bridges between Direct Support Staff and Other Loved Ones in a Person’s Life*
- *So, What IS Supported Living?*
- *Life Rules: A Conversation about Supported Living and Regulation*
- *Georgia Options’ Thoughts on Building Great Staff*
- *Lessons Learned in Supported Living*
- *Building Partnerships with Families: How Did We Get Here and What are We Going to Do About It?*
- *“Hard and Happy Lessons” of Supported Living: Tackling Questions about Choice, Roles, Capacity and Vision*
- *A Culture of Constant Conversation: Building an Organization of Respect*
- *Building an Organizational Mission and Vision*
- *Show Me the Money! How Georgia Options Does Individualized Budgeting*
- *Concepts in Supported Living and Community Based Services*
- *Geographic and Non-Geographic Barriers to Prenatal Health Care in a Southeastern Kentucky Community*

**VOLUNTEER EXPERIENCE**

**General Volunteer** *disAbility Resource Center/CIL, Wilmington, North Carolina*

**April 2009-December, 2009**

**Grant Writer** *Arc of North Carolina-Wilmington; Georgia Options, Inc.*

**March 2006-December, 2009**

**Legislative Advocate** *Unlock the Waiting List Campaign*

**October 1999 – May 2001**

**Healthcare Intake Worker** *Mercy Mobile Healthcare of Saint Joseph’s Hospital*

**January 1998 - May 2001**

## PROFESSIONAL SKILLS

### Collaboration and Strategic Thinking

- Commitment to *Asset Based Community Development* principles
- Group facilitation
- PATH facilitation
- Consensus building and conflict resolution
- Ability to develop professional relationships in diverse communities

### Person Centered Organizational Management

- Design and implementation of organizational systems that facilitate best practice
- Ability to conceptualize and articulate a compelling organizational vision
- Personnel management
- Organizational budget development
- Organizational financial management
- Special events organization
- Crisis response
- Grant development, research, and writing
- Volunteer development and retention
- Competency in conducting critical incident and personnel investigations
- Commitment to culturally-sensitive and inclusive management practices

### Communication

- Ability to synthesize complex systems and present them in simplified, “user-friendly” ways.
- Public speaking and speech writing

### Research

- Regulatory and statutory interpretation
- Application of research tools and resources

PROFESSIONAL AND CHARACTER REFERENCES AVAILABLE UPON REQUEST

## **Attachment M**

**TITLE:**

Money Follows the Person Program Specialist

**SCOPE OF WORK:**

To analyze and interpret data, assess federal and state regulations, rules and provider contracts, for use in developing and managing the Money Follows the Person (MFP) project's strategic plan.

**ACCOUNTABILITIES:**

Manage the Money Follows the Person (MFP) project strategic plan and assist with project management.

Serve as the liaison to the local and state agency's Transition Coordinators.

Research, develop and draft protocols and outreach materials, including the person-centered-planning process, for the Transition Coordinators.

Coordinate education, outreach and training activities for staff, other agencies, advisory councils and community providers.

Make formal presentations to appropriate state bureaus, inpatient facilities, community agencies, advisory and planning councils to build strong collaborations, to implement and improve policies and protocols.

Analyze and interpret reports from Transition Coordinators and other relevant reports; make recommendations for improvement to the Project Director.

Consult with associated groups and agencies to ensure coordination in the development and implementation of the project's strategic plan.

Provide information to inpatient facilities regarding the goals and expectations of the project.

Produce regular reports as required by the MFP grant and the Project Director.

Perform other duties as required by the Project Director.

### **MINIMUM QUALIFICATIONS**

Education: Bachelor's degree from a recognized college or university with a major study in a field relevant to adults with disabilities. Each additional year of approved formal education may be substituted for one year of required work experience.

Money Follows the Person Operational Protocol  
N.C. Department of Health and Human Services

Experience: Four years' professional or paraprofessional experience in a field or occupation relevant to services provided by and protocols in the Department of Health and Human Services, Division of Medical Assistance with responsibility for program implementation, direct service delivery, planning or program evaluation. Each additional year of approved work experience may be substituted for one year of required formal education.

License/Certification: Valid driver's license and/or access to transportation for use in statewide travel.

DISCLAIMER STATEMENT: The job description lists the essential functions of the position and is not intended to include every job duty and responsibility specific to the position. An employee may be required to perform other related duties not listed on the supplemental job description provided that such duties are characteristic of that classification.

SIGNATURES: I have reviewed this job description for content.

Reviewer's Name, Title & Position #: \_\_\_\_\_, # \_\_\_\_\_

\_\_\_\_\_  
Reviewer's Signature

\_\_\_\_\_  
Date Reviewed

I have reviewed the content of the above job description with my supervisor.

\_\_\_\_\_  
Employee's Name and Signature

\_\_\_\_\_  
Date

## Attachment N

<b>North Carolina Money Follows the Person Rebalancing Demonstration Preliminary Budget</b>						
<b>Demonstration Personnel</b>						
	<b>CY 2007</b>	<b>CY 2008</b>	<b>CY 2009</b>	<b>CY 2010</b>	<b>CY 2011</b>	<b>TOTAL</b>
Project Director	\$0	\$59,428	\$60,914	\$62,437	\$63,998	246,777
Program Specialist	\$0	\$59,428	\$60,914	\$62,437	\$63,998	246,777
Admin Assistant	\$0	\$27,496	\$28,183	\$28,888	\$29,610	114,177
Fringe Benefits	\$0	\$27,075	\$27,752	\$28,446	\$29,157	112,430
<b>TOTAL</b>	<b>\$0</b>	<b>\$173,427.00</b>	<b>\$177,763.00</b>	<b>\$182,208</b>	<b>\$186,763</b>	<b>\$702,161</b>
<b>Other Administrative</b>						
MMIS Configuration	\$1,000,000					\$1,000,000
<b>Total Administrative</b>						<b>\$1,720,161</b>



Money Follows the Person Operational Protocol  
N.C. Department of Health and Human Services

**NC Money Follows the Person Demonstration  
Worksheet for Proposed Budget  
ATTACHMENT N2**

**Instructions:** Please fill in only the cells highlighted in YELLOW. All other cells will autopopulate. Please DO NOT alter any formulas.

