

## Georgia Money Follows the Person



# Operational Protocol

Grant # 1LICMS030163

Georgia Department of Community Health  
Atlanta, Georgia

Revised October 2015  
Version 1.6

# Georgia MFP Operational Protocol Version 1.6

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## **PROJECT INTRODUCTION**

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

Georgia has long demonstrated a commitment to providing healthcare systems that enable its citizens to receive compassionate care and long-term services and support in settings that are appropriate to individual needs and independence, steadily increasing its funding for home and community based services (HCBS). While 27% of the state's long-term services and support budget was expended on HCBS in SFY 2005, by SFY 2013 that share had risen to 49% (see Table A.2.4 for details of rebalancing efforts). The state, however, has reached a point where new hurdles need to be overcome. For example, to address fragmentation in outreach, information and referral, the state is using interagency agreements and the Money Follows the Person (MFP) Demonstration to coordinate outreach, information and referral using the 12 Regional Aging and Disability Resource Connections (ADRCs). The Money Follows the Person Demonstration has allowed Georgia's leaders to take rebalancing to the next level. The goal of the rebalancing demonstration is to increase the percentage of HCBS to just over 50% of all Long-Term Services and Support spending by the end of the grant in December 2020. Through MFP, Georgia has achieved 2 - 3% growth in annual spending on Home and Community-Based Services (HCBS) (see Table A.2.2).

In May 2007, the Centers for Medicare and Medicaid Services (CMS) awarded Georgia the Money Follows the Person (MFP) Rebalancing Demonstration grant established by the Deficit Reduction Act of 2005 and amended by the Affordable Care Act of 2010. The Georgia Department of Community Health (DCH) implemented the Money Follows the Person (MFP) rebalancing demonstration on September 1, 2008 with an interagency agreement to service participants with developmental disabilities through the Georgia Department of Behavioral Health and Developmental Disabilities/Division of Developmental Disabilities (DBHDD-DD) and a contract with private vendor for transition coordination services for older adults and participants with physical disabilities/TBI.

The contract with the private vendor ended June 30, 2011. On July 1, 2011, DCH/MFP began an interagency agreement with the Georgia Department of Human Services' Division of Aging Services (DHS/DAS) to create the first multiple-agency initiative of its kind in the state's Medicaid program's history. The MFP rebalancing demonstration grant affords Georgia the opportunity to further rebalance the system of care, allowing the state to eliminate barriers or mechanisms that prevent or restrict flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the setting of their choice.

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The Department of Community Health (DCH) serves as the State Medicaid Authority and is the administrator of the MFP rebalancing demonstration project. DCH is responsible for all aspects of its successful implementation. As such, it acts as the overall coordinator for policy and operational issues related to the MFP Demonstration.

Currently, the MFP demonstration project operates through two interagency agreements – an agreement with the Department of Human Services, Division of Aging Services (added in July 2011), and the Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities (DBHDD-DDD) and Division of Community Mental Health, Office of Children, Youth Adults and Families (Community Based Alternatives for Youth – CBAY), added in July 2012. These interagency agreements increase capacity and leverage the resources and expertise of multiple agencies while assuring the continued provision of Home and Community Based Waiver and mental health services, when necessary.

The MFP transition process is similar under both agreements – both agencies conduct marketing, outreach, and screening of potential MFP participants. Both facilitate person-centered planning and both facilitate transitions from inpatient facilities.

## **Interagency Agreement with DHS/DAS**

Under the Interagency Agreement, DHS/DAS is responsible for:

- Hiring MFP Field Personnel, i.e. MDSQ Options Counselors (MDSQ OCs) and MFP Transition Coordinators (MFP TCs)
- Ensuring that field personnel have core and specialized competencies
- Offering options counseling and transition coordination services statewide to older adults and participants with physical disabilities and TBI who wish to transition using MFP demonstration services and qualified HCBS waiver services or transition without waiver services using Medicaid state-plan and other community resources,
- Documenting and reporting on process and outcomes.

Working from the 12 Regional ADRCs, MDSQ Options Counselors perform the following functions:

- Screen interested residents, interview potentially eligible individuals for MFP
- Provide LTSS information and referral assistance to older adults and persons with physical and developmental disabilities, based on MDS Q referrals
- Assist individual's to access and use of local resources based on an individual's needs, values and preferences related to LTSS
- May screen individuals for Elderly and Disabled waiver services using the Determination of Need-Revised (DON-R) assessment to determine the need for waiver services
- Maintain a toll-free line for callers.

Under the interagency agreement, MDSQ Options Counselors and MFP Transition Coordinators working from the 12 Regional Aging and Disability Resource Connections (ADRCs) facilitate transitions from nursing facilities. ADRCs are

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designated as the State Contact Agencies for MDS Section Q referrals – the section that allows individuals living in nursing facilities to express interest in learning more about living outside a nursing facility. MDSQ Options counselors work with individuals to discuss options to return to the community, with MFP being one of those options. In addition to information and referral to MFP, Options Counselors provide flexible staffing and support the work of MFP Transition Coordinators.

### **Interagency Agreement with DBHDD**

Under the agreement with DBHDD-DDD, Regional Hospital Case Expeditors (CEs) and Planning List Administrators (PLAs) in conjunction with hospital staff, facilitate transitions from ICFs in the state hospital system. There is an established MFP transition protocol.

Under the existing Interagency Agreement, DBHDD-DDD is responsible for:

- Hiring Planning List Administrators (PLAs), and Case Expeditors (CEs)
- Offering transition services statewide to MFP participants with intellectual and developmental disabilities who wish to transition from ICF/IIDDs and nursing facilities using MFP demonstration services and qualified waiver services
- Ensuring the competencies of field personnel
- Documenting and reporting on process and outcomes.

Working from ICF/IIDDs, CEs and PLAs perform the following functions:

- Develop Person Centered Descriptions with individuals, families and others who know the individual to describe the hopes, dreams and goals for the individual
- Identify support services (waiver, MFP, state plan, community, etc.) needed for successful transition to the community
- Assist individuals and families to connect with potential providers of services
- Coordinate provider introductions (“meet and greet”), transition planning meetings, Individual Service Plans (ISP) meetings and Discharge Meetings
- Conduct Pre and Post Site Visits to community living environments to ensure the health, welfare and safety of participants and to ensure that community-based services are in place and operational

Under the interagency agreement with DBHDD – Division of Community Mental Health, Office of Children, Young Adults and Families, the State of Georgia promotes Community Based Alternatives for Youth (CBAY) with mental illness and continues to actively engage in efforts to decrease the number of youth residing in Psychiatric Residential Treatment Facility (PRTF). These efforts support the vision of full access to community based living envisioned by self-advocates, family members, and disability advocates in the State. By adding this population to the MFP Operational Protocol, youth with mental illness will have access to transition services and supports following treatment provided in a PRTF. Not only will MFP demonstration services be available to them, but the rich array of services available through the Medicaid State Plan’s Rehabilitation Option also will serve to bolster stability in the community.

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Under the existing Interagency Agreement, DBHDD-Office of Children, Young Adults and Families, Community Based Alternatives for Youth (MFP CBAY) is responsible for:

- External Review Organization case management personnel
- Offering MFP CBAY transition services statewide to youth with mental illness
- Ensuring the competencies of case management personnel
- Documenting and reporting on process and outcomes.

Working within PRTFs, case management personnel perform the following functions:

- Develop Person Centered transition plans with individuals, families and others who know the individual (note that upon discharge from the PRTF, MFP CBAY youth do not enter HCBS waivers)
- Identify MFP CBAY services needed for successful transition to the community
- Assist individuals and families to connect with potential providers of services
- Coordinate provider introductions (“meet and greet”), transition planning meetings, Service Plan meetings and Discharge Meetings
- Conduct visits to community living environments to ensure the health, welfare and safety of participants and to ensure that community-based services are in place and operational

These interagency agreements increase capacity and leverage the resources and expertise of multiple agencies while assuring the continued provision of HCBS after the one-year transition period.

From its inception, the MFP rebalancing demonstration has sought out and collaborated with networks of community stakeholders; relying on these groups for direction and input. The MFP Steering Committee and various project advisory groups, state departments, local governments, community-based organizations, inpatient health care facilities, advocates, and consumer groups have each played and continue to play a role in monitoring and improving the project (see *Appendix A: Georgia’s MFP Stakeholders Listing by Company Name*).

MFP is connected to the Settlement Agreement with the US Department of Justice and the State. Signed in October 2010, the Settlement Agreement provides for services for individuals who are currently institutionalized or at risk for institutionalization, to prevent future admissions to state hospitals. The basis of the agreement is the *Olmstead v. LC* (1999) Supreme Court decision. The Settlement Agreement focuses on deinstitutionalization of individuals with mental illness and developmental disabilities. Under the interagency agreement with DBHDD-DDD, MFP is transitioning participants with developmental disabilities from ICF/IIDDs as required by the Settlement Agreement. The terms of the Settlement Agreement continue through 2015, but the Georgia *Olmstead Plan* is a coordinated, long-term strategy. MFP supplements and expands current *Olmstead Initiative* using transition services and waiver programs that offer alternatives to institutional placement for Medicaid eligible individuals. In concert with Georgia’s *Olmstead Plan*, MFP is transitioning older adults, participants with intellectual or developmental disabilities,

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participants with physical disabilities and youth with mental illness. To ensure continued collaboration between MFP and the Olmstead Planning Committee, the Commissioner (DCH) has designated the Assistant Chief of Medicaid to serve on the Olmstead Planning Committee. The MFP Project Director reports directly to the Assistant Chief.

- Olmstead Initiative - The Georgia's Olmstead Initiative has evolved over time to identify areas to make quality community services more available and accessible to Georgians with disabilities within the resources available; to call for more consistency in statewide plans for identifying those who are eligible for community placement and evaluating their needs for services; and to call for more person-centered planning to closely involve the individual and family in deciding what services are suitable. The plan also addresses important issues such as:
  - Affordable, accessible and integrated housing
  - transportation
  - work force development to provide greater and higher quality choices in services
  - consumer and family education
  - improved monitoring and oversight of services to better ensure the health and safety of individuals living in the community and the quality of services being provided
- Georgia Home and Community Based Waivers
  - Elderly and Disabled Waiver – MDSQ Options Counselors (OCs) and MFP Transition Coordinators (TCs) complement and enhance the current efforts of the Department of Human Services Division of Aging Services, Area Agencies on Aging (AAAs), Aging and Disability Resource Connections (ADRCs), waiver case management entities, provider associations, the Office of the State Long-Term Care Ombudsman, nursing home discharge planners/social workers, nursing home family councils, advocates, and other points of entry to service systems. Though this Waiver Program maintains a wait list for eligible individuals, waiver slots are held for elderly, blind and physically disabled MFP participants of all ages to transition each year of the project into the Elderly and Disabled Waiver program, ensuring that services are sustained after the MFP one-year transition period.
  - Independent Care Waiver Program (ICWP) for Persons with Physical Disabilities and/or Traumatic Brain Injury (TBI) between the ages of 21 and 64 - OCs and TCs partner with all of the above and Georgia Medical Care Foundation (the assessment entity for the ICWP waiver), Aging and Disability Resource Connections (ADRCs), Centers for Independent Living (CILs), the Brain and Spinal Injury Trust Fund Commission, Side by Side Brain Injury Clubhouse, Community Service Boards and regional and local service provider networks. DCH has appropriated additional slots each year for MFP participants with

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physical disabilities and/or TBI between the ages of 21 and 64 to transition into the ICWP waiver.

- New Options Waiver (NOW) and Comprehensive Supports Waiver (COMP) for Persons with Developmental Disabilities (DD) – Planning List Administrators (PLAs) and Case Expeditors (CEs) expand on the efforts of the Department of Behavioral Health and Developmental Disabilities (DBHDD), the state's DD Council, the Association of Retarded Citizens (ARC), People First Georgia, Unlock the Waiting Lists, and regional and local DD service provider networks. Under the Interagency Agreement with DBHDD-DDD, the State has a yearly appropriation of waiver slots in NOW and COMP waivers for persons transitioning using MFP.

The Operational Protocol for the MFP Demonstration includes the required elements that must be submitted and approved by the Centers for Medicare & Medicaid Services (CMS) before enrolling individuals in the Demonstration or claiming the enhanced Federal match (FMAP) for provision of MFP demonstration and supplemental services, qualified waiver services and state plan services.

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

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

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

### **Goals and Objectives of Georgia's MFP Demonstration**

Georgia's MFP Demonstration addresses the long-term services and support needs of four specific populations: older adults, persons with developmental disabilities, persons with physical disabilities and/or traumatic brain injury (TBI)-and youth with mental illness (see *Section A.2 Benchmarks* for more detail). The Operational Protocol illustrates Georgia's commitment to rebalancing long-term services and support (LTSS), to person-centered planning, participant self-direction, quality assurance and continuous quality improvement, transparency and openness in project design, development, implementation, monitoring and evaluation.

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

- The Elderly and Disabled Waiver Program (CCSP and SOURCE), provides home and community-based services to Medicaid eligible members who are elderly, blind and/or physically disabled (ABD),
- The Independent Care Waiver Program (ICWP), that offers services to eligible adults, (ages 21-64 with physical disabilities or TBI, that live in their own home or in a community setting, and
- The New Options Waiver (NOW) and The Comprehensive Supports Waiver (COMP) that offer home and community-based services to people who have developmental disabilities.

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

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

In an effort to provide additional alternatives to institutional stays, Georgia's MFP project uses the state's home and community-based service (HCBS) waivers, MFP demonstration services and State Plan services to transition Medicaid eligible, qualified individuals residing in an inpatient setting for a minimum of 90 consecutive days.

Once transitioned, participants may receive HCBS waiver services as long as they meet waiver criteria. Participants will receive State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, state funded programs, and local community funded services. **Including MFP CBAY participants, the state is seeking enhanced match for all MFP demonstration services, qualified HCBS and State Plan services provided to MFP participants.**

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

- Transition 2,970 individuals to community settings,
- By CY2020, achieve an increase in HCBS expenditures to 50% as compared to long-term services and support (LTSS) expenditures
- Use the enhanced FMAP rate to reinvest savings realized by the state into additional waiver services and other rebalancing and sustainability initiatives.

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

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**Objective 2: To eliminate barriers and mechanisms, whether in State law, State Medicaid Plan, State budgets, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in setting of their choice.**

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

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

MFP funding supports a broad range of transition services, including resettlement assistance, through local peer support networks and ombudsman services that assist participants with community knowledge, experience and local resources. The MFP Housing Manager and housing workgroup members continue to develop opportunities and resources to assist MFP participants with housing options and increase the State’s ability to address long and short term goals for expanding Georgia’s supply of affordable, accessible and integrated housing (see *Section B.9 Housing*, for details).

MFP funds demonstration services (see *Appendix B: MFP Transition Services Table*) to help participants transition into the community and set up their qualified residence. MFP enhances current systems for accessing information and services by incorporating a Team Training Process so that MDSQ Options Counselors, MFP Transition Coordinators, DDD Planning List Administrators and Case Expeditors, LTC Ombudsman, CIL Transition Counselors and Peer Supporters receive training together. Applying a team approach to training improves coordination between systems.

Working in collaboration with the Balancing Incentives Program (BIP), a collaborative referral network is being developed building on the Aging and Disability Resource Connections (ADRC) Network, the Area Agency on Aging (AAA) Network, the Georgia Independent Living Network (GILN), the Office of the State Long-Term Care Ombudsman, and the DBHDD Regional Network and other service points. The collaborative referral network will result in a transparent, easily accessible and open system for obtaining information and referral to Long Term Services and Support (LTSS), including MFP, waiver (HCBS) information and resources, knowledge of where to go and how to obtain assistance. These processes

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have strengthened the coordinating systems for planning and service delivery and unify referral processes across all LTSS.

MFP in cooperation with the Balancing Incentive Program (BIP) grant have utilized a systems approach that targets potential candidates served by multiple agencies, striving to coordinate, blend, and braid programs and funding to create a comprehensive and coordinated service system at the community level.

**Objective—3: To increase the ability of the State Medicaid Program to assure continued provision of home and community-based long-term services to eligible individuals who choose to transition from an institution to a community setting.**

Planning for MFP takes into account available resources and the responsibility to provide 'choice' to Medicaid beneficiaries eligible for LTSS and HCBS. For the state to facilitate the movement of individuals from institutional settings to community-based settings, requests for appropriations for waiver 'slots' are made for each budget period and in each Supplemental Budget for MFP. Georgia's annual budgets are influenced by fluctuations in the economy, unexpected events, changes in state and federal laws and regulations and changes in state and citizen priorities. Based on these considerations, individuals eligible for the MFP Demonstration will not be referred to a waiver program waiting list unless the number of qualified MFP candidates exceeds the reserved capacity of the waiver. Through reserved capacity in Elderly and Disabled Waiver (CCSP and SOURCE), ICWP, NOW, and COMP waiver programs, the state assures that transitioning participants enter these waivers immediately upon discharge from the institution (with the exception of MFP CBAY children and youth with mental illness who do not transition using a HCBS waiver). The state is seeking the enhanced match for MFP demonstration and supplemental services, qualified waiver services and State Plan services provided to MFP participants.

The state continues HCBS services to transitioned individuals beyond the demonstration period. Transitioned individuals may enter an HCBS waiver program and receive services as long as they meet the institutional level of care criteria for services offered in Georgia's HCBS waivers. At any point that they no longer meet waiver criteria, participants are assisted in transitioning to Medicaid State-Plan services, non-Medicaid services and state and community services as their needs and eligibility require.

Under MFP CBAY, Georgia transitions youth with mental illness into the full array of Community Behavioral Health Rehabilitation Services (CBHRS) made available through the State Plan Medicaid Rehabilitation Option. These services are available in complement to MFP services and will lend continuity of care at the conclusion of MFP services. CBHRS include access to services and support of higher intensity, such as Intensive Family Intervention, that will also ease the transition from the most intensive services available through MFP. The availability of this MFP service for youth with mental illness has enabled Georgia to continue to evaluate the outcomes of providing these services that were originally made available through

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the PRTF Demonstration waiver. When Congress passes legislation to allow states to use the 1915(c) authority to provide home and community-based services that waive the PRTF level of care, having more long-term evaluative data will enable Georgia to be that much better informed.

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

Most MFP participants enter an appropriate HCBS waiver on the day of discharge from the nursing facility or institution. They are afforded the same level of safeguards as those available to participants enrolled in existing waivers, as described in 1915c waiver Appendix H; Elderly and Disabled Waivers, the Independent Care Waiver Program (ICWP) and the Developmental Disability Waivers (NOW and COMP). Through an ongoing process of discovery, remediation and improvement, DCH assures that each waiver provides for system-level, mid-level and front-line Quality Assurance (QA) and Quality Improvement (QI). DCH further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. DCH continues to implement and improve the Quality Management Strategy for each waiver as specified in 1915c Appendix H.

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

MFP Field Personnel (MDSQ OCs, MFP TCs, PLAs and/or CEs) and Ombudsman are required to report on critical incidents experienced by MFP participants and complaints made during the transition period – from the date of the signed MFP consent through the period of MFP participation. See Appendix AB: *MFP Sentinel Event Form* and Appendix AF: *MFP Participant Complaint Form* for the reporting tools. All MFP Field Personnel are required to provide details of and implement process improvement plans. Complaints about MFP transition services can be made by any participant to any MFP Field Personnel, Ombudsman or DCH/MFP staff member. *Sentinel Event Forms and Participant Complaint Forms* are reviewed by the Project Director and MFP Project Compliance officer. They analyze critical incidents and complaints and recommend changes to MFP policy and procedures and waiver policies that will reduce critical incidents and complaints. LTCO services to MFP participants include resolution of concerns and complaints. LTCOs make

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aggregated data about LTCO activities available to DCH/MFP for the purpose of developing and implementing quality improvement plans.

