



## **MISSOURI's**

**MONEY FOLLOWS THE PERSON (MFP)  
REBALANCING DEMONSTRATION:  
My Life, My Way, My Community**

# **OPERATIONAL PROTOCOL**

**Revision 1.3  
October 2016**

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## **A1. Abbreviations**

AAA – Area Agencies on Aging

ADRC – Aging and Disability Resource Center

CDS – Consumer Directed Services

CIL – Centers for Independent Living

DD – (Division of) Developmental Disabilities

DHSS – Department of Health and Senior Services

DMH – Department of Mental Health

DSDS - Division of Senior and Disability Services

HCBS – Home and Community-Based Services

ICF-MR – Institutional Care Facilities for the Mentally Retarded, Habilitation Centers

IMD - Psychiatric Hospital

ISL – Individualized Supported Living

LOC – Level of Care

LTC – Long term care services (includes HCBS)

MDS (Section Q) - Minimum Data Set

MHD – MO HealthNet Division

PCP – Person-Centered Planning

PHA – Public Housing Authority

PRTF – Psychiatric Residential Treatment Facility

QoL – Quality of Life Surveys

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MISSOURI'S OPERATIONAL PROTOCOL**

**A2. Required Contents of the Operational Protocol**

**Project Introduction**

This protocol outlines the major steps and processes that support the successful transition of participants from institutional to community settings. These steps are discussed in detail within this protocol. The following table gives a broad overview from the perspective of the potential participant.

How will I learn about MFP?	<ul style="list-style-type: none"> <li>• Information will be provided during your annual Person Centered Planning Meeting.</li> <li>• Long Term Care Ombudsman, Area Agencies on Aging, and Centers for Independent Living will distribute information during contact with potential participants.</li> <li>• Informational materials will be distributed to advocacy groups, family, friends and others.</li> <li>• Options Counselors will provide information to yes responses to MDS Section Q</li> </ul>
How will I be supported to plan my move to the community?	<ul style="list-style-type: none"> <li>• A planning team including yourself will be organized to help plan your transition.</li> <li>• The team will assist you to identify the services and supports you need to live in the community.</li> <li>• You will have access to services for your home to make it ready for you to move in.</li> </ul>
Where will I live?	<ul style="list-style-type: none"> <li>• You will be given options and be able to visit and choose where you want to live.</li> <li>• Your options will include renting or owning a home, living with a family member who owns or rents their home, living in a group home of 4 or less individuals, etc.</li> </ul>
What type of support will I have in the community?	<ul style="list-style-type: none"> <li>• You will have a transition coordinator that will assist you to coordinate your services and supports.</li> <li>• There will be someone you can reach 24 hours a day.</li> </ul>
What about my safety in the community?	<ul style="list-style-type: none"> <li>• The state has processes in place to help ensure that you will be safe.</li> <li>• Quality of Life Surveys will be done to monitor your progress.</li> <li>• You will have someone you can reach 24 hours a day if something is wrong.</li> </ul>

The overall goal of this initiative is *“to support Missouri citizens who have disabilities and those who are aging to transition from institutional to quality community settings that are consistent with their individual support needs and preferences.”* This initiative will enhance existing efforts to transform the long-term support system that provides services for the elderly and people with disabilities and will result in an increased use of home and community-based, rather than institutional, long-term care services. As a result of this demonstration the state will:

**Objective 1: Transition 1922 individuals with disabilities and/or or who are aging from habilitation centers and nursing facilities to the community**

Strategies:

- Through annual person centered planning meetings for people living in habilitation centers, identify individuals who wish to transition to communities, and provide all assistance needed to implement the transition.
- DSOS will contract with CILs and AAAs for options counseling and transition coordination. Options counselors will identify potential participants through MDS Section Q referrals for individuals in nursing facilities. If an eligible individual wishes to transition to a community setting, transition services will be provided through a person-centered approach. The state will also continue to identify and outreach to potential self-referrals, family members and others.

Outcomes:

- A minimum of 1922 eligible individuals will choose to move from Medicaid-funded beds to communities. The state will assist any eligible individual who wishes to transition out of a facility, whose needs can be met by the array of community-based services available in the state, regardless of whether they are part of the actual MFP demonstration.
- The need for long term beds in state-operated facilities will decrease as more individuals are served in communities.

**Objective 2: Eliminate barriers that prevent individuals currently residing in state or private facilities from accessing needed long-term community support services**

Strategies:

- Provide demonstration transition services to set up a new household, expenditure up to \$2400, for participants transitioning from nursing facilities to communities to be used within 365 days of transition.
- Increase the level of outreach provided by Centers for Independent Living and LTC Ombudsmen to individuals residing in nursing facilities.
- Collaborate with other statewide networks, such as Area Agencies on Aging, and Missouri Brain Injury Program, for additional outreach activities.
- Broaden options for contracting with qualified providers to increase service capacity.
- Identify and track, through a web-based system, reasons why individuals are unable to leave facilities (unable to meet Medicaid financial eligibility criteria in community, guardian refuses permission to transition, needs cannot be met with current service array, etc).
- Implement self-directed service options throughout system.

Outcomes:

- Increased awareness about home and community options for individuals who live in facilities.
- Better data on specific barriers to transition will enable state to target initiatives tailored to address those barriers.
- Increased number of people opting to self-direct.

**Objective 3: Improve the ability of the Missouri Medicaid Program to continue the provision of Home and Community Based Services (HCBS) to individuals choosing to transition to communities**

Strategies:

- Reinvest savings from reduction of need for beds in habilitation centers into HCBS.
- Gather data from Quality of Life surveys on positive outcomes to support future budget requests for continued/increased funding of HCBS.

Outcomes:

- Increased proportion of Missouri's total long term care funding will be for HCBS.
- Increasing numbers of individuals who are eligible for long term care services and supports who will choose HCBS options over facility-based care.

**Objective 4: Ensure procedures are in place to provide continuous quality improvement in HCBS.**

Strategies:

- Quality management system for demonstration participants will be same level of quality assurance and improvement already provided under Missouri's 1915(c) HCBS waivers.
- 100% of demonstration participants will have the opportunity to participate in Quality of Life surveys.
- Redesign process for licensure and review of community-based providers contracting with the Division of DD.
- Gather and track information via the MFP web-based system on factors affecting a participant's success in the community; such as critical incidents, hospitalizations, reinstitutionalizations, etc.

Outcomes:

- Improved methods of reporting, tracking and integrating data to better identify trends and patterns, leading to more immediate and effective corrective action.
- Increased levels of participant satisfaction in HCBS.

**A3 Populations Served**

Missouri's MFP will transition participants from four target groups:

Aged (Elderly) – participants who are ages 63 or older

Physically Disabled – participants with physical disabilities ages 18-62

Developmentally Disabled – participants with a developmental disability, ages 18 and older

Developmentally Disabled/Mentally Ill – participants with co-occurring developmental disability and mental illness, ages 18 and older

#### **A4. Coordinator Roles Defined**

Transition Coordinator – The Transition Coordinator works to successfully transition MFP participants into the community and arranges any services, supports and follow-up that are needed. The Transition Coordinator monitors services and supports and progress of the participant. Please note: for DSDS participants, the transition coordinator works closely with the participant for the entire 365 day period. For DD participants, the DMH Transition Coordinator works with individuals who are seeking transition into the community, their families and guardians to explore and choose options for transition to the community, and facilitates all the processes needed to ensure that the individual successfully transitions to community living.

Community Living Coordinator (DMH) – The DD Community Living Coordinator acts as the Transition Coordinator for DD participants who transition from a nursing home. The Community Living Coordinator also maintains contact with the Service Coordinator throughout the transition period for all DD participants and completes follow up reports via the MFP web-based system.

Service Coordinator (DMH) - The Service Coordinator monitors the services and supports the developmentally disabled participant receives once living in the community, facilitates the annual plan and arranges any additional services, supports or follow up that is needed. The Service Coordinator takes over after the Transition Coordinator has facilitated the participant's transition into the community.

Please note: For DD participants, coordination will be provided by a team which includes the **Transition Coordinator** (who is primarily involved with the initial transition process for participants moving out of a Habilitation Center) or a Community Living Coordinator (who is primarily involved with the initial transition process for participants moving out of a nursing home, and for the remaining 365 days in the community for all DD participants regardless of the kind of care facility they moved from). **Community Living Coordinators** (work closely with newly transitioned participants for the first 90 days and also follows their progress throughout the year by communication with the Service Coordinator). The **Service Coordinator** maintains close contact with the participant for the remainder of their 365 days. The Service Coordinator will provide regular updates to the Community Living Coordinator who communicates changes to MFP Program Staff and enters updates into the MFP web-based system. As there will be a team approach for DMH in following a participant throughout their 365 days, in this Operational Protocol, please note that the term “Transition Coordinator” can include various coordinators within the DMH transition team as well as the DSDS transition coordinators.

MFP Regional Coordinator (DSDS) – DSDS has established five state regions for Adult Protective and Community Services, and each of these regions has a designated MFP Regional

Coordinator. MFP Regional Coordinators will provide technical assistance for AAAs and CILs staff who will provide options counseling and transition coordination services.

#### A4. Benchmarks

The following are the five benchmarks that will be measured for the Missouri's Money Follows the Person Demonstration. There is also more information regarding measures the state will be evaluating in Section D.

- **Benchmark #1: The number of eligible individuals in each target group who transition.**

The following table represents the projected number of eligible individuals in each target group to be assisted in transitioning from an inpatient facility to a qualified residence during each year of the demonstration beginning January 1, 2007.

Grant Year	Elderly	Physically Disabled	Individuals with DD	Dual Diagnosis: DD and MI	TOTAL
2007	2	3	2	0	7
2008	10	20	24	5	59
2009	18	47	71	2	138
2010	20	43	27	3	92
2011	35	53	43	11	142
2012	70	86	62	7	225
2013	35	92	34	2	163
2014	53	108	22	3	186
2015	64	120	61	4	249
2016	54	127	32	2	215
2017	57	134	25	2	218
2018	61	141	24	2	228
TOTAL	479	973	427	43	1922

- **Benchmark #2: Expenditures for HCBS during each year of the demonstration program.** The following table represents the expenditures for HCBS for all individuals including one time MFP Demonstration HCBS. MFP Demonstration HCBS are for participants who transition from nursing facility to community as part of the MFP demonstration for each state fiscal year. The MFP Demonstration HCBS have been placed on a separate line without a trend forward. The DMH and DHSS HCBS amounts were based on the State Fiscal Year 2007 Medicaid expenditure data

and were trended forward by 4% per year for each year of the demonstration. Services included are: Aged and Disabled Waiver, AIDS Waiver, Physical Disabilities Waiver, Independent Living Waiver, DD Waiver, Community Support Waiver, Adult Day Care, Homemaker services, Respite Care services, Personal Care, Targeted Case Management. The state did not request a trend factor be applied to the *MFP Demonstration HCBS* in this demonstration. Year 1 will not begin until the Operational Protocol is approved. The unusually high percentage increases over the past few years were due to Missouri's efforts to assist individuals to remain in or return to the community. Missouri anticipates the percentage of increase to level-out since many individuals have already enrolled in HCBS programs.