<b>State/Grantee:</b>		Please express FMAP as a decimal. (example: 68.32%=.6832)		
<b>NORTH CAROLINA</b>				
<b>Grant #:</b>		<b>State FMAP</b>		<b>Enhanced FMAP</b>
<b>1LICMS030170</b>		<b>FFY 2007</b>	0.6452	0.5
<b>Demonstration Program Title:</b>		<b>FFY 2008</b>	0.6405	0.5
<b>NC Money Follows the Person</b>		<b>FFY 2009</b>	0.6405	0.5
		<b>FFY 2010</b>	0.6405	0.5
		<b>FFY 2011</b>	0.6405	0.5

				<b>FFY 2007</b>	<b>FFY 2008</b>
	<b>State Name</b>	North Carolina	<b>State FMAP*</b>	0.6452	0.6405

**Populations to be Transitioned (unduplicated count)**

*Unduplicated Count* - Each individual is only counted once in the year that they physically transition.  
All population counts and budget estimates are based on the *Calendar Year (CY)*.

	Elderly	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis
CY 2007	0	0	0	0	0
CY 2008	1	4	8	0	0
CY 2009	5	22	51	0	0
CY 2010	7	30	61	0	0
CY 2011	9	24	82	0	0
Total Count	22	80	202	0	0
			<b>Total of Population</b>		<b>304</b>

**Demonstration Budget**

*Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services* are defined in the RFP.

*Administration - Normal* - costs that adhere to CFR Title 42, Section 433(b)(7); *Administrative - 75%* - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10); *Administrative - 90%* - costs that adhere to CFR Title 42 Section 433(b)(3)

*Federal Evaluation Supports* - costs related to administering the Quality of Life Survey (reimbursed @ \$100 per survey).

*Rebalancing Fund* is a calculation devised by CMS to estimate the amount of State savings attributed to the *Enhanced FMAP Rate* that could be reinvested into rebalancing benchmarks.

*Other* - Other costs reimbursed at a flat rate (to be determined by CMS)

<b>Total Expenditures (2007 - 2011)</b>	<b>Rate</b>	<b>Total Costs</b>	<b>Federal</b>	<b>State</b>
Qualified HCBS		\$ 3,304,206.00	\$ 1,652,103.00	\$ 1,652,103.00
Demonstration HCBS		\$ 957,956.00	\$ 478,978.00	\$ 478,978.00
Supplemental		\$ -	\$ -	\$ -
Administrative - Normal		\$ 656,331.00	\$ 328,165.50	\$ 328,165.50
Administrative - 75%		\$ 1,182,208.00	\$ 886,656.00	\$ 295,552.00
Administrative - 90%		\$ 16,055.00	\$ 14,449.50	\$ 1,605.50
Federal Evaluation Supports		\$ -	\$ -	\$ -
Other		\$ -	\$ -	\$ -
State Evaluation		\$ -	\$ -	\$ -
<b>Total</b>		<b>\$ 6,116,756.00</b>	<b>\$ 3,360,352.00</b>	<b>\$ 2,756,404.00</b>

Per Capita Service Costs	\$ 14,020.27
Per Capita Admin Costs	6100.638158
Rebalancing Fund	\$ 2,131,081.00

Money Follows the Person Operational Protocol  
N.C. Department of Health and Human Services

CY 2007	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	\$ -	\$ -	\$ -	Actual Grant Award for CY	
Demonstration HCBS	0.5	\$ -	\$ -	\$ -	Total Fed Costs	14449.5
Supplemental	0.6452	\$ -	\$ -	\$ -	Balance	-14449.5
Administrative - Normal	0.5	\$ -	\$ -	\$ -	Award Request for next year	
Administrative - 75%	0.75	\$ -	\$ -	\$ -	Total (Balance + Request)	<b>-14449.5</b>
Administrative - 90%	0.9	\$ 16,055.00	\$ 14,449.50	\$ 1,605.50		
Federal Evaluation Supports	1	\$ -	\$ -	\$ -		
Other	1	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.5	\$ -	\$ -	\$ -		
<b>Total</b>		\$ 16,055.00	\$ 14,449.50	\$ 1,605.50		
CY 2008	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	\$ 53,044.00	\$ 26,522.00	\$ 26,522.00	Actual Grant Award for CY	
Demonstration HCBS	0.5	\$ 45,597.00	\$ 22,798.50	\$ 22,798.50	Total Fed Costs	886202
Supplemental	0.6405	\$ -	\$ -	\$ -	Balance	-886202
Administrative - Normal	0.5	\$ 173,763.00	\$ 86,881.50	\$ 86,881.50	Award Request for next year	
Administrative - 75%	0.75	\$ 1,000,000.00	\$ 750,000.00	\$ 250,000.00	Total (Balance + Request)	<b>-886202</b>
Administrative - 90%	0.9	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1	\$ -	\$ -	\$ -		
Other	1	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.5	\$ -	\$ -	\$ -		
<b>Total</b>		\$ 1,272,404.00	\$ 886,202.00	\$ 386,202.00		
CY 2009	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	\$ 765,755.00	\$ 382,877.50	\$ 382,877.50	Actual Grant Award for CY	
Demonstration HCBS	0.5	\$ 247,885.00	\$ 123,942.50	\$ 123,942.50	Total Fed Costs	595701.5
Supplemental	0.6405	\$ -	\$ -	\$ -	Balance	-595701.5
Administrative - Normal	0.5	\$ 177,763.00	\$ 88,881.50	\$ 88,881.50	Award Request for next year	
Administrative - 75%	0.75	\$ -	\$ -	\$ -	Total (Balance + Request)	<b>-595701.5</b>
Administrative - 90%	0.9	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1	\$ -	\$ -	\$ -		
Other	1	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.5	\$ -	\$ -	\$ -		
<b>Total</b>		\$ 1,191,403.00	\$ 595,701.50	\$ 595,701.50		
CY 2010	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	\$ 1,239,079.00	\$ 619,539.50	\$ 619,539.50	Actual Grant Award for CY	
Demonstration HCBS	0.5	\$ 420,171.00	\$ 210,085.50	\$ 210,085.50	Total Fed Costs	1040623.5
Supplemental	0.6405	\$ -	\$ -	\$ -	Balance	-1040623.5
Administrative - Normal	0.5	\$ 148,685.00	\$ 74,342.50	\$ 74,342.50	Award Request for next year	
Administrative - 75%	0.75	\$ 182,208.00	\$ 136,656.00	\$ 45,552.00	Total (Balance + Request)	<b>-1040623.5</b>
Administrative - 90%	0.9	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1	\$ -	\$ -	\$ -		
Other	1	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.5	\$ -	\$ -	\$ -		
<b>Total</b>		\$ 1,990,143.00	\$ 1,040,623.50	\$ 949,519.50		
CY 2011	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.5	\$ 1,246,328.00	\$ 623,164.00	\$ 623,164.00	Actual Grant Award for CY	
Demonstration HCBS	0.5	\$ 244,303.00	\$ 122,151.50	\$ 122,151.50	Total Fed Costs	823375.5
Supplemental	0.6405	\$ -	\$ -	\$ -	Balance	-823375.5
Administrative - Normal	0.5	\$ 156,120.00	\$ 78,060.00	\$ 78,060.00	Award Request for next year	
Administrative - 75%	0.75	\$ -	\$ -	\$ -	Total (Balance + Request)	<b>-823375.5</b>
Administrative - 90%	0.9	\$ -	\$ -	\$ -		
Federal Evaluation Supports	1	\$ -	\$ -	\$ -		
Other	1	\$ -	\$ -	\$ -		
State Evaluation (if approved)	0.5	\$ -	\$ -	\$ -		
<b>Total</b>		\$ 1,646,751.00	\$ 823,375.50	\$ 823,375.50		

