MONEY FOLLOWS

THE

PERSON

Demonstration Grant Narrative

Project Period
January 1, 2007 – December 31, 2007

State of Missouri: Money Follows the Person Rebalancing Demonstration

Project Abstract

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 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 five year demonstration the state will:

Objective #1: Transition a minimum of 250 individuals who have disabilities and those who are aging who choose to move to the community from state Habilitation Centers and Nursing Facilities to the community. This demonstration will include participants with significant developmental and psychiatric disabilities living in state Habilitation Centers and individuals with significant physical and aging related disabilities living in Nursing Facilities. Individuals who choose to participate will receive support and assistance to plan their transitions and to access needed community services (e.g. housing, medical care). Following the demonstration, participants will receive ongoing community services and supports (e.g. waivers, state plan services).

Objective #2: Eliminate barriers that prevent individuals currently residing in state institutions from accessing needed long-term community support services. This demonstration will improve access to a variety of important transition services (e.g. person centered planning, transition support funds) and community services (e.g. mental health services for individuals who experience co-occurring developmental and psychiatric disabilities).

Objective #3: Improve the ability of the Missouri Medicaid program to continue provision of home and community based long-term care services to individuals who choose to transition from institutional to community settings following this demonstration. This demonstration will address existing barriers to money following the person from institutional to community settings to fund needed community supports and increase opportunities for individuals to self-direct their community services and supports.

Objective #4: Ensure that procedures are in place to provide for continuous quality improvement in long-term care services. This demonstration will facilitate collaborations with existing state system transformation efforts designed to enhance integrated Quality Management systems that support consumer choice, consumer satisfaction, and positive systems changes.

This project will be accomplished through partnerships with multiple stakeholders that include individuals with disabilities and their families, state agencies, legislators, community providers, consumer advocacy groups, the University of Missouri, and others. The Missouri Department of Social Services Division of Medical Services, the single state agency responsible for the administration of Missouri's Medicaid Program, will have overall responsibility for administration of this project in partnership with the Missouri Department of Mental Health (Divisions of Mental Retardation/Developmental Disabilities and Comprehensive Psychiatric Services) and the Missouri Department of Health and Senior Services. The ongoing collaboration and participation of these multiple stakeholders in the design and implementation of this project will be supported through the Missouri Personal Independence Commission which is charged with advising the Governor on necessary policy and program changes to assure that Missourians of all ages and disabilities have access to needed community support services.
Total Five Year Budget: $22,223,795

PART I: SYSTEMS ASSESSMENT AND GAP ANALYSIS

What is in Place and Working: In the State of Missouri many forces are converging to improve and transform the long-term support system that provides services and supports for people with disabilities and long-term illnesses. At this time executive, legislative, state agencies, and consumer/family leaders are collaborating on a number of important initiatives that are designed to address shortcomings and gaps in long-term support systems. These initiatives include Medicaid reform, mental health system transformation initiatives, institutional transition initiatives, efforts to enhance self-direction in services, and others. Following is an overview of some of these current key initiatives:

Medicaid Reform: In 2005 a Medicaid Reform Commission was created and charged with developing a report with recommendations for reforming, redesigning and restructuring a new Medicaid system in Missouri. The recommendations in this report address the three major components of reform: eligibility, availability and delivery of care. In the context of these three components, the report addresses issues within seven areas that include mental health and long-term care. Following are a few of the recommendations that were generated in these two areas:

Mental Health

1. Seek Medicaid waivers to assure that an ***appropriate array of services and supports are available*** for individuals with developmental disabilities and serious mental illnesses.
2. Support local ***investment in mental health services and supports***.
3. Promote the ***use of new technologies***, (e.g. telemedicine, electronic medical records).

Long-Term Care

1. Create a mechanism that ***educates and informs consumers*** about long-term care options.
2. Encourage safety and the ***placement in the least restrictive environment***.

3. Establish a ***single point of entry*** that includes a statewide-standardized assessment, evaluates individual needs and provides information about long-term care options.

Relation to Money Follows the Person: These recommendations address a number of key issues related to a system in which money can follow the person. These include access to a single point of entry, improved use of technology, more informed choices, improved services and supports and enhanced quality.

Missouri Division of MRDD Systems Transformation Initiative: The state of Missouri has received a 5 year grant from the Centers for Medicare and Medicaid Services *"to support people with developmental disabilities of any age or payer source to live in their communities through maximized independence, dignity, choice, and flexibility*." The project is designed to assist the state of Missouri to improve its' system of community long-term support for people with developmental disabilities through:

- Supporting individuals to ***transition from state habilitation centers to the community***
- Improving access to important community service information and peer support needed to ***assist individuals to make informed choices*** and transition to the community
- Developing ***needed behavioral and medical community services***
- Improving the ***quality of the community direct support workforce***, and
- ***Enhancing quality improvement and information technology systems*** to support an improved quality of life for individuals with developmental disabilities.

Relation to Money Follows the Person*:* Funding through the Money Follows the Person Demonstration would compliment and enhance efforts to rebalance Missouri's long-term support service programs and provide the additional support needed to assist individuals to transition from state institutions to the community.

Missouri Mental Health Transformation Initiative: Creating Communities of Hope: The state of Missouri is a recent recipient of a 5 year grant from the Substance Abuse and Mental Health Services Administration. Through this grant Missouri will foster the development of **"Communities of Hope"** where the promotion of mental health across the entire population and the whole lifespan, and the prevention of substance abuse, mental illness, and developmental disabilities for all its' citizens are fully realized. Through this initiative Missouri will develop and implement a Comprehensive State Mental Health Plan that transcends all departments involved in the delivery and financing of mental health services. Missouri's vision of a transformed system is supported by four cornerstones:

- ***Consumer & Family Driven:*** The voices of consumers and family members drive the design, promotion, delivery, and evaluation of a resiliency and recovery oriented system.
- ***Community-Based:*** Local communities throughout the state invest in the mental health of their citizens and create an abundance of opportunities to promote positive mental health.
- ***Easily Accessible:*** The mental health needs across the life span of Missourians are met by easy, early, and equal access to a mental health "system" that mobilizes and brings together the right people with the right expertise and the right resources.
- ***Openly Accountable:*** The system is culturally competent, trauma-informed, and based on evidence; capitalizes on the advancements of technology and that promote efficiency, and breakthroughs in disability prevention and new systems of care.

Relation to Money Follows the Person: This project will work to reform the Missouri mental health system and address key money follows the person elements through initiatives such as developing a comprehensive approach to cultural competence, expanding workforce development efforts, and utilizing technology to address rural access gaps.

"Right-Sizing" Habilitation Centers: The Division of MRDD obtained approval from the Mental Health Commission on March 11, 2004 to incrementally reduce Habilitation Center bed capacity by transitioning individuals to communities, when appropriate supports are available and the individual and their guardian choose to make the move. In July 2003 the census for all Habilitation Centers was 1,247. During the past three years this census has been reduced to 997 (July 2006). Bed reductions will continue to occur by identifying Habilitation Center consumers who can be served safely in the community effectively with the appropriate community support services. Many of the individuals who still reside in Habilitation Centers have complex support and care needs. The enhanced funding through the "Money Follows the Person" Demonstration will allow the state to focus on community based care for those individuals who remain. The money to purchase the necessary community support services to allow these consumers to be successful in the community will follow the individual from the Habilitation Center to the community. The division's plan identifies a number of system barriers that need to be addressed to support transitions to the community. These include financing options, direct support provider capacity, and crisis response systems. A list of these issues can be found in **Appendix A.**

Relation to Money Follows the Person: For rebalancing initiatives to be successful there must be commitment of leadership at the highest levels of government. The state plan to transition individuals from state institutions to the community is a demonstration of this commitment.

The Missouri Independence Plus Initiative: The Missouri Division of Mental Retardation and Developmental Disabilities (MRDD) received a 3-year grant from the Center for Medicare and Medicaid Services (CMS) to plan, develop and implement a life-enhancing consumer-directed system in Missouri that allows people with disabilities, and their family, choices and control in their supports and services. The project piloted a variety of consumer directed services including

identifying ways participants can negotiate and exercise control of allocated resources within their budgets and the use of support brokers selected by the consumer. Support broker has been added to two MRDD 1915(c) waivers, individuals may choose an independent plan facilitator, and information and training for consumers, stakeholders and professional staff on self-direction are being completed.

Relation to Money Follows the Person: The Independence Plus initiative addressed a number of barriers to self-direction. Participation in the money follows the person demonstrations will allow the state of Missouri to further develop and expand self-directed principles and services.

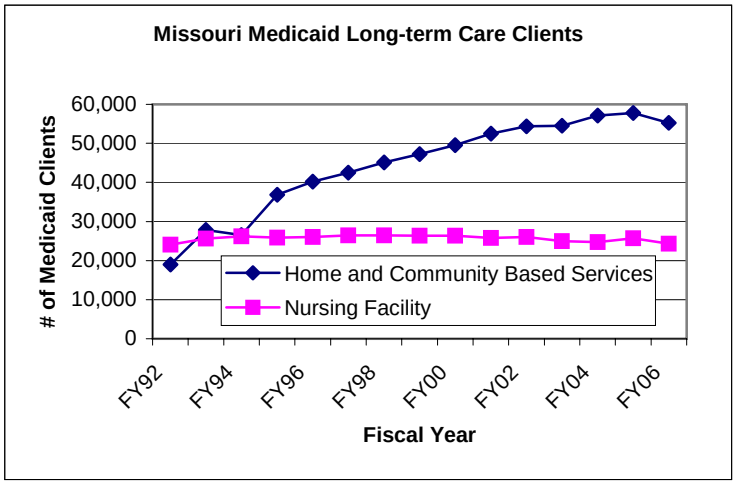
The initiatives described above reinforce the commitment of the state of Missouri to increase the use of home and community-based, rather than institutional, long-term care services. These initiatives are consistent with key money follows the person elements that are needed for Missouri to move toward a more balanced long-term care system.

Description of the Current Long Term Support Delivery System, Funding Mechanisms, and, Expenditures: Missouri has developed a wide variety of home and community based alternatives to institutional care over the past three decades. In-home service programs began under Social Service Block Grant funding in the 1970s and provided basic in-home services such as personal care and homemaker services. In 1981, Missouri added personal care as an optional Medicaid state plan benefit. In 1982, Missouri applied for one of the nation's first 1915(c) Home and Community Based (HCB) waivers (now called the Aged and Disabled Waiver) to provide homemaker/chore and respite care for the elderly. The Mental Retardation/Developmental Disabilities (MR/DD) Waiver was implemented in 1988 and the AIDS/HIV Waiver in 1990.