	SFY 2007	SFY 2008	SFY 2009	SFY 2010
HCBS	\$833,986,647	\$867,346,113	\$902,039,957	\$938,121,556
Demonstration	\$0	\$12,944	\$80,469	\$55,396
Total	\$833,986,647	\$867,359,057	\$902,120,426	\$938,176,952

	SFY 2011	SFY 2012	SFY 2013	SFY 2014
HCBS	\$975,646,418	\$1,014,672,275	\$1,055,259,166	\$1,097,469,533
Demonstration	\$85,212	\$119,917	\$261,678	\$218,463
Total	\$975,731,630	\$1,014,847,392	\$1,055,576,044	\$1,097,743,196

	SFY 2015	SFY 2016	SFY 2017	SFY 2018
HCBS	\$1,141,368,314	\$1,187,023,047	\$1,234,503,969	\$1,283,884,128
Demonstration	\$292,399	\$434,400	\$458,400	\$484,800
A.T.		\$175,000	\$175,000	\$175,000
Total	\$1,141,660,713	\$1,187,632,447	\$1,235,137,369	\$1,284,543,928

- Benchmark #3: A percentage increase in HCBS provided through DD Waiver versus state owned ICF/MR for each year of the demonstration program.** In FY 2006 the state of Missouri's expenditures for state owned ICF/MR were \$84,797,699 (27%) and expenditures for HCBS under the DD waiver were \$310,576,289 (73%). Information will be obtained from the Medicaid annual expenditure reports for state fiscal year. The state anticipates a 2 percentage point increase in DD HCBS due to awareness of available services as a result of implementation of Money Follows the Person demonstration. It is anticipated that the expenditures for state owned ICF/MR will decrease but there is no anticipation of changes to expenditures in nursing homes due to an aging population and increased amount of nursing home reimbursement. The following are projections for percentage changes during each fiscal year.

State Fiscal Year	DD Waiver Expenditures	ICF/MR expenditures
SFY 2007	73%	27%
SFY 2008	75%	25%
SFY 2009	77%	23%

SFY 2010	79%	21%
SFY 2011	81%	19%
SFY 2012	83%	17%
SFY 2013	85%	15%
SFY 2014	87%	13%
SFY 2015	89%	11%
SFY 2016	91%	9%

**Benchmark #4: Continue to keep the number of MFP eligible individuals who are unable to obtain affordable/accessible housing below 3 percent.** From the inception of the program and as of January 1, 2012, out of 732 individuals eligible for MFP, only 15 assessed/qualified individuals were identified as unable to transition due to the lack of sufficient affordable or accessible housing. As the project continues to grow, MFP project staff will work to ensure individuals who have difficulty finding adequate housing will remain below 3 percent. Information about the number of participants that have been assessed and who qualify for the MFP program that have indicated finding housing as a barrier to transition will be captured by project staff through reporting in a web-based system. Also, inquiries will be made regarding those assessed and qualifying participants that do not transition within a 365 day period to ensure whether a lack of affordable or accessible housing kept them from transitioning into the community. Staff assigned will work with those participants who are unable to locate housing to ensure all avenues have been exhausted for appropriate/affordable housing.

Calendar Year	Percent Unable to Transition Due to Lack of Affordable or Accessible Housing
2011	2%
2012	1.98%
2013	3.36%
2014	4.7%
2015	3.69%

- Benchmark #5: Number of individuals self-directing a portion of their HCBS.** Currently there are 8851 people receiving HCBS through DMH/Division of DD, 196 of those people, or 2.28%, are self-directing their care. Currently there are 44,291 aged and/or disabled individuals receiving HCBS through DHSS/DSDS, of those 18.4% or 8155 are self-directing their care. The state will measure the increase in self-direction for all individuals receiving HCBS and those who are self-directing as well as those who are participating in the MFP demonstration. The state anticipates through implementation of Money Follows the Person Demonstration and removal of barriers to self direct there will be an overall increase in self-direction of all HCBS of at least 2%. The state anticipates that at least 25% of MFP participants will self direct their care with a cumulative total of anyone who has been in MFP who are self-directing being 63 out of the 250.

**Percentage of all individuals receiving HCBS self-directing care**

	Percentage of DD and those with a co-occurring MI Self-Directing	Percentage of Aged and Physically Disabled Self-Directing
SFY 07	3%	18%

SFY 08	5%	20%
SFY 09	7%	22%
SFY 10	5.10%	24%
SFY 11	6.6%	26%
SFY 12	7.5%	18%
SFY 13	5%	20%
SFY 14	7%	22%
SFY 15	9%	24%
SFY 16	11%	26%

**MFP participants who are or have been a MFP participant during the demonstration period and continue to self-direct services**

	MFP Participants	Number self-directing
2007	7	1
2008	66	16
2009	205	51
2010	297	74
2011	436	109
2012	609	152
2013	752	188
2014	895	223
2015	1038	259
2016	1187	296

## **B. Demonstration Implementation Policies and Procedures**

### **1. Participant Recruitment and Enrollment**

The MFP Demonstration will include the entire geographical area of the state. The following will discuss the recruitment and enrollment process for State Habilitation and Nursing Facilities.

**Habilitation Centers:** People with developmental disabilities who reside in a Missouri Habilitation Center will be considered as a possible participant. Individual Service Plans, which are individualized and person-centered, are prepared at the Habilitation Center during the PCP meeting on an annual basis; at this time transition into the community is discussed. Habilitation Center staff and transition coordinators use a variety of methods to inform individuals of the possibility of community living and services that are available to them. These methods include sharing brochures and videos highlighting success of participants who have transitioned to the community, sharing lists of community providers and their brochures and websites describing the supports they provide, presenting information about community support options at Parent Organization meetings, offering individuals and families the opportunity to meet with other individuals and families who have experienced transition, etc. Individuals may also be considered if an interest to transition occurs at any point during their stay at the habilitation center.

**Nursing Facilities:** The contracted transition coordinators, MFP Regional Coordinators and Missouri Long Term Care Ombudsman currently have access to residents of nursing

facilities who have physical disabilities or who are elderly and will assist in recruiting participants. Missouri state regulation requires distribution of the “The Our Parents, Ourselves” brochure, prior to or upon the admission of a nursing facility. This guide will be used by the MFP Regional Coordinator and Ombudsman in providing education during their visits or to anyone contacting them of their wish to return to the community.

This demonstration will transition individuals out of habilitation centers and Nursing Facilities. A description of each facility is listed below:

**Habilitation Centers:** In the State of Missouri, ICF/MRs are referred to as Habilitation Centers. The state has both public and private ICF-MRs. All Medicaid enrolled habilitation centers in the state of Missouri can participate. Individuals who wish to transition from any of these facilities will be considered as a potential participant. A habilitation center is an intermediate care facility for individuals with developmental disabilities; it meets the requirement of an inpatient facility under 6071(b)(3) of the Deficit Reduction Act.

**Nursing Facilities:** All Medicaid enrolled nursing facilities in the state of Missouri may participate. Individuals who wish to transition from a nursing facility will be considered as a potential participant. Nursing facilities are a covered inpatient facility under 6071(b)(3) of the Deficit Reduction Act.

The individual must have resided in a Habilitation center or a Nursing Facility no less than 90 days prior to the date of transition. The 90 days must not be non-Medicaid short term rehabilitation days. The individual must have been receiving Medicaid benefits for inpatient services furnished by a habilitation center or nursing facility. For those individuals transitioning from a Habilitation center the MFP eligibility requirements will be determined by the transition coordinator during the PCP meeting. For those transitioning from a nursing facility, eligibility requirement will be determined by DSDS staff. Medicaid eligibility requirements will be verified in the state eligibility Family Assistance Management Information System (FAMIS) and will be monitored by the MFP project director.

The individual must have resided in an inpatient facility for 90 days, and they must transition from a certified facility after at least one inpatient Medicaid paid day in that qualified (certified) institution. The days counted include days in a Hospital, Nursing Home, ICF-MR or an IMD inpatient setting toward those 90 consecutive days, including when an individual transfers between qualified institutions. This would include days in an IMD (Psychiatric Hospital or PRTF) and from ICFs-MR that have been de-certified but the qualified Medicaid recipient presently resides in a qualified institution in which they will transition into the community under MFP.

The person’s demonstration days will be cumulative over the demonstration period. If a person returns to an inpatient facility for less than 30 days, they will remain a participant in the program and the end date of participation in MFP will be extended to account for any institutional days to complete the 365 days of community living. If they are re-institutionalized for 30 days or greater at any point during the demonstration period they will be considered suspended from the MFP demonstration program. However, the former participant can be reactivated prior to the

completion of 365 days without having to re-establish the 90 day institutional residency requirement. The end date of enrollment will be extended to account for any institutional days to complete the 365 days of community living. Every effort will be made to allow the participant to remain in the community. Arrangements may be made to secure the participants place of residence on a case by case basis. Waiver slots will be retained for up to 60 days if there is a professional medical opinion to indicate the person will be ready to return to the community at that time.

The participant's transition coordinator must input admit dates of any hospitalizations or return to an inpatient facility into the MFP web-based system. When the participant returns to the community or resumes participation in the MFP program, coordinators must input the discharge date into the MFP web-based system as well.

Participants who have been re-institutionalized after completing 365 days in the program may participate again if they are qualified individuals and have met the 90 day institutional residency requirement. Each case will be reviewed; barriers will be identified that caused the first transition to be unsuccessful, a new transition plan will be developed that will address those barriers, and the current needs and wants of the participant will be considered. Each case will be monitored closely by the respective department state staff to assure their needs will be met at the time of discharge. Prior to re-enrollment, measures should be taken to determine if the Plan of Care could not be carried out as a result of:

- a) Medical and/or behavioral changes resulting in the necessity of readmission into the inpatient facility.
- b) The lack of community services that adequately supported the participant that were originally identified in the original plan of care.
- c) The plan of care was not supported by the delivery of quality services.

After determining the basis for re-institutionalization, and changes are made to the plan of care that take into consideration the possible causes for a return to institutional care, a former participant who completed 365 days in the program may be re-enrolled.

The following are the procedures and processes that the state will utilize to ensure that the participants have the information they need to make informed choices about their care for Habilitation center and Nursing Facility potential participants and their guardians.

**Habilitation Centers:** Habilitation center staff annually provides training and education by reviewing a Client Rights brochure (Attachment E) with individuals and their guardians. The brochure specifies rights individuals receiving services through the Division of DD have under Missouri state law (Sec. 630.15, RSMo.) The brochure also informs individuals and their parents or guardians that they can contact the clients rights monitor with the Department of Mental Health if they think they are being abused, neglected, or have had rights taken away. Contact information includes an e-mail address, toll-free and toll phone numbers, fax number, and written address. Habilitation center staff also obtain annually a signed Client's Rights Receipt to demonstrate rights information was provided to the individual or legal guardian.