MFP CBAY has an established quality management system embedded in both the administering (DCH) and operating (DBHDD) agencies of Community Behavioral Health Rehabilitation Services. This includes program integrity and auditing functions of providers by the DCH and credentialing, certification, training, technical assistance, and auditing by the DBHDD. Further, DBHDD housed (planned, implemented, monitored, etc.) and will continue to operate the formal, comprehensive quality assurance system it initiated under the PRTF Demonstration Waiver. Even though there is no waiver for new applicants to transition into, the waiver quality assurance infrastructure continues to be active in support of the youth who remain in the waiver until they graduate or age out.

CBAY, with a Quality Improvement Council at its hub, will ensure that these MFP services will undergo an ongoing process of discovery, remediation and improvement. The State assures 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) and by performing administrative oversight. Both the DCH and the DBHDD share responsibility of quality record and program reviews and statistical tracking of utilization trends and expenditures. Further, the MFP Coordinator will randomly review ISP's against services provided to ensure that they do not exceed institutional cost. Findings will be reported to the DCH. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. The services, infrastructure and outcomes monitoring and management strategies formerly adopted by the PRTF Demonstration Waiver will be utilized for these specific MFP services as well to ensure systematic and consistent management for the targeted population.

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## A.2 BENCHMARKS

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

The two required benchmarks are:

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

MFP will transition 2,970 participants from inpatient facilities to community-based settings. Focus will be placed on four specific populations:

- Older adults (OA)
- participants with intellectual and developmental disabilities (I/DD)
- participants with physical disabilities/TBI (PD/TBI)
- children and youth with mental illness (YMI)

**Table A.2.1 MFP Transitions by Target Group**

Calendar Year	Older Adults	Intellectual/ Developmental Disabilities	Physical Disability/ TBI	Youth with Mental Illness	Totals
Actual 2008	2	20	1		23
Actual 2009	42	110	43		195
Actual 2010	63	88	94		245
Actual 2011	64	168	72		304
Actual 2012	153	126	1191		470
Actual 2013	120	71	181	46	418
Actual 2014	89	3	150	75	317
Projected 2015	50	150	75	75	350
Projected 2016	50	16	75	75	216
Projected 2017	50	16	75	75	216
Projected 2018	50	16	75	75	216
<b>Totals</b>	<b>733</b>	<b>784</b>	<b>1032</b>	<b>421</b>	<b>2970</b>

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**2. Increase HCBS expenditures under Medicaid each year of the demonstration and will continue to do so during the next five years of the demonstration.**

The MFP rebalancing demonstration offers Georgia the opportunity to increase the HCBS expenditures under Medicaid each year of the demonstration by transitioning individuals out of inpatient facilities to community settings.

As indicated in the table below:

- DCH reports annual increases in Medicaid HCBS spending for all HCBS populations served,
- DCH anticipates 2-3% annual increases in all HCBS spending CY2014 – CY2018
- Rebalancing funds will be reinvested in the MFP demonstration for the development of new services that support MFP participants and growth of HCBS infrastructure.

**Table A.2.2 Total Georgia Medicaid HCBS Spending**

<b>Calendar Year</b>	<b>HCBS Expenditures</b>	<b>Transition Expenditures (MFP)</b>	<b>Total HCBS Expenditures</b>	<b>% Increase in HCBS</b>
<b>Actual 2010</b>	\$801,738,252	\$872,282.08	\$802,610,534.08	
<b>Actual 2011</b>	\$855,928,362.86	\$1,245,527.35	\$857,173,890.21	6%
<b>Actual 2012</b>	\$919,078,989.59	\$2,095,133.73	\$921,174,123.32	7%
<b>Actual 2013</b>	\$943,963,667.57	\$2,025,668.54	\$945,989,336.11	3%
<b>Actual 2014</b>	\$940,205,177.35	\$2,607,129.15	\$942,812,306.50	7%
<b>Projected 2015</b>	\$1,012,729,638.00	\$29,172,464.00	\$1,041,902,102.00	2%
<b>Projected 2016</b>	\$1,039,566,973.00	\$30,211,904.00	\$1,069,778,877.00	3%
<b>Projected 2017</b>	\$ 959,009,280.90	\$ 2,659,271.73	\$ 961,668,552.63	2%
<b>Projected 2018</b>	\$ 987,779,559.32	\$ 2,712,457.17	\$ 990,492,016.49	2%

**Three additional benchmarks that have been selected by the State**

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

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

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For the purpose of this benchmark, a successful transition is considered to be (1) a Medicaid eligible older adult, a person with a disability or a CBAY youth with mental illness, (2) who transitions from an inpatient facility and may or may not use HCBS waiver services, (3) who transitions to a qualified community-based residence and (4) who completes the MFP period of participation, with or without interruptions in that period due to short-term institutional admissions. As funds are realized by the state based on the enhanced FMAP, these funds will be used to develop and refine a transition tracking system. The following is a list of several performance indicators that are being tracked:

- Number of completed transition screenings (not done for IDD and YMI)
- Number of completed Individualized Transition Plans (ITPs/ISPs)
- Number of MFP participants discharged from inpatient facilities,
- Number of completed transitions (completed period of MFP participation)

A manual tracking Excel spreadsheet is used to collect and analyze data beginning with the first MFP screenings in September 2008. The MFP demonstration enables Georgia to enhance its transition system through funding for the work of MDSQ Options Counselors, MFP Transition Coordinators, Long-Term Care Ombudsman and MFP Demonstration services. The following table reports the transition tracking system performance data. Data was collected beginning in September 2008. Numbers beginning in CY2010 represent a substantial increase over CY2009. CY2013 data indicated a decrease in ITPs/ISPs and transitions when compared to CY2012, but overall successful transitions continued to increase year over year. Projections are based on MFP Benchmark #1.

**Table A.2.3 MFP Transition Tracking System**

Performance Indicators	Actual CY2008	Actual CY2009	% Increase	Actual CY2010	% Increase	Actual CY2011	% Increase
Completed transition screenings (not IDD/CBAY)	4	126	97%	367	66%	327	-12%
Completed ITPs/ISPs	22	204	89%	298	32%	299	0%
Transitioned/ Discharged	22	198	89%	249	20%	286	13%
Completed MFP participation	0	22	100%	184	88%	237	22%
Performance Indicators	Actual CY2012	% Increase	Actual CY2013	% Increase	Projected CY2014	Projected CY2015	Projected CY2016
Completed Transition Screenings	515	37%	513	-0.4%			
Completed ITPs/ISPs	479	38%	345	-39%	362	381	400
Transitioned/ Discharged	415	31%	334	-24%	351	369	387
Completed MFP participation	310	24%	414	25%	435	457	508

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The MFP Transition Tracking System allows the state to track, analyze, and report on the performance of the system. System outputs can be adjusted to produce desired outcomes. Transition Tracking System data continues to be collected, analyzed, trended and reported at the MFP Quarterly Steering Committee Meetings.

#### **4. Increase HCBS expenditures relative to institutional long-term expenditures under Medicaid for each year of the MFP demonstration.**

The MFP demonstration project offers Georgia the ability to increase the HCBS expenditures under Medicaid each year of the demonstration versus institutional long-term care by transitioning individuals out of inpatient facilities.

As indicated in the table below:

- DCH anticipates an overall expenditure increase in LTSS and all of the community based programs by CY 2016.
- Projected 2% increase in Institutional Expenditures and 2-3% increase in LTSS Community Expenditures (from Benchmark #2).

**Table A.2.4 Long-Term Services and Support (LTSS)- Rebalancing Spending Process**

Calendar Year	HCBS Expenditures with COS 440	Transition Expenditures (MFP)	Institutional Costs (COS 110 and 160)	Rebalancing %
<b>Actual 2010</b>	\$931,333,258.80	\$872,282.08	\$1,028,245,117.95	44%
<b>Actual 2011</b>	\$1,031,048,223.10	\$1,245,527.35	\$1,039,441,542.03	45%
<b>Actual 2012</b>	\$1,146,763,400.28	\$2,095,133.73	\$1,120,478,814.32	49%
<b>Actual 2013</b>	\$1,159,489,782.31	\$1,874,117.28	\$1,134,839,674.51	49%
<b>Actual 2014</b>	\$1,100,988,205.11	\$2,025,668.54	\$1,157,421,816.56	49%
<b>Projected 2015</b>	\$1,012,729,638.00	\$29,172,464.00	\$1,061,466,037.00	50%
<b>Projected 2016</b>	\$1,039,566,973.00	\$30,211,904.00	\$1,066,773,367.00	50%
<b>Projected 2017</b>	\$1,070,753,982.00	\$31,118,261.00	\$1,098,776,568.00	50%
<b>Projected 2018</b>	\$1,092,169,062.00	\$31,740,626.00	\$1,120,752,099.00	50%

#### **5. Increase number of participants living on their own or with family instead of in a group setting.**

The Department of Community Health/Medicaid Division/MFP along with contractor agencies the Department of Human Services/Division of Aging Services (DHS/DAS), the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the State Housing Finance Authority, the Department of Community Affairs (DCA), will collaborate to increase the available options of affordable, accessible, supportive and integrated housing in an unprecedented effort to remove barriers to community living experienced by MFP participants.

DCH/MFP has joined the strategic, state-wide housing development initiative being led by DCA. Strategically DCH MFP in partnership with DCA will create a coordinated

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system that links MFP participants in need of housing to housing agencies to professional management companies and independent landlords with available housing resources. Efforts continue to build and expand relationships with local public housing authorities, local housing developers, professional management companies and other housing agencies in an effort to identify unused capacity and create additional subsidized housing options. MFP will identify, monitor and report on the following housing development goals:

- Table A.2.5-A) MFP participants returning to live with family members by county of residence at discharge (data from MFP Discharge Day Checklist).
- Table A.2.5- B) MFP participants returning to 'home owned by participant' by county of residence at discharge.
- Table A.2.5-C) MFP participants selecting option 'own home/family home' as 1st choice during the transition planning process.

**Table A.2.5-A Baseline Count of 'Lives with Family' by County**

- MFP participants returning to live with family members by county of residence at discharge

Count of Project Begin Date (Discharge)	Lives w/Family		Yes Total	Grand Total
	Yes 2012	Yes 2013		
County				
Appling	1		1	1
Bacon		1	1	1
Baldwin	1	1	2	2
Barrow	3	3	6	6
Bartow	1	2	3	3
Ben Hill		1	1	1
Bibb	2	4	6	6
Bleckley		2	2	2
Brantley	1		1	1
Brooks		1	1	1
Bryan	1	2	3	3
Bulloch	1		1	1
Burke	3	1	4	4
Calhoun		2	2	2
Candler		1	1	1
Carroll	2	1	3	3
Catoosa		1	1	1
Chatham	1	4	5	5
Chattooga	1		1	1
Clarke		5	5	5

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Count of Project Begin Date (Discharge)	Lives w/Family		Yes Total	Grand Total
	Yes 2012	Yes 2013		
County				
Clay	1		1	1
Clayton		2	2	2
Cobb	3	1	4	4
Coffee		1	1	1
Colquitt		1	1	1
Columbia	3	3	6	6
Coweta		1	1	1
Crawford	1		1	1
Crisp		1	1	1
Dekalb	3	4	7	7
Dodge	1		1	1
Dougherty		1	1	1
Douglas		2	2	2
Early		1	1	1
Effingham	1		1	1
Elbert	1	1	2	2
Evans		1	1	1
Floyd		2	2	2
Forsyth	2	2	4	4
Franklin		1	1	1
Fulton	6	1	7	7
Gilmer		1	1	1
Glynn	2	2	4	4
Gordon	2		2	2
Greene		1	1	1
Gwinnett	4	1	5	5
Habersham		1	1	1
Hall	1	5	6	6
Hart	1		1	1
Heard	1		1	1
Henry	2	1	3	3
Houston	4	1	5	5
Jackson	2	3	5	5
Jeff Davis	1		1	1
Jefferson	1		1	1
Jenkins	1		1	1
Johnson	1	1	2	2

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Count of Project Begin Date (Discharge)	Lives w/Family		Yes Total	Grand Total
	Yes 2012	Yes 2013		
County				
Jones	1	1	2	2
Lamar	2		2	2
Lanier		1	1	1
Laurens	2	1	3	3
Liberty		1	1	1
Lincoln	2	1	3	3
Lowndes		2	2	2
Lumpkin	1	1	2	2
Madison		1	1	1
McDuffie	1	1	2	2
Murray	1		1	1
Muscogee	1	2	3	3
Newton	1	2	3	3
Oglethorpe		1	1	1
Peach	1	1	2	2
Rabun		2	2	2
Richmond	4	10	14	14
Rockdale		1	1	1
Spalding	2	1	3	3
Stephens	1		1	1
Sumter		3	3	3
Tattnall		1	1	1
Terrell	2		2	2
Thomas		2	2	2
Tift	1	1	2	2
Toombs	2		2	2
Towns	1	1	2	2
Troup	2	1	3	3
Upson	1	1	2	2
Walton	3	1	4	4
Ware		1	1	1
Washington		2	2	2
Webster		1	1	1
White		2	2	2
Whitfield	1		1	1
<b>Grand Total</b>	<b>96</b>	<b>122</b>	<b>218</b>	<b>218</b>

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**Table A.2.5-B Baseline Count of Housing Owned by Participant by County**

- MFP participants returning to 'home owned by participant' by county of residence at discharge

<b>Count of Housing (Discharge)</b>			
<b>County</b>	<b>2012</b>	<b>2013</b>	<b>Grand Total</b>
Atkinson		1	1
Baldwin		1	1
Barrow		3	3
Berrien	1		1
Bibb	1	1	2
Bulloch	1		1
Burke	1		1
Carroll	1	1	2
Catoosa		2	2
Chatham		2	2
Chattooga	1		1
Clay	1		1
Clayton	1		1
Coffee	1		1
Coweta	1	1	2
Dooly	1		1
Effingham		1	1
Emanuel		1	1
Floyd		1	1
Forsyth	1		1
Fulton	1	2	3
Glynn	1		1
Gordon	2		2
Gwinnett	1	1	2
Habersham		1	1
Hall		2	2
Hancock	2		2
Haralson		2	2
Houston		2	2
Jackson	1	2	3
Johnson	1	1	2
Jones		1	1
Laurens	4	1	5
Lincoln		1	1

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<b>Count of Housing (Discharge)</b>			
<b>County</b>	<b>2012</b>	<b>2013</b>	<b>Grand Total</b>
Lowndes		1	1
Lumpkin	1		1
Macon		1	1
McDuffie	2		2
Meriwether	1		1
Miller		1	1
Murray	1		1
Paulding		1	1
Peach	1		1
Rabun		2	2
Richmond	1	3	4
Spalding	1		1
Taliaferro	1		1
Thomas	1	1	2
Tift	1	1	2
Toombs	1		1
Troup	2		2
Turner	1		1
Upson	1	1	2
Warren	1		1
Washington		2	2
Wheeler		1	1
White		1	1
Whitfield	1		1
Wilkes		1	1
<b>Grand Total</b>	<b>43</b>	<b>48</b>	<b>91</b>

- Chart Years are Calendar Years
- CY 2012 includes counts of MFP Older Adult (OA), Physical Disability(PD)/TBI and Intellectual and Developmental Disability (IDD) participants
- CY 2013 includes MFP OA, PD/TBI, IDD and CBAY participants

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**Table A.2.5-C Baseline Count of ‘Own Home/Family Home’ as 1<sup>st</sup> Choice**

- MFP Participants selecting option ‘own home/family home’ as 1st choice during the transition planning process. Does not include MFP IDD participants or MFP CBAY participants; housing choice during the transition planning phase is not captured for these populations.

Calendar Year	Count by Housing Type		Grand Total
	01 - Own Home	02 - Family Home	
<b>Actual 2008</b>		1	1
<b>Actual 2009</b>	8	28	36
<b>Actual 2010</b>	13	44	57
<b>Actual 2011</b>	24	40	64
<b>Actual 2012</b>	50	54	104
<b>Actual 2013</b>	50	48	98
<b>Projected 2014</b>	51	49	100
<b>Projected 2015</b>	52	50	102
<b>Projected 2016</b>	53	51	104
<b>Grand Total</b>	<b>301</b>	<b>365</b>	<b>666</b>

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

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

### **MFP Demonstration ‘Eligible Individual’ Defined (42 USCS § 1396a)**

- In accordance with Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 30, the term ‘eligible individual’ means, with respect to an MFP demonstration project of a State, an individual in a State--Who, immediately before beginning participation in the MFP demonstration project –
  - Resides in an inpatient facility (and has resided for a period of not less than 90 consecutive days)
  - Is receiving Medicaid benefits for inpatient services furnished by such inpatient facility for at least one day; and
  - With respect to whom a determination has been made that, but for the provision of home and community-based long-term services, the individual would continue to require the level of care provided in an inpatient facility and, in any case in which the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act [42 USCS Section 1396n(i)], the individual must continue to require at least the level of care which had resulted in admission to the institution; and
  - Who transitions to a qualified residence upon discharge from the inpatient facility
  - Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitation services for a period for which payment for such services is limited under title XVIII [42 USCS Section 1395 et seq.] shall not be taken into account for purposes of determining the 90-day period required under (A)(i).

## **Recruiting Procedures to Recruit MFP Participants**

In collaboration with the Balancing Incentives Program (BIP), the overall goal of outreach, marketing and education efforts is that all points-of-entry and information and referral networks provide accurate information about MFP transition services, HCBS qualified waiver services and Medicaid State Plan services. To achieve this goal, MFP field personnel and demonstration project partners focus on developing systematic outreach through all points-of-entry and Information & Referral networks. Outreach, marketing and educational presentations, booklets and informational brochures, public service announcements (PSAs) and information posts on the DCH, DBHDD and DHS/DAS public websites are used to inform the community about the MFP Demonstration, qualified waiver services and state plan services. Information about MFP and how it works has been added to already existing outreach, marketing, education and training undertaken by DCH.

As described in some detail in *Section A: Introduction /Goals*, Georgia DCH has an Interagency Agreement with the Department of Human Services/Division of Aging Services (DHS/DAS) to perform option counseling and transition screenings to assess inpatient residents identified using the Minimum Data Set Section Q (MDSQ) as interested in information about community living. MDSQ Options Counselors (MDSQ OCs) and MFP TCs are co-located in each of the 12 regional Area Agencies on Aging/Aging & Disability Resource Connections (AAA/ADRCs). MDSQ OCs and MFP TCs recruit elderly, blind and physically disabled individuals or all ages and inpatient residents with intellectual and developmental disabilities for the MFP demonstration.

MFP has served participants with IDD since the beginning of the demonstration (see *Section A: Introduction/Goals* for more details) under an interagency agreement with the DBHDD-Division of Developmental Disabilities. Planning List Administrators and Case Expeditors recruit individuals located in ICF/IDDs throughout the state. These individuals are screened based on eligibility criteria and referred to MFP. In CY 2013, MFP began serving youth with mental illness under the same interagency agreement with DBHDD -Division of Behavioral Health/CBAY. Under the agreement, PRTFs refer eligible youth to MFP CBAY.

