Money Follows the Person

Operational Protocol

Grant # 1LICMS030163

Georgia Department of Community Health
Atlanta, Georgia

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PROJECT INTRODUCTION

The Georgia Department of Community Health (DCH) was created in 1999, with the responsibility for insuring over two million people in the state of Georgia, to maximize the state's health care purchasing power and to coordinate health planning for state agencies. DCH is designated as the "single state agency" for the administration of the Medicaid program under Title XIX of the Social Security Act.

Georgia has long demonstrated a commitment to providing care systems that enable its citizens to receive compassionate care in settings that are appropriate to individual needs and independence, steadily increasing its funding for home and community based services (HCBS). While 27% of the state's long-term care budget was expended on HCBS in SFY 2005, by SFY 2006 that share had risen to 30%. The state, however, has reached a point where new hurdles need to be overcome. The Money Follows the Person Demonstration allows Georgia's leaders to take rebalancing to the next level.

Money Follows the Person Demonstration Grant (MFP)

In May 2007, the Centers of Medicare and Medicaid Services (CMS) awarded Georgia the Money Follows the Person (MFP) Rebalancing Demonstration grant established by the Deficit Reduction Act of 2005. The MFP grant affords Georgia the opportunity to further rebalance the system of care, allowing the state to eliminate barriers or mechanisms that prevent or restrict flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the setting of their choice.

The Department of Community Health (DCH) is the administrator of the MFP Project and is responsible for all aspects of its successful implementation. As such, it acts as the overall coordinator for policy and operational issues related to the MFP Demonstration and works with various stakeholders, state departments, local governments, community-based organizations, inpatient health care facilities (hospitals, nursing or sub-acute care facilities, or intermediate care facilities for persons with Mental Retardation), advocates, and consumer groups to implement the project at the local level (see *Appendix A: Georgia's MFP Stakeholders Listing by Company Name*).

The MFP Project will supplement and expand current Olmstead Initiative and waiver programs that offer alternatives to institutional placement for individuals, including current Medicaid funding that is obligated under contract to a private vendor and Department of Human Resources' efforts to screen and assist in transitioning persons residing in institutions into home and community based services.

- Olmstead Initiative - The Georgia's Olmstead Initiative has evolved over time to identify areas to make quality community services more available and accessible to Georgians with disabilities within the resources available; to call for more consistency in statewide plans for identifying those who are eligible for community placement and evaluating their needs for services; and to call

for more person-centered planning to closely involve the individual and family in deciding what services are suitable. The plan also addresses important issues such as:

  - Affordable, accessible and integrated housing
  - transportation
  - work force development to provide greater and higher quality choices in services
  - consumer and family education
  - improved monitoring and oversight of services to better ensure the health and safety of individuals living in the community and the quality of services being provided

- Older Adults (Elderly and Disabled Waiver) – Transition Coordinators will complement and enhance the current efforts of the Department of Human Services Division of Aging Services, Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), waiver case management entities, provider associations, the Office of the State Long-Term Care Ombudsman, nursing home discharge planners/social workers, nursing home family councils, advocates, and other points of entry to service systems.
- Persons with Physical Disabilities and/or Acquired Brain Injury (ABI) (Independent Care Waiver) – TCs will partner with all of the above and Georgia Medical Care Foundation (the assessment entity for the ICWP waiver), Aging and Disability Resource Connections (ADRCs), Centers for Independent Living (CILs), the Brain and Spinal Injury Trust Fund Commission, Side by Side Brain Injury Clubhouse, Community Service Boards and regional and local service provider networks.
- Persons with Developmental Disabilities (DD) (NOW and COMP Waivers) – TCs and Case Expediters will expand on the efforts of the Department of Behavioral Health and Developmental Disabilities (DBHDD), the state's DD Council, the Association of Retarded Citizens (ARC), People First Georgia, Unlock the Waiting Lists, and regional and local MR/DD service provider networks.

The ICWP waiver has appropriated an additional 100 slots per year to transition older adults and persons with physical disabilities and/or ABI.

On September 1, 2009, the Department of Human Services issued a memorandum to the Department of Community Health stating that additional slots for MFP would no longer be funded due to significant budget reductions. The Department of Community Health is submitting this amendment to the MFP Operational Protocol to reflect that loss of capacity. This reduction in waiver services most directly impacts older adults, though some individuals with physical disabilities may also be affected in their choice of waiver options.

The state has a contract in place with a private vendor to facilitate transitions for individuals who may wish to transition out of institutions and into the Elderly and Disabled or ICWP waiver programs.

The Department of Behavioral Health and Developmental Disabilities staff performs the same transition functions in Intermediate Care Facilities for people with Mental Retardation (ICF/MRs). The efforts of case expediters and transition coordinators will be supplemented with funding from MFP, under the DCH/DBHDD Interagency Agreement, to enable the state to transition an additional estimated 150 persons per year with DD into the NOW and COMP waivers.

The Operational Protocol for the MFP Demonstration includes the required elements that must be submitted and approved by the Centers for Medicare & Medicaid Services (CMS) before enrolling individuals in the Demonstration or claiming Federal dollars for provision of direct services to participants/members.

The purpose of the Operational Protocol is to provide information for:

- Federal officials and others, so they can understand the operations of the Demonstration.
- State and federal monitoring staff that are planning a visit.
- State project director and staff who use it to guide program implementation.
- Regional partners who use it as an operational guide.
- External stakeholders who use it to understand the operation of the Demonstration.

Subsequent changes to the MFP Demonstration and the Operational Protocol must be reviewed by the Project Director, HHS/OCR and stakeholders and approved by DCH and CMS. A request for change(s) must be submitted to CMS 60 days prior to the date of implementing the proposed change(s). All aspects of the MFP Demonstration, including any changes to this document, are managed by the Department of Community Health, Medicaid Division, Long-term Care Section (DCH) (See *Section C.1 Organizational Structure*).

Goals and Objectives of Georgia's MFP Demonstration

Georgia's MFP Demonstration addresses the long-term care needs of three specific populations: older adults, persons with developmental disability or mental retardation, persons with physical disabilities and/or acquired brain injury (ABI)- (see *Section A.2 Benchmarks* for more detail). The Operational Protocol illustrates Georgia's commitment to rebalancing long-term care, to person-centered planning, self-direction, quality assurance and continuous quality improvement, and to transparency and openness in program development, implementation and evaluation.

The Demonstration builds on and supplements services in the current 1915c waivers that serve the above populations. Georgia's current waivers include:

- The Elderly and Disabled Waiver Program that provides home and community-based services to people who are older adults and/or functionally impaired or have disabilities. These individuals are also referred as the Aged, Blind, or Disabled,

- The Independent Care Waiver Program (ICWP), that offers services to adults (age 21-64) with physical disabilities or ABI, that live in their own home or in a community setting, and
- The New Options Waiver (NOW) and The Comprehensive Waiver (COMP) that offer home and community-based services to people who have developmental disabilities.

Georgia's MFP goals and objectives address the four demonstration objectives outlined in the Deficit Reduction Act:

Objective 1: To increase the use of home and community-based, rather than institutional, long-term care services.
In an effort to provide additional alternatives to institutional stays, Georgia's MFP project will use the state's home and community-based Medicaid waivers and MFP demonstration and supplemental services to transition Medicaid eligible, qualified individuals residing in an institutional setting for a minimum of six months.

Once transitioned, participants may receive HCBS waiver services as long as they meet waiver criteria. Participants will receive State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, state funded programs, and local community funded services. The state is not seeking enhanced match for State Plan services provided to MFP participants.

Through marketing, development of supportive peer networks and identifying individuals who prefer to transition to community settings, the state will move toward rebalanced spending in favor of home and community-based services and supports. Over the period of the grant, the state will:

- Transition 618 individuals to community settings,
- By 2011, increase federal and state expenditures on HCBS by over $36 million,
- The FY2011 HCBS long-term care budget is estimated to increase to 40.2% compared to the 30.3% spent in FY 2005.
- Use the enhanced FMAP rate to reinvest savings realized by the state into the Demonstration infrastructure and supplemental services, by offering demonstration and supplemental services to assist individuals to transition into a community setting.

Georgia's stakeholders are committed to redirecting the excess capacity in nursing homes and ICF/MRs to alternative uses. For example, MFP will work with the Georgia Health Care Association to develop strategies to re-deploy existing nursing home capacity for other purposes (e.g. skilled respite services and/or adult day health).

Objective 2: To eliminate barriers and mechanisms, whether in State law, State Medicaid Plan, State budgets, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to

receive support for appropriate and necessary long-term services in setting of their choice.

During statewide stakeholder forums (see *Section B.4 Stakeholder Involvement* for details), participants identified numerous barriers to effective systems for resettlement and explored ways to eliminate these barriers to transitioning to the community from institutions. Chief among the identified barriers were:

- Lack of adequate, affordable, integrated and accessible housing and rental subsidies for participants with limited income and no community supports,
- Lack of financial resources for one-time expenditures needed to transition,
- "Fear of the unknowns" associated with relocation.
- Lack of a coordinating system for planning and service delivery among state, regional, and local entities, and
- Lack of a unified information and referral system to all waivers that linked interested participants to services and resources needed for transition.

MFP funding supports a broad range of supplemental demonstration services, including resettlement assistance, through local peer support networks that assist participants/members with community knowledge, experience and local resources. The Housing Coalition workgroup (see *Section B.9 Housing*, for details) is developing opportunities and resources to assist MFP participants with housing options and increasing the state's ability to address long and short term goals for expanding state's supply of affordable, accessible and integrated housing.

MFP will fund transition services (see *Appendix B: MFP Transition Services Table*) to help people transition into the community and set up their new qualified residence. MFP will enhance current systems for accessing information and services by incorporating a Team Training Process so that MFP Transition Coordinators and Peer Supporters receive training with case managers from each waiver prior to MFP demonstration implementation (please note, throughout this document the term "case manager" may be used to refer to case managers across waivers – within the waivers these individuals may be referred to as care coordinators or support coordinators instead of case managers). Using a team approach will improve current coordination between systems.

MFP will develop a collaborative resource network by building on the Area Agency on Aging-AAA/Gateway Network, the Georgia Independent Living Network (GILN), the Aging and Disability Resource Centers (ADRC) network, the Office of the State Long-Term Care Ombudsman, and the DBHDD Regional Network and other service points. The collaborative resource network will result in a transparent, easily accessible and open system for obtaining services, long-term care information and resources, knowledge of where to go for assistance and how to obtain basic information. These processes will strengthen the coordinating systems for planning and service delivery and unify referral processes across all waivers.

Objective—3--To increase the ability of the State Medicaid Program to assure continued provision of home and community-based long-term

services to eligible individuals who choose to transition from an institution to a community setting.

An individual eligible for the Demonstration will not be referred to a waiver program waiting list unless the number of qualified MFP candidates exceeds the reserved capacity of the waiver. With regard to waiver waiting lists, the state will amend the MFP Operational Protocol to reflect the Olmstead agreement, once the agreement has been signed by the state. Through reserved capacity (i.e. slots) under the ICWP, NOW, and COMP waiver programs, the state will assure that transitioning participants enter those waivers immediately upon discharge from the institution.

The state will assure that services will continue to transitioned individuals beyond the demonstration period. Transitioned individuals may enter an appropriate 1915c home and community based waiver program and receive services as long as they meet the institutional level of care criteria for services offered in Georgia's 1915c waivers. At any point that they no longer meet waiver criteria, participants will be assisted in transitioning to non-Medicaid state and community resources as their needs require.

Objective 4: Ensure that a strategy 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.

MFP participants will be afforded the same level of safeguards as those available to participants enrolled in existing waivers, as described in 1915c waiver Appendix H; Elderly and Disabled Waiver, the Independent Care Waiver Program (ICWP) and the Mental Retardation Waivers (NOW and COMP). Through an ongoing process of discovery, remediation and improvement, the Department of Community Health (DCH) assures that each waiver provides for system-level, mid-level and front-line Quality Management Strategy (QMS). DCH further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. DCH continues to implement and improve the Quality Management Strategy for each waiver as specified in 1915c Appendix H (see *Section B.8 Quality Management Systems*).

For example, for older adults under the Elderly and Disabled waiver, DCH has established a number of Quality Management Strategy (QMS) workgroups to ensure an ongoing focus on continuous quality improvement in the operation, results and performance of waiver programs. The purpose of the QMS workgroups is to assign roles and responsibilities for QMS, standardize processes, develop and implement monitoring tools for discovery, performance indicators for data collection and analysis, strategies for remediation and opportunities for continuous quality improvement. MFP will join with the QMS workgroups to monitor and improve MFP services and operations offered to the elderly population within the Elderly and Disabled waiver services (see *B.8 Quality Management Systems* for details).

Quality Assurance for Individuals with Physical Disabilities and/or Acquired Brain Injuries (ABI) is governed under the ICWP Continuous Quality Improvement (CQI) Committee, which consists of Utilization Review (UR), contracting agencies and case managers, and DCH staff. The ICWP CQI Committee meets on a monthly basis. Activities of the CQI committee include: conducting, analyzing and reporting on participant customer satisfaction surveys; providing training, reviewing sentinel events/health and welfare of participants through risk assessment, planning and prevention; reviewing access data and reports; reviewing procedures and reports regarding person-centered planning; medical records reviews; performance reviews of case management staff; claim payment reviews and monitoring of self-directed personal support services (PSS) options. MFP staff will join with the CQI Committee in efforts to monitor and improve MFP services offered along with ICWP services (see *Section B.8 Quality Management Systems*).

The Department of Behavioral Health and Developmental Disabilities has designed a number of MR/DD Waivers Implementation Work Groups to address various issues associated with the NOW and COMP waivers. Each workgroup is led by a staff member in the Division of Developmental Disabilities with other staff of DBHDD serving as core staff for the workgroups. Membership in workgroups was expanded to include various community stakeholders. Currently there are waiver work groups that focus on: Transition to New Services, Billing System and Prior Authorization, New Rate Structure and Individual Waiver Allocation Determination, Provider Application Development/Revision, SIS Assessment and Individual Budget Determination, Policy and Standards Development/Revision, Participant Direction, and the Quality Management Strategy. All of these groups have system and service improvements as their ultimate goal.

DCH assures that MFP participants will receive the same or additional assurances as identified in section *B.8 Quality Management Systems*. Section *B.8 Quality Management System,* describes the safeguards available to MFP participants enrolled in these waivers, the roles and responsibilities of each agency or entity involved in quality monitoring, quality improvement and remedies for quality problems experienced by MFP participants. The section describes the reports that are regularly generated and reviewed to meet the QMS assurances: 1) level of care determinations, 2) service plans, 3) identification of qualified providers, 4) participant health and welfare, 5) waiver administrative oversight and evaluation of QMS, 6) financial oversight of the waivers, 7) risk management processes, 24/7 emergency backup and critical incident reporting systems.

* NOTE: Throughout this Operational Protocol, older adults are served under the Elderly and Disabled Waiver, individuals with Physical Disabilities and/or ABI are served under the Independent Care Waiver (ICWP), and persons with developmental disabilities (DD) are served under the NOW and COMP Waiver Programs.

A.1 Case Study: Older Adult

This case study describes the transition process for Mrs. Ruth Habersham, a 79 year old female with short-term memory loss, hearing loss in the left ear, vision loss, mobility limitations (walks slowly using a rollator-rolling walker), dexterity limitations (reduced range of motion in the right arm due to shoulder replacement), and a history of heart disease and reduced heart function due to a heart attack. Ruth has limitations that meet the qualifications for the Elderly and Disabled Waiver Program. Ruth currently resides in Wesley Woods Nursing Home in Augusta, GA and is transitioning into the Elderly and Disabled Waiver Program, and will be able to take advantage of several of the Money Follows the Person (MFP) Supplemental and Demonstration Services.

This section describes each of the following steps undertaken to resettle Ruth in the community: 1) identification/referral, 2) pre-transition planning, 3) transition period (day 1 to day 365), and 4) post-transition (day 366 and beyond). The description includes the agencies involved in these steps, roles and responsibilities at each step, services and supports, options and choices and backup provisions. This section concludes with a description of how Ruth would be accommodated if she required a short-term hospital or nursing facility/rehab stay and how this stay would impact her MFP/waiver services.

Ruth Habersham, a 79 year old woman, resides at Wesley Woods Nursing Home in Augusta, GA. Ruth raised a family for most of her life. She was a trained nurse and practiced nursing intermittently along with raising her family and helping with the family business. She has had several bypass surgeries and has reduced heart function due to a heart attack. She suffers from short-term memory loss. Ruth has lived at Wesley Woods for the last 6 months. She needs assistance with her ADLs and takes meals at the cafeteria. Before entering Wesley Woods Nursing Home, Ruth and her husband, George, age 75, shared an apartment in Augusta, Georgia. George provided the assistance that Ruth needed on a daily basis. Six months ago, George was diagnosed with colon cancer and had to undergo surgery and several weeks of recovery at a rehab center. Because George could no longer provide for Ruth's care and because Ruth was Medicaid eligible, the decision was made to place Ruth in Wesley Woods Nursing Home.

Ruth has been at Wesley Woods for six months. During this time, George was released from the rehab center, but has not fully recovered from his surgery. He is starting colon cancer treatments. Due to George's situation, Ruth felt she would not be able to care for herself to the extent that she was able to with George's assistance prior to his surgery. Though Ruth has made a few friends at Wesley Woods Nursing Home and participates in a few of the social activities, she wants to move back to her home and wants to be with George, but she knows that she can't care for him. Ruth's children take her to church activities and family outings. Ruth has asked her adult children for assistance in moving back to her home. Ruth's son, Kenneth (her Power of Attorney) doesn't think that Ruth can live at home without the care that George previously provided. Kenneth's concern was that Ruth had a

good situation at Wesley Woods and he didn't want Ruth to lose it. Both Kenneth and George expressed this concern to Ruth and the discharge planner.

One day, Ruth received a brochure describing a program called Money Follows the Person (MFP) including information about how she could call a MFP Transition Coordinator to discuss services that would help her live at home (see *Appendix C: MFP Tri-Fold Recruiting Brochure*). (Ruth received the brochure because she expressed a desire to return to the community during a routine facility visit with a long-term care ombudsman).

The MFP brochure listed and described transition services that were offered in the community and available to older adults and to people with disabilities. MFP brochures were also sent to Wesley Woods. A short time later, the MFP TC made a presentation about MFP to residents at Wesley Woods. During the presentation, the MFP TC explained that residents could meet with a Transition Team to discuss relocation in the community. The MFP TC also informed Wesley Woods' residents during the presentation that they could invite anyone they chose to attend the meeting.

The long-term care ombudsman paid another visit to Wesley Woods and in the process visited and spoke more with Ruth. Ruth told the ombudsman she was thrilled about the possibility of moving back to the senior living apartment she had previously shared with George, but she was unsure about how she would take care of herself and George at home. Ruth expressed a desire to learn how the new MFP program might make this possible. The ombudsman helped Ruth schedule a meeting with the Transition Team. The Team convened and Ruth invited George, their son Kenneth and his wife, Janet) the MFP Transition Coordinator (MFP TC), the Wesley Woods discharge planner/transition staff member, and representatives from Walton Options for Independence and the Aging and Disability Resource Center (ADRC) in Augusta.

Ruth might have also been referred to the MFP project through a AAA/Gateway Case Manager, the nursing staff at Wesley Woods, friends or other family members, or through outreach and marketing efforts that could have led to self referral.

2) Pre-transition/Discharge Planning

At the Transition Team meeting, Ruth discussed her situation at Wesley Woods and described the difficulty she had taking care of herself at home and what George had been doing to assist her. She was worried about taking care of herself and taking care of George (who was undergoing cancer treatment). She was concerned about her short-term memory loss. George, Ken and Janet talked about how much Ruth wanted to return home, but they were concerned about the help she needed and some of the barriers. Ruth's mobility needed to be improved, maybe with a scooter to use inside and outside the home. The apartment needed to be modified to accommodate the use of a scooter and to allow Ruth to stay in the scooter when using the kitchen and the bathroom. Because George could no longer provide assistance, Ruth needed help with ADLs including personal care, food preparation and medication monitoring. She also needed help cleaning house and needed help

with IADLs. She needed someone to check on her several times a day and someone to take her to doctor and therapy appointments, including visits to the audiologist for adjustments to her hearing aids.

Informed Consent
The Team members discussed services available under the Elderly and Disabled Waiver and under MFP, including personal support services (PSS) to help with personal care. The Nursing home discharge planner informed Ruth that her bed at Wesley Woods may not be available after she transitioned, but that she would be placed in the next available bed if she found that she was not able to live at home, and had to return to the nursing facility. They discussed modifications to the apartment to accommodate a scooter. During the discussion, the MFP TC explained Ruth's rights and responsibilities under MFP and explained the MFP services. Ruth was able to understand and gave her consent to participate in MFP. Ruth was apprehensive, but she wanted to move forward with the process. Ruth signed the *Authorization for Use or Disclosure of Health Information* (see *Appendix D1*) *and the MFP Consent for Participation* (see *Appendix D2*). The MFP TC completed the *MFP Transition Screening Form* (see *Appendix* G). The group began work on the preliminary transition plan and the MFP TC arranged for a follow-up meeting with Ruth to further assess her needs and discuss the possibility for transition. The MFP TC and Wesley Woods discharge planner agreed to continue to work together to assist Ruth.

Person-Centered Planning
The Transition Team (the MFP TC, a case manager with the Elderly and Disabled waiver, the Wesley Woods discharge planner, and a representative from Walton Options/ADRC) met with Ruth again at Ruth's request. The meeting also included George and Janet. The group discussed barriers to moving Ruth back to the Augusta Senior Living Apartments. The MFP TC and the waiver case manager discussed how some of Ruth's needs would be addressed using the MFP program. Other services would be covered by the Elderly and Disabled Waiver through involving other community agencies for assistance. The MFP TC let Ruth, George and Janet decide whether they wanted to follow up on community referrals or whether they would like the MFP TC to assist them in making the calls. The release of information allowed the MFP TC to obtain needed information about Ruth to build a personal profile. During person-centered planning, the group discussed Ruth's personal goals, adaptive strengths, health/nutrition, walking ability, mobility device needs, hearing and vision limitations, her self-care, ADL and IADL needs, specialized medical equipment needs (scooter, scooter rack for vehicle, hearing aid, supplies), her recreation/leisure interests, her transportation needs, her financial resources and the barriers that might be encountered as she transitioned. The MFP TC wrote up the results of the person-centered planning in the *Individualized Transition Plan (ITP)* (see *Appendix Q1 and Q2*). Ruth's ITP included a list of the MFP Pre- and Post-Transition Services she would receive (Part A), waiver services she needed (Part B) and any other State Plan Service she might benefit from (Part C).

Personal Support Services and Self-Direction
The group also discussed how Ruth and George could choose to get Ruth's personal support services (PSS) through an agency that would arrange for workers to come to the Augusta Senior Living Apartments to assist her. After six months, Ruth could choose to self-direct her PSS services. Ruth and George as her representative could hire and select Ruth's PSS staff. Ruth and George felt that hiring Ruth's PSS staff sounded overwhelming, but that in the future they agreed they might think about self-directing part of Ruth's services.

The MFP TC also referred Ruth and George to a peer supporter program that would connect her with someone else who had lived at Wesley Woods and then transitioned back home. Ruth and George were both interested in talking to someone who was living at home using the Elderly and Disabled Waiver. The peer supporter program was offered through Walton Options for Independence, a Center for Independent Living in Augusta. Peer supporters were a covered service through the MFP program.

Case Manager Pre-Screening
Ruth's AAA Gateway staff completed a pre-screening for the Elderly and Disabled Waiver. Based on the screening process it was determined that Ruth may be eligible to receive services from the Elderly and Disabled Waiver, and a referral was made to the AAA contracted waiver case management agency for a full waiver assessment. Ruth didn't have difficulty communicating via telephone and expressed a desire to have a reminder call before future meetings to help her remember and prepare for the meeting.

Elderly and Disabled Waiver Assessment and Developing the Service Plan
A RN with the case management agency contacted Ruth to schedule a time to meet with her to complete the initial assessment and service plan. The case manager received information that the Transition Team had collected in Ruth's personal profile and the information from the pre-screening. The RN case manager received this information and completed assessments including; the MDS-HC, Determination of Need-Revised (DON-R), the Geriatric Depression Scale or Beck Depression Inventory or Cornell Scale, Environmental Assessment, Caregiver Burden Inventory and Mini Mental Status. Once these assessments were complete, the case manager worked with Ruth (and George) to develop the Service Plan for all the waiver services that Ruth was to receive under the Elderly and Disabled Waiver. Ruth's physician was asked to review the service plan and certified that she met nursing level of care.

24/7 Emergency Backup Plans
Ruth's service plan also included personal risk triggers from the MDS-HC. Each risk was identified in the service plan with individualized contingency plans, 24/7 emergency phone contacts to the Care Coordinator and to each service provider. Ruth's service providers were required to provide 24/7 emergency backup services and to instruct direct care staff in Ruth's care. The service plan also included emergency plans for natural disasters, power outages and interruptions in routine care.

The Wesley Woods discharge planner assisted with obtaining necessary documents for the financial information to order a scooter for Ruth. The MFP TC obtained the necessary paperwork to obtain a scooter carrier and had it installed on the family car so that the scooter would go with Ruth when she and George made community trips. The discharge planner and waiver case manager made arrangements to meet Ruth, George and Janet at home so they could assess Ruth's situation. During the home assessment, Ruth described her daily routine and the kinds of help she believed she needed. George described what he had been doing to assist Ruth and the type of help he felt she needed and the help he thought he might be able to provide. Janet also discussed the help she thought that she and Ken might be able to provide. Janet indicated that she was willing to act as part of Ruth's 24/7 emergency backup, if her regular PSS worker failed to show up for work. The review of the apartment space was completed and the group agreed that the bathroom door needed to be widened and the shower/tub needed to be upgraded to a modular tub unit with a door that would allow Ruth to sit while showering and bathing.

The service plan included PSS daily hours, delivery of a noon meal and a 24/7 emergency system. MFP services included peer supporters and trial PSS, to allow Ruth to spend a few nights at home with George to get used to working with PSS staff, before she transitioned. MFP covered moving expenses--a van that George rented to help moved Ruth's personal belongings back to the apartment. MFP also provided for Caregiver Training for George and Janet, periodic contact from a long-term care ombudsman, the scooter carrier for the family vehicle and a modular bathing unit (purchased using funds in MFP Equipment and Supplies budget) installed in the apartment. The MFP TC completed the *Authorization for MFP Services* to authorize the purchase of these services (see *Appendix S)*. The Augusta Senior Living Apartments manager agreed to pay for widening the bathroom door and for the installation of the new bathing unit. MFP covered the purchase of the modular bathing unit. Because the bathing unit cost more than $1,000, the MFP TC obtained three quotes for the unit from three different vendors using the *Quote Form for Equipment & Supplies, Environmental Modifications and/or Vehicle Adaptations* (see *Appendix T*).

Each invoice for MFP services was paid by the Community Transition Financial Service, or Fiscal Intermediary (FI). The Fiscal Intermediary provided financial services for payments for the MFP demonstration and supplemental services for Ruth. The FI paid service providers directly for services rendered based on her Individualized Transition Plan and invoiced properly (for more detail, see *Appendix S: Authorization for MFP Services, Appendix U: MFP Vendor Payment Request to TC, Appendix V: MFP DCH DHR Vendor Import File*).

The MFP TC contacted Department of Community Health (DCH) Member Services and completed the necessary information to switch Ruth's eligibility from Wesley Woods to the Elderly and Disabled Waiver. Ruth's next SSI monthly check would go to paying her share of the apartment rent and helping her live back at the apartment with George. The MFP TC also arranged for Ruth to spend several nights

at the apartment working with PSS staff and the peer supporter before her discharge date.

The Initial Quality Of Life (QOL) Survey
The MFP TC arranged for the Quality of Life (QOL) survey to be completed approximately 30 days prior to Ruth's discharge date from Wesley Woods. The surveyor contacted Ruth at Wesley Woods and made arrangements to complete the survey face to face.

3) Transition Period (day 1 to day 365)

On the day that Ruth moved out of Wesley Woods Nursing Home the MFP TC assisted George to arrange for a van to help move her bed and personal belongings back to the apartment. The MFP TC completed the *Discharge Day Checklist* (see *Appendix R*). The case manager came to make sure that everything was in place. Each day for the next couple of weeks a peer supporter visited Ruth and helped train Ruth, George and Janet on management of personal support services (PSS).

The MFP TC checked on Ruth and George at the end of the first week in the apartment to ensure that all services in the service plan were occurring as arranged and to see if there was a need for any additional MFP services, equipment or supplies. Things were progressing nicely for Ruth and George.

The MFP TC visited with Ruth and George at the end of the first month to ensure that Ruth was receiving all services in her service plan and to see if any additional services were needed. If additional MFP transitional services were needed, the MFP TC would complete the *Request for Additional MFP Services* (see *Appendix X)*. The MFP TC and waiver case manager continued to monitor the services that Ruth received and kept in regular contact with her service providers.

The Follow-up Quality Of Life (QOL) Survey
The MFP TC arranged for a surveyor to complete the Follow-up Quality of Life (QOL) survey during the 12th month of Ruth's community placement. The surveyor contacted Mrs. Habersham at her apartment and made arrangements to complete the follow-up survey face to face.

During the 12th month of placement, the MFP TC and the case manager met with Ruth, George and Janet and explained the transition to the regular Elderly and Disabled waiver and what changes, if any, they might expect. Together, they updated the service plan and identified if Ruth needed additional waiver services or needed adjustments to current services. The MFP TC left her contact number and asked Ruth, George or Janet to contact her if they had any questions.

4) Post-Transition (day 366 and beyond)

The transition to the Elderly and Disabled waiver occurred on day 366 without any problems. The case manager checked periodically to see if any additional services were needed. The case manager continued to monitor the services that Ruth received and kept in regular contact with her service providers.

5) Short-Term Hospitalizations or Nursing Facility/Rehab Stays

MFP Re-enrollment Process

If Ruth needed to be hospitalized for any reason during the MFP demonstration for less than 30 days, she would not be considered an institutional resident. As soon as her condition stabilized, she would be able to return to the Augusta Senior Living Apartments and resume MFP and waiver services. If the hospital stay was 30 days or longer, she would be discharged from MFP and would then be considered an institutional resident. In this case, the TC would complete the *Participant Enrollment Status Change Form* (see *Appendix Y*) to track the change in enrollment status and stop the MFP participant 'clock' (for details, see *Appendix Z: MFP Manual Tracking Database Screens*). The MFP TC also would also complete the *MFP Sentinel Event Report* (see *Appendix* AB). If Ruth was re-admitted to a nursing home/institution and had a stay of over 30 days, she would NOT need to meet another MFP 6 months institutional residency requirement, but she would be re-evaluated for discharge to the community and re-enrolled into the MFP program to determine if any changes in the service plan were warranted to prevent a re-admission to an institution. For stays of longer than six months, institutional residency requirements would apply and Ruth would need to be re-evaluated like a "new" MFP participant.

A.1 Case Study: Physically Disabled and ABI

This case study describes the transition process for James Brown, a 35 year old physically disabled male living in a nursing home with loss of memory sustained from head and lower extremity injuries suffered in Iraq, decreased attention/concentration, headaches which cause vision distortions, slow thinking and response, irritability, and diagnosis with depression. James uses a power wheelchair to get around. He has limited upper body strength, but is able to perform some ADLs without assistance. He can stand and walk very short distances with the aid of a cane and he can do sit-to-stand transfers. James has long-term memory loss and suffers from headaches that can cause him to lose consciousness when medications are not taken.

This case study will describe James' background and the following transitioning steps undertaken to assist James to resettle back into the community: 1) background/identification/referral, 2) pre-transition planning, 3) transitioning and discharge and 4) post-transition (30 days after discharge, 366 days after discharge and beyond). The description includes the agencies involved in these steps, roles and responsibilities at each step, services and support options, choices and backup provisions. This section concludes with a description of how James would be accommodated if he required a short-term hospital or nursing facility/rehab stay and how this stay would impact his MFP and waiver services.

James was a truck driver for three years. In 2005 he was offered a job opportunity to drive trucks in Iraq with Holmes Construction Company, a private contractor, to drive their trucks in support of "Operation Iraqi Freedom." He excitedly accepted the offer with Holmes Construction. James had been in Iraq two weeks when a roadside bomb struck his vehicle. The destruction destroyed one third of the surrounding area, killing several people and critically wounding James. James suffered damage to over half of his body, including a closed head injury that caused him to lose consciousness. James had extensive surgery to his lower spine and legs. He spent 6 months unresponsive and unaware of his surroundings at Walter Reed Army Medical Center in Washington D.C.