The Missouri Department of Mental Health has a web site [www.dmh.mo.gov](http://www.dmh.mo.gov) which provides individuals and families a link to view Client Rights, Abuse & Neglect Definitions, and the

Reporting and Investigation process which includes contact information. The DMH Client Rights Brochure information is posted on the web at <http://dmh.mo.gov/constituentservices/rights.html> . The brochure on Individual Rights of Persons Receiving Services from the Division of DD is located at <http://dmh.mo.gov/docs/dd/indrightrights.pdf>. The Division of DD's process for informing staff, providers and individuals on reporting alleged abuse or neglect can be found at <http://dmh.mo.gov/opla/keepingmentalhealthservicessafe.html>

**Nursing Facilities:** DSDS staff will distribute the "Silence is not Golden" brochure (Attachment F) which provides a toll free hotline number for abuse, neglect and exploitation to the individual, family and guardian. The brochure gives examples of elder abuse and warning signs to watch for if you are a guardian or family member. DSDS staff will discuss the information on the Home and Community Based Services Care Plan with the participant (Attachment G) which states participant rights and responsibilities at the time of assessment and services planning. A copy of this care plan, which contains contact information on the toll free hotline, is given to the participant.

DHSS maintains a website which provides details regarding the reporting of elder abuse. This information is posted at <http://www.health.mo.gov/safety/abuse/>. The link provides a brief overview as well as contact information for making reports of abuse, neglect or exploitation.

Regional coordinators will provide information to individuals receiving HCBS regarding participant rights during the initial and annual reassessment or in the event of changes to a service plan.

## **2) Informed Consent and Guardianship/Conservatorship**

The procedure to obtain informed consent is consistent statewide. A transition coordinator or MFP Regional Coordinator will meet with the individual or their guardian to review all aspects of the demonstration. This will include information on the enhanced match funding, process for enrollment, eligibility criteria, process for transition planning, community service options and continued supports after year one. The individual or guardian will be informed of their rights, and provided a written explanation of their rights and the appeals process. The individual's transition coordinator/community living coordinator will continue to be available to the individual/guardian to facilitate the transition process and address questions and concerns as necessary. Those who wish to participate in the demonstration will complete the Money Follows the Person Participation Agreement (Attachment H). Individuals who wish to participate in the demonstration and who have a guardian may do so with the consent of the guardian. The level of the participant's involvement in the six months preceding application for Money Follows the Person will be determined through conversations with habilitation center/nursing facility staff, the MFP applicant, and the appointed guardian. It will be explained that the guardian's participation in and cooperation with the transition process is imperative, and that active involvement is expected. Contact between guardian and participant will be recorded in the participant's case notes. Guardians will be made aware that their input on demonstration related surveys is critical in determining that the needs of the MFP participant continue to be met in ensuring the success of the transition.

Once all information is disseminated to the potential participant and the individual indicates interest in transitioning, the Money follows the Person Participation Agreement will be used as an educational tool to describe to the individual or guardian the participation requirements of Money Follows the Person Demonstration. Prior to signing the agreement, the transition coordinator will explain each step. If the individual or their guardian agrees to participate, they must sign the form. In the case of a guardianship, the transition coordinator will work with the guardian to explain the importance of interaction with the participant.

Guardianship and Conservatorship are established through legal processes and are not habilitative services by definition. Missouri State Statute RSMo Chapter 475 governs the laws pertaining to guardianship. Habilitation center staff are responsible for assisting families in understanding the role and function of guardians and conservators. These legal processes will be discussed with families in the same manner and using the same guiding principles that all other legal services are discussed. Life planning for people with developmental disabilities will include the assessment of an individual's functional skills relative to the potential need for a guardian and/or conservator. The decision to pursue guardianship and/or conservatorship is usually a private family matter. It is only when an individual has no qualified family members (i.e., family members that will not abuse, exploit or neglect the individual, and who have the capacity to care for the needs of the individual) to support them, or when family members are unable or unwilling to be part of the individual's support network and when all other reasonable efforts to support the individual and assure their health and safety fail that the service coordinator would take a lead role in pursuing this legal process for an individual they support. The Missouri statutes recognize that individuals may be partially incapacitated, that is perfectly able to make decisions in one area of life, while needing significant support in another. If it is determined by those who know and care about the individual that the only alternative is guardianship, then limited guardianship can be considered. With limited guardianship, the individual retains certain legal rights and freedoms that may directly impact quality of life.

Guardianship is the legal process of determining an individual's capacity to make decisions for himself/herself regarding personal affairs such as where he/she lives or the care he/she requires. When an individual has been determined to be legally incapacitated, the Probate Court in Missouri is responsible for appointing a guardian. A guardian may be appointed in full or on a limited basis depending on the needs and capabilities of the individual.

Conservatorship is similar to guardianship, but differs in that it deals only with the financial affairs of an individual. The court appoints a conservator after it is found that an individual doesn't have the capacity to manage his/her finances. A conservator has no authority to make decisions regarding the individual's personal affairs. Only a guardian has such power. A conservator may also be appointed on a full or limited basis.

Guardianship and/or conservatorship are established to protect those individuals who have a disability of any kind that prevents them from making decisions about their health and safety. The law contains many safeguards and reporting provisions designed to prevent someone from having a guardian appointed unnecessarily or someone from abusing the powers of the guardianship or conservatorship.

Individuals exercise or are assisted in exercising all rights under the Constitution of the United States and those are stated in State Statute. Individuals have information on the rights and

responsibilities of citizenship. Individuals are involved in any process to limit their rights and are assisted through external advocacy efforts. Individuals are entitled to due process when limitations are imposed.

If the interdisciplinary team, which consists of the individual, family members, professional staff including direct care staff (when applicable), and anyone else that the individual wishes to have advocate for them agrees that the individual served is in need of a guardianship or conservatorship then the habilitation center staff should assist in pursuing this legal process.

Assessing the need for guardianship and or conservatorship is ultimately the responsibility of the Probate Division of the county where the individual resides. There are many provisions placed in Missouri State Statute 475 that require guardians and conservators responsible for making certain that the individual's needs are met so that they are safe, healthy, and have reasonable quality of life. Missouri Statute 475.082, makes the guardian or conservator responsible for reporting to the court on an annual basis the status of the individual and the status of the individual's finances.

The following describes the procedures and processes used by Habilitation Centers and Nursing Facilities in assessing guardianship.

**Habilitation Center:** Plans of Care are required to be signed by the guardian and are sent to guardians on an annual basis or upon revision. Guardians are notified of each planning meeting and invited to attend. Guardians are notified of any unusual incidents such as hospitalizations, changes in health or behavioral status, etc.

Each Regional Office has the position of Guardianship Coordinator, who:

- Assists families in understanding guardianship options and exploring alternatives to guardianship when appropriate.
- Consults with staff and families regarding the pursuit of guardianship/conservatorship when appropriate for individuals served by the Regional Office
- Provides referral to appropriate community legal services.
- Assists Transition coordinators in completing the necessary forms used to petition for guardianship and to gain information regarding the individual for the court (see documents listed at the end of this section).

**Nursing Facilities:** Most individuals residing in nursing facilities who seek transition into the community do not require guardianship. However, in those cases where DSDS staff become aware of a situation in which guardianship/conservatorship may be appropriate, contact is made with family members, providers, and treating professionals to verify the likelihood of need. In these rare instances, qualified family members and friends are encouraged to petition for guardianship/conservatorship. However, if there is no appropriate individual, DSDS staff will contact the Public Administrator in the relevant county and request that the Public Administrator petition for guardianship. If the Public Administrator does not petition, DSDS staff will contact the Department's Office of General Counsel to pursue filing the petition.

### **3) Outreach/Marketing/Education**

An informational brochure has been developed and will be revised as needed to reflect current program changes; a copy of the MFP brochure is included as Attachment I. Any future changes to marketing materials will be shared with the MFP Stakeholders group for comment and recommendation. The brochure will be used to educate facility staff, service workers, families, and potential demonstration participants. The brochure includes an overview of the demonstration, eligibility criteria, available services and contact information. A provider notice was sent out via web to all enrolled Medicaid providers to inform them about Money Follows the Person Demonstration and its requirements (Attachment J). The MFP home webpage, [on.mo.gov/mfp](http://on.mo.gov/mfp), has been developed by MO HealthNet to distribute any changes or updates to the MFP demonstration throughout the demonstration.

Brochures and web-based information will be used to disseminate information about MFP. The MFP Stakeholder group will employ a grassroots approach to future outreach activities, which will include working with the many advocacy groups, local organizations and local agencies located throughout the state. Information will be posted on the MFP home page. The entire state will be targeted for outreach.

Information will be disseminated throughout the entire state. Informational materials will be placed at Regional Centers, Nursing Facilities, Habilitation centers, Centers for Independent Living, Area Agencies on Aging, Senior Centers, Local Public Health Agencies and County Family Support Offices. State staff will keep advocacy groups abreast of changing information and best practices.

The state has already initiated training regarding MFP through informational presentations with groups such as; People First, Missouri DD Council, Statewide Independent Living Council, Nursing Home Ombudsman, Housing Task Force and others. Each habilitation center has regular transition team meetings where information is shared with transition coordinators and habilitation center staff.

DHSS holds monthly meetings to update Assistant Regional Managers of any changes in regard to programs or policies. This information is disseminated to field staff at least quarterly during staff meetings. DHSS will hold quarterly meetings with MFP Regional Coordinators. Mandatory meetings will be required on an as-needed basis with DHSS contracted transition coordinators. The project director and MFP staff have and will continue to identify and request to present at forums and seminars that are being held around the state by advocacy groups, organizations and community efforts surrounding activities involved with the MFP Demonstration.

DSS operates several information hotlines. One is the Medicaid Recipients Services hotline. This is available for Medicaid Recipients who have questions related to their Medicaid eligibility, covered services, etc. If a recipient with limited English proficiency calls, interpreting services are made available.

All DHSS employees and programs have access to the State of Missouri contract for providing interpretation and translation services. Guidance and information on the current contract is always available through the Department's Office of Human Resources. The Office of Human Resources informs staff of this policy/contract at the time of employment by providing them a

document they must sign acknowledging they have received the information. Language Identification Cards are provided to Department employees. The Language Identification Card list the languages most frequently encountered in North America, grouped by the geographical region where they are commonly spoken. A staff person would determine the geographic region where they believe the non-English speaker may be from. The card portion for the Region is shown to the individual. The message under each language says “point to your language. An Interpreter will be called.” The over-the-phone interpretation is available 24 hours a day, 7 days a week.

The Missouri DMH has established an Office of Deaf and Linguistic Support Services to assist people who have limited ability to communicate in English or who are deaf or hard of hearing so they may access and receive the treatment services they need.

All providers of services under contract with the DMH are required to provide free language assistance per Title VI of the Civil Rights Act. The Individual Language Preference Identification Flashcard is available to agencies and provides a way for agencies to identify the preferred language of people with limited English proficiency. If an individual is suspected to have limited English proficiency the flashcard will be shown to the individual. The agency records the language checked on the flashcard, locates an interpretive service provider for this language and records this information on the form. Any other assistance that might be needed, such as translated documents, etc. is included in the “Notes” section of the form. The language chosen is entered into the individual database when posting individual information. The flashcard is placed in the client’s file with a flag on the outside of the file to alert staff that the individual has limited English proficiency.

Transition coordinators will work very closely with current staff, family members and friends in communicating with individuals with special needs.