As a result of a 1992 Legislative initiative, Missouri Care Options (MCO) was implemented to provide information to Missouri citizens about making choices regarding a variety of long-term care options. MCO was created to best meet the long term care needs and

enhance the integrity, independence, and safety of Missouri's older adults through ready access to quality community based long-term care options. The top priority of MCO was to allow individuals to remain in their homes rather than enter a nursing home, and in doing so, moderated growth in nursing home spending while increasing funding for home and community based services. Through work by DHSS staff, including the Central Registry Unit (which is responsible for providing information and referrals for long-term care services), individuals seeking long-term care options are provided with choices to help the person select "the right care in the right setting at the right time and at the right cost to the public."

During the last decade, Missouri has continued to expand home and community based options through Medicaid state plan amendments, new waivers, and amendments to existing waivers. The following graph depicts the changes that have occurred from 1992 to 2006 in the number of individuals receiving Medicaid funded services through home and community based programs and within nursing facilities (see **Appendix B**). During this period there has been a 190% increase in individuals receiving community services while those receiving care in nursing facilities decreased slightly. Since the state began offering in home services in 1992 the cost of that in-home care has always been considerably less than institutional care. In FY 2006, the average annual cost per individual was $6,012 for in-home services while the cost of Nursing Facility care, including ancillary services, was $32,345.



Missouri's current community based long term care support system includes services authorized and funded through the Department of Mental Health and the Department of Health and Senior Services. Each department provides a variety of long-term institutional and community-based services. The following describes their available services.

Missouri Department of Mental Health (DMH): The Missouri DMH provides services and supports for individuals who experience a wide range of disabilities. The Division of Comprehensive Psychiatric Services (CPS) and Division of Mental Retardation and Developmental Disabilities (MRDD) provide long-term institutional and fund community based services for individuals with psychiatric and developmental disabilities.

Comprehensive Psychiatric Services: The Division divides Missouri into 25 service areas to **serve individuals with psychiatric and mental health disabilities**. Each service area has a contracted Community Mental Health Center designated as the division's administrative agent. These administrative agents serve as the primary entry and exit point for state mental health services and are responsible for the assessment and services to persons in their assigned areas and for providing follow-up services for persons released from state-operated inpatient services. CPS operates eleven inpatient facilities, providing acute, long term rehabilitation and residential care for youth and adults as well as forensic, sexual predator and corrections services for adults. The number of psychiatric institutional beds as of May 31, 2006 was 1,531. During FY 2006, 7,618 individuals were served in these facilities. In FY 2006, the Division of CPS served 71,763 individuals, including 16,543 children and youth with serious emotional disturbances (SED) and 55,049 adults with mental illness in community based services. Of this total, 29,431 adults were served through the Medicaid funded Community Psychiatric Rehabilitation program and 5,773 through supported community living. Following is a brief overview of existing services:

Community Psychiatric Rehabilitation Program (CPR): The CPR is a Medicaid supported community-based program funded through Medicaid State Plan under the rehabilitation option that provides services and supports to individuals living in the community. The program provides an array of key services to adults with serious mental illness and children and youth with severe emotional disturbances. Service plan rehabilitation option services that will be included in this demonstration are: intake and annual evaluations, medication services, physician consultation, community support, crisis intervention, and psychosocial rehabilitation (PSR). PSR services help persons with psychiatric disabilities to learn or relearn social and vocational skills and to acquire the supports needed for family, school and community integration. In order to help the participant gain or regain practical skills for community/family living, service activities include teaching, improving and encouraging adaptive skills in a variety areas of daily living (e.g. personal hygiene, cooking, shopping, budgeting).

Division of CPS Expenditures: In FY 06 the Division of CPS spent $367,326,379 on institutional and community services. Table 1 provides a breakdown of these resources.

Table 1: FY 06 CPS Institutional and Community Expenditures

	Individuals Served	State General Revenue	Federal	Other	Total
Facility Based Programs	7,618	159,868,270	3,946,342	1,367,862	**$165,182,474**
Community Programs	71,763	98,501,035	103,634,511	8,359	**$202,143,905**
Total	**73,294**	**$258,369,305**	**$107,580,853**	**$1,376,221**	**$367,326,379**

Division of Mental Retardation and Developmental Disabilities (MRDD): The Division of Mental Retardation and Developmental Disabilities (MRDD), **provides lifespan services to individuals with developmental disabilities** such as mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. The division operates 17 facilities that provide or purchase specialized services. Eleven regional centers form the framework for

the system of community supports and services. The 11 regional centers, the primary points of entry into the system, provide eligibility determination, assessment and case management services. The Division also operates six habilitation centers, which provide institutional residential care and habilitation services. In 1988, the division began participation in the Medicaid Home and Community-based Waiver program, designed to help expand needed services throughout the state. Following are definitions of some of the most common services:

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 3 individuals with disabilities may reside together and qualify for ISL services.

Day Habilitation 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 program or off-site, in the individual's home or community.

Therapies: A variety of therapies are available through the MRDD Waiver including physical, occupational, speech, and behavioral therapy.

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 persons normally providing the care.

Supported Employment: Work in an integrated setting with on-going support services.

Transition Services: Individuals 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 MRDD also provides Targeted Case Management to individuals with MR/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.

Division of MRDD Expenditures: In FY 06 the Division of MRDD spent an average of $90,968 on Intermediate Care Facility placements and an average of $48,902 those served under the Comprehensive Waiver. Table 2 provides a breakdown of resources spent on these services.

Table 2: FY 06 MRDD ICF and Comprehensive Waiver Expenditures

	Participants	**Costs**	**Acute Care Costs (non ICF/MR or Waiver**	**Total**
Intermediate Care Facility	1,098	$93,823,903 *$88,772 average*	$6,058,414 *$5,538 average*	**$99,882,317** ***$90,968 average***
Comprehensive Waiver	7,592	$308,210,968 *$40,597 average*	$62,750,841 *$8,277 average*	**$371,261,809** ***$48,902 average***
Total	**8,690**	**$402,034,871**	**$68,809,255**	**$470,844,126**

The Department of Health and Senior Services (DHSS): DHSS serves the citizens of Missouri by working to improve the health and quality of life for Missourians of all ages. DHSS provides a range of services to individuals with a wide variety of disabilities including **those with physical disabilities, long-term illnesses, and disabilities as a result of aging.**

Community Services: DHSS provides a wide variety of community services including:

In-home Services: The department supports the provision of in-home services to individuals through contracts with various entities (in-home service providers) located throughout the state. The providers hire, train, and schedule the staff required to deliver services in an individual's private residences. These services are provided through both State Plan services and the Aged and Disabled Waiver.

Consumer-Directed Services: The department offers consumer-directed personal care assistant services that support individuals with physical disabilities to self-direct the services needed for them to live independently in their homes and communities. DHSS contracts with community entities who must demonstrate the ability to provide services including advocacy, independent living skills training, peer counseling and information and referral. These entities provide support to participants in how to hire, train, fire, and retain attendants. These services are provided through both the State Plan and Independent Living Waiver.

Adult Day Health Care: The department provides organized programs consisting of therapeutic, rehabilitative and social activities provided outside the home (for a period of less than 10 hours) to persons with functional impairments of at least a nursing facility level of care.

Program of All-Inclusive Care for the Elderly (PACE): The department is offering a comprehensive service delivery and finance model for the frail elderly (only available in St. Louis Area) that includes but is not limited to; primary medical care, therapy, transportation, inpatient acute care, home health care and nursing facility care. Services are provided at the center, the home, the hospital, or a nursing facility, depending upon the needs of the individual.

Department of HSS Expenditures: In FY 06 the average Medicaid expenditure for long-term nursing facility care costs was $32,344 and the average Medicaid expenditure for community-based care was $6,010 for 55,233 individuals. Table 3 provides a breakdown.

Table 3: FY 06 HCBS and Nursing Facility Expenditures

	Participants	Title XIX Expenditures
Nursing Facility	24,282	$785,400,000
HCBS	55,233	$332,000,000

Description of Major Legislative Initiatives: Table 4 provides a summary of some of the legislation that has passed during the last 4 years that have created systems changes in the state:

Table 4: Legislative Summary

Bill	Change
2005 Bills	
SB539	Created the Medicaid Reform Commission charged with developing recommendations for reforming, redesigning and restructuring Missouri's Medicaid system. Modifies provisions dealing with various health care and social service programs (e.g., Medicaid, MO Senior RX, and PCA programs). Sunsets the current Medicaid program 6/30/2008.
SB 501	Established an "Office of Comprehensive Child Mental Health" within the Dept. of Mental Health to implement a comprehensive mental health service system plan.
SB 518	Creates the Assistive Technology Trust Fund, which will consist of gifts, donations, grants, and bequests from individuals or groups given for the purpose of AT.
SB521	Expands the membership of the Community Service Commission to include the Lieutenant Governor or his or her designee.
SB 500	Revises the First Steps Program with services delivered through a regional system that will encourage participation of local service providers, including DMH programs.
HCS HB 462 & 463	Provisions of the bill provide some immunity from civil liability for treatment professionals and others who provide suicide interventions and establishes a State Suicide Prevention Council to advise the Office of Child Mental Health
2004 Bills	
SCS/SB1003	Required the Dept. of Mental Health in partnership with all child serving departments to develop a comprehensive children's mental health service system.
SB 1160	Establishes the Prescription Drug Repository Program within the DHSS.
SB1274	Establishes MO Area Health Education Centers program, designed to improve availability and quality of health care personnel.
2003 Bills	
SB0266	Required Dept. of Mental Health, Division of MRDD to develop a plan to address the needs of persons on waiting lists for services.
SCR 11	Directs DHSS with Department of Insurance and any teaching hospital under control of public universities in MO to evaluate the establishment of a Comprehensive Patient Education and Healthcare Cost Improvement Program.
SCR 13	Creates a subcommittee within Joint Committee on Legislative Research charged with investigating ways to reduce costs to state government and increase quality of services to citizens through utilizing private resources.
HB 855	Changes laws about insurance coverage for mental illness and chemical dependency.
2002 Bills	
SB 236	Persons institutionalized in nursing homes who are Medicaid eligible and who wish to move to the community shall be eligible for a "transition to independence" grant.

Description of Systems of Care, Waivers, and State Plan Services: 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.