## Attachment O

### List of Acronyms

<b>Acronym</b>	<b>Full description</b>
CMS	Center for Medicaid and Medicare Services
CAP/Choice	Community Alternatives Program/Choice
CAP/DA	Community Alternatives Program/Disabled Adults
CAP/MR-DD	Community Alternatives Program/Mentally Retarded/Developmentally Disabled
PACE	Program of All-Inclusive Care for the Elderly

## **Attachment P**

### **North Carolina's ADRC Nursing Home Transition and Diversion Program Grant Request**

#### **Abstract:**

In North Carolina, the Aging and Disability Resource Centers (ADRC) are known as Community Resource Connections (CRCs). We are requesting funding to accomplish three goals: 1) to become prepared for the implementation of MDS 3.0 Section Q through training opportunities about the referral process and by building a trained Local Contact Agency (LCA) network; 2) to expand the CRC network by facilitating Community Engagement events in identified underserved areas; 3) to increase community understanding of transition opportunities, including Money Follows the Person (MFP), through facilitated, local community conversations and other outreach efforts.

Funding this request will strengthen the CRCs' role in MFP by addressing one of MFP's greatest needs: the need for increased referrals. It will accomplish this by developing the LCA role and through CRC expansion efforts. This request is intended to complement CRCs' other requests under the *Implementing the Affordable Care Act* funding announcement and other MFP funding initiatives that will more firmly embed the CRC Network in the transition process.

#### **Current Status of ADRC and MFP-ADRC Partnership**

CRCs began in 2004 and now operate in 28 counties across the state, with anticipated expansion to 40 counties by the end of 2010. Local CRC composition typically includes: local aging service providers, the local Area Agency on Aging, a Center for Independent Living, the local Department of Social Services, local healthcare entities and other local entities. CRCs serve the long-term support needs of adults over 60 years old, their caregivers and adults with disabilities, with an increased effort to incorporate the specific needs of people with developmental disabilities. The CRCs' core functions are: information and assistance; options counseling; facilitating streamlined, programmatic and financial eligibility determinations for public programs; person-centered transitions; quality assurance and continuous improvement. While CRCs' formal role in transition efforts is still crystallizing, CRCs will serve as the LCAs for upcoming referrals through the MDS 3.0 Section Q and eventually will serve as the State's network for coordinating transition activities. Various partnering agencies within the CRCs bring considerable experience to both inpatient facility transition and diversion efforts.

CRC and MFP staff have informally collaborated in meaningful ways during the past twelve months. For example, the CRC Project Director has facilitated the emerging transition coordination partnership between the MFP and the Division of Vocational Rehabilitation's Independent Living Program. The MFP Project Director served on a CRC applicant evaluation committee and currently serves on the State's CRC Strategic Planning Committee. Staff from the Office of Longterm Services and Supports (OLTS), which oversees CRC implementation, and MFP staff are collaborating with the Division of Health Service Regulation to develop and implement protocols for the State's MDS 3.0, Section Q. Further, OLTS has incorporated MFP-related deliverables into the partnership agreements with its local CRC agencies.

#### **Project Structure**

The requested resources will support CRC infrastructure and CRCs' collective capacity to support MFP and other transition services by 1) providing local CRCs with funding to develop the LCA function; 2) expanding the CRC network, which better ensures transition efforts in these areas are coordinated; 3) building local interest in the CRC network through outreach efforts. These proposed efforts will be statewide, with Goal Two and Goal Three also focused on areas not yet covered by the CRCs. The efforts are consistent with stakeholder recommendations regarding the need for more training and outreach related to MFP, MDS 3.0 Section Q and the CRCs. The proposed activities also utilize resources and tools developed as part of the 2005 *Person-Centered Planning Implementation Grant* and are consistent with the goals and priorities of other CRC initiatives.

This collaboration is strongly supported both within both the Division of Medical Assistance (MFP's parent division) and its parent agency, the NC Department of Health and Human Services. DMA and OLTS will formalize their collaboration through an interagency memorandum of agreement (IMOA). The CRCs' strategic planning initiative, which is due to be completed in March, 2011, will map out our sustained collaboration.

#### **Project Management**

The CRC Project Director and the MFP Project Director will collaboratively administer these resources in a way that is responsive to the needs of local CRCs and stays true to the requests outlined in this grant. As will be outlined in an IMOA, DMA will allow OLTS to access designated funds directly from MFP's cost center for those functions that CRCs will perform. OLTS will administer the efforts outlined in Goal One and Goal Two, with MFP staff being available to help plan, advise and participate in events as appropriate. MFP staff will coordinate the outreach efforts outlined in Goal Three. We intend to utilize MFP administrative funding to help ensure OLTS has the infrastructure in place to effectively implement the tasks outlined within this proposal. This includes funding for a full-time state level staff person for CRCs and funding to designate a long-term support specialist within our state's call center.