## **To Recruit Older Adults and Persons with Physical Disabilities and TBI**

Working state-wide from the 12 Regional Area Agencies on Aging (AAA/Gateway Network)/Aging and Disability Resource Connections (ADRCs), MDSQ Options Counselors (MDSQ OCs) receive and follow-up on MDS Section Q referrals from Medicaid nursing facilities state-wide. MDSQ OCs follow-up on MDSQ referrals from points-of-entry. Follow-up includes face-to-face visits to nursing facility residents. Referred residents are screened for MFP, using the *MFP Screening Form* (see *Appendix G*). While this is the primary recruiting strategy to recruit older adults and persons with physical disabilities and/or TBI, other recruitment strategies include direct outreach and marketing to nursing facility residents, resident councils, administrators, social workers/discharge planners.

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As State Long-Term Care Ombudsman (LTCO) working in nursing facilities, they make referrals to MFP. Residents refer themselves to MFP, friends and family make referrals. Centers for Independent Living (CILs) and provider organizations make referrals. In addition, waiver case management entities and legal advocates all make referrals to MFP. An electronic version of the MFP Referral Form is available to be completed on the MFP website ([dch.georgia.gov/mfp](http://dch.georgia.gov/mfp)). MFP staff members take referrals over the phone. Division of Aging Services (DAS) staff takes field referrals from all points-of-entry into the LTSS system.

### **To Recruit Individuals with IDD**

DBHDD-DDD MFP staff coordinates recruitment with Planning List Administrators (PLAs) and Case Expeditors (CEs) in ICF/IIDDs, State Operated Hospitals and Medicaid Skilled Nursing Facilities (SNF) to screen inpatients identified for transition on the "Olmstead List." Additional referrals are obtained from the state's DD Council, the Association of Retarded Citizens, and regional and local service provider networks. MDSQ OCs and MFP TCs identify and recruit beneficiaries with IDD currently residing in nursing facilities, who meet eligibility criteria. DDD/MFP State Staff assist and oversee elements of the transition process.

### **To Recruit Youth with Mental Illness**

The existing referral process utilized by community-based behavioral health providers and PRTFs incorporates referrals to MFP services for youth with mental illness. However, existing tools, such as the MFP Tri-Fold Recruiting Brochure, MFP Referral form, and Transition Screening have been modified to include this new target population.

Youth who are being considered for entry into the MFP demonstration as a means of transitioning out of a PRTF will be referred by their treatment team at the PRTF when the treatment team, led by the treating physician, believes that young person's needs can be served outside the PRTF through MFP and other available state plan services. Youth considered for transition meet the required MFP eligibility criteria for institutional length of stay of at least 90 consecutive days with one day paid by Medicaid, PRTF level of care, and transition to qualified housing.

The PRTF treatment team referral is first submitted to the youth and/or his/her family along with the MFP Tri-Fold Recruiting Brochure, MFP Referral Form, and Transition Screening Form. When the family elects to consider transition through MFP, the treatment team at the PRTF will complete the MFP enrollment packet to initiate the process and provide the necessary assessment information for level of care determination. The enrollment packet includes the following: completed Checklist for Transition, Transition Screening Form, Individual Service Plan, and Discharge Day Checklist and supporting evaluation information such as the CAFAS, CASII, and clinical assessments performed by interdisciplinary team members of the PRTF. Once approved and the youth and his/her family agree to discharge into MFP services, they will receive education on the MFP services available including their choice to select a Care Management Entity (CME). The family then selects the CME and the CME assigns a Care Coordinator.

### **Procedures for Screening and Enrolling Potential Participants**

MFP field personnel (i.e. MDSQ OCs, CEs and PLAs and EROs) have experience in screening and referring to LTSS and HCBS waiver services for specific target populations and have excellent professional communication skills. Field personnel receive education related to this process including training on MFP, completion of referrals, screenings and enrollment processes and forms, standards of promptness, and expectations for collaboration between inpatient staff and community providers through the transition process. All necessary contact information is available. Field personnel are provided State points of contact (DBHDD-DDD and CBAY MFP Coordinators and DHS/DAS MFP Transition Coordinators) related to this process for questions and technical assistance.

Under the two Interagency Agreements, MFP field personnel use (but will not be limited to) the following strategies to screen and enroll potential participants in inpatient facilities:

- make initial contact with participants,
- observe candidates in the institutional setting for functional needs, strengths, limitations, barriers and resources, and document service needs,
- conduct face-to-face screenings with participants, family/support networks and discharge planners (Social Workers and/or Administrators) and determine Medicaid and MFP eligibility
- provide participants with information about MFP (see *Appendix C: MFP Tri-Fold Recruiting Brochure*) and information about HCBS waivers and community resources (see *Appendix E: Home and Community Services; A Guide to Medicaid Services in Georgia*),
- obtain signed informed consent from candidate or guardian to participate in the MFP demonstration, stating the candidate's desire to enroll in MFP and transition into an existing waiver (see *Appendix D1: MFP Consent for Participation and Appendix D2: MFP Release of Health Information*),
- informing participants of their rights and responsibilities under MFP
- be provided with access to all records that exist within the nursing/institutional facility, obtain permission to release records (see *Appendix D2*),
- complete a screening tool (see *Appendix G: MFP Transition Screening Form*), to build a personal profile of each MFP participant that includes medical, financial, functional and psychosocial information, needs for housing, services and items necessary to establish a community-based residence,
- facilitate referrals to appropriate waiver networks to complete applications for waiver services,
- obtain and review the FACE sheet to establish the original admission date to the nursing facility; Medicaid status is reviewed using the Georgia Medicaid Management Information System (GAMMIS) "Member" information; once screening is completed and the participant has been assisted with the waiver application,
- For residents in ICF/IIDDs, PLAs and CEs undertake the screening and enrollment process ; residents/families are provided with information about

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MFP, eligibility for MFP is determined and the consent and release of health information (see Appendix D1 and D2) are signed

- For youth with mental illness in PRTFs, the youth is identified and the youth (and family) are provided information about MFP (see *Appendix H*); the enrollment packet is completed and submitted to the ERO, level of care is verified and the ERO reviews the enrollment information for MFP eligibility; once MFP eligibility is determined, the enrollment packet is forwarded to the CME; after the CME receives the referral, the Care Coordinator must make contact with the family to create the initial individual service plan.

### **Procedures for Denial or Termination of MFP Participants**

If a participant signs informed consent (see *Appendix D1: MFP Informed Consent*), is screened and is found to be ineligible for the MFP Demonstration, MFP field personnel provide information about other long-term support service options and are required to give the individual a *Notice of Denial or Termination Letter* (see *Appendix AC*). The MFP participant may request a fair hearing, if she/he disagrees with the decision. Information about requesting a fair hearing is included in the letter.

### **Procedures for Transition Planning with Participants**

After screening and enrollment are completed, a person-centered transition planning team is convened and planning for transition begins. Under the two Interagency Agreements, MFP field personnel (i.e. MDSQ OCs, MFP TCs, CMEs, PLAs and CEs) use (but will not be limited to) the following strategies to develop Individualized Transition Plans (ITP, See *Appendix O*), Individualized Service Plans (ISPs) or Action Plans for MFP participants:

- ensure person-centered planning is conducted consistent with required practices.
- convene a transition team that includes (but is not limited to) the following; participant, circle-of-friends/circle-of-support/natural supports, family members/extended family, social worker/discharge planner/treatment team, case manager/care coordinator, MFP field personnel and school representatives where appropriate.
- ensure that the results of person-centered planning are written in the *Individualized Transition Plan (ITP)* (see *Appendix O* or the Person-centered Description (PCD) and that all members of the transition team are aware of and complete their assigned duties.
- Work with the transition team to assess participant needs for MFP transition services (see *Appendix B: MFP Services Table*); qualified HCBS waiver services, Medicaid state-plan services and other community services where available, ensuring effective use of each type of service.
- educate and inform MFP participants about MFP demonstration services with individual service caps during the MFP period of participation.
- Educate and inform MFP participants about participant-directed options under waiver programs.

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- educate and inform MFP participants about peer community supports and youth peer supports and if participant selects this MFP service, assist participant to locate and meet with qualified and where available, a certified peer supporter
- collaborate with the transition team and case manager/care coordinator to ensure waiver assessments and service plans are completed, participant/family goals/desired community outcomes are identified, discussed and documented, that health and nutrition goals are documented, and that there is continuity in medications and prescription timelines; document 24/7 emergency backup plans and crisis and stabilization management plans.
- assist participants in securing personal identification documents
- assist participants in locating qualified housing, ensure that appropriate modifications are undertaken to ensure usability, accessibility, health, safety and welfare of participants.
- assist in preparing the qualified residence to ensure a supportive emotional environment.
- assist participants to identify and use local transportation options.
- Ensure that planned services utilize MFP services first followed by state plan services second (funding of last resort) and together are used effectively.
- Ensure that MFP Quality of Life survey is completed and the participant and circle-of-support are knowledgeable about future expectations for completing periodic surveys/evaluations.

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

### **Procedures for Transitions with MFP Transition Services only/no Waiver**

As indicated in *Procedures for Transition Planning with Participants* detailed above, participants transition from inpatient facilities using MFP demonstration services and most enter a HCBS waiver upon discharge. In some cases, participants choose to transition without waiver services or as is the case with MFP CBAY, youth with mental illness transition using demonstration and Medicaid state plan services such as community mental health services (see B.5 Benefits and Services for a detailed

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description). Finally, there are MFP participants who do not meet HCBS waiver eligibility criteria for any waiver, but are assisted in transitioning using demonstration services. When MFP participants opt for transitions without HCBS waiver services, the state assures that, upon discharge from the institution, a Continuing Medicaid Determination (CMD) is done to establish entitlement for the most appropriate Medicaid aid category for the MFP participant. The MFP participant continues to receive MFP transition services for the MFP period of participation and state plan services under this Medicaid aid category. MFP field personnel inform MFP participants that when they transition without HCBS waiver services, they can choose to change their mind and accept waiver services without being placed on a HCBS waiver waiting list.

For MFP participants who do not enter a HCBS waiver upon discharge from the inpatient facility, a 24/7 backup plan is developed during the ITP planning process and is written up in the ITP (see Appendix O, Q8). The focus of the MFP 24/7 emergency backup plan for non-waiver participants is on participant health, welfare and safety and identifies such things as emergency egress from qualified housing, what to do during severe weather or power outages, and who to call about equipment failures. The TC is responsible for distributing the plan to the transition team and 'testing' the 24/7 emergency backup plan with the participant on moving day or shortly thereafter to ensure that the participant understands and is able to follow the plan. In addition, both the TC and the LTCO or Home Care Ombudsman (depending on housing choice) make monthly contact with the participant to resolve any problems.

### **Waiting Lists for MFP Services**

Funding for the MFP program is limited. There are a limited number of 'slots' of reserved capacity in each waiver. Therefore, only a certain number of participants receive waiver services based on available 'slots.' When reserved waiver capacity is exceeded, MFP uses a 'first-come-first-served' approach to service delivery. The date of the initial MFP screening will be used to prioritize the MFP waiting list. This date is on the first page of the MFP Transition Screening Form (see *Appendix G: MFP Transition Screening Form*). An MFP participant will be selected from the MFP waiting list, based on length of time on the waiting list. With regard to waiver waiting lists, the state has amended the MFP Operational Protocol to reflect the settlement agreement with the US Department of Justice. MFP continues to support the Olmstead Planning process (DCH Medicaid Deputy Chief is a member of the Planning Committee). Once the Olmstead agreement has been signed by the state, DCH/MFP will amend the OP as necessary to facilitate the goals and assist in achieving the outcomes of the Olmstead Agreement. There is no waiting list for MFP CBAY services for youth with mental illness who meet the PRTF level of care.

### **MFP Re-enrollment Process**

If a MFP participant is re-institutionalized (returns to the nursing facility or hospital) for any reason during the MFP project for no more than 30 days, the participant will NOT be considered an institutional resident. As soon as the participant's condition

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stabilizes, the participant can return to her/his place of residence in the community and resume MFP services.

If the nursing facility or hospital stay is 31 days or longer, the participant is suspended from MFP and waiver services and is considered an institutional resident. The suspended participant may be reactivated/readmitted to MFP and waiver services any time prior to the completion of the MFP period of participation, without re-establishing the 90 consecutive-day institutional residency requirement. Once discharged from inpatient care, the individual resumes their status as an MFP participant and is eligible to receive MFP services for any remaining days up to the maximum 365 days of demonstration participation period. No inpatient days will be counted toward the total of the 365 days of the MFP Period of Participation.

Youth with mental illness enrolled in MFP CBAY services may receive institutional services for up to thirty (30) days without jeopardizing MFP enrollment. However, if the institutional services are utilized for 31 days or more, the youth must discharge from MFP demonstration. Youth who have previously been enrolled in MFP, but have since discharged may re-enroll in MFP services by going through the application process again and demonstrating that all criteria are met, without re-establishing the 90 consecutive-day inpatient residency requirement.

### **MFP Re-enrollment Process for Former MFP Participants**

Georgia will re-enroll former MFP participants who have been re-institutionalized after completing their initial MFP period of participation, if they are qualified individuals who have been in a qualified institution for at least 90 consecutive days, less any short-term rehabilitative days as per Regulatory guidance on "Eligible Individual" (see Section B.1: *MFP Demonstration 'Eligible Individual' Defined*).

In order to re-enroll a former MFP participant, Georgia will develop and maintain a process to re-evaluate the former MFP participant's ITP/ISP or plan of care. The ITP/ISP or Plan of Care will be reviewed by the MFP field personnel before re-enrolling the participant into the MFP demonstration.

The protocol for the re-enrollment of former MFP participants includes:

- Documentation of medical and/or behavioral changes that resulted in re-institutionalization to an inpatient facility
- Documentation the lack of community services available to support the participant, community services discussed in the ITP/ISP or Plan of Care/Services Plan that were either insufficient or not available, and how the lack of community services contributed to re-institutionalization
- Documentation of how the ITP/ISP or Plan of Care/Services Plan was not supported by the delivery of quality services.

The former MFP participant may be re-enrolled for another MFP period of participation, once the reasons for re-institutionalization have been determined using the protocol above, and changes are made to the MFP ITP (ISP or care plan) considering the possible causes for the reinstitutionalization. Georgia will report an

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annual summary of the numbers of re-enrollments for a second MFP period of participation and the causes of re-institutionalization.

### **Money Follows the Person Recruiting Text**

Georgia Money Follows the Person helps people living in inpatient facilities to transition and resettle into qualified residences in the community. If you have lived in an inpatient facility for at least 90 consecutive days, you may be eligible for MFP demonstration services, services for youth with mental illness and home and community-based services (HCBS) through Georgia's Medicaid program.

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

MFP offers transition services to help people resettle in qualified housing in communities of choice. After receiving MFP demonstration services for a period of 365 days, MFP participants will continue receiving services through Medicaid Home and Community Based Waiver Services (HCBS), Medicaid State Plan services, non-Medicaid federal funds such as the Social Services Block Grant and the Older Americans Act, state funded programs, and local community support systems and funding, as long as they remain eligible.

MFP participants (older adults, persons with physical disabilities and/or TBI, and persons with developmental disabilities select from the following list of MFP transition services to assist them:

- Peer Community Supports
- Trial Visits with Personal Support Services
- Household Furnishings
- Household Goods and Supplies
- Moving Expenses
- Utility Deposits
- Security/Rent Deposits
- Transition Supports
- Transportation
- Life Skills Coaching
- Skilled Out-of-Home Respite
- Caregiver Outreach and Education
- Home Care Ombudsman Visits
- Equipment, Vision, Dental and Hearing Services
- Specialized Medical Supplies
- Vehicle Adaptations
- Environmental Modifications for Accessibility
- Home Inspections
- Supported Employment Evaluation

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Youth with mental illness entering MFP CBAY may receive a combination of the following MFP demonstration services;

- Community Transition
- Care Management
- Care Management – Transition
- Behavioral Assistance
- Family Peer Support Services
- Youth Peer Support Services
- Transportation
- Expressive Clinical Services
- Clinical Consultative Services
- Supported Employment
- Financial Support Services
- Respite
- Customized Goods and Services

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

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

- The Department of Human Services Division of Aging Services at 1-866-55-AGING (552-4464), or
- The Office of the State Long-Term Care Ombudsman at 1-888-454-5826.
- The Georgia Department of Community Health Money Follows the Person project, at 404-651-9961,

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

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

#### **How Guardians are Appointed in Georgia**

A candidate/inpatient is assumed to be competent and able to consent to participation in the MFP Demonstration, unless the candidate/inpatient has been deemed incapacitated by a court and a legal guardian has been appointed. If the candidate/inpatient does not have a court-appointed guardian, she/he has the right to make decisions regarding MFP participation. Persons with Power-of-Attorney (POA) are not legal guardians. Persons indicating that they have legal guardianship must produce copies of court documents indicating this status. If an individual cannot produce copies of legal court documents indicating legal guardianship, MFP personnel obtain a signed *MFP Consent for Participation* from the candidate/inpatient (see *Appendix D1*) and move forward with screening and transition planning using person-centered planning.

If the candidate/inpatient has a court-appointed legal guardian, the guardian may act on the participant's behalf. The guardian signs the *MFP Consent for Participation* (see *Appendix D1*). MFP field personnel inform the guardian of MFP transition services and planning processes and include the guardian and ward in planning. The guardian acts on behalf of the participant and makes planning decisions regarding MFP with input from the ward and in accordance with Georgia guardianship law. MFP facilitators/personnel encourage guardians to take into account the wishes of their ward to the fullest extent possible.

Any competent person who agrees to serve as a guardian may be appointed to do so. Agencies and institutions providing care and custody to an incapacitated individual are prohibited from becoming his/her guardian. As a last resort, the Department of Human Services (DHS) may be appointed guardian.

### **Informed Consent and Involving Guardians in MFP Transitions**

Strategies used to inform potential MFP participants, family members, friends and/or guardians include: liberal opportunities to receive information about MFP (see *Section B.1 Participant Recruitment and Enrollment*); opportunities to discuss MFP transition services and waiver service options with MFP field personnel (MDSQ OCs, MFP TCs, DD PLAs, DD CEs, CBAY CME) before signing the *Release of Health Information and Informed Consent Form* (see *Appendix D1 and D2*); opportunities to discuss waiver options and MFP field personnel/facilitators before and during waiver assessment (see *Section B.6 Participant Supports* and *Section B.7 Self-Direction*); requirements for guardians; and waiver requirements for the development of service plans with input from MFP participants, family members, caregivers, friends and/or a legal guardian.

As described in *B.1 Participant Recruitment and Enrollment*, inpatients, family members, caregivers, friends and/or guardians will be provided with easy to use, understandable information, or information in alternative formats, about MFP transition services and core waiver services, eligibility criteria, how to apply and what to expect (see *Appendix C: MFP Brochure* and *Appendix E: Home and Community-Based Services: A Guide to Medicaid Waiver Programs in Georgia*). Information about MFP is provided along with information about core waiver services and State Plan services through statewide Point-of-Entry partners including: AAA/Gateway networks, Aging and Disability Resource Connections (ADRCs), Centers for Independent Living (CILs), provider networks, and the regional DBHDD network. Potential MFP candidates have opportunities to receive and discuss information with MFP Field Personnel/Facilitators (i.e. MDSQ OCs, MFP TCs, DD PLAs and/or CEs, CBAY CMEs) during face-to-face meetings and follow-up discussions. Once inpatients have received information about MFP and have indicated interest in MFP/transitioning, consent and release of health information are obtained from the MFP candidate/family or guardian. The involvement of family members and those having limited Durable Power of Attorney (DPOA) for healthcare decisions is encouraged, but only the participant or the legal guardian can consent to participate in the Demonstration. Copies of legal documents indicating guardianship are obtained and reviewed. During subsequent development of transition and service plans (see *Appendix O*), participants, family members/friends, caregivers and guardians are all involved in person-centered planning and circles of support.