Systems of Care: The recommendations of the "Governor's Children and Family Summit" directed the Missouri Department of Mental Health to lead statewide efforts in developing a system of care for children and youth with serious emotional disturbances. There are existing projects in three areas of the state, St. Louis, Springfield, and in Northwest Missouri. The focus of these projects includes early identification, integrated services, and a continuum of care.

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

Table 5: State Plan Service Overview

State Plan Services	Medicaid	Social Service Block Grant/General Revenue
Adult Day Health Care (full day)	X	
Adult Day Health Care (1/2 day)	X	
Advanced Personal Care	X	X
Authorized Nurse Visits	X	X
Basic Personal Care	X	X
PACE (Program of All-Inclusive Care for the Elderly is only available in certain areas of St. Louis)	X	
Personal Care Assistance (Consumer Directed)	X	
Community Psychiatric Rehabilitation Program (CPR)	X	X

Medicaid Home and Community Based 1915(c) Waivers: Table 6 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 MRDD, Aged & Disabled, and Independent Living Waivers will provide a major portion of the HCB long term care services for participants in this project. See **Appendix C** for a detailed chart.

Table 6: Overview of Missouri Waivers

Program Name	Administration	Overview
Comprehensive MRDD Waiver	Division of MRDD	An array of specialized services, including residential services, are covered by Medicaid for participants who have MR/DD conditions
Community Support Waiver	Division of MRDD	An array of specialized services, excluding residential services, are covered by Medicaid for participants who have MR/DD conditions. $22,000 annual cap applies.
Lopez Waiver	Division of MRDD	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	Department of HSS	Allows certain disabled and elderly persons who are Medicaid eligible to receive expanded services in their home as an alternative to nursing home services
Physically Disabled Waiver	Department of HSS	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	Department of HSS	Allows some persons with AIDS or HIV to receive medically oriented home care. Covered services include private duty nursing, attendant care, personal care & supplies
Independent Living Waiver	Department of HSS	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 consumer (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

Description of Current Efforts to Provide Opportunities for Individuals to Self-Direct Services and Supports: Existing opportunities for individuals to self-direct services include:

Through the Independence Plus Initiative a variety of consumer directed services have been piloted by the Division of MRDD including identifying ways participants can negotiate and exercise control of allocated resources within their budgets and the use of support brokers selected by the consumer. Plans are being developed to expand these opportunities.

Through the MRDD waiver individuals may choose to self-direct personal assistant, in-home respite, and support broker services. The Division of MRDD contracts with a fiscal management provider for payroll services or the Personal Assistant can choose an assistant employed by an agency (agency with choice).

State Plan services offer consumer-directed personal care services that support adults with physical disabilities to self-direct the services needed for them to live independently in their homes and communities. DHSS contracts with community entities to provide support to participants in how to hire and retain attendants. The Independent Living Waiver makes available additional hours of consumer directed personal care for adults who have needs that exceed the State plan limitations.

The Division of CPS implemented the Procovery program model of Kathleen Crowley and the Procovery Institute as a vehicle to enhance its focus on recovery. Procovery is an approach based on a voluntary model of engaging and empowering consumers to take more active roles in directing their lives, including the services they receive. Consumers and providers have embraced this program model with 80 Procovery Circles currently ongoing.

Description of Current Institutional Diversion and/or Transition Programs: As previously described, the state of Missouri is engaged in a variety of initiatives that are designed to improve the long-term community support system and to increase the use of home and community based long-term care services and reduce reliance on institutional care. Following are a few examples:

The Division of MRDD, as previously described, plans to reduce the number of individuals with developmental disabilities living at state habilitation centers. The closure of one of the facilities has been announced by the Governor. Since 1999, 352 individuals have transitioned to the community from habilitation centers statewide. These efforts are supported through ***Money Follows the Person Legislation*** (House Bill 10), which enables flexible funding to follow the individual to the community from state operated ICF/MR facilities.

As the Division of MRDD has worked to transition people from habilitation centers to the community, they began to encounter individuals who had a dual diagnosis of mental illness.

Beginning in 2005, the Division of CPS partnered with the Division of MRDD to open a temporary transitional program at St. Louis Psychiatric Rehabilitation Center (SLPRC). Once funds were appropriated, a more permanent program at Southeast Missouri Mental Health Center (SEMMHC) was established to assist with providing integrated dual diagnosis treatment for these individuals to help them in transitioning to the community. Consumers have benefited from these services with a number being discharged to the community from SLPRC and several currently in transition from SEMMHC. The Division of CPS has also recently issued an Application for Demonstration Projects in order to develop and implement a transitional community program. By developing Transitional Community Programs to fill the gap between institution and community services, CPS plans to partner with agencies and support them to provide intensive treatment, adequate staffing and oversight for successful transitions.

A number of efforts have also been focused on supporting nursing facility transitions. For example, the Division of Regulation and Licensure (DRL) is responsible for surveying nursing facilities throughout the state. When a survey team becomes aware of a resident who is interested in transitioning out of a nursing facility, the team monitors the facility's efforts in working with the resident to plan and support these transitions. In addition, many of the Independent Living Centers (ILC) in the state work within their regions to support nursing home transitions for persons with physical disabilities. The ILC's support transitions by assisting in locating affordable/accessible housing, arranging for needed consumer personal care or arranging for peer consultants, and assisting with nursing home discharge planning.

Description of System Gaps: In the development of this proposal multiple stakeholders were engaged in discussions regarding shortcomings and gaps that the state experiences as it seeks to increase the use of home and community based long-term care services and reduce reliance on

institutional care. Input was received through discussion with multiple state consumer advisory groups, state councils, and focus groups. These are listed in Part Four of the narrative. Comments received from these groups included: a.) training for direct service staff on best practice interventions for co-occurring psychiatric and developmental disabilities be a priority; b.) youth of transitional age, residing in institutions, be included in the demonstration; c.) housing alternatives be developed as waiting lists for public housing are long; d.) designing transition services to "fit the person"; e.) creating a good person centered transition plan; f.) expanding personal assistant supports; and g.) increasing flexibility to self-direct services. Table 7 provides a summary of a number of system gaps as they relate to key elements of "money that follows the person". These gaps and approaches to addressing them are discussed in more detail for each target group within the Demonstration Design section of this proposal.

> *"Find out what the consumer and family want- Don't expect them to fit into a slot"*
> Focus Group Comment

Table 7: Overview of System Gaps

Elements	System Gaps
Accessing Services	Public Administrators not willing to permit a move from facilities to community-based services.
Flexible Financing Options	Need to develop protocols and policies that allow moving money from the long term care budget to the home and community based budget to support nursing home transitions.
Accessible Transition Support Services	Waiting lists for accessible and affordable housing. Access to community crisis response systems. Access to intensive transition supports. Access to transition funds to assist in setting up a household.
Quality Community Workforce	Lack of cross training between CPS and MRDD community providers to support services for individuals with dual diagnosis.
Self-Directed Services	Limited opportunities for individuals to self-direct services.
Access to Transition Coordinators	For those individuals residing in a long-term care facility, accessing services is primarily dependent on support and assistance from facility staff, ombudsman volunteers, and family members.
Comprehensive IT and QM Systems	Lack of easy accessibility to available information and a system that supports trending, sharing, and reporting
Interagency and Public/Private Collaboration	Separate funding streams and operations result in "silos" between the state divisions.

Collaborations Needed to Ensure Success of this Demonstration: The success of this project 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.

The Missouri Division of Medical Services (DMS), the single state agency responsible for the administration of Missouri's Medicaid Program, will have overall responsibility for administration of this project. DMS and project partners will support the ongoing collaboration and participation of multiple stakeholders in the design and implementation of this project through the Missouri Personal Independence Commission (PIC). Missouri's Lt. Governor and a disability advocate, co-chair this commission which is charged with advising the Governor on necessary policy and program changes to assure that Missourians of all ages and disabilities have access to a range of needed community support services. The PIC was created through executive order in April of 2001. The objective of this commission is "to monitor Missouri's implementation of Title II of the ADA, with guidance provided by the U.S. Supreme Court in *Olmstead* and subsequent cases" (see **Appendix D** for a copy of this executive order).

The PIC includes individuals with disabilities, family members of people with disabilities, senior citizens, advocacy groups, the lieutenant governor, four members of the general assembly and representatives from the Departments of Social Services, Mental Health, Health and Senior Services and Elementary and Secondary Education. See 2005 PIC Annual Report in **Appendix E**.

The PIC will engage multiple stakeholder groups in a protocol development process at the beginning of the project that will guide the implementation and management of the demonstration. This protocol will address a variety of key issues that include participant selection methods, service delivery plans, and quality assurance methods. As a part of the

protocol development process the state will include the active participation of institutional providers (e.g. Habilitation centers, Nursing facilities). Their cooperation and participation will assist with screening, planning and conducting needs assessments.