There are no cost sharing requirements for home and community based services. Individuals will be notified of cost sharing responsibilities for other Medicaid State Plan services using the state’s current method of notification for any Medicaid eligible individual. Eligibility and cost sharing issues will be addressed and discussed with the DMH participants during the personal centered planning meeting. Transition coordinators will notify participants of cost sharing responsibilities during the initial assessment and care planning meeting. Individuals who are participating in the Money Follows the Person Grant will be required to meet the current eligibility requirements; there will be no new eligibility requirement changes for the Money Follows the Person Demonstration Grant. Recipients will also be notified of Medicaid eligibility and cost sharing through the Medicaid Fee/MC+ Fee-For-Service Recipient Handbook (Attachment L).

#### **4) Stakeholder Involvement**

The My Life, My Way, My Community/ Money Follows the Person (MFP) stakeholders group was formed as the next step in our effort for continuous quality improvement. The focus of the stakeholder group is on individuals who have a disability and/or are aged and are currently residing in a nursing facility or habilitation center. The stakeholder group will be a valuable asset in providing recommendations on how to move the MFP program forward. Recommendations on

changes to the program policies, marketing, training, outreach, and elimination of barriers will be the focus of the group.

The success of the stakeholder group is contingent on multiple stakeholder collaborations that include individuals with disabilities and their families, state agencies, legislators, community providers, consumer advocacy groups, and others. For true rebalancing of the systems to occur, key stakeholders need to be engaged in discussions regarding issues such as bed/institutional closure and conversion of institutional resources to support Home and Community Based services.

1. My Life, My Way, My Community/Money Follows the Person (MFP) stakeholders group is charged with the following responsibilities:
2. To examine whether existing programs and services provide individuals with disabilities who may be eligible for community-based treatment with appropriate information regarding this option;
3. To facilitate communication and collaboration between state agencies and the disability community in accomplishing the objectives of the Home and Community-Based Services;
4. To monitor and assess continuing development of the process to transition eligible institutionalized individuals who are elderly or who have disabilities for community-based treatment into appropriate community settings;
5. To recommend the creation and implementation of a targeted public education and marketing plan to educate the general public on topics relative to community transitioning from institutional settings;
6. To recommend modifications or changes that may be needed to improve existing home and community-based services and consumer-directed care programs;
7. To recommend potential means of expanding home & community-based services or consumer-directed care programs;
8. To meet at least quarterly.

My Life, My Way, My Community/Money Follows the Person (MFP) Stakeholders Group meets on a quarterly basis. Members will monitor Missouri's implementation of the Money Follows the Person Demonstration and will provide input to the state over the life of the demonstration. Members will also have input in the Operational Protocol. The Operational Protocol is viewed as a "work in progress" and will continue to evolve as changes are made to Missouri's long term care system, through budget appropriations, legislation, and other initiatives that will lead to better access to and higher quality of home and community-based services.

Current membership includes the following individuals:

Area Agency on Aging, ARC, APSE-MO, Missouri DD Council for Developmental Disabilities, Statewide Independent Living Council, Missouri Department of Mental Health, Ombudsman, Missouri Association of Nursing Home Administrators, Missouri Brain Injury Advisory Council, People First, Missouri Veterans Commission, Governor's Council on Disability, Mo House of Representatives, Vocational Rehabilitation, Missouri Health Care Association, Missouri Department of Health and Senior Services, Missouri Housing Development Commission, and Self Advocates representing all target groups.

In addition to individuals with disabilities and advocates who are members of the My Life, My Way, My Community/Money Follows the Person (MFP) Stakeholders Group, other numerous state individual advocacy organizations and associations will be involved in discussions regarding overcoming barriers to transitioning individuals to the community. Consumers are required participants in many of the State's councils, task forces and planning meetings.

Institution staff will be included in the service planning of each participant eligible to transition. They will be included in discussions regarding barriers and concerns with the transition process, as well as recommendations for improvement.

If during an assessment or at any time an individual expresses a wish to transition into the community, the provider will be responsible for notifying the transition coordinator at the Habilitation Center, or the MFP Regional Coordinator for those transitioning from a nursing facility to begin the transition process. If anytime during a patient's stay in an institution the individual wishes to transition the proper entity will be notified.

If during the administration of the MDS Section Q questionnaire or at any time an individual expresses a wish to transition into the community, the nursing facility will be responsible to enter the referral information into the MFP web-based system, which triggers contractors to do options counseling. After this, if the contractor determines this is an MFP referral, they enter this information into the MFP web-based system, which triggers MFP Regional coordinators to do MFP assessment.

Participants will be responsible for notification of changes in living situation, problems that are occurring with service providers or staff, changes in support or service needs, changes in health, inpatient hospitalizations or any service interruptions. This may be done by the person, a family member, guardian, provider or anyone else that is closely involved with the participant. Once the transition coordinator receives this information they will coordinate with all parties to make whatever arrangements necessary, such as change services, moving arrangements, guardian consent, or whatever actions are needed based on the situation. Upon receipt of new information regarding changes affecting the participant or their status, the transition coordinator will enter updates via the MFP web-based system.

Habilitation Centers are responsible for planning while the individual is in the institution, and participate in the development of transition plans. Once the individual has transitioned to the community, the community living coordinator/service coordinator becomes primarily responsible for planning. The habilitation staff is then available to provide technical assistance to the provider agency; such as if someone begins having a behavior issue the provider or Regional Office staff can call the Habilitation Center for information/recommendations.

Nursing facilities provide restorative services to encourage independence, activity and self-help according to each resident's needs. Residents have the right to participate, and are encouraged to participate in their treatment plans, including discharge planning.

## **5) Benefits and Services**

The delivery mechanism for the grant participants will be fee-for-service. The Medicaid mechanism through which qualified HCBS that will be provided at the termination of the demonstration period will be Medicaid State Plan, and waiver services as long as the participant remains eligible. Appendix C-3 of the HCBS Waivers specifies provider qualification criteria. The State has a provision built into the current DD and Independent Living 1915(c) waivers that reserves capacity for individuals transitioning from ICF/MR and Nursing Facilities. Reserved slots will be held at the onset of transition into the community; once they reach the end date of grant participation they will enter into the saved slot. The same process will be used for those waivers that do not have reserved slots. The project director will work in collaboration with the DMH and DHSS on monitoring this process. If it appears that waivers are reaching maximum capacity the waiver(s) may be amended to include more slots. The state will assure the process will be seamless to the participant by having a slot available at the onset of participation. The services provided during the grant will continue to be provided once the one year period is over, with the exception of MFP Demonstration HCBS for moving costs, housing related expenditures, and purchase of assistive technology and related devices and services, etc. as designated by the MFP guidelines for those participants transitioning out of nursing facilities. The below chart identifies the qualified HCBS for individuals participating in the MFP demonstration. There is a onetime HCBS demonstration service available for a person transitioning from a nursing facility described below. A participant may only participate in one waiver at a given time, but may be moved from one waiver to another during the one year demonstration based on their needs.

Program Name	Administration	Overview
Comprehensive DD Waiver	Division of DD	An array of specialized services, including residential services, are covered by Medicaid for participants who have DD conditions
Community Support Waiver	Division of DD	An array of specialized services, excluding residential services, are covered by Medicaid for participants who have DD conditions. \$22,000 annual cap applies.
Lopez Waiver	Division of DD	Allows some children living with their family who are under 18 and are PTD and are not otherwise eligible for Medicaid to become eligible for Medicaid and receive specialized services.
Aged & Disabled Waiver	DHSS/DSDS	Allows certain disabled and elderly individuals (age 63 or older) who are Medicaid eligible to receive expanded services in their home as an alternative to nursing home services
Physically Disabled Waiver	DHSS/DSDS	Allows private duty nursing and some specialized equipment and supplies to be provided to a small number of individuals for whom such services were funded by Medicaid prior to age 21
AIDS/HIV Waiver	DHSS/DSDS	Allows some individuals with AIDS or HIV to receive medically oriented home care. Covered services include private duty nursing, attendant care, personal care & supplies
Independent Living Waiver	DHSS/DSDS	Allows some adults with physical disabilities who require nursing home level of care, to hire and supervise their own workers. Utilizes a fiscal intermediary to pay workers on behalf of the individual (employer); personal care in excess of state plan, and some home modification or equipment can also be provided if cost effective; limitation on total hours of personal care

**MFP Demonstration HCBS:** After an individual is found eligible for the MFP demonstration, the transition coordinator selected to assist in transition is responsible for identifying the need for MFP Demonstration HCBS. The contracted transition coordinator will submit an itemized prior authorization request to the DSIDS Program Oversight Unit for review and approval. If DSIDS

staff determines the requested services are appropriate for participant needs and qualify for reimbursement, they will prior authorize up to, but not more than \$2400 per participant. The contracted transition coordinator may bill for reimbursement of Medicaid MFP Demonstration HCBS anytime during the year of MFP participation through use of a procedure code and modifier. If, during the course of the demonstration, it is determined the participant needs additional MFP Demonstration HCBS, a prior authorization may be requested as long as the total amount per participant does not exceed the \$2400 limit. MFP Demonstration HCBS will include home modifications, deposits, household items, cleaning supplies, toiletries, furniture, groceries and other items as identified on an as needed basis. Participants that transition through the Department of Mental Health and who utilize DMH waivers are ineligible for MFP Demonstration HCBS because funds exist within the waivers that cover all of the above mentioned items or modifications.

The following provides an overview of the primary systems of care, state plan services, and waivers that provide long-term services and supports for individuals with disabilities and long-term illnesses in Missouri.

**State Plan Services:** There are a variety of state plan Medicaid services available to provide needed community supports and services including adult day care, in-home nursing services, a variety of personal care programs such as self-directed personal care, and the Community Psychiatric Rehabilitation Program. Table 5 provides an overview of these services.

**State Plan Service Overview**

State Plan Services	Medicaid
Advanced Personal Care	X
Authorized Nurse Visits	X
Basic Personal Care	X
Personal Care Assistance (Self-Directed)Basic Personal Care	XX
Community Psychiatric Rehabilitation Program (CPR)PACE (Program of All-Inclusive Care for the Elderly is only available in certain areas of St. Louis)	XX
Targeted Case ManagementPersonal Care Assistance (Self-Directed)	XX
Community Psychiatric Rehabilitation Program (CPR)	X
Targeted Case Management	X

Following are definitions of some of the most common services, this list is not all inclusive of all available services:

**Medicaid Home and Community Based 1915(c) Waivers:** Attachment N contains a summary description of the current wide array of options under the Medicaid Home and Community Based Waivers in Missouri. Three of these waivers, the Comprehensive DD, Aged & Disabled, and Independent Living Waivers will provide a major portion of the HCBS long term care services.

Following are the definitions of some of the most common services:

**Adult Day Care:** Adult Day Care programs provide a structured program of therapeutic, rehabilitative, social and leisure activities in a monitored setting. The programs offer supportive services to the participant, as well as to the family, by providing care and supervision in a protective environment during the day. Participants attend the program on a scheduled basis.

**Residential Habilitation:** Services to provide care, skills training in activities of daily living, home management, and community integration. Services can be offered in licensed, certified, or accredited group homes, residential centers, or semi-independent living situations.

**Individualized Supported Living (ISL):** A non-facility form of residential habilitation that provides support and training services to an individual in the individual's own residence. Individuals may live alone or with their families or may share living arrangements with others. When living arrangements are shared, no more than 4 individuals with disabilities may reside together and qualify for ISL services.