As with any partnership with ambitious goals, we anticipate challenges to arise, including 1) coordinating multiple roles and competing priorities; 2) honest disagreement among staff and stakeholders about how to best accomplish our mutual goal of supporting people to live in their own homes and communities; 3) ensuring resources and structures remain flexible to remain responsive to the emerging and shifting needs of local partners. Both the MFP and the CRCs have strong (often overlapping) local partners that help guide, advise and implement our efforts. When challenges arise, these local partners will play a central role in developing effective solutions. Further, State MFP and CRC staff have a relationship with each other that is defined by mutual respect and a commitment to play to the strengths of our respective organizations. When challenges arise, we will continue to address them as we already do: through respectful, honest dialogue, relying on formal agreements to remind us of our responsibilities.

#### **Goals, Objectives, Outcomes and How We'll Do It**

##### **Goal One: To Help North Carolina Prepare for the Implementation of MDS 3.0, Section Q**

The State's MDS 3.0 Implementation Workgroup has determined that, where available, the CRC Network will serve as the LCA in local communities. In areas not covered by the CRCs, the OLTS will arrange for LCA coverage. **The objectives of the this goal are:** 1) Develop training materials and methods for individuals and agencies that will serve as LCAs to ensure they have the capacity to effectively screen, counsel and refer potential transition candidates; 2) Provide resources to assist local CRCs in serving as the LCA; 3) Partner with the Divisions of Health Service Regulation, Aging and Adult Services and other state and local agencies, host five regional "MDS/MFP Roadshows" training events across the State for nursing facility staff about Section Q of MDS 3.0; 4) Paying the person-centered thinking training registration fees for up to 150 LCA staff. **The anticipated outcomes of this goal are:** 1) Our state will have a formal network of trained LCAs by December 31, 2010 and 2) Nursing facility providers will have an increased understanding of both MDS and the opportunities available through MFP and other transition efforts, as measured by completed

“Roadshow” evaluations. **The components that need to be developed and arranged to meet this goal include:** 1) Letters of Agreement with LCAs; 2) an LCA “toolkit;” 3) space and services needed to host the person-centered thinking training; 4) an effective evaluation tool.

**Goal Two: To Expand the CRC Network into Identified Underserved Areas**

In order for the CRC network to effectively function as the State’s transition coordination network, CRCs must be present in all areas of the state. There are pockets and regions in our state that do not yet have the technical capacity or sufficient infrastructure to support a CRC. Yet, within these regions, there are strong individual entities that if engaged, could serve as the anchor for CRC development. **Our objectives under this goal are:** 1) Based on our work during the “MDS/MFP Roadshow,” identify up to five focal areas in underserved communities and discuss possible participation in the exploratory process of developing a CRC known as “Community Engagement;” 2) Host up to four, facilitated two-day Community Engagement events in interested communities, involving local leadership from the aging, disability and healthcare communities; 3) Enter into a contract with the University of North Carolina School of Social Work’s Jordan Institute for Families to facilitate the planning and execution of these events; and 4) Provide technical assistance as needed.

**The anticipated outcome for this goal:** at least two new CRC development projects will be initiated as a result of the “Roadshow” and Community Engagement efforts. **The components that need to be developed to meet this goal include:** 1) Revising the contract with the Jordan Institute for Families.

**Goal Three: To Get the Word Out about MFP and Other Transition Opportunities**

While MFP has funding designated for statewide outreach efforts (like a documentary, etc.), information is often best shared through relationships at the local level. **The objectives of this goal are:** 1) In areas not covered by the CRCs, MFP will collaborate with CRC expansion efforts and other community partners to fund at least eight “community conversations” over the course of this grant. These conversations are intended to generate local interest among families of potential MFP participants, local service agencies and the community at large. These conversations will also discuss the role of the LCA and introduce the CRC program. 2) Provide better support to the MFP stakeholder group, the MFP Roundtable, than the MFP staff currently are able to provide. This will include coordinating and managing quarterly stakeholder meetings, the Roundtable e-mail distribution list and other Roundtable supports. Doing so will build the Project’s capacity to communicate effectively with stakeholders.

3) We are also requesting funding for conference fees in order for MFP, OLTS and local CRC staff to present at statewide venues.

**The anticipated outcomes of this goal include:** 1) MFP will receive at least 50 new, qualified referrals in the first year and up to 100 qualified referrals the second year as a result of these outreach efforts. These referrals will increase the pool of MFP participants and the number of transitions; 2) Local communities will have an increased understanding of MFP and other transition opportunities, as reflected on an evaluation completed at the end of each “Community Conversation” and each MFP Roundtable meeting. **The**

**components that need to be developed or arranged to meet this goal include:** 1)-procuring a contracted entity to coordinate the Community Conversation and Roundtable support efforts; 2) developing outreach materials for distribution that reflect all transition opportunities and the LCA function; 3) developing an evaluation tool to be distributed to Conversation participants and analyzed by MFP and CRC Project staff.

## ATTACHMENT Q

### Preliminary Practices Guiding NC MFP Rebalancing Fund's Development and Distribution

#### **MFP Rebalancing Fund Purpose:**

Consistent with federal expectations of states participating in the MFP Project, NC MFP's Rebalancing Fund ("the Fund") is intended to fund and support initiatives that strengthen home and community-based support options and build community capacity to better support individuals who are at risk of institutionalization or have transitioned out of institutional settings. The Fund's resources are generated from the savings NC incurs as a result of MFP's enhanced federal match on services provided to MFP participants.

At this time in NC, funds cannot be used to support ongoing services (like additional waiver slots). Additionally, the Rebalancing Fund will prioritize funding projects that have benefit/impact across all disability populations.

#### **Distinction of "Rebalancing" and "Rebalancing Fund"**

- "Rebalancing" is typically the term used to describe the practice of shifting funding and resources reserved for institutional services into community services.
- The "MFP Rebalancing Fund" describes the fund that holds the savings the State incurs as a result of the enhanced federal match NC receives on qualified and demonstration services provided to MFP participants. The NC MFP Rebalancing Fund is automatically calculated annually based on NC Medicaid claims data for MFP participants.

#### **Important : These Practices Should be Considered Preliminary**

As we begin to administer MFP Rebalancing Funds, the MFP staff, in conjunction with Steering Committee and stakeholder recommendations may modify these practices to better support the Fund's purpose and to be more responsive in implementing these practices.