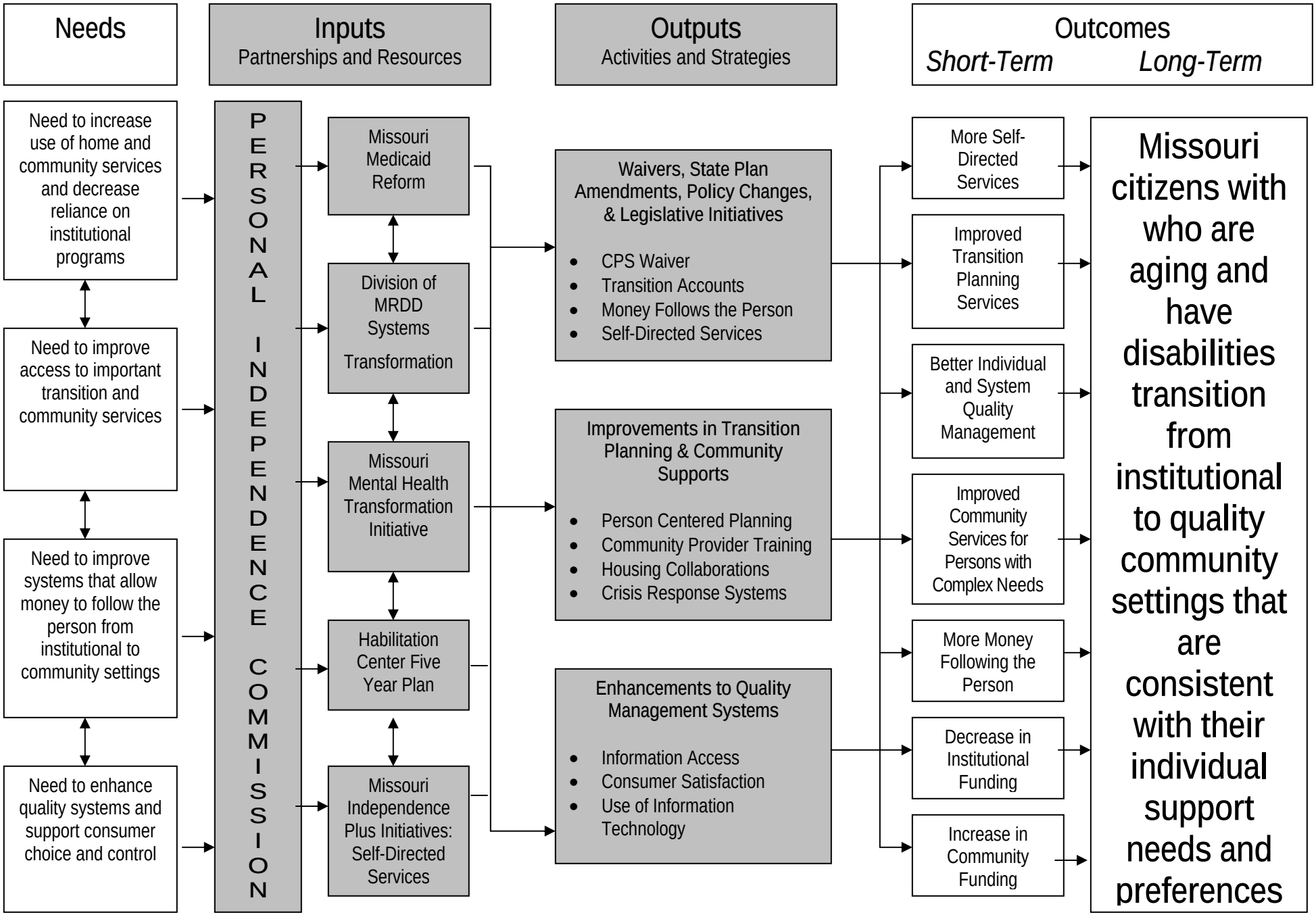
Description of Systems to Assure Quality: The Division of MRDD and Division of Senior Services have policies and procedures in place to ensure that Missouri 1915(c) HCBS Waivers they administer meet CMS required assurances. Each State agency has its own ongoing processes of discovery, remediation and improvement to assure the health and welfare of participants. A number of systems, procedures, and policies are in place to monitor and address quality assurance issues for eligible individuals. A more complete description of these Quality Assurance measures is contained beginning on page 40 of this proposal.

Legislative and Other Changes Needed to Implement Demonstration: Table 8 on the following page details a logic model for this demonstration. This logic model highlights the broad needs/gaps which will be addressed through this demonstration, the partnerships and resources available to address these needs, the activities and strategies (interventions) which will be employed through the project, and the outcomes (e.g. short term, long term) to be achieved. Through the protocol development process, stakeholder input will be used to further discuss needs and refine strategies that are designed to achieve stated outcomes. Interventions fall within three areas including.

- Waivers, State Plan Amendments, Policy Changes, & Legislative Initiatives
- Transition Planning and Community Services
- Quality Management

These interventions are designed to address identified system gaps that are needed to implement this demonstration.

Table 8. Money Follows the Person Logic Model



Application Part 2: Demonstration Design

The Pre-Implementation Phase

Project Goal and Objectives: The overall goal of this project 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 demonstration will enhance existing efforts to transform the long-term support system that provides services and supports for people with disabilities. Table 9 highlights the project objectives that are designed to achieve the overall project goal and outcomes:

Table 9: Project Objectives and Outcomes

Project Objectives	Project Outcomes
1. To transition a minimum of 250 individuals who have disabilities and those who are aging from state Habilitation Centers and Nursing Facilities to the community.	• Increase in community funding • Decrease in institutional funding
2. To eliminate barriers that prevent individuals currently residing in state institutions from accessing needed long-term community support services.	• Improved transition planning services • Improved community services for persons with complex needs
3. To improve the ability of the Missouri Medicaid program to continue provision of home and community based long-term care services to individuals who choose to transition from institutional to community settings following this demonstration.	• More money following the person • More self-directed services
4. To ensure that procedures are in place to provide for continuous quality improvement in long-term care services.	• Better individual and system quality management

Protocol Development Process: Under the umbrella of the Personal Independence Commission (PIC), consumers and other project stakeholders will engage, in an inclusive protocol development process which will make clear the Goals, Objectives, Outcomes, and Strategies of the demonstration. The responsibilities of the PIC will be to: guide the development of the operational protocol; oversee the implementation of the operational protocol; organize the work groups and provide direction and clarification; and provide a link between lead state agencies

and stakeholders to ensure interested parities are informed of the progress. The protocol development process will include the following steps:

Step One: Form workgroups around each target group. Workgroups will be formed for each target group (see page 29). These workgroups will be comprised of a variety of stakeholders and will include consumers, families, state agencies, housing representatives, institutional providers, community providers, and others.

Step Two: Facilitate strategic planning for each target group. The workgroups will focus on planning within the following areas: Recruitment and Informed Consent of Participants; Facilitating Transition Planning and Self-Direction; Enhancing Flexible Use of Medicaid Funds so that Money Follows the Person; Development of Needed Community Resources; and Assuring Quality and Consumer Satisfaction. Workgroup members will be provided with information on past and current efforts surrounding the above areas and will conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis based upon the needs of their target group. Following the analysis, workgroups will identify desired outcomes (e.g. In light of the issues identified, what do we need to either increase or decrease to support successful transitions). Each workgroup will prioritize strategies by measuring strategies against impact and feasibility (e.g. How much impact will this strategy have on the outcome?; How feasible is it that we can accomplish this strategy considering time, money, resources, etc.?).

Step Three: Integration of planning outcomes into a project protocol. Project staff will integrate the information received through the above planning processes into an overall project protocol and plan that addresses the needs of all target groups and meets the protocol guidelines provided by CMS. The draft protocol will be reviewed by the workgroups and the PIC and revisions made based upon feedback and recommendations received.

Interventions Needed to Expand Community-Based Long-Term Care Capacity and Sustain the Demonstration Participants in Community-Based Care Settings: Interventions to expand the community-based long-term care capacity, sustain demonstration participants, and support future individuals who transition to the community from institutional settings fall within three areas. These interventions are designed to address identified system gaps that are needed to implement this demonstration. Table 10 provides an outline of these areas:

Table 10: Planned Interventions

Areas for Change	Planned Interventions
Waivers, State Plan Amendments, Policy Changes, & Legislative Initiatives	• Expanded options to self-directed services (e.g. access to fiscal intermediaries) • Creation of a Division of CPS 1115 waiver to serve those with M.I. • Creation of a MOU to guide service delivery for those with dual diagnosis • Development of transitional housing funds an legislative changes to support • Protocols to move money from institutional to community programs
Transition Planning and Community Services	• Improved crisis response systems • Increased workforce training and cross training • Expanded access to transition coordinators and person centered planning • Improved housing collaborations
Quality Management	• Improved data collection, monitoring/analysis and reporting • Additional collection and reporting of consumer satisfaction measures

Following is a discussion of how this demonstration will approach needed changes for each target group and collaborate with other state initiatives to achieve the desired results. For each target group we have identified the primary barriers they face in relation to key elements of a system in which money follows the person (Appendix A from RFP) and discussed planned interventions to address each barrier.

People with Developmental Disabilities Transitioning from Habilitation Centers: As previously described, the Division of MRDD was awarded a CMS funded Systems Transformation grant that is working to address barriers in the areas of quality management, information technology, and community services. These initiatives will assist in addressing barriers and supporting implementation of this demonstration. The following provides an overview of the initiatives and interventions that are planned to address each barrier.

Accessible Transition Support Services- ***Gap:*** One of the barriers to transitioning individuals from Habilitation Centers has been the lack of capacity of the community long-term support system to respond effectively to crisis situations and provide the types of proactive behavioral supports that are needed to support and maintain individuals with complex support needs in their communities. ***Strategy:*** To address this need the Division of MRDD is planning demonstrations of innovative models for the provision of crisis intervention through the creation of 2-4 community pilot initiatives. The intent is to implement a new model of crisis intervention statewide based on the "lessons learned" during the demonstrations. (Timeline: Begin 2/07)

Quality Community Workforce- ***Gap:*** One of the biggest challenges to providing quality community supports for people with developmental disabilities in Missouri is the ability to find, recruit, and retain qualified direct support professionals (DSPs). For example, the lack of access to competent DSPs is consistently sited as a major barrier to transitioning individuals with significant disabilities to the community. ***Strategy:*** To address this need, a statewide partnership has been formed to plan and create the Missouri College of Direct Support, a program to train and credential DSPs in Missouri. There are currently 17 community service provider agencies participating in the planning and piloting of the initial MCDS curriculum. A steering committee is planning for statewide expansion of this initiative. (Timeline: In process)

Comprehensive Quality Management and Information Technology Systems- ***Gap:*** Much progress has been made in developing a comprehensive quality management system. However, infrastructure improvements still need to be made to the systems that would support trending, reporting, and sharing of information with multiple stakeholder groups. ***Strategy:*** To address this need, the Division of MRDD is working on QM initiatives to increase the numbers of consumer, self-advocates and families who participate in the transformation and use of the

system. Emphasis is being place on the use of IT to support better data collection, monitoring/analysis and reporting systems to assure quality care. (Timeline: In process)

Self-Directed Services- ***Gap:*** The Division of MRDD has piloted a variety of consumer directed services including identifying ways participants can negotiate and exercise control of allocated resources within their budgets and the use of support brokers selected by the consumer. There exists, however, a need to expand self-directed options and provide opportunities for individuals who are transitioning to self-direct services and supports. ***Strategy:*** To address this need, the Division of MRDD added the use of Service Brokers as a fundable service under the MRDD waiver. The Service Broker may assist participants in arranging, directing, and managing services. In addition, plans are being developed to increase the options for use of fiscal intermediaries and provide increased choice related to self-directed services. (Timeline: FY 07/ongoing)

People with Co-Occurring Developmental and Mental Health Disabilities Transitioning from Habilitation Centers: The following provides an overview of the initiatives and interventions that are planned to address each barrier and includes projected timelines.