After James' condition stabilized, he was referred for a neuropsychological evaluation. The neuropsychiatry evaluation determined he had severely injured his spinal cord causing loss of mobility and deficits in his memory and judgment. These losses required supervision and 24/7 care. Holmes Construction Company paid James' hospital bill and medical expenses; however, James did not have health insurance to support 24/7 personal care support he needed for activities of daily living (ADLs). With the assistance of the hospital discharge planner, James' mother, Sandra Brown, became his guardian and he applied for Medicaid. The hospital discharge planner assisted Ms. Brown with arrangements to get James transported home to Georgia. Together they found a placement at the Owens Nursing Home (ONH) in Atlanta. After several more months of therapy and treatments at Walter Reed, James relocated to Atlanta and moved into ONH.

Upon arrival at ONH, Ms. Brown signed several forms, including the nursing home admission packet. She also received a packet with several brochures and pamphlets. After the long journey James was tired. He was taken to a private room funded for thirty days by Holmes Construction Company. The next day James was introduced to his environment and started rehabilitation therapy. James' eligibility for Medicaid was approved and on the 31st day of his stay at ONH, and he was moved from the private room to a semi-private room. James was introduced to a roommate and his personal belongings were moved into smaller compact area, forcing Ms. Brown to place larger items in storage. After six months of stay at ONH with rehab therapy, James' condition gradually improved. He learned to use a power chair for mobility and regained some of his ability to speak. He became more involved with people in the facility, but often exhibited irritability and frustration towards family and friends that visited him.

One day James' roommate was taken to the hospital and replaced with a gentleman that required wound care and more personal care assistance. James on the other hand manages to do some of his ADLs with difficulties but needs assistance in bathing, dressing and getting in and out of bed. The disruptions from the roommate frustrated James and caused him to be verbally abusive to staff and other residents. James started talking to friends and family about leaving the facility and living with people his own age. James spoke to his mother about the situation.

A few days later, the ombudsman visited Owens Nursing Home. The ombudsman was accompanied by a Money Follows the Person Transition Coordinator (TC). Both introduced themselves and talked with the resident council about MFP demonstration and community options. James attended the discussion, read the information given out and talked with his mother about moving out of the facility. James and Ms. Brown met with the Social Worker and contacted the MFP TC through a toll free number. On speaker phone the MFP TC spoke to James and Ms. Brown about MFP transition services and applying for a waiver. James was asked about his wishes to live in a community setting. He expressed why he wanted to move out and stated he wanted to be with others his own age. The TC set an appointment to visit with James and Ms. Brown at the nursing facility.

2) Pre-Transition Planning

At the meeting, the TC met with James, Ms. Brown, the LTCO and the social worker/discharge planner at ONH to explain the MFP program in more detail and how MFP could assist James. The challenges of finding housing, different living arrangements, and MFP and waiver service options were explained. The TC also explained that some services received in the nursing home would not be available in the community. The outreach booklet about home and community services, *Home and Community Services: A Guide to Medicaid Waiver Programs in Georgia* (see *Appendix E*) and a brochure about Money Follows the Person demonstration services, (see *Appendix C: MFP Tri-Fold Recruiting Brochure*) were reviewed with the group. They were informed that MFP provided pre- and post-transition services for 365 days and on day 366 participants continued to receive waiver services, but not MFP services (s*ee Section B.1 Participant Recruitment & Enrollment*). The group discussed James' personal goals and reviewed possible waiver services and options.

Ms. Brown explained that she has legal guardianship and provided the TC with a copy of the guardianship, but stated that she felt that he would do better in a different setting. Ms. Brown asked questions about his personal support needs and provider of his personal care. The TC explained that personal support services (PSS) would help with James' personal care. The TC offered the group the opportunity to think about their decision and arranged to introduce them to a Peer Supporter. The peer supporter had encountered similar challenges as James and would be available to share personal experiences about resettling and living in the community. The TC closed the meeting and gave out his contact information and asked James and Ms. Brown to call him if they had questions.

Informed Consent and Preliminary Transition Planning

Angie, a Peer Supporter with the local Center for Independent for Living (CIL), visited James two days later. Angie met with James and shared her story of living in a nursing home for over 15 years and finally transitioning back into a community setting. Angie explained that James would need to understand his decision and to accept those things that he would be responsible for doing when he left the nursing home (such as cooking and taking his medications). Together they talked about community services and supports, activities in the community, services that he might be eligible for and his freedom.

A follow up visit was scheduled by the MFP TC with James, Ms. Brown and with their permission the LTCO was invited, the peer supporter Angie, the ONH social worker, and Billy and Ruth Ann White (James' friends). During the meeting the TC explained James' rights and responsibilities under the MFP program and MFP services. James and Ms. Brown understood and gave consent to participate by signing the *Authorization for Use or Disclosure of Health Information* (see *Appendix D1*) and the *MFP Consent for Participation* (see *Appendix D2*). The MFP screening process was completed using the *MFP Transition Screening Form* (see *Appendix G*). James' only income was SSDI. Budget issues were discussed. Housing options were discussed. James wanted to live in Atlanta, in south Fulton where he had grown up. His first choice was to locate an apartment. Ms. Brown wasn't against James' decision and offered that he could live at home. Billy and Ruth Ann White agreed to help James look for an affordable apartment and help him move his personal belongings. The group reviewed and discussed available community housing resources. They also discussed the roommate match process, monthly expenses required to sustain James in a community setting, and the role and responsibilities for each person assisting with the transitioning process.

The MFP TC explained the Independent Care Waiver Program (ICWP) and assisted James and Ms. Brown to complete the application process. The ICWP application was submitted for processing and the TC contacted Georgia Medical Care Foundation (GMCF) to arrange the assessment to determine waiver eligibility.

James and Ms. Brown agreed to visit a CIL center and meet with Angie and the MFP TC. Angie arranged transportation for James to visit the CIL. The MFP TC, James and Ms. Brown attended. Angie introduced them to other individuals with disabilities who had recently transitioned into the community and introduced them to several who were waiting to transition. James met Sally, a 49 year old female with cerebral

palsy who had transitioned 8 months previously from an institution. Mark, a 30 year old quadriplegic, was injured in an automobile accident. Mark's sister Genie helped him describe his transition experience and how his new adaptive wheelchair had enabled him to live independently.

During their visit at the CIL, James and Ms. Brown received information about problems with accessing Housing Choice Vouchers for rental assistance in Atlanta and Fulton County. Angie, the peer supporter, discussed with James and his mother some of the challenges regarding locating affordable housing in the Atlanta and Fulton County areas. James was told that there were no Housing Choice Vouchers available from the Atlanta Housing Authority and none available from the Fulton County Housing Authority. Neither housing authority would have Housing Choice Vouchers available before 2011. Most housing authority signature properties and most high-rise apartment buildings had waiting lists of at least one year due to displacement of current residents as a result of property rehabilitation construction.

The MFP TC described an arrangement that MFP had with the Department of Community Affairs (DCA) that reserved Housing Choice Vouchers for people just like James transitioning form a nursing home (see *Appendix AA: Referral for Housing Choice Vouchers*). There was a Housing Choice Voucher available, but it was available in Gwinnett County in the Norcross area. This would mean that James would have to look for housing in Gwinnett County. While James was determined to leave the nursing home, he decided not to apply for the Housing Choice Voucher in Gwinnett County through the DCA program, because he didn't want to live in Norcross. Angie described another housing option; Tax Credit Housing—affordable housing units located in apartment complexes throughout the metro area for persons with low income. Angie described how through pooling resources with a roommate, James might qualify for a Tax Credit unit. James indicated that he was interested in pursuing this type of housing arrangement. The TC notified the American Red Cross to search for a suitable roommate match for James.

During the housing search process, Angie and the MFP TC worked with James to obtain a photo ID and complete the MARTA Paratransit application process. James received his MARTA Paratransit card and learned to schedule Paratransit trips to review apartments.

Angie introduced James to Jerome, a 34 year old man with cerebral palsy. Like James, Jerome used a powerchair but could walk very short distances and could do sit-to-stand transfers. James and Jerome seemed to 'hit-it-off' and were both interested in and willing to explore the roommate option. Jerome was living in a nursing home and was working with Angie to resettle in Atlanta. Angie worked with James and Jerome to understand what their expenses would be to live in the community, i.e. for rent, utilities, phone, food, transportation, etc. She helped them identify the share of expenses each would be responsible for and how much they could expect to spend on rent. This Independent Living training helped James and Jerome to be more realistic about where they could afford to live. Angie showed James and Jerome how to use the Georgia Housing Search tool (www.GeorgiaHousingSearch.org) to locate affordable housing in the metro area and how to contact property managers to locate more information about Tax Credit

units. With coaching from Angie, James and Jerome continued to search for almost four months for a two-bedroom, two-bath apartment. Several times, they identified apartments and made on-site visits only to find out that the apartment was on the second floor with no elevator or that the outside entrance to the apartment was up several stairs.

They finally located a unit in an apartment complex not far from the airport in College Park. They were both familiar with the College Park area. On-site inspection reveled that the apartment had a zero-step entrance and the interior doors, including the bathroom door, were wide enough to accommodate a powerchair. The apartment was within easy traveling distance using public transit to a grocery store and not far (by MARTA train) from James mother's home in Oakland City. The men liked the apartment and location and together completed the apartment lease application and provided required income verification. James used MFP funds to make his security deposits. The men received notice that their application had been accepted by the apartment manager and that the unit would be available for occupancy in 30 days. James used MFP funds to make utility deposits for electricity, phone and basic cable. The MFP TC completed the *Authorization for MFP Services (*see *Appendix S)* to authorize the pre-transition services and assisted James and the apartment manager to complete the *Vendor Request for Payment to TC* form (see *Appendix U*) for the security deposit.

Waiver Assessment and Person- Centered Planning
James and Ms. Brown received notification from Georgia Medical Care Foundation (GMCF) that a Registered Nurse was scheduled to complete an assessment to determine eligibility for the Independent Care Waiver Program (ICWP). The TC scheduled a planning meeting with the GMCF RN, James, Ms. Brown, Billy and Ruth Ann (friends of James), the ONH social worker, and the rehab specialist at ONH. Together they discussed James' circle of support, his personal goals, strengths and ability to care for some personal needs, health and nutritional needs, self-care, ADL and IADL needs, transportation needs, his financial resources and his ability to take medications alone. The MFP TC wrote up the results of the person-centered planning in the *Individualized Transition Plan (ITP)* (see *Appendix Q1 and Q2*). James's ITP included a list of the MFP Services he would receive (Part A), waiver services he needed (Part B) and any other State Plan Service he might benefit from (Part C).

The RN conducted and completed the face-to-face assessment along with the Participant Assessment Form (PAF) and the DMA-6 form was reviewed. James signed the Release of Information and Freedom of Choice forms. The RN developed the initial service plan to document the amount and type of services that James needed.

Two weeks later, James received his approval letter indicating that he was accepted to receive ICWP services. Enclosed was a list of available case managers. He was given two weeks to notify Georgia Health Partnership (GHP) of the case manager selected. James and Ms. Brown selected a case manager and the TC submitted the documentation to GHP. The ICWP case manager conducted a face-to-face visit with

the MFP TC, James and Ms. Brown within three days at ONH. The case manager discussed the ICWP waiver program, services, her role and responsibilities, their rights (to include complaint and grievance processes as well as self-direct options) and choices in detail. Together the group re-reviewed the *Individualized Transition Plan* (ITP), and developed the ICWP service plan to include:

- Case Management- James selected a case manager to assist with selecting ICWP service providers and coordinating PSS hours.
- Personal Support Services- Perform personal care tasks to assist James with ADLs.
- Specialized Medical Equipment and Supplies- James will need equipment to function at home including specialized wheelchair seating, shower transfer bench, 17½ inch high toilet, grab bars, hand-held shower, special clothing and simple devices to assist him in personal care and with IADLs.
- Counseling- James would benefit from counseling services to assist him with his depression and adjusting to live in the community.
- Non-Emergency Transportation Services – Provide James with transportation if needed to medical appointments.
- Self-Directed Personal Support Services- Provide James with the options to self-employee PSS.
- Personal Emergency Response System (PERS) – Provide James with an electronic communication device, a portable button to signal a response center if assistance is needed.

The following MFP transition services were included in James' Transition Plan:

- Peer Supporter – Angie will assist James with networking to build connections to individuals in the local community and locate affordable and appropriate housing and accessible transportation.
- Household Furnishings – Provide James with assistance to obtain basic household furnishings (table, lamps, etc.) and general setup for his apartment.
- Household Goods and Supplies – Provide James with basic household goods and supplies, cookware and toiletries for his apartment.
- Moving Expenses – Assist James to rent a U-Haul trailer to move his personal items from storage with the assistance of his friends.
- Utility Deposit – Assist James with utility deposits for his apartment.
- Security Deposit – Assist James with the security deposit on his apartment.
- Fiscal Intermediary/Community Transition Financial Service – Provide financial services for payments for the MFP pre- and post-transition services obtained on behalf of James.

The waiver Service Plan was approved and signed by James and Ms. Brown. The Freedom of Choice, Member Rights and Responsibilities and the Memorandum of Understanding forms were also reviewed, approved and signed.

Self–Directed PSS Training and 24/7 Emergency Backup

Ms. Brown, the MFP TC and the ICWP Case Manager all encouraged James to make the choice to select self-direction under ICWP. James opted to self-direct his PSS with Ms. Brown's assistance. James opted to be the employer of record for PSS services and to manage his personal support hours. James' case manager provided training to James, Ms. Brown, Billy and Ruth Ann about the employer option. Information was provided about the differences between self-directed and provider-managed PSS. The benefits, risks and responsibilities were reviewed and discussed. Prior Approval was obtained by the case manager for the ICWP services. Written training material and a copy of the service plan was provided to James and Ms. Brown. Ms. Brown, Billy and Ruth Ann White agreed to be James' 24/7 emergency backup, if the PSS staff didn't show up for work or if an emergency occurred and assistance was needed (for details, see *Section B.2 Informed Consent, Guardianship, Grievance/Complaint and Critical Incident Reporting Systems* and *Appendix AB: MFP Sentinel Event Report*). Ms. Brown provided James with a cell phone to communicate with everyone.

Initial Quality of Life (QOL) Survey

The MFP TC arranged for a surveyor to complete the Quality of Life (QOL) survey approximately 30 days prior to his discharge. The surveyor contacted James and made an arrangement to conduct the survey face to face.

MFP Fiscal Intermediary/Community Transition Financial Services

With assistance from Angie, James found a roommate (Jerome) and the two men secured affordable housing. James and Jerome used the Georgia Housing Search (georgiahousingsearch.org) website to locate available apartments near a MARTA bus line. Having obtained his MARTA Paratransit pass, James was able to arrange for transportation to visit several apartment complexes around Atlanta with his prospective roommate Jerome and friends Billy and Ruth Ann White. Working with Angie, his peer supporter from the CIL, James found a Tax Credit apartment in College Park. MFP Equipment and Supplies funds were used to obtain grab bars for each bathroom and to install them around the bathtub and commode. These funds were used to purchase a 17½ inch high, low-flow toilet to replace the existing commode, a hand-held shower and a shower transfer bench for James' bathroom. The TC completed the *Authorization for MFP Services* (see *Appendix S*) and the *MFP DCH DHR Vendor Import File* (see *Appendix* V) to get these items paid as pre-transition services so they could be installed prior to the move. The apartment manager was not against making minor modification to the apartment and agreed to install the grab bars, the new toilet and the hand-held shower device. Angie and the TC coached James on how to arrange to make the utility deposits. They assisted James to obtain basic household furnishings. The TC assisted James with finding a primary care physician in the area near the apartment and an appointment was scheduled. James received prescriptions for his medication. All MFP services were

paid by the Fiscal Intermediary. The FI invoiced DCH and received the approval from the MFP office for the MFP expenses.

3) Transitioning and Discharge Date

Through the work of Angie, the peer supporter, James was introduced to a potential roommate named Jerome, age 34. Like James, Jerome used a powerchair for mobility and was currently living in a nursing home in Rome, Georgia, and seeking to relocate to Atlanta. The gentlemen seemed to 'hit-it-off' from their first introduction and agreed to work together to locate a suitable apartment.

Once James received notification that his apartment application had been accepted and the unit would be ready for the men in 30 days, the documentation and information to terminate James' eligibility from a nursing home resident and change his status to a community resident was reviewed and discussed with James and Ms. Brown. They were instructed to notify the Social Security Administration and provide them with a discharge date for James. The TC and Ms. Brown arranged monthly communication for the TC to review any barriers with James that he might be encountering and to answer questions or to address concerns. Additional post-transition services could be obtained for James during the 365 days of MFP using the *Request for Additional MFP Transition Services* (see *Appendix X*). The TC contact information was provided to James and Ms. Brown.

On the date of James' discharge, Billy and Ruth Ann arrived early with the U-Haul truck. The TC completed the *Discharge Day Checklist* (see *Appendix* R) and discussed James' service plan, 24/7 emergency backup system, and the TC's contact information was provided to him. The ONH charge nurse provided him with his remaining medication and reviewed the physician discharge orders. The social worker provided James with his discharge documents. Billy and Ruth Ann White moved James' clothing and personal items to the U-Haul truck and James left ONH. Ms. Brown and James' case manager and his new roommate Jerome (who had moved in the previous day) all greeted James at the apartment. Ms. Brown had cleaned and unpacked several items that were moved from storage to make things comfortable for the roommates. The case manager re-reviewed the service plan with James and reviewed the service scheduled for him.

The TC telephoned James the following week at the apartment. James and Jerome were getting along well. James stated that he and his roommate were enjoying learning to cook and prepare some of their own meals. He also reported that Angie had accompanied him to the local Walgreens to get his prescriptions filled and things were going great. His friend Billy White was coming by daily and sometimes had dinner with the roommates. James told the TC that he enjoyed watching T.V., visiting the CIL and the Side by Side Brain Injury Clubhouse in Stone Mountain. He enjoyed his visits with Billy and Jerome. James reported that the installation of the new toilet was complete but that the installation of the grab bars in the bathtub and around the commode were moving slowly, but he didn't have any concerns because he was using sit-to-stand transfers on/off the toilet and using the shower transfer bench and hand-held shower device for showers.

4) Post-Transition on or before 30th day and day 366 and beyond

The MFP TC contacted James and Ms. Brown three weeks following James' discharge to discuss any concerns and/or issues. James and Jerome, the new roommate, were adjusting well together. The TC asked James a series of questions about the ICWP waiver services that he was receiving, personal support services and living accommodations. When James expressed a need for the hand held shower handle to be lowered, the TC 'coached' James through the process of approaching the apartment manager and discussing the need to relocate the hand-held shower. When it was discovered that several new parts were needed, the TC completed the *Request for Additional MFP Transition Services* (see *Appendix X*) and the additional parts were purchased from MFP funds remaining in Equipment and Supplies budget (see *Appendix B: MFP Demonstration and Supplemental Services Table*). James discussed changes to his service plan with the TC and stated he had changed certain hours for personal care. He had requested that he and Jerome be approved to share personal support hours, since Jerome was also receiving ICWP services. The ICWP case manager and Ms. Brown had approved the change. James was informed that his ICWP waiver services would continue beyond day 366 of the MFP demonstration program. A report of the visit was forwarded to DCH.

5) Short-Term Hospitalizations or Nursing Facility/Rehab Stays

MFP Re-enrollment Process

If James needed to be hospitalized for any reason during the MFP demonstration for less than 30 days, he would not be considered an institutional resident. As soon as his condition stabilized, he would be able to return to the apartment and resume MFP and waiver services. If the hospital stay was 30 days or longer, he would be discharged from MFP and would then be considered an institutional resident. In this case, the TC would complete the *Participant Enrollment Status Change Form* (see *Appendix Y*) to track the change in enrollment status and stop the MFP participant 'clock' (for details, see *Appendix Z: MFP Manual Tracking Database Screens*). The MFP TC also completed the *MFP Sentinel Event Report* (see *Appendix* AB). If James was re-admitted to a nursing home/institution and had a stay of over 30 days, he would NOT need to meet another MFP 6 months institutional residency requirement, but he would be re-evaluated for discharge to the community and re-enrolled into the MFP program to determine if any changes in the service plan were warranted to prevent a re-admission to an institution. For stays of longer than six months, institutional residency requirements would apply and James would need to be re-evaluated like a "new" MFP participant.

A.1 Case Study: Developmental Disability

This case study describes the transition process for Sally Mae Johnson, a 49 year old female with mild mental retardation and severely involved cerebral palsy (CP), who uses a power wheelchair. Ms. Johnson currently resides in Central State Hospital, a state ICF/MR, and is transitioning into the New Options Waiver (NOW). She will also be able to take advantage of several of the Money Follows the Person (MFP) pre- and post-transition services. This section describes each of the following steps undertaken to resettle Ms. Johnson in the community: 1) identification/referral, 2) pre-transition planning, 3) transition period (day 1 to day 365), and 4) post-transition (day 366 and beyond). The description includes the agencies involved in these steps, roles and responsibilities at each step, services and supports, options and choices, and backup provisions. This section concludes with a description of how Ms. Johnson would be accommodated if she required a short-term hospital or nursing facility/rehab stay and how this stay would impact her MFP and waiver services.

Sally Mae Johnson is a 49 year old female with mild mental retardation and severely involved CP. She uses a powerchair for mobility and is Medicaid eligible. Her speech is difficult to understand, but she can make herself understood by using a communication board on her lap tray. She has resided at Central State Hospital (CSH) in Milledgeville, Georgia for 27 years. A native of Thomasville, Georgia, she lived with her mother, Mavis Johnson, until she was 22 years old. Approximately one year after graduating from the Seminole County Schools in Thomasville, she was admitted to CSH, because her mother could not provide for her care.

During the last few months, Sally Mae Johnson has been inquiring about leaving CSH and has been asking questions about group homes, getting her own apartment or sharing an apartment with her friend, Francis Jones, who also resides at CSH. The Planning List Administrator at Central State Hospital had engaged Sally Mae, her mother, her friend Francis Jones, and Regional and CSH staff in discussions of opportunities and possibilities for transitioning Sally Mae to the community using the NOW waiver. During these meetings, Ms. Johnson was provided with outreach materials about the NOW waiver (see *Appendix E: Home and Community Services: A Guide to Medicaid Waiver Programs in Georgia)* and outreach materials about Money Follows the Person services (see *Appendix C: MFP Tri-Fold Recruiting Brochure*). Ms. Johnson's personal goals, waiver services and options, and transition services available under MFP were described. The Planning List Administrator explained the program to Ms. Johnson and how the services would get her resettled into a qualified group home (of four or fewer unrelated persons), a place of her own or a place she could share with her friend, Francis Jones. During the discussion, the Hospital Planning List Administrator discussed the changes that Ms. Johnson would most likely experience moving from CSH to the community.

2) Pre-transition/Discharge planning

Person-Centered Planning, Informed Consent and Guardianship

Several person-centered planning meetings were conducted at CSH. The planning group involved Ms. Johnson, the Hospital Planning List Administrator, the hospital

case expeditor, the social worker and her current case manager. The group assisted Ms. Johnson to locate and contact friends and relatives who Ms. Johnson wanted to involve in person-centered planning. During the informed consent discussion, it was discovered that Sally Mae's mother, Mavis Johnson, was Sally Mae's legal guardian. This issue needed to be resolved, because Mavis Johnson, age 84, had recently suffered a serious heart attack and some mild dementia and had moved into a nursing home in Thomasville, as a Medicaid patient. Ms. Johnson told the group that she didn't want her mother to be her guardian any longer and felt that with help she could make her own decisions. The group discussed the process of terminating guardianship. Before moving on, the group worked with Ms. Johnson to terminate guardianship. With guardianship terminated and informed consent obtained, the group reviewed the medical records and gathered the information necessary to build a personal profile of Ms. Johnson.

Early Involvement of the MFP Transition Coordinator/Case Expeditor
The MFP Regional Transition Coordinator/Case Expeditor (TC/CE) was contacted by the Hospital Planning List Administrator and asked to be involved, because the group wanted to determine what MFP transition services could be used by Ms. Johnson for resettlement.

Developing the Transitional Plan
A date was selected and the group (the Transition Team) was convened to complete the Transition Plan and revise and re-develop the Individualized Services Plan (ISP). Because Ms. Johnson had resided at CSH for more than 20 years, she had an existing ISP, case files, medical records and results of assessments. However, these assessments needed to be updated and the ISP needed to be redeveloped to include community living goals. These existing documents and meeting discussions were used to create the Transition Plan and to begin the process of redeveloping the ISP. The Transition Plan documented the need for services and the timeframe in which services were needed. The Transition Plan included information about Ms. Johnson's community living options and preferences (sharing an apartment with her friend); her functional needs, her motivation to relocate and concerns she had about moving out of CSH.

The Team explained the rights and responsibilities under the waiver. Sally Mae signed the *MFP Consent for Participation* (see *Appendix* D2). They gathered information about Ms. Johnson's personal goals, adaptive strengths, health/nutrition, mobility, communication, social/recreational skills and needs (including the need for an Augmentative and Alternative Communication (AAC) device), her self care, her specialized medical equipment, her community living skills, her vocational interests, her transportation needs, her financial resources, and barriers that might be encountered as she transitioned. Working together, the Planning List Administrator and Regional MFP TC/Case Expeditor assigned specific tasks to Ms. Johnson and to each member of the transition team for pre-placement, post-placement and follow-up activities that needed to occur for a smooth transition. The Team assisted Ms. Johnson to gather the required documents and complete a Medicaid waiver application (see *Appendix F: Application for Mental Retardation or Developmental Disabilities Services*).

The Planning List Administrator and MFP TC/CE distributed copies of the Transition Plan with specific transitional assignments to Ms. Johnson and to all persons having an assignment to complete. A discharge date was agreed upon and updates to assessments were scheduled with the Intake and Evaluation Team (I&E Team). The MFP TC/CE completed the *MFP Authorization for MFP Services* (see *Appendix S*) and the *MFP DCH DHR Vendor Import File* (see *Appendix V*). The Transition Team reconvened to review the Transition Plan four weeks before the discharge date to monitor any changes and follow the implementation of the MFP pre-transition services.

Early Involvement of the Support Coordinator for MFP Participants
Because the reserve capacity of the waiver was not yet exceeded, Ms. Johnson was not placed on a waiver waiting list. Ms. Johnson needed the assistance of a support coordinator to facilitate assessment, planning and arrangement of waiver and MFP services. Once the Transition Plan was completed and the redevelopment of the ISP was started, the Hospital Planning List Administrator provided Ms. Johnson with a list of support coordination agencies. With assistance from her support network, Ms. Johnson selected a support coordination agency.

Updating the Waiver Assessments
Ms. Johnson's Medicaid waiver application was received and processed and an appointment was set to update the information from her Support Intensity Scale (SIS) assessment. The I&E Team also completed the Health Risk Screening Tool (HRST) to identify potential risks to Ms. Johnson's health and safety and to plan for managing these risks in the community. The Hospital Planning List Administrator and the MFP TC/CE supplied the I&E Team members with the profile information that had been developed from the Transition Plan.

Each member of the I&E team met with Ms. Johnson, the Planning List Administrator, the MFP TC/CE and the support coordinator to review and discuss the updated results of the assessments. Together they determined the individualized supports that Ms. Johnson needed, including living arrangements, staffing needs, and medical supports, together with the employment, educational and leisure opportunities that Ms. Johnson was interested in pursuing. Ms. Johnson was notified that she was eligible for the NOW waiver seven days after the I&E Team completed their assessments. Funding for her waiver 'slot' was available through Money Follows the Person and she was not placed on a waiver waiting list.

Redeveloping the Individual Service/Support Plan (ISP)
A meeting was scheduled to rewrite Ms. Johnson's current ISP with new community living goals and MFP services. Ms. Johnson chose her friend, Francis Jones, and her uncle and aunt to participate with her in the redevelopment of her Individualized Service Plan (ISP). At the meeting, the Planning List Administrator, the MFP TC/CE and the support coordinator discussed Ms. Johnson's service options under the NOW waiver and MFP supplemental and demonstration services. The rewritten ISP included the following services:

- *Support Coordination*-Ms. Johnson was able to select a case management service. The support coordinator's task is to connect Ms. Johnson with the community services that she needs and to monitor these services.
- *Community Living Supports*-individually tailored supports that assist Ms. Johnson with personal care and protective oversight and supervision. Community Living Support services include training in and personal care/assistance with activities of daily living (ADLs), such as bathing, dressing, toileting, and transferring, and with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication, money management, basic first aid, arranging and transporting participants to medical appointments, accompanying participants on medical appointments, documenting food and/or liquid intake or output, reminding participants to take medication, and assisting them with self-administration of medication.
- *Specialized Medical Equipment*- A new power wheelchair was included in Ms. Johnson's ISP to replace the one she has been using for seven years at CSH. Arrangements were made for Ms. Johnson to receive a seating assessment, and power mobility assessment prior to leaving CSH, with the understanding that she would not receive her new wheelchair and seating system until she transitioned out of CSH. A Hoyer Lift was also included in her ISP, for use at the apartment when she transitioned. The ISP also included an environmental control system to allow her to control locks on doors, door openers, lights, TV and room temperature. The ISP included a new AAC device for Ms. Johnson. Ms. Johnson's new power wheelchair and specialized seating system were covered by the State Medicaid Plan. The Hoyer Lift, the environmental controls and AAC device were covered by the NOW waiver.
- *Adult Speech and Language Therapy Services*- Because the ISP included a new AAC device for Ms. Johnson, Speech and Language Therapy services were obtained to evaluate her for the new AAC device, procure and customize her AAC device to meet her needs. The Speech and Language Pathologist (SLP) provided Ms. Johnson with technical assistance and training for learning to us her new AAC device.
- *Environmental Accessibility Adaptation*-provided Ms. Johnson with modifications to her apartment, including removing cabinets under sinks in the kitchen and bathrooms for wheelchair access and installing a switch-operated door opener on the front entrance to her apartment door
- *Vehicle Adaptation*-Ms. Johnson's uncle and aunt own a full-sized van. This waiver service provided for the installation of a wheelchair lift on the van so that the uncle and aunt (who are providing backup PSS services) would be able to transport Ms. Johnson to places she needed to go, including evenings and weekends or when paratransit is unavailable.

The following one-time MFP pre and post-transition services were included (see *Appendix B: MFP Demonstration and Supplemental Services Table*):

- *Peer Community Support*-provided Ms. Johnson with visits from a peer supporter, who assisted Ms. Johnson to make connections with other local people with disabilities, community associations, including her local Center for Independent Living and local events and services for people with disabilities.
- *Trial Visit-Personal Support Services*-provided Ms. Johnson with Personal Services and Supports (PSS) staff for a two-night trial visit to the community prior to transitioning
- *Household Furnishings*-provided Ms. Johnson with assistance to obtain basic household furnishings (bed, table, etc) to setup in her apartment
- *Household Goods and Supplies*-provided Ms. Johnson with basic household goods and supplies, cook ware and toiletries for her apartment
- *Moving Expenses*-assisted Ms. Johnson to rent a U-Haul trailer to move her clothing and personal items to her new apartment (with the assistance of her uncle and aunt)
- *Utility Deposit*-Assisted Ms. Johnson with funds to pay her utility deposit on the apartment
- *Security Deposit*-Assisted Ms. Johnson with funds to pay a security deposit on her apartment
- *Transportation*-Assisted Ms. Johnson to pay for transportation during pre-transition, to locate housing and connect to other community resources
- *Community Transition Financial Services*-provided financial services for payments for the MFP demonstration and supplemental services obtained on behalf of Ms. Johnson
- *Equipment and Supplies*-Provided Ms. Johnson with a personal computer, special adjustable computer table, track-ball mouse and specialized software and provided for training from an assistive technology specialist from *Tools for Life*.

The redeveloped ISP included Ms. Johnson's service plan, Personal Focus (personal goals for community living), Action Plans, Summary of Services (as listed above but in more detail), updated assessment information, risks and plans to manage risks, 24/7 emergency backup plans, Transfer/Discharge Summary and the ISP Signature Page. The ISP included options for Ms. Johnson to direct her own PSS staff (she opted for co-employer/employer of record), budget amounts for all services, budgets for one-time MFP services, information about filing complaints and information about updating the ISP (every 12 months or more often as needed).

Freedom of Choice Form

The I&E team was responsible for ensuring that Ms. Johnson signed the *Freedom of Choice* Form. Ms. Johnson signed a document, the *Freedom of Choice* form, indicating that she had freely chosen her support coordinator and her service providers. The *Freedom of Choice* form ensures that Ms. Johnson will be given choices of support coordinators and service providers both at waiver onset and as long as she is enrolled in waiver services. The Intake and Evaluation team

explained these choices to Ms. Johnson. With assistance from her support coordinator, MFP TC/CE and support network, Ms. Johnson selected the service providers she wanted to use for her services. The support coordinator was responsible for ensuring that she received all the services in the ISP in a timely manner, ensured that her health and safety was protected and developed appropriate goals and objectives designed to increase her independence in the community.