**Day Services:** Services to enable individuals to achieve optimal physical, emotional, sensory and intellectual functioning. Services include training families in treatment, intervention and support methodologies. Services are provided to individuals or to groups and provided either on-site, at the day services site or off-site, in the individual's home or community.

**Therapies:** A variety of therapies are available through the DD Waiver including physical, occupational and speech. The waiver also offers behavioral analysis services.

**In-Home and Out-Of-Home Respite Care:** Services provided to individuals unable to care for themselves, on a short-term basis, because of the absence or need for relief of those individuals normally providing the care.

**Community Employment:** Work in an integrated setting with on-going support services. Other employment related services are available to assist individuals in their employment goals.

**Transition Services:** Participants transitioning from an institution may access transition services to cover necessary costs including security deposits, household items, and supplies.

**Personal Assistant Services:** Assistance with any activity of daily living (e.g. grooming, meal preparation) or instrumental activity of daily living (e.g. shopping, banking, recreation).

In addition to these services other services provided include transportation, environmental accessibility adaptations, specialized medical equipment and supplies, crisis intervention, community specialist services, communication skills instruction, support broker, and counseling. The Division of DD also provides Targeted Case Management to individuals with DD under 1915(g) of the Medicaid state plan. The service assists individuals to gain access to medical, social, educational, mental health, and community-based services and supports.

### **Assistive Technology Demonstration Services**

For many seniors, and adults with disabilities, assistive technology (AT) can be a significant tool in the ability to live in the community rather than residence in a nursing home. AT can allow individuals who are transitioning to more effectively engage in their community, develop social networks, and communicate with friends, family and others, and be more independent in their homes.

The addition of Environmental Accessibility Accommodations (EAA) as an available MFP demonstration service can be a significant tool in meeting those accessibility needs for persons

wishing to move back into the community. The lack of affordable accessible housing is one of the key barriers to transition for many individuals.

Finally, Vehicle Access Modifications (VM) can increase a person's access in, to, and out of the vehicle and maximize safe transport. In situations where accessible transportation may make the difference for a participant to engage more fully in their community, VM can be a key component.

Currently in Missouri, the proposed Home and Community Based Services (HCBS) are available only to individuals with developmental disabilities who qualify for one of Missouri's five developmental disability waivers. They are largely unavailable to individuals through any of Missouri's other HCBS waivers. Missouri's Independent Living Waiver technically allows coverage for Specialized Medical Equipment (SME) and Environmental Accessibility Adaptations (EAA) but only under very specific conditions. The services must result in a decrease in Personal Assistance Services. There were no participants that received SME or EAA services through Missouri's IL Waiver in SFY14 and very few accessed the service in any prior years. Nor are AT, EAA, or VM available services under Missouri's Aged and Disabled waiver.

As a result, aged and disabled individuals, other than those with developmental disabilities, do not have access to these services. Assistive technology can be a significant support for people who have disabilities and who are elderly to move from a nursing facility to a quality community setting that meets their needs. AT is a relatively low-cost service compared to many other HCBS services, but can make a significant impact to this target group to be integrated back into community living to the fullest extent possible, and to maintain or improve their functional abilities and independence.

For example:

- Medication dispensers for individuals transitioning out of a nursing home to assist with medication compliance.
- GPS tracking for an individual with elopement history.
- Hearing aids for an adult. (Inability to hear is often a key factor leading to isolation and inhibition of community ties for persons wishing to stay out of institutional settings).
- Keyless home entry and other home automation (environmental) controls for persons with mobility deficits who have difficulty interacting with home electronic appliances.
- Sensors to monitor movement around the home to notify caregivers remotely about changes in daily patterns.
- Strobe light doorbell and bed shaker fire alarms for individuals with limited hearing.
- Portable electronic print enlarging devices to allow seniors with vision impairments to continue to access print materials.

These are only a very few examples. There are many others including AT aids for daily living, health tracking and management, and many others that can make a significant difference in an individual's ability to achieve and maintain a successful transition from a nursing home.

These AT, EAA, and VM services would be available only to a target population of Missourians wishing to transition who do not otherwise have access to services through HCBS waivers or MO HealthNet state plan services. We propose that the Assistive Technology definition be the same as the federal definition, which is also the definition used in Missouri's developmental

disability waivers, and that the maximum annual dollar limit on the service be \$5,000 per MFP participant accessing the demonstration services. The services would need to be accessed during the 365 day first-year transition period.

### Implementation Model

Missouri Assistive Technology (MoAT) is a state agency housed in the Missouri Department of Education and would play a central role in the implementation of these services. A Memorandum of Understanding between the MO HealthNet Division/Department of Social Services and Missouri Assistive Technology/Department of Education will outline billing procedures and processes. MoAT is the state entity implementing the federal Assistive Technology Act as well as administering other programs involving assistive technology devices and services, environmental access modifications and vehicle access modifications for individuals with disabilities in Missouri, such as:

- MoAT provides AT devices and services for participants in the Division of Developmental Disabilities DD waivers. MoAT also helped the Division develop their Guidelines and Referral form when AT was added as a service in Missouri's DD HCBS waivers.
- MoAT administers a program with Missouri's Department of Health and Senior Services to provide a program to provide funding for AT, EAA, VM for families of children and adolescents with disabilities.
- MoAT administers Missouri's telecommunications equipment distribution program to provide assessment, equipment and training for consumers with all types of disabilities who have difficulties in their homes accessing the telephone or a computer.
- MoAT is the entity certified by the FCC to provide assessments, equipment and training in the National Deaf-Blind Equipment Distribution Program.
- MoAT provides a range of consultation services to a wide variety of organizations throughout the state related to assistive technology devices and implementation and coordinates funding resources from a wide variety of source for consumers and case managers.

### Implementation Model

MoAT will utilize its own staff for the assessment, acquisition, and follow-up for the MFP demonstration services. MoAT will also implement a train-the-trainer model to expand the number of qualified personnel in regions throughout the state for these activities. In terms of process, the steps in the implementation process for the individuals in an MFP transition will be:

1. MFP contact agencies will make referrals to MoAT for transition candidates who may benefit from AT/EAA/VM in order to a) increase ability to perform activities of daily

living, b) increase control of their environment, and c) enhance functioning with greater independence in their home.

2. The referral will be assigned to a MoAT AT Technology Specialist and an assessment will be scheduled within 30 days of referral.
3. The consumer and contact agency coordinator will receive a checklist summary from MoAT outlining responsibilities and to help both keep track of the process.
4. The Tech Specialist reviews all potential resources to assess whether available through other sources.
5. The Tech Specialist completes recommendations/drawings/specs for AT/EAA/VM.
6. In the case of EAA, permission to proceed from the consumer/property owner will be obtained by MoAT.
7. MoAT will obtain quotes will be obtained from potential contractors.
8. The project will be reviewed /approved by the MoAT program coordinator.
9. Project authorization is sent by MoAT to the contractor in the case of EAA. In the case of AT or VM, a purchase order is sent to the vendor.
10. Upon completion, project is inspected by the technology specialist and approved by the consumer/contact agency.
11. Contractor receives payment from MoAT.
12. MoAT will arrange for any training/follow-up in the case of AT where needed in order for consumer to fully benefit.
13. MoAT will invoice the MO HealthNet Division/Department of Social Services for the federal amount. The invoice will include the date of service, name, service provided, total dollar amount, state portion & federal portion for which MoAT is billing.

MoAT will also collect data and information to assess the extent to which the demonstration services contributed to successful MFP transitions of seniors and other individuals with disabilities with the fullest possible participation in the community.

## **6) Consumer Supports**

The Our Parents, Ourselves brochure will be used as a tool to inform the participant about available services. The Missouri MFP Brochure and Missouri Medicaid/MC+ Fee-For-Service Recipient Handbook a will also be provided to each participant. Education will be provided by the DD transition coordinator during the person centered planning process. For residents in nursing facilities, the transition coordinator will discuss options during their face to face visit for assessment and care planning. Transitioning processes are outlined in the Division of DD's

Transition Guidelines available on the DMH website at <http://dmh.mo.gov/dd/docs/communitytransitionmanual.pdf>, and the transition processes developed by participating agencies such as the Centers for Independent Living and Area Agencies on Aging will be used by staff to educate participants. Going through the transition processes will act as a check list of areas to discuss with the participant.

Emergency backup plans will be developed on an individual basis by the participant with a fallback plan if the system fails. Addressed in the following are back-up procedures and policies for Habilitation centers and Nursing Facilities.

**Habilitation Centers:** Division of DD participants who are self-directed are required to identify the demographics of their emergency/back-up plan in their Individual Service Plan. The backup plan identifies what must be done to prevent risks to health and safety: how people should respond when an emergency occurs; and who should be contacted and when.

The Got Choice Handbook (<http://dmh.mo.gov/docs/dd/gotchoicehandbook.pdf>) will be used by the Division of DD Regional Office for individuals transitioning out of Habilitation Centers as a guide to direct participants in developing a back-up system that is appropriate for their needs and also what to do in case the back-up plan fails. If the individualized backup system does not work, and it is not an emergency requiring 911 assistance, the participant should inform their service coordinator immediately. If it is after regular working hours, they should still call the local regional office. They will either be connected to an answering service that will contact staff or they will receive instructions regarding how to contact the on call staff directly. The transition coordinator will explain how the afterhours answering service works at the regional office during the transition process. All contact information will be listed in the participant's backup plan.

**Nursing Facilities:** Providers are required by state regulation to ensure back-up services are available to individuals they provide services to. See Appendix A(b) for more information. At the time of the assessment and service planning, the participant is given contact information regarding who to call in the event of service delivery failure or to inquire about the need for additional services, etc. Participants should first contact their transition coordinator to discuss concerns or needs. Participants have additional resources available through Regional MFP Coordinators and local agencies contracted for transition coordination. The transition plan shall include a minimum of three individuals which the participant may contact in the event of an emergency. The transition coordinator may or may not be included depending on the support system which exists for the participant. In the event the contracted agency provides after hours coverage for participants they serve, this information shall be provided to the participants served under the Long Term Care Rebalancing Opportunities Contract. Individuals who do not have an appropriate emergency plan shall not be transitioned to the community.

## 7) Self-Direction (See Appendix A)

NOTE: Those individuals with co-occurring diagnosis are included in Appendix A for the DD population. These individuals will have access to all services that the DD population has in addition to CPR state plan services.

Appendix A Section 3, Letters (l) and (m) is all inclusive of the states information in regard to termination either by participant or state.

The state has set a goal that at least 25 percent of MFP participants will choose to self-directed services.