Accessing Services- ***Gap:*** Many individuals with dual diagnosis who reside in Habilitation Centers have public administrators who are not willing to permit a move to the community. This is largely based on some distrust of the community-based system, the length of time they had been in facility-based programming, and a fear that they, the public administrator, would be left "holding the bag" if the transition to community was unsuccessful. ***Strategy:*** To address this need, the state will promote the development of collaborative transition planning between the facility treatment team, community providers, and the public administrator. The team will focus on the treatment/service components that will most enhance successful transition. The project will also promote regular and continuous (at least monthly) communication between the public

administrator and providers involved in community-based treatment regarding status and progress, including any identified major problems and strategies being implemented to address these. Assurances will also be provided that if, after all available resources and services options have been exhausted, placement in community is not successful that DMH will return the individual to facility-based services to address issues that contributed to failure and improve opportunities for future success. (Timeline: 18 months)

Accessible Transition Support Services- ***Gap:*** Individuals who experience both a developmental and psychiatric disability lack access to community support systems that provide enough support and offer the type of intensive treatment and rehabilitation opportunities that are needed to support successful transitions into the community. This includes development of appropriate day activities. ***Strategy:*** To address this need transitional community programs need to be developed. The Division of CPS is planning for an 1115 waiver that would divert some of the disproportionate share funds generated by inpatient facilities to enhance home and community based and enhance successful community transitions. (Timeline: 18 months)

Quality Community Workforce- ***Gap:*** In Missouri the Divisions of MRDD and CPS each contract with a cadre of community providers who have expertise in providing services and supports for the consumers served by each Division. To adequately support individuals with dual diagnosis, however, there needs to be improved collaboration and cross training between these providers. ***Strategy:*** To address this need, the project will facilitate cross divisional (CPS and MRDD) efforts to develop curricula and training for provider staff from both divisions. (Timeline: Developed in year one, implemented in year 2)

Interagency and Public/Private Collaboration- ***Gap:*** One of the primary barriers to services that people with dual diagnosis face are separate funding streams for MRDD and CPS services.

This results in "silos" between the two Divisions and a lack of integration of resources. In addition, many individuals with co-occurring conditions do not qualify for services for their mental illness from the CPS community delivery system. ***Strategy:*** To address this need, a memorandum of understanding will be developed between CPS and MRDD establishing provisions for delivering coordinated services to dually diagnosed individuals based on needs identified in their overall plan. (Timeline: 3 months)

Elderly and those with Disabilities Transitioning from Nursing Facilities: The following provides an overview of the initiatives and interventions that are planned to address each barrier and includes projected timelines:

Flexible Financing Options- ***Gap:*** There has been little movement of money from the long term care budget to the home and community based budget to support nursing facility transitions. This needs to be addressed in order to provide needed ongoing services for participants and to support long term rebalancing efforts. ***Strategy:*** To address this need the state will work to more fully implement provisions of HB 1011, the appropriations bill for DSS. This legislation states in section 11.485 that funding for nursing facilities is also available for other long term care services. The state will explore and develop protocols, within the parameters of this legislation, that support movement of long term care funds to the community budget. (Timeline: Year One)

Accessible Transition Support Services- ***Gap:*** There exists a variety of barriers including access to affordable and accessible housing and access to transition funds to assist an individual in setting up a new household as they plan their transitions. ***Strategy:*** To address this need, the state will expand collaborations with local housing authorities to explore ways to secure accessible and affordable housing. In addition, through this demonstration the state would recommend a legislative change to expand the use of transition accounts as a method of assisting

with transitional housing expenses for individuals transitioning from nursing facilities to the community. (Timeline: Year One/Ongoing)

Quality Community Workforce- ***Gap:*** There is a need to improve training for personal care attendants. In addition, there is limited availability of PCAs in rural areas of the state. ***Strategy:*** To address this need the DHSS is establishing regulations governing a Certified In-home Aide, similar to a Certified Nurses Assistant. This would establish a certification process whereby an individual or in-home service provider could employ an aide and be reasonable assured that specific training requirements were met. (Timeline: 2 Years)

Self-Directed Services- ***Gap:*** State Plan services offer consumer-directed personal care assistant services that support individuals with disabilities to self-direct the services needed for them to live independently in their homes and communities. A barrier exists in that certain skilled services are not covered under the consumer directed model. ***Strategy:*** To address this need, the state will identify those targeted individuals in facilities who may have a need for skilled in home services. Through the protocol development process, and in dialog with our stakeholders, we will identify solutions to adding skilled services to the consumer directed personal care program. The state has a variety of self-directed PCA services and will explore expansions of self-direction to other types of services. (Timeline: 18 months)

Access to Transition Coordinators- ***Gap:*** For those individuals residing in a nursing facility, accessing services is dependent of support and assistance from facility staff, ombudsman volunteers, and family members. As a result, there is a tremendous amount of inconsistency in the type and quality of support available to support individuals to plan and support their transitions. ***Strategy:*** Through this initiative we will provide participants access to Transition Coordinators who will support them in planning their transitions. Once an individual has been

identified the transition coordinators will work in partnership with the AAAs and the ILCs in the area to support transitions. (Timeline: Ongoing)

Table 11 provides an overview of the strategies and interventions described above that are designed to address system gaps:

Table 11: Overview of Strategies and Interventions

Target Groups	Planned Strategies & Interventions
People with Developmental Disabilities Transitioning from Habilitation Centers	• Application of new community models of crisis intervention • Expansion of College of Direct Support training • Enhanced access to QM information through IT • Expansion of Support Brokers and Fiscal Intermediary services to enhance self-direction
People with Co-Occurring Developmental and Mental Health Disabilities Transitioning from Habilitation Centers	• Outreach to public administrators • Creation of CPS 1115 waiver • Cross training of MRDD and CPS providers • Development of a CPS and MRDD memorandum of understanding to enhance service delivery
Elderly and those with Disabilities Transitioning from Nursing Facilities	• Development of protocols to move money from long-term care budgets to community budgets • Expanded housing collaborations & access to transitional housing funds • Certification of in-home aides • Expansion of in-home self-directed skilled PCA services • Access to transition coordinators

The Implementation Phase

Description of the Target Populations Including the Number of Individuals Transitioned, the Sites of the Demonstration, and the Institutions from Which they will be Transitioned:

This demonstration will serve 3 distinct target groups. For each target group the minimum length of time they will have received institutional care will be 6 months. Following is a description of each group:

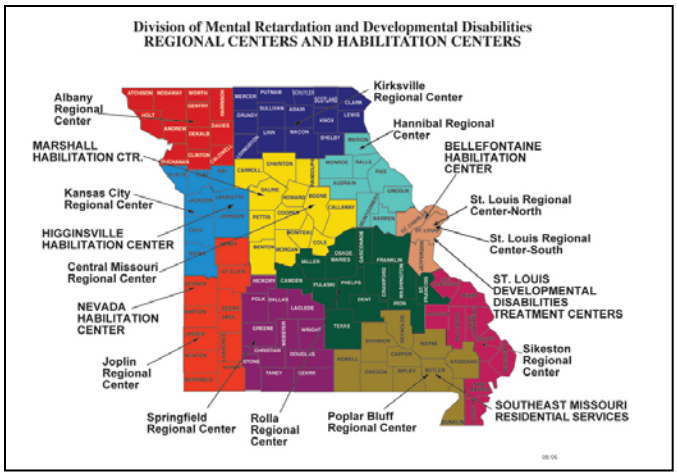
People with Developmental Disabilities Residing in State Habilitation Centers: In the state of Missouri, as of July 2006, there are currently 997 individuals with developmental disabilities residing in six state Habilitation Centers (see table 12). As previously described, the state is actively working to rebalance its system and transition individuals to the community from the

Habilitation Centers. In the state of Missouri of the 342 individuals who have left habilitation centers since 2004, 254 had primary conditions of mental retardation or developmental disabilities.

Table 12: Habilitation Center Census

Habilitation Center	Dual Diagnosis	Total Census
Bellefontaine	47	192
Higginsville	82	121
Marshall	99	241
Nevada	29	135
DDTC	33	223
SEMRC	23	85
Total	**313**	**997**

Through this demonstration we will target individuals living in all 6 Habilitation centers (see attached map) from across the state of Missouri. A total of 125 individuals will transition from these centers to the community during the 5 year demonstration period (25 each year). These individuals will transition to communities and residences of their choice across the state.



People with Co-Occurring Developmental Disabilities and Mental Health Disabilities Residing in Habilitation Centers: One of the barriers that the state has experienced in rebalancing its' system is transitioning individuals from state Habilitation Centers who have a dual diagnosis. These are individuals who meet all the qualifying requirements of the Medicaid funded Community Psychiatric Rehabilitation Program (CPR) (see page 8 for a description). The CPR program is funded under the Medicaid Rehabilitation Option and services are designed to maintain individuals within the community at a level of care less restrictive than an inpatient psychiatric setting. CPR services are restricted to individuals who through psychiatric evaluation and assessment are found to be seriously mentally ill. As previously mentioned, there are currently 997 people in state Habilitation centers. Of them, 313 (31.4%) have a CPR qualifying

diagnoses. In addition, of the 342 people discharged from Habilitation centers since FY 2004, 88 (25.7%) had a CPR qualifying diagnoses. Of these 342 people, only 30 received services from the division of CPS and only 12 received community based services. The 12 people receiving community supports received varied services including psychiatric assessments, medication services and community supports. They also received service coordination through the Division of MRDD Regional Centers. This data points to a need for improved integrated dual diagnosis community services. Through this demonstration we will transition 5 individuals each year (25 total) from Habilitation Centers to qualified residences of their choosing across the state.

Elderly (age 60 and older) and Those with a Disability (age 18-59) Residing in Nursing Facilities: This project will serve eligible adults who, at the time of entry into a nursing facility, have met the minimum level of care (LOC) requirements for nursing facility placement – 21 points. For this demonstration project, we are planning to target individuals that have been in a facility for at least six months. Level of care is measured by determining needs in nine different areas of care (e.g. mobility, nutrition, medication, behavioral, etc.). The LOC 'point system' is in increments of 3 --- none/0, minimum/3, moderate/6, and maximum/9 points. It is estimated that in the state of Missouri, there are approximately 200 consumers that currently reside in nursing facilities that meet this LOC criteria. Clients will be assessed based upon interest in moving into the community, appropriateness for HCB services, and support by other social networks. Our goal will be to transition 100 individuals from nursing facilities to the community during the 5-year demonstration (approximately 20 each year). These individuals will transition to communities and residences of their choice across the state.