Self-Directed PSS Training and 24/7 Emergency Backup
Ms. Johnson selected the co-employer option—to become the employer of record for personal support services (PSS) to provide assistance with Activities of Daily Living (ADLs). The support coordinator and MFP TC/CE provided training to Ms. Johnson, her friend and family members (uncle and aunt) on the co-employer option. She was provided information on self-direction that highlighted the differences between self-directed and provider-managed. The benefits, risks and responsibilities were covered, both verbally and through the materials in the *NOW Handbook on Participant Direction*. She decided that she wanted her aunt and uncle to be part of her 24/7 emergency backup in the event that her regular PSS staff person didn't show up for work or if she had a flat on her powerchair and needed someone to help her get it repaired/replaced (for details, see *Section B.2 Informed Consent, Guardianship, Grievance/Complaint and Critical Incident Reporting Systems* and *Appendix AB: MFP Sentinel Event Report*).

The MFP TC/CE and the support coordinator worked with Ms. Johnson to obtain needed documentation and to begin the process to receive her SSI payments (currently going to CSH) and helped her open a checking account.

The MFP TC/CE and the support coordinator assisted Ms. Johnson to complete an application for a *MFP Referral Letter for DCA Housing Choice Voucher Program* (see *Appendix AA*). Through a special arrangement with the GA Department of Community Affairs (DCA), the MFP project has reserved capacity for a number of *Housing Choice Vouchers* for people just like Sally Mae and Francis, transitioning out of a state institution to the community. Under the *Housing Choice Voucher* program, Sally Mae could only qualify for a one-bedroom, one-bath unit (the same was true for Francis) because neither woman needed a live-in personal care attendant. Because Sally Mae wanted to live close to Francis, this made the housing search a more difficult challenge—locating two units next to each other or as a duplex. The MFP TC/CE and support coordinator worked with Sally Mae to complete the application process. Sally Mae needed to obtain a photo ID, income verification and a new social security card (hers had been lost). DCA manages the public housing in Baldwin County where Milledgeville is located. With the assistance of the MFP TC/CE and support coordinator, the *Housing Choice Voucher* application was completed and submitted to DCA for processing (see *Appendix AA: Referral for Housing Choice Voucher*).

While waiting for the application to be processed, the Transition Team helped Sally Mae and Francis search for housing options in Baldwin County using the Georgia Housing Search tool (www.georgiahousingsearch.org). As they located available

units, they did on-site visits to review amenities. After searching for almost three months and not locating anything that met their criteria, they became aware of a newly completed affordable housing complex, built by a local Community Housing Development Organization (a local non-profit) using HOME and Permanent Supportive Housing Development funds awarded through DCA. The first phase of the affordable housing complex was already filled, but the second phase of construction was completed but unoccupied. These units were accessible and accepted vouchers, but were reserved for migrant farm workers. Together with DCA, the Transition Team approached the developer, the Community Housing Development Organization, and asked if the reserve capacity units could be used by the two women with *Housing Choice Vouchers*. The Community Housing Development Organization accepted the offer. This process took another 30 days to work through. During this time, Sally Mae received notification of her voucher. Francis received similar notification. Shortly thereafter, Sally Mae received notification that the Community Housing Development Organization had accepted her and reserved an accessible one bedroom, one bathroom unit with a zero-step entrance and roll-in shower. Shortly after, Francis received similar notice. Both women would have units next door to each other in the new complex. Sally Mae used MFP funds to make both security (rent) and utility deposits. The MFP TC/CE completed the *MFP Authorization for MFP Services* (see *Appendix S*) and assisted the apartment manager to complete the *MFP Vendor Payment Request to TC* (see *Appendix U*) to receive payment for the security deposit, a pre-transition service. The MFP TC/CE completed the *MFP DCH DHR Vendor Import File* (see *Appendix V*) and the FI paid the apartment complex and utility vendors. The DCH MFP office received an invoice from the FI (see *Appendix O: FI Invoice to DCH for Payment*). After verification, the invoice was paid (for more detail, see *Appendix I: MFP Flowcharts and Text Descriptions*).

The MFP TC/CE and support coordinator helped Sally Mae to locate a new Primary Care Physician. The MFP TC/CE and support coordinator helped her schedule appointments with her current doctor at CSH and assisted her to get prescriptions refilled, so she would have adequate supplies during the transition process. She was introduced to a Community Guide and a peer supporter. The community guide and peer supporter introduced Sally Mae to other people with disabilities like Sally Mae who were resettled in the Milledgeville area. The community guide and peer supported worked with Sally Mae to arrange for her to stay for two nights with a person who had a similar situation to the situation that Ms Johnson wanted, so that she could gain knowledge and skills in managing PSS staff and using technology for independent living.

The Initial Quality Of Life (QOL) Survey

The MFP TC/CE arranged for the QoL surveyor to complete the Quality of Life (QOL) survey approximately 30 days prior to Ms. Johnson's discharge date. The surveyor contacted Ms. Johnson at CSH and made arrangements to complete the survey face to face.

MFP Pre-Transition Services and Community Transition Financial Services/Fiscal Intermediary

As discussed earlier, Ms. Johnson received notification of approval for a *Housing Choice Voucher*. Working with the MFP TC/CE and support coordinator, she used MFP Transportation Services to visit several apartment complexes with her friend Francis Jones. They located one bedroom, one bathroom units next door to each other in a newly constructed affordable housing project developed by a local Community Housing Development Organization.

Ms. Johnson used MFP funds available to obtain basic household furnishings; a complete bed and bedding, dinning room table and 2 chairs and several lamps. She also obtained a washer and dryer for the apartment and made arrangements for delivery after she moved into the apartment. Using MFP Household Goods and Supplies funds, she obtained some basic cooking utensils, dishes, silverware and basic supplies for the bathroom (see *Appendix B: MFP Demonstration and Supplemental Services Table*).

Each invoice for these MFP services was paid by the Fiscal Intermediary (FI). The FI provided financial services for payments for the MFP services for Ms. Johnson. The FI paid service providers directly for services rendered based on the ISP and invoiced properly. The MFP TC/CE completed the *MFP Authorization for MFP Services* (see *Appendix S*) and the assisted vendors to complete the *MFP Vendor Payment Request to TC* (see *Appendix U*) to receive payment for the services rendered. The MFP TC/CE completed the *MFP DCH DHR Vendor Import File* (see *Appendix V*) and the FI paid each vendor accordingly. The DCH MFP office received an invoice from the FI (see *Appendix O: FI Invoice to DCH for Payment*). After verification, the invoice was paid (for more detail on these processes, see *Appendix I: MFP Flowcharts and Text Descriptions*).

Eligibility and SSI Changes

The MFP TC/CE assisted Ms. Johnson to complete the Medicaid form that terminated institutional eligibility and changed her status to receive Home and Community-Based Waiver Services. The MFP TC/CE contacted the Department of Community Health (DCH) Member Services in Atlanta and Member Services created a Lock-in Span for 365 days to indicate that Ms. Johnson was receiving MFP services during that period.

Ms. Johnson received notification from the Social Security Administration that she would begin receiving her benefits directly deposited to her checking account on the third day of the next month. With all the pieces in place, preparations were made to move Ms. Johnson on the discharge date.

3) Discharge/Transition Period (day 1 to day 365)

On the discharge date (moving day), the MFP TC/CE and support coordinator and Ms. Johnson's aunt and uncle convened to review the ISP services, to discuss the 24/7 emergency backup system and to assist with the move. Ms. Johnson used the MFP Moving Expenses funds to rent a U-Haul trailer large enough to move her personal property and items she had obtained for the apartment. The move was

completed and Ms. Johnson was settled in the apartment. The following day, Francis Jones was moved into the apartment next door.

On the discharge date, Central State Hospital provided the following:

- Case information from the hospital record
- Current Medicaid card
- A 30 day supply of current medications (and remaining supplies in the medication unit)
- Personal clothing packed in suitcases and inventoried
- A current financial statement
- Contact information for friends, discharge planner, social worker and doctor at Central State Hospital

The MFP TC/CE checked on Ms. Johnson and Ms. Jones at the end of the first week to ensure that all services in the ISP were occurring as arranged and to see if there was a need for any additional MFP services, equipment or supplies. Things were progressing nicely for the both Ms. Johnson and Ms. Jones. The MFP TC/CE called Ms. Johnson monthly to ensure that she was receiving all services in the ISP and to see if any additional services were needed. Ms. Jones received similar calls. The MFP TC and support coordinator continued to monitor the services that Sally Mae received and kept in regular contact with her service providers. The neighbors seemed to be getting along well and had started a joint project to develop a raised flower bed/vegetable garden with wheelchair access.

The Follow-up Quality Of Life (QOL) Survey

The MFP TC/CE arranged for a surveyor to complete the Follow-up Quality of Life (QOL) survey during the 12th month of Ms. Johnson's new community placement. The surveyor contacted Ms. Johnson at her new apartment and made arrangements to complete the follow-up survey face to face.

4) Post-Transition (day 366 and beyond)

During the 12th month of placement, the MFP TC/CE and the support coordinator met with Ms. Johnson and explained that MFP services would end but NOW waiver services would continue. Together, they updated the ISP and identified if Ms. Johnson needed additional waiver services or needed adjustments to current services. The MFP TC/CE left Ms. Johnson her contact number as asked Ms. Johnson to contact her if she had any questions or concerns.

On day 366, MFP services ended but NOW waiver services continued without any interruptions. The revised ISP was operational and the support coordinator ensured that Ms. Johnson was receiving all services in the ISP and would check periodically to see if any additional services were needed. The support coordinator continued to monitor the services that both women received and kept in regular contact with their service providers.

5) Short-Term Hospitalizations or Nursing Facility/Rehab Stays

MFP Re-enrollment Process

If Sally Mae needed to be hospitalized for any reason during the MFP demonstration for less than 30 days, she would not be considered an institutional resident. As soon as her condition stabilized, she would be able to return to the apartment and resume MFP and waiver services. If the hospital stay was 30 days or longer, she would be discharged from MFP and would then be considered an institutional resident. In this case, the TC would complete the *Participant Enrollment Status Change Form* (see *Appendix Y*) to track the change in enrollment status and stop the MFP participant 'clock' (for details, see *Appendix Z: MFP Manual Tracking Database Screens*). The MFP TC/CE also completed the *MFP Sentinel Event Report* (see *Appendix* AB). If Sally Mae was re-admitted to a nursing home/institution and had a stay of over 30 days, she would NOT need to meet another MFP 6 months institutional residency requirement, but she would be re-evaluated for discharge to the community and re-enrolled into the MFP program to determine if any changes in the service plan were warranted to prevent a re-admission to an institution. For stays of longer than six months, institutional residency requirements would apply and Sally Mae would need to be re-evaluated like a "new" MFP participant.

A.2 BENCHMARKS

Georgia's MFP project will measure the progress of five benchmarks, two specifically required by CMS and three that have been selected by the state. DCH and stakeholders identified these benchmarks to focus on lasting improvements and enhancements to the home and community based long-term care system to better enable money to follow the person from the institution into the community. Continuous reviews, participant assessments, surveys, data collection, community reviews, and stakeholder input will provide feedback about progress toward meeting the benchmarks and the services being provided. This feedback will be used to continuously adjust project activities to assure that the benchmarks and stakeholder interests are met.

The two required benchmarks are:

1. **The projected numbers of eligible individuals in each target group who will be assisted in transitioning each fiscal year of the demonstration:**

This population benchmark target for the MFP project will allow DCH to transition 618 consumers from institution care to community-based settings. Focus will be placed on three specific populations:

- Older adults
- participants with developmental disabilities
- participants with physical disabilities/ABI

Table A.2.1 MFP Transitions by Target Group

CY	Older Adults	DD	Physical Disability/ ABI	Totals
2008	2	20	1	**23**
2009	42	110	43	**195**
2010	30	110	60	**200**
2011	30	110	60	**200**
Totals	**104**	**350**	**164**	**618**

* NOTE: Throughout this Operational Protocol the **Elderly and Disabled Waiver** represents older adults, the **Independent Care Waiver (ICWP)** represents individuals with Physical Disabilities and/or ABI, and the **NOW and COMP Waiver Programs** represent individuals with developmental disabilities.

2. Georgia anticipates increasing HCBS expenditures relative to institutional long-term expenditures under Medicaid for each year of the demonstration program.

The MFP demonstration project offers Georgia the ability to increase the HCBS expenditures under Medicaid each year of the demonstration program by transitioning individuals out of nursing homes and Intermediate Care Facilities (ICF/MRs).

As indicated in the table below:

- DCH projects increases in Medicaid HCBS spending for all HCBS populations served over the next four years
- DCH anticipates an overall expenditure increase, during the demonstration period, in all of the community based programs by over $36 million, by 2011.
- The enhanced FMAP will be used to reinvest funds to the MFP demonstration and supplemental services during the demonstration years.

Table A.2.2 Total Georgia Medicaid HCBS Spending

FFY	HCBS Expenditures for all non-MFP Medicaid beneficiaries	MFP HCBS Expenditures	Total HCBS Spending (Sum of MFP & non-MFP spending)	Annual Percentage Growth
2006 Actual	$602,948,440.00	0	$602,948,440.02	NA
2007 Actual	$673,897,224.00	$17,195	$673,914,419.00	11.77%
2008 Actual/Est.	$804,687,940.09	$1,444,617	$806,132,557.09	19.62%
2009 Estimated	$885,210,031.95	$9,390,346	$894,600,377.95	10.97%
2010 Estimated	$928,470,531.65	$12,610,331	$941,080,862.65	5.2%
2011 Estimated	$975,944,058.23	$13,003,274	$988,947,332.23	5.09%
Totals	$4,871,158,225.92	$36,465,763	$4,907,623,988.92	

Three additional benchmarks that have been selected by the State

3. Improving Processes for Screening, Identifying and Assessing Candidates for Transitioning to increase the rate of successful transitions by 5% each year of the demonstration.

This benchmark sets up indicators that measure the performance of Georgia's system for transitioning participants. These indicators are designed to track and measure outputs and outcomes of screening, assessment and successful resettlement in the community, based on the current system in place as compared to the MFP system. To the best of our knowledge, no such effort to track the performance of Georgia's transition system has been undertaken. Because this is 'new territory,' there may be a need to adjust the performance indicators as more is known about the utility of the indicator and how the indicator can be tracked.

For the purpose of this benchmark, a successful transition is considered to be (1) a Medicaid eligible older adult or person with a disability, (2) who needs HCBS services to reside in the community, (3) who transitions to a qualified community-based residence and (4) who resettles in the community for a minimum of six months, with or without interruptions in that period due to short-term institutional admissions. As funds are realized by the state based on the enhanced FMAP, these funds will be used to develop and refine a transition tracking system. The following lists several performance indicators that can be tracked for each system (current and MFP):

- Number of completed transition screenings
- Number of completed Individualized Transition Plans/Person Centered Descriptions
- Number of qualified persons entering home and community services
- Number of successful transitions (six months in community)
- Number of fully completed transitions (365 days in the community)
- Others as indicated

A tracking system has been developed (see *Appendix Z: MFP Manual Tracking Database Screens*) to track successful transitions. Key HCBS stakeholders from DCH, DHS, and DBHDD and key internal and external stakeholders from HCBS initiatives including MFP, Olmstead and the Nursing Home Diversion project participated in the development. The manual tracking database will be used to collect and analyze data with the first MFP screenings in September 2008.

The MFP demonstration enables Georgia to enhance its transition system through funding for Transition Coordinators and transition services. Under the transition program in place prior to MFP, the state had contracted with a private vendor to screen likely candidates for transitioning from nursing facilities. Potential candidates were identified through the use of the Minimum Data Set (MDS). The screening and assessment process included an interview to explain the transition process and provide information on home and community based services.

This early attempt at a transition system will be compared to the new MFP transition process. Performance data will be collected, analyzed, trended and reported to the MFP TouchPoint Project Management meeting beginning in January 2009. It will become a permanent report to the MFP TouchPoint Management Team. The following tables illustrate how the early attempt to track transitions and MFP transition tracking system track performance data. The data used in the tables is projected because data will not be collected until September 1, 2008. Numbers beginning in CY2010 represent a slight increase over CY2009. The numbers are projected based on MFP Benchmark #1 and will be corrected as real data becomes available.

Table A.2.3 Current Transition System

System Outputs	CY2008	CY2009	CY2010	CY2011
-Completed transition screenings	NA	NA	NA	NA
-Completed Individualized Transition Plans or Person Centered Descriptions	NA	NA	NA	NA
-Persons entering home and community services	NA	NA	NA	NA
System Outcome				
-Resettled for 6 months	NA	NA	NA	NA
-Completed 365 days of MFP	NA	NA	NA	NA

Table A.2.4 MFP Transition System

System Outputs	Actual CY2008	Actual CY2009	Projected CY2010	Projected CY2011
-Completed transition screenings	60	358	375	375
-Completed Individualized Transition Plans or Person Centered Descriptions	52	193	250	250
-MFP participants entering HCBS waivers	22	197	200	200
System Outcome				
-Resettled for 6 months	0	99	95%	95%
Completed 365 days of MFP	0	22	90%	90%

Comparison of the earlier system and the MFP transition system will allow the state to track, analyze, and report on the performance of the HCBS system. For example, the tracking system will be used to measure how much of each of the outputs is needed to produce one successful transition. In other words, once data is collected for each output indicator for a calendar year and the number of successfully resettled participants is known for that calendar year, analysis of output indicators will reveal how many of each were needed to produce one successful outcome under each system—a resettlement of at least 365 days. Once this is known, system outputs can be adjusted to produce desired outcomes.

4. Georgia will increase HCBS expenditures relative to institutional long-term expenditures under Medicaid for each year of the demonstration program.

The MFP demonstration project offers Georgia the ability to increase the HCBS expenditures under Medicaid each year of the demonstration program versus institutional long-term care by transitioning individuals out of nursing homes and Intermediate Care Facilities (ICF/MRs).

As indicated in the table below:

- DCH anticipates an overall expenditure increase, from 2005, in all of the community based programs by over $392 million by 2011.
- The FY2011 HCBS long-term care budget is estimated to increase to 40.2% compared to the 30.3% spent in FY 2005.

Table A.2.5 Long-Term Care Services- Rebalance Spending Process

Fiscal Year	LTC Institutional Expenditures	%	HCBS Expenditures	%
2005 Actual	$1,340,391,812	69.7%	$583,053,980.02	30.3%
2006 Actual	$1,346,965,550	69.1%	$602,948,440.00	30.9%
2007 Actual	$1,251,368,659	65.0%	$673,914,419.00	35.0%
2008 Actual/Est.	$1,283,614,256	61.4%	$806,132,557.09	38.6%
2009 Estimated	$1,386,031,643	60.8%	$894,300,377.95	39.2%
2010 Estimated	$1,427,709,804	60.3%	$941,080,862.65	39.7%
2011 Estimated	$1,470,636,931	59.8%	$988,947,332.23	40.2%

5. Increase opportunities for self-directed care in all HCBS waivers by 5% per year of the demonstration project.

Georgia's option for all HCBS participants to self-direct personal support services (PSS) in the Medicaid HCBS programs is an available in each of the state's current waivers. The MFP demonstration project will build on these efforts with enhanced outreach, marketing and education opportunities about self-direction of services to candidates for transitioning. This measurable benchmark will reflect the state's commitment to increasing consumers' knowledge, understanding and utilization of self-directed services.

The state's current self-directed options are available to older adults, individuals with physical disabilities and those with mental retardation/developmental disabilities.

- Elderly and Disabled Waiver – offers self-directed Personal Support Services/Personal Support Extended and Financial Support Services options.
- The New Options Waiver (NOW) offers Natural Support Training Services as a self-directed alternative to provider managed service delivery options.

- The Independent Care Waiver Program has Consumer-Directed Personal Support Services and Financial Support Services as an optional service delivery mechanism for persons age 21-64 with physical disabilities or ABI.

It is Georgia's goal for the MFP project to expand understanding and awareness for Medicaid eligible persons to self-direct services, increasing the number of persons choosing self-directed option by 5% per year. Data in the table below is projected based current self-direction (CY 2008).

Table A.2.6 Self-Direction by Waiver

Calendar Year	Elderly & Disabled Waiver	MRWP	ICWP	Totals
CY2008	70	145	52	267
CY2009	74	153	55	282
CY2010	78	161	58	297
CY2011	82	169	61	312

B.1 Participant Recruitment and Enrollment

This section describes how, when and by whom MFP participants will be recruited for the MFP demonstration project. This section also describes MFP screening, eligibility determination and assessment processes, what knowledge and skills recruiters have, recruiting tools, screening processes and screening tools to ensure participants are appropriate candidates for transition, how and when MFP participants are informed of their rights and responsibilities, and MFP rollout in the state. This section concludes with a description of policies for re-enrollment in MFP after an institutional stay. A draft of the MFP recruiting brochure is included (see *Appendix C: MFP Tri-Fold Recruiting Brochure*). The brochure text contains specific information about MFP and will be distributed as described later in this section.

MFP Transition Coordinators Recruitment Strategies

MFP Transition Coordinators (TCs) will recruit older adults for the Elderly and Disabled Waiver Program throughout the state of Georgia. MFP TCs will recruit participants with physical disabilities and ABI for the Independent Care Waiver Program (ICWP). MFP TCs within the Department of Behavioral Health and Developmental Disabilities (DBHDD) will recruit individuals located in ICF/MRs throughout the state for the Mental Retardation Waiver Programs (NOW and COMP).

MFP will assist with transitioning individuals receiving Medicaid funding in a nursing home or ICF/MR with a mental health diagnosis, if the candidate meets qualifications for Medicaid community based services. MFP participants transitioning out of nursing homes or ICF/MRs will receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, state funded programs and local community funded services. The state is not seeking enhanced match for State Plan services provided to MFP participants.

Additionally, as part of ongoing Olmstead efforts, DBHDD tracks individuals in state hospitals who have been there for more than 60 days and places them on the Mental Health Planning List when they are considered clinically ready for discharge. DBHDD has confirmed its commitment to continue its transition efforts for individuals with Mental Illness with existing resources.

The state has a contract in place with a private vendor to perform transition screenings to assess nursing facility members identified by the Minimum Data Set (MDS) and link eligible participants to the Elderly and Disabled and ICWP waivers. For the NOW and COMP waivers, DBHDD staff performs the same functions in ICF/MRs. The latter efforts will be supplemented with funding from MFP, under the DCH/DBHDD Interagency Agreement, to enable the state to transition an additional estimated 150 persons/year into the NOW and COMP waivers.

The expanded functions of the MFP Transition Coordinators will greatly increase the scope of the current private vendor contract. Therefore, the state will submit a request for proposals (RFP) to perform the duties and responsibilities of MFP Transition Coordinators for Elderly and Disabled and ICWP waiver participants served by the demonstration project. Under the two contracts (private vendor and DBHDD), contractor responsibilities include:

- Hiring a team of qualified transition coordinators (TCs),
- Offering statewide transition services to persons with developmental disabilities who wish to transition to a MRWP waiver
- Offering statewide transition services to MFP participants who wish to transition to the ICWP waiver or Elderly and Disabled waiver,
- Ensuring that TCs have specialized knowledge in the following areas:
    - Working with older adults and people with physical disabilities and acquired brain injury (ABI), and developmental disabilities
    - Eligibility for Money Follows the Person and Georgia's waiver programs,
    - Americans with Disabilities Act determinations and implications for practice,
    - Health care and long-term care,
    - Home and Community Based waiver options,
    - Independent living and required adaptation,
    - Community and regional resources,
    - Person centered planning and individual care planning,
    - Power-of-attorney/guardianship and informed consent,
    - Durable medical equipment and assistive technology, and
    - Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information

To Recruit Older Adults

The following MFP recruitment and enrollment strategies will supplement and expand current Olmstead Initiatives and waiver processes. MFP TCs will complement and enhance the current efforts of the DHS Division of Aging Services, Area Agencies on Aging (AAA/Gateway Network) including the Aging and Disability Resource Centers (ADRCs), waiver case management entities, provider associations, the Office of the State Long-Term Care Ombudsman, nursing home discharge planners/social workers, nursing home resident councils, advocates, and other points-of-entry as outlined below. Eligible older adults will enter the Elderly and Disabled Waiver Program.

To Recruit Persons with Physical Disabilities and/or Traumatic Brain Injury

The following MFP recruitment and enrollment strategies will supplement and expand current Olmstead Initiatives and waiver processes. MFP TCs will complement and enhance the current efforts to partner with ADRCs, Centers for Independent Living (CILs), Georgia Medical Care Foundation (the assessment entity for the ICWP waiver), the ICWP provider network, the Brain and Spinal Injury Trust Fund Commission, and regional and local service provider networks. MFP TCs will

recruit participants with physical disabilities/ABI for the ICWP waiver statewide. TCs will place special emphasis on recruiting persons with physical disabilities and ABI in existing ADRC and CIL services areas: Atlanta, Decatur, Rome, Macon (Middle Georgia), Augusta/Warrenton (East Georgia), Savannah (Coastal Georgia), Gainesville and Bainbridge (Southwest Georgia) in an effort to link MFP participants with peer supporters from these networks. However, MFP will be functional in the three remaining regions of the state (i.e. the Southern Crescent, Lower Chattahoochee and Southeast Georgia regions) throughout of the grant period.

To Recruit Persons with Developmental Disabilities (MR/DD)

MFP TCs within the Department of Behavioral Health and Developmental Disabilities (DBHDD) will recruit individuals located in ICF/MRs throughout the state for the NOW and COMP waiver programs. Under the agreement with DBHDD, the regional transition coordinators work with the case expeditors to provide the same services. MFP TCs/CEs coordinate their recruiting efforts with DBHDD, the state's DD Council, the Association of Retarded Citizens, and regional and local service provider networks. MFP TCs will assist and oversee elements of the transition process. DBHDD actively recruits individuals to transition from ICF/MRs or State Operated Hospitals.

Recruiting and Screening Potential Participants

Transition Coordinators will have experience in screening and arranging specialized services and supports for a specific target population and must have excellent professional communication skills. Under the two contracts, Transition Coordinators (TCs) will use (but will not be limited to) the following strategies to recruit:

- obtain referrals from point-of-entry systems,
- obtain referrals through MDS data mining,
- obtain referrals from participants, family members, caregivers, or guardians,
- make initial contact with participants,
- observe candidates in the institutional setting for needs, strengths, limitations and document service needs,
- conduct face-to-face interviews with participants, family/support networks and discharge planners (Social Workers and/or Administrators) and
- provide participants with information about MFP (see *Appendix C: MFP Tri-Fold Recruiting Brochure*) and information about HCBS waivers and community resources (see *Appendix E: Home and Community Services; A Guide to Medicaid Services in Georgia*),
- obtain signed informed consent from participants or guardians to participate in the MFP demonstration, stating the participant's desire to enroll in MFP and transition into an existing waiver (see *Appendix D1: Authorization for Use or Disclosure of Health Information and Appendix D2: MFP Consent for Participation*),
- be provided with access to all records that exist within the nursing/institutional facility, obtain permission to release records (see *Appendix D1*),

- use a screening tool (see *Appendix G: MFP Transition Screening Form*), to build a personal profile of each MFP participant that includes medical, financial, functional and psychosocial information, needs for housing, services and items necessary to establish a community-based residence,
- facilitate referrals to the appropriate waiver networks to complete pre-screening, assessment and required tasks for waiver services,
- assist participants to complete an application for waiver services,
- ensure person-centered planning is conducted consistent with best practices and ensure that the results of person-centered planning are written in the *Individualized Transition Plan (ITP)* (see *Appendix Q1: Individualized Transition Plan and Appendix Q2: MFP Guidelines for Completing the ITP*) or the Person-centered Description (PCD) and that all members of the transition team are aware of and complete their assigned duties.
- match participant needs to MFP pre and post-transition services available
- match participant needs to HCBS waiver services and community resources, ensuring effective use of each type of service
- educate and inform MFP participants about self-direction options under the waiver programs
- collaborate with the waiver's Transition Team and case manager to ensure the waiver assessment and service plans are completed
- assist participants in securing personal identification documents.

Using a team approach, TCs will meet with participants, families/friends, discharge planners (Social Workers and Administrators), waiver case managers, and peer supporters to create and implement transition plans agreed upon by participants/guardians. Transition plans will be developed using person-centered planning and circles of support. Resources for transition will be identified including assistance with SSDI/SSI. Transition plans will address needs for personal services and supports, 24/7 emergency backup, transportation, specialized medical equipment, assistive technology, housing, basic furnishings, and basic moving costs. TCs will coordinate pre-transition services objectively with regards to a participant's needs, recognizing that each person is different even though their disabilities might be similar. TCs will introduce MFP participants to peers who have successfully been resettled in the community. TCs may arrange, if applicable, for one or more overnight stays with peers, so that MFP participants will gain knowledge and understanding about independent living.

Waiting Lists for MFP Services

Funding for the MFP program is limited. There are a limited number of 'slots' of reserved capacity in each waiver. Therefore, only a certain number of participants receive services based on available funds. When reserved waiver capacity is exceeded, MFP uses a 'first-come-first-served' approach to service delivery. The date of the initial MFP screening will be used to prioritize the MFP waiting list. This date can be found on the first page of the MFP Transition Screening Form (see *Appendix G: MFP Transition Screening Form*). An MFP participant will be selected from the waiting list, based on length of time on the waiting list. With regard to waiver waiting lists, the state will amend the MFP Operational Protocol to reflect the Olmstead agreement, once the agreement has been signed by the state.

MFP Enhancements to Current Recruitment Processes

These MFP recruitment and enrollment strategies will supplement and expand current Olmstead Initiative and waiver processes:

- Older Adults– Transition Coordinators will complement and enhance the current efforts of the DHS Division of Aging Services, Area Agencies on Aging (AAAs), ADRCs, waiver case manager entities, provider associations, ombudsmen, nursing home discharge planners/social workers, nursing home family councils, advocates, and other points of entry to service systems
- Persons with Physical Disabilities and/or ABI – TCs will partner with all of the above and Georgia Medical Care Foundation (the assessment entity for the ICWP waiver), Centers for Independent Living, the Brain and Spinal Injury Trust Fund Commission, regional and local service provider networks.
- Persons with MR/DD – TCs will expand on the efforts of the Department of Behavioral Health and Developmental Disabilities (DBHDD), the state's DD Council, the Association of Retarded Citizens, regional and MR/DD local service provider networks.

Competencies of MFP Transition Coordinators

Transition coordinators (TCs) will receive initial training prior to beginning transitioning work with participants (see *Section B.3 Outreach, Marketing and Education* for a complete description of the state's staff training plan). MFP steering committee members, DCH, DHS, and DBHDD stakeholders will collaborate to develop training curriculum requirements and training sessions. In addition to training for TCs, other groups will receive training, including HCBS case managers (Elderly and Disabled, ICWP, NOW and COMP), DBHDD staff, AAAs, ADRCs and the Georgia Independent Living Network.

Training sessions will develop the following competencies (knowledge and skills):

- Scope and benchmarks of the MFP demonstration,
- Independent living philosophy and participant choice counseling,
- Person-centered planning and circles of support,
- MFP eligibility criteria, MFP screening tools and using MDS data,
- Informed consent, complaint processes and critical incident reporting,
- Involving guardians and persons who have durable power of attorney,
- Eligibility criteria for HCBS waivers and State Plan services,
- HCBS waiver systems, service options, self-directed service options,
- Tools for identifying affordable, accessible and integrated housing and developing relationships with community housing providers,
- Tools for working with Point-of-Entry systems--AAA/Gateway, ADRC, CILs, Regional DBHDD,
- Access to advocacy systems such as Legal Aid and the Office of the State Long-Term Care Ombudsman
- Regional community resources by disability population,
- Transportation options,

- Team approaches for working with waiver case managers and other professionals and advocates working on resettlement,
- Authorizing MFP pre and post-transition service expenditures, reporting and documentation,
- Procurement of specialized medical equipment and assistive technology for independent living,
- Customer Service, follow-up and conducting the Quality of Life survey, and
- MFP reporting and documentation requirements, including maintaining protected health information (PHI) in accordance with HIPAA regulations.

MFP Transition Coordinator Roles and Responsibilities

Transition Coordinators:

- Offer statewide transition services to participants with developmental disabilities, older adults, and participants with physical disabilities/ABI.
- Attend DCH mandated training to gain knowledge about MFP eligibility, MFP demonstration services, home and community-based waiver options, other community and regional resources, principles of independent living, self-directed care and person-centered planning.
- Attend trainings with the HCBS case managers, Division of Aging Services (DAS) and Department of Behavioral Health and Developmental Disabilities (DBHDD), Area Agencies on Aging Area (AAAs), Aging & Disability Resource Center (ADRC) and Georgia Independent Living Network (GILN).
- Obtain referrals of potential transitioning candidates from a variety of referral sources including, but not be limited to, institutional staff, long-term care ombudsmen, Minimum Data Set (MDS), point-of-entry systems, consumers and families and from the DBHDD transition team for the MR/DD population.
- Distribute outreach, marketing and educational materials to the community, participants and families/friends, regarding the MFP and HCBS waiver programs. Review material with participants/representatives and assist with understanding available options during face-to-face interviews.
- Use the *MFP Transition Screening Form* (see *Appendix G*) to screen and conduct face-to-face interviews with members, family/support networks, facility discharge planners (Social Workers and/or Administrators), and ombudsmen (attendance based on member's approval) and to explain the transition process and assess if the individual is interested in leaving the nursing facility or ICF/MR. Build a personal profile of the participant, including gathering medical, financial data, functional and psychosocial information, members' needs for pre and post- transition services, housing, transportation and other community services necessary to re-establish a community-based residence.
- Obtain signed informed consent from participants or authorized representatives (guardians) to participate in the Demonstration. The consent indicates the choices of the participant and provides information/access to all records (see *Appendix D1: Authorization for Use or Disclosure of Health Information and Appendix D2: MFP Consent for Participation*).