In some cases, family members and guardians have been reluctant to allow institutionalized persons to choose to transition to community living. One strategy used by MFP field personnel has been to identify current waiver participants who have successfully resettled in the community and who have guardians. Guardians of successfully transitioned participants are asked to visit with guardians of institutionalized persons considering transition under MFP. Visits with guardians of successfully resettled waiver participants will help guardians considering transition to understand and weigh both the benefits and risks of resettlement. Discussions between guardians, participants, transition personnel and waiver CCs/CMs, have moved the transition process forward. If necessary, the assistance of a Long-Term Care Ombudsman (LTCO) can be requested by the participant/family/guardian. For

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example, if a person in a nursing facility or ICF/IIDD indicates interest in resettlement in the community, but a family member or guardian is opposed and will not allow the process to move forward, a LTCO is asked to intervene. LTCO educate family members about legal guardianship and clarify that only a legal guardian is permitted to override a participant's wishes. Family members of participants who are not legal guardians may not override the participant's wishes. In addition, LTCO educate guardians about the participant's Bill of Rights and when necessary, refer the participant/consumer for free legal assistance (i.e. Atlanta Legal Aid Society, Georgia Advocacy Office, and Georgia Legal Services) and/or additional legal help to reverse guardianship. On the other hand, if any member of the transition team believes that a participant/consumer is actually opposed to community placement, but the participant's guardian is for such a placement, a LTCO is asked to intervene for the purpose of working with the guardian regarding the participant's preference to continue institutional placement and educating the guardian about the limits of guardianship.

Following waiver enrollment and transition to the community, MFP TCs (or CBAY CMEs) make monthly calls and periodic face-to-face visits with participants, family members, caregivers and guardians to ensure that participants are receiving all MFP transition services and waiver services as specified in the ITP(or CBAY Action Plan) and waiver Plan of Care/Service Plan. When participants have guardians, MFP TCs follow-up with the guardian to answer any questions and/or provide additional information about the MFP grievance and complaint processes regarding MFP transition services. MFP field personnel leave their contact information and the contact information for waiver care coordinators/case managers and ask guardians to call with questions or if problems arise. Finally, participants can choose the services of a home care ombudsman by selecting the MFP Home Care Ombudsman (HCO) demonstration/transition service. HCO provides regular monthly contacts with a qualified home care ombudsman for the review of a participant's health, safety and welfare; advocacy for participant's to respond to and resolve complaints related to MFP and waiver services and how these services are provided (for more details, see Section B.5 and *Appendix B*).

### **Informed Consent for Older Adults and Persons with Physical Disabilities/TBI**

At the time of the initial face-to-face screening for MFP eligibility determination and after receiving and reviewing information about MFP transition services and core wavier services along with information on their rights and responsibilities, MFP candidates are consented using the *MFP Consent for Participation* and a standardized *MFP Release of Health Information* (see *Appendix D1 and D2*).

Under the Elderly and Disabled Waiver Program and Independent Care Waiver Program, participants are consented and informed of their rights and responsibilities during the initial face-to-face assessments conducted by qualified waiver assessment personnel. The state assures that each individual found eligible for waiver services will be given free choice of all qualified providers of each service included in his or her written service plan. Choice of provider is documented on the

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written service plan. The Freedom of Choice forms, signed during initial face-to-face assessments, are maintained for a minimum of three years by the case management agency.

### **Informed Consent for IIDD**

For individuals residing in ICF/IIDDs, Planning List Administrators (PLAs) and Case Expeditors (CEs) provide and review MFP transition service information and NOW and COMP waiver services along with participant's rights and responsibilities during the development of the Person-Centered Description/individualized service plan (ISP). At these planning meetings, MFP candidates from the Olmstead Planning Lists are consented using the *MFP Consent for Participation* and complete a standardized *MFP Release of Health Information* (see *Appendix D1 and D2*).

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

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

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

### **Informed Consent for Youth with Mental Illness**

As part of enrolling in MFP services, each participant signs a document indicating Freedom of Choice. Although this signature documents the choice of community services, it also documents that the participant has choice of Care Management Entity (CME) providers and direct service providers at service onset and during enrollment in MFP services should the participant ever desire to make a change. In this process, the intent is to inform and to document that the participant and his or her legal representative are (1) informed of alternatives to institutionally-based services, (2) given the choice of either PRTF or Home and Community-Based Services, and (3) informed of available services. A signed document is on file indicating Freedom of Choice with witness signature(s) by the referring PRTF. The original signed Freedom of Choice document is maintained by the referring

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provider(s) for at least 5 (five) years. DBHDD maintains an electronic version of the documentation of Freedom of Choice for at least 5 (five) years. Copies are also maintained by the care management entity provider(s) for at least 5 (five) years. A copy of the form is maintained in the participant's record by each provider for at least 5 (five) years.

The MFP program for Youth with Mental Illness follows the Guardianship policies and protocol as described earlier in this section. Legal guardians are involved in all planning for youth with mental illness in place of or in addition to biological family members.

### **Grievance and Complaint Processes for MFP Demonstration Services**

MFP field personnel are required to report participant/family complaints occurring during the transition process; from the date the participant signs the MFP Informed Consent for Participation and throughout the MFP service period. Complaints about MFP transition services can be made to any MFP field personnel, DBHDD DD/MFP office staff, DHS/DAS MFP office staff or DCH staff. See Appendix AE: MFP Participant Complaint Form for the reporting participant/family complaints. Participant Complaint Forms are reviewed by DCH MFP project director and staff.

During initial face-to-face screenings with MFP field personnel, MFP participants are informed about grievance and complaint procedures related to MFP demonstration services. MFP participants contact their MFP field personnel, LTCO, DHS/DAS/MFP staff or the DCH/MFP office staff to report a complaint regarding MFP demonstration services. The *MFP Participant Complaint Form* (see Appendix AE) is used to report a complaint. The form directs the recorder of the complaint to resolve the complaint by developing an action plan, steps taken to prevent the complaint from reoccurring and time frames for evaluating the effectiveness of the action plan. Resolution may involve facilitating a conference with the MFP participant, the provider, and other supports such as family members in order to address all relevant details associated with the complaint. Within 10 business days of receiving the complaint, completed complaint forms must be sent to the DCH/MFP office for review by DCH/MFP Project Director and/or the Compliance Monitor/Quality Management Specialist. The Project Director and/or the Compliance Monitor/QMS Specialist follows-up with MFP field personnel, participants/families, agencies and vendors and others involved to review complaints and ensure appropriate resolution and process improvement. If consensus cannot be achieved for the action plan and the complaint cannot be resolved to the satisfaction of the parties, participants receive a letter with information needed to request a fair hearing with DCH. The letter includes information on how to request the fair hearing and how to obtain pro bono legal assistance (see Appendix Z: *Notice of Right to Appeal a Decision*).

All complaints regarding MFP demonstration services are categorized according to MFP service type, investigated, resolved and the record of disposition of the complaint is maintained by the MFP Compliance Monitor/QMS Specialist and reported to the MFP Steering Committee and Project Evaluation Advisory Team to identify trends and to develop a plan for continuous quality improvement. The MFP

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Evaluation Advisory Team is tasked with the development of related policy and/or procedure revisions.

### **Grievance and Complaint Processes for Participants entering E&D Waivers**

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

At the initial face to face assessment, appropriate waiver assessment personnel advise participants of their rights including their right to voice complaints and grievances. Examples of possible complaints (i.e. poor provider performance, aides not reporting as scheduled, lack of supervision, or allegations of abuse, neglect, or exploitation and violation of rights) are provided to participants along with procedures for reporting complaints.

Complaints or grievances are initially addressed by the case manager. Allegations of abuse, neglect, exploitation or violation of participant rights must be reported to DCH Program Integrity (for example, if the participant is living in a personal care home or community living arrangement); to the DCH Healthcare Facility Regulation Division or Adult Protective Services (APS) if the participant resides in a non-institutional setting, as required by law. In an effort to ensure that participants and/or caregivers receive consistent and objective treatment when grievances are reported, case managers immediately intervene to work with the participants and providers to facilitate an acceptable resolution for the waiver participant. Resolution may involve facilitating a case conference with the client, the provider, and other supports such as family members or guardians in order to address all relevant details associated with the complaint. If the problem cannot be resolved, a grievance committee is convened to address the concerns and a solution is recommended within seven days.

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

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

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

### **Grievance and Complaint Procedures for Participants Entering NOW & COMP**

DBHDD ensures that consumers, representatives, guardians, associations, agencies, contractors, sub-contractors, or those who seek to become involved with the delivery or receipt of home and community based services may file complaints and grievances. All complaints and grievances are accepted, reviewed, and investigated; in addition, a response is provided promptly to the individual(s) who submitted the complaint or grievance in accordance with the procedures in this policy (link: [https://pstat-live-media.s3.amazonaws.com/pdf\\_cache/policy/175832/Complaints%20and%20Grievances%20Regarding%20Community%20Services-%2019-101.pdf?Signature=HVIT2gk9X5uYvvjA%2BRS3gemyZSA%3D&Expires=1408544609&AWSAccessKeyId=AKIAJS7VN6JKKNCNGCXA](https://pstat-live-media.s3.amazonaws.com/pdf_cache/policy/175832/Complaints%20and%20Grievances%20Regarding%20Community%20Services-%2019-101.pdf?Signature=HVIT2gk9X5uYvvjA%2BRS3gemyZSA%3D&Expires=1408544609&AWSAccessKeyId=AKIAJS7VN6JKKNCNGCXA)). No person is retaliated against or denied services for making a complaint or grievance. Complaints involving allegation of abuse, neglect, or other reportable incidents are managed in accordance with DBHDD policies regarding reporting of incidents, and are not subject to the procedures included.

#### **General Procedures**

A. Complaints and grievances may be filed against DBHDD State Office, Regional Offices, service providers having a contract or letter of agreement with the DBHDD, and state operated community service providers. DBHDD recognizes that complaints are dealt with at all levels throughout the system.

B. DBHDD State Office, Regional Offices, and providers each designate staff to receive, process, investigate, follow-up and report complaints and grievances.

C. Within the DBHDD State Office, the Office of External Affairs (OEA) is the designated entity for the management of complaints and grievances, and follows a standard process for managing complaints and grievances. Complaints and grievances should be handled as close to the point where the problem is initiated. OEA is especially focused on complaints and grievances that occur frequently, that relate to high risk situations, and/or that may reflect some type of larger systemic problem.

D. Complaints and grievances must:

- Be taken, whether received via telephone, in person, in writing, by referral, fax, email;
- Be documented, either by the complainant or by the person taking the complaint or grievance;
- Identify the provider, where applicable;
- State the nature of the complaint or grievance;
- Identify the person(s) involved (if possible), and/or the name and contact information of the person (if possible) filing the complaint or grievance; and
- Be kept on file for 5 years.

OEA can provide tools for documentation of this information upon request.

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E. Staff encourages individuals who have a complaint or grievance regarding a provider to initiate their complaint/grievance process according to the provider's internal policy. A party may file an initial complaint or grievance to the DBHDD State Office. In such event, the following steps are taken:

1. The complaint/grievance is sent to DBHDD Office of External Affairs (OEA)  
Phone: 404-657-5964  
Fax: 770-408-5439  
Email: DBHDDconstituentservices@dhr.state.ga.us
2. OEA sends out an email to the applicable Regional Coordinator (RC), Regional Services Administrator (RSA), their Administrative Assistant; and other state staff when appropriate.
3. The complaint/grievance is assigned by the RC, RSA, or State Office staff to the appropriate staff member for follow-up and resolution in accordance with this policy;
4. Staff performs follow up and provides the RC, RSA, or State Office staff with a summary or their initial response to the complainant, which is then communicated to OEA within two (2) business days; and
5. Regional or State Office staff notifies OEA, within five (5) business days of receiving the complaint or grievance, of the finding(s) and the recommendation(s) for resolving the complaint or grievance.
6. The Regional, State Office, or OEA contacts the complainant to follow up with the findings and recommendation for resolving the complaint or grievance.

F. Reporting complaints and grievances to Legal Services

During conversation with the complainant, the Regional Office, when possible, determines if the matter under complaint or grievance is the subject of pending or current litigation. If the complaint or grievance may be or is the subject of current litigation, the Regional Office immediately contacts the DBHDD Office of Legal Services for guidance.

### **Procedures Specific to Complaints and Grievances Against Service Providers**

A. Individuals being served or other stakeholders may register complaints or grievances with service providers.

B. The Regional Office follows specific steps in addressing complaints and grievances made directly to the Regional Office regarding providers or services. Upon receipt of a complaint or grievance, the Regional Office first determines whether the complaint or grievance will be processed by the Regional Office or whether the complaint or grievance must be referred to another agency or entity. If the complaint or grievance involves legislators or media then the Regional Office notifies the Office of External Affairs (OEA).

1. Complaints requiring referral outside the Regional Office: If the complaint or grievance will not be processed by the Regional Office, the Regional Office staff notifies the complainant, by telephone or in writing, within five (5) business days of receipt of the complaint or grievance, explaining the reason(s) the Regional Office cannot properly address the complaint or grievance. For example, complaints or grievances involving client rights should be first referred to the Client's Rights Subcommittee for the provider

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serving the complainant. Whenever possible, Regional Office staffers provide sufficient information to the complainant for referral to the appropriate entity for relief.

2. Complaints involving providers: The Regional Office determines whether the complainant has filed the complaint or grievance first with the provider, and if any resolution was suggested by the provider.

a. If the complainant has filed the complaint or grievance with the provider, but:

- The complainant is dissatisfied with the provider's suggested resolution; or
- The complainant does not want to or refuses to communicate with the provider;

or

- The provider has not taken any action regarding the complaint or grievance, then the Regional Office reviews and attempts to resolve the complaint or grievance. If complaint or grievance is of a client's rights nature, Regional Office requests that the provider immediately transmit to the Regional Office a copy of the provider's decision, together with a copy of the Client's Rights Subcommittee' recommendation and other documents utilized in the review. If the complaint relates to reportable incidents in accordance to DBHDD policies, then those policies are followed.

b. If the complainant has not filed the complaint or grievance with the provider, the Regional Office:

- Advises the person that it is generally best to address their complaint or grievance to the provider, unless circumstances warrant otherwise and offers the complainant the option of either addressing it themselves or having the Regional Office staff forward the complaint/grievance to the provider.
- If necessary, records the complaint or grievance and forwards it to the provider.
- Informs the complainant that the complaint or grievance has been forwarded to the provider and that the provider will contact the complainant to resolve the matter.
- Follows up with the provider within five (5) business days of the referral to verify that the complaint or grievance has been or is in the process of being resolved. The Regional Office is not prohibited from reducing the time period for this follow up.

c. When following up on a referral of the complaint or grievance to the provider, the Regional Office may find that the following pertains:

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- No process for resolution has commenced. The Regional Office then records the reason(s) why no process has begun and conducts a review of the complaint or grievance as described below; or
- The provider has begun to review the complaint or grievance and is working toward a resolution, the Regional Office records that information and requests that the provider forward to the Regional Office notice of resolution of the complaint or grievance. The Regional Office does not need to take additional action unless the circumstances demand further inquiry or action.

3. Regional Office Review/Investigation: The Regional Office conducts and completes a review of the complaint or grievance within five (5) business days of receipt of the complaint or grievance or within five (5) business days of the date it is determined the provider has not begun a resolution process.

a. Review elements: The Regional Office's review/investigation provides, at a minimum, that:

- Informal resolution, where appropriate, is utilized;
- Investigative methods deemed most suitable to determine the facts are utilized. Such methods may include, but are not limited to, personal interviews, telephone calls, and/or review of documents and correspondence. The reviewer/investigator has access to all documents and records and personnel relevant to the investigation. In addition, the Regional Office may request the assistance of other offices in DBHDD;
- Confidential information is protected against unauthorized disclosure;
- Conflicts of interest are avoided and where discovered, immediately corrected; and
- Whenever appropriate or necessary, a signed release of information is obtained.

b. Extensions: The Regional Coordinator may grant an extension of this time frame upon request and upon a showing of good cause, such as the complexity of the issue(s) or if fact gathering warrants additional time. If the Regional Coordinator approves an extension, the Regional Office notifies the complainant of the extension and indicates the approximate time frame within which the review will be concluded. Where applicable, a copy of the notice of extension is also forwarded to the provider. If an extension exceeds twenty (20) business days from the date of receipt of the complaint or grievance, the complainant receives an update from the Regional Office.

4. Findings/Resolution: The notification of findings/resolution of any complaint or grievance related to client rights includes an explanation of the

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appeal process. A copy of the findings and recommendations is kept on file along with the complaint or grievance and a copy must be forwarded to the provider, if applicable.

If complaint or grievance is of a client's rights nature, the Regional Office sends a copy of the complaint and recommendations to the complainant and the Office of External Affairs (OEA).

5. Appeal: When a complainant is dissatisfied with the resolution proposed by the Regional Office, the complainant may request that the Regional Office forward a copy of the complaint or grievance, all relevant material, and all proposed resolution(s) to DBHDD OEA. A complainant is not precluded from filing an appeal directly to the DBHDD Commissioner or OEA, in which case the Commissioner or designee contacts the Regional Office to request copies of all material(s) relevant to the complaint or grievance. If possible, the Commissioner or designee completes the review of the complaint or grievance within ten (10) business days of receipt of the appeal and all relevant materials. The Commissioner or designee provides a resolution for the complainant that is final. A copy of the final resolution is forwarded to the Regional Office and, if applicable, to the provider. The Regional Office and where applicable, the provider, must maintain on file a copy of the final resolution of all complaints and grievances for no less than six (6) years.

C. In addition to an appeal, a party may file an initial complaint or grievance to the DBHDD State Office. The DBHDD website <http://dbhdd.georgia.gov> includes information about how to do so.

### **Grievance and Complaint Processes for CBAY Youth with Mental Illness**

At enrollment grievance and complaint processes are explained to the youth and/or their family. This includes fair hearing protocols for the application of any limits, reduction of services, or denial of services as well the general complaint process. At the local level of the MFP Program for Youth with Mental Illness, the state has designated Care Management Entities to operate the grievance/complaint system. In an effort to ensure that participants and/or families receive consistent and objective treatment when grievances are reported, Care Coordinators are charged to immediately intervene to work with the participants, family, and other entities involved in the complaint to facilitate an acceptable resolution for the participant. In the event of any complaint the participant and/or family will complete a *MFP Participant Complaint Form*. The submission of the complaint form will trigger a Child and Family Team meeting to be scheduled if the issue is urgent; if not, the issue is to be addressed at the next regularly scheduled monthly Team meeting. The complaint form directs the reporter to resolve the complaint by developing an action plan, steps taken to prevent the complaint from reoccurring and time frames for evaluating the effectiveness of the action plan. Including the complaint issue on the Child and Family Team meeting agenda creates a formal avenue through which to address all relevant details associated with the complaint. The action plan developed by the Team must be documented as part of the Complaint Form completion process. Once completed, the Complaint Form is to be submitted to the DBHDD MFP Coordinator. Within 10 business days of receiving the complaint,

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completed complaint forms must be sent by the DBHDD MFP Coordinator to the DCH/MFP office for review by DCH/MFP Project Director. The Project Director follows-up with the MFP Coordinator, participants/families, agencies and vendors and others involved to review complaints and ensure appropriate resolution and process improvement. If consensus cannot be achieved for the action plan and the complaint cannot be resolved to the satisfaction of the parties, the MFP Coordinator provides a letter to participants with information needed to request a fair hearing with DCH. The letter includes information on how to request the fair hearing and how to obtain pro bono legal assistance (*see Appendix AF: Notice of Your Right to a Hearing*).