#### **The Establishment of the NC MFP Rebalancing Fund Steering Committee**

Initiated at the MFP Roundtable Meeting in August, 2011, NC MFP established and convened its NC MFP Rebalancing Fund Steering Committee ("Steering Committee"). This committee is comprised of community and state volunteers from the MFP Roundtable, state contracts representatives and MFP staff. The Steering Committee shall include at least one self or parent advocate.

The purpose of the committee is to advise NC MFP staff on developing and monitoring a Rebalancing Fund Structure that:

- supports MFP's four objectives,
- reflects the insight, wisdom and creative thinking of the MFP Roundtable members and other MFP advisers and
- demonstrates responsible, efficient stewardship of public dollars.

#### **The MFP Rebalancing Fund Steering Committee Membership:**

- New members are recruited at the annual November Roundtable meeting and supplemented as needed. Extend the invitation at the November Roundtable, supplemented throughout year as needed.
- Blend of state and community membership, including self-advocate and two MFP staff.

- Members agree to MFP Rebalancing Fund Steering Committee Agreements, including conflict of interest considerations.
- Meets quarterly, the month before the MFP Roundtable is set to meet.
- Serves in an advisory capacity
- Estimated term of advisory group members: 2 years.

#### **MFP Rebalancing Fund Steering Committee Membership Agreements**

- We commit to thoughtful, “gently honest” dialogue that keeps us focused on our objectives.
- We commit to following up on our “to dos” to the best of our ability.
- Steering Fund Committee members understand that participation in this committee may result in being excluded from sitting advising the Project on Rebalancing Fund Priorities and funding opportunities if a member represents a group that may also be applying for these Resources.
- We’ll do our best to attend the MFP Roundtable meetings as we are able.
- MFP staff also commits to finding comfortable space, having a call number, bringing snacks and trying to get information to members as soon as we can (ideally, at least 2 days in advance).

#### **How Rebalancing Funds are Managed:**

- MFP is responsible for the management of all funds but will partner with sister agencies wherever possible to oversee contract and other agreements funded with Rebalancing Fund Dollars
- MFP staff is responsible for coordinating Rebalancing Fund Steering Committee meetings and providing updates to this Committee on the status of the Rebalancing Fund and funded initiatives at every meeting.
  - Rebalancing Fund Steering Committee members will receive financial reports of each Rebalancing Fund initiative at each Rebalancing Fund Steering Committee meeting.
- Rebalancing Fund status report provided at every Roundtable beginning May, 2012.
- Rebalancing Fund priorities are re-evaluated every 3 years, after the completion of stakeholder survey outlined below.

#### **How MFP Rebalancing Fund Funding Priorities are Set:**

- MFP/DMA-identified priorities and parameters
- Roundtable provides guidance and input
- Stakeholder survey identifies additional priorities
  - Survey conducted every 3 years.
  - Identified subject-matter advisory groups make recommendations
  - MFP staff and partners present priorities to November Roundtable for consideration.

#### **MFP Rebalancing Fund Annual Transfer:**

- After receiving confirmation from CMS that MFP’s annual supplemental budget request has been approved and Fund calculation for the preceding year is accurate, DMA financial staff will transfer the proper amount into NC MFP Rebalancing Fund annually by March 31<sup>st</sup>. This transfer date may shift slightly based on CMS’ budget approval timeline.

**How Rebalancing Funds are Distributed:**

- Based on MFP stakeholder recommendations and DMA priorities, MFP staff and Rebalancing Steering Committee determine funding amount available for each initiative.
- If a contract is needed to fund the proposed initiative, members of applicable advisory group and Rebalancing Steering Committee help Project in throughout the vendor selection process and in developing contract language.
- To better embed practices/oversight with state agencies that may have more direct expertise, MFP will prioritize working with state partners to manage any MFP-funded grantees, but will also build the capacity to manage contracts directly as needed.
- MFP staff reserve the right to limit the number of contracts the Project manages directly at any given time.
- In order to provide sufficient time to implement the initiative, funds are allocated to an initiative between two to three years, depending on Advisory Group’s recommendations.

**Rebalancing Fund Applicant/Grantee Requirements:**

- Applicants to the Rebalancing Fund may be either state agency or community organization.
- All applicants must list their “in kind” commitment.
  - No financial match required on Rebalancing Fund Initiatives at this time
  - “In kind” may include staff time, administrative expense, volunteer time, etc.
- Quarterly Reporting requirements
  - One page update
  - Report on outcomes outlined in RFA/RFP/IMOA
  - Submitted to the Rebalancing Steering Committee and to the Roundtable
  - Grantees identify a Roundtable meeting to attend and present at that meeting.

**Preliminary Timeframes if New Award (based on work to date)**

- QE March
  - CMS Funding Awarded, Rebalancing Amount for Prior Year Confirmed
- QE June
  - Rebalancing Steering Committee + Advising Committee Advising Project Staff in developing IMOA, RFA, etc.
    - Ideally finished by May Roundtable.
    - Attempt to award grant by beginning of SFY (July).
- QE September
  - Funding implemented, awarded for 2-3 years
- QE December:
  - First written report to Steering Committee
  - First in-person report to November Roundtable.

### **Changing Priorities for Rebalancing Funds between Survey Cycles**

If priorities change between survey cycles:

1. No shift in priorities shall result in the premature discontinuation/modification of funding for currently funded initiatives.
2. MFP staff will present need to change priorities to Rebalancing Steering Committee. Presentation will include: why change is needed and how it will impact current/proposed priorities.
3. MFP staff will incorporate recommendations of Rebalancing Steering Committee and present to next Roundtable, incorporating Roundtable feedback as needed.
4. DMA reserves the final right to determine priorities regarding how Rebalancing Funds shall be used, however MFP relies heavily on the MFP Roundtable, advisory committees and Rebalancing Steering Committee to guide and shape funding priorities.

If grantee needs to modify how the money will be spent (i.e. changing how Rebalancing Funds are used within a contract with grantee)

1. Grantee must submit any proposed modifications to the MFP staff in writing.
2. MFP staff will seek guidance from identified advisory group about logic/wisdom of proposed revision.
3. If advisory group approves, MFP will discuss how to best revise with Rebalancing Steering committee and will make necessary contract revisions.
4. MFP staff will report changes at following Roundtable meeting and any concerns/issues regarding these modifications will be taken into consideration before future modifications are mad.