## 8) Quality

The state will integrate the MFP demonstration into existing 1915(c) HCBS waivers. The MFP program will incorporate, at a minimum, the same level of quality assurance and improvement required of existing HCBS waivers, whether participants are covered under a waiver or state plan services, during the transition and during the 12 month demonstration period in the community. Quality information will also be obtained via the MFP web-based system. Users will enter information about each participant relating to any hospitalizations, critical incidents, or other issues affecting their success in the community. Missouri Division of DD, Division of CPS, and DHSS each have established Quality Management systems. The following is a brief overview of these systems:

**Current Systems:** The Division of DD and DSDS have policies and procedures in place to ensure that Missouri 1915(c) HCBS Waivers they administer meet CMS required assurances. Each State agency has its own ongoing processes of discovery, remediation and improvement to assure the health and welfare of participants by monitoring: a) level of care determinations; b) individual plans and services delivery; c) provider qualifications; d) participant health and welfare; e) financial oversight and f) administrative oversight of the waiver. All problems identified through these discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. The State's single state Medicaid Agency, Department of Social Services, conducts reviews of waiver operations, in accordance with interagency agreements.

The Division of DD has an approved Quality Management Plan following the new 1915(c) waiver application requirements for its DD Comprehensive waiver. Division of Senior Services has Quality Management plans which will be updated to the new requirements when the Elderly/Disabled and Independent Living waivers are renewed under CMS' new 1915(c) application requirements.

**Assuring Health and Safety:** The Division of DD employs case managers at its 6 regional and 6 satellite offices around the state. These case managers, and some employed by Missouri Senate Bill 40 County Boards, provide case management for individuals served by the division including waiver participants. They are responsible for determining waiver eligibility, facilitating person centered planning, authorizing necessary services, and frontline monitoring. In addition, the DMH has a critical event or incident reporting system, an Office of Individual Affairs that receives and resolves complaints, a Licensure and Certification Unit, a Contract Unit, and a centralized investigation unit. Each regional office has quality assurance staff that are responsible for working with providers to ensure corrective action is taken as required and for encouraging quality enhancement and assuring the health and safety of individuals they serve. In addition, the Division of DD is working toward a plan for home and community-based contractors to be accredited by either the Council on Quality Leadership (CQL) or Commission on Accreditation of Rehabilitation Facilities (CARF).

The Department of Health and Senior Services (DHSS) is a state department which has a Division of Senior and Disability Services (DSDS) which is mandated by the State to investigate and intervene when a report alleging abuse, neglect and exploitation is received to the Central Registry Unit (CRU) to protect the health and welfare of the participant. In a case of Abuse & Neglect, the participant will be advised to call DHSS Central Registry Unit (CRU) between the hours of 8 a.m. and 8 p.m. Bureau of Contract Oversight is charged with providing over-sight of the MFP Program in all 5 regions of the state. Attachment (Z) is a state map that identifies the DSDS regions of the state. MFP Participants who are getting HCBS go through a reassessment annually to determine if the services continue to meet their needs or if a change in services is necessary. Throughout the duration of the MFP Demonstration Services period, contact will be maintained with the MFP participant during their 365 days of community living, on a monthly basis at a minimum, to ensure the transition plan continues to adequately meet their needs and that their quality of life in the community meets their expectations.

The Division of CPS conducts certification and monitoring of community agencies (those which do not have national accreditation) that provide services for people with psychiatric disabilities. This includes conducting pre-surveys for each agency being monitored (e.g. data is collected on incidents, injuries and complaints); surveys to determine compliance with certification standards (e.g. interviews with individuals and staff; review of personnel and clinical records); and post-surveys to inform the agency of the findings, including deficiencies and recommendations for program improvement. Community agencies that have attained full accreditation under standards for behavioral health from CARF International, The Joint Commission, or Counsel on Accreditation shall be granted certification.

**Quality Management Improvements in process:** The primary system gaps relate to improvements in quality management systems that track and share individual outcomes/satisfaction and information related to quality of services. This issue is currently being addressed through the various existing transformation efforts which are exploring the use of information technology systems to improve tracking and reporting. For example, the Division of DD is exploring the development of “provider report cards” as an approach to supporting improved choice related to quality services. The Division of DD is exploring the feasibility of national accreditation for all home and community based providers.

DHSS has an established Quality Assurance Section of the Long Term Care Rebalancing Opportunities Contract for options counseling and transition coordination. It states that a contractor’s quality assurance plan must measure satisfaction by the participants, and the contractor must establish and operate in accordance with a written procedure using a form for the resolution of any complaints made against the contractor, which is initiated by the state agency.

If the DSDS has concerns with the contractor's performance as it relates to provision of services which are not resolved to the satisfaction of the state agency through the quality assurance process, or when the state agency has serious concerns regarding egregious situations (i.e., failure to report elderly abuse etc.), the state agency may issue a "letter of concern" to the contractor. The contractor shall submit a corrective action plan to the state agency within five (5) calendar days of receipt of the "letter of concern". The state agency shall review the proposed corrective action plan and approve or deny the plan within ten (10) calendar days. Contractors will have the opportunity to submit a second corrective action plan. If this corrective action plan is not approved, no additional referrals will be made to the contractor.

During the assessment process and development of the service plan, DSDS staff/the transition coordinator will discuss with the participant, guardian or family member which MFP Demonstration HCBS are required to transition them into the community. DSDS staff/the transition coordinator will work collaboratively with the MFP Regional Coordinator and other appropriate agencies in the area to which the participant is transitioning in order to ensure that their needs are met and barriers to residing in the community are addressed. DSDS staff, taking into consideration the recommendation of the agencies involved in the transition, will give final approval of all funds and services. The transition coordinator will input the transition planning information into the MFP web-based system. DSDS will track how MFP Demonstration HCBS were used and their effectiveness in supporting successful transitions. The Institute of Human Development at the University of Missouri-Kansas City will provide training to Quality of Life Surveyors who will administer the QoL Survey to each participant prior to and at one year from the date of transition and at two years after transitioning into the community.

## **9) Housing**

The type of housing that each participant moves to will be documented on the referral form (Attachment Q) and entered into a data base for Money Follows the Person participants. Missouri's Guide to Housing Assistance Programs, (Attachment R) has been developed by the State to be used as an educational guide and a resource for housing throughout the state. Transition coordinators, and other agencies and advocacy groups may use this as a resource guide in helping the participant locate possible housing. This guide also provides information on how each living arrangement is funded.

Individuals who are participants in this demonstration will be transitioned to a variety of qualified community settings and residences. Through the support of transition coordinators, each participant will be supported to create a person centered transition and community plan that will assist the participant to identify and access a variety of paid and unpaid supports and to achieve an inclusive lifestyle of their choice in the community. Each plan will identify the type of residential setting to which the individual will transition and the supports needed for them to live quality lives in each setting. Transition coordinators will also assist these participants in applying for housing assistance and supports (e.g. Section 8 Voucher). All residences to which participants will transition will meet the following CMS criteria: a home owned or leased by the participant or the participant's family member; an apartment with an individual lease; or a residence, in a community-based residential setting, (no more than 4 people).

Demonstration participants have several housing options to choose from, including the following:

- **Division of DD Waiver Individualized Supported Living (ISL) and Personal Assistant Services:** ISL services provides support and training services to an individual in the individual's own residence. Individuals may live alone or with their families or may share living arrangements with up to 3 other unrelated individuals.
- **DHSS In-home Services:** DHSS supports the provision of in-home services to individuals in a variety of living arrangements, including but not limited to, their own homes, homes of family members or senior housing units. These home and community-based services are provided through both State Plan and Aged and Disabled Waivers.

**Housing Collaborations:** Missouri does not have a Department or Division of Housing. Two state agencies, the Department of Economic Development (DED), Community Development Group and the Missouri Housing Development Commission (MHDC) set housing policy and administer a number of U.S. Department of Housing and Urban Development (HUD) grant programs. DED administers the state's Community Development Block Grant funds which can be utilized for a number of housing activities. MHDC is the State's housing finance agency. They are responsible for administering HOME funds that are block granted to the state by HUD.

At the policy level, the Department of Economic Development coordinates and prepares the State of Missouri Consolidated Plan for HUD. The plan recognizes the need for increasing affordable housing options for individuals with disabilities and their families. The Plan established five priorities for the 2008-2012 planning cycle: Affordable housing for low-income families; Affordable housing for homeless families and families with other special needs; Affordable homeownership for low and moderate income families; Preservation of affordable housing for low-income persons and families; Affordable housing for the elderly.

At the local level, a number of additional housing options exist. Public Housing Agencies manage a number of housing units and often have units set aside for elderly and citizens with disabilities. Private non-profit agencies are involved in the housing arena and apply for HUD Section 811 and Section 202 programs. The DMH has a Housing Team that helps link people receiving mental health services to a variety of housing services (e.g. rental assistance). Regional Offices and CILs have developed relationships with many housing management companies such as the housing authorities, senior citizen's housing agencies and community landlords who assist in locating housing for individuals currently transitioning out of habilitation centers or nursing facilities.

The state will continue to work with Public Housing Authorities (PHA) and present at meetings. The state will continue to encourage PHAs to commit a number of vouchers to individuals who are transitioning out of nursing facilities and habilitation centers. A draft copy of the letter of request is attached (Attachment Y).

The Missouri DD Council will be partner to the state in addressing housing issues. In its plan, the Council identified objectives that included increasing the number of accessible and affordable housing options and increasing the number of individuals with a home of their choice. One of the past projects supported by the Council was the Home of Your Own (HOYO) project. The state will continue to collaborate with the planning council to support efforts for people to

become home owners. The HOYO program has helped over 30 Missourians with developmental disabilities to obtain homes throughout the state.

The council has awarded a contract to develop an on-line housing registry. This registry will be a comprehensive registry to affordable, accessible and integrated housing that includes resources for financing, modifying and maintaining a home for the purpose of increasing access to community housing options for persons with developmental disabilities in Missouri. This registry will allow the person, family and guardian more choices in available housing. The state will advocate through task forces, committee meetings, and through public speaking about MFP and any other opportunities that may arise to help populate the registry with accessible and affordable housing.

Missouri also has a Mental Health Housing Trust Fund, established in 1993 under Section 215.054 of the Missouri Revised Statutes. Proceeds from the sale of surplus real property formerly used by the DMH are paid into this fund and used to finance the rental, purchase, construction, or rehabilitation of community-based housing for individuals served by the DMH.

DMH Community Living Coordinators at each Regional Office have been designated as the contact for housing issues in their region. Community Living Coordinators will serve as regional contact regarding housing resources for people with disabilities; maintain and share information with Service Coordinators, individuals, families, guardians, and providers regarding resources for those who are homeless, in need of accessible housing, and/or financial assistance for renting and purchasing homes; maintain knowledge of housing resources available through the Department of Mental Health, HUD, USDA, FHA, and rental and utility assistance programs; assist in the team planning process for individuals and families to locate homes in locations of their choice that enhance their access to their communities, and are adapted to meet their needs throughout their lifespan, allowing them to age in place; educate individuals, families, guardians, and service coordinators on trends and developments regarding housing for people with disabilities; work with individuals, families, providers, and Service Coordinators to access resources for modifying existing homes to meet accessibility needs; and work with providers to educate them about housing options and in locating resources for development of homes in incorporating universal design.

### **Housing Coordinator and Housing Specialist**

The MFP Housing Support Initiative was added to Missouri's MFP contract with the University of Missouri Kansas City, Institute for Human Development (IHD), effective January 1, 2015.. The Institute for Human Development assigned Tom McVeigh as the coordinator and liaison for the MFP Housing Initiative.

IHD will assist, or secure support for MFP consumers referred by MFP in locating affordable/accessible housing in a location suitable to the consumer, where the consumer can live while receiving support services.