*Any participant denied entrance into or terminated from the MFP Program for Youth with Mental Illness is offered the opportunity to request a Fair Hearing.*

If the most recent clinical information does not support approval of enrollment or continued enrollment, a Denial of PRTF Level of Care letter informing the member of the right to a fair hearing is also generated, which includes the rationale for the member not meeting Admission or Level of Care Criteria. The ERO sends a Referral Summary and a copy of the Denial Letter to the DBHDD State Office, DBHDD General Counsel, DBHDD Regional Office of responsibility, the MFP Program office, and Referring Party. The letter to the applicant/participant is sent certified mail. If the applicant/participant is an adult, the letter will only be addressed to the applicant/participant. If the applicant/participant is a minor or an adult with a legal guardian, the letter will be addressed to the applicant/participant in care of their legal custodian/guardian.

If no response requesting a fair hearing is received/postmarked within 15 days of the Certified Mail being received, no further action is needed since no fair hearing was requested.

If a response requesting a fair hearing is received/ postmarked from the applicant/participant or their legal custodian/guardian within 15 days of the Certified Mail being received, the request is processed as follows:

- If it is determined that the reason for appeal is related to medical necessity, DBHDD State Office submits a copy of the PRTF Referral Summary and Denial Letter to DBHDD's Medical Director or designee for a tertiary in-house clinical review.
- If it is determined that the reason for appeal is unrelated to medical necessity, DBHDD Medical Director or designee will not complete a review.

DBHDD State Office/Child & Adolescent (C&A) Services notifies DBHDD General Counsel and DBHDD ERO of a request for fair hearing. DBHDD State Office/ C&A Services provides DBHDD General Counsel with copies of the PRTF Admission Criteria, ERO Referral Summary, Denial Letter, copy of Return Receipt of USPS Certified Mail, and request from applicant/participant or their custodian/guardian for a fair hearing.

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DBHDD General Counsel requests a hearing from The Office of State Administrative Hearings. The Office of State Administrative Hearings schedules a hearing date, time, and location and informs DBHDD General Counsel and the applicant/participant of the hearing. DBHDD General Counsel informs DBHDD C&A Services and the ERO of the hearing date, time, and location.

On the date of hearing DBHDD General Counsel and the member, or their legal custodian/guardian, with their desired representation meet before The Office of State Administrative Hearings. If the ruling is upheld, no further action is necessary and PRTF Level of Care is denied. The applicant/participant has the option to appeal the ruling. If the ruling is overturned, PRTF Level of Care is approved. DBHDD has the option to appeal the ruling if the DBHDD believes it is in the best interest of the applicant/participant and the integrity of the MFP program to deny entrance. If DBHDD chooses to not appeal, DBHDD will await court documentation from the Office of State Administrative Hearings and provide a copy to the ERO, MFP Program, and Referring Provider to permit enrollment into MFP.

The DBHDD or the applicant/participant may appeal the ruling of the Office of State Administrative Hearings to the Appeals Petitioner at the Department of Community Health. If DBHDD or the applicant/participant disagrees with the ruling, they have the option to appeal to Superior Court for a final determination.

When a service limit is employed by the MFP program, the DBHDD MFP Coordinator must document the decision to specify: (a) the services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the MFP period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

The grievance process to follow applies to either a denial of an Individualized Service Plan in whole because elements of the plan do not meet standards or denial when a service limit has been applied to an Individualized Service Plan that reduces previous levels of specific service(s). In either instance, it means that the DBHDD/C&A clinical team, including the MFP Coordinator, have reviewed all available documentation and have determined that there is insufficient information to support the approval of the Individualized Services Plan as submitted. When a denial decision happens, notices are created and emailed, along with feedback forms and submitted to the CME Supervisor via email by the MFP Coordinator. The CME has 5 days to take the notice of denial or reduction to the family and explain it to the youth and/or family. The notice outlines the steps the participant and/or family must take to exercise fair hearing rights. They are responsible for explaining the participant's/family's rights and having the notice of denial or reduction signed. The participant and/or family may sign that they agree or

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disagree with the decision and the notice is submitted back to the state office within 10 days.

If a response requesting a fair hearing is received/ postmarked from the member or their legal custodian/guardian within 15 days of the Certified Mail being received, DBHDD State Office/C&A Services notifies DBHDD General Counsel and DBHDD ERO of a request for fair hearing. DBHDD State Office/ C&A Services provides DBHDD General Counsel with copies of the PRTF Admission Criteria, ERO Referral Summary, Denial Letter, copy of Return Receipt of USPS Certified Mail, and request from applicant/participant or their custodian/guardian for a fair hearing.

DBHDD General Counsel requests a hearing from The Office of State Administrative Hearings. The Office of State Administrative Hearings schedules a hearing date, time, and location and informs DBHDD General Counsel and the applicant/participant of the hearing. DBHDD General Counsel informs DBHDD C&A Services and the ERO of the hearing date, time, and location.

On the date of hearing DBHDD General Counsel and the member, or their legal custodian/guardian, with their desired representation meet before The Office of State Administrative Hearings. If the ruling is upheld, no further action is necessary and PRTF Level of Care is denied. The applicant/participant has the option to appeal the ruling. If the ruling is overturned, PRTF Level of Care is approved. DBHDD has the option to appeal the ruling if the DBHDD believes it is in the best interest of the applicant/participant and the integrity of the MFP program to deny entrance. If DBHDD chooses to not appeal, DBHDD will await court documentation from the Office of State Administrative Hearings and provide a copy to the ERO, MFP Program, and Referring Provider to permit enrollment into MFP.

The DBHDD or the applicant/participant may appeal the ruling of the Office of State Administrative Hearings to the Appeals Petitioner at the Department of Community Health. If DBHDD or the applicant/participant disagrees with the ruling, they have the option to appeal to Superior Court for a final determination.

All complaints regarding MFP services are categorized according to MFP service type and maintained on a project complaint log. A brief note documenting the resolution to the complaint/grievance is included on the log. All complaints are reviewed immediately by the MFP Compliance Monitor and Project Director and quarterly by the MFP Evaluation Advisory Team to identify trends and to develop a plan for continuous quality improvement. The MFP Evaluation Advisory Team is tasked with the development of needed policy and/or procedure revisions.

Reporting of and response to grievances and complaints for MFP CBAY Youth with Mental Illness is shared with the Quality Council for statewide stakeholder review [redacted for anonymity] and continuous quality improvement initiatives. Allegations of abuse, neglect and exploitation must be reported by the Care Coordinator to the appropriate DCH, DBHDD, and DHS (Department of Human Services) offices as required by law if the participant resides in a non-institutional setting.

## **Critical Incident Reporting Systems**

Georgia's critical incident reporting systems serves participants through the existing HCBS waivers, including the Elderly and Disabled Waivers (CCSP and SOURCE), the Independent Care Waiver Program (ICWP) and the NOW and COMP Waiver Programs. This section describes how critical incidents are reported and investigated and the processes for receiving and reviewing critical incident reports, assuring follow up is implemented, and how incident reports are used in continuous quality improvement.

Critical incidents are defined in each 1915c waiver application and include factors that threaten or result in failure to maintain a safe and humane environment for participants. Factors that are defined and reported as sentinel events/critical incidents include allegations of abuse, neglect, exploitation, hospitalizations, emergency room visits, deaths, deaths determined to be due to abuse, neglect, or exploitation, deaths in which a breakdown in the 24-hour back-up system was a contributing factor, involvement with criminal justice system, medication administration errors, and other critical incidents to be identified by CMS, the MFP Compliance Monitor or the MFP Project Director. Refer to section *B.6 Consumer Supports* and *B.8 Quality Management Systems* for details on the operation, monitoring, tracking and reporting of critical incidents related to the use of 24/7 Emergency Backup systems. Under state law, all health care providers and their staff/volunteers are mandated reporters of abuse, neglect, and/or exploitation. These incidents are reported to waiver program managers at the operating agency (DHS, DBHDD, or DCH). For incidents involving MFP participants, TCs and CEs complete an *MFP Sentinel Event report* and submit it to the DCH MFP Office (see *Appendix AB: MFP Sentinel Event Form*). Incidents involving MFP youth with mental illness must be reported to the DCH MFP Compliance Monitor and Project Director and the DCH Behavioral Health Director.

## **Critical Incident Reporting Systems for All MFP Participants**

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

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

- Calling 911 or other emergency numbers to obtain immediate medical or law enforcement interventions if needed
- Provision of immediate and ongoing medical intervention if required
- Immediate implementation of measures to protect the health, safety and/or rights of the individual, including relocation of the participant to another facility or program if needed

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- Notification, as appropriate (including written notifications where required), of to family, guardian, next of kin, or emergency contact indicated in the participant service record, and to waiver case manager/care coordinator/support coordinator
- Reporting of the incident to the waiver operating agency (DHS, DBHDD, or DCH)
- As appropriate, additional reporting of the incident to licensure and/or certification agencies, Adult or Child Protective Services, local law enforcement agencies, and DCH Program Integrity
- Investigation of the incident by the provider agency and case manager at a minimum and any of the above entities as applicable
- Written report of the findings of the investigation to the operating agency
- Submission of a written plan of action
- As needed, on-site inspection of the facility/program to assure the plan of action is implemented
- Review of all incidents in regularly scheduled joint meetings of DCH, DHS, and DBHDD
- Analysis of incident data to identify systemic changes needed to prevent recurrences, such as revision to state policies and procedures.

In addition to the above procedures, MFP participants' critical incidents are tracked and reported by MFP field personnel (MDSQ OCs, MFP TCs and CEs/PLAs) and office staff within each respective agency using the *MFP Sentinel Event report*. The completed form is submitted to the DCH MFP office and reviewed by the MFP Compliance Monitor and Project Director (*see Appendix AB: MFP Sentinel Event Form*). MFP field personnel are required to report on the following sentinel events/critical incidents experienced by MFP participants: abuse, neglect, exploitation, hospitalizations, emergency room visits, deaths, deaths determined to be due to abuse, neglect, or exploitation, deaths in which a breakdown in the 24-hour back-up system was a contributing factor, involvement with criminal justice system, medication administration errors, and other critical incidents to be identified by CMS, the MFP Compliance Monitor or the MFP Project Director. Refer to section B.6 for details on the operation and monitoring of 24/7 Emergency Backup systems. The Sentinel Event Action Plan is required to include strategies and services available through MFP that can be used to prevent or reduce the occurrence and/or severity of future events. Field personnel are required to institute process improvement and evaluate the effectiveness of such processes in an effort to reduce risk to participants. Process improvement plans are reviewed by the Compliance Monitor and are reported quarterly in aggregate to the MFP Project Evaluation Advisory Team to identify trends and to develop a plan for continuous quality improvement. The MFP Evaluation Advisory Team is tasked with the development of needed policy and/or procedure revisions related to the reduction of SEs.

Providers of services to MFP CBAY youth with mental illness have a formal written critical incident reporting procedure that meets DBHDD policy requirements. Community providers report serious incidents promptly and investigate them in order to identify problems and develop effective corrective actions that will reduce

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future incidents. MFP participants' critical incidents are reported by Care Coordinators using the *MFP Sentinel Event report*. In addition to those entities identified in policy who are required to receive serious incident reports, serious incidents involving MFP youth must be reported to the DCH MFP Compliance Monitor and Project Director and the DCH Behavioral Health Director. In all cases, the DBHDD Regional Coordinator may also conduct his/her own investigation when circumstances warrant.

The Sentinel Event Action Plan is required to include strategies and services available through MFP that can be used to prevent or reduce the occurrence and/or severity of future events. Care Coordinators with the DBHDD MFP Coordinator and in conjunction with the CBAY Quality Council are required to institute process improvement and evaluate the effectiveness of such processes in an effort to reduce risk to participants.

### ***B.3 Outreach, Marketing, Education and Training***

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

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

In conjunction with the Balancing Incentives Program (BIP), the overall goal of on-going outreach, marketing, and education is that all points-of-entry and information and referral networks provide accurate information about MFP and HCBS waiver programs. Through the interagency agreement with the Department of Human Services, Division of Aging Services (DHS/DAS), the 12 Regional Aging and Disability Resource Connections (ADRCs) provide education, outreach and marketing to state agency staff and nursing home staff. As Georgia's designated "local contact agencies," ADRCs implement, monitor and improve the effectiveness of the MDS Section Q referral process. The interagency agreement with DHS/DAS and the 12 Regional ADRCs serves to increase and improve access to resources in home and community based settings. The interagency agreement aligns MFP and BIP with the goal of helping to rebalance the state's LTSS system.

Nursing facilities contact their ADRC representative, DHS/DAS, Long-Term Care Ombudsman (LTCO) or DCH/MFP when a nursing facility resident expresses a desire to leave the facility either verbally or during completion of the MDS. ADRC Options Counselors (MDSQ OCs) educate nursing facility residents and facility discharge staff regarding available LTSS options in the community. MDSQ OCs screen interested individuals and provide information about MFP, or if the information seeker doesn't meet MFP eligibility criteria, OCs refers to other LTSS and HCBS options. OCs develop collaborative relationships with MFP TCs and state office staff, and are part of the network of community partners providing outreach on the MFP. In addition to an existing statewide structure and knowledgeable and professional staff, Georgia's ADRCs maintain a well-developed and constantly updated resource database that includes LTSS and other home and community-based resources (follow the link to: [Georgiaservicesforseniors.org](http://Georgiaservicesforseniors.org)). This extensive database places MFP field personnel in an ideal position to provide comprehensive MFP, LTSS and HCBS information.

DHS/DAS has developed a system of reporting and feedback to continuously monitor the quality of options counseling and transition coordination. Both the Division of Aging Services and the state Medicaid office have access to DCH Program Integrity units responsible for the development of continuous quality improvement measures and tracking systems and this resource will be included as a method of ensuring quality service delivery. 92% of Medicaid nursing homes have made at least one MDS Section Q referral. Of the 2770 MDSQ referrals made during

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SFY2014, slightly less than 10% met MFP eligibility criteria, were consented and became MFP participants. DAS is developing outreach targeting nursing facilities that have not made MDSQ referrals.

DBHDD provides on-going outreach, marketing and education from both the state office and regional offices. Information about MFP services has been added to DBHDD marketing and outreach tools and is shared with potential participants, families, caregivers and service providers to provide an overview of the MFP demonstration project, benefits, activities, and rights and responsibilities of participants once enrolled.

### **The Expanded Role of Long-term Care Ombudsmen (LTCO)**

The State Office of the Long-Term Care Ombudsman seeks to improve the quality of life for institutional residents of long-term care facilities (nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities – ICF/IIDDs, personal care homes, assisted living centers, and community living arrangements). The LTCO State Office certifies and trains community ombudsmen who work to resolve concerns of long-term care facility residents statewide, including those of MFP residents engaged in the MFP transition process.

For example, residents who wish to relocate from a nursing home frequently tell their local LTCO. The resident may already have indicated this desire during the MDS Section Q interview. When problems occur in the resident's plans to transition, such as unreturned phone calls, conflicting information, interference by facility staff and family, and other complaints, local LTCOs are a trusted source for the resident to report a complaint and seek action to resolve the complaint.

LTCOs have historically supported MFP policy and have participated in the demonstration project in three of the twelve LTCO regions in Georgia. With the reauthorization of MFP under ACA, LTCOs are utilized in the process across the state. With MDS Section Q implementation, LTCOs face new demands to respond to inquiries from residents, family members, providers, and other professionals about the relocation process and non-institutional residential options.

Based on the interagency agreement with DHS/DAS, administrative funds provide for a fulltime staff person to oversee LTCO activities related to Section Q implementation, training for local LTCOs including trainings with partners such as Aging and Disability Resource Connections (ADRCs) staffs, Centers for Independent Living (CILs) staffs, Department of Community Health (DCH) staff and others, and reimbursement to LTCO programs for MFP-related activities, including but not limited to advocacy (assistance with problem identification and barrier removal) to ensure that Section Q referrals are being received by MFP field personnel from licensed long-term care facilities, that MFP screening and transition planning processes are being conducted, and that transitions are occurring according to the ITP/ISP or similar transition plan.

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Through Area Agencies on Aging (AAAs), the Georgia LTCO Program contracts with 13 local LTCO programs to provide advocacy, outreach and education services to residents in licensed long-term care facilities across the state. ADRCs that serve as the **local contact agency** (LCA) in Georgia and AAAs view the LTCO program as a resource for responding in-person to requests for help from residents of long-term care facilities. LTCOs are needed to:

- Provide advocacy, options counseling and education about MDS Section Q and MFP screening, planning and transition processes,
- inform residents about their rights, and inform family members and providers about resident's rights; and
- Work to resolve residents' complaints.

LTCOs maintain positive working relationships with licensed long-term care facility staffs and the LCAs to assist with successful relocations. With these relationships, LTCOs are uniquely qualified to negotiate among facility staff, relocation staff, family members and residents when barriers are encountered. Because LTCOs make a minimum of quarterly visits to all skilled nursing facilities, and in many cases make monthly or more frequent visits, residents have access to an advocate who will carry messages on the resident's behalf to all necessary parties and make every effort to resolve complaints to the satisfaction of the resident.

As specified in Section 712(d) of the Older Americans Act, LTCOs must not disclose identifying information about a resident of a skilled nursing facility without the resident's consent. Furthermore, residents are protected by law from retaliation for voicing complaints. Including LTCOs in the implementation of MDS Section Q and MFP assures residents they have a trusted advocate to assist them if problems arise.

The Georgia LTCO program has statewide capacity to provide support to residents who wish to relocate from a licensed long-term care facility to the community.

- LTCOs support residents by providing counseling and education about the MFP process and other community living options to residents, family, and facility staff. LTCOs are required to provide education and counseling as well as complaint resolution services to residents of licensed long-term care facilities.
- Collaboration between the LTCO programs, the ADRCs as the LCA and the state Medicaid agency administering the grant are important for the success of and quality improvement process of the MFP Demonstration.

The involvement of LTCOs in the MFP process has improved the overall effectiveness of the Georgia MFP demonstration grant. As Georgia strives to meet its transition goal of 2,970 by 2018, LTCOs are in a position to assist with educating and advocating for residents, families and facility staff about the program. Residents trust LTCOs to advocate on their behalf and to assist with complaint resolution throughout the relocation process. As a third party advocate, LTCOs receive concerns from all parties and work with necessary entities on behalf of the

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resident to remove barriers and ensure the resident has access to available benefits and services. Regardless of the source of a complaint, the LTCO takes direction from the resident, thus ensuring an individualized relocation plan and improving the resident's chances of successful resettlement in the community.

As Section Q continues to generate new inquiries from residents with all levels of need and income, an LTCO is needed to provide an in-person response for many of these residents. The LTCO's visits will reduce stress on the resident, assist in referrals to ADRCs, improve accountability of licensed long-term care facility staff, and provide all parties with an additional resource during relocation.

See also *B.5 Benefits and Services*, for a description of *Home Care Ombudsman* (HCO) services for MFP participants after discharge from the inpatient/institutional setting.

### **MFP Targeted Outreach and Marketing**

Area Agencies on Aging (AAAs) provide information seekers with information about Elderly and Disabled Waiver services, and if the person doesn't qualify, the AAA makes a referral to another appropriate waiver or state service. Depending on the information seeker's situation, s/he will be directed to the appropriate point-of-entry. To achieve this goal, DCH is using BIP and MFP to focus on developing systematic outreach through all points-of-entry and Information & Referral networks.