## ATTACHMENT R

### NC MFP Projected Expenditures CY 2013 – CY 2016

	CY 2012 Actual Expenditures	CY 2013 Projected Expenditures	CY 2013 Actual Expenditures	CY 2014 Projected Expenditures	CY 2014 Actual Expenditures	CY 2015 Projected Expenditures	CY 2015 Actual Expenditures	CY 2016 Projected Expenditures	CY 2016 Actual Expenditures
<b>Total</b>	\$1,361,348,437	\$1,361,348,437	\$1,509,284,533	1,509,284,533					
<b>% increase from prior year</b>			10.87%						
<b>Service Detail</b>									
1915c waivers	\$705,452,520		\$374,143,987						
State Plan	\$473,459,710		\$535,231,029						
LTS portion of Managed Care	\$180,251,811		\$598,506,910						
MFP Qualified and Demonstration Expenses	\$2,184,396.00		\$1,402,607.00						

## ATTACHMENT S



### North Carolina *Money Follows the Person* (MFP) in the MCO Landscape

#### What MFP Is

The North Carolina *Money Follows the Person* Demonstration Project is a state and federal Medicaid initiative that supports individuals to transition out of qualified facilities and back into their own homes and communities.

Conceptualized in 2005 under the 2005 *Deficit Reduction Act* and extended through 2020 under the *Affordable Care Act*, the Money Follows the Person Demonstration Project provides enhanced funding and technical assistance to support states in transitioning qualified individuals and to address the barriers that impede a person's ability to effectively live in his community.

Interested states apply to CMS to participate in the MFP Demonstration Project. Housed with the NC Division of Medical Assistance, North Carolina's MFP Demonstration Project began supporting people to transition in 2009.

Currently, North Carolina's MFP Project works closely with established Medicaid waiver programs to support three primary populations to transition: individuals with physical disabilities; older adults and individuals with intellectual and developmental disabilities (I/DD). While individuals within these three populations sometimes also experience mental illness, NC MFP does not currently target individuals whose mental illness is their sole disability.

#### Requirements for a Beneficiary to Enroll in MFP

Individuals interested in transitioning under the MFP Demonstration Project must apply and be approved for enrollment into the Program.

Application and submission instructions are found at [www.ncmfp.ncdhhs.gov](http://www.ncmfp.ncdhhs.gov) under *General Information about the Application and Transition Process*

To be approved for MFP, the applicant must:

1. Be *currently* residing in a *qualified facility*. Qualified facilities include:
  - a. state developmental centers,
  - b. private ICFs-IDD;
  - c. skilled nursing facilities,
  - d. acute care hospitals;
  - e. psychiatric residential treatment facilities; or

- f. under very limited circumstances, state psychiatric hospitals<sup>2</sup>.
2. Have resided in a qualified facility for at least three months immediately prior to discharge;
3. Receives Medicaid;
4. Is eligible for home and community-based waiver services.
5. Must be able to transition into a *qualified residence* which includes:
  - a. own or family's home (regardless of rental/ownership status);
  - b. A group facility of four beds or less.
  - c. An adult foster living placement<sup>3</sup>

For additional information about MFP's eligibility requirements, please review the Money Follows the Person *Operational Protocol's* (Operational Protocol) Eligibility Section, found at [www.ncmfp.ncdhhs.gov](http://www.ncmfp.ncdhhs.gov), under *Our Project's Guidelines* or contact the Project's staff at 1-855-761-9030.

Important Note about Adult Care Homes and Assisted Living Facilities: Under current federal policy, assisted living facilities/adult care homes do *not* constitute a *qualified facility*. As a result, individuals residing in these facilities are not eligible to transition through the NC MFP Program.

### **Applying for the NC MFP Project**

In order for an individual to be enrolled in the NC MFP Project and receive the Project's waiver and enhanced services, the individual must have an approved application and informed consent on file.

Applications are available at the [www.mfp.ncdhhs.gov](http://www.mfp.ncdhhs.gov), under *General Information about the Application and Transition Process*. Both the application and the informed consent form are included under the application link.

Currently, anyone may submit an application on a person's behalf, so long as the application is complete. MCOs are encouraged to submit MFP applications on behalf of individuals who are seeking access to an MFP Innovations slot.

Applications are submitted to the MFP Project staff, following the instructions on the Application itself.

### **Important Considerations Regarding NC MFP Application Process**

1. Only MFP Project staff may approve applications.
2. An individual must have an approved application on file PRIOR to transitioning.
3. An approved application does not automatically guarantee an MFP-funded waiver slot. MCOs are still responsible for determining the individual's eligibility for Innovations services. The MFP Project defers to the MCO and waiver managers within the Department of Health and Human Services' determination of an individual's waiver eligibility.

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<sup>2</sup> If an individual in a state psychiatric hospital is under the age of 22 or over the age of 65, MFP may be able to support the transition, *so long as* the individual *also* qualifies for NC Innovations services.

<sup>3</sup> In North Carolina, this option is only available to individuals receiving an *NC Innovations* waiver.

4. MFP applications do not expire, however if the application is over a year old, MFP will need an updated informed consent form.

#### **Duration of MFP Participant's Enrollment Status**

A person is considered an MFP participant upon enrollment into the MFP Program. A person maintains this designation for *one year* after transition. During this year, MFP's project-specific resources outlined in this guidance are available to this participant.

If an MFP participant returns to a facility setting during the year of MFP participation, the Project has specific criteria regarding *disenrollment* and *reenrollment* into the Project.

For additional information about these disenrollment and reenrollment practices, please refer to the *Operational Protocol*, found at [www.ncmfp.ncdhhs.gov](http://www.ncmfp.ncdhhs.gov), under *Our Project's Guidelines* or contact the Project's staff at 1-855-761-9030.

#### **How MFP Relates to MCOS**

MCOs are directly involved in MFP through two key populations:

1. MFP eligible individuals who have Intellectual/Developmental Disabilities (I/DD).
2. MFP eligible individuals who have physical disabilities, are transitioning under other Medicaid long-term care services (i.e. CAP DA) and also demonstrate a support need related to a mental illness or an addiction disorder.

#### **MFP Participants and Special Care Needs Care Coordination Designation**

MFP participants often represent the most complex individuals. As a result, MFP participants should be designated individuals with Special Care Needs.