- Provide links to peer support network services, including links to persons with similar experiences to provide support, knowledge and community information about resettlement in the community using HCBS waiver services.
- Assist participants to secure personal identification documents.
- Assist participants to complete a waiver referral and follow-up with waiver case managers for approval.
- Assist participants in locating and securing housing, arranging security and utility deposits, and arranging for environmental modifications for accessibility.
- Assist participants to locate and obtain transportation, household furnishings, household goods and supplies.
- Authorize all MFP demonstration services and track expenditures for members in coordination with the MFP Fiscal Intermediary and DCH, and maintain accountability and documentation of activities, limitation and caps, and supply documentation to MFP project staff as requested.
- Contact DCH Member Services to change the participant's eligibility from nursing facility/institutional to community based.
- Assist participants in stopping their Social Security (SSI/SSDI) checks from going to the institution.
- Coordinate the procurement of and availability of equipment, supplies and services not otherwise covered by Medicaid but needed by the participant to maintain or improve independence in the community. This may include but is not limited to durable medical equipment, assistive technology devices and services, environmental control systems, and augmentative and alternative communication (AAC) devices.
- Ensure coordination of vehicle adaptations (if needed) not otherwise covered by Medicaid to improve participants' access to the community and independence, including the approval and issuance of vouchers for such adaptations.
- Approve invoices for all MFP supplemental and demonstration services.
- Assist participants by purchasing incidental items allowed under the grant necessary for successful transition.
- Arrange for the *Quality of Life* (QoL) survey to be completed approximately 30 days prior to discharge and arrange for the surveyor to conduct the QoL Survey at 12 months post community placement.
- Complete the *Discharge Day Checklist* (see *Appendix* R) and make follow-up contact with the participant during the first week and at 30 calendar days post community placement and with the follow-up monthly contact during the MFP period.
- Maintain records on all members interviewed and transitioned; submit reports and completed documentation as requested by MFP project staff.

- Successfully transition targeted numbers by population.
- Facilitate on-going communication with waiver case managers.

MFP Re-enrollment Process

A MFP demonstration participant is discharged from MFP if the participant is re-institutionalized for 30 days or more, in accordance with CMS guidelines. The participant is then considered to be an institutional resident. A participant may reenter the demonstration without meeting another six months institutional residency requirement if the institutional stay is less than six months, but the participant will need to be re-evaluated for discharge to the community to determine if any changes in the service plans are warranted to prevent a re-admission to an institution. The case manager will conduct a re-assessment per waiver policy, for institutional stays of longer than six months. Institutional residency requirements apply and the participant will be re-evaluated like a "new" MFP participant.

Money Follows the Person (see *Appendix H: MFP Recruiting Text*)

Georgia Money Follows the Person helps people living in nursing homes and Intermediate Care Facilities for people with Mental Retardation (ICF/MRs) to transition and resettle into qualified residences in the community. If you have lived in a nursing home or ICF/MR for at least six (6) months, you may qualify for the MFP program.

MFP offers transition services to qualified Medicaid eligible older adults, adults and children with physical disabilities, traumatic brain injury, developmental disabilities and mental retardation.

MFP uses home and community-based Medicaid waiver services and 'one-time' transition services to help people to resettle in an apartment or home or a group home with four or fewer unrelated adults. After receiving 365 days of MFP services, MFP participants will continue receiving services through the Medicaid Home and Community Based Waiver Services (HCBS), Medicaid State Plan services, non-Medicaid federal funds such as the Social Services Block Grant and the Older Americans Act, state funded programs, and local community support systems and funding, as long as they remain eligible.

MFP participants may qualify for the following 'one-time' transition services to assist them:

- Peer Community Supports
- Household Furnishings
- Household Goods and Supplies
- Moving Expenses
- Utility Deposits
- Security/Rent Deposits
- Transition Supports
- Trial Visits for Personal Support Services or Personal Care Homes

- Transportation
- Skilled Out-of-Home Respite
- Caregivers Training
- Long-Term Care Ombudsman Services
- Equipment and Supplies
- Vehicle Adaptations
- Environmental Modifications for Accessibility

Persons eligible for MFP will not be referred to a waiver program waiting list, provided the waiver has capacity. If waiver services are available, MFP participants will enter a waiver immediately upon discharge from the institution. Waiver services will continue to transitioned individuals beyond the 365 day MFP demonstration period. Transitioned individuals enter an appropriate waiver program and receive waiver services as long as they meet the institutional level of care criteria for these services.

If you are interested and want more information on Money Follows the Person, you can contact:

- The Georgia Department of Community Health Money Follows the Person project, at 404-651-6889 or 404-657-9323,

- The Department of Human Services Division of Aging Services at 1-866-55-AGING (552-4464), or

- The Office of the State Long-Term Care Ombudsman at 1-888-454-5826.

B.2 Informed Consent, Guardianship, Grievance/Complaint and Critical Incident Reporting Systems

This section describes the informed consent, guardianship, grievance/complaint and critical incident reporting systems in place for MFP participants entering current HCBS waivers under the Georgia Demonstration, including the Elderly and Disabled Waiver Program, the Independent Care Waiver Program (ICWP) and the NOW and COMP waivers. This section describes procedures and forms used to fully inform participants and caregivers about their rights and responsibilities in the MFP demonstration, including the options (or requirements) participants have after the one-year transition period. This section identifies procedures for involving guardians before, during and after transition and procedures for informing guardians of MFP benefits and risks and for reversing guardianship, when necessary. This section concludes with a description of the grievance/complaint system, the entities responsible for receiving and reviewing complaints and critical incident reports, responding to problems concerning complaints and critical events and investigating participant complaints regarding violation of their rights.

How Guardians are Appointed

In those cases where the participant is unable to fully comprehend the options or consequences of his or her choice, a guardian may act on his or her behalf. Any competent person who agrees to serve as a guardian may be appointed to do so. Agencies and institutions providing care and custody to an incapacitated individual are prohibited from becoming his/her guardian. As a last resort, the Department of Human Services (DHS) may be appointed guardian. The Department of Community Health (DCH) and DHS assume that the individual is competent, unless a court has determined otherwise. Whenever a participant has been adjudicated incapacitated, the guardian is informed about the options and acts on behalf of the participant and makes the final decision. Until the individual is deemed incapacitated by the Court s/he has the right to participate in and make decisions regarding care and services.

Informed Consent and Involving Guardians in MFP Transitions

Strategies used to inform potential MFP participants, family members, friends and/or guardians include: liberal opportunities to receive information about MFP (see *Section B.1 Participant Recruitment and Enrollment*); opportunities to discuss MFP options and services with Transition Coordinators (TCs) before signing the *Authorization for Release of Information and Informed Consent Form* (see *Appendix D1 and D2*); opportunities to discuss traditional waiver options and MFP transitional services with the waiver case manager during waiver assessment (see Section *B.6 Participant Supports* and *Section B.7 Self-Direction*); requirements for guardians; and waiver requirements for the development of service plans with input from MFP participants, family members, caregivers, friends and/or a legal guardian.

As described in *B.1 Participant Recruitment and Enrollment*, institutionalized persons, family members, caregivers, friends and/or guardians will be provided with easy to use, understandable information, or information in alternative formats, about MFP and core waiver services, eligibility criteria, how to apply and what to

expect. Information about MFP is provided along with core waiver services through statewide Point-of-Entry partners including: AAA/Gateway networks, Aging and Disability Resource Centers (ADRCs), Centers for Independent Living (CILs), provider networks, and regional DBHDD service councils and providers. Potential MFP candidates have opportunities to receive and discuss information with MFP Transition Coordinators (TCs) during face-to-face meetings and follow-up discussions. Once institutionalized persons have received information about MFP and have indicated interest in MFP/transitioning, TCs will obtain consent and release of information to determine if the participant has a guardian or Durable Power of Attorney (DPOA). TCs will obtain copies of these legal document(s) and review them to establish the extent of the surrogate decision making power that exists. During subsequent development of *Individualized Transition Plans* (see *Appendix Q1 and Q2*), TCs will involve participants, family members/friends, caregivers and guardians in person-centered planning and circles of support.

Working with waiver case managers (CMs), TCs will identify current waiver participants who have successfully resettled in the community and who have guardians. TCs will ask these guardians, if interested, to visit with guardians of institutionalized persons considering transition under MFP. Visits with guardians of successfully resettled waiver participants will help guardians considering transition to understand and weigh both the benefits and risks of resettlement. Discussions between guardians, participants, TCs and CMs may be enough to move the process forward. If not, an ombudsman will be called in to assist at the request of the participant. For example, if a person in a nursing home indicates interest in resettlement in the community, but the guardian is opposed and will not allow the process to move forward, an ombudsman may be asked to intervene. LTC ombudsmen educate guardians about the participant's Bill of Rights and when necessary, can refer the participant/consumer to free legal assistance (i.e. Atlanta Legal Aid Society) for additional legal help to reverse guardianship. On the other hand, if any member of the transition team believes that a participant/consumer is actually opposed to community placement, but the participant's guardian is for such a placement, a long-term care ombudsman may be asked to intervene for the purpose of working with the guardian regarding the participant's preference to continue institutional placement and educating the guardian about the limits of guardianship.

Following waiver enrollment and resettlement to the community, TCs visit with participants, family members, caregivers and guardian to ensure that participants are receiving all MFP and traditional waiver services as specified in the service plan. When resettled participants have guardians, TCs follow-up with the guardian to answer any questions and/or provide additional information about grievance and complaint processes. TCs are expected to leave their contact information and the contact information for waiver case managers and ask guardians to call with questions or if problems arise.

Informed Consent for Older Adults and Persons with Physical Disabilities/ABI

Under the Elderly and Disabled Waiver Program and Independent Care Waiver Program, participants are informed about MFP and waiver services available during the initial face-to-face assessments conducted by the case manager. Participant choices are documented on a standardized *Authorization for Use or Disclosure of Health Information* (see *Appendix D1*) *and MFP Consent for Participation* (see *Appendix D2*). The state assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written service plan. Choice of provider is documented on the written service plan. The Freedom of Choice forms, signed during initial face-to-face assessments, are maintained for a minimum of three years by the case management agency.

Informed Consent for Persons with Developmental Disabilities

Under the NOW and COMP Waiver Programs, as part of enrolling in waiver services, each participant signs a document indicating Freedom of Choice. Although this signature documents the choice of community services, it also documents that the participant has choice of providers and support coordinators both at waiver onset and as long as enrolled in waiver services. The Intake and Evaluation team explains this choice to each participant.

In this process, the intent is to inform and to document that the participant and his or her guardian will be (1) informed of alternatives and services available under the waiver and (2) given the choice of either institutional or Home and Community-Based Services. An overview of services is offered and is designed to make the participant reasonably familiar with service options. The presentation of such information is designed to match the level of comprehension for each individual. Once this information has been provided, the Intake and Evaluation team is responsible for seeing that each participant and/or his or her representative sign a document indicating Freedom of Choice and for witnessing the signature(s).

The original signed documentation of Freedom of Choice is maintained by the Intake and Evaluation team for at least five years. Copies are also maintained by the original provider(s) for at least five years. A copy of the form is maintained in the participant's record for at least five years

Quality Improvements to Informed Consent

At MFP statewide stakeholder forums, participants reported that there existed a good deal of confusion regarding issues of informed consent, power of attorney and guardianship. Among the issues reported were:

- A false stereotype by some that all persons in institutions are incompetent
- The lack of augmentative and alternative communication devices for communicating with members who have communication difficulties
- Limited understanding of the proper uses of power of attorney and guardianship.

To address these issues, TCs, advocates and stakeholders will work together to:

- Develop printed materials in laymen's language that can be distributed to members
- Develop additional training for all partners in the MFP project on the basic principles of power of attorney and guardianship
- Develop training for legal professionals, advocates, residents and their family members on the appropriate uses of the same.

Grievance and Complaint Processes for Older Adults and Persons with Physical Disabilities/ABI

Under the Elderly and Disabled Waiver Program, The Georgia Department of Human Services (DHS) Division of Aging Services (DAS), and the Department of Community Health share the responsibility for overseeing the reporting of and response to grievances and complaints. Under ICWP, the Department of Community Health is responsible for overseeing the reporting of and response to grievances and complaints. At the local level of the Elderly and Disabled Waiver, the state has designated case management agencies to operate the grievance/complaint system.

At the initial face to face assessment, the case manager advises participants of their rights including their right to voice complaints and grievances. Examples of complaints or grievances that may be reported are: poor provider performance, aides not reporting as scheduled, lack of supervision, or allegations of abuse, neglect, or exploitation. These complaints or grievances would then be addressed by the case manager. Allegations of abuse, neglect and exploitation must be reported to either the DCH Healthcare Facility Regulation Division or Adult Protective Services (APS) if the participant resides in a non-institutional setting, as required by law. In an effort to ensure that participants and/or caregivers receive consistent and objective treatment when grievances are reported, case managers immediately intervene to work with the participants and provider to facilitate an acceptable resolution for the waiver participant. Resolution may involve facilitating a case conference with the client, the provider, and other supports such as family members in order to address all relevant details associated with the complaint. If the problem cannot be resolved, a grievance committee is convened to address the concerns and a solution is recommended within seven days.

All complaints are categorized according to type (i.e. missed visits or lack of supervision) and maintained on a complaint log held at the case management agency. A brief note documenting the resolution to the complaint/grievance is included on the log. All complaints are reviewed monthly to identify trends and to develop a plan of action for follow up. Waiver program managers review these monthly complaint reports and develop needed policy and/or procedure revisions. Waiver program managers will forward these monthly reports to the MFP Project Director when these reports involve MFP participants.

When applicable, complaints/grievances are referred to the Office of State Long-Term Care Ombudsman as well as the DCH Healthcare Facility Regulation Division, the agency which gives the license/permit to operate. Waiver participants and caregivers are informed by case management that the filing of complaints is not a

prerequisite or substitute for a Fair Hearing. If the grievance process is unable to resolve the differences, the participant/caregiver is provided with information on initiating a request for fair hearing with the state agency.

Grievance and Complaint Processes for Persons with MR/DD

Under the NOW and COMP Waiver Programs, any participant (or his/her guardian or parent) or staff member may file a complaint alleging that a participant's rights have been violated. A person who considers filing such a complaint is encouraged to resolve the matter informally by discussing it first with the persons involved, or Program Consumers' Rights staff, as specified in the Program's Quality Improvement Plan. The participant is not required to use the procedures established in lieu of other available remedies, including the right to directly contact the Personal Advocacy Unit at the Department of Behavioral Health and Developmental Disabilities or to submit a written complaint to the Regional Coordinator, Program Director or Governor's Advisory Council. Waiver participants are informed that the filing of complaints is not a prerequisite or substitute for a Fair Hearing.

In order to ensure that such internal quality improvement investigations and monitoring activities are completed fully and in an in-depth manner, to encourage candid evaluations, and to ensure that adequate corrective action is taken in all cases, all review actions taken and all documentation remain confidential. A Consumers' Rights Subcommittee reviews services from all programs contracted by the Department either directly or indirectly. The Consumers' Rights Subcommittee functions as a part of the program's ongoing quality improvement process, as described in the Program's Quality Improvement Plan.

The complaint is filed with the Consumers' Rights Subcommittee of the consumer's program, and it may be filed on a form provided by the program. If the consumer states the complaint orally, specific assistance is given in proceeding with the complaint and completing the form. Complaints may be made by telephone to consumers' rights staff persons, who may complete the form. Staff members whose alleged conduct gave rise to the complaint may be informed of the complaint.

As soon as possible, but within seven business days after the complaint is filed, the Consumers' Right Subcommittee investigates the complaint, resolves it if possible, completes a disposition report, and files it with the Quality Improvement Committee's records. If after interviewing the complainant it is found that the complaint does not state an allegation that, if true, would constitute a violation of regulations or other applicable law, the complaint may be rejected in writing. In cases of such rejection, the original rejection notice is filed in the Quality Improvement Committee's records, and a copy is sent to the complainant. In all investigated complaints, the staff employs the investigatory method deemed most suitable to determine the facts.

The Program's Quality Improvement Committee completes a brief disposition report on each investigated complaint and forwards to DBHDD for approval. The report states the parties involved, the complaint, and whether the complaint was resolved

or not. The original report is filed on forms provided by DBHDD in the Committee records, and a copy is sent to the DBHDD Regional Coordinator, the Director of the Program, and to the Department's Quality Improvement Committee through the Personal Advocacy Unit. The complainant is notified of the action taken by the Committee. If the complaint is rejected or is not resolved by the Committee to the satisfaction of the consumer (or his guardian or parent of a minor) or the complainant, either the consumer or the complainant may file a written request for a review of the complaint. The request may be rejected without a review if either the complaint or the request for review is not filed in a timely fashion, or if the complaint does not state an allegation that, if true, would constitute a violation of these regulations or other applicable law.

Within five working days after the conclusion of the review, the reviewer submits a written report of the review. The consumer or the complainant may appeal the rejection or other decision by filing a written request for review with the Regional Coordinator or his/her designee.

Within ten working days of the filing of the request for review, the Regional Coordinator, or designee, issues a disposition of the appeal. The Regional Coordinator may reject the request in writing without a review if either the complaint or the request for review is not filed in a timely fashion, or if the complaint does not state an allegation that, if true, would constitute a violation of State regulations or other applicable law.

The consumer or the complainant may appeal the Regional Coordinator's rejection or other decision by filing a written request for review with the Director of the DBHDD Division of Developmental Disabilities. Upon the filing of such a request, the Regional Coordinator is notified, and the Regional Coordinator shall immediately transmit to the Director a copy of the Regional Coordinator's rejection or decision, together with a copy of the previous reviewer's recommendations, the Program Director's decision, and other documents used in the review, if any.

Within ten working days of the filing of the request for review, the Director or his/her designee issues a disposition of the appeal. This decision of the Director or his designee is based upon a review of the request for review and the documents forwarded by the Regional Coordinator; no evidentiary hearing is conducted by the Director or his designee. In the decision, the Director or his/her designee may affirm, reverse, or modify the Regional Coordinator's rejection or other decision, or s/he may return the case to the Regional Coordinator. If the Director or his designee returns the case to the Regional Coordinator, the Director or his/her designee specifies the matters to be addressed in the further proceedings and the period within which those proceedings shall be concluded. In no event is the period for completing the further proceedings, including the reviewer's submission of an additional report, the Regional Coordinator's issuance of another rejection or other decision, and the Director's or his/her designee's issuance of a decision, more than 14 working days. The original of the Director's or his/her designee's decision is filed in the Director's records, and copies are sent to the Regional Coordinator and to the complainant. The decision of the Director is final.

In addition to the filing of complaints about alleged violations of consumer's rights under DBHDD regulations or other applicable law, a waiver participant or family member/representative may submit grievances/complaints about waiver service access and delivery to the support coordinator and/or to the DBHDD Regional Office. The support coordinator works with the waiver participant or family member/representative and the provider in an attempt to resolve the problem. If resolution is not possible, the support coordinator presents the grievances/complaints to the DBHDD Regional Office in the weekly meetings or, if urgent, by phone. The Regional Office staff review the grievances/complaints and work with providers to resolve them and investigate as needed. The DBHDD Regional Office may require a corrective action plan to assure resolution of the problem. The support coordinator monitors the corrective action plan. The official filing of a complaint/grievance by a waiver participant or a family member/representative requires a response in writing from the Regional Office within 30 days of the filing.

Providers are required to provide persons served with information about their rights at the onset of services and annually thereafter. The information includes how the consumer may voice complaints or grievances. This information is provided in a manner the person/family can understand, and is documented. The person/family member signs a statement that this information was given to him/her and explained so s/he could understand it. The providers are required to have policies and practices which allow the compilation and review of reports concerning the numbers of grievances and complaints, the response time in resolving them, and the final resolution for improving the system's responsiveness to consumer concerns.

If a person believes his/her rights of choice of service(s) or provider(s) have been violated, s/he follows the process of voicing this grievance or complaint to the support coordinator. If the person is dissatisfied with the outcome, s/he may elevate his/her grievance or complaint to the Regional Office, and if not resolved at the Regional Office, may carry the grievance or complaint further to the DHR Office of Developmental Disabilities. Waiver participants are informed that the filing of grievances/complaints is not a prerequisite or substitute for a Fair Hearing.

Critical Incident Reporting Systems

Georgia's MFP critical incident reporting systems will serve participants through the existing HCBS waivers, including the Elderly and Disabled Waiver Program, the Independent Care Waiver Program (ICWP) and the NOW and COMP Waiver Programs. This section describes how critical incidents are reported and investigated and the processes for receiving and reviewing critical incident reports, assuring follow up is implemented, and how incident reports are used for program improvements.

Critical incidents are defined in each 1915c waiver application and include factors that threaten or result in failure to maintain a safe and humane environment for

consumers. Chief among those factors that are defined as critical incidents are allegations of abuse, neglect, exploitation, medication errors, deaths, allegations of criminal activity, unexpected absences from residential facilities, and injury to participants. Under state law, all health care providers and their staff/volunteers are mandated reporters of abuse, neglect, and/or exploitation. These incidents are reported to waiver program managers at the operating agency (DHS, DBHDD, or DCH). For incidents involving MFP participants, TCs will complete an *MFP Sentinel Event report* and submit to the DCH MFP Office.

Critical Incident Reporting Systems for All Populations

Under the Elderly and Disabled Waiver Program, the Department of Human Services (DHS) and DCH share the responsibility for overseeing the reporting of and response to critical events. Under the MR waiver programs, the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the DCH share the responsibility for overseeing the reporting of and response to critical events. Under the Independent Care Waiver Program (ICWP), the Georgia Department of Community Health is responsible for overseeing the reporting of and response to critical events.

All waiver programs require the following in response to critical incidents:

- Calling 911 or other emergency numbers to obtain immediate medical or law enforcement interventions if needed
- Provision of immediate and ongoing medical intervention if required
- Immediate implementation of measures to protect the health, safety and/or rights of the individual, including relocation of the participant to another facility or program if needed
- As appropriate, notification to family, guardian, next of kin, or emergency contact indicated in the participant service record
- Reporting of the incident to the waiver operating agency (DHS, DBHDD, or DCH)
- As appropriate, additional reporting of the incident to licensure and/or certification agencies, Adult or Child Protective Services, local law enforcement agencies, and DCH Program Integrity
- Investigation of the incident by the provider agency and case manager at a minimum and any of the above entities as applicable
- Written report of the findings of the investigation to the operating agency
- Submission of a written plan of action
- As needed, on-site inspection of the facility/program to assure the plan of action is implemented
- Review of all incidents in regularly scheduled joint meetings of DCH, DHS, and DBHDD
- Analysis of incident data to identify systemic changes needed to prevent recurrences, such as revision to state policies and procedures.

B.3 Outreach, Marketing, Education and Training

This section describes plans to conduct outreach, marketing, education, and staff training that will enable stakeholders, professionals and community members to refer eligible older adults and people with disabilities to MFP screening systems (points-of-entry). This section describes how the state and regional MFP teams will leverage formal and informal relationships and knowledge of community resources to move the MFP agenda and goals forward and facilitate the transition of participants to community living. This section concludes with examples of outreach, marketing, and education materials used in the program.

Inclusion of MFP in Current Outreach, Marketing, and Education Efforts

The overall goal of current outreach, marketing, and education is that all points-of-entry and information and referral networks will provide accurate information about HCBS waiver programs and accurate information about MFP. For example, Area Agencies on Aging (AAAs) will provide information seekers with information about Elderly and Disabled Waiver services, and if the person doesn't qualify, the AAA will make a referral to another more appropriate waiver or state service. Depending on the information seeker's situation, s/he will be directed to the appropriate point-of-entry. To achieve this goal, the state is focused on developing systematic outreach through all points-of-entry and Information & Referral networks.

The state conducts outreach, marketing, and educational presentations, provides booklets and informational brochures, uses public service announcements (PSAs), and posts information on its public websites to inform the community about home and community-based waiver services (HCBS). Information about the MFP Demonstration Project and how it works will be added to already existing outreach, marketing, education, and training undertaken by the state. For example, Communications Services at DCH will assist the MFP project in preparing and releasing press releases about MFP. Outreach information about MFP will be added to existing DCH Medicaid Division Office of Long-term Care web pages, fact sheets, and other outreach and marketing materials. Project partners in the Department of Human Services and the Department of Behavioral Health and Developmental Disabilities will work to promote MFP through similar channels.

MFP Targeted Outreach and Marketing

Targeted outreach will proceed through a proactive process of face-to-face communication, relationship building, presentations, informational forums, interagency meetings, training presentations, marketing and outreach materials (*Appendix C: MFP Tri-Fold Recruiting Brochure and Appendix E: Home and Community Services, A Guide to Medicaid Services in Georgia*), written materials available in plain English for better understanding for persons with cognitive impairments, materials translated into Spanish and French (but not limited to only these languages as provided by DHS's Limited English Proficient and Sensory Impaired Customer Services Office), and materials made available in alternative formats for individuals with sight, visual, and hearing impairments.

Efforts will focus on providing information about MFP along with information about all HCBS waiver services and options. MFP will be marketed to a broad range of entities. Outreach, marketing, and education will be targeted to:

- Georgia Healthcare Association, hands-on hospital and facility/institutional discharge planners, social workers, and rehabilitation hospitals,
- CIL networks, advocacy organizations, and caregiver support groups,
- Peer support networks including People First Georgia, the ARC of Georgia, Side by Side Brain Injury Clubhouse, Community Friendship network, Community Service Boards, and family members of institutionalized residents,
- Point–of-entry systems, AAA/Gateway, ADRCs, CILs, Service Link Resource Centers, Regional DBHDD offices, waiver and other community based service providers who provide information and referral to all HCBS waivers,
- Professionals doing members' eligibility determination, including the DHS Division of Family and Children Services (DFCS) staff who resolve members' eligibility/benefits issues associated with moving participants from nursing homes and institutions to HCBS waivers,
- Selective physician offices, crisis intervention services, Georgia Behavioral Health Link,
- State and regional housing authorities, public housing authorities, and the Department of Community Affairs,
- Legal and judicial officials and the Office of Civil Rights (OCR),
- Ombudsman staff and volunteers, and
- Senior Centers, Meals on Wheels, and Community Mental Health Centers.

MFP will supplement and expand current Olmstead Initiative and waiver outreach, marketing and education strategies:

Outreach to Older Adults

Transition Coordinators (TCs) will complement and enhance the current outreach, marketing and education efforts of the DHS Division of Aging Services, Area Agencies on Aging (AAAs), ADRCs, waiver case manager entities, provider associations, ombudsmen, nursing home discharge planners/social workers, nursing home family councils, advocates, and other points-of-entry to service systems.

Outreach to Persons with Physical Disabilities/ABI

TCs will partner with all of the above and Georgia Medical Care Foundation (the assessment entity for the ICWP waiver), Centers for Independent Living, the Brain and Spinal Injury Trust Fund Commission, rehabilitation and veterans hospitals, and regional and local service provider networks to enhance the outreach, marketing, and education being done by each entity.

Outreach to Persons with Developmental Disabilities

TCs will expand on the outreach, marketing, and education efforts of DBHDD, the state's DD Council, People First Georgia, the Association of Retarded Citizens, Community Service Boards, regional and local service provider networks.

MFP Outreach and Recruiting using HCBS Booklets

MFP Transition Coordinators (TCs) and Regional Transition Staff (DBHDD) will distribute the HCBS booklet, *Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia* (see *Appendix E*), along with information about MFP, as a method of outreach. For older adults and persons with disabilities residing in nursing facilities or ICF/MRs, receipt of this booklet may be the first contact with a TC or a Regional Transition Staff person. The booklet describes Georgia's HCBS waiver programs for older adults, persons with physical disabilities, developmental disabilities. The booklets are intentionally designed to be very brief and simple regarding waiver eligibility requirements, and are not specific to any sub-population. The booklet is available in several languages and in alternative formats for persons who are blind/low vision. The booklet is written in plain English to assist persons with cognitive/language challenges. Local recruiters will determine what formats are needed to ensure accommodations are made for individuals with various disabilities. For outreach to persons who are deaf, local recruiters will have sign language interpreters available to assist at face-to-face meetings to develop preliminary transition plans, and during subsequent training sessions.

The booklet, *Home and Community Services: A Guide to Medicaid Waiver Programs in Georgia* (see *Appendix E*) provides general information about the following areas:

- Community Alternatives
- Medicaid
- How to Apply for Medicaid Home and Community-Based Waiver Services
- Each Medicaid Waiver program
- Money Follows the Person (MFP)
- What's covered and not covered by Medicaid
- Individual's Rights and Responsibilities
- Contact Information (e.g. county health departments, Area Agencies on Aging and other aging entry points, Regional DBHDD offices and the Social Security Administration)

Additional information about MFP will be distributed along with this booklet (see *Appendix H*). The booklet is widely distributed to nursing homes, Centers for Independent Living (CILs), ICF/MRs, Area Agencies on Aging (AAA), Aging and Disability Resource Centers (ADRCs), and Senior Centers. MFP TCs and Regional Transition Staff (DBHDD) will distribute the booklet and MFP specific materials in their respective state regions, based on targeted outreach strategies. In addition to the recruiting efforts (see *Section B.1 Participants Recruitment and Enrollment)* of MFP TCs and Regional Transition Staff (DBHDD), the state uses Peer Supporters, state agencies, AAAs, ADRCs, CILs, professional and non-professional networks (see *Section B.4 Stakeholder Involvement*), advocacy agencies/individuals, and ombudsmen to distribute marketing and outreach materials specific to the MFP demonstration program.

DBHDD will provide Regional Transition Staff with an electronic file version of the booklet and MFP materials. Local outreach teams will add local contact information

and arrange for printing and distribution. The information identifies the MFP demonstration program as a collaborative effort between the state, the Federal Government, and local communities. Local contact information will ensure that response is timely and reflective of the locally coordinated MFP activities.

MFP Informational Recruiting Brochure

A MFP recruiting brochure will be printed and distributed as indicated below. The MFP informational brochure will be used to recruit participants, friends/family members, and guardians. See *B.1 Participant Recruitment and Enrollment* for more information on how recruiting, screening and enrollment occur. The MFP informational brochure covers the following areas:

- MFP one-time transition services,
- person-centered planning and circles of support,
- developing a preliminary transition plan,
- enrollment in HCBS waivers,
- participant services and supports,
- self-direction,

The brochure will be the primary tool used to recruit MFP participants. MFP TCs and Regional Transition Staff will recruit participants in targeted locations (nursing homes, ICF/MRs, inpatient facility lobbies, resident councils, etc.). MFP community transition teams (i.e. MFP transition coordinators, MR/DD Regional transition staff, peer support networks, ombudsmen, waiver case managers, community vendors and providers) will distribute the MFP informational brochure according to their outreach and marketing strategies based on their targeted populations. MFP TCs and Regional Transition Staff will use the informational brochure to recruit potential participants during the face-to-face interviews to explain MFP and HCBS waiver services.

To market the MFP demonstration program and to develop rapport with groups in the community, transition teams will distribute the MFP informational brochures to discharge planners' and social workers' offices, AAAs, ADRCs, CILs, SOURCE network offices, senior centers, county health departments, targeted community organizations, nursing facility staff and administrators, and hospital discharge planners. Inpatient facility partners must be familiar with the project as a first step in establishing trust with potential MFP demonstration participants. The brochure will identify the state and local programs that are participating.

As an education/training tool, state MFP project staff and local teams will encourage healthcare trade associations and other appropriate groups to make MFP informational brochures available to invite these entities to participate in the Georgia MFP demonstration program. The brochure will be used widely by state staff, members of the Georgia MFP Steering Committee, other interested stakeholders, and various community liaisons to meet personally with the inpatient facility staff to review the project and discuss the transition process.

Effective Use of Media

General participant recruitment *Public Service Announcements* will be developed and used for recruiting. Narrative examples will be provided to radio and television stations and other media outlets throughout the life of the Money Follows the Person project. The following is a sample narrative for a PSA:

> *Long-term care services and supports can be provided in lots of different ways. If you or a loved one lives in a nursing home and you wish to live at home, you may be able to get the help you need to move back home. To learn more about the Georgia Money Follows the Person Community Transition project in your area call _____ at _____, or visit our website at _____.*

The state will supply a generic *press release* about MFP that can be used to submit to regional publishers of newspapers, bulletins, newsletters and websites. Local teams may make modifications to the general narrative to fit the characteristics of their regions. A state-level *press release* will use a similar narrative as that of the *public service announcement*. Recruitment efforts to the general population may generate high levels of telephone traffic from individuals interested in avoiding a nursing facility stay rather than calls from individuals already residing in a nursing facility. Local transition teams will anticipate their unique community's needs, write their own protocols to handle phone inquiries, and develop a process to redirect callers who request information related to the MFP demonstration.