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

Targeted outreach about MFP proceeds through a proactive process of face-to-face communication, relationship building, presentations, informational forums, interagency meetings, training presentations, marketing and outreach materials (*Appendix C: MFP Tri-Fold Recruiting Brochure and Appendix E: Home and Community Services, A Guide to Medicaid Services in Georgia and Appendix H: MFP Participant Transition Planning Guide*). Materials are written in plain English for better understanding for persons with cognitive impairments. Materials will be translated as needed into Spanish and other languages as provided by DHS's Limited English Proficient and Sensory Impaired Customer Services Office), including the availability in alternative formats for individuals with sight, visual, and hearing impairments.

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

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

MFP has supplemented and expanded current Olmstead Initiative and waiver outreach, marketing and education strategies:

### **Outreach to Older Adults**

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

### **Outreach to Persons with Physical Disabilities/TBI**

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

### **Outreach to IIDD**

DD/MFP Planning List Administrators and Case Expeditors expand on the outreach, marketing, and education efforts of DBHDD, the Governor's Council on Individuals

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with Intellectual or Developmental Disabilities (GCDD), People First Georgia, the Association of Retarded Citizens, Community Service Boards, regional and local service provider networks.

### **Outreach to MFP CBAY Youth with Mental Illness**

Targeted activities will proceed through a proactive outreach to the C&A service system provider network, Care Management Entities, youth and families and other stakeholders to market this new service option and educate about how this program will align and differ from CBAY waiver processes. These activities began with a public information session led by DBHDD to introduce MFP CBAY to this new audience.

A work plan continues to build on that introduction to continue communication efforts with stakeholders as well as make the necessary modifications to written policies, applications, forms, and training modules. The work plan additionally includes training to the ERO, Crisis Stabilization centers, and PRTF providers to familiarize them with new policies and protocol and educate on revised roles and responsibilities. Presentations to sister child-serving agencies and advocates have been conducted to ensure public awareness.

### **Outreach and Recruiting using HCBS Booklets**

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

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

- Community Alternatives
- Medicaid
- How to Apply for Medicaid Home and Community-Based Waiver Services
- Each Medicaid Waiver program

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- Money Follows the Person (MFP)
- What's covered and not covered by Medicaid
- Individual's Rights and Responsibilities
- Contact Information (e.g. county health departments, Area Agencies on Aging and other aging entry points, Regional DBHDD offices and the Social Security Administration)

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

DBHDD provides Regional Transition Staff with an electronic file version of the booklet and MFP materials. Local outreach teams add local contact information and arrange for printing and distribution. The information identifies the MFP demonstration program as a collaborative effort between the state, the Federal Government, and local communities. Local contact information ensures that response is timely and reflective of the locally coordinated MFP activities.

### **MFP Informational Recruiting Brochure**

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

- What MFP is, who is involved and who to contact for more information,
- MFP transition services,
- Information on MFP environmental modifications,
- person-centered planning and circles of support,
- enrollment in HCBS waivers,
- participant services and supports,
- self-direction,

The brochure and poster are the primary tools used to recruit MFP participants. MDSQ OCs, MFP TCs and DBHDD-DDD Regional Transition Staff recruit participants in targeted locations (nursing homes, ICF/IIDDs, inpatient facility lobbies, resident councils, etc.) by placing brochures and posters in conspicuous areas in facilities, and leaving them with residents and staff. MFP community transition teams (i.e. MFP transition coordinators, DDD Regional transition staff, peer support networks,

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LTC ombudsmen, waiver case managers, community vendors and providers) distribute the MFP informational brochure according to their outreach and marketing strategies based on their targeted populations. MDSQ OCs, MFP TCs and Regional Transition Staff use the informational brochure to recruit potential participants during the face-to-face interviews to explain MFP and HCBS waiver services.

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

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

### **Effective Use of the MFP Website**

The creation of a link to the Georgia Money Follows the Person Demonstration ([www.dch.georgia.gov/mfp](http://www.dch.georgia.gov/mfp)) project on the DCH website demonstrates to potential participants, their communities and families, that the project is state and federally sanctioned. Topics covered on the site are the same as topics covered in the MFP Informational Brochure to ensure consistency of information and to provide the ability to easily navigate and locate information about MFP and HCBS Waivers. Information about Demonstration activities are regularly updated. The MFP website also contains links to relevant reports, studies, resources, organizations, training programs and DCH and community services.

### **DCH/MFP Competency-Based Training (CBT) Plan**

MFP training workgroup comprised of MFP steering committee members, DCH waiver specialists, DHS/DAS, and DBHDD-DDD and DBHDD-CBAY stakeholders, collaborated to develop competency-based training and delivered training sessions in 2008 - 2011. MFP field personnel received initial training in July 2011. In addition to core competency training, other groups received training, including HCBS case managers, DBHDD, AAAs, ADRCs and CIL staffers. This training developed the following core competencies (KSA – knowledge, skills and attitudes):

- MFP scope, benchmarks, eligibility criteria and transition services,
- MFP Outreach and responding to referrals from Point-of-entry and MDSQ
- Dignity of risk, independent living philosophy, CILs, and dependency,

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- History of institutionalization of people with disabilities and disability etiquette,
- Olmstead, guardianship, and resident rights,
- Assisting participants with LTC and Community Ombudsman services,
- Informed consent and completing the MFP Screening Form
- Waiver eligibility criteria, service options, and completing applications,
- Person-centered planning, completing the MFP Individualized Transition Plan,
- MFP Complaint processes and critical incident reporting,
- Assisting participants with Peer Community Support and Life Skills Coaching,
- Assisting participants to use tools to locate affordable, accessible and integrated housing,
- Assisting participants to complete applications for Housing Choice Vouchers,
- MFP Environmental modification services and working with home inspectors and licensed contractors,
- Customer Service, follow-up and conducting the Quality of Life survey, and
- MFP reporting and documentation requirements, including maintaining protected health information (PHI) in accordance with HIPAA regulations.

Ongoing training develops the following specialized competencies using a variety of delivery methods:

- Procurement of specialized medical equipment and assistive technology,
- Assisting participants to use MFP Life Skills Coaching and Independent Living Skill training services.
- MFP Environmental modification services and working with home inspectors and licensed contractors,
- Team approaches for working with waiver case managers, professionals and advocates working on resettlement,
- Authorizing MFP service expenditures, reporting and documentation,
- Assisting participants to locate and use MFP and local employment services.

### **Additional Education and Training that includes MFP**

The Department of Human Services, Division of Aging Services (DHS/DAS) conducts quarterly trainings for MDSQ OCs and MFP TCs at each of the 12 regional Area Agencies on Aging and provides 'cross-waiver' trainings to the AAAs, ADRCs and service provider networks. Centers for Independent Living (CILs) and ADRCs are ideal agencies to receive cross-waiver training to help them market and educate consumers about MFP/waivers. DHS/DAS develops and provides ongoing training about MFP through AAA/Gateway/ ADRCs/service provider networks to train professionals, managers and front-line staff to make appropriate referrals for MFP screenings. In addition, MDSQ OCs and MFP TCs work closely with AAAs, ADRCs, CILs and service provider field staff to continue to improve MFP and link MFP participants to local community resources. Because CILs provide a number of core services (i.e. information and referral, peer support, advocacy, independent living skills training), MFP TCs have been trained to inform participants about local CILs and link participants with CIL peer support networks for assistance during transition.

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

### **B.4 Stakeholder Involvement**

This section describes the roles and responsibilities of consumers/participants, institutional, and other key stakeholders in the design, implementation, and evaluation of the Georgia MFP demonstration project. The State assures the continued involvement of MFP participants/family members, consumers/advocates, institutional and other key stakeholders through involvement in 1) MFP Working Groups, 2) Stakeholder Forms, 3) Quarterly Steering Committee Meetings, and 4) surveys, interviews and trainings. Beginning with the Nursing Home Transition Grant in 2004, the Department of Community Health (DCH) has been engaged in Long-term Care systems transformation with a broad coalition of Georgia stakeholders. Georgia has taken concrete steps to create new and sustainable public processes designed to involve stakeholders in HCBS waiver research, planning, implementation, and evaluation.

#### **MFP Working Groups and Initial Design of the MFP Demonstration**

DCH received notice of MFP funding in May 2007 and re-convened its MFP steering committee on June 22, 2007. The steering committee, initially formed to prepare the Georgia MFP application *Call to Action*, decided to retain the broad coalition to use stakeholders' expertise and leverage resources outside DCH. According to the Request for Proposals (RFP) submitted to Centers for Medicare and Medicaid Services (CMS), the DCH Chief of Medicaid, the Deputy Director and the steering committee determined that the project design would be that of a demonstration with an enhanced service package. MFP participants would enter an existing HCBS waiver and receive an enhanced package of MFP demonstration services post-discharge for the MFP period of participation. Waiver services would continue to be provided after the MFP demonstration ended.

A project director was hired and a project team was assembled. A project charter, scope statement and business objectives were created and approved by executive management. To obtain broad stakeholder involvement in the design, development, implementation, and evaluation of the Georgia demonstration, MFP Working Groups were convened to develop specific project design elements. Working groups were appointed at a joint meeting of the Chief of Medicaid and the Commissioners from DCH, DBHDD and DHS. The appointments were made to 1) leverage resources of partner agencies, 2) draw upon the experiences of the Nursing Home Transition Grant, and 3) draw on the expertise of the advocacy community. MFP working group met regularly to develop the tools and define the processes necessary to implement MFP. Each working group focused on the development of one of the following operational elements:

- Element 1: Outreach, Marketing and Referral Processes
- Element 2: Transition Coordination Tools and Processes
- Element 3: MFP Participant Tracking and Fiscal Service Processes
- Element 4: MFP Contractor Training
- Element 5: Quality Management Systems (QMS)/Project Evaluation
- Element 6: Affordable, Accessible, Supportive and Integrated Housing

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As the Demonstration moved from the design phase to implementation/executing and monitoring/controlling phases, these working groups were re-organized to focus on the need for monitoring project outputs, outcomes and impact, addressing issues/problems and recommending changes to policy and procedures and engaging in continuous quality improvement. Currently the following are operational –

<b>Name</b>	<b>Meeting Frequency</b>	<b>DCH MFP Convener</b>	<b>Charge/Issues</b>
<b>Steering Committee and Stakeholder Forums</b>	Quarterly	Project Director	All project issues from other subcommittees, recommends changes to policy and procedures
<b>Project Evaluation Advisory Team</b>	Quarterly	Project Director and External Evaluator	Collection, analysis and reporting of QoL survey data; Analysis of MFP demonstration services use; Logic Model Measures of outputs, outcomes and impacts
<b>Housing Subcommittee</b>	Semi-Annual and Ad Hoc	MFP Housing Manager	Housing and related issues
<b>Marketing and Awareness Subcommittee</b>	Semi-Annual and Ad Hoc	MFP Data Specialist	Project Marketing & Outreach
<b>Quality Assurance Subcommittee</b>	Semi-Annual and Ad Hoc	MFP Federal Reporting Manager	Project Quality Management, Federal Reporting
<b>Training and Employment Subcommittee</b>	Semi-Annual and Ad Hoc	MFP Planning & Policy Specialist	Contractor Training; Direct Services Workforce Development and Participant Employment Initiative

### **Stakeholder Forums and the Development of the Operational Protocol**

To obtain broad stakeholder involvement in the design of the MFP Demonstration, a series of stakeholder forums were convened to collect and analyze project/customer/stakeholder requirements. In addition to the large and diverse steering committee, a purposeful sample of Home and Community Based Service (HCBS) waiver participants (participants/guardians, family members/caregivers) were recruited, from which systematic data could be collected and analyzed for input into the design of the Demonstration and the development of the MFP Operational Protocol. Eight stakeholder forums were convened in five different

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regions of the state. During these stakeholder forums, participants were asked to engage in various types of activities (i.e. idea generation and consensus building) and focused discussions. As is the case with participation/action research methods, several steps were followed to collect, analyze, synthesize and report on the results of stakeholder engagement.

Stakeholder forums were conducted in the following manner:

- Step 1: Targeted stakeholder outreach and recruitment was undertaken.
- Step 2: Forum facilitators (MFP staff members) developed activity and discussion guides used to conduct stakeholder forums.
- Step 3: Stakeholder forums were convened around the state.
- Step 4: Stakeholder input and comments were collected and content analyzed.
- Step 5: Reports were prepared and reviewed by stakeholders.
- Step 6: System/customer requirements were generated.
- Step 7: MFP Operational Protocol was prepared and reviewed by stakeholders.

### **Targeted Outreach and Recruiting**

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

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

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

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**Table B.4.1 Customer/Consumer Forum Involvement/Demographics**

Location & Date	Disability Connectio ns, Macon 11/16/07	disABILITY Link, Decatur 12/07/07	Walton Options, Augusta 01/11/08	LIFE, Savannah 01/18/08	BAIN, Bainbridge 01/25/08	Total
<b>Gender</b>						
Females	5	4	10	1	4	24
Males	5	9	6	6	5	31
Total	10	13	16	7	9	55
<b>Primary Disability</b>						
Elder	1	0	0	1	0	2
Blind	1	2	1	0	0	4
Physical Disability/ABI	6	9	13	5	7	40
Developmental Disability	2	1	2	1	1	7
Mental Health	0	1	0	0	1	2
Total	10	13	16	7	9	55
<b>Living Situation</b>						
Nursing Home	1	0	2	4	3	10
Assisted Living Facility	0	0	4	0	1	5
Personal Care Home	0	1	1	0	1	3
Apartment	5	4	2	2	4	17
House	4	6	7	1	0	18
Not disclosed	0	2	0	0	0	2
Total	10	13	16	7	9	55
<b>Waiver Use</b>						
Waiting (housing/slot)	1	0	0	4	6	11
SOURCE	3	2	0	0	0	5
CCSP	0	0	2	1	0	3
ICWP	4	8	9	2	0	23
MRWP	0	1	1	0	0	2
Not using a waiver	2	2	4	0	3	11
Total	10	13	16	7	9	55

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

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**Table B.4.2 Steering Committee Stakeholder Forum Demographics**

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

Currently, the MFP Steering Committee holds quarterly scheduled meetings and is composed of representatives from all stakeholder groups including:

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

Outreach to the Social Security Administration, the Georgia Department of Labor and Division of Vocational Rehabilitation is continuing in an effort to solicit participation from these groups. Finally, outreach to regional transportation planners is underway to involve these providers. For a complete listing, see *Appendix A1: Georgia's MFP Stakeholders Listing by Company Name*.

The Table below provides more detail about the current makeup of the Steering Committee by number of persons and the composition of the group. Not all MFP Steering Committee members attend every meeting, but consumers, CIL reps and professional advocates tend to attend in larger numbers than other groups.

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**Table B.4.3 Current MFP Steering Committee Members by Category/Group**

AAA/ ADRC Staff	Legal, Advocate, CIL, LTCO	DCH Staff	DBHD D DD Staff	DHS DAS Staff	Regulatory, DFCS	State Govt, Evaluation	CMS/ SSA/ Labor/ DVR	Referral/ Provider/ Vendor	Housing DCA, PHAs
15	74	12	10	10	5	6	4	36	8

## Stakeholder Forums Develop the Operational Protocol

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

## Systematic Data Collection

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

## Stakeholder Requirements for the Demonstration

Facilitators worked together to analyze stakeholder input in a process referred to as content analysis. This involved sifting and sorting comments and preparing topical summaries. Summaries were revised based on reviews with stakeholders. Using the summary reports, stakeholder requirements were generated for the design of the Demonstration. The design was described in detail in the Operational Protocol. These requirements can be found throughout the sections of the MFP OP. The MFP OP was reviewed by steering committee members at the official kickoff meeting on April 8, 2008, at a forum in Macon, Georgia. The protocol was subsequently revised and represented the ideas and views of stakeholders (e.g. Medicaid members/family members, professionals, advocates, etc.) regarding the design, development and implementation/operation of the MFP demonstration.

As the MFP demonstration was executed and operations began, processes for continuous quality improvement were implemented including a project logic model to identify and measure MFP outputs, outcomes and impacts. DCH MFP project personnel engaged in a number of planning, executing, monitoring and controlling activities, including, creating the project scope and work breakdown structure, engaging in procurement and contracts processes (RFQC), determining quality standards, creating a Policy and Procedures Manual to ensure quality contractor operations, identifying project communication requirements, identifying and

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analyzing project risks and planning responses including contractor training, implementing a project requirement 'change order' process, holding progress meetings and participating in project audits and CMS site visits.

*Revisions to the Operational Protocol are made available to current MFP Steering Committee members for review and comment. The protocol includes revisions based on stakeholder requirements collected and analyzed from meetings with internal and external stakeholders, contractors and MFP Steering Committee and Evaluation Team members during the last year. Three issues surfaced including,*

- Problems with the Individualized Transition Plan (ITP) process and time frames for contract deliverables
- Delays in contract reimbursement for deliverables due to delays in documentation being received by DCH MFP
- The need for more flexibility in spending for MFP demonstration services, i.e. the removal of individual caps on MFP demonstration services and the implementation of participant self-direction/budget authority.

As approved or rejected by CMS, these issues have been addressed in the revisions to the Operational Protocol and will be addressed in revisions to the Policy and Procedures Manual.

### **Ongoing and Future Stakeholder Involvement**

Ongoing stakeholder involvement continues using similar methods. Quarterly steering committee meetings continue to be open to the general public in an effort to improve project communications and maintain transparency. The MFP steering committee and MFP Evaluation Advisory Team meet on a quarterly basis, to review project performance, provide guidance on project evaluation activities and make recommendations for changes to policy and procedures.

For example, the MFP Housing Subcommittee has undertaken several initiatives to increase access to affordable, accessible, and integrated housing. The Training and Employment Subcommittee meets to review training plans and training materials prior to implementation. Other working group sessions continue to be conducted on an Ad Hoc basis, using a variety of methods, including conference calls and meetings, as major revisions to policies and procedures are needed.

As part of the PRTF Waiver/CBAY Sustainability planning in anticipation of the end of the CBAY Waiver demonstration project, families, advocates and providers were provided multiple avenues for guiding the design of services for youth with mental illness afforded through the MFP program. Focus interviews were held with various stakeholder groups to include the Children's Health Insurance Program Reauthorization Act Stakeholders advisory committee, the State Mental Health Planning and Advisory Council, and the CBAY Quality Council, which includes waiver providers, PRTF providers, community providers, and families. A subset of various stakeholders met with the DCH to present findings and recommendations from the waiver demonstration experience. As a result, the services that now comprise the scope of MFP services for youth with mental illness were refined based on

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utilization, participant feedback, and in consideration of the most current national research on evidence-based practices.

Through the next two years of the demonstration, stakeholders will be asked to provide input using forums, work groups, surveys, interviews, observations, and trainings. MFP participants, family members, and caregivers will be asked to participate in stakeholder forums and to provide encouragement and support, such as sharing experiences, to MFP members resettling in the community.

As needed, to insure full participation of stakeholders, meetings are being held throughout the state in accessible venues, requests for reasonable accommodations are being provided and transportation costs incurred by consumers that attend these meetings are reimbursed, if requested. These participatory methods strengthen MFP, empower full and direct consumer participation, and assist the state to identify areas of development and improvement. Openness, transparency and sustainability are the hallmarks of Georgia MFP. Methods that actively engaged stakeholders are necessary to produce the highest quality participant transition experience, engage in continuous quality improvement, identify lessons learned and recommend permanent services, policies and procedures that should be operationalized in Georgia Medicaid.