Qualified Residences to which Participants will be Transitioned: 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 (see page 39) that will assist the individual 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 individuals 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 individual or the individual's family member; an **apartment** with an individual lease; or a residence, in a **community-based residential setting**, (no more than 4 people).

In part one of this narrative we described the types of community based long-term care services that are available to support individuals in the community and their homes (see page 7). The following are just a couple of the available housing options for demonstration participants.

Division of MRDD 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 2 other unrelated individuals.

DHSS In-home Services: The department supports the provision of in-home services to individuals are provided through contracts with various entities throughout the state. These 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 four priorities for the 2003-2007 planning cycle: *Increase funding for the Missouri Housing Trust Fund and assure that a portion of those funds serve people with disabilities; Implement housing rehab activities to assist consumers in maintaining their home; Increase the supply of affordable housing; and Increase awareness of ADA laws.*.

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 mental health service consumers to a variety of housing services (e.g. rental assistance).

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.

Needed Collaborations: There is a need to create new partnerships with the state agencies responsible for development of housing – the Department of Economic Development and the Missouri Housing Development Commission. These partnerships could be formed under the

umbrella of the PIC and build on the work of the existing PIC housing committee. For example, this PIC Committee worked on a Housing Resource Guide that outlines the housing options/services available to people with disabilities and seniors. The committee could review the current housing and long-term care systems and provide input into the development of memorandums of understanding among agencies that will improve coordination and linkages of housing and services for persons who are aging and have disabilities.

The Missouri Planning Council will be partner to the state in addressing housing issues. In its' five year 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. We will work closely with the Council to address these issues.

Services that Participants will be Offered During the Demonstration and Those HCBS Services Available Following the Year They Receive Services Through the Demonstration:

Through the input of multiple stakeholders the operational protocol which is developed will include a finalized package of services that will be delivered to demonstration participants. This package will include services for each target group. Participants will have access to a variety of waiver and state plan services for which they qualify. These services were described in detail beginning on page 7 of this narrative and will comprise the primary services that are available to participants following the year they receive services through the demonstration. Table 13 provides an outline of the primary types of services that we anticipate providing for demonstration participants. At this time we do not anticipate creating additional HCB Demonstration Services because participant transition and community support needs can be met through existing HCB program services. We have, however, identified a need for additional Supplemental Demonstration Services for individuals transitioning from nursing facilities.

Table 13: Demonstration Participant Services

Target Groups	Qualified HCB Program Services	HCB Demonstration Services	Supplemental Demonstration Services
People with D.D.	• Comprehensive Waiver • Community Support Waiver • Targeted Case Management • State Plan Personal Care	None Anticipated	None Anticipated
People with Dual Diagnosis	• CPR Program • Targeted Case Management	None Anticipated	None Anticipated
Elderly and Those with Disabilities	• State Plan Services • Aged & Disabled Waiver • Independent Living Waiver	None Anticipated	Housing (Transition Start-up costs Identified Below)

Supplemental Housing Services: The supplemental services identified are one time costs and will not be continued after the demonstration period. These are services that are not qualified HCB long-term care services and meet the need that was previously discussed to support individuals transitioning from nursing facilities to establish homes and residences in the community. These services include assisting with one time transition services such as helping to furnish the home, assisting with payment of security deposits and necessary set-up fees, and cleaning prior to occupancy. This demonstration would also assist with modifications and adaptations to assist in making the home accessible as needed. Missouri state statutes contains provisions for the establishment of Transition to Independence grants (see table 14). Such grants were to be established and administered by the Division of Vocational Rehabilitation in consultation with the Department of Social Services and these agencies would seek federal and private grant moneys to fund this program. Through this demonstration the state would recommend a legislative change to update this language to include the Division of Senior and Disability Services, increase the amounts to

Table 14: Transition to Independence Grants

208.819. 1. Persons institutionalized in nursing homes who are Medicaid eligible and who wish to move back into the community shall be eligible for a one-time Missouri transition to independence grant. The Missouri transition to independence grant shall be limited to up to fifteen hundred dollars to offset the initial down payments and setup costs associated with housing a person with disabilities as such person moves out of a nursing home.

$2,400, and include the elderly in addition to individuals with disabilities. It would be our plan to use these accounts as a method of assisting with transitional housing expenses for individuals transitioning from nursing facilities to the community.

Self-Directed Services: It should also be noted that self-directed options are available for qualified individuals with disabilities through the Division of MRDD and the DHSS that allows participants to self-direct personal assistant and other services (e.g. support brokers). These options will be offered to qualified participants in this demonstration. **Appendix F** contains a grid that compares consumer directed to agency based care options.

Anticipated Requests for the Waivers Necessary to Operate the Program, Including Modifications to Existing Waivers and State Plan Amendments: At this time the state anticipates the development of a new waiver to serve individuals with psychiatric disabilities. As previously described, discussions are under way to create a Home and Community Based 1115 waiver through the Division of CPS that would divert some of the disproportionate share funds generated by inpatient facilities to enhance home and community based service capacity. Any diverted funds would be used to expand community based services and would be especially focused on the development of intensive services to enhance successful community transitions as well as to maintain individuals in the community who otherwise would require inpatient care.

Description of Methods to Increase the Dollar Amount and Percentage of HCBS Expenditures: Following are the methods that will be used for each target group:

People with Developmental Disabilities and Co-Occurring Developmental and Mental Health Disabilities Transitioning from Habilitation Centers: The state Habilitation Center funding is flexible and can be used to purchase community support services during the fiscal year and then transferred during the next budget cycle. The state will transfer funds from the

Habilitation Center budgets into Community Services during each fiscal year of the demonstration as a result of transitioning 30 individuals (150 total) during the 5 years.

Elderly and Those with Disabilities Transitioning from Nursing Facilities: To support nursing facility transitions, money from the long-term care budget will be moved to the home and community based budget. The state will transfer funds from the long-term care budgets into Community Programs during each fiscal year of this demonstration to ensure the transition of 20 individuals (100 total) during the 5 year period.

List of Proposed Benchmarks to Establish Empirical Measures to Assess the States Progress in Rebalancing its' Long-Term Care System: Table 15 provides a list of benchmarks that the state of Missouri will use to assess progress in rebalancing:

Table 15: Rebalancing Benchmarks

Outcome Indicator	Outcomes Achieved	Process to Measure Outcomes
Increase in State Medicaid support of home and community-based long-term care services	Increased Medicaid funding directed to community based services during each year of the demonstration	Progress measured annually using information obtained from the DMH and DHSS data sets
Number of eligible individuals assisted to transition to qualified residences	50 eligible individuals assisted to transition to qualified residences during each year of the demonstration (25 MRDD, 5 co-occurring, 20 elderly and those with disabilities)	Annual counts of those who transition within each target group
Satisfaction and other quality measures for those who transition	85% of those who transition each year express satisfaction with services, supports and quality of life	Participant Experience Surveys and Interviews

Processes for How the State Intends to Target and Recruit Individuals to Transition From Institutional Settings to the Community, Including Specific Strategies and Procedures: A recommendation form the Missouri Home and Community-Based Services Report was that *"a person centered planning process should be conducted with each person who transitions from the institution to a community setting. This process should follow the person into the community to assure that the supports needed in the community are available"*. Person centered approaches are grassroots efforts in which a team of individuals supports an individual to design and

implement action strategies to assist them to achieve their vision for the future. Person centered planning is an approach that supports individuals to have informed choices and to be self-directed in planning and managing their own supports.

To support the transitions of each target group a ***Lead Transition Coordinator*** has been identified (see staffing and budget section). These individuals are knowledgeable regarding person centered planning processes and will assure that transition planning is based on informed choices and includes the participation of individuals important to the person. Specifically these transition coordinators will assure the following:

Informed Consent and Choice: The Transition Coordinators will assure that each eligible individual, or the individual's authorized representative, are provided the opportunity to make an informed choice regarding whether to participate in this demonstration project. Information will be provided which explains how the program works, what the benefits are, what supports are offered and how to apply to participate. During the protocol development process we will engage stakeholders, including institutional providers, in discussions to plan the most effective methods through which to communicate with and provide information to the target groups. We anticipate that this will include developing marketing materials and working closely with grassroots community groups such as local People First chapters, Division of MRDD Regional Centers, local mental health centers, the AAA's, and Independent Living Centers. Participants will also be given choices to select the qualified residence in which they will reside. As part of the transition planning process, actual community-based living options will be discussed and visited.

Screening and Assessments: The state agency partners in this demonstration utilize a variety of screening and assessment tools that support current program (e.g. Medicaid eligibility) and transition planning. Through the protocol development process the state will review these

current screening and assessment procedures to see if they are providing the types of information that enhances transition planning for the target groups. We will consider modifications to these existing procedures and will also review a variety of assessment tools from other states.

Transition Planning and Supports: There are already transition processes in place that can be built upon and enhanced to support community transitions for each target group. Through this demonstration the following will be provided:

For People with Developmental Disabilities Transitioning from Habilitation Centers: Habilitation Centers have Transition Coordinators who work closely with Regional Center Placement Coordinators in the area of the state where the individual wishes to live. These individuals work with planning teams to assist in identifying available community living options and other needed resources. The Transition Coordinator will also work with the individual and family/guardian to make an informed choice regarding support providers and to make arrangements for the individual to visit and transition to the residences they select.

People with Co-Occurring Developmental and Mental Health Disabilities Transitioning from Habilitation Centers: Transition Coordinators at Habilitation Centers will work with Regional Center staff and also with the appropriate Community Mental Health Center to arrange for an intake evaluation and subsequently arrange for appropriate CPR services. Most individuals will need medication services and physician consultation. Some may need additional services including but not limited to community support, psychosocial rehabilitation, counseling, and crisis intervention. Transition planning will occur in partnership with MRDD staff.

For Elderly and Those with Disabilities Transitioning from Nursing Facilities: The transition coordinator or designee will facilitate planning discussions with the individual, guardian, or family member to identify needs, explore residential support options, and to plan for

needed supportive services. The transition coordinator will work in partnership with the nursing facilities discharge planner to plan for and secure needed items to set up a new household.