The creation of a link to the Georgia Money Follows the Person Demonstration project on the DCH website demonstrates to potential participants, their communities and families, that the project is state and federally sanctioned. Topics covered on the site are the same as topics covered in the MFP Informational Brochure to ensure consistency of information and to provide the ability to easily navigate and locate information about MFP and HCBS Waivers. Information about Demonstration activities will be regularly updated beginning in November 2008. The site also contains links to relevant reports, studies, resources, organizations, programs and DCH/DHR and community services.

Current Education and Training and MFP

Training of MFP transition coordinators and MR/DD regional transition staff is covered in the OP section, *B.1 Participant Recruitment and Enrollment*.

Systematic, 'cross-waiver' training is currently done by each system for its partners. MFP will provide each system vetted training materials about MFP, prior to the beginning of the Demonstration, to enable system professionals, managers and front line staff to make appropriate referrals of eligible individuals for MFP screening. For example, in the Department of Human Services (DHs), the Division of Aging Services (DAS) conducts quarterly training at each of the 12 regional Area Agencies on Aging and provides 'cross-waiver' trainings to the AAAs, ADRCs and service provider networks. Centers for Independent Living (CILs) and ADRCs are ideal agencies to receive cross-waiver training that would help them market and

educate consumers about MFP/waivers. MFP will link with DAS to develop and provide MFP training through DAS to AAA/Gateway/ADRCs/service provider networks to train professionals, managers and front-line staff to make appropriate referrals for MFP screenings. In addition, MFP TCs will work closely with AAAs, ADRCs, CILs and service provider field staff to implement MFP and link MFP participants to local community resources. Because CILs provide a number of core services (i.e. information and referral, peer support, advocacy, independent living skills training), MFP TCs will be trained to inform participants about local CILs and link participants with CIL peer support networks for assistance during transition.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) provides on-going and systematic cross-waiver trainings through its regional offices. MFP state staff will work with DBHDD staff to develop MFP training materials that can be delivered along with existing training. DBHDD offers specific training on transitioning within hospitals, designed to help professionals make appropriate referrals and provide pre-transition services. DBHDD will include MFP information in training it provides on waiver service options designed for providers and families. DBHDD trains providers to understand differences in waivers and the language used to describe support services. DBHDD has developed a 'Tool Kit' for training personnel involved in transition and will develop MFP information as part of the 'Tool Kit.'

MFP Specific Training

Some MFP training will be basic and delivered to all audiences, while other training will be core and related/supplemental for staff involved in various aspects of transition. General training on MFP waiver options and services, participant benefits, referrals, eligibility criteria, and how MFP interacts with traditional waivers will be developed for recruiting and training MFP participants, family/friends, caregivers and general audiences.

Training will be developed for and delivered to each of the following audiences based on the following priority and based on MFP deployment: 1) point-of-entry/I&R personnel, 2) eligibility determination/gate-keepers, 3) personnel involved in transition—transition coordinators, targeted discharge planners and NF/institutional staff, 4) nursing facility administrators, 5) contracted vendors and service delivery personnel, and 6) participants and their families. MFP training will be integrated into existing training and ongoing due to high staff turnover. A 'speaker's bureau' will be developed to facilitate state-wide training based on geographic area and training topic. This speaker's bureau will be supported by the development of appropriate training materials.

Training materials already in use will be modified to include information about MFP so that professionals, managers and front-line staff will have the knowledge and skills necessary to make appropriate referrals for MFP screenings.

Core training topics will include (but are not limited to) the following:

- History of Transitioning in Georgia, MFP, Benchmarks and Scope

- MFP one-time transition services,
- participant rights and responsibilities,
- informed consent,
- screening and matching needs to MFP services
- person-centered planning and the individualized transition plan,
- resources for resettlement (i.e. SSI/SSDI),
- enrollment in HCBS waivers,
- participant services and supports,
- self-direction,
- Medicaid eligibility and the role of DFCS
- Conducting the Quality of Life Survey
- housing and rental subsidy programs, and
- accessing local transportation options.

Related/Supplemental training topics will include (but are not limited to) the following:

- introduction to disability and working with older adults
- working with peer support networks
- working with guardians and the limits of guardianship
- DME and assistive/adaptive technology and services
- Non-Medicaid and community resources.

MFP will develop and deliver training using the following training delivery methods, as needed (subject to funding and budget approval): 1) face-to-face scripted PowerPoint slide presentations, 2) Lunch-and-Learn sessions, 3) using distance-learning technology to develop and deliver training, and 4) using peer supporters with disabilities to provide training.

Training for Transition Coordinators will be developed and delivered beginning in September 2008. Training for TCs will be scheduled, evaluated and tracked. Training will be developed and delivered for training point-of-entry networks, discharge planners and other institutional staff, and nursing facility after TCs have received initial training. Training for MFP participants and family/friends and caregivers will be developed and delivered as needed throughout the life of the project.

Nursing Home Staff Training

Local transition teams (i.e. MFP TCs, regional transition staff with DBHDD, ombudsmen, and peer supporters) will be asked to do presentations about MFP to nursing home and institutional staff as part of their outreach, marketing and recruiting strategies. Trainings will build on nursing home/institutional staff knowledge to enable them to make appropriate referrals for MFP screenings, understand independent living philosophy and the dignity of persons with significant disabilities. Staff will be trained to provide residents with accurate and timely information about community living and waiver options. Staff will receive basic training in:

- How to obtain assistive technology for independent living, including environmental control systems, augmentative and alternative communication (AAC) devices, ADL equipment and specialized computer access equipment so that MFP TCs can help participants control their environments, communicate their choices, accomplish personal care and make requests for information about resettlement through HCBS waivers
- How to obtain durable medical equipment so that residents who are transitioning will be trained, if appropriate, on the equipment before they leave the nursing home
- How to work effectively with Center for Independent Living counselors, peer support networks, case managers and transition coordinators to ensure effective transitions
- How to assist members with appropriate use of durable power of attorney and guardianship.

B.4 Stakeholder Involvement

This section describes the roles and responsibilities of consumers/participants, institutional, and other key stakeholders in the design, implementation, and evaluation of the Georgia MFP demonstration project.

Beginning in 2004 with the Nursing Home Transition Grant, the Department of Community Health (DCH) has been engaged in Long-term Care systems transformation with a broad coalition of Georgia stakeholders. Georgia has taken concrete steps to create new and sustainable public processes designed to involve stakeholders in HCBS waiver research, planning, implementation, and evaluation.

DCH received notice of MFP funding in May 2007 and re-convened its MFP steering committee on June 22, 2007. The steering committee, formed to prepare the Georgia MFP application *Call to Action*, decided to retain the broad coalition used to create the MFP application in an effort to use stakeholders' expertise and leverage resources outside DCH. To obtain broad stakeholder involvement in the development, implementation, and evaluation of the Georgia demonstration, a series of stakeholder forums were planned. In addition to the large and diverse steering committee, a purposeful sample of Home and Community Based Service (HCBS) waiver participants (participants/guardians, family members/caregivers) were recruited, from which systematic data could be collected and analyzed for input into system requirements for the MFP OP. Eight stakeholder forums were convened in five different regions of the state. During these stakeholder forums, participants were asked to engage in various types of activities (i.e. idea generation and consensus building) and focused discussions. As is the case with participation/action research methods, several steps were used to collect, analyze, synthesize and report on the results of stakeholder engagement.

The **purpose** of statewide stakeholder forums was to actively engage current HCBS waiver participants, institutionalized Georgians considering resettlement, family members, caregivers, professional advocates, and other key stakeholders in a public process designed to create, implement, evaluate, and improve the MFP demonstration. It is the **responsibility** of these stakeholders to provide input that can be used to produce an MFP Operational Protocol, MFP policies and procedures, operational (implementation) guidance and program evaluation guidance.

Stakeholder forums were conducted in the following manner:

Step 1: Targeted stakeholder outreach and recruitment was undertaken.
Step 2: Forum facilitators (MFP staff members) developed activity and discussion guides used to conduct stakeholder forums.
Step 3: Stakeholder forums were convened around the state.
Step 4: Stakeholder input and comments were collected and content analyzed.
Step 5: Reports were prepared and reviewed by stakeholders.
Step 6: System/customer requirements were generated.

Step 7: MFP Operational Protocol was prepared and reviewed by stakeholders.
Step 8: Stakeholders were asked to participate in work groups to develop MFP processes.
Step 9: MFP Policy & Procedures will be reviewed by work groups and revised based on stakeholder input.

Targeted Outreach and Recruiting

A purposeful sample of waiver customers/consumers (current waiver users and persons considering resettlement), family members, and caregivers were recruited to participate in customer/consumer forums. Targeted outreach and recruitment was undertaken with the assistance of Centers for Independent Living (CILs). CILs sent out a Letter of Invitation prepared by MFP staff members and made follow-up phone calls to interested waiver participants.

Five customer/consumer forums at Centers for Independent Living (CIL) and ADRC sites were convened. CILs and ADRCs were selected because they represent the five geographic regions of the state, are cross-disability in orientation, deliver core transition services, are knowledgeable about current HCBS waiver services, and create long-term relationships with waiver participants successfully resettled in their respective communities.

Fifty-five customers/consumers have participated in five customer/consumer forums. A post priori analysis of direct participation indicated that they were a mix of both female and male, somewhat cross-disability in orientation (most had various physical disabilities), but representative of all populations targeted by MFP: older adults, persons with physical disabilities and traumatic brain injury (PD/ABI), and persons with developmental disability or mental retardation. Eleven participants were waiting for a waiver slot or housing to resettle in the community. Participants were living in a number of different types of housing and were using several different waivers. A majority of participants were using the Independent Care Waiver Program (ICWP). Table B.4.1 summarizes the demographic information gathered during stakeholder forums.

Table B.4.1 Customer/Consumer Involvement/Demographics

Location & Date / Category	Disability Connections, Macon 11/16/07	disABILITY Link, Decatur 12/07/07	Walton Options, Augusta 01/11/08	LIFE, Savannah 01/18/08	BAIN, Bainbridge 01/25/08	Total
Gender						
Females	5	4	10	1	4	24
Males	5	9	6	6	5	31
Total	10	13	16	7	9	55
Primary Disability						
Elder	1	0	0	1	0	2
Blind	1	2	1	0	0	4
Physical Disability/ABI	6	9	13	5	7	40
Developmental Disability	2	1	2	1	1	7

Mental Health	0	1	0	0	1	2
Total	10	13	16	7	9	55
Living Situation						
Nursing Home	1	0	2	4	3	10
Assisted Living Facility	0	0	4	0	1	5
Personal Care Home	0	1	1	0	1	3
Apartment	5	4	2	2	4	17
House	4	6	7	1	0	18
Not disclosed	0	2	0	0	0	2
Total	10	13	16	7	9	55
Waiver Use						
Waiting (housing/slot)	1	0	0	4	6	11
SOURCE	3	2	0	0	0	5
CCSP	0	0	2	1	0	3
ICWP	4	8	9	2	0	23
MRWP	0	1	1	0	0	2
Not using a waiver	2	2	4	0	3	11
Total	10	13	16	7	9	55

Steering committee members participated in four steering committee forums prior to implementation. Steering Committee members represented a mix of consumers/advocates, professionals from various state agencies, service providers, vendors, and policy, planning, and compliance and evaluation professionals. Not every steering committee member participated in every work session, but analysis indicated that a mix of these professionals had participated in the four stakeholder forums. The total number of consumers/advocates in these four Steering Committee forums varied between 3 and 16 persons. Like professionals and providers, not every consumer/advocate participated in each forum work session, but analysis indicated that consumers/advocates represented 25% to 40% of all attendees at each of the four steering committee forums. Table B.4.2 summarizes the demographic information gathered during steering committee forums to date

Table B.4.2 Steering Committee Stakeholder Forum Demographics

Location & Date / Category	Atlanta, GA, Dept. of Community Health 06/22/07	Macon, GA Disability Connections 11/16/07	Decatur, GA County DFACS Office 12/18/07	Macon, GA Middle GA AAA 04/8/08
AAA/Gateway/ADRC	1	1	1	5
Consumer/Advocate/Ombudsman	3	18	12	10
Dept. of Community Health (DCH)	3	5	3	4
Dept. of Human Resources (MHDDAD/DAS)	4	8	2	6
Providers/Vendors	1	6	9	2
Housing-Dept. of Community Affairs/PHA/HUD	0	2	2	1
Compliance/Evaluation (GMCF)	0	1	1	0
Total	12	41	30	28

The MFP Steering Committee is composed of representatives from all stakeholder groups including:

- Georgia state agencies - the DCH Director of Long-term Care, MFP program staff and several HCBS waiver program managers, representatives from the Department of Human Services Division of Aging Services (DAS), and representatives from the Department of Behavioral Health and Developmental Disabilities (DBHDD);
- Partnering organizations such as Area Agencies on Aging, the Gateway Network, Aging and Disability Resource Connections (ADRCs), and the Georgia Council on Aging;
- Legal and professional disability advocates including the Georgia Council of Developmental Disabilities (GCDD), Georgia Legal Aid Society, Georgia Advocacy Office, People First of Georgia, the Association of Retarded Citizens of Georgia, Georgia Centers for Independent Living, the director of the Georgia Independent Living Network (GILN) and several ombudsmen from around the state;
- Vendors and service providers;
- Housing representatives from Atlanta Public Housing Authority, the Department of Community Affairs and Housing and Urban Development;
- State compliance and evaluation professionals.

Outreach to the Social Security Administration, the Georgia Department of Labor and Division of Vocational Rehabilitation is continuing in an effort to solicit participation from these groups. Finally, outreach to regional transportation planners is underway to involve these providers. For a complete listing, see *Appendix A: Georgia's MFP Stakeholders Listing by Company Name*.

Stakeholder Forums

Using the *MFP Operational Protocol Instruction Guide* supplied by the Centers for Medicare & Medicaid Services (CMS), MFP staff members and key informants prepared a *Workgroup Facilitator Guide* for use at each stakeholder forum. The activity and discussion guide was developed based on informational needs specified in the *MFP Operational Protocol Instruction Guide,* Sections A, B and C. The activities and discussion questions were used to generate qualitative comments about the 'current state' and the 'desired state' of HCBS waiver services, with particular focus on how MFP should be designed and operationalized.

Systematic Data Collection

At the beginning of each stakeholder forum, MFP staff members made a brief presentation about MFP, the integrated model for service delivery, project scope, and timelines. To leverage the knowledge of stakeholders at each forum, groups of more than 15 were sub-divided to encourage more participation. Facilitators (MFP staff members) moderated groups of 12 to 15 participants, using the *Workgroup Facilitator Guide*. Each stakeholder forum lasted approximately 3 hours.

Analysis, Reporting and Development of MFP

Facilitators worked together to analyze stakeholder input in a process referred to as content analysis. This involved sifting and sorting comments and preparing topical

summaries. Summaries were revised based on reviews with stakeholders. Using the summary reports, system requirements were generated for the MFP Operational Protocol. These requirements can be found throughout the sections of the MFP OP. System requirements became the basis for designing the MFP OP. The MFP OP was reviewed by steering committee members on April 8, 2008, at a forum in Macon, Georgia. The protocol was subsequently revised and represented the ideas and views of all stakeholders (customers/consumers/professionals/advocates) regarding the development and operation of the MFP demonstration.

Ongoing and Future Stakeholder Involvement

Ongoing stakeholder involvement has proceeded using similar methods. For example, consumers, advocates and professionals were formed into five work groups to discuss and develop MFP processes, staffing, and the roles and responsibilities of MFP Transition Coordinators. The MFP housing coalition work group has undertaken several initiatives to increase access to affordable, accessible, and integrated housing. MFP service codes, service limitations, and reimbursement rates were drafted by the Member Tracking and Fiscal Services work group.

The development of MFP Policies and Procedures proceeded using similar methods to actively engage steering committee members, waiver participants, family members, and caregivers. Work group sessions may continue to be conducted using a variety of methods, including conference calls and meetings, if major revisions to policies and procedures are needed.

Steering committee sessions will be open to the general public in an effort to maintain transparency. In addition to work groups, the MFP steering committee will meet on a regular basis, most likely quarterly, to review implementation and provide guidance on demonstration evaluation.

Through the four years of the demonstration, stakeholders will be asked to provide input using forums, work groups, surveys, interviews, observations, and trainings. During implementation, successfully resettled waiver participants, family members, and caregivers will be asked to provide encouragement and support, such as sharing experiences, to MFP members resettling in the community.

As needed, to insure full participation of stakeholders, meetings will be held throughout the state in accessible venues and transportation costs incurred by consumers will be reimbursed, if requested. These participatory methods strengthen MFP, empower full and direct consumer participation, and assist the state to identify areas of development and improvement. Openness, transparency and sustainability are the hallmarks of Georgia MFP. Methods that actively engaged stakeholders are necessary to produce the highest quality transition programs and services.

B.5 Benefits and Services

This section describes the current Home and Community Based Service (HCBS) waiver delivery systems in place for participants entering the MFP demonstration. MFP will use the Medicaid 1915c waiver services and MFP transition services to help people resettle in the community. Current HCBS waivers include the Elderly and Disabled waiver program, the Independent Care Waiver Program (ICWP) and the NOW and COMP Waivers. This section identifies procedures for service delivery for each population that will be served through the MFP demonstration and mechanisms in place to ensure that MFP participants remain eligible for Medicaid HCBS waivers after the 365 day demonstration period. Populations targeted include qualified Medicaid recipients who have resided in an institutional setting (i.e. nursing home, ICF/MR) for a period of at least six months and who have expressed interest in resettlement. Current HCBS waivers serve older adults, persons with physical disabilities, persons with traumatic brain injury, and persons with developmental disabilities or mental retardation.

MFP will assist with transitioning individuals receiving Medicaid funding in a nursing home or ICF/MR with a mental health diagnosis, if the candidate meets qualifications for Medicaid community based services. MFP participants transitioning out of nursing home or ICF/MRs will receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, state funded programs, and local community funded services. The state is not seeking enhanced match for State Plan services provided to MFP participants.

Additionally, as part of ongoing Olmstead efforts, the Department of Behavioral Health and Developmental Disabilities (DBHDD) tracks individuals in state hospitals who have been there for more than 60 days, and when they are considered clinically ready for discharge, they are placed on the Mental Health Planning List. DBHDD has confirmed its commitment to continue its transition efforts for individuals with Mental Illness with existing resources.

Person-Centered Planning and Individualized Transition Plans under MFP

Once MFP candidates have been identified, recruited, and have completed informed consent, MFP Transition Coordinators (TCs) complete the *MFP Transition Screening Form* (see *Appendix G*) during subsequent face-to-face discussion with each prospective participant and anyone the participant wants to include. TCs will use person-centered planning to identify preferences and goals to be included in the *Individualized Transition Plan* (ITP) (see *Appendix Q1 and Q2*). During the pre-transition period, TCs link MFP participants with community resources, including housing and transportation, and with Peer Support Services as appropriate. It is the TC's responsibility to assist the participant through person-centered planning. The participant should lead person-centered planning to the extent possible. The TC's role is to assist the participant to identify personal and community resources and to select MFP services that match needs and remove barriers. The TC will make the referral to an appropriate waiver, review functional independence, discuss needed

assistance with ADLs/IADLs, personal support services needs, accessibility needs and transportation needs. Participants will have the freedom to choose representatives to help them with the planning process (e.g. ombudsman, families, caregivers, or friends).

The results of person-centered planning are used to create the *Individualized Transition Plan* (ITP) and later are used in the participant's service plan. It is the TC's responsibility to refer the participant to the appropriate waiver and make contact with the appropriate waiver case management agency. It is the TC's responsibility to coordinate meetings and interviews between the participant and the waiver case manager and assessment team.

TCs provide, or arrange for, a wrap-around set of supports to prepare the MFP participant to transition and work with waiver case managers to ensure adequacy of services and supports and participant satisfaction. TC activities include responsibility for assembling and facilitating the transition team for each participant, coordinating the array of services and providers that will be needed on or shortly after the move to the community, and arranging the time-sensitive transition services that are needed in order for the participant to resettle, including everything from internal administration of HCBS assessments, to supporting the participant in identifying a personal support network. Self-direction is the cornerstone of the transition model.

HCBS waiver assessments are conducted as outlined in 1915c documents. Each HCBS waiver uses a different assessment tool to determine waiver eligibility and to plan for services and supports. TCs will use the MFP Screening Tool to gather information about participants' goals, service needs, and information for discussion with the appropriate waiver case manager. Along with waiver assessment information, information from the MFP screening will be used to develop the waiver service plan.

The Long-Term Care Ombudsman program currently serves only persons in long-term care institutions. Under MFP, ombudsmen will participate in transition planning while the participant remains in the long-term care facility, if requested. The LTCO post-transition services will be offered to all MFP participants in the Elderly and Disabled and ICWP Waiver programs, with the exception of those transitioning into a licensed group setting (ombudsmen make regularly scheduled visits to these locations). If this MFP service is selected, the ombudsmen will make periodic contact with participants to review the quality of services, monitor satisfaction, ensure safety and participant choice, and protect participant rights.

The Fiscal Intermediary (FI) - Community Transition Financial Services listed as a demonstration service will provide financial service for payments for the MFP demonstration and supplemental services offered to members enrolled in the demonstration project at a fee of 18 percent of total demonstration and supplemental services used, as listed in the individualized transition plan for services per member. The TCs will authorize and track all MFP demonstration and supplemental services for members and coordinate with the FI and DCH. The TCs

and DCH will maintain documentation using a manual tracking database (see *Appendix Z: MFP Manual Tracking Database Screens*) and ensure accountability for utilization of MFP demonstration and supplemental services (for more detail, see *Appendix S: Authorization for MFP Services, Appendix T: Quote Form for Equipment & Supplies, Environmental Modifications and/or Vehicle Adaptations, Appendix U: MFP Vendor Payment Request to TC, Appendix V: MFP DCH DHR Vendor Import File, Appendix X: Request for Additional MFP Services* and *Appendix Y: MFP Participant Enrollment Status Change Form*).

Home and Community Based Services for Older Adults

It is the TC's responsibility, after completing the MFP Screening Form, to refer the participant to the appropriate waiver through the Area Agency on Aging (AAA) Gateway network. Gateway staff will perform the screening and refer to the case management agency to have the initial assessment completed (for process detail, see *Appendix I: MFP Process Flowcharts and Text Descriptions*). The Gateway network is already established statewide and offers an extensive database of information about services for the elderly and persons with all types of disabilities.

The Elderly and Disabled Waiver program operates under a CMS home and community-based waiver (1915c). The program assists individuals who are Aged, Blind, or Disabled, and/or functionally impaired, to continue to live in their own homes and communities as an alternative to nursing facility placement. Individuals served by the programs are required to meet the same level of care for admission to a nursing facility and be Medicaid eligible or potentially Medicaid eligible and in some cases, receiving Supplemental Security Income (SSI).

Goals: The Elderly and Disabled Waiver program is a consumer-oriented program with the following goals:

- To provide quality services, consistent with the needs of participants, that are effective in improving/maintaining the member's independence and safety in the community as long as possible
- To provide cost-effective services
- To involve the member, family members, caregivers and/or guardians in the provision and decision making process regarding member care
- To demonstrate compassion for those served by treating them with dignity and respect through providing quality services.

Objectives: Elderly and Disabled waiver objectives are to: promote independence through self-directed services; to enhance quality and improve health services and outcomes through the efforts of the Quality Management Strategy Workgroup; and to continue to provide programs and services that will assist individuals to reside in their home and community as an alternative to nursing home placement.

Organizational Structure: The Department of Community Health Medicaid Division oversees the performance of the waiver and is responsible for provider enrollment, reimbursement, and utilization review. The Department of Human Services Division of Aging Services is responsible for the day-to-day operation of

the waiver program. The Area Agency on Aging (AAA) serves as the point of contact for members, service providers, and representatives. The DHS Division of Family and Children Services determines Medicaid eligibility and member cost share (if any) for potentially Medicaid eligible members.

Service Delivery Method: The waiver program offers a variety of services as an alternative to institutional care as indicated on the Table that follows. A system of coordinated community care and support services are implemented to assist functionally impaired individuals to live in their own homes or with their families. As a way to promote independence and freedom of choice, there is a self-directed service which is available for members who are eligible or members may opt for traditional service delivery.

Services to Be Offered to Older Adults

Older adults will receive the full range of the qualified HCBS services included in the waiver in which they are enrolled and the MFP demonstration and supplemental services as indicated in the Table below for 365 days. See *Appendix B: MFP Demonstration and Supplemental Services Table* for a delineation of reimbursement rates and service limitations.

Home and Community Based Services for Persons with Physical Disabilities/ABI

Participants with physical disabilities or traumatic brain injuries (ABI) will be assisted in transitioning by TCs. It is the TC's responsibility after completing the MFP Screening Form to contact Georgia Medical Care Foundation (GMCF) to conduct the waiver assessment. Once the member has been approved for Independent Care Waiver Program (ICWP) Services, the member is responsible for selecting an approved ICWP case manager.

Up to the level of reserved capacity, there is no waiting list for MFP participants enrolled in the ICWP waiver program. When reserved capacity is exceeded, MFP uses a 'first-come-first-served' approach to service delivery. The date of the initial MFP screening will be used to prioritize the MFP waiting list. The ICWP waiver will be amended to have reserved capacity of 100 slots per year for persons transitioning from long-term care facilities to the community through Money Follows the Person. The state will request budget increases for the additional slots needed for reserved capacity for ICWP through 2011. With regard to waiver waiting lists, the state will amend the MFP Operational Protocol to reflect the Olmstead agreement, once the agreement has been signed by the state.

The ICWP program offers services to eligible Medicaid recipients who are severely physically disabled or with traumatic brain injury, between the ages of 21 and 64, and meet one of the following criteria:

a. Are medically stable enough to leave the hospital, but cannot do so without the support services available through this program.

b. Will be admitted to a hospital on a long-term basis without the support services available through this program.
c. Are at immediate risk of nursing facility placement.

The services offered through ICWP are a supplement to the care that can be provided to individuals by their family and friends in the community.

Goals: The Independent Care Waiver (ICWP) program is a consumer-oriented program with the following goals:

- To provide quality services, consistent with the needs of persons with severe physical disabilities and/or ABI, that are effective in improving/maintaining participant independence and safety in the community as long as possible.
- To provide cost effective services.
- To involve participants, family members, caregivers and/or guardians in the provision and decision making process regarding services, care, safety and health.
- To coordinate the enrollment of a specified number of participants who are in a nursing home and are assessed and meet the eligibility criteria of the waiver and have expressed a desire to reside in the community.
- To provide the option to self-direct personal support services to participants and/or their guardian who express a desire to self-direct a portion of their services and are identified as having the ability to do so.

Organizational Structure: The Department of Community Health Medicaid Division is responsible for the administration and operation of the waiver. DCH is responsible for the development of all program policies and procedures and assuring that they are written in accordance with all federal regulations that govern the waiver.

The Department contracts with GMCF to conduct the assessments of all waiver applicants to determine if they meet the criteria for ICWP waiver services. GMCF is also responsible for the evaluations and re-evaluations of all ICWP members.

Service Delivery Method: The waiver program offers a variety of services as an alternative to institutional care. In addition to the core services, ICWP covers specialized medical equipment and supplies, counseling, and home modification. ICWP does not pay for room and board. The applicant, the case manager, and the applicant's family and/or friends work together as a planning team to establish a service plans. The plan describes the applicant's present circumstances, strengths, needs, the services required, a listing of the providers selected, and a projected budget.

Services to Be Offered to Persons with Physical Disabilities/ABI

Persons with Physical disabilities/ABI will receive the full range of the qualified HCBS services included in the waiver in which they are enrolled and the MFP demonstration and supplemental services as indicated in the Table below for 365

days. See *Appendix B: MFP Demonstration and Supplemental Services Table* for a delineation of reimbursement rates and service limitations.

Home and Community Based Services for Persons with Developmental Disabilities

Two HCBS waivers for persons with MR/DD provide for the inclusion of supports needed beyond the transition process – the New Options Waiver (NOW) and the Comprehensive (COMP) waiver. Individualized supports will be identified through the person-centered planning process and included in budget and purchase planning.

Transition Coordinators/Case Expediters (TC/CEs) will assist and oversee elements of the transition process. The Department of Behavioral Health and Developmental Disabilities (DBHDD) actively assists individuals to transition from ICF/MRs or State Operated Hospitals into the community. MFP will support the DBHDD transition process. The program has reserved capacity of 150 slots per year for persons that transition from ICF/MRs to the community through the Money Follows the Person Demonstration Grant. The state will request budget increases for the additional slots needed for reserved capacity in the NOW and COMP waivers through 2011.

TC/CEs are responsible for assisting in the screening of eligible individuals. A person-centered team planning process is used to identify an individual's preferences, strengths, capacities, needs and desire to transition into the community. Others within the team could include persons who are closest to the individual (e.g. family members, friends and hospital staff).

The MR/DD service structure has Regional Transition staff. Since 1993, a regional structure has been in place to provide access to long-term care for consumers with developmental disabilities. Five regional offices plan for, manage, and monitor all direct services delivered in that region. These offices are the central point for case expediting, intake and evaluation, and facilitation of support coordination. Regional transition staff (state employees) includes:

Case Expediters in each regional office are charged with actively assisting consumers toward community placement with appropriate supports.

- Intake and Evaluation- Conducts face-to-face initial screening to determine service need and preliminary eligibility (screening provides presumed eligibility or ineligibility; a comprehensive evaluation is intended to confirm eligibility status) of the individual for MR/DD services. The screener completes an *Intake Screening Summary*, which documents the individual and family circumstances related to the need for services, the services actually needed, and the timeframe in which the services are needed.
- Planning List Administrators or I & E Managers are responsible for managing the MR/DD Transition List. This list identifies individuals that are receiving assistance to transition from ICF/MRs into the community.

- Support Coordination- The system of support coordination (case management) is the state's mechanism for ensuring that recipients of services are provided access to the information and services they need on an ongoing basis. This system customizes services by identifying appropriate paid, community, and natural supports, maintaining the health and safety of the consumers being transitioned, and developing appropriate goals and objectives to increase level of independence.

Participants who transition from ICF/MRs will also have access to services through Aging and Disability Resource Centers (ADRCs) which provide another avenue to access information and services and is closely linked to DD regional case expediters.

The NOW and COMP waivers will make available a wide range of quality of care and quality of life services that are sufficiently flexible to allow customization based on personal needs and preferences. These include traditional agency directed services as well as innovative, self-directed services.

These programs are separate home and community-based waivers for people with developmental disabilities such as autism, cerebral palsy, or epilepsy that require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Both the NOW and COMP waivers offer personal choice and control over the delivery of waiver services by affording opportunities for many of the services to be available for self-direction.

Both waiver programs will offer services and support that enable individuals to remain living in their own or family home and participate in community life. However, it is anticipated that the majority of individuals that transition from ICF/MRs will be enrolled in the COMP program, which offers comprehensive and extensive waiver services to enable individuals with urgent and intense needs to avoid institutional placement. Both waivers offer individualized budgeting, enhanced flexibility in service delivery, and increased opportunities for self-direction and community connections.

Services to Be Offered to Persons with Developmental Disabilities

Persons with MR/DD will receive the full range of the qualified HCBS services included in the waiver in which they are enrolled. All will also be offered MFP Demonstration and Supplemental Services as indicated in the Table below. See *Appendix B: MFP Demonstration and Supplemental Services Table* for a delineation of reimbursement rates and service limitations.

Transitioned participants will receive HCBS waiver services as long as they meet waiver criteria. Participants will receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federal funded services, state funded programs, and local community support system funded services. See Table B.5.1 for summary of these services. The state is not seeking enhanced match for State Plan services provided to MFP participants.