## **B.5 Benefits and Services**

This section describes 1) service systems used for the delivery of MFP demonstration and supplemental services, qualified HCBS waiver services and state-plan services for MFP populations served, 2) assurances that MFP participants will by-pass any waiver waiting lists due to 'reserved capacity' available in HCBS waivers, and 3) a listing with billable units and rates paid for each MFP demonstration service. The state is seeking the enhanced match for MFP demonstration and supplemental services, qualified waiver services and State Plan services provided to MFP participants.

As was discussed in Section *B.1 Participant Recruitment and Enrollment*, DCH has Interagency Agreements in place for the operation of the MFP Demonstration with the Department of Human Services/Division of Aging Services (DHS/DAS), the Department of Behavioral Health and Developmental Disabilities/Division of Developmental Disabilities (DBHDD/DDD) and the DBHDD-Division of Community Mental Health, Community Based Alternatives for Youth (DBHDD-DCAS/CBAY).

Under these agreements, MFP field personnel recruit participants for the MFP demonstration and for waiver services that are appropriate and that meet participants needs. The work of MFP field personnel and project office staff is funded using 100% MFP grant funds (administrative). While options counseling and transition coordination services are provided through administrative mechanisms, MFP demonstration and supplemental services are provided using fee-for-service mechanisms.

MFP demonstration services offered to participants are authorized by MFP field personnel (MDSQ OCs, MFP TCs, PLAs, and/or CEs) and tracked by the Fiscal Intermediary, and reported to DCH. Interagency agreements require DHS/DAS, DBHDD/DDD and DBHDD/DCMH/CBAY to maintain documentation and a tracking mechanism that ensures accountability for utilization of MFP services.

### **Delivery of MFP Demonstration Services to Older Adults and Participants with Physical Disability/TBI**

MFP demonstration services are delivered using fee-for-service mechanisms, based on person-centered approaches. Each MFP participant is assisted to match MFP services with goals, needs and resources. MFP services have individual service caps. If a documented need should arise, the MFP project director can on a case-by-case basis, approve additional funds for specific services by allowing two services to be combined, but the combined caps cannot be exceeded. MFP TCs authorize MFP services based on person-centered planning as documented and justified in the Transition Plan (ITP/ISP). Transition planning must include an individually calculated budget amount for each authorized MFP service based on the rate of the fee-for-service (see *Appendix B: MFP Services and Rate Table Revised 030615* and *Appendix S: Authorization of MFP Transition Services*). In brief, the transition planning process includes the following steps –

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1. While an inpatient, potential candidates are provided with information about MFP and HCBS (*Appendix C, E*)
2. Participant signs the MFP Consent and Release of Health Information and is screened, including but not limited to an assessment of social needs, healthcare needs, medical equipment needs, functional assessment using the DON-R, a determination of housing needs, waiver service history (if any), and financial resources (see *Appendices G, D1, D2*)
3. Participant is assisted in convening transition team (circle-of-friends) and is assisted to complete a wavier application as appropriate.
4. During the person-centered planning process, the participant's needs are reviewed based on information from the Screening/DON-R and the participant's preferences and goals are identified and discussed. The transition team (circle-of-friends) assist the participant to identify resources, held by the participant, available through the circle-of-support, available in the community, and services and support available through State Plan Medicaid, 1915c waiver and the MFP Demonstration (see *Appendix O*),
5. Participant is assisted with completion of the MFP Individualized Transition Plan (ITP), based on results of the Screening/DON-R and identified goals, resources and plans to achieve goals (see *Appendix O*)
6. Based on goals as stated in the ITP, the participant is assisted to identify appropriate MFP demonstration services necessary to progress toward goals and improve function and to calculate a budget for each identified demonstration service that stays within the individual service cap (see *Appendix B*)
7. Participant is assessed for appropriate waiver and waiver services, through a comprehensive waiver assessment process,
8. Participant receives an acceptance/denial letter regarding the waiver assessment process. If accepted by the waiver, the letter informs the participant about the waiver services for which she/he is qualified; the participant selects a waiver case manager from a list of providers.
9. MFP field personnel authorize MFP services (*Appendix S*) based on assessment of functional needs and the goals as set in the ITP, the results of person centered planning and a review process with the transition team. The waiver case manager/care coordinator authorizes the services in the waiver service plan (ISP).
10. Most participants discharge from the institution and enter an appropriate waiver (*Appendix R*)
11. Vendor(s) are identified for the delivery of MFP demonstration services and provide quotes (where required) (*Appendix T*)
12. Vendors deliver MFP demonstration services and complete documents necessary for reimbursement through Fiscal Intermediary (FI) (*Appendix U*)
13. MFP field personnel authorize payment from FI to vendor (*Appendix V*)
14. DCH accounting uses MFP Demonstration funds to reimburse FI (*Appendix O*)

### **Delivery of MFP Demonstration Services to Participants with IDD**

The process is similar for the delivery of MFP services to participants with intellectual and developmental disabilities entering either the NOW or COMP waiver.

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Reimbursement procedures are handled through the Office of Developmental Disabilities within DBHDD-DDD. Essentially, DBHDD-DDD uses state general revenues to provide 'up-front' funding to vendors for MFP services. The DBHDD-DDD/MFP assessment, planning and reimbursement process includes the following steps –

1. Planning List Administrators or Case Expeditors provide inpatient candidates information about MFP, waiver and state plan services (*Appendix C, E*)
2. Participant is in the ICFIDD and meets MFP and waiver eligibility criteria
3. Participant signs MFP Consent and Release of Health Information (*Appendix D1, D2*)
4. Participant is assisted in convening transition team (circle-of-family/friends) and is assisted to complete a wavier application for the New Options Waiver (NOW) or Comprehensive (COMP) waiver
5. Participant is assessed for waiver services, through a comprehensive waiver assessment process,
6. Participant receives an acceptance/denial letter regarding the waiver assessment process. If accepted by the waiver, the letter informs the participant about the waiver services for which she/he is qualified, and the participant selects a case manager from a list of providers.
7. Participant is assisted with identification of community living goals and the completion of the Person-Centered Description; participant is assisted with development of the Individual Service Plan (ISP) based on the waiver assessment and the goals set in the Person-Centered Description.
8. Based on the services set in the ISP and the goals set in the Person-Centered Description, the Participant identifies and justifies MFP demonstration services; participant is assisted with the selection of a qualified provider for the delivery of all services
9. MFP/DDD staff authorize MFP services (*Appendix S*)
10. Participant discharges from the institution and enters waiver
11. Vendor delivers services and provides DBHDD-DDD with service invoice and supporting documents (*Appendix U*)
12. MFP/DDD staff submit invoice and documents to FI (*Appendix V-DDD*)
13. FI reimburses DBHDD-DDD
14. DCH accounting uses MFP grant funds to reimburse FI (*Appendix O*)

### **Delivery of MFP Demonstration Services to Youth with Mental Illness**

1. Participant is in the PRTF and meets MFP eligibility criteria as determined by the External Review Organization (ERO).
2. PRTF Treatment team provides participants/family information about MFP and community-based services
3. Participant selects MFP, signs MFP Consent and Release of Health Information
4. Participant selects Care Management Entity and Care Coordinator
5. PRTF Treatment Team, now including the Care Coordinator, a Core Behavioral Health Provider representative, and any other members chosen by the family convenes a transition team
6. A youth- and family-centered transition plan/Individualized Service Plan is developed (*see Appendix H*)

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7. The MFP application packet is completed and submitted to the DBHDD-DCMH/CBAY
8. DBHDD-DCMH/MFP CBAY staff authorize MFP CBAY Demonstration services (*Appendix S*)
9. Participant discharges from the institution and enters community-based MFP services (*see Appendix R*)
10. If not selected during initial transition planning, a Family Peer Partner and/or Youth Peer are selected by the participant
11. Providers deliver services according to the initial 14 day transition plan.
12. By Day 14, the Child and Family Team meets to assess, identify additional or different needs, and develop a revised Individualized Service Plan as needed.
13. By Day 30, the Child and Family Team meets again to re-assess, identify additional or different needs, and develop a revised long-term Individualized Service Plan as needed and meets every 30 days thereafter.
14. The initial 14-day and 30-day plans are reviewed and approved by DBHDD-DCMH/MFP CBAY for monitoring and quality assurance and periodically every two months thereafter.
15. Provider delivers services according to each revised plan and bills the FI vendor monthly (*See Appendix U*)
16. FI Vendor submits service invoice and supporting documents to DBHDD-DCMH/MFP CBAY for review and approval (*See Appendix V2*).
17. Upon approval, DBHDD-DCMH/MFP CBAY submits a claim to GAMMIS. The claim is paid based on claims payment processes and mechanisms.
18. DCH accounting procedure uses MFP grant funds to reimburse Medicaid for payments made on behalf of MFP.

### **Delivery of Qualified HCBS Waiver Services to MFP Participants**

Traditional HCBS waiver claims processes and delivery systems are in place for participants entering the MFP demonstration and HCBS waivers. MFP uses 1915c waiver services and MFP transition services to help participants resettle in the community. After their MFP period of participation ends, participants remain eligible for HCBS waivers and state plan services that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, state funded programs, and local community funded services. The state is seeking enhanced match for MFP demonstration services, qualified waiver services and Medicaid State Plan services provided to MFP participants.

### **Person-Centered Planning and Individualized Transition Plans under MFP**

Once MFP candidates have been identified, recruited, and have completed informed consent, field personnel complete the *MFP Transition Screening Form* (*see Appendix G*) or similar during subsequent face-to-face discussions with each prospective participant and anyone the participant wants to include in her/his transition team (circle-of-friends). Field personnel use person-centered planning to identify preferences and goals that are included in the *Individualized Transition Plan* (*see Appendix O*). During the pre-discharge planning phase, MFP participants are linked with community resources, including housing and transportation, and Peer

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Community Support Services as appropriate. The participant is assisted or coached through person-centered planning. The participant leads person-centered planning to the extent possible. Field personnel assist the participant to identify personal and community resources and to select MFP services that match needs and remove barriers. Field personnel assist participants to select and make a referral to a waiver (as appropriate), review functional independence, discuss needed assistance with ADLs/IADLs, personal support service needs, accessibility needs and transportation needs. Participants have the freedom to choose representatives to help them with the planning process (e.g. ombudsman, families, caregivers, or friends).

The results of person-centered planning are used to create the *Transition Plan* (ITP/ISP). Field personnel refer the participant to waiver services (as appropriate) and assist the participant to make contact with the appropriate waiver case management agency (once selected). Field personnel coordinate meetings and face-to-face waiver assessment interviews between the participant and the waiver assessment team. For IIDD MFP participants, this planning process occurs in the ICF and is captured in an Individualized Service Plan. Most IIDD MFP participants enter the NOW or COMP waiver. For youth with mental illness, this planning process occurs in the PRTF and participants/families develop an individualized Action Plan comprised of MFP CBAY demonstration services.

MFP field personnel arrange for a wrap-around set of services and supports to prepare the MFP participant to transition to the community. Field personnel work with waiver case managers/care coordinators to ensure adequacy of services and supports and participant satisfaction. Field personnel are responsible for assembling and facilitating the transition team for each participant, coordinating the array of services and providers that will be needed on or shortly after the move to the community, and arranging the time-sensitive transition services that are needed in order for the participant to resettle, including everything from internal administration of HCBS assessments, to supporting the participant in identifying a personal support network. Participant selection of MFP demonstration services is the cornerstone of the transition process. Participants are assisted to match their goals, needs and resources with available MFP Demonstration services. Recognizing that each individual demonstration service has a cap, participants are assisted to calculate how much of a specific MFP demonstration service will be needed so as not to exceed the individual service cap. Should the need present for additional funding for a MFP Demonstration Service (see Appendix B), the MFP Project Director can authorize the combining or grouping together of several MFP services, providing for flexibility in services and funding based on need.

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

## **The Expanded Role of Long-Term Care Ombudsman (LTCO)**

Under MFP, LTCOs participate in transition planning while the participant remains in the licensed long-term care facility, if requested. LTCO services are offered to all MFP participants, with the exception of those transitioning into a licensed group setting (ombudsmen already make regularly scheduled visits to these locations). When this MFP service is requested, LTCOs make contact with participants in inpatient facilities to review the quality of services, monitor satisfaction, ensure safety and participant choice, and protect participant rights.

## **Current MFP Demonstration and Supplemental Services**

MFP participants receive the following MFP demonstration services. What follows is a brief description of the service, how the service works and rates with billable units. MFP transition services must be authorized. MFP services must be justified in the participant's transition service plan and vendors are required to provide appropriate documentation regarding the delivery of MFP services.

**The Fiscal Intermediary (FI)** provides financial service for payments for the MFP demonstration services offered to enrolled participants. The fee paid for the FI service remains the only 'supplemental' service offered at a regular/non-enhanced FMAP rate. All MFP demonstration services listed below are at an enhanced FMAP rate.

The MFP demonstration services listed below go beyond current waiver services or they are designed to extend waiver services in unique ways. The state implemented the MFP demonstration, in part, to identify appropriate services that when added to current waivers would increase the efficacy of services in achieving desired clinical outcomes and non-clinical community outcomes.

## **Peer Community Support (PES)**

**Description:** This service provides for face-to-face visits to participants for the purpose of discussing transition experiences, problem solving, pursuing leisure and recreational opportunities in the community and building connections to individuals and associations in the community. A case note is required to document each contact. This service is delivered by a QVSP peer supporter. The QVSP peer supporter may also be certified peer specialist through the Georgia Peer Support Network (see <http://www.disabilitylink.org/docs/psp/peersupport.html> for more details)

**How It Works:** As selected and justified in the transition plan, peer supporters engage participants in transition-related activities before, during and after transitions. Peer supporters are typically individuals whose life experience is similar to that of the MFP participant. For example, a peer supporter may have a disability (that may or may not be similar to that of the participant) and may have resided in a nursing facility and have familiarity with the barriers faced during transition. Peer supporters assist participants to build circles-of-friends, identify

and build safety nets (community resources available in times of crisis), review housing options, and/or use available transportation options to engage participants in community activities. Three face-to-face contacts are required, additional contacts can be arranged as needed. Participants have the right to suspend and resume periodic contacts during MFP period of participation.

**Rate:** Based on goals set in ITP/ISP. One unit = one quarter hour contact, billable in quarter-hour increments, at \$12.50 per unit; a maximum of 40 units, for a total not to exceed \$2000; used during the MFP period of participation. Rate includes all costs associated with delivery of service.

### **Trial Visits-Personal Support Services (PSS)**

**Description:** This service provides a brief period of personal support services or residential services during a trial visit to the community before transitioning. The primary purpose of this service is to give the participant an opportunity to manage and direct Personal Support Services (PSS) staff in a qualified residence. On a case-by-case basis, this service can be used post-transition by a participant who's PSS services are arranged but delayed.

**How it works:** As selected and justified in the transition plan, participants use this service to learn to direct Personal Support Services (PSS) staff. Participants may need practice managing PSS staff on a trial basis before leaving an inpatient facility. This service may be particularly helpful for participants who have limited natural supports from family and friends. If a PSS provider has already been identified to provide services through a waiver upon discharge, the participant may wish to use this service to have a trial visit with that provider. However, the hours provided through this service do not affect the number of hours that will be provided through the waiver once the participant has discharged. On rare occasions post-discharge, if the participant's PSS services do not begin within the first 24 hours, this service can be used to fill the service gap.

**PSS Rate:** Based on goals as set in ITP/ISP, this service pays for personal support services during a trial visit to the community. 1 unit of personal support = the current rate provided by the appropriate waiver. The maximum number of trial PSS hours available will vary by waiver, but cannot exceed \$1044 per participant. Service is used during the MFP period of participation. This service provides for PSS visits paid at the current rate funded through the waiver the participant will be entering. For example, participants entering the ICWP waiver can receive trial PSS visits with enrolled ICWP providers at a rate per hour that matches the rate paid in that waiver. Under ICWP, CCSP and SOURCE, PSS hours are not to be provided as continuous 24-hour care, but rather in blocks of time consistent with what the participant will be receiving once living in the community. If this service is used post-discharge, it should be integrated with natural supports when and where available.

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**PCH/CLA Rate:** Based on goals as set in the ITP/ISP, this service pays for residential services during a trial visit to the community. 1 unit of residential services (to be provided through an enrolled waiver Personal Care Home) = the current PCH per day rate. In NOW/COMP, 1 unit of CLSS/CRA = 1 day at the current rate. Not to exceed \$1044 per participant. Service is used during the MFP period of participation.

### **Household Furnishings (HHF)**

**Description:** This service provides assistance to participants requiring basic household furnishings. This service is intended to help the participant with the initial set-up of their qualified residence.

**How It Works:** During the transition planning process, participant's needs are discussed, including identifying any furnishings that they already own (still in their home, in storage, etc.), as well as furnishings available from family, friends, and other sources. As selected and justified in the transition plan, this service details remaining furniture needs and includes them in the transition plan along with tasks for locating and pricing the needed items. Basic household furnishings include but are not limited to items such as: table, chairs, bed, desk, dressers, or large appliances (such as a washer and dryer) that are needed to allow the participant to furnish a qualified residence. This service can be used to obtain basic items such as a personal computer, a printer, a radio or stereo, and/or DVD player that are used by a participant to enhance independence and reduce dependence on service personnel, obtain information related to personal safety, health, welfare, employment and training, communicate, connect with support groups, make medical appointments, order/obtain supplies or groceries, search for resources, arrange transportation services, access weather alert information, attend classes, conduct employment searches or engage in similar activities. Items procured must be functional and based on needs as identified in the ITP. Two quotes are required for purchase of a single piece of equipment costing \$1000 or more. These items are intended for use by or for the participant, and are not intended to replace or upgrade the existing items in the home of a relative. However, it may be necessary to purchase items to supplement those available in the home of a relative in order for the participant to have items available for their own use.

**Rate:** Based on goals as set in ITP/ISP. This service is used during the MFP period of participation. This service is limited to \$1,500 per participant.

### **Household Goods and Supplies (HGS)**

**Description:** This service provides assistance to participants requiring basic household goods (e.g., cookware, toiletries). This service is intended to help the participant with the initial set-up of their qualified residence, but these funds may be used throughout the year in certain

circumstances. This service may include a one-time purchase of groceries (up to \$200) to assist a participant with setting up their qualified residence. Alcohol and tobacco products cannot be purchased with these funds.

**How It Works:** During the transition planning process, participant's needs are discussed, including any household goods and supplies that they already own, as well as items available from family, friends, and other sources. Selected and justified in the transition plan, this service details remaining needs for household goods and includes them in the transition plan. Tasks for locating and pricing needed items are identified and delegated. Basic household goods and supplies include, but are not limited to the following; bedding, towels, washcloths, cooking items, cleaning supplies, plates and silverware, etc. See Appendix P: *Startup Household Goods and Supplies* for a list of recommended household startup items. This table can be used to assist the participant to identify what they already have and what is needed. The participant is encouraged and assisted to shop wisely.

**Rate:** Based on the goals as set in the ITP/ISP. This service is limited to a maximum of \$750 per participant. The purchase of groceries is limited to a one-time purchase of \$200. To be used during the MFP period of participation.

### **Further Guidance on Household Goods for Participants in PCHs**

The Division of Healthcare Facilities Regulation within DCH requires that Personal Care Homes provide certain basic furnishings to all residents, but additional items may be necessary to improve the health, safety and well-being of the participant while living in the PCH. These items might include a wardrobe for storing clothes and personal belongings and/or a desk for reading, writing or preparing work for school or employment.