Description of the Cross Agency and Cross Service Delivery System Collaboration: Significant consumer, cross agency and stakeholder collaboration will support this transition program. The Appendices include numerous letters of support and commitment from consumers, providers, state agencies, institutional providers, and others. These stakeholders will be actively involved in the protocol development process outlined within this application and will provide ongoing support for implementation of strategies. These ongoing collaborations will be supported during and after the demonstration through the PIC. The role of the PIC and a more detailed description of partnerships can be found on page 17 of this proposal.

Description of the State's Current QM System, Where the Gaps are, and What will be Implemented to Ensure the Health and Safety of Consumers Who are Transitioned: The Missouri Division of MRDD, Division of CPS, and Department of HSS each have established Quality Management systems. The following is a brief overview of these systems:

Current Systems: The Division of MRDD and Division of Senior Services 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 MRDD has an approved Quality Management Plan following the new 1915(c) waiver application requirements for its MRDD 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 MRDD employs case managers at its 11 regional centers around the state. These case managers, and some employed by Missouri Senate Bill 40 County Boards, provide case management for persons 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 Consumer Affairs that receives and resolves complaints, a Licensure and Certification Unit, a Contract Unit, and a centralized investigation unit. Each regional center has quality assurance staff who are responsible for working with providers to ensuring corrective action is taken as required and for encouraging quality enhancement and assuring the health and safety of individuals they serve.

The Division of Senior and Disability Services serves as the State Unit on Aging and carries out the mandates of the State regarding investigation and intervention in cases of adult abuse, neglect, and financial exploitation, and provides oversight to programs and services for seniors and adults with disabilities. The Division Bureaus are responsible for providing program oversight and has a Central Registry Unit for receiving reports of adult abuse, neglect and exploitation, distribution for investigation, and tracking status. Participant care plans are

reviewed at least annually by Division staff and as part of the review process staff ask specific questions regarding the quality and continuity of services received. When a problem is detected, the Division staff assist in the resolution of the problem and in cases of abuse, neglect, or exploitation would investigate and take action to protect the health and welfare of the participant. **Appendix G** contains a statement of Assurances regarding necessary safeguards to protect the health and welfare of recipients under the Aged and Disabled Waiver

The Division of CPS conducts certification and monitoring of community agencies who 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 consumers 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.

Quality Management Gaps: The primary system gaps relate to improvements in quality management systems that track and share individual consumer 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 MRDD is exploring the development of "provider report cards" as an approach to supporting improved choice related to quality services. In 2003 CMS awarded a Quality Assurance/Quality Improvement grant to the DHSS. One large part of the effort is conducting a comprehensive Consumer Satisfaction Survey of roughly 10% of the people served by DHSS. The purpose of this survey is to assess the consumers' general satisfaction with the services they receive. The survey tool chosen for this project is the Participant Experience Survey (PES) developed by the MEDSTAT group.

Through this project we will expand upon the current DHSS initiative and explore the use of the *PES* as a tool to evaluate consumer satisfaction outcomes for demonstration participants. We would survey a consumer after he/she has been transitioned for six months and again 12 months later. The results would be compared to the two years of data collection from the larger sample to track and trend responses.

Description of Barriers that Prevent the Flexible Use of Medicaid Funds and a Summary of Strategies the State will Employ Under the Demonstration to Eliminate Those Barriers:

There has been little movement of money from the long term care budget to the home and community based budget to support nursing facility transitions. Through House Bill 10, flexible funding is available to residents of state operated ICF/MR facilities that enables funding to follow the individual to the community. In addition, through House Bill 1011 funding for nursing facilities is also available for other long-term care services. Through this demonstration the state will explore and develop protocols, within the parameters of this legislation, that supports and reduces barriers to the movement of long-term care funds to the community based budgets. This will allow individuals residing in state Habilitation Centers and nursing facilities to have money follow them from these settings to the community to provide needed services and supports. This will be addressed during the protocol development process.

Analysis of Use or Enhancement of Existing IT Systems to Address Identification of MFP Participants: Existing information technology systems will be used as follows:

Demographic Information Identifying Medicaid and MFP Participation Eligibility Prior to Transition: DMRDD will verify in the Department of Social Services Medicaid eligibility system that individuals have been eligible for Medicaid ICF/MR services in a Habilitation Center for at least 6 months before determining the individual eligible to participate in the MFP

program. A search of diagnosis demographic information in the DMH CIMOR system will identify individuals who reside in Habilitation Centers who have a serious mental illness in addition to mental retardation and/or a developmental disability. This information will lead to individuals with co-occuring conditions with needs that can be met with a combination of DMRDD Home and Community Based Waiver Services and Community Psychiatric Rehabilitation Services funded through Division of CPS.

When an individual and/or their legal representative has made the choice to transition, demographics of the individual will be set-up in a DMRDD tracking data base. The data base will track steps that are planned with estimated dates, steps that are completed with completion dates, and who is responsible for the action. This tracking system will serve as a management tool so that transitions will move forward in a carefully planned manner that ensures that proper steps are taken along the way to ensure the person's health and safety and that an overall successful transition is achieved for the individual.

For individuals who reside in nursing facilities, DHSS will verify that potential participants have received Medicaid funded Nursing Home services for at least 6 months by checking the DSS Medicaid Eligibility system. DHSS will also review the MDS data base to identify individuals who have indicated a desire to live outside of a nursing home.

Financial Information to be Reported for Services Eligible for Enhanced FMAP According to the MFP Demonstration: DHSS and DMRDD will determine if the Department of Social Services Medicaid Eligibility system can be modified to add a new level of care indicator. Currently, codes in the level of care field indicate if a person is in a Medicaid funded nursing home or a Medicaid funded Habilitation Center (ICF/MR). MFP partners will ask DSS if it is feasible to add a new level of care indicator to identify MFP participants. This would allow all

paid Medicaid claims to be tracked and identified for all MFP participants as the field would include a start and stop date which would cover the individual's 12-month funding period.

Both DMRDD and DHSS will individually track all MFP participants in their respective systems. The tracking information will include at a minimum, the individual's name, Medicaid identification number, Social Security Number, and date of transition. If DSS is unable to add a MFP indicator to the level of care field, DMRDD and DHSS will assist Division of Medical Services staff in identify MFP participants quarterly, and a search of the MMMIS paid claims files for MFP covered services will be conducted to identify expenditures that are eligible for reimbursement under the MFP program. DMRDD and DHSS will also provide to DMS the Social Security Numbers (SSN) of all participants to be reported to CMS for its 'Finder File', and will assist DMS in collecting minimum data set elements that CMS require be reported.

Assessment Data to Monitor Quality of Services Post Transition: Through this project we will engage in both process and outcome evaluations. The process evaluation will produce qualitative information about project implementation and explore the experiences, satisfaction, and challenges indicated by the various stakeholders. A particular focus of this evaluation will be to examine practices that support or hinder the transition of individuals from institutional to community settings. For example, what were the most and least productive approaches to screening and identifying candidates for transition, or what supported or hindered the ability of participants to self-direct their supports. An outcome evaluation will also be conducted that has a particular focus on tracking consumer satisfaction outcomes and will include conducting interviews/surveys with individuals in each target group at various points during and after their transitions. Finally, we will evaluate progress toward eliminating barriers that have restricted the flexible use of Medicaid funds to enable individuals to receive needed long-term care services.

PART 3: PRELIMINARY BUDGET AND ORGANIZATIONAL STAFFING PLAN

1. Organizational Structure: 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). DSS, the Single State Medicaid Agency, will be lead organization for the Missouri MFP Initiative, and will coordinate with DMH and DHSS. DMH is responsible for transitions of individuals with MR/DD (including those with MI diagnosis) from state habilitation centers, oversight and administration of MRDD HCB services and community psychiatric services, and for service coordination. DHSS is responsible for transitions of individuals with physical disabilities or illnesses from nursing facilities, for oversight and administration of Missouri Care Options HCB services, and for case management.

2. Staffing Plan: DSS MFP Project Director 1.0 FTE: Responsible for implementation of the demonstration. This position will be filled immediately following notification of award, and will be classified in the Missouri State Merit system as a Social Service Manager, a high-level administrative position responsible for planning, coordinating, and directing Medicaid programs. The MFP coordinator position is a full time (100 percent level of effort) position that will be located at the state Medicaid agency. This position will closely coordinate with MFP project liaisons within the DMH and the DHSS. The annual salary will be $55,000 dollars. (See Appendix for position description)

DMH: Fred Fridlington, MRDD Project Liaison, .30 FTE. Mr. Fridlington will fill the role of statewide transition coordinator for the Division of MRDD, overseeing all transitions from State Habilitation Center into communities. Mr. Fridlington will oversee the work of the Transitional Coordinators, Placement Coordinators, and other division staff located throughout the state, with

day-to-day responsibilities for transitions. Mr. Fridlington is a member of the DMH MRDD Executive Team, reporting to the director of the DMRDD and coordinating closely with the division's six Regional Center Directors. The state estimates that 30 percent of his time will be devoted to MFP related activities. The annual amount of salary for grant activities is $20,547. Nancy Schetzler, Administrative Assistant, 0.10. FTE: Ms. Schetzler will provide administrative support to Mr. Fridlington. The amount of her salary budgeted to MFP is $3,633. Julie Carel, CPS Project Liaison, 0.10 FTE. Ms. Carel's role will be Critical Services Manager, overseeing the provision of community psychiatric services provided through DMH Administrative Agents to individuals with dual diagnoses transitioning from state habilitation centers into communities. **DHSS:** Michael Armstrong, DSDS Project Liaison, 1.0 FTE. Mr. Armstrong will fill the role of statewide transition coordinator for individuals with physical disabilities or illnesses transitioning from nursing facilities into communities. Mr. Armstrong will liaison with the DSDS Bureau Chief for Home and Community-based Services, who oversees all field operations in the division. Resumes for staff are given in the Appendix.

3. Budget Presentation and Narrative

Fringe Benefits - Fringe benefits claimed under the MFP demo are projected to be $27,592 in year 1. Salary and fringe benefits are trended forward in years 2, 3, 4, and 5 of the MFP, by 2 percent per year. **Equipment -** Expense and equipment for the MFP is projected to be $3,816 in year 1 and $11,014 dollars for all five years of the project. **Evaluation Contract:** 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 consumer 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. Christine Rinck will direct evaluation activities. She has a experience in evaluating federal grants (e.g., MCH, CMS, Dept. of Education, Office of Adolescent Prevention Programs, Administration on Developmental Disabilities), and state programs as well. The costs for conducting evaluation activities are estimated to be $20,000 dollars in year 1 of the project and $30,000 dollars per year thereafter.