- MFP participants with I/DD using the NC Innovations waiver will have access to the care coordination as will all Innovations recipients.
- MFP participants with physical disabilities or older adults *may* also have mental health support needs. While the MCO may not be responsible for coordinating the transition process, care coordinators may be asked to participate in the transition planning process to ensure that individuals are effectively linked with necessary mental health supports.

#### **Supports to MFP Participants with Intellectual/Developmental Disabilities Utilizing MFP- NC Innovations Slots**

##### **NC Innovations Slot Distribution/Allocation**

- DMA allocates MCOs slots specifically for MFP-related transitions each year of the NC Innovations waiver.
- MFP application approval and slot assignment must be finalized before the transition occurs.
- MFP slots are allocated on a first come, first serve basis, based on an individual's **anticipated transition date**.
- An MFP application may be submitted at any time while the individual is in the facility.

- An MFP applicant is considered approved for MFP once the MFP staff reviews and approves the applicant's application.
- Approval for entry into the MFP Project is necessary to **access** an MFP/Innovations waiver slot, but **does not automatically guarantee** an MFP/Innovations slot.
- MCOs assign MFP/Innovations slots based on slot availability and only if the MFP participant **also** meets NC Innovations waiver criteria.

### **Using NC MFP NC Innovations Slot**

The individual intended to use the MFP/Innovations slot must be an **approved** MFP participant **prior** to transitioning.

### **Important Considerations about Individuals With Dual Diagnoses and MFP (I/DD and MI)**

In addition to participants residing in State Developmental Centers, private ICF-IID, nursing facilities or acute care hospitals, NC MFP is also an available resource to individuals with co-occurring diagnoses under the following circumstances:

1. I/DD individuals who are in a state psychiatric hospital *and* are not excluded under the federal IMD exclusion.
2. I/DD individuals who are residing psychiatric residential treatment facilities
3. I/DD individuals in short-term specialty unit programs at state developmental centers.

To be included in MFP, individuals must *also* be eligible and receive an NC Innovations waiver slot and must also meet MFP's eligibility criteria (three months in facility, etc.).

### **MFP Transition Protocols and Expectations**

To be authorized to use MFP/Innovations slots, MCOs will follow the MFP application and transition protocols as outlined in the MFP Transition Coordination Handbook and the Transition Roles and Responsibilities out of State DD Centers, available at [www.ncmfp.ncdhhs.gov](http://www.ncmfp.ncdhhs.gov), under *General Information about the Application and Transition Process*

**These identified staff must receive training to be designated MFP Transition Coordinators *before* the transition occurs.**

**MFP does not assume responsibility for training on care coordination functions or other functions within the MCO's scope.**

Trainings will be held periodically and can also be organized on request. To request an MFP Transition Coordination training session, please contact Trish Farnham at [trish.farnham@dhhs.nc.gov](mailto:trish.farnham@dhhs.nc.gov).

**Accessing Administrative Payments for Staff and Clinical Capacity Building Funding (fka “MFP TYSR funds” or “Start Up Funds”) for Innovations-MFP Participants with Intellectual or Developmental Disabilities (I/DD)**

- MFP recognizes that strong staff training and clinical consultation are often the most critical “start up” needs a transitioning individual with I/DD may have. MFP encourages individuals and their transition teams to consider utilizing MFP “start up funds” for this purpose as appropriate. Managed Care Organizations (MCOs) will be authorized to access up to \$3,000.00 per MFP I/DD participant to support person-specific community-based staff and clinical capacity building. Accordingly, MFP has re-categorized its Transition Year Stability Resource Funds to meet training needs not allowed under the Innovations’ Transition Services waiver service.
- These funds shall be available to cover authorized, transition-related expenses incurred 60 days prior to the transition date and up to 356 days after the transition occurs.
- These resources are not included in the MCO’s capitated rate payment but are *additional* resources available to MCOs to support MFP participants.
- *Staff and Clinical Capacity Building Funding (“SCCB Funds”)* Guidelines:
  - MFP shall reimburse for direct support staff training at a rate of \$21.40 per hour and clinical consultation at the applicable billing rate.
  - These resources are for training and consultations specific to the MFP participant (i.e. person specific training, participation in planning meetings)
  - These resources cover the time of direct support staff training, not administrative staff time for participating in planning sessions.
  - For the most current SCCB procedures and invoice, please visit the MFP website at [link here]
- MFP *may* authorize additional expenditures for other items or services not covered under the Innovations Transitions Services or by Medicaid.
- To access these funds, the MCO will submit on its letterhead an itemized request to the MFP staff, using the attached template. The MCO will attach relevant invoices and receipts when submitting the request.
- If MFP authorizes the request, MFP staff will initiate an administrative payment to the requesting MCO.
- The MCO is then responsible for ensuring that appropriate vendors and provider are paid for the services invoiced.
- SCCB funds are reimbursement-based. Until further notice, MFP will not be able to advance funding for SCCB expenses.
- MFP will reimburse the MCO authorized SCCB-related expenses for MFP participants who do not transition, but will require additional information from the MCO regarding to the reasons why the transition did not occur.
- MFP participants who are elders or individuals with physical disabilities also have access to MFP “start up funds” but these funds are not managed by the MCO, but rather the participant’s transition coordination entity. Please See MFP’s Transition Year Stability Resource policy for these individuals.

For additional information about the MFP SCCB funds, please review the information available under the *General Information about the Application and Transition Process* found at [www.ncmfp.ncdhhs.gov](http://www.ncmfp.ncdhhs.gov).

**Additional Reporting Requirements**

Wherever possible, MFP will draw from established datasets (i.e. IRIS for incident reports) to address federal reporting needs.

However, DMA staff may request ad hoc reports as needed from MCOs to satisfy federal reporting requirements that cannot be met through current existing data sets.

### **Learning and Training Opportunities**

#### **Transition Coordination Trainings (Required prior to providing transition support to MFP participant).**

- MFP Transition Coordinator trainings are offered quarterly or on an as needed basis.
- Over time, MFP's training requirements will be incorporated into the Department's larger transition coordination capacity building initiatives.