The IHD will establish and maintain a working knowledge of federal, state and local housing finance programs, and will serve as liaison to the Missouri Housing Development Commission, the State's Housing Finance Agency.

The IHD will work with housing authorities and other affordable housing providers to establish priorities, participate in targeted funding opportunities and otherwise increase the supply of housing options for persons with disabilities or who are aged transitioning from institutions.

Consultation, evaluation and support will be provided to MFP transition coordinators in the expansion of their work with builders, developers, and others in their specific regions by the IHD.

In addition to representing MFP in housing groups/coalitions as appropriate, the IHD will foster housing opportunities for rental and ownership options through expansion of the working relationships with builders, developers, and others in the housing community who can develop quality, affordable, universally designed housing to support the MFP housing initiative.

The IHD will increase the knowledge of stakeholders and advocates regarding the development of housing for citizens with disabilities transitioning from an institution, through direct training and in consultation with MFP transition coordinators. Networking with other community organizations who support increasing affordable, universally designed housing within Missouri will be undertaken. Assistance will be provided with hard to place MFP consumers in finding affordable, accessible housing.

#### **10) Continuity of Care Post the Demonstration**

The State has a provision built into the current DD and Independent Living 1915(c) waivers that reserves capacity for individuals transitioning from ICF/MR and Nursing Facilities. Reserved slots will be held at the onset of transition into the community; once they reach the end date of grant participation they will enter into the saved slot. The same process will be used for those waivers that do not have reserved slots. The project director will work in collaboration with the DMH and DHSS on monitoring this process. If it appears that waivers are reaching maximum capacity the waiver(s) may be amended to include more slots. The state will assure the process will be seamless to the participant by having a slot available at the onset of participation. The services provided during the grant will continue to be provided once the one year period is over, provided that the participant remains eligible, with the exception of MFP Demonstration HCBS used during the demonstration for moving costs, housing related expenditures, etc. as designated by the MFP guidelines for those participants transitioning out of nursing facilities. Missouri has several unused slots available in the AIDS waiver that can be utilized for individuals who qualify. It is anticipated that as the AIDS population gets older more of these waiver services will be needed.

Services provided through the 1915(c) Aged and Disabled waiver services and through the Medicaid State Plan will require no monitoring above and beyond the routine administration and tracking already in place; there are no limitations on the number of individuals who can receive these services. Reporting through the MMIS for the purpose of tracking Money Follows the Person participants will be the only needed changes. Both processes will be seamless to the participant.

Missouri does not anticipate having any State Plan Amendments at this time because participant transition and community support needs can be met through existing HCBS program services. Future state plan amendments may be necessary as a result of legislative or budget initiatives.

## **C. Organization and Administration**

### **1. Background and Overview**

The Department of Social Services is the single state agency responsible for the administration of Missouri's Medicaid program. The Division of Medical Services, a division within DSS, is responsible for administering the Missouri Medicaid program.

The Department of Social Services (DSS) will be the lead organization for the Missouri MFP Initiative, and will work in collaboration with the Department of Mental Health (DMH) and the Department of Health and Senior Services (DHSS). DMH is responsible for transitions of individuals with DD (including those with MI diagnosis) from habilitation centers, oversight and administration of DD HCBS and community psychiatric services, and for service coordination.

The Missouri Department of Mental Health was first established as a cabinet-level state agency by the Omnibus State Government Reorganization Act, effective July 1, 1974. The Department of Mental Health (DMH) is organizationally comprised of three program divisions that serve approximately 150,000 Missourians annually, along with six support offices. DMH makes services available through state-operated facilities and contracts with private organizations and individuals. The Division of Mental Retardation and Developmental Disabilities (DD), established in 1974, serves a population that has developmental disabilities such as mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22, with the expectation that they will continue. To be eligible for services from the Division, persons with these disabilities must be substantially limited in their ability to function independently. The Division improves the lives of persons with developmental disabilities through programs and services to enable those persons to live independently and productively. In 1988, the Division began participation in the Medicaid home and community-based waiver program, designed to help expand needed services throughout the state. In addition, six habilitation centers and 11 Regional Offices serve individuals with developmental disabilities. DMH will be responsible for transitions of individuals with DD and those with co-occurring MI. Attachment K is a map of Missouri showing the regions of the state that the Regional Offices operate.

Missouri Revised Statutes Chapter 205 Section 968 authorizes Missouri counties to establish boards and to assess a local tax to provide services to individuals with developmental disabilities. Counties with such taxes may fund residential and other services, in addition to sheltered workshop programs. Eighty-six (86) Missouri counties have County Boards for Developmental

Disabilities, also known as “SB 40 Boards.” County DD Boards are an important part of the community system of services for people with developmental disabilities. County DD Boards may use their local public funding to leverage federal Medicaid reimbursement for service coordination (targeted case management) and/or waiver services. Over 50% of County DD boards have formed a partnership with the state to provide TCM services but this number is growing due to additional state support provided to county DD boards in the division's FY08 budget. Over 65% of County DD Boards use local public funds to purchase and/or provide DD waiver services. In most counties where the County DD Board provides service coordination, residents may choose a case manager either from the County Board or from the Division of DD Regional Center. Likewise, when County DD boards also offer DD waiver services, individuals qualifying for DD waiver services have a freedom of choice from among all providers serving the county in which they wish to reside.

In 2006, The Mental Health Commission, and a Mental Health Task Force, both recommended the Division of DD continue to explore public private relationships for the provision of service coordination and supports for individuals with developmental disabilities. To this end, the Division of DD will continue to change its’ Regional Office structure as County Boards begin to increase their capacity to provide service coordination.

The Department of Health and Senior Services serves the citizens of Missouri by working to improve the health and quality of life for Missourians of all ages. The department is organized into four programmatic divisions. The DSDS investigates allegations of elder abuse and administers programs designed to maximize independence and safety for adults who are at risk of abuse, neglect, and financial exploitation or have long-term care needs that can be safely met in the community. The DSDS is responsible for oversight of staff located within five regions of the state. Attachment (Z) is a state map that identifies the DSDS regions of the state.

Centers for Independent Living are non-residential, private, non-profit consumer controlled community based organizations providing services and advocacy for persons with all types of disabilities. They assist individuals with disabilities to achieve maximum potential within their families and communities. There are 22 centers for independent living in all major metropolitan and many rural areas throughout Missouri, many with branch offices, for statewide access in all 115 Missouri counties.

The MFP Stakeholder Group is the lead stakeholder organization to provide guidance and oversight of the Money Follows the Person Demonstration. The stakeholder group will provide recommendations on how to move the MFP program forward; including changes to policies, marketing, training, outreach and elimination of barriers.

**2. Staff**

The number of key staff is assigned and paid for by the grant is four: The Project Director, Assistant Project Director, Program Specialist and Support Staff.

Julie Juergens, Project Director	Hired
Shawn Brice, Assistant Project Director	Hired

Elise Davenport, Program Specialist	Hired
Sarah Burns, Support Staff	Hired

**The MFP Project Director** is responsible for the planning, coordination, implementation, and direction of the Money Follows the Person Demonstration. The MFP Project Director will oversee and coordinate all Medicaid agency responsibilities related to Money Follows the Person Demonstration, including but not limited to guiding the development and uploading of the operational protocol, facilitating broad-based stakeholder input during the demonstration, and ensuring accurate tracking of demonstration participants through the Medicaid Management Information System, reporting of expenditures and administrative data to the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), overseeing the administration of Medicaid 1915(c) Home and Community-Based Waivers (HCB) and other Medicaid State Plan services for demonstration participants, serve as primary contact with CMS for administration of the Money Follows the Person Demonstration.

The Project Director is an employee of the state’s Department of Social Services, Mo HealthNet Division. The Project Director is a Department of Social Services full time employee, and the DMH Statewide Transition Coordinator will be using 30% of her time in Money Follows the Person Grant activities, support staff for the Transition Service Coordinator will spend 10 % of their time, and support staff for the Project Director will spend 50% of their time on the Money Follows the Person grant.

Money Follows the Person Project Director will be responsible for implementation of the demonstration. Julie Juergens fills the position as Project Director; a high-level unclassified administrative position within the Department of Social Services, Division of Medical Services responsible for planning, coordinating, and directing unique Medicaid programs. The MFP Project Director position is a full time (100 percent level of effort) position. This position will closely coordinate with MFP project liaisons within the DMH and the DHSS.

Lisa Turner will fill the role of statewide transition coordinator for the Division of DD, overseeing all transitions from Habilitation center into communities. Ms. Turner works closely with the Transition Coordinators, Community Living Coordinators, and other division staff located throughout the state with day-to-day responsibilities for transitions. Ms. Turner reports to the Assistant Director of DD and coordinates closely with the division’s 12 Regional Office Directors.

Shomari Rozier will be spending 100% of his time at DSDS providing oversight in his role as Aging Program Specialist and will be assisted by Janet Bloemke, who serves as a Project Specialist. Ms. Bloemke’s part-time position is 100% dedicated to working on oversight and contract monitoring and assisting the Aging Program Specialist with various duties., . Mr. Rozier’s role includes serving as a transition analyst and providing Long Term Care Rebalancing Opportunities Contract oversight.

**The Assistant Project Director** will be responsible for assisting the MFP Project Director in carrying out the requirements of the grant. Some of the assistant director’s duties include the development of policies for the program through analysis of collected data from various sources such as other state agencies, Centers for Medicare and Medicaid (CMS), etc., amending the MFP

Operational Protocol as state policies change and as determined necessary by each state agency involved in the grant and by CMS, and assistance with the implementation of any new policy guidance. The Assistant Director will also be responsible for coordinating stakeholder efforts, analyzing data on various aspects of the program, such as institutional stays on participants in MFP. Gather and verify continued eligibility in the program, loss of Medicaid, date of death, moved, etc, and gather data to assist in completion of the Semi-Annual report to CMS. The Assistant Director will also review and organize comments on the state evaluation completed by the University of Missouri – Kansas City, compile financial data to complete quarterly financial reports, and other duties as assigned.

The **Program Specialist** will assume dual responsibility for oversight and coordination between state agencies and oversight the follow-up care for individuals transitioned. Some other duties the Program Specialist is responsible for include; maintenance of MFP database and web-based system for CMS reporting and continue work on development of efficient ways to collect data, coordinate and track all enrollments for assigned populations, and monitor the Quality of Life Survey process. Other duties include responding to inquiries from participants, providers, sister agencies and the general public and coordinating with sister agencies on the development of surveys, forms, case review forms, etc. The Program Specialist will also be responsible for the development of materials such as newsletters, web pages, and outreach materials, and will work with housing coordinators and with Public Housing Authorities to confirm MFP eligibility for those individuals transitioning out of an institution. The specialist will conduct case reviews of transitioned participants and interface with relevant state agencies on reporting and case issues, including incident reporting and investigation. Overall evaluation of the program, such as identification of barriers, coordination of services and quality issues are also the responsibility of the Program Specialist.