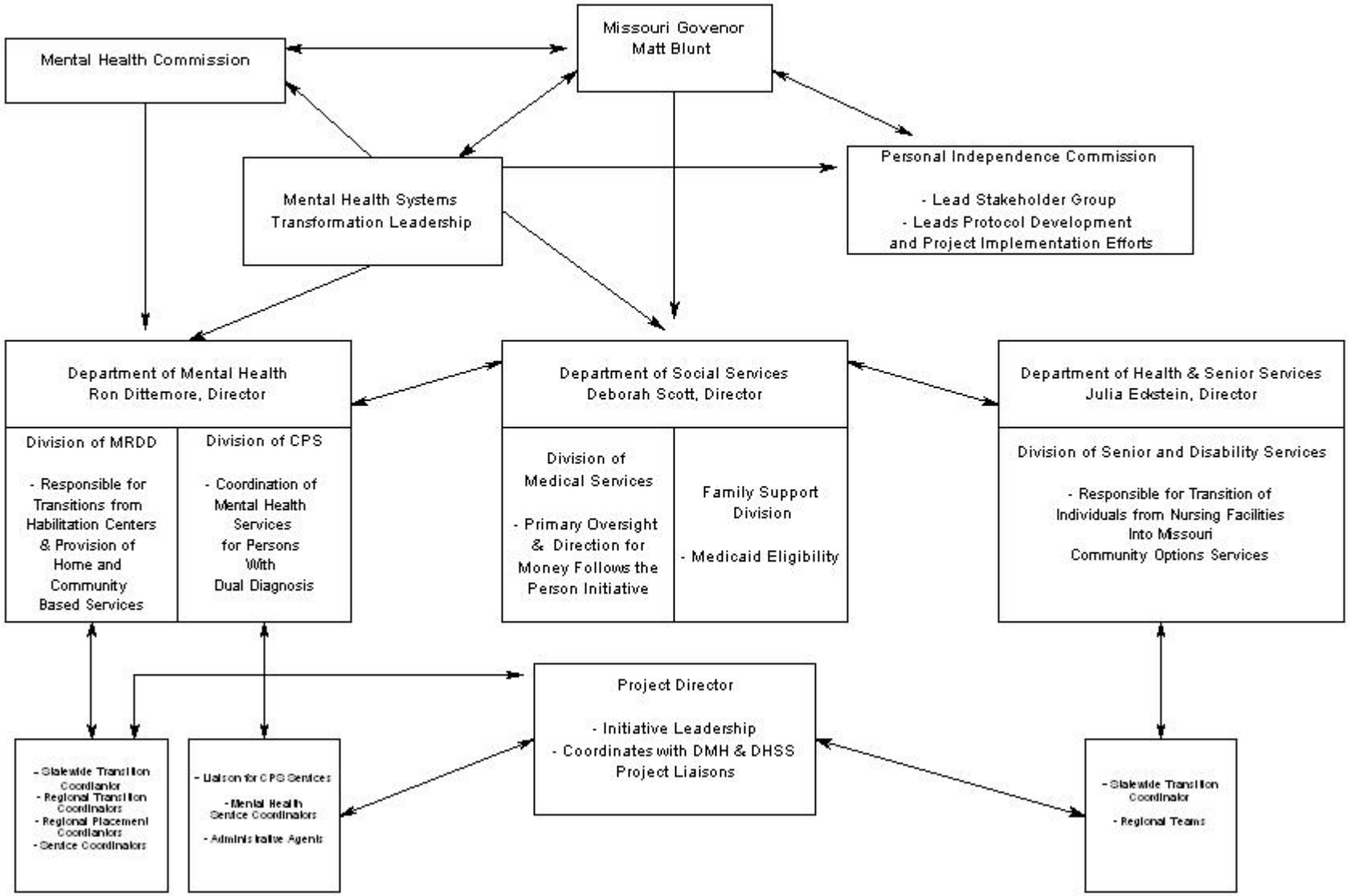
Total Administrative Cost - The total cost for all administrative activities related to the demonstration project is $130,588 in year 1, and $706,661 over all 5 years of the project. The federal portion (at 50 percent FMAP) for project administration is estimated to be $353,331 during the 5 year project period. Amounts for administrative activities are listed on **Attachment 4** ***Money Follows The Person DMH/DHSS Budget Table.***

Qualified HCBS Expenditures - Qualified HCBS services are those services currently provided under Missouri's approved 1915(c) waivers for individuals with developmental disabilities and to elderly and disabled individuals. In addition, persons with the dual diagnoses of mental retardation and mental illness will receive mental health rehabilitation (MH rehab) services provided under Missouri's Medicaid state plan. The Federal portion (at the enhanced match rate of 80.795 percent) requested for qualified HCBS service expenditures provided in year 1 of the grant is $3,303,368 dollars. In year 2 the federal portion is estimated at $3,369,435. In year 3 the federal portion is estimated at $3,436,824. In year 4 the federal portion is estimated at $3,505,561. Finally, in year 5 the federal portion is estimated at $3,575,672.

The Department of Mental Health estimates that 30 individuals will be transitioned from habilitation centers to individual supported living arrangements in each year of the project. These persons will receive community-based services and supports through individualized supported living arrangements (ISL). The average cost for ISL in year 1 is $320.36 dollars per day. The costs are annualized and trended forward, by 2 percent per year, over the 5 demonstration period. In addition, the Department of Mental Health will provide 5 of these individuals state plan mental health MH rehab services. The average cost for MH rehab in year 1 is $7.81 dollars per day. These costs are annualized and trended forward, by 2 percent per year. The total cost for MH rehab services in year 1 is $14,253 dollars. During the five years of the Money Follows the Person Demonstration (MFP), the Division of Senior and Disability Services (DSDS) intends on transitioning 20 nursing facility (NF) clients each year into the community. For State Fiscal Year 2007, the NF cost cap (i.e. the annual average cost of a Medicaid NF client) is $2,282/month. It is assumed that moving clients into the community will cost, at maximum 100% of the NF costs. Under MFP, clients moving out of NF into an HCB environment will receive an enhanced match. The federal portion for HCBS will be $457,617 dollars during Year 1. Total federal spending during the five years at the enhanced FFP will be $2,381,456 for the 100 clients transitioned over the course of the demonstration.

Supplemental Services - Additionally, MFP transitioning clients will receive $2,400 ($200/month for 12 months) in funds to be used during their transition to community-based care. These funds can be used by recipients for moving costs, housing related expenditures, etc., as designated by the MFP guidelines for supplemental enhancements. Over the course of the five years, $240,000 will be designated for these funds, to be reimbursed at the current FFP rate ($92,184 general revenue, $147,816 federal).

Missouri Money Follows The Person Organizational Chart



PART 4: ASSURANCES

Informed Consent: Potential participants in Missouri's Money Follows the Person Project, and/or their legal representative, will be given written information describing this project, including a description of eligible community-based living arrangements. Individuals who want to transition to community-based services will be asked to sign an acknowledgement statement indicating they were informed of their right to choose between continued institutional services or alternative community based services and have chosen alternative community based services. As part of the transition planning process, actual eligible community-based living arrangement options will be discussed. Participants and/or legal representatives will be encouraged to visit the options and will be provided assistance in scheduling and making visits as needed. The participant and/or their legal representative will be asked to sign an acknowledgement statement prior to the actual transition that they were provided choice in selecting their community-based residence. All acknowledgement forms that are signed indicating choice of service type, provider and community-based residence will be kept in the individual's personal records maintained by Department of Mental Health or Department of Health and Senior Services, as is appropriate.

Stakeholder Input: The success of this project is contingent on multiple stakeholder collaborations that include individuals with disabilities and their families, state agencies, legislators, community providers, consumer advocacy groups, and others. Numerous state organizations and associations that represent consumer advocates, families, community providers and others have written letters in support of this project and have pledged their commitment to be partners in its development (see attachments). In the development of this proposal multiple stakeholders were also engaged in discussions regarding shortcomings and gaps that the state

experiences as it seeks to increase the use of home and community based long-term care services and reduce reliance on institutional care. Input was received through discussion with multiple state consumer advisory groups, state councils, and focus groups regarding the application for "Money Follows the Person". Following is a listing of the organizations and the dates of the discussions:

Personal Independence Commission (PIC): The state's intent to apply for the "Money Follows the Person" grant was discussed at the September, 2006 meeting of the PIC. In addition, several telephone discussions with the co-chair of the Personal Independence Commission, and with staff in the office of the Lieutenant Governor (The Lieutenant Governor also co-chairs the PIC) took place during October, 2006.

Missouri Planning Council for Developmental Disabilities: The state's intent to apply for the "Money Follows the Person" was discussed with the Planning Council during the July, 2006 meeting. The Planning Council which includes individuals with developmental disabilities, families and other stakeholders have made a commitment to work with the state on this demonstration and is especially interested in issues related to housing.

Voices of concern: While many Missouri Stakeholders are very supportive of the state's efforts to rebalance the long term care system so that individuals with disabilities can be fully included in communities, some organizations, such as the Mental Retardation Association of Missouri, Inc, the habilitation center parent associations, and some family members of individuals living in state-operated facilities are concerned about the state's commitment to ensuring that facility-based care continues to be available for individuals whose needs cannot be safely met in community settings, and for families who choose institutions rather than community-based services for their loved ones.

The state agencies will continue to dialogue with these groups as we work toward rebalancing our long term care system to ensure safe choices at all points in the continuum. The state agencies responsible for the long term care system in Missouri are committed to providing the highest quality of care across the entire continuum. No individual will be transitioned to the community unless the appropriate services and supports, specific to the needs of that individual, are in place prior to transition. In addition, the choice of the individual and their legal guardian is a fundamental requirement for community placement. No one is transitioned to the community when the legal guardian has requested institutional placement.

The recommendations of the Mental Health Commission support the commitment to high quality services with appropriate state oversight, and it is anticipated the Mental Health Task Force, charged by the Governor to submit recommendations for the state's mental health system by the end of this year, will also re-affirm this commitment.

Maintenance of Effort: The state assures that total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the Money Follows the Person demonstration project than for the greater of such expenditures for fiscal year 2005 or any succeeding fiscal year before the first of the year of the MFP demonstration project.

Reporting and Evaluation: In accordance with the specifications that CMS establishes, the State assures it will submit timely reports on data and outcomes of the Missouri Project. Additionally, the State assures it will conduct and submit the results of its evaluation of the MFP demonstration according to specifications established by CMS.