#### **NC MFP Roundtable (Voluntary)**

- NC MFP Stakeholders' listserv that announces MFP-specific opportunities, including the NC MFP *Learning Series* outlined below.
- Quarterly Stakeholders' meeting.
- To participate in the NC MFP Roundtable's activities, please email [mfpinfo@dhhs.nc.gov](mailto:mfpinfo@dhhs.nc.gov)

#### **MFP/MCO Discussion Group (Voluntary)**

- Along with its partners within DMA, DMH and DSOHF, MFP hosts a discussion group on the 3<sup>rd</sup> Thursday of every month from 1:00-2:00.
- To receive announcements about MFP/MCO discussion group, please contact: Rachel Noell at [Rachel.noell@dhhs.nc.gov](mailto:Rachel.noell@dhhs.nc.gov)

#### **MFP Learning Series (Voluntary)**

A monthly 2 hour webinar and conference calls that focuses on different elements of quality transition planning. Open to everyone, but targets the topics and needs most relevant to transition coordinators.

Topics have included:

- Understanding the ADA and the *Olmstead* Decision
- Accessing Housing
- Understanding Guardianship
- Support Supported Employment
- Understanding Telesupport Options
- Understanding Peer Supports

## ATTACHMENT T

### Supporting People to Thrive: MFP Follow Along Practices



<b>Minimum Follow Along Contact Schedule</b>		
<b>Month</b>	<b>Minimum Required Activities for Regular Transitions</b>	<b>Minimum Required Activities for High Engagement Transitions</b>
Day of Transition	<ul style="list-style-type: none"> <li>• Confirming services/key supports (medications, adaptive equipment, housing needs) are in place.</li> <li>• Present in-person or available by phone on moving day.</li> <li>• Notify MFP of Transition</li> </ul>	
Month 1 (Within 30 days of Transition)	<p>Two visits, in person:</p> <ul style="list-style-type: none"> <li>• 1<sup>st</sup> within one week of transition (within 48 hours recommended)</li> <li>• 2<sup>nd</sup> within first month (if TC and care coordination same entity, may substitute care coordination/case management visit)</li> </ul> <p>Weekly phone call to participant, family and/or residential provider.</p>	<p>Same as Regular</p> <p>+</p> <p>Team Meeting</p> <ul style="list-style-type: none"> <li>- May be by phone or in person</li> <li>- Meeting also satisfies requirements outlined in DD Center Discharge Protocol;</li> <li>- CAP IDT team meeting also satisfies this requirement.</li> <li>- POC/ISP revision team meeting also satisfies this requirement.</li> </ul>
Month 2	<ul style="list-style-type: none"> <li>• Minimum one in-person visit</li> <li>• Weekly phone call.</li> </ul>	<ul style="list-style-type: none"> <li>• Minimum two in-person visit</li> <li>• Weekly phone call</li> </ul>
Month 3 Within 90 days of Transition	<ul style="list-style-type: none"> <li>• Minimum one in-person visit</li> <li>• Phone calls as needed.</li> <li>• If transition coordinator is “phasing out” at this point, visit must include coordinated handoff to ongoing case manager.</li> </ul>	<ul style="list-style-type: none"> <li>• Minimum one in-person visit</li> <li>• All other weeks--phone call to participant/family/residential provider</li> <li>• If transition coordinator is “phasing out” at this point, visit must include coordinated handoff to ongoing case manager</li> <li>• Team Meeting (See Team Meeting requirements outlined in “Month 1, Within 30 Days</li> </ul>

		of Transition”)
Month 4-11	<ul style="list-style-type: none"> <li>Ongoing care management entity continues to provides incident reports to MFP program.</li> </ul>	<ul style="list-style-type: none"> <li>Monthly in-person visit,</li> <li>All other weeks, by phone call</li> <li>SUB CAP transitions may follow CAP DA Case management visitation and contact requirements so long as individual is stable.</li> <li>Team meeting must occur at least once each quarter post transition until MFP participation ends. (See Team Meeting requirements outlined in “Within 30 Days of Transition”).</li> </ul>
Twelfth Month	<ul style="list-style-type: none"> <li>Ongoing care management entity continues to provides incident reports to MFP program.</li> <li>For SubCAP, Transition entity responsible for MFP closeout</li> </ul>	

**Incidents that Occur During the MFP Participant’s Year**

- MFP participants are under the same critical incident reporting requirements as all recipients under the relevant NC waiver. (Innovations, CAP DA, etc.). MFP requirements may exceed current waiver requirements, but should not be construed as reducing requirements currently outlined in waiver quality assurances.
- If any of the following incidents occur during the MFP participant’s year, the transition coordination entity shall report it to MFP staff within 48 hours of learning of the incident and shall initiate a *debriefing meeting* with relevant team members to debrief on events and analyze next steps.
- Teams are person and circumstance specific and MFP defers to the transition coordination entity for determining who needs to participate in the Debriefing. MFP anticipates that the following team members will be involved unless circumstances dictate otherwise:
  - A representative from the transition coordination entity (i.e. transition coordinator, care manager, etc.)
  - The MFP participant and/or family representative, as appropriate
  - Relevant community service providers, as appropriate
  - Facility staff, as appropriate
  - Medical/behavioral clinical personnel, as appropriate.
- MFP staff may also participate in these meetings and reserves the right to request documentation of a meeting’s activities. These meetings are not intended to be “fault finding investigations” but rather opportunities for:
  - reflecting on root causes of critical incidents;
  - improving an individual’s service and support structure;

- c. preventing more critical incidents in the future.
5. The following events trigger an MFP Debriefing Meeting:
- a. An individual returns to a higher level of care facility
  - b. An individual is discharged by a primary community provider (residential, personal support, day services).
  - c. An individual utilizes crisis respite services
  - d. An unanticipated death
  - e. Utilization of the Emergency Room Department
  - f. An assault resulting in injury either by the individual on another or on the individual.

**How MFP will monitor Follow Along Activity:**

1. MFP reserves the right to request documentation of all visits.
2. In an effort to monitor *desired outcomes* over mere documentation, MFP will evaluate the quality of the transition process, including the follow up by sampling MFP participants and surveying them within 90 days of transition. Our goal is that 90% of all transitioning individuals will correctly respond to the following three questions:
  - a. Clear who point of contact is on the day of transition
  - b. Felt the like transition coordinator understood needs and was responsive
  - c. If transition coordinator is no longer a part of the team, participant is clear on who to contact if have issues with:
    - i. Residential/Personal Support Services
    - ii. Housing
    - iii. Medical care
    - iv. Behavioral support
  - d. Feels team gets together as often as is necessary
3. MFP will also evaluate transition, recidivism and quality of life trends by population and transition entity to further identify areas of strengths and challenges in the transition process and practices.