The **Support Staff** will be responsible for supporting the MFP Project Director, Assistant Project Director and Program Specialist. Responsibilities include maintaining schedules for staff supported, making travel arrangements for staff supported, assisting with preparation of documents and reports to be submitted to Centers for Medicaid and Medicare, developing and maintaining documents and forms for the MFP program, and arranging in and out of state travel for MFP stakeholder participants and self-advocates, scheduling meetings, and other duties as assigned.

### **DMH MFP Staff**

Following are descriptions of various positions at the Department of Mental Health for Money Follows the Person transitions of developmentally disabled participants. Please note that as of January 1, 2016, these positions are fully funded outside of the grant.

### **Transition Service Coordinator**

The Transition Service Coordinator spends 40% of her time on the program, and a second Transition Service Coordinator spends 10% of her time on the project. The coordinators provide transition oversight for ICF/MRs. Their duties include identifying individuals in habilitation centers to transition to the community, tracking individuals in habilitation centers through the annual person-centered planning process, and to coordinate the transition process between the habilitation centers and regional offices to ensure transitions occur properly. The coordinators

will work to eliminate barriers by following up with regional offices when transitions do not occur.

### **Deputy Director**

The Deputy Director spends 10% of her time on the program. This position will direct and coordinate the overall planning, development and administration of new provider development, including division directives, code of state regulation, HCBS waiver service definitions, and serve as a resource for regional office provider relations staff. The deputy director will review and/or revise programs to ensure compliance with laws, regulations, policies, accreditation and certification standards; participate in the development, implementation or interpretation of new or revised program, departmental, or legislative initiatives; and serves as liaison to address federal, state, local and community organizations or other groups pertaining to new provider development.

### **Director of Special Community Services**

The Director of Special Community Services spends 40% of her time on the program and will have a variety of tasks, but will place a great deal of effort in increasing the number of individuals who are self-directing their care. This director provides support to regional office self-directed support coordinators, works with division staff to expand and enhance self-directed waiver options, and works with families, advocates and other organizations to promote self-determination in all supports for individuals with disabilities.

### **Behavior Analyst**

The two Behavior Analysts will both spend 10% of their time on the program and will be responsible for providing oversight, technical assistance and support to regional offices and habilitation centers for individuals with significant behavioral issues being supported in the community or in the habilitation centers. They will also provide oversight and technical assistance to habilitation centers for individuals who require increased levels of supervision to ensure interventions toward less restrictive supervision and increased independence are ongoing and effective. These staff will provide oversight and technical assistance, including training and case consultation, to Behavioral Review Committees and Behavior Resource Teams in the regional offices and habilitation centers.

### **Director of Quality Enhancement**

The Director of Quality Enhancement spends 10% of her time on the project, and will assist in the development of system change to mitigate and eliminate system barriers. This director provides data reports on DD MFP consumers' incident and injury reports, as well as on the results of service monitoring activities and on certified/accredited community providers who serve DD consumers who are participants. They will include MFP consumers in case review procedures. This director will also assist the project director in semi-annual reporting of outcomes to CMS.

### **DSDS MFP Staff**

The Aging Program Specialist II staff person and the DSDS Project Specialist (a part-time, hourly position) will be responsible for the planning, development and implementation of all MFP policies and protocols, coordination of housing issues on a case by case basis for DHSS MFP participants, and oversight of the transition contract with the AAAs and CILs with input from the Regional MFP Coordinators. These staff will spend 100% of their time in these roles. They will also develop policies and procedures for implementation of the MFP program for the identification and transition of elderly and disabled adults, and will interpret, clarify and modify procedures when required. They will review and analyze federal regulations and proposed and adopted legislation to determine the impact on the department; develop recommendation for the agency's response or recommends a plan for implementation, and coordinate with the Bureau of Program Integrity for the development and amendment of policy and procedure documents. In addition to providing oversight for the Long Term Care Rebalancing Opportunities Contract, they will monitor the contractual compliance of the AAAs and CILs, and verify the reimbursement to the AAAs and CILs for numbers of transitions. The Aging Program Specialists are responsible for reviewing and approving all MFP Demonstration HCBS requests from AAAs and CILs. They will provide leadership and direction in implementation of the Long Term Care Rebalancing Opportunities Contract. They will compile and analyze reporting, on a monthly basis at a minimum, from AAAs and CILs in order to fulfill CMS/MFP reporting requirements, and work closely with the MFP Project Director and Assistant Director in semi-annual reporting, protocol amendments and supplemental budget request calculations. The Aging Program Specialists will work closely with the Project Director's staff in developing and maintaining working relationships with Public Housing Authorities and Housing Finance Agencies to facilitate the location of housing for participants, and will work collaboratively with the MFP Stakeholder group to establish other necessary relationships for housing outreach efforts.

### **MFP Regional Coordinators**

MFP Regional Coordinators are responsible for the coordination and oversight of the Money Follows the Person (MFP) Demonstration Grant operations within a region. Five coordinators have been hired to serve the state's five regions. MFP Regional Coordinators will provide technical assistance for AAAs and CIL staff in the implementation of all MFP transition activities. MFP Regional Coordinators will report any instances of abuse or neglect to DSDS. DSDS will forward information as necessary to Central Office staff with any required summary.

MFP Regional Coordinators are responsible for determining MFP eligibility criteria upon notification by contract staff of a potential MFP participant. Once a potential participant meets MFP eligibility criteria, MFP Regional Coordinators shall schedule and conduct Level of Care assessments and will assist in coordinating with all required parties (the participant/family member, guardian/conservator, transition coordinator, nursing facility discharge planner) to develop a Person Centered Plan authorizing HCBS if needed. MFP Regional Coordinators will develop working relationships with nursing facilities, providers, vendors and other community organizations in order to provide technical assistance when necessary on the policies and procedures of the MFP program. Regional Coordinators will review case files when necessary and accompany the contracted AAA and CIL staff on home visits, while keeping Central Office staff informed of problems and suggested resolutions. They will keep AAA and CIL staff well informed of managerial decisions and new program requirements provided by the MFP Project

Director. When requested, they will attend MFP Stakeholder meetings to provide updates and to collaborate with committee members for continuous quality improvement.

The transition of participants from a nursing facility to the community will be directly monitored by DSDS/MFP Regional Coordinators. One MFP Coordinator will be selected from each of the state's five regions to assist in the day-to-day requirements of overseeing transitions in their area. Any contacts with or related to the MFP participant will be documented in narrative form and submitted to DSDS Program Oversight Unit on a monthly basis for review. The Program Oversight Unit will oversee the MFP Regional Coordinators and ensure appropriateness of transition plans.

Staff from within DSS, DMH and DHSS who are responsible for programs related to services provided through the MFP Demonstration will be involved and utilized for information throughout the grant.

The University of Missouri Kansas City Institute for Human Development (UMKC-IHD), a University Center for Excellence will support the internal evaluation of the MFP project, conducting both process and outcome evaluations. The UMKC-IHD will focus on tracking individual satisfaction outcomes during the project. The center will evaluate the progress made toward eliminating barriers restricting the flexible use of Medicaid funds that individuals otherwise could use to receive needed long-term care services. UMKC-IHD will also assist the state with collecting CMS required evaluation data. UMKC-IHD has a long history of evaluating projects in Missouri. They have worked closely with the state on numerous evaluation initiatives including the current CMS Systems Transformation project. Dr. Robert Doljanac will direct evaluation activities. Resume is attached (Attachment T)

The employing state agency will be responsible for assessment and performance of their hired staff, according to the requirements of the Missouri Personnel System.

The current Medicaid MMIS system is set up to deny duplicate claims for waiver and state plan services that will be utilized under the MFP grant. The Missouri Medicaid Audit and Compliance Unit monitors for fraudulent claims billing. Section 2.6 of the Provider Manuals addresses the policy on Fraud and Abuse; this information can be found at <http://dss.mo.gov/mhd/providers/index.htm>. There is no anticipation of change to the current system other than those specified by the grant for reporting purposes.

### **3. Information Technology**

Missouri is in the end of the development period and early implementation stages of the MFP web-based system to enhance the infrastructure for the following purposes: Nursing Home Minimum Data Set, Section Q referrals; Options Counseling; Money Follows the Person (MFP) referral; transition planning; and follow-up. The original process Missouri used was a manual process that requires a trail of paperwork to switch many hands that allows for lost information and skewed data reporting. With this web based system the information entered would come from the source of the individual who obtained the data. This reporting system would also enable the state to provide more accurate data for the required semi-annual report. There has been a pilot training to make sure the system operates and functions in a user friendly format as well as

collects all data that is required. Training was conducted with users of the new system, and training will continue around the state to all users, including state staff, contracted staff and nursing facilities. The state MFP project staff will continue to be responsible for entering data until all training is completed. Once training is completed the MFP Project Director and MFP staff will monitor to ensure data is being entered correctly.

The development committee will work with IT staff to develop the reporting components of the system to meet the requirements of the MFP Semi-Annual reporting as well as other state reporting initiatives.

By creating this system the MFP program will be better able to monitor participants and will have information more readily available for reporting and for day to day activities of the program. The program will be able to have all participant information in one file and will be able to run reports on various activities of the transition process to identify barriers and problems. This system will also minimize errors in reporting.

#### **D. Evaluation**

The purpose of the semi-annual evaluation is to report on the effectiveness of the State of Missouri's Money Follows the Person Project, provide information for program improvement and provide information about program operations and effectiveness. This evaluation process will generate data briefs and reports that can be used to provide vital information to the public, and key legislative members. These reports can also be used by MFP stakeholders as part of community outreach to attract individuals to participate in the program and return more individuals to the community.

The semi-annual program evaluation reports on the project's implementation process and outcomes and will examine points throughout the transition process from institutions to community settings. These stages include but are not limited to: how the persons in the project are selected as participants; the type of funding they will receive; the type of residence they will occupy; the support services they will receive; and their satisfaction with these services. Information will be gathered on MFP participants that leave the program to help identify the reasons for their leaving. This information can be used to identify trends and aid in the development of supports and services to help maintain support for individuals living in community settings. This will become important as individuals with more complicated needs return to the community and aid the MFP Project in reaching their benchmarks for successful community transitions.

- The following objectives have been developed to examine and evaluate various aspects of the MFP project. It is intended that these objectives will provide feedback on essential components of the project that are necessary for the project to be successful.
- Establish practices and policies to screen, identify, and assess persons who are candidates for transitioning into the community through the MFP project.
- Development of flexible financing strategies or other budget transfer strategies that allow "money to follow the person."

- Availability and accessibility of supportive services for MFP participants. Supportive services include a full array of health services, ‘one time’ transitions services, adaptive medical equipment, housing and transportation.
- Performance of a cost analysis on support service costs for individuals participating in the MFP Project.
- Development of policies and practices to improve quality management systems to monitor services and supports provided to participants in the MFP Project.
- Persons eligible to participate in MFP and who decline or those persons enrolled in MFP and who cease participation in MFP will be evaluated to determine the reasons for their decisions. Individuals who die while participating in MFP will also have their cause of death examined

### **Utilization of Data**

Missouri’s Money Follows The Person project staff utilizes collected evaluation data in a variety of ways. Data is used to evaluate program effectiveness and cost effectiveness, to identify barriers, to establish outcomes and is also utilized to shape education and training efforts. Data briefs are used to educate stakeholders; including advocates, governmental parties, and agency representatives, which helps them to make important recommendations.