Table B.5.1 Benefits and Services for MFP Participants by Waiver

Elderly/Disabled Waivers (CCSP/SOURCE)	*Independent Care Waiver Program (ICWP)*	*New Options Waiver Program (NOW)*	*Comprehensive Waiver Program (COMP)*
➢ Adult Day Health	➢ Adult Day Care	➢ Adult Occupational Therapy Svs	➢ Adult Occupational Therapy Svs
➢ Alternative Living Services	➢ Behavior Management	➢ Adult Physical Therapy Services	➢ Adult Physical Therapy Services
➢ Emergency Response Services	➢ Case Management	➢ Adult Speech and Language Therapy Services	➢ Adult Speech and Language Therapy Services
➢ Enhanced Case Management	➢ Consumer-Directed PSS	➢ Behavioral Supports Consultation	➢ Behavioral Supports Consultation
➢ Financial Management Services	➢ Counseling	➢ Community Access	➢ Community Access
➢ Home Delivered Meals	➢ Enhanced Case Management	➢ Community Guide	➢ Community Guide
➢ Home Delivered Services	➢ Environment Modification	➢ Community Living Support	➢ Community Living Support
➢ Out-of-Home Respite	➢ Fiscal Intermediary	➢ Environmental Access Adaptation	➢ Community Residential Alternative
➢ Personal Support Services (PSS)/(PSSX)/ Consumer Directed	➢ Personal Emergency Monitoring	➢ Financial Support Services	➢ Environmental Access Adaptation
➢ Skilled Nursing Services	➢ Personal Emergency Response	➢ Individual Directed Goods and Svs	➢ Financial Support Services
	➢ Personal Emergency Response Installation	➢ Natural Support Training	➢ Prevocational Services
	➢ Personal Support Services	➢ Prevocational Services	➢ Specialized Medical Equipment
	➢ Respite Services	➢ Respite Services	➢ Specialized Medical Supplies
	➢ Skilled Nursing	➢ Specialized Medical Equipment	➢ Support Coordination
	➢ Specialized Medical Equipment and Supplies	➢ Specialized Medical Supplies	➢ Supported Employment
	➢ Vehicle Adaptation	➢ Support Coordination	➢ Transportation
		➢ Supported Employment	➢ Vehicle Adaptation
		➢ Transportation	
		➢ Vehicle Adaptation	
Other Non-Medicaid Services			
➢ Adult Protective Services	➢ Adult Protective Services	➢ Adult Protective Services	➢ Adult Protective Services
➢ Caregiver Supports	➢ Social Services Block Grant Svs	➢ State Funded Services	➢ State Funded Services
➢ Older Americans Act Services	➢ State Funded Services		
➢ Social Services Block Grant Svs			
➢ State Funded Services			

B.6. Consumer Supports

The following section identifies the organizations (state, regional and local agencies, contracted agencies, etc.) that provide pre-transition and transition services (including case management) to MFP participants under each HCBS waiver for three specific Medicaid eligible targeted populations (older adults, persons with developmental disabilities, persons with physical disabilities and/or acquired brain injury). It describes the work and qualifications of MFP Transition Coordinators (TCs) and how they collaborate with waiver case managers.

In addition, this section describes the roles and responsibilities of the state, local, and contract agencies for providing 24/7 emergency back-up to MFP participants for all services available, including: direct service workers, transportation, equipment repair/replacement and other critical health or supportive services.

As indicated above, Georgia's Money Follows the Person program is a statewide demonstration project, focused on three specific Medicaid eligible populations who are currently residing in an institutional setting for a minimum of six months. The MFP demonstration will build upon and supplement the state's current Olmstead Initiative that assists persons to transition from facilities back to the community by linking them to existing waivers.

Description of Two MFP Contracts and an Interagency Agreement

Contract #1--Initially, the state had a contract in place with a private vendor to do assessments and assist with referrals to HCBS waivers. In order to operationalize the MFP program by the start date of September 1, 2008, this contact was expanded to meet the roll-out requirements of MFP.

Contract #2--Because the expanded functions of the Transition Coordinators will greatly increase the scope of the current private vendor contract, the state will submit a request for proposals (RFP) for a contractor to perform the duties and responsibilities of Transition Coordinators for Elderly and Disabled and ICWP waiver participants served by the demonstration project. The RFP for this contract was released in July 2009. This new contract will require the contractor to hire qualified Transition Coordinators to perform that function for older adults and persons with physical disabilities.

Interagency Agreement--For MR/DD populations transitioning into the NOW and COMP waivers, the current Interagency Agreement with the Department of Behavioral Health and Developmental Disabilities (DBHDD) was expanded to support the current efforts to transition individuals with MR/DD through MFP. DBHDD already performs Transition Coordinator functions in ICF/MRs statewide; their current efforts will be supplemented with funding from MFP to enable the state to transition MFP participants into the NOW and CHSS/NOW waivers.

To develop and manage this process, DCH will do the following:

- oversee execution of the RFP process for TCs for the Elderly and Disabled and ICWP applicants,
- provide the operational policies and procedures for transition coordination for all applicants,
- conduct programmatic reviews, monitoring, quality assurance and quality improvement for the transition coordination efforts,
- pay all invoices submitted after review and approval of the deliverables,
- provide on-going guidance and project coordination within DCH and with the Department of Human Services and the Department of Behavioral Health and Developmental Disabilities,
- identify appropriate information, resources and technical assistance necessary for the contractors to complete assigned tasks, and
- conduct financial and programmatic audits.

Under the two contracts (private vendor contract and DBHDD Interagency Agreement), contractor responsibilities include:

- hiring a team of qualified transition coordinators (TCs),
- offering statewide transition services to persons with mental retardation and/or developmental disabilities who wish to transition to the NOW and COMP waivers,
- offering statewide transition services to MFP participants who wish to transition to the ICWP waiver or the Elderly and Disabled Waiver,
- ensuring that TCs have specialized knowledge in the following areas:
    - Working with older adults and people with physical disabilities and acquired brain injury (ABI), and developmental disabilities
    - Eligibility for Money Follows the Person and Georgia's waiver programs,
    - Americans with Disabilities Act determinations and implications for practice,
    - Health care and long-term care,
    - Home and Community Based waiver options,
    - Independent living and required adaptation,
    - Community and regional resources,
    - Person centered planning and individual care planning,
    - Power-of-attorney/guardianship and informed consent,
    - Durable medical equipment and assistive technology, and
    - Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information

The contractors and TCs will be required to attend trainings with the Home and Community Based (HCBS) waiver case managers, DHS Division of Aging Services (DAS), DBHDD Division of Developmental Disabilities, Area Agencies on Aging (AAA), Aging and Disability Resource Connections (ADRCs), and the Georgia Independent Living Network (GILN).

MFP Transition Coordinator Qualifications

The most important qualification for MFP Transition Coordinators is a desire to assist elders and persons with various disabilities to resettle in the community and

understand the barriers these individuals encounter in resettlement. Work experience with at least one of the populations served under the MFP Demonstration is strongly preferred.

The ideal qualifications for an MFP TC working with older adults includes experience working in various community-based agencies, including Senior Centers, the AAA/Gateway network including Aging and Disability Resource Centers (ADRCs), SOURCE network, Georgia Council on Aging, and/or experience providing community services to elders. Knowledge of the barriers to resettlement and knowledge of senior housing options is preferred. Knowledge of waiver services offered under the Elderly and Disabled Waiver is preferred.

The most important qualification for MFP TCs serving persons with physical disabilities and/or Traumatic Brain Injury is a desire to assist these persons to resettle in the community and an understanding of the barriers to resettlement. Experience working with persons with physical disabilities and/or ABI in a non-institutional or community-based setting is preferred. Experience providing community services to persons with physical disabilities/ABI is preferred. Knowledge of physical disability and ABI is preferred. Working experience in a Center for Independent Living, ADRC, Georgia Medical Care Foundation (the assessment entity for the ICWP waiver), the Brain and Spinal Injury Trust Fund Commission, or regional and local service provider networks or experience providing community-based waiver services is preferred. Knowledge of housing options or experience providing housing services for persons with physical disabilities and/or ABI is highly preferred. Knowledge of services offered under the Independent Care Waiver Program (ICWP) is preferred.

The most important qualification for MFP TCs serving persons with developmental disabilities is a desire to assist these individuals to resettle in the community and an understanding of the barriers to resettlement. Work experience in the MR/DD system is preferred. Under the agreement with DBHDD, MFP TCs work as Regional Community Transition Coordinators/Case Expediters. Case Expediters in each regional office are charged with actively recruiting and assisting participants toward community placement with appropriate supports. MFP TCs/CEs coordinate their efforts with DBHDD, the state's DD Council, the Association of Retarded Citizens, and regional and local MR/DD service provider networks. Experience providing community services to persons with MR/DD is preferred. Knowledge of housing options or experience providing housing services for persons with MR/DD is preferred. Knowledge of services offered under the NOW and COMP waivers is preferred. A qualified Mental Retardation Professional is preferred.

Collaboration between Transition Coordinators and Waiver Case Managers

After completing the MFP Screening with the participant, TCs play an important role in the transition process and in building a collaborative relationship with waiver case managers (CMs). TCs collaborate with CMs to ensure a smooth transition to waiver services. To develop early partnerships, TC's and CM's geographic service areas will be matched as closely as possible. After recruitment and initial screening, TCs will make appropriate referrals to waiver CMs for assessments. Prior to the CM

conducting the waiver assessment, TCs will screen MFP participants and provide waiver CMs with baseline information about the participant, including goals, disability diagnosis, functional abilities, cognitive/language function, needed personal support services, family/support network, equipment, housing, and transportation needs.

CMs conduct the assessments for waiver services. Beyond completing the assessment, CMs play a 'behind the scenes' role during the pre-transition period, assisting TCs with information and collaborating on the development of plans for pre and post-transition services. CMs assist TCs to plan for and establish risk management systems, including 24/7 emergency backup systems. TCs follow-up with MFP participants at 30 days to ensure that service plans have been implemented.

Training of TCs and CMs is critical. TCs and CMs will be training together and trained to work collaboratively using team approaches when possible. Both TCs and CM need specialized knowledge in waiver services/options, transition, self-direction, following service budgets, procurement of specialized medical equipment and assistive technology devices, arranging for peer supports, locating housing and transportation, and obtaining other community resources.

24/7 Emergency Backup

Georgia's MFP emergency backup system will serve participants though the existing HCBS waivers. As described in each 1915c waiver application, emergency backup systems are unique to each waiver, but include common elements. What follows is an abbreviated description of how 24/7 emergency backup plans are developed in service plans and how participants use them.

24/7 Emergency Backup for Older Adults and Persons with Physical Disabilities and/or ABI

Under the Elderly and Disabled Waiver Program the Georgia Department of Human Services (DHS) Division of Aging Services (DAS), the Department of Community Health, and waiver case managers share the responsibility for overseeing the reporting of and response to the need for emergency back-up. Likewise, under the NOW and COMP waivers, emergency back-up systems are a shared responsibility of DCH, DBHDD, and waiver case managers. Under the Independent Care Waiver Program (ICWP), the Georgia Department of Community Health and case managers are responsible for overseeing the reporting of and response to emergency back-up needs.

In all waivers, information from the initial assessment and reassessments is used to identify risks to waiver participant health and safety. Each identified risk is included in the service plan with individualized contingency plans for emergency back-up.

Each participant is provided with 24/7 emergency phone contacts for the waiver case manager and for service providers. Vendors/agencies are required to provide 24/7 backup for direct care staff and to instruct direct care staff on participant

needs and preferences. Participants using self-directed options must identify at least two individuals (i.e. friends, family members, etc) in their emergency plans to assist them in the event that provider staff doesn't show up. The service plan includes plans for equipment failures, transportation failures, natural disasters, power outages, and interruptions in routine care. For providers agencies, 24/7 on-call backup is mandated. In addition, some participants receive an Emergency Response Services (ERS) system. The ERS system monitors the participant's safety and provides access to 24/7 emergency intervention for a medical or environmental crisis. The ERS is connected to the participant's telephone and programmed to signal a response once activated form a device that is worn or attached to the participant. ERS home units are programmed to dial a toll-free number to access a central monitoring station. Monthly testing of the ERS is undertaken by ERS providers and a battery backup is provided.

Case management agencies document all emergencies. Case managers triage each incident and request additional emergency response, if needed. When there is an immediate threat to the health, safety, and/or welfare of the waiver participant, case managers may immediately (within 24 hours) relocate the member to another setting. As with critical incidents, use of the 24/7 emergency backup system is reported to waiver program manager in the appropriate waiver operating agency. The waiver program managers will forward these monthly reports to the MFP Project Director. Additionally for MFP participants, MFP TCs must complete the *MFP Sentinel Event Report* (see *Appendix* AB) for each event and forward the completed document to the MFP Project Director who will investigate the event and take appropriate corrective action.

24/7 Emergency Backup Persons with Developmental disabilities

Under the NOW and COMP waivers, DBHDD uses a standardized process for reporting and response to the need for emergency back-up. Service plans identify risks using assessment reports from the Health Risk Screening Tool (HRST). Action plans for each identified risk are prepared, with efforts to minimize risks and identify if supports interfere with what is most important to the participant. Service plans detail the provider agency's backup plans for staff coverage and capacity to provide additional staff on an intermittent basis. Service plans cover equipment and transportation failures and emergency backup plans for self-directed options. In these instances, the service plan also specifies an individual backup plan to address contingencies such as emergencies occurring when a support worker's failure to appear when scheduled presents a risk to the participant's health and welfare. The service plan of any waiver participant who participant-directs must include an assessment of risk and specify an individualized risk management plan. The case manager ensures that the service plan meets all requirements for waiver participants who opt for self-direction. Participants, family members of participants and/or guardians, or any other persons may initiate reports of critical incidents to case managers, providers and/or the DBHDD Investigation Section.

Quality Improvements to Emergency Backup Systems

Currently, all Area Agencies on Aging maintain toll-free numbers for access to emergency back-up services for aging persons and persons with disabilities.

Statewide hotlines for emergency assistance for MR waiver participants are already in place, offering help to waiver participants in crisis, just as 9-1-1 offers emergency assistance above and beyond the participant's individualized emergency backup plan. The state of Georgia has a single toll-free phone number to connect to local services for mental health, developmental disabilities, and addictive diseases. The Georgia Crisis & Access Line (GCAL), 1-800-715-4225, is funded by DBHDD. The website, www.mygcal.com, offers users a list of providers and services. In the past, there have been numerous numbers throughout the state, which caused a considerable amount of confusion. Now, MFP participants will only need to know one number: 1-800-715-4225. GCAL is managed and operated by Behavioral Health Link (BHL), an Atlanta-based health and crisis call center. DBHDD and BHL have worked diligently to increase statewide awareness of GCAL, and MFP participants will benefit from this statewide service (see *Section B.8 Quality* for more details).

B.7 Self-Direction or Participant Direction

This section describes the self-direction support systems in place for MFP participants entering current HCBS waivers under the Georgia Demonstration, including the Elderly and Disabled Waiver Program, the Independent Care Waiver Program (ICWP) and the NOW and COMP Waiver Programs. Each waiver provides participants with opportunities and supports for self-direction. This section begins with a description of MFP pre-transition services, participant-centered service plan development, service plan implementation and monitoring, and self-direction approaches, goals, and decision-making authority. This section includes a description of procedures for voluntary and involuntary switches from self-direction and describes the agencies responsible for participant counseling. This section concludes with recommendations for improvement to self-direction using the Georgia MFP demonstration, based on comments received from statewide forums with stakeholders.

Self-Direction for Older Adults and Persons with Physical Disabilities/ABI

Participants, family members and caregivers receive their initial information about self-direction options during initial screening conducted by Transition Coordinators (TCs). TCs complete the *MFP Transition Screening Form* (see *Appendix G*) that guides them through referral to an appropriate waiver, assessment of resources, assistance needed with ADLs/IADLs, personal support services needs, housing needs, accessibility needs, and transportation needs. The *MFP Transition Screening Form* also gathers information about the participant's health, therapies, specialized medical equipment and assistive technology needs, and community resettlement needs for basic household goods and furnishings (see *Appendix G*). The *MFP Transition Screening Form* information is used to make an appropriate referral to a HCBS waiver. TCs refer participants to appropriate waivers and make contact with waiver case managers, advising them of the member's desire to self-direct care. TCs coordinate meetings and interviews between the participant and the waiver case management agency and the waiver assessment team. Waiver assessments are conducted by waiver case managers as outlined in each of the state's 1915c approved waivers.

TCs use person-centered planning to identify preferences and goals for inclusion in the participant's *Individualized Transition Plan (ITP)* (see *Appendix Q1 and Q2*) including the participant's desire to self-direct their care.

The Elderly and Disabled waiver and ICWP waiver provide for employer authority and budget authority over PSS. Once enrolled in a waiver, the participant may select and interview PSS providers, choose qualified provider(s) and/or become the employer of record, and select a Financial Management Service (FMS). The participant then hires, trains, schedules, manages, and discharges PSS staff. The options are similar for participants entering the NOW and COMP waivers. These waivers provide participants with employer authority, including a co-employer option, and budget authority, to select and manage nearly all waiver services.

Under the Elderly and Disabled and ICWP waivers, participants can choose self-direction, but only for personal support services. The self-directed budget is the waiver allocation assessed by need and reduced by Financial Management Services (FMS) and other selected services. The waiver participant or his/her family/guardian is informed by the case manager that the self-directed budget includes the funds needed for Financial Management Services (FMS) and that the monthly FMS rate is protected and not subject to self-direction. The case manager assists the waiver participant or family/guardian with the development of the self-directed budget.

If an ICWP waiver member decides to transition into the Consumer Directed Care (CDC) option, the assessment agency, Georgia Medical Care Foundation (GMCF) submits the Prior Authorization budget for personal support services (PSS) hours to the fiscal intermediary (FI) and to the case manager. If the member opts to enter into the traditional agency provided services, GMCF submits the PA to the case manager only.

The service plans of waiver participants/guardians who opt for self-direction and become the employer of record must specify support worker qualifications required to meet the needs of the waiver participant. In these instances, the service plan also specifies an individual backup plan to address contingencies such as emergencies occurring when a support worker's failure to appear when scheduled presents a risk to the participant's health and welfare. The service plan of any waiver participant who self-directs must include an assessment of risk and specify an individualized risk management plan. The case manager ensures the service plan meets all requirements for waiver participants who opt for self-direction.

Self-Direction for Persons with Developmental Disabilities

Under NOW and COMP, the process is similar. For waiver participants opting for self-direction, the support coordinator reviews the roles and responsibilities of the participant and/or his or her family/representative. Participants can choose the co-employer option and/or budget authority to manage approved services.

Under all waivers, the case managers educate, mentor and coach participants in employer tasks and management of self-directed service budgets. Participants can select a Financial Management Service (FMS). The FMS trains participants/guardians, provides technical support, provides payroll, accounting, budget assistance, twice monthly statements and handles worker tax/insurance deductions. FMS provide background checks for potential PSS direct service workers.

Procedures for Voluntary and Involuntary Switches from Self-Direction

Participants may voluntarily choose to return to the traditional agency directed services if they determine that they lack the interest or ability to self-direct their services. To assure that they return to the traditional waiver services while maintaining continuity of care, communication with the case manager (CM) is critical. The CM will educate the participant on giving adequate notice to their

worker(s). This will provide the CM time needed to follow standard procedures to switch the option. When voluntary switches occur, the participant and/or guardian contacts the case manager, who brokers services with a waiver enrolled provider agency selected by the participant, updates the service plan, and removes the enrollment in the Financial Management Service on the PA and service plan. The CM assures and monitors the health and welfare of the participant during the transition.

In the Elderly and Disabled and ICWP waivers, the participant may be involuntarily switched from self-direction to provider-managed services for any of (but not limited to) the following reasons: 1) failure to meet responsibilities and/or identified health and safety issues for participant, 2) failure to maintain maximum control over daily schedule, 3) inability to complete accurately and timely all FMS documents, to manage budget—leading to over use of PSS budget for 2 consecutive months, 4) use of state backup plan one or more times per month for 2 consecutive months, 5) not meeting the goals of the Service Plan for 2 consecutive quarters. The case manager plans and implements return to traditional services, reports health, safety, fraud, or abuse concerns to appropriate state agencies.

When removal from the self-directed option occurs, the participant will return to the traditional agency directed option without loss, reduction or interruption of services. A switch from self-directed services does not terminate the participant from the waiver program. The case manager maintains communication with the participant to ensure a smooth transition from one service option to the other and educates the participant (or guardian) on how to give adequate notice to the employees. This provides the case manager with time needed to follow standard procedures to switch the self-directed option, broker services with a waiver enrolled provider agency, remove the FMS services, and update the participant's service plan to reflect the change. The case manager notifies the financial management service provider of the change. There is no appeal process if, based on stated eligibility criteria, the case manager terminates the participation in self-directed services and returns the participant to the traditional agency-directed option. However, participants can always appeal any reduction in services or any termination of services. Providing initial enrollment criteria are met, after one year from the date of the re-entry into the traditional option, participants may be eligible to re-enter the self-directed services option.

Education on Self-Direction

MFP participants will be provided with current information available to waiver participants through their case manager as indicated in 1915c waivers. Participants are provided with educational materials for the development of services budgets, training on household expenses and budgets, understanding differences between wants and needs, financial literature about the use of fiscal intermediaries, literature about the requirements for service budgets, billing procedures, time sheets and documentation of services, and equipment (i.e. a fax machine) to assist in management tasks. Participants entering the Elderly and Disabled and ICWP waivers receive the *Consumer-Directed Option Employer Manual*. Participants entering the NOW and COMP waivers will receive the *Handbook on Participant Direction.*

Financial Management Agencies under Contract with the State

There is currently one financial management agency enrolled with the Georgia Medicaid Program. However, any willing and capable provider is eligible to enroll at any time. Stakeholder feedback indicates that there may be other providers interested in enrolling in this service.

System for Monitoring and Documenting the Number of MFP Participants Choosing Self-Direction

MFP will obtain this information using MMIS data reports and from case management organizations that report data to the state about self-directed care.

Opportunities for Quality Improvements to Self-Direction

During state-wide stakeholder forums, steering committee members and waiver participants reported that:

- More education and training about self-direction is needed. Nursing home and institutional residents wanted information about self-direction that was accurate and easy to understand. Often consumers were not aware of their rights to self/consumer/participant-direct.

To address stakeholders concerns, MFP will work with waiver staff to ensure that accurate and 'user-friendly' information about self-direction is created and provided during recruiting, screenings and assessments/re-assessments. Reviews and updates to existing self-directed materials will be undertaken, including revisions to the *Consumer-Directed Option Employer Manual*. In addition, MFP will work with waiver program managers, Georgia MFP partners, and steering committee members to ensure that Transition Coordinators are trained and that outreach and state-wide training is conducted on an on-going basis for participants, their guardians, professionals, and providers.

- Additional options for self-direction are desired under the ICWP and Elderly and Disabled waivers.

To that end, MFP will work with waiver program managers, steering committee members and external stakeholders to create the systems and infrastructure needed to support the move to Independence Plus designation for the Elderly and Disabled waiver and ICWP during application renewal.

- There is concern about the limited number of Financial Management Services providers.

As indicated previously, MFP staff will work with waiver staff to research the availability of additional FMS providers in other states and encourage them to enroll in Georgia as well.

- There is a need to increase the availability and visibility of qualified persons to render services for persons who wish to self/consumer/participant-direct.

In an effort to address these issues, MFP staff will work with and assist the waiver specialists to expand efforts to increase the availability of providers through certification of direct support professionals and Certified Medication Aides in all waivers, as has been done with MR programs. The DBHDD, the Governor's Council of Developmental Disabilities, and the Department of Adult and Technical Education launched a direct support professional certificate training program at four state technical colleges.

This very successful program has continued to expand with new classes at additional colleges being added each quarter. Reaction to the certification program has been extremely positive from participants (Direct Support Professionals) and their employers. The Office of Developmental Disabilities has identified desired outcomes for the Direct Support Professional Certification Program, specifying indicators and developing data collection procedures used in the measurement of these outcomes. Results are used by DBHDD and other stakeholders in decision making regarding future funding, expansion, and incentives for the certificate program.

Statewide trainings and individual provider technical assistance on medication administration (including documentation) have been presented by Division of DD and Office of Provider Certification staff. Representatives from the Division and other experts in the field are working with the Georgia Board of Nursing and the Georgia Board of Examiners of Licensed Practical Nursing to support a change in Georgia law that would provide for trained individuals without registered or practical nursing licenses to administer medication in licensed residential settings. In 2006, the General Assembly passed and the Governor signed legislation creating a training curriculum and certification program for Certified Medication Aide. The Department of Technical Adult Education has implemented the training program. The legislation is written to sunset in 2011, at which time determinations about continuing the use of medication aides in Georgia would be made. Prior to 2011, MFP will work with stakeholders and advocates to ensure that the legislative changes become permanent and consider expansion of the services to additional settings.

B.8 Quality Management System

Georgia's MFP Demonstration uses existing HCBS waivers. MFP participants will be afforded the same level of safeguards as those available to participants enrolled in existing waivers, as described in 1915c Appendix H; Elderly and Disabled Waiver (Number: GA.0112.90R2, Amendment Number: GA.0112.R05.01, Effective Date: 10/01/07); the Independent Care Waiver Program (ICWP, Waiver Number: 4170.90.R2, Effective Date 12/31/2005), the Mental Retardation Waivers (MRWP/NOW, Waiver Number: GA.12.01.00, Effective 10/01/07) and Comprehensive Supports Waiver Program (CHSS/COMP, Waiver Number: GA.10.00.00, Effective 10/01/07).

Through an ongoing process of discovery, remediation and improvement, the state assures that each waiver provides for system-level, mid-level and front-line QMS strategies. DCH further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. DCH continues to implement and improve the Quality Management Strategy for each waiver as specified in 1915c Appendix H.

For example, under the Elderly and Disabled waiver, DCH has established a number of Quality Management Strategy (QMS) workgroups to ensure an ongoing focus on continuous quality improvement in the operation, results, and performance of waiver programs. The purpose of the QMS workgroups is to assign roles and responsibilities for QMS, standardize processes, develop and implement monitoring tools for discovery, performance indicators for data collection and analysis, strategies for remediation, and opportunities for continuous quality improvement.

The ICWP Continuous Quality Improvement (CQI) Committee, which consists of Utilization Review, contracted agencies, case management, and DCH staff, meets on a monthly basis. The CQI committee is charged with oversight of the entire ICWP waiver program. Activities of the CQI committee include: conducting, analyzing, and reporting on participant customer satisfaction surveys; providing training, reviewing sentinel events/health and welfare of participants through risk assessment, planning and prevention; reviewing access data and reports; reviewing procedures and reports regarding person-centered planning; medical records reviews; performance reviews of case management staff; claim payment reviews; and monitoring of self-directed PSS options.

In the Department of Behavioral Health and Developmental Disabilities, the Division of Developmental Disabilities (DD) has designed a number of new MR/DD Waiver Implementation Work Groups to address various issues associated with the NOW and COMP waivers. Each workgroup is led by a staff participant in the Division of DD, with other staff of DBHDD serving as core staff for the workgroups. Membership in workgroups was expanded to include various community stakeholders. Currently there are waiver work groups that focus on: Transition to New Services, Billing System and Prior Authorization, New Rate Structure and Individual Waiver Allocation Determination, Provider Application Development/Revision, SIS (Support Intensity Scale) Assessment and Individual

Budget Determination, Policy and Standards Development/Revision, Participant Direction, and the Quality Management Strategy. Although only one of the groups is specifically targeted at quality management, each of these groups has system and service improvement as its ultimate goal.

DCH assures that MFP participants will receive the same assurances as all waiver participants as identified in this section. This section describes the safeguards available to MFP participants enrolled in these waivers, the roles and responsibilities of each agency or entity involved in quality monitoring, quality improvement, and remedies for quality problems experienced by MFP participants. This section describes the reports that are regularly generated and reviewed to meet the QMS assurances: 1) level of care determinations, 2) service plans, 3) identification of qualified providers, 4) participant health and welfare, and 5) waiver administrative oversight and evaluation of QMS.

1. Level of Care (LOC) Determinations

Under the Elderly and Disabled Waiver, completed assessments guide level of care determinations. An MDS-HC tool provides comparative data that is tracked monthly by case management agencies to determine variance in the percent of waiver participants meeting LOC criteria and number of participants recertified annually based on a statewide benchmark set by DCH. DCH monitors agency compliance with the benchmark. Agencies that fall below 5% of the statewide average are required to submit an action plan for remediation and improvement to DCH. The Division of Aging Services (DAS) and DCH meet quarterly to review trend data and submitted action plans.

DCH staff conducts annual reviews using the State Monitoring Guide as a discovery tool to review and analyze approximately 10% of waiver claims statewide for accuracy of LOC determinations. When problems are identified, case managers are responsible for developing action plans for correction. DAS staff provides ongoing technical assistance and training to case managers in the assigned regions to resolve level of care eligibility questions and implement strategies for continuous quality improvement.

Case managers are required to maintain a copy of the participant's LOC. They are required to conduct monthly quality assurance monitoring of LOC determinations, to verify congruence of information and level of care eligibility. Case managers review the individual's LOC annually and when the participant's health changes impact LOC. Failure of the case manager to accurately complete the LOC can result in a request for refund by DCH.

Under ICWP the contracting agency conducts face to face assessments and reassessments using the Patient Assessment Form (PAF) and DMA-6. These assessment tools are used to support the Nursing Home and Hospital Level of Care determination. Quarterly and annually thereafter, the contracting agency reviews the DMA-6 prior to the participant's anniversary date to ensure that participants remain eligible for the program. The ICWP Program Specialist meets monthly with

the contract agency to review participant records, including LOC, to assure that the LOC are timely and accurate.

Under the NOW and COMP waivers, DBHDD maintains an electronic database, the Waiver Information System (WIS), to assist with LOC discovery process. This real-time database reports any LOCs that are not completed in a timely manner. The Division of DD reports monthly compliance levels for each region to DCH. DCH reviews each report and provides feedback to DBHDD as needed. A corrective action plan is required for any region that falls below a 90% compliance level in any given month. Any negative trends are noted and, as necessary, plans for remediation and improvement are developed and implemented. These remediation and improvement strategies and implementation results are discussed with DCH in the quarterly DBHDD/DCH meetings.

DBHDD Information & Evaluation (I&E) staff meets at least quarterly. The LOC process and WIS data are discussed. Any negative trends are noted and, as necessary, plans for remediation and improvement are developed and implemented. Remediation and improvement strategies and implementation results are discussed with DCH in the quarterly DBHDD/DCH meetings. DBHDD contracts with an external evaluation agency to conduct Individual Records Audits on a yearly basis. Documentation regarding the LOC process is considered as part of this external review. Approximately 10% of all waiver records are reviewed.

Regional Offices are assigned the task of reviewing discovery data as well as identification and remediation of underlying problems that lead to negative findings. Each Regional Office reviews and approves Individual Service Plans and Level of Care documentation. The Division of DD monitors the remediation process.

The DBHDD uses a Web-Based Management System to record and track:

- Initial Application for Services data
- Date of completion of various parts of the process
- Copy of Application, Intake Screening Summary and ancillary notes and testing required to determine eligibility with schedule and completion dates
- Initial and annual LOC assessments (with assessment reports from approved instruments) including:
    - Supports Intensity Scale
    - Health Risk Screening Tool
    - Social Work, Nursing, Psychological and Therapy Assessments
    - DMA-6 (LOC determination form)

The Web-Based Management System provides DBHDD follow-up data including pending LOC expirations, participants' transfers across regions and participants' discharge from services. Regional Offices review and evaluate the LOC data collected. Protocols on review of LOC reports are under development by the LOC redevelopment workgroup. The Division of Developmental Disabilities is researching best practice quality management strategies for monitoring LOC decisions and addressing inappropriate LOC determinations. Several LOC quality indicators have

been established and a review and remediation protocol has been designed including identification of the parties/entities responsible for implementation.

2. Service Plan Description and Service Delivery

Under the Elderly and Disabled waiver, participants and their representatives have the right and responsibility to participate in the development of the service plan with the RN and case manager. The Elderly and Disabled waiver service plan is reviewed with the participant within 60 days of admission and at least every four months thereafter.

The Division of Aging Services (DAS) along with the DCH Utilization Review (UR) Team uses a system of monitoring the Elderly and Disabled waiver service plans statewide to ensure that service units are implemented according to service plans. DAS randomly monitors 10% of service plans for implementation and UR conducts reviews of service plan implementation with 90% of providers every two years. DAS and DCH meet quarterly to review any negative findings and trends. Plans for remediation and improvement are developed and implemented. DAS monitors 100% of statewide Area Agencies on Aging (AAA) for participant assessment/re-assessment and service plan development and implementation. DAS uses a discovery process with providers as well. DAS collects and analyzes service delivery information from each provider. DAS reviews 100% of service orders authorizing service types, frequency, and cost of services. DAS also collects data on the percent of service units delivered compared to service units ordered. Collected data is compiled into a report. During joint quarterly meetings, DAS provides the report to DCH, detailing statewide service delivery, including the percent of service plans reviews completed timely, percent of annual service plan reassessments completed timely, percent of service units delivered compared to service units ordered, and percent of participants offered choice between services and institutional care. AAAs that fall below a threshold of 90% compliance are required to submit an action plan detailing remediation for improvement.

Under ICWP, service plan development begins at the initial visit between the contracting agency, the participant, family or guardian. As mentioned in the ICWP 1915c application, Appendix D, participants have the right and responsibility to participate in the development of their services plan and the selection of their service providers. Case managers review these service plans monthly and quarterly and make revisions as necessary. In order to ensure service units are developed and implemented according to the service plan, the DCH Utilization Review team conducts 90% reviews of all providers statewide every two years. DCH meets quarterly with the contracting agency to review any negative trends, and when necessary develops plans for remediation for quality improvement. The CQI committee monitors correction plans and identifies opportunities for quality improvements.

Under the NOW and COMP waivers, support coordinators facilitate meetings with participants/representatives for the development of service plans. A random sample of service plans is reviewed by state DBHDD office staff on a quarterly basis. Weaknesses identified in service plans are noted and trended. Statewide training on

service plan development and implementation is conducted by DBHDD and contracted staff. Input is sought from stakeholders including support coordination, assessment, and service provider staff regarding the content and presentation format of service plan training. Regional Office staff review five to ten percent of all service plans on a monthly basis. Audit results are shared with support coordination agencies (providers) and DBHDD, with the expectation that providers address identified issues.

Support coordinators monitor and report on service delivery to document that services detailed in the plan are being delivered as prescribed. Negative provider ratings, reported by support coordinators and/or participants/representatives are reviewed by the Health and Human Rights Coordinator in the Division of Developmental Disabilities. Findings are trended by type and provider. Trends are reported to DBHDD staff and decisions are made regarding remediation and quality improvement. More information on support coordination oversight can be found in the section entitled Participant Health and Safety.

The Web Information System (WIS) provides reports related to the management of service plans and service delivery. The "Participant ISP Expiration Report" is reviewed by Operations Analysts in the Regional DBHDD Offices. The "Participant ISP Due Report" is used as a workload management tool that projects service plans due within the next 30, 60, and 90 days. These service plan compliance reports are shared with DCH. A full description of the role of the new WIS data management system and its role in quality management of the ISP is included in the annual report to CMS.

DBHDD and DCH assessment staff meets at least quarterly. The LOC process and WIS reports are discussed. Negative trends are noted and, as necessary, plans for remediation and improvement are developed and implemented. Plans for remediation, improvement strategies, and implementation results are discussed with DCH in the quarterly DBHDD/DCH meetings. The annual Individual Records Audit by an external contacted agency includes a review of service plans. Individual Service Plans (ISPs) are assessed for completeness and quality. The review agency reports findings to the Division of Developmental Disabilities. Findings of the review become the focus of statewide training in the following year.

The National Core Indicators (NCI) project serves as the basis of a new performance measurement system for DBHDD and as benchmarks of Georgia's performance against the performance of other states. DBHDD's Office of Continuous Quality Improvement and Evaluation has partnered with the Division of Developmental Disabilities to develop and conduct a survey, report results, and review quality improvement strategies using the NCI. Individual and family surveys are conducted; results of the surveys are used to determine participant/family satisfaction with all waiver services, including support coordination services and MFP supplemental demonstration services.

DBHDD continues to contract for training and technical assistance related to processes and protocols for ensuring that participants transitioning from

institutional settings have the services and supports they need, including MFP supplemental demonstration services, so they can experience the community life envisioned in their Individual Services Plans. The focus of technical assistance is on 50 to 100 participants transitioning from state operated ICF/MRs to waiver services annually. Stakeholders continue to be involved in the process, including participants, their friends and family, ICF/MR and community staff, support coordinators, and I&E staff. Information gained is disseminated and incorporated into new processes and protocols regarding person-centered planning and participant transition.

The DBHDD Waiver Implementation QMS workgroup has identified several opportunities for quality enhancements. The QMS workgroup is undertaking a redesign of the Web-based Management System to record and track data required for discovery and follow-up including:

- Convert ISP to electronic format
- Provide secure electronic signatures
- Record and track ISP due dates, meeting schedules, and dates of actual meetings
- Sort ISP scheduling issues by:
    - Service provider, region, support coordination Agency, and support coordinator
    - Time and location of ISP meetings
    - Cancellations and reasons for cancellation
- Maintain assessment data from Supports Intensity Scale (SIS). Support coordination staff are administering the SIS. The process of comparing SIS indicated supports against actual services and supports provides discovery data and results in the development of higher quality ISPs and more effective service delivery statewide.

3. Identification of Qualified Providers

Under the Elderly and Disabled Waiver, DCH has the final responsibility for approving Medicaid provider applications. Medicaid provider numbers are assigned by a contracting agency. The Healthcare Facility Regulation Division (HFR) verifies annual recertification of licensure or certification and addresses licensure violations that may occur.

For the Elderly and Disabled waiver program, the Department of Human Services Division of Aging Services (DAS) maintains a Provider Enrollment System to verify that provider agencies meet required licensure and/or certification standards to assure that providers are qualified and able to meet the service needs of the waiver participants prior to recommending them to DCH for enrollment. For providers *not* required to be licensed by HFR, DAS verifies adherence to waiver requirements. DAS uses the Provider Enrollment System to monitor and improve provider enrollment. Data is collected and analyzed on the length of time the provider has been in business, licensure verification to conduct business in the state, standing with the offices of the Secretary of State and Inspector General, compliance with state licensing, funding, and regulatory entities associated with enrollment in

Medicaid and non-Medicaid services, provider enrollment applications, supporting documentation, and results of site visits. DAS verifies, on a periodic basis, that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards and reports finding to providers for remediation.

The Healthcare Facility Regulation Division monitors, inspects and licenses or registers primary health care, long-term care and residential child care programs. HFR certifies various health care facilities to receive Medicaid and Medicare funds. HFR ensures that provider facilities, services and programs meet state and other mandatory requirements and prepares reports regarding provider deficiencies in licensure and certification. These reports are reviewed by DAS provider specialists who are responsible for ensuring that providers maintain licensure and/or certification and adhere to waiver policies and procedures. Additionally, DAS provider specialists obtain and review information on providers from the Office of the State Long-Term Care Ombudsman, from DCH Program Integrity reports, and from DAS Program Integrity reports. DAS provider specialists use this information to measure provider compliance with waiver rules and regulations. The provider specialists offer technical assistance and training to providers and ensure that providers develop and implement action plans for remediation and improvement.

Providers receive ongoing training and technical assistance. Waiver program specialists and contracted staff deliver training to provider staff twice each year. The Elderly and Disabled waiver program Pre-Enrollment training sessions are conducted by DAS office staff and contractors on a monthly basis. For providers who have submitted an application and received a site visit, DAS conducts a quarterly New Provider Training session. New Provider Training covers standards and HFR rules and regulations. Providers with deficiency areas discovered during Utilization Review (UR) audits are required to attend additional trainings. Other events trigger training, including provider change of ownership and the hiring of new employees.

Under ICWP, the State Provider Enrollment (PE) unit is responsible for screening all provider applications upon initial request to be a Medicaid provider. The PE unit verifies the license and/or certification of the initial provider enrollment application. The ICWP program specialist reviews all applications and the determination made by the PE unit and makes the final determination. Program specialists work with the HFR to verify annual recertification of licensure or certification and to address any licensure violations that may occur throughout the year. HFR monitors, inspects and licenses or registers primary health care, long-term care and residential child care programs. HFR certifies various health care facilities to receive Medicaid and Medicare funds. HFR ensures that provider facilities, services and programs meet state and other mandatory requirements. HFR prepares reports regarding provider deficiencies in licensure and certification. These reports are reviewed by ICWP program specialists who are responsible for ensuring that providers maintain licensure and/or certification and adhere to waiver policies and procedures. The DCH Program Integrity (PI) unit conducts reviews on ICWP providers. During PI reviews, the service plan is reviewed in relation to the payments made to the provider. When there are discrepancies in the number of hours billed by the

provider and the actual number of hours employees worked, penalties are placed on the provider, including recoupment of over-payments.

Under the NOW and COMP waivers, agencies provide proof of appropriate licensure to HFR prior to being approved as waiver providers. Provider applications are evaluated by designated staff in the DBHDD Provider Certification Unit. If approval is recommended by the Provider Certification Unit, applications are forwarded to DCH for final review and approval.

At the systems level, DBHDD policy requires most direct service provider agencies (i.e., all providers contracting with DBHDD through and its regional offices, or receiving funding in an amount of $250,000 or more per year) to be qualified and appropriately accredited through one of several nationally recognized accreditation agencies (i.e. JCAHO, CARF, etc), based on the scope of services provided. Policy requires all remaining direct service providers to be certified by DBHDD. Providers under accreditation are reviewed by the accreditation bodies at least every three years and providers under certification are reviewed by DBHDD every two years and must be in compliance with all DBHDD core standards before certification is granted. Regional DBHDD offices are responsible for evaluating network providers within their region. Each region reviews provider accreditation and certification status annually at the time of contract renewal.

DBHDD uses a variety of discovery mechanisms that trigger reviews of performance and action plans for remediation and improvement. These include participant death and/or serious incident report, failure of a provider to meet re-accreditation or re-certification, aggregated reviews conducted by support coordinators that indicate negative performance trends, concerns received by DBHDD from any credible source, negative results from DBHDD consumer and family satisfaction surveys, and/or failure to meet DBHDD core standards during Special Reviews.

Front line staff (support coordinators) complete site visits on all residential settings prior to participants moving into any setting. Sites may not be occupied until all requirements are satisfied. Support coordinators document and report to DBHDD Regional Offices that providers are properly licensed or no longer properly licensed as a routine part of the support coordination monitoring process.

DBHDD state and regional staff discuss findings from the review of various discovery sources. Given the findings, staff may decide on any number of remediation and quality improvement processes. If serious health and safety concerns are identified, DBHDD, in collaboration with DCH, may decide to revoke the agency's provider number, cease doing business with the agency, and move the participants to qualified provider agencies. If there are concerns relating to payment by Medicaid for services not documented as rendered, the information is forwarded to the Program Integrity Unit in DCH, which conducts its own investigation. Information about the activities of DBHDD, including provider issues, is shared with DCH at the Joint Quarterly Meeting. DCH may request additional information as necessary.

To improve provider performance, DBHDD has established a Provider Profile System. The Provider Profile System captures information about each provider and about regional provider resources, including the number of consumers served, numbers of serious incidents and deaths, contract compliance, financial status, and accreditation/certification status. Updates to the system are made monthly by regional offices. This provider profiling system contains important aggregate information for region and state decision makers.

To improve provider performance, DBHDD has established a statewide Coordinator of Provider Training and Development. The Coordinator of Provider Training and Development is located within the Division of Developmental Disabilities Services, and has the responsibility of developing a strong and stable community provider system based on best evidence-based practices in the field of disabilities. Initial provider training and development initiatives include workforce development, establishment of a provider forum, and improvements in provider database, enrollment, certification, and licensure. Additional initiatives are to be identified through trend analysis.

To improve the performance of direct support professionals, DBHDD, the Governor's Council of Developmental Disabilities and the Department of Adult and Technical Education, launched a direct support professional certificate training program at four state technical colleges. The very successful program has continued to expand with new classes at additional colleges being added each quarter. Reaction to the certification program has been extremely positive from participants (Direct Support Professionals) and their employers. The Division of Developmental Disabilities has identified desired outcomes for the Direct Support Professional Certification Program, specifying indicators and developing data collection procedures used in the measurement of these outcomes. Results are used by DBHDD and other stakeholders in decision making regarding future funding, expansion, and incentives for the certificate program.

The Division of DD's Provider Application Development workgroup has undertaken a redesign of the provider enrollment system. The workgroup has created a list of the strengths/capacities that successful service provider organizations should be expected to have (by individual waiver service). In concert with stakeholders, the workgroup has developed an application that can document that an applicant provider is qualified. Changes are being made to the application review and approval process to assure that applications and approvals are efficient and that qualified providers are approved and available to begin service provision in a pre-determined length of time.

4. Participant Health and Welfare

Information from the MDS-HC is used to identify risks to the Elderly and Disabled Waiver participant's health and welfare. Each identified risk is included in service plan with individualized contingency plans. Under the Elderly and Disabled waiver program, each risk trigger from the *MDS-HC* is identified on the service plan with individualized service plans to minimize risks. Participants/guardians receive information about the participant's civil rights and responsibilities from case

managers and providers upon admission to the waiver. They are informed of the right to be free from mental, verbal, sexual, and physical abuse, neglect, exploitation, isolation and corporal or unusual punishment and how complaints and/or concerns are reported.

The Elderly and Disabled waiver program case management agencies document emergencies and complaints. Case managers immediately report incidents to the Healthcare Facility Regulation Division via telephone, if the provider is licensed and regulated by HFR. Case managers also prepare a written report of the incident and send it to HFR. Non-licensed entities are reported to DHS Adult Protective Services (APS). When there is an immediate threat to the health, safety, and/or welfare of the waiver participant, case managers immediately (within 24 hours) relocate the member to another setting.

Provider agencies are responsible for conducting an investigation of critical incidents/events and reporting their findings within five working days to case management agencies and if applicable, to HFR, the Office of the State Long-term Care Ombudsman, Adult Protective Services, local law enforcement, the participant's physician, family, and/or guardian. When indicated, findings are reported to appropriate certification and/or licensing boards. It is the responsibility of the provider agency to have written policies and procedures that address steps the agency takes to prevent abuse, neglect, and exploitation; actions the agency takes when such incidents are reported; and actions the agency takes to prevent future occurrences of such incidents. During provider agency investigations of critical incidents/events, case managers may be asked to monitor the agency and participant and follow-up on discoveries/reports/allegations of abuse, neglect, or exploitation.

Case managers also maintain a monthly provider 'complaint log.' The complaint log documents non-compliance issues that jeopardize the health and safety of participants. Action plans to remediate deficiencies are prepared and implemented by the case managers and the Area Agencies on Aging. If necessary, services are re-brokered with another provider to ensure that health and safety needs of participants are being met. For participants using Alternative Living Services (ALS), case managers complete a checklist of review and monitoring criteria at each face-to-face visit with the participant. The checklist performance indicators cover compliance with policies and procedures, standards for participant health and safety, documentation of RN supervision, medication administration, incident reporting and follow-up, participant condition, and environmental safety. Case managers work with providers to implement action plans to remediate poor performance. Case managers aggregate data from complaint logs and checklist reviews and report findings to the AAA. If issues cannot be resolved, case managers report findings to DAS for further action. DAS, in concert with HFR and the DCH Long-term Care Office, will transfer a participant into a safer setting, if the participant is found to reside in an ALS that jeopardizes his/her health and safety.

Under ICWP, risks to health and welfare are identified during the initial assessment and are reassessed at least annually. During the assessment, the Participant

Assessment Form (PAF) is used to assess risks, and these identified risks are addressed with action plans. Case managers provide participants with a list of approved providers. Participants or guardians select providers. Providers are required to have procedures in place to identify backup staff for emergency situations. The case manager documents these backup staffing plans in the service plan.

The case manager meets with the participant no less than once a month. Case managers are trained to observe and document critical incidents and report them to the contracting agency nurse. The nurse does a face to face assessment to determine impact on participant health and safety. Case mangers also keep complaint logs. Complaints are reported to ICWP Program Specialists and the Program Integrity (PI) unit. PI maintains a toll free number that is made available to participants. Participants are provided a list of phone numbers for ICWP Program Specialists, the contracting agency, and other agencies that are available to assist them. Case managers are mandated reporters of abuse, neglect, and/or exploitation. Case managers report all unexpected deaths for investigation and follow-up with Department of Community Health and local police.

All cases of neglect and abuse are required to be reported to the Department of Community Health and the contracting agency within 24 hours. A follow-up report is required in three working days from the case manager and/or provider agency. The state requires that a thorough investigation be completed and submitted to DCH within two weeks. A Plan of Correction is requested at that time. DCH staff and the contracting agency review these reports and if the Plan of Correction is inadequate, the case manager is notified and the Plan is corrected. If the complaint involves care of a participant, HFR is notified to investigate. If the matter cannot be resolved based on the report submitted by the case manager, DCH requests the Program Integrity unit to investigate and report findings. The DCH staff and the contracting agency nurse review these reports and remedial actions for quality improvements, including revisions to policy, training, and/or technical assistance.

The CQI committee reviews all participant sentinel events including deaths of participants. In addition, the ICWP CQI committee conducts an annual participant satisfaction survey. The committee uses the results for discovery. The committee uses survey results to develop a number of strategies for quality improvements, including new and revised policy, training, and technical assistance. The committee also functions as first line support for participant's complaints.

Under NOW and COMP, DBHDD maintains safe and humane environments for waiver participants to prevent abuse, neglect and exploitation. Risks to health and welfare are assessed using the Health Risk Screening Tool (HRST). RNs review risk assessment and HRST information for all waiver participants and assure that service plans contain corresponding health and/or programmatic strategies that specifically and effectively address identified risks. If service plans don't adequately address risks, plans are returned to the support coordination agency for revisions. Quality trends are reported to the Information & Evaluation Manager. Trends are discussed with the Division of DD and targeted training or other remediation and

quality improvement strategies are developed to address service plan quality. Support coordinators monitor the health and welfare of participants.

A Critical Incident Reporting system is used to collect and analyze data. Reports are reviewed for identification of trends related to participant health and welfare. The DBHDD Investigations Section is responsible for the final review of and response to critical incidents and events that affect waiver participants. The community provider is responsible for conducting an administrative review of reports prior to the Investigative Section's reviews and for implementing any needed corrections after incidents have been investigated. Trends are communicated to DCH and when findings indicate that participant health and/or welfare is compromised, DBHDD and DCH staff work collaboratively for quick resolution.

The Division of Developmental Disabilities has established a statewide network of approximately 40 Human Rights Committees (HRCs). A coordinator from Health and Human Rights works with the network of Human Rights Committees to serve participants in 36 MR/DD Service Areas. Human Rights Committees are groups of local citizens who provide independent oversight as a local intermediary structure in matters related to the rights of citizens with developmental disabilities who reside in the state of Georgia. Examples of types of issues/concerns to be reviewed by HRCs include: mistreatment, abuse, neglect, exploitation, misuse of pharmaceuticals, restraints and behavioral programs and interventions. Volunteer membership includes medical professionals, pharmacist/medication experts, self advocates, other advocates, parents, other family members, law enforcement personnel, business people, and representatives of faith-based organizations. Issues heard by HRCs receive follow-up with documentation of resolution. Division of DD staff communicates with local HRC leadership on a monthly basis. The Division of DD uses HRC information as discovery, to track trends monthly, and to respond systemically with remediation and quality improvement as needed. The Division of DD communicates with region staff monthly regarding issues and concerns identified through the HRCs.

The Division of DD is developing a Division certification process. The review process is led by the Provider Certification Unit staff, but the review team includes external stakeholders: providers, people with disabilities, family participants, and provider agency board participants. The schedule for reviews will be every two to three years. Development and testing on this proposal have already begun between staff in the Division of DD and the Provider Certification Unit. Other internal and external stakeholders (including providers) have joined in the design process. A redesigned and more efficient and effective provider review process is nearing completion.

5. Waiver Administrative Oversight and Evaluation of QMS

For all waivers, The Department of Community Health (DCH) Medicaid Division maintains ultimate authority and responsibility for all waiver operations by exercising oversight over the performance of waiver functions by other state and local/regional non-state agencies. For this reason DCH has been and continues to be an active participant in QMS Workgroups. DCH participates with workgroups to develop quality performance indicators. DCH determines the roles and

responsibilities of persons involved in measuring performance and making improvements. DCH works with QMS workgroups to establish processes and strategies for remediation and improvement.

DCH retains oversight to ensure that state performance thresholds are met or exceeded by all levels of the QMS, including level of care, service plans and delivery, quality providers, health and welfare, emergency backup systems, incident report management systems, and financial accountability. DCH receives information and reports on all QMS processes and participates in periodic evaluation and revision of the QMS.

Under the Elderly and Disabled Waiver, DAS provides copies of analysis and reports to DCH. DCH conducts monitoring and analysis of the Division, the AAAs, case managers, and service provider activities. Corrective Action Plans are required whenever performance indicator variances do not meet state norms. DCH Program Integrity provides additional monitoring and investigation and reports findings to DCH. DCH and DAS meet at least quarterly to review program performance, monitoring reports, action plans for remediation, and opportunities for quality improvement. DCH clarifies the roles of the entities responsible for making improvements in systems performance and sets specific timelines for implementation.

Under ICWP, DCH Program Integrity (PI) reviews approved units of services for ICWP participants and monitors payments made in accordance with approved units. The CQI committee is charged with oversight of the entire ICWP waiver program. Activities of the CQI committee include: conducting, analyzing and reporting on participant customer satisfaction surveys; providing training, reviewing sentinel events/health and welfare of participants through risk assessment, planning and prevention; reviewing access data and reports; reviewing procedures and reports regarding person-centered planning; medical records reviews; performance reviews of case management staff; claim payment reviews; random audits of contracting agencies; and monitoring of self-directed PSS options.

Under NOW and COMP, DBHDD is the operating authority. DCH and DHR staff meet at least quarterly to oversee the operation of the waiver program. This quality management body (DCH/DBHDD) reviews reports, follows up on identified issues, and remediates problems. The two departments hold additional monthly meetings to discuss issues related to provider performance, remediation, and quality management strategies. DCH Program Integrity provides additional monitoring and investigation to assist in assuring program compliance.

6. Financial Oversight of the Waivers

For all waivers, The Department of Community Health (DCH) Medicaid Division maintains ultimate authority and responsibility for financial accountability to CMS and the executive and legislative branches of state government (for process detail related to the integration of MFP and HCBS waiver services and financial processes, see *Appendix I: MFP Flowcharts and Text Descriptions, Appendix N: New CMS-1500 Claim Form, Appendix O: FI Invoice to DCH for Payment, Appendix V: MFP DCH*

DHR Vendor Import File and *Appendix Y: Participant Enrollment Status Change Form*).

The DHS Division of Aging Services (DAS) monitors the day-to-day operations and financial accountability for the Elderly and Disabled Waiver. DAS uses the Aging Information Management System (AIMS) to collect financial data, including monthly Service Authorizations for participant services and payment data from the DCH fiscal intermediary. This data is analyzed monthly by DAS to assure statewide program expenditures are within budget allocation. The AAAs are required to review expenditures versus allocation monthly. DAS uses a Client Health Assessment Tool (CHAT) to collect specific data on program activities including number of participants admitted or discharged, active participant counts and participants pending Medicaid who will retroactively impact the waiver budget. The AAAs are responsible for reviewing participant costs that are above a pre-determined threshold and requesting justification from the care coordination agency. DAS and the AAAs are responsible for reviewing the care coordination lapse report quarterly to assure expenditures are within the allocated budget.

MFP will join the DAS Financial Accountability Team at regular scheduled meetings to develop and implement the following opportunities for quality enhancement:

- Review of average expenditures for waiver programs to ensure that expenditures do not exceed the average cost per participant statewide; the average length of stay statewide; the average de-authorization rate statewide and the percent of services billed without documentation of service delivery.
- Utilization Review of services rendered, including MFP demonstration and supplemental services, according to service plan. Compliance indicators include the percent of service units billed without adequate documentation and proven fraudulent billing.

Under ICWP, financial accountability is monitored and reviewed by the ICWP CQI committee. All participant services require prior authorization from the contracting agency. Agency nurses are responsible for approving participant service plans for a period of 365 days. Service unit procedure codes are entered into the Medicaid Management Information System (MMIS). Approved units are attached to budgets entered into MMIS. Corrections can be made to entered information to ensure that payments are made correctly. Edits prevent provider over billing/over payment and can be made to participant information, including: dates of services, date of birth, number of approved units, and approved rates (for more details, see *Appendix I: MFP Flowcharts and Text Descriptions)*. DCH Program Integrity (PI) conducts reviews of ICWP providers. PI reviews service plans, approved service units, delivered service units, and payments made to each provider. When discrepancies in service units billed (i.e. hours of PSS billed) and actual service units delivered (i.e. PSS employee hours worked) are found, PI places penalties on providers, including recoupment of over payments.

Under NOW and COMP, DBHDD is responsible for daily operations and accountability is monitored and reviewed by DCH (for more detail, see *Appendix I: MFP Flowcharts and Text Descriptions)*. Under NOW and COMP, the Program Integrity Unit (PI) is responsible for conducting the survey of provider services and billing to ensure the integrity of the payments that have been made by Medicaid to providers for waiver services. PI will annually review a random sample of a minimum of 50 of the waiver service provider records. PI will also review upon request or report any agency suspected of fraud. The 50 records are representative of all service provider types. The sample represents about 1% of all members served. PI reviews records to ensure compliance with program policies.

When PI performs a records review of a service provider agency the records are reviewed for documentation of all services rendered by all disciplines, to include dates of services and signatures of same, supervision of services as required, copies of support coordinator's monitoring documentation on records, service plan copies, DMA-6, DMA-80, training documentation for disciplines as required, Freedom of Choice forms, billing records, aide worksheets, and issues of recovery of reimbursement. Each provider of services is given a preliminary statement of deficiencies found, and is informed that they will receive the official report from DCH, with request for refund letter if applicable. In-home assessments are conducted with participants and significant others/caretakers. Assessments include a review of services, duties of disciplines, supplies, medical equipment, adaptive devices and use of same, environmental modifications, condition of home, appearance of client , functional abilities, mental and emotional status, assistance required, unmet needs, overall assessment, and plan/recommendations regarding continued care for recipient.

An exit conference is conducted following a survey. All client recorded deficiencies are detailed at that time. Any issues of recovery of reimbursement are detailed. This is the preliminary report to the providers and they are informed that the official report will be forthcoming. Any provider questions and concerns are addressed at this conference. In cases of recipient recommendations made to the Department (adverse actions), from the UR auditor and agreed with by the Department's program manager or DMA analyst, a recipient letter is sent to the client/representative, notifying of same, with instructions on how to appeal the action.

All provider UR reports are completed and sent to each applicable provider, with a request for a corrective plan for all deficiencies cited. Recipient letters and letters of recovery are forwarded as applicable. Follow up to ongoing recovery process is conducted as warranted. Follow up reviews are conducted as warranted in cases of major provider noncompliance to program policies, major recoupable deficiencies cited, member safety issues, etc.

7. Emergency Backup Systems

Emergency backup systems are unique to each waiver; 24/7 emergency backup plans are developed and deployed based on risks assessed in service plans.

Under the Elderly and Disabled Waiver Program the Division of Aging Services (DAS) and the Department of Community Health share the responsibility for overseeing the reporting of and response to emergencies and critical events. Under the Independent Care Waiver Program (ICWP), the Georgia Department of Community Health is responsible for overseeing the 24/7 emergency backup system.

Information from the MDS-HC is used to identify risks to the Elderly and Disabled Waiver Program waiver participant's health and safety. Each identified risk is included in the service plan with individualized contingency plans. This is similar in the Independent Care Waiver Program (ICWP). Participant risks are addressed with action plans using the *Care Path*. The participant's physician signs off on the LOC/*Care Path* plan. Under the Elderly and Disabled waiver program, each risk trigger from the *MDS-HC* is identified on the service plan with individualized contingency plans to minimize risks. Participants/guardians receive information about the participant's civil rights and responsibilities from case mangers and providers upon admission to the waiver. They are informed of the right to be free from mental, verbal, sexual, or physical abuse, neglect, exploitation, isolation, and corporal or unusual punishment, and how complaints and/or concerns are reported.

Each participant is provided with 24/7 emergency phone contacts for the case manager and for service providers. Vendors/agencies are required to provide 24/7 backup for direct care staff and to instruct direct care staff on participant needs and preferences. Participants using self-directed options must identify at least two individuals (i.e. friends, family members, etc) in their emergency plans to assist them in the event that PSS staff doesn't show up. PSS employees must agree to the plan. The service plan includes plans for equipment failures, transportation failures, natural disasters, power outages, and interruptions in routine care. For providers agencies, 24/7 on-call backup is mandated. In addition, each participant receives equipment and training to use an Emergency Response Services (ERS) system. The ERS system monitors participant's safety and provides access to 24/7 emergency intervention for a medical or environmental crisis. The ERS is connected to the participant's telephone and programmed to signal a response once activated from a device that is worn or attached to the participant. ERS home units, installed by a licensed Low Voltage Contractor, are programmed to dial a toll-free number to access a central monitoring station. Monthly testing of the ERS is undertaken by ERS providers and a battery backup is provided.

Case management agencies document emergencies and complaints. Participants and/or guardians report incidents to case managers within three days. Case managers triage each incident and request additional emergency response, if needed. Case managers immediately report the incident to Healthcare Facility Regulation if the provider is licensed and regulated by HFR. Case managers prepare a written report of the incident and send it to HFR. Non-licensed entities are reported to DHS Adult Protective Services (APS). When there is an immediate threat to the health, safety, and/or welfare of the waiver participant, case managers immediately (within 24 hours) relocate the member to another setting. Provider agencies are responsible for conducting an investigation of critical

incidents/events and reporting their findings within five working days to case management agencies and if applicable, to HFR, the Office of the State Long-term Care Ombudsman, Adult Protective Services, local law enforcement, the participant's physician, family, and/or guardian. When indicated, findings are reported to appropriate certification and/or licensing boards. It is the responsibility of the provider agency to have written policies and procedures that address steps the agency takes to prevent abuse, neglect, and exploitation; actions the agency takes when such incidents are reported; and actions the agency takes to prevent future occurrences of such incidents. During provider agency investigations of critical incidents/events, case managers may be asked to monitor the agency and participant and follow-up on discoveries/reports/allegations of abuse, neglect, or exploitation.

Under NOW and COMP, DBHDD is responsible for the 24/7 emergency backup system. Serious risks are identified based on discussions during the Individual Service Plan meeting and information obtained from assessments and team members. Clear and specific protocols are developed to support identified risks, including plans for 24/7 emergency backup. Specific questions to be asked in the ISP process regarding various common risks include:

- Chronic and acute health problems
- Need for assistance to evacuate in an emergency
- Vulnerability to injury by hot water
- Need for assistance with personal finances
- Documentation of a person's ability to be without supervision for short periods
- Potential dangers associated with choking
- Potential dangers associated with household chemicals

The checklist of common risks and dangers introduces the conversation on other risks specific to the individual.

The individual's Health Risk Screening Tool is reviewed for health, safety, and behavioral risks. The annual assessments are reviewed for information regarding risks, and all team members are encouraged to bring up risks or concerns not identified in these various reviews and assessments. This discussion provides the team with the opportunity to honestly and collaboratively identify and discuss risks while listening to and respecting the individual's perspective.

An action plan or protocol must be developed for each identified risk. The Action Plan/Protocol describes the risk and details the actions that will be taken to protect the individual from the risk and provide for 24/7 emergency backup. The Action/Protocol becomes part of the Individual Service Plan and includes clear and specific information describing the identified risk, what staff (particularly direct support professionals) need to know about that risk, and specifies the actions to be taken to protect the individual. The DBHDD's Guide for Developing an Individual Service Plan reminds staff to "consider ways in which the individual's health and safety may be in jeopardy, align and develop supports that will help minimize risks, and identify if those supports interfere with what is most important to the

individual. Participating in this process provides the setting for creative problem solving."

The location of the specific risk Action Plan/Protocol is documented in the ISP Risk Plan. (i.e., in an Action Plan in the ISP, a medical protocol located in the individual's notebook, an emergency evacuation protocol located in the home/center, a Behavior Support Plan in the individual's file at the group home, etc.). All protocols and plans must be accessible to direct support staff at all times.

Assessment of Other Concerns/ Problems
In addition to the assessment of health and safety risks, other service delivery problems and concerns are addressed in the service plan development process. For example, the plan details the provider agency's 24/7 emergency backup plan for assuring coverage and supervision in the event that a direct staff person does not report for his/her shift. Necessary staff-to-consumer ratios are documented. The agency identifies its capacity to provide additional staff response when needed on an intermittent basis for contingencies such as when a waiver participant is ill and needs extra care or when an individual's behavior threatens the safety of herself or others.

Any administrative concerns regarding the individual's services are discussed in the service plan development process. For example, if it is determined that a participant has outgrown or otherwise needs additional adaptive equipment, the Individual Service Plan will note the need for further assessment and include a goal with timelines for obtaining any additional or replaced equipment. Waiver participants or their families/representatives who opt for self-direction and become the employer of record of support workers are required to have an individual 24/7 emergency backup plan to address contingencies such as emergencies occurring when a support worker's failure to appear when scheduled presents a risk to the participant's health and welfare. The 24/7 emergency individual backup plan is specified in the ISP.

Emergency Backup Plan for MFP Services

MFP Contracted Services
For contracted services (i.e. Peer Community Support, Trial Visits, contracted Moving Services, etc.), the MFP TC recruits vendors, agencies, and/or contractors to provide these services. Each needed service is included in the participant's Individualized Transition Plan (ITP) and authorized using the *MFP Authorization for Pre and Post-Transition Services*. After the service is rendered, the TC receives an invoice form the vendor/agency/contractor and transmits this information to the Fiscal Intermediary (FI). The FI pays the invoice. Contingencies for emergency backup are included in the transition plan. If the vendor, agency, or contractor cannot provide a scheduled service to the MFP participant, the vendor, agency or contactor is required to call the participant and try to reschedule the service with the participant. If that is not satisfactory to the participant, the vendor, agency, or contractor will offer a back-up service for the originally scheduled service. In

addition to arranging alternatives with the MFP participant, the vendor, agency, or contractor is expected to contact the Transition Coordinator with this information.

MFP Fee-For-Services

Fee-for-service purchases (such as Household Furnishings, Household Goods and Supplies, etc.) are made through the Fiscal Intermediary. One-time goods and/or services needed by the MFP participant are discussed during the development of the transition plan. The Transition Coordinator includes needed goods and/or services in the Individualized Transition Plan (ITP) and authorizes these services using the *MFP Authorization for MFP Services (*see *Appendix S*). The participant and TC work together to locate and determine the cost of the goods and/or services. The TC authorizes the purchase of the goods and/or services and provides the documentation that specifies how they meet the transition goals in the transition plan. The TC obtains and delivers the goods/services and transmits the invoice information to the Fiscal Intermediary using the *MFP DCH DHR Vendor Import File (*see *Appendix V)*. A paid invoice or receipt that provides clear evidence of the purchase must be kept with the participant's transition plan to support all goods and/or services purchased along with the *Vendor Payment Request to TC (*see *Appendix U*). The Fiscal Intermediary also tracks the purchases. If a vendor fails to provide the purchased goods and/or services, the TC is responsible for canceling the transaction and/or obtaining a refund from the vendor. The TC and MFP participant must locate another vendor willing to supply the goods and/or services.

Quality Improvements to the Critical Incident Reporting Systems

The Division of Developmental Disabilities has established a statewide network of approximately 40 Human Rights Committees (HRCs). A coordinator from Health and Human Rights works with the network of Human Rights Committees to serve participants in 36 MR/DD Service Areas. Human Rights Committees are groups of local citizens who provide independent oversight as a local intermediary structure in matters related to the rights of citizens with developmental disabilities who reside in the state of Georgia. Examples of types of issues/concerns to be reviewed by HRCs include: mistreatment, abuse, neglect, exploitation, misuse of pharmaceuticals, restraints and behavioral programs and interventions. Volunteer membership includes medical professionals, pharmacist/medication experts, self advocates, other advocates, parents, other family members, law enforcement personnel, business people, and representatives of faith-based organizations. Issues heard by HRCs receive follow-up with documentation of resolution. Division of DD staff communicates with local HRC leadership on a monthly basis. The Division of DD uses HRC information as discovery, to track trends monthly, and to respond systemically with remediation and quality improvement as needed. The Division of DD communicates with region staff monthly regarding issues and concerns identified through the HRCs.

QMS and the Development of Qualified Personal Support Services Staff

DBHDD, the Governor's Council of Developmental Disabilities, and the Department of Adult and Technical Education, launched a direct support professional certificate training program at four state technical colleges. The very successful program has

continued to expand with new classes at additional colleges being added each quarter. Reaction to the certification program has been extremely positive from participants (Direct Support Professionals) and their employers. The Division of Developmental Disabilities has identified desired outcomes for the Direct Support Professional Certification Program, specifying indicators and developing data collection procedures used in the measurement of these outcomes. Results are used by DBHDD and other stakeholders in decision making regarding future funding, expansion, and incentives for the certificate program.

Statewide trainings and individual provider technical assistance on medication administration (including documentation) have been presented by Division of DD and Provider Certification staff. Representatives from the Division and other experts in the field are working with the Georgia Board of Nursing and the Georgia Board of Examiners of Licensed Practical Nursing to support a change in Georgia law that would provide for trained individuals without registered or practical nursing licenses to administer medication in licensed residential settings. In 2006, the General Assembly passed and the Governor signed legislation creating a training curriculum and certification program for Certified Medication Aide. The Department of Technical Adult Education has implemented the training program. The legislation is written to sunset in 2011, at which time determinations about continuing the use of medication aides in Georgia would be made.

B.9 Housing

This section describes the state's plans and processes for verifying that all residences into which MFP participants are placed meet MFP statutory definitions for "qualified residences," housing quality standards or state and local codes as applicable, and physical conditions standards of any financing source assisting in the development of the unit or providing rental assistance for the member to live in the unit. This section describes the state's plans and processes for ensuring that all housing providers will be fully licensed and/or certified, as appropriate, by state or local entities. This section concludes with a description of the state's plan to increase access to affordable, accessible, integrated housing for individuals with disabilities.

Qualified Residences

MFP Transition Coordinators are required to transition eligible MFP participants to a qualified residence. Under MFP, a qualified residence includes:

- a home owned or leased by the transitioning individual or the individual's family member, or
- an apartment leased to the transitioning individual, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control
- a residence, in a community-based residential setting, in which no more than four unrelated individuals reside
- Housing Quality Standards (HQS) will be followed for all housing with development or rental assistance funding through the U.S. Department of Housing and Urban Development and used by MFP participants. HQS inspections will be completed by the applicable state or local entity administering the HUD funds.

MFP participant residency will be tracked during the demonstration using an indicator on the MMIS system, the members' county code.

Qualified Residences/Providers

MFP participants transition into existing Medicaid 1915c waiver services. HCBS waiver services will be used along with MFP transition services to help people resettle in the community. Elderly MFP participants will enter the Elderly and Disabled waiver program; participants with physical disabilities and/or ABI will enter the Independent Care Waiver Program (ICWP); and participants with developmental disabilities will enter the NOW and COMP waivers. The state has processes and mechanisms in place for verifying that all qualified residences into which MFP participants may be placed will be fully licensed and/or certified, as appropriate, by state or local entity. The section describes the state's processes for ensuring that all housing providers are fully licensed and/or certified, as appropriate, by state or local entities.

For example, under the Elderly and Disabled waiver program, the Department of Human Services (DHS) Division of Aging Services (DAS) maintains a Provider Enrollment System to verify that provider agencies meet required licensure and/or certification standards to assure that providers are qualified and able to meet the service needs of the waiver participants prior to recommending them to DCH for enrollment. For providers *not* required to be licensed by the Healthcare Facility Regulation Division of DCH (HFR), DAS verifies adherence to waiver requirements. DAS uses the Provider Enrollment System to monitor and improve provider enrollment. Data is collected and analyzed on the length of time the provider has been in business, licensure verification to conduct business in the state, standing with the offices of the Secretary of State and Inspector General, compliance with state licensing, funding, and regulatory entities associated with enrollment in Medicaid and non-Medicaid services, provider enrollment applications, supporting documentation, and results of site visits, if applicable. DAS verifies, on a periodic basis, that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards and reports finding to providers for remediation.

HFR monitors, inspects, and licenses or registers primary health care, long-term care, and residential child care programs. HFR also certifies various health care facilities to receive Medicaid and Medicare funds. HFR ensures that provider facilities, services, and programs meet state and other mandatory requirements. HFR prepares reports regarding provider deficiencies in licensure and certification. These reports are reviewed by DHS provider specialists who are responsible for ensuring that providers maintain licensure and/or certification and adhere to waiver policies and procedures. Additionally, DHS provider specialists obtain and review information on providers from the Office of the State Long-term Care Ombudsman, from DCH Program Integrity reports, and from DHS Program Integrity reports. DHS provider specialists use this information to measure provider compliance with waiver rules and regulations. DHS provider specialists provide technical assistance and training to providers and ensure that providers develop and implement action plans for remediation and improvement.

Front line waiver staff (case managers) use a checklist to document the presence of a current license and compliance with permitted capacity, HFR rules and regulations, and compliance with waiver policies and procedures for all enrolled providers annually and/or at site visits. Non-compliance is reported to DAS and HFR for follow-up, remediation and resolution.

Providers receive ongoing training and technical assistance. Waiver program specialists and contracted staff provide training to provider staff twice each year. The Elderly and Disabled waiver program Pre-Enrollment training sessions are conducted by DAS office staff and contractors on a monthly basis. For providers who have submitted an application and received a site visit, DAS conducts a quarterly New Provider Training session. New Provider Training covers standards and HFR rules and regulations. Providers with deficiency areas discovered during Utilization Review (UR) audits are required to attend additional trainings. Other

events trigger training, including provider change of ownership and the hiring of new employees.

Under ICWP, the CQI committee conducts on-site home reviews of a statistically significant number of participants (usually 10% or 60 to 100 randomly chosen onsite visits per year). Performance criteria are measured for service plan goals, declines/improvements in participant health status against ICWP eligibility criteria, and reassessments of required service plans to determine needed PSS hours, supplies, equipment, additional services and supports to meet service plan goals. Deficiencies discovered are communicated to appropriate parties and plans for remediation are developed and implemented. The committee monitors correction plans and identifies opportunities for quality improvements.

Under the NOW and COMP waivers, agencies provide proof of appropriate licensure to HFR prior to being approved as waiver providers. Provider applications are evaluated by designated staff in the DBHDD Provider Certification Unit. If approval is recommended by the Provider Certification Unit, applications are forwarded to DCH for final review and approval.

At the systems level, DBHDD policy requires most direct service provider agencies (i.e., all providers contracting with DBHDD through the division and its regional offices, or receiving funding through the division, in an amount of $250,000 or more per year) to be qualified and appropriately accredited through one of several nationally recognized accreditation agencies (i.e. JCAHO, CARF, etc), based on the scope of services provided. Department policy requires all remaining direct service providers to be certified by DBHDD. Providers under accreditation are reviewed by the accreditation bodies at least every three years and providers under certification are reviewed by DBHDD every two years and must be in compliance with all DBHDD core standards before certification is granted. Regional DBHDD offices are responsible for evaluating network providers within their region. Each region reviews provider accreditation and certification status annually at the time of contract renewal.

DBHDD uses a variety of mechanisms that trigger reviews of performance and action plans for remediation and improvement. These include participant death and/or serious incident report, failure of a provider to meet re-accreditation or re-certification, aggregated reviews conducted by support coordinators that indicate negative performance trends, concerns received by DBHDD from any credible source, negative results from DBHDD consumer and family satisfaction surveys, and/or failure to meet DBHDD core standards during Special Reviews.

Front line staff (support coordinators) complete site visits on all residential settings prior to participants moving into any setting. Sites may not be occupied until all requirements are satisfied. Support coordinators document and report to DBHDD Regional Offices that providers are properly licensed or no longer properly licensed as a routine part of the support coordination monitoring process.

DBHDD and regional staff discuss findings from the review of various sources. Given the findings, staff may decide on any number of remediation and quality improvement processes. If serious health and safety concerns are identified, DBHDD, in collaboration with DCH, may decide to revoke the agency's provider number, cease doing business with the agency, and move the participants to qualified provider agencies. If there are concerns relating to payment by Medicaid for services not documented as rendered, the information is forwarded to the Program Integrity Unit in DCH, which conducts its own investigation. Information about the activities of DBHDD, including provider issues, is shared with DCH at the Joint Quarterly Meeting. DCH may request additional information as necessary. To improve provider performance, DBHDD has established a Provider Profile System. The Provider Profile System captures information about each provider and about regional provider resources, including the number of consumers served, numbers of serious incidents and deaths, contract compliance, financial status, and accreditation/certification status. Updates to the system are made monthly by regional offices. This provider profiling system contains important aggregate information for regions and state decision makers. Waiver participants and their families will soon have access to this information to assist them in decision making regarding provider choice.

Increasing Access to Affordable, Accessible and Integrated Housing

The Housing Coalition work group is comprised of representatives from the Department of Community Affairs (DCA), the Department of Community Health (DCH) MFP project, the Department of Behavioral Health and Developmental Disabilities, and representatives from the Department of Human Services Division of Aging Services. DCA administers the programs of the Georgia Housing and Finance Authority, non-metro public housing authorities, and other housing organizations in an effort to coordinate resources to improve access to affordable, accessible, and integrated housing. While access to home and community based services has increased, access to housing continues to be a major barrier. The MFP demonstration project will provide opportunities for 618 Medicaid individuals living in institutions to resettle in their communities. However, the success of MFP is dependent on access to affordable, accessible, and integrated housing. The Housing Coalition work group will assist in planning and discussions, needs assessment, removing policy barriers, developing rental subsidy programs, developing state-wide referral mechanisms, and increasing access to affordable, accessible, and integrated housing for HCBS waiver participants, including MFP participants.

DCA is tasked with preparing a plan to address Georgia's affordable housing needs using available funds, federal and state, as received through the HOME Investment Partnership (HOME), Housing Choice Vouchers, Community Development Block Grant (CDBG), Emergency Shelter Grant (ESG), and Housing Opportunities for Persons with AIDS (HOPWA) programs. The Annual Action Plan for Consolidated Funds (ConPlan) describes how state, local, private, and federal resources will be used to increase the supply of affordable housing and economic opportunities for low and moderate income Georgians, including Medicaid eligible older adults and persons with disabilities. The stated priorities are:

- To increase the access of Georgia's special need populations to a continuum of housing and supportive services which address their housing, economic, health and social needs.
- To increase the access of Georgia's older adult population to a continuum of housing and supportive services which address their housing, economic and social needs.
- Future discussion and planning will occur to address specific ConPlan to assist Medicaid eligible older adults and persons with disabilities transitioning from nursing homes and other state institutions to the community using HCBS waiver services.

The Housing Coalition work group will work with DCA to expand rental subsidies and housing options for older adults and persons with disabilities. Working with DCA, the Housing Coalition partners will undertake planning for the following long-range and near-term initiatives:

Long-range Initiatives

- Remove regulatory barriers to affordable, accessible housing in Georgia
  - Continue implementation of the Georgia Planning Act of 1989, through the state's Minimum Planning Standards, requiring each jurisdiction to examine issues related to the provision of adequate and affordable housing (MFP Transition Coordinators (TCs) will be encouraged to report housing needs in their communities)
  - Encourage local governments to amend zoning ordinances and land use controls that create barriers to affordable, accessible and integrated housing
- Review and discuss ideas of how to address limitations of federal regulations on the use of HOME funds
- Implement recommendations in Analysis of Impediments to Fair Housing Choice in Georgia
- Research the feasibility of affordable assisted living projects for frail elderly
- Encourage communities though Community HOME Investment Program (CHIP) to target development of affordable, accessible and integrated housing for older adults and people with disabilities.

To implement long-range initiatives, Housing Coalition partners will work collaboratively through planning discussions and various public processes as outlined in the ConPlan Citizen Participation and Consultation Process.

Near-term Initiatives

- Work with DCA and metro Public Housing Authorities to discuss and strategize future plans that incorporate the following:
  - Expand rental opportunities for MFP and HCBS participants
  - Implement and expand permanent supportive housing (PSH) options
  - Expand Housing Choice Vouchers for MFP participants (see *Appendix AA: Referral for Housing Choice Voucher*)
  - Develop MOUs with Public Housing Authorities (PHAs) for rental vouchers for MFP participants

- Create Bridge Subsidy Programs with PHAs
- Improve access to existing rental assistance programs
- Increase targeted outreach to Medicaid eligible older adults, people with disabilities
- Increase Housing Education and awareness of Housing Search Tools
- Expand home ownership and home modification programs
- Expand funding for the Home Access (HA) Program
- Promote home ownership for MFP participants using vouchers

Near-Term Strategies and Activities

Implement and Expand Permanent Supportive Housing Programs (PSHP)

The purpose of this program is to produce funding for the production of affordable rental housing with accompanying supportive services for eligible Homeless Tenants through the allocation of federal HOME and State Housing Trust Fund for the Homeless monies. In addition, project based rental assistance (Housing Choice Vouchers-HCV) are available for 100% of PSHP units occupied by eligible Homeless Tenants within DCA's HCV service area. To assist the MFP initiative, DCA has expanded the definition of an eligible Homeless Tenant to include an individual who has a primary nighttime residence that is an institution (e.g. nursing homes, hospitals, ICF/MRs that provide an inappropriate residence for individuals that could be better suited for community integration with support services). Presently, supportive housing units in Macon and Augusta are also available to MFP consumers. PSH projects under construction or under review with preliminary commitments include locations in Savannah, Atlanta, Fort Valley, Rome, and Columbus. The total number of units completed or under construction is 225 with 203 units under review.

Expand Low Income Housing Tax Credit/HOME Rental Housing Loan Programs

Low Income Housing Tax Credit/HOME Rental Housing Loan programs provide equity and low interest loans, respectively, for the production of affordable rental housing. All first floor units are accessible with 5% fully adapted for individuals with disabilities. An additional 2% are set-aside for visually/hearing challenged. The programs are competitively allocated statewide. The 2007 and 2008 Qualified Allocation Plan, which governs the allocation of both resources, includes provisions to encourage the set-aside of units for individuals with special needs. Developers must provide an agreement with a local service provider(s) for referral of potential tenants to the property. Through the MFP initiative, greater coordination between service providers and project developers must occur to enhance access to these set-aside units by MFP consumers.

Expand the Housing Choice Voucher (HVC) Programs

DCA administers allocation of Housing Choice Vouchers in 149 or Georgia's 159 counties. To assist the MFP initiative, DCA has reserved 106 Housing Choice Vouchers for use by MFP participants (see *Appendix AA: Referral for Housing Choice Vouchers*). The tenant-based rental assistance program assists households to rent safe, decent, and sanitary dwelling units in the private rental market. MFP participants are eligible for the program because most MFP participants do not have incomes that exceed 50% of the area median income as adjusted for family size.

The Housing Coalition will work with DCA to evaluate alternatives to encourage enhanced access to these voucher resources by MFP and HCBS participants. In addition, the MFP program is committed to developing discussions with metro PHAs, those not under the auspices of DCA, in an effort to reach out to these metro PHAs for additional voucher resources for MFP participants. In consultation with DCA, MFP community transition partners and Transition Coordinators will approach these PHAs to develop plans for allocations and priorities for MFP participants. In consultation with DCA and PHAs across the state, the Housing Coalition will discuss mechanisms that can be used to develop extensive regional interagency coordination and cooperation to expand the number of available Housing Choice Vouchers. MFP TCs will work with housing developers to promote the need for very low income subsidized rental housing options for MFP participants. MFP will use MMIS data to track and report the number of participants using Housing Choice Vouchers each year during the MFP Demonstration Project.

Create PHA Partnerships

Centers for Independent Living (CILs) and Aging and Disability Resource Connections (ADRCs) continue to play important roles in resettling people with disabilities and older adults in their communities. MFP TCs will work with their local ADRCs and CILs to develop mechanisms to establish agreements with local Public Housing Authorities (PHAs). Partnerships will focus on developing rental vouchers and will emphasize the need for PHAs to prioritize housing needs for persons transitioning from state institutions and nursing facilities (MFP participants), the creation of waiting list preferences for these individuals, and the inclusion of additional rental vouchers in the PHA Administrative Plans.

Create Bridge Rental Subsidy Programs

Bridge rent subsidy program plans will be reviewed to use rental assistance resources – such as HOME or funding from human service agencies – to provide temporary rental assistance until a person receives a Housing Choice Voucher. Plans for bridge subsidies would help MFP participants obtain affordable housing while they apply for and/or wait for a permanent Housing Choice voucher. In consultation with DCA, Housing Coalition work group partners will explore ways to work with local governments that receive HOME funds directly from HUD and PHAs to (1) identify funds for Bridge Subsidy Programs, (2) partner with PHAs to develop strong linkages, and (3) create Housing Choice Voucher waiting list preferences for persons transitioning from state institutions and nursing facilities (MFP participants) to be included in the Administrative Plan. With plans to work with DCH and PHAs for possible adequate supplies of vouchers, MFP participants can resettle and the bridge subsidies can continue to be recycled among MFP participants in need of rental assistance.

Improve Access to Existing Rental Assistance Programs

Housing Coalition work group partners will work with DCA and PHAs to expand the definition of “disabled household” to include unrelated adults with disabilities living together, extend housing search times beyond 120 days, and allow vouchers to be used in congregate settings, group homes (with 4 or fewer unrelated adults) and in roommate situations.

Increase Housing Education and Access to Housing Search Tools
The research tool available at www.GeorgiaHousingSearch.org provides MFP participants and all Georgians with access to information about affordable rental housing opportunities, including those that have certain accessibility features. It also provides secure, behind the scenes access to additional housing information that would be beneficial to assist MFP candidates. MFP Transition Coordinators (TCs) must participate in Confidentiality Training to gain access to the secure sections of the site. MFP state staff will work with DCA, local PHAs and other state housing programs to educate and inform about MFP, the need for affordable, accessible and integrated housing and the need for rental subsidies (vouchers) for MFP participants.

Expand the Home Access (HA) (Environmental Modification) Program
The Georgia State Housing Trust Fund for the Homeless received a $300,000 annual increase in the SFY 2007 budget to expand the HA program for accessibility modifications at owner-occupied homes in which a person with a physical disability resides. MFP supplemental demonstration service funding for environmental modifications will augment funding available through the HA program and expand it to serve MFP participants. MFP TCs will work with local Centers for Independent Living (CILs) and Aging and Disability Resource Connections (ADRCs) to assist them in becoming local contract administrators for the HA program. In addition, the Credit Able Program (loan guarantee program) will be leveraged to fund accessibility modifications needed by MFP participants.

Promote Home Ownership for MFP Participants using Vouchers
Through the Home ownership option of the Housing Choice Voucher (HCV) program, MFP participants using vouchers will receive information about the use of voucher payments to pay for home ownership mortgages. Through consultation, discussions and planning with DCA and other local public housing authorities administering the HCV program, MFP TCs may have the opportunity to promote this option to MFP voucher recipients. In addition, the CHOICE option under the Georgia Dream Homeownership Program could be used to enhance down payment assistance for MFP participants.

Through long-range initiatives and near-term strategies and activities, the Housing Coalition work group partners will collaborate with PHAs and DCA to leverage state, local, private, and federal resources to increase the potential supply of affordable, accessible and integrated housing to resettle Medicaid eligible older adults and persons with disabilities.

B.10 Continuity of Care Post-Demonstration

This section describes procedures used before, during and at the end of the 12 month MFP demonstration to ensure that MFP participants continue their eligibility for Medicaid HCBS waiver services, including how MFP participants enter each HCBS waiver program and how continuing eligibility is determined. This section concludes with a description of options that exist if the individual no longer qualifies because they do not meet nursing facility/institutional level-of-care criteria or do not qualify under Georgia Medicaid financial criteria for community-based waiver services.

MFP will use existing Medicaid 1915c waiver services and MFP transition services to help participants resettle in the community. Each MFP participant will transition into a current HCBS waiver and will receive MFP services in addition to the waiver services as identified in *Section*, *B.5 Benefits and Services*. MFP participants will be enrolled into one of the four waivers: the Elderly and Disabled waiver program, the Independent Care Waiver Program (ICWP) or the NOW or COMP waivers. Because MFP participants will be served through existing waivers, procedures and mechanisms for service delivery are already in place to ensure that MFP demonstration participants can continue to be served under Medicaid HCBS waivers after the 365th day of demonstration services, as long as they continue to meet waiver eligibility requirements. Current HCBS waivers serve each targeted MFP population: the elderly, persons with physical disabilities, persons with traumatic brain injury, and persons with developmental disabilities or mental retardation. MFP participants from these populations have resided in an institutional setting (i.e. nursing home, ICF/MR) for a period of at least six months and have expressed an interest in resettlement.

Continuity of care post-transition will be assured for each demonstration participant through each of the following MFP mechanisms:

Transition screening—these processes will be adapted to gauge the likelihood of a successful transition for each MFP participant. Using the MFP Transition Screening Form (*see Appendix G: MFP Transition Screening Form)*, MFP TCs will gather information about the candidates background, personal goals, resources, and functional needs in order to closely match the person to the most appropriate HCBS waiver. During the screening process, MFP TCs will also identify individuals for whom a transition is either not feasible or is medically contra-indicated and compare these findings to how far MFP, along with the waiver and state plan services, can go to accommodate the needs of the individual.

Person-Centered Planning Process—will be used to assist the participant to re-connect or to connect to community resources for the first time. Person-centered planning will assist the MFP TC to help the participant discover what s/he wants, resources (both personal and community), and who can assist them in terms of circles-of-support. This person-centered planning process will ensure successful resettlement and help the MFP participant reconnect to the community in a manner that will sustain the participant long after the MFP demonstration is ended.

The results of person-centered planning will be captured in the *Individualized Transition Plan* (ITP) (see *Appendix Q1 and Q2*). MFP TCs will write and implement the ITP. The ITP should help reduce the overall time needed to make a successful transition by identifying and removing barriers to resettlement and by facilitating assessment and service planning through coordination with waiver staff, waiver services, and MFP services to ensure a smooth transition and entrance into an appropriate HCBS waiver. MFP participants transitioning out of nursing homes or ICF/MRs will receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, State funded programs, and local community funded services. The state is not seeking enhanced match for State Plan services provided to MFP participants.

Quality of Life Survey—results of the QoL survey will assist both the MFP and waiver programs to improve the quality of their services. The QoL results will help to ensure that evaluative findings are used to improve overall transition services in the state. Long-range, operational changes will result from QoL findings.

Services That Continue Beyond the Demonstration

The state will assure that HCBS waiver services will continue to transitioned individuals, as appropriate, beyond the demonstration period. Transitioned individuals entering an appropriate 1915c home and community based waiver program will continue to receive services as long as they continue to meet eligibility criteria. Once transitioned, participants will continue receiving HCBS waiver services, and if appropriate and applicable, Medicaid State Plan services, non-Medicaid federally funded services, state funded programs, and local community support systems and funding. Utilization reviews, consumer input, and appropriation of funds by the General Assembly will also impact on continuation of MFP services beyond the demonstration period.

The state considers MFP an opportunity to test the feasibility of continuing demonstration and supplemental services, future inclusion in waivers, and/or addition of services to current HCBS waivers. The state has conceived benchmark #3 in an effort to compare MFP transition processes to current transition processes the state has in place. With data collected from Benchmark #3 (and all benchmarks) and the data tracking the state will engage in throughout the MFP demonstration, the state will be able to measure the effectiveness of and understand how MFP services have improved the state's ability to resettle older adults and persons with various types of disabilities in the community.

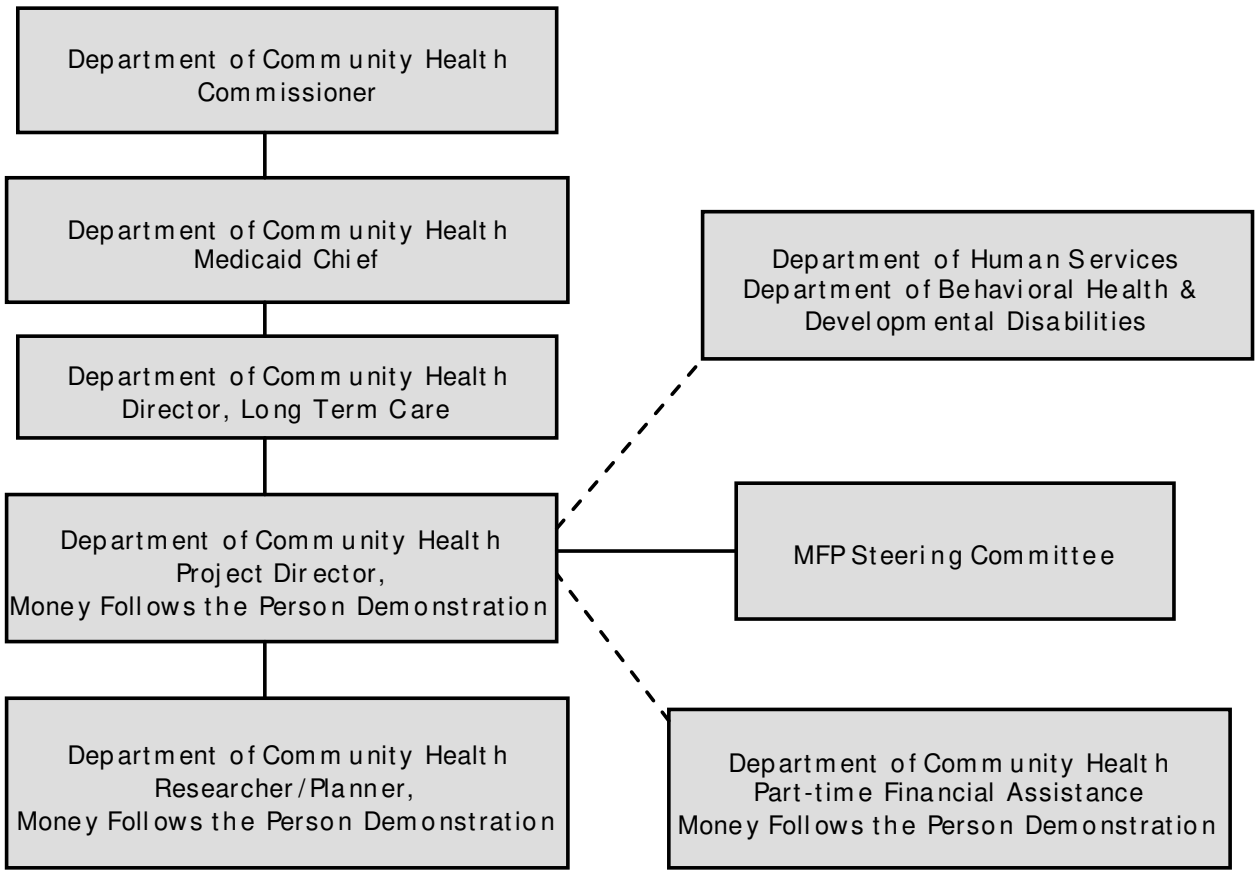
C.1 Organizational Structure

Overall authority, administration, oversight and supervision of Georgia's MFP demonstration program reside in the Medicaid Division in the Department of Community Health (DCH), Long-term Care section.

The MFP Project Director and Researcher/Planner are employed by DCH. DCH is responsible for administering and implementing Georgia's MFP demonstration program in accordance with the approval of this operational protocol by CMS. The Project Director provides direct management of the MFP project under the supervision of the Director of the DCH Long-term Care section. The Researcher/Planner performs complex and comprehensive research for the MFP project under the supervision of the MFP Project Director.

A Project Coordinator, employed by the Department of Behavioral Health and Developmental Disabilities, manages activities in DBHDD and serves as a liaison to the Project Director with limited responsibilities.

Georgia's MFP Demonstration Organizational Chart



C.2 Staffing Plan

Authority for the administration and supervision of the MFP Program will reside in the Medicaid Division of the Department of Community Health (DCH), the recipient of the MFP grant award. DCH is responsible for ensuring the grant is implemented according to the operational protocol design approved by CMS, to include tracking expenditures and MOE targets, financial reporting, semi-annual progress reports, and coordination with the national contractors for technical assistance and evaluation.

The MFP grant funding enables Georgia to further enhance its Olmstead Initiatives. The state will submit a request for proposal (RFP) to perform the duties and responsibilities of MFP Transition Coordinators. Transition Coordinators will screen and assist those members residing in institutions wanting to transition by identifying member's needs for one-time transition services and home and community based services necessary. See section *B.2 Benchmarks* and *B.6 Consumer Supports* for specific details.

The MFP Project Director and Project Researcher/Planner, both employees of DCH, will be responsible for carrying out the responsibilities residing in DCH and for interagency coordination in the implementation of the program, under the supervision of the Director of DCH Long-term Care section. For resumes and job descriptions of project staff, see *Appendix J1: MFP Project Director Resume and Appendix J2: Resume for MFP Project Planner*.

The MFP Project Director responsibilities include:

- oversees execution of the RFP process to hire transition coordinator contractor
- identifies appropriate information, resources, and technical assistance necessary for the awarded contractor to complete assigned tasks
- provides the operational policies and procedures
- conducts programmatic reviews and audits, monitoring, quality assurance, and quality improvement
- reviews and approves the DCH private vendor's contract deliverables related to the demonstration project
- monitors grant expenditures against approved limits
- provides on-going guidance and project coordination within DCH and the Department of Human Services (DHS) and Department of Behavioral Health and Developmental Disabilities (DBHDD)
- reviews participant service plans to ensure program requirements are met
- establishes prior authorization limits
- sets reimbursement rates
- performs utilization management functions and reviews consumer survey data
- conducts statewide stakeholder forums.

The Elderly and Disabled waiver program is a joint effort between DCH and DHS, and the Mental Retardation waiver programs day-to-day management is a joint

effort of DCH and DBHDD. The Independent Care Waiver Program (ICWP) is managed by the Long-term Care section of DCH.

C.3 Billing and Reimbursement Procedures

Pending final cost and time estimates for systems changes and the availability of funding, the Department of Community Health will determine whether claims for the MFP demonstration will be processed through its existing MMIS system (MFP Implementation Ticket 8720) or by a manual process of invoicing (for process detail, see *Appendix I: MFP Flowcharts and Text Descriptions*). Irrespective of the decision, monitoring procedures will be in place to ensure against duplication of payment and fraud.

Additionally, DCH will query and check edits and audit processes for providers of services, members' eligibility and lock-in span (to prevent overlapping spans), track MFP span for enhanced match not to exceed a total of 365 days, and reference data (i.e. procedure codes, rates and limitations) during the adjudication process for validation to allow claims to process and pay providers (see *Appendix Z: MFP Manual Tracking Database Screens)*. Claims will either pay as approved, suspend, or be denied based on MFP and waiver service reimbursement validation processes (see *Appendix O: FI Invoice to DCH for Payment, Appendix S: Authorization for MFP Services, Appendix V: MFP DCH DHR Vendor Import File* and *Appendix Y: Participant Enrollment Status Change Form*).

Providers will receive a Remittance Advice (RA) of all claims status submitted and processed through MMIS. Financial data for each claim will be extracted from MMIS to complete the MFP financial reporting requirements.