## **Moving Expenses (MVE)**

**Description:** This service may include rental of a moving van/truck and staff or the use of a moving or delivery service to move a participant's goods to a qualified residence.

**How It Works:** During transition planning, the participant's circle of support is asked to assist the participant on moving day, either through the use of their personal vehicles or by providing labor for moving. Selected and justified in the transition plan, this service can then be used to rent a moving van/truck, a trailer, or pay for the services of a moving company, or delivery fees associated with newly purchased goods, as appropriate. This service provides assistance to participants who need to have their belongings moved to their qualified residence in the community, from where they are located (i.e. the inpatient facility, in storage, with family or friends, or from the place of purchase). Although this service is intended as a one-time set-up service to help establish a qualified residence, under certain circumstances it may be used as needed during the MFP period of participation.

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**Rate:** Based on goals as set in ITP/ISP, to be used during the MFP period of participation, limited to \$850 per participant.

### Utility Deposits (UTD)

**Description:** This service is used to assist participants with required utility deposits for a qualified residence.

**How It Works:** As selected and justified in the transition plan, these funds can be used to turn on electricity, gas, water, telephone, cable and internet service. These funds can be used to pay past due utility bills in order to reconnect services to the qualified residence.

**Rate:** Based on goals as set in the ITP/ISP, limited to \$500 per participant. Used during the MFP period of participation.

### Security Deposits (SCD)

**Description:** This service is used to assist participants with housing application fees and required security deposits for a qualified residence.

**How It Works:** As selected and justified in the transition plan, these funds can be used to pay the security deposit (flat fee, first month's rent, etc.) and/or application fees required to secure a rental unit that meets qualified residence criteria.

**Rate:** Based on goals as set in the ITP/ISP, limited to \$1,000 per participant. To be used during the MFP period of participation.

### Transition Support (TSS)

**Description:** This service provides assistance to help participants with unique transition expenses (obtaining documentation, accessing paid roommate match services, obtaining internet services, etc.). This service provides funding for needs that are unique to each participant, but necessary for a successful transition.

**How It Works:** As selected and justified in the transition plan, these funds may be used to help participants connect to the internet, communicate using email, resolve transition barriers that are unique to each participant. This service can be used for the following (not an exhaustive list) –

- to obtain a birth certificate or other documentation that requires a fee,
- to pay rental unit application fees
- to pay a past due utility bill that must be paid in order to have a utility turned on (Note: this service can only be used to pay a past due utility bill after the Utility Deposit service has been exhausted and a past due utility bill is still preventing the participant from transitioning).
- to cover the reasonable cost of internet service during the period of MFP participation. Total cost for internet services during the MFP period of participation cannot exceed the TSS service cap and amount available for internet services is reduced by using

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TSS to defray other eligible TSS service costs. Internet service provider (ISP) services must be justified in the transition plan. Justifications must include use by the participant to enhance independence and reduce dependence on service personnel, obtain information related to personal safety, health, welfare, employment and training, and/or similar activities, based on goals as set in the transition plan.

**Rate:** Based on goals as set in ITP/ISP, limited to \$600 per participant. To be used during the MFP period of participation.

### Transportation (TRN)

**Description:** This service assists participants with transportation needed to gain access to community services and resources (i.e. housing). This service is designed to supplement existing public and private transportation and should be used when other forms of transportation are not available. This service does not replace the Medicaid non-emergency transportation (for medical appointments) or emergency ambulance services.

**How It Works:** As selected and justified in the transition plan, this service assists participants with transportation needed to gain access to community. Transportation funds can be used for trips related to transition, trial visits to the community, viewing housing options and personal care homes to find a suitable, qualified residence, obtaining needed household furnishings, goods and supplies, obtaining documents such as personal identification, transportation needed on the day of discharge and trips related to locating and securing employment and employment-related services.

**Rate:** Based on goals as set in the ITP/ISP, one unit = a one-way trip. Service is capped at \$500 per participant. Service is designed to supplement existing public and private transportation. Service can be used to cover the cost of multiple one-way or round trips. Limited to use during the MFP period of participation.

### Life Skills Coaching (LSC)

**Description:** This service provides for life skills coaching and independent living skills training. Participants must be assisted to: 1) complete an individualized training needs assessment (ITNA), 2) complete up to 30 hours of customized training focused on skill development, led by a qualified trainer/coach 3) participate in individual and group activities designed to reinforce skill development, and 4) evaluate the impact of the training. This service requires structured, didactic, instructor-lead, customized training/coaching based on the results of the ITNA.

**How It Works:** As selected and justified in the transition plan, this service requires an ITNA and the development, delivery and evaluation of customized, trainer-lead training by a qualified trainer/coach. This

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service differs from Peer Community Support because it requires structured, didactic, instructor-lead, customized training/coaching. Participants complete an independent living and life skills training needs assessment (MFP-ITNA) with assistance from MFP field personnel or the qualified life skills coach. The service is authorized based on the need for life skills/independent living skills training/coaching. A qualified trainer/coach is identified. To be qualified, trainers/coaches must be knowledgeable in the content area, have experience as IL trainer or life skills coach and complete the Qualified Vendor/Service Provider training course (see [www.dch.georgia.gov/mfp](http://www.dch.georgia.gov/mfp) , under subheading 'MFP Training-Webinars'). Together with the participant, the trainer/coach acquires or develops a customized training curriculum based on the results of the individualized needs assessment. The coaching/training is delivered. The training/coaching involves the participant in individual and group activities designed to build and reinforce independent living and life skills. Training topics may include, but are not limited to the following: building circles-of-support/safety nets/personal safety, managing personal finances, managing health conditions and medications, personal hygiene, home management/ cleaning, nutrition management/food prep/cooking, managing personal support services, self-direction, travel training/access to community services, recognizing addiction cycles, coping skills/managing your emotions/positive self-talk, healthy relationships, sexuality and disability, etc. Once coaching/training is completed, coaches/trainers are responsible for preparing a post-training evaluation (may take various forms including written or observation of skill development). Coaches/trainers use the results of the post-training evaluations to assist participants with referrals to community resources for additional follow-up activities. Qualified trainers, life skills coaches and peer supporters may be used to deliver this service.

**Rate:** Based on goals as set in the ITP/ISP, one unit = one half-hour of contact training/coaching or group/individual training activities, billable at \$25 per half-hour, based on the hours of training/coaching provided, delivered by a qualified trainer/coach. Service is limited to \$1,500 per participant and must be used during the MFP period of participation.

### **Skilled Out-of-Home Respite (SOR)**

**Description:** This service provides a brief period of support or relief for caregivers or family members caring for an elderly or disabled MFP participant. This service will pay for up to 14 days of skilled out-of-home respite necessary during the MFP period of participation. The respite is done at a Georgia qualified nursing facility or community respite provider approved through a Georgia waiver program. On a case-by-case basis this service can be used by a participant who is waiting for environmental modifications to be completed to their qualified residence.

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**How It Works:** This service is provided by a qualified Georgia nursing facility or community respite provider.

**Rate:** Based on goals as set in the ITP/ISP. One unit = \$134.17 per day, limited to 14 units, capped at \$1,880 and limited to use during the MFP period of participation.

### Caregiver Outreach & Education (COE)

**Description:** This service provides outreach, information, referral and education to 'volunteer caregivers who support an MFP participant. This service includes; 1) an assessment that identifies sources of a caregiver's stress, 2) consultation and education with a qualified, trained caregiver specialist to develop a Caregiver Support Plan with strategies to reduce caregiver stress and 3) assistance to identify and obtain local services and resources to meet the caregiver's needs. The qualified caregiver specialist documents activities with case notes. This service is not provided in order to educate paid caregivers.

**How It Works:** As selected and justified in the transition plan, this service can be provided to live-in, non-paid caregivers (family members or friends) who provide care, companionship and/or supervision to MFP participants. This service is designed to reduce the stress experienced by caregivers by providing consultation and education on a wide array of services and community resources designed to meet the caregiver's unique needs. Based on the caregiver's assessment, a Caregiver Support Plan is developed and used to educate caregivers. Caregiver education may be available through local agencies.

**Rate:** Based on goals as set in the ITP/ISP. 1 unit = one half-hour of contact caregiver training, billable at \$25 per half-hour, based on the number of units of caregiver outreach and education delivered by a qualified caregiver specialist, limited to \$1,000 per participant, used during the MFP period of participation. Rate includes all costs associated with delivery of service. Only the trained caregiver specialist and/or the specialist's provider agency are allowed to invoice the FI for this service.

### Home Care Ombudsman (HCO)

**Description:** This service provides periodic, face-to-face (F2F) contacts made by a qualified home care ombudsman. Together participants and home care ombudsman review the participant's health, welfare and safety and develop advocacy to assist participants to respond to and resolve complaints related to MFP and waiver services and how these services are provided. Service is limited to participants who transition into a qualified residence (as defined under DRA of 2006 and ACA 2010). Three F2F contacts are required, additional contracts (F2F or phone contacts) can be arranged as needed. A case note is required to document each contact.

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**How It Works:** As selected and justified in the transition plan, this service provides regular monthly and face-to-face (F2F) contact for review of transitioned participants' health, welfare and safety. Home care ombudsmen make visits and phone calls to participants to discuss any issues related to the MFP and HCBS services they are receiving. Home care ombudsman cannot be state employees. Home Care Ombudsman are qualified by the Office of the State Long-Term Care Ombudsman and are specially trained to assist participants with advocacy strategies that empower participants to respond to and resolve complaints related to MFP and waiver services and how these services are provide. Service is limited to participants who transition into a qualified residence (as defined under DRA of 2006 and ACA 2010). Contact with participants occurs during the first 30 days post-transition, at 6 months and before the 11th month in the community and a case note is required to document each contact. Three F2F contacts are required, additional contract (F2F or phone calls) can be arranged as needed. Participants have the right to suspend and resume periodic contacts during the MFP period of participation. MFP field personnel request a completed MFP Ombudsman Payment Request form (see Appendix AF) from the Home Care Ombudsman. The ombudsman completes the MFP Services Rendered For and Payment Instruction sections of the form and the description of the services rendered, including the amount billed. The ombudsman next submits this form to MFP field personnel. Field personnel verify the information. The completed form is submitted along with a copy of the ombudsman's W-9 and the Vendor Import File (see Appendix V) to both the Fiscal Intermediary and the DCH MFP office via secure transfer protocol. Once the information has been verified and approved, the Fiscal Intermediary issues payment directly to the ombudsman or ombudsman's agency.

**Rate:** Based on goals as set in the ITP/ISP. One unit = one quarter hour contact, billable in quarter-hour increments at \$37.50, delivered fee-for-service by a qualified Home Care Ombudsman who is not a state employee, limited to \$1,800 per participant, used during the MFP period of participation.

### **Equipment, Vision, Dental, and Hearing Services (EQS)**

**Description:** This service provides equipment, vision, dental, hearing aids and related services and certain types of assistive technology and services that are not otherwise covered by Medicare or Medicaid. Equipment and services obtained are necessary to enable participants to interact more independently and/or reduce dependence on physical supports and enhance quality of life. Covers normal and customary charges associated with one vision examination and one pair of basic prescription glasses. Covers normal and customary charges for one dental examination and cleaning and/or dental work necessary to maintain or improve independence, health, welfare and safety. Covers normal and customary charges for hearing aids and related services.

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Most MFP participants are covered by Medicaid, but some participants have coverage under Medicare as well. For participants who are receiving both Medicare and Medicaid benefits, all equipment that is covered by their Durable Medical Equipment (DME) benefit must be purchased using their DME benefit.

**How It Works:** As selected and justified in the transition plan, these funds can be used to obtain equipment, vision, dental and hearing services, durable medical equipment, adaptive or assistive technology devices, not covered by Medicare and Medicaid under the participant's DME benefit. The equipment must be needed to enable a participant to interact more independently, enhance quality of life and reduce dependence. This service does not cover the purchase of supplies such as adult diapers, etc. (see Specialized Medical Supplies, for more information). This service can be used to cover the normal and customary charges associated with one vision examination and one pair of basic, prescription glasses. This service can be used to cover the normal and customary charges for one dental examination and cleaning and/or minor dental restorations necessary to maintain or improve independence, health, welfare and safety of the participant. This service covers normal and customary charges for basic hearing aids and related services. This service does not cover repairs to existing equipment, only replacement.

Except for items and services in the list below (listed items are not covered by the participant's Medicare or Medicaid DME benefit), it is necessary to submit a claim or a prior authorization and receive a denial, before obtaining items under this service. When items from the list below are obtained, a citation from the Medicaid DME manual must be included in the transition plan indicating the item or service is not covered by the participant's DME benefit. For more information, refer to Part II Policies and Procedures manual for Durable Medical Equipment (DME), Part II Section 906 Non-covered Services, Policies and Procedures for Orthotics and Prosthetics (O&P) and Part III, Hearing Services or contact the DCH Medicaid DME O&P Program Specialist at 404-657-9270.

The following equipment DOES NOT require denial of coverage documentation, but DOES require the above citation in the transition plan:

- Environmental Control Systems/equipment (e.g. devices used by participants to control lights, heat, ventilation and air conditioning or door openers)
- Comfort and convenience equipment for participant use (e.g., over-the-bed trays, chair lifts or bathtub lifts)
- Institutional-type equipment for participant use (e.g., cardiac or breathing monitors except infant apnea monitors and ventilators)
- Fitness equipment for participant use (e.g. exercycle)

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- Self-help devices (e.g., Braille teaching texts)
- Equipment used by the participant for training/pre-employment skill development (e.g., computer/monitor/keyboard, printer/fax/copier, computer access devices, and/or adjustable workstations)
- Infant and child car seats, activity chairs, corner chairs, trip trap chairs, floor sitters, feeder seats, hi or low seats, etc.)
- Blood pressure monitors and weight scales for participant use
- Safety alarms and alert systems for participant use
- One pair of prescription eye glasses, exam and fitting
- Dental exam, x-rays, cleaning and minor dental restorations
- Hearing Aids, exam and fitting
- Special Clothing used by the participants, such as specially designed vests to assist with wheelchair transfers and re-positioning, adaptive clothing for individuals with limited mobility, clothing designed with G-tube access openings and other easy access clothing specifically designed for individuals with disabilities.

Automatic shipping to MFP participants will not be permitted. No items should be billed to DCH MFP or a Fiscal Intermediary prior to delivery to the MFP participant. For MFP EOS funds to be used, the vendor must receive a DME claim denial or a prior authorization denial. This process supports GA Medicaid DME policy regarding the need for a letter of medical necessity. With evidence of one of these denials, field personnel authorize the purchase. If the item is only partially covered through Medicaid or Medicare, field personnel authorize the remaining cost to be paid using MFP funds. Documentation of the item's cost and the applicable coverage denials must be submitted through appropriate agencies and kept for audit purposes.

Field personnel assist participants in obtaining quotes for the needed equipment. Two quotes are required on the Quote Form for MFP Transition Services (see Appendix T) for the purchase of a single piece of equipment that costs \$1000 or more. One such quote may be obtained from the DCH Medicaid DME O&P Program Specialist at 404-657-9270. If a quote is selected that is not the lowest quote, provide a justification for the selected quote. Sign the form to authorize the equipment purchase. Supporting documentation should include the quotes from vendors. Send the completed Quote Form for MFP Transition Services to the FI and DCH MFP office via FTP.

**Rate:** Based on goals as set in the ITP/ISP. Service is limited to \$4,000 per participant, used during the MFP period of participation.

### **Specialized Medical Supplies (SMS)**

**Description** Service includes various specialized medical supplies that enable MFP participants to maintain or improve independence, health, welfare and safety and reduce dependence on the physical support

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needed from others. The service includes incontinence items, food supplements, special clothing, bed protective pads, diabetic supplies and other supplies that are identified in the approved in the MFP transition plan and that are not otherwise covered by Medicare or Medicaid. Ancillary supplies necessary for the proper functioning of approved supplies are also included in this service.

**How It Works:** Specialized Medical Supplies (SMS) needed by the participant are identified in the approved transition plan. Most MFP participants are covered by Medicaid, but some participants have coverage under Medicare as well. For participants who are receiving Medicaid or who are receiving both Medicare and Medicaid benefits, specialized medical supplies covered by their Durable Medical Equipment (DME) benefit must be purchased using their DME benefit. Except for items listed below, a DME claim denial or a prior authorization denial is required before this service can be used to obtain specialized medical supplies. Specialized Medical Supplies listed below are not covered by Medicare or Medicaid DME benefit, but may be covered by one or more 1915c waivers. For SMS listed below, it is not necessary to submit a claim and receive a denial, before obtaining supplies under this service. It is necessary to provide a citation from the DME manual in the transition plan that the SMS is not covered. Citations should come from Part II Policies and Procedures manual for Durable Medical Equipment (DME). Contact the DCH Medicaid DME O&P Program Specialist at 404-657-9270 for more information.

The following items DO NOT require State Plan denial of coverage documentation but DO require the citation from the DME Manual:

- Incontinence items (e.g. diapers, pads and adult briefs) for participants 21 years of age or older
- Diabetic supplies (not covered by Medicaid, syringes, etc.)
- Nutritional supplements and formula for participants 21 years of age or older, who eat by mouth (e.g., Ensure, Isomil, Boost)
- Prescription medication not covered by Medicaid or Medicaid
- Supplies necessary for the proper functioning of approved devices
- Infection control supplies, such as non-sterile gloves, aprons, masks and gowns, when services are not provided by an agency or separately reimbursed by Medicaid.

Automatic refills and automatic shipping to MFP participants will not be permitted. No delivery mileage will be paid for the delivery of specialized medical supplies. Vendors normally deliver SMS and vendors may charge a delivery fee, but vendors may not add a fuel or mileage surcharge in addition to the delivery fee. The delivery fee should be uniform and customary. MFP participants should not be required to pay additional delivery fees that are not paid by other customers. No items should be billed to DCH/MFP or a Fiscal Intermediary prior to delivery to the MFP participant. Shipping charges should be clearly identified on the invoice from the vendor, but in

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cases where they are separate (this should be rare), shipping charges can be submitted on the MFP Vendor Import File and reimbursed using Moving Expenses (MVE) or Transition Support (TSN). MFP field personnel are not expected to deliver SMS and should only do so when no other means of delivery can be found. Two quotes are required on the Quote Form for MFP Transition Services (see Appendix T) for the purchase of a single specialized medical supply that costs \$1000 or more. One such quote can be obtained from the DCH Medicaid DME O&P Program Specialist at 404-657-9270. If a quote is selected that is not the lowest quote, provide a justification for the selected quote. Sign the form to authorize the equipment purchase. Supporting documentation should include the quotes from vendors. Send the completed Quote Form for MFP Transition Services to the FI and DCH MFP office via FTP.

**Rate:** Based on goals as set in the ITP/ISP, limited to \$1,000 per participant, used during the MFP period of participation.

### Vehicle Adaptations (VAD)

**Description** This service enables individuals to interact more independently, enhancing their quality of life and reducing their dependence. Limited to participant's or the family's privately owned vehicle and includes such things as driving controls, mobility device carry racks, lifts, vehicle ramps, special seats and other interior modifications for access into and out of the vehicle as well as to improve safety of the participant while the vehicle is being operated.

**How It Works:** This service must be selected and justified in the transition plan. Vehicle adaptations include the installation of driving controls (when applicable), mobility device carry racks, a lift or ramp for wheelchair or scooter access, wheelchair tie-downs and occupant restraints, special seats or other modifications that are needed to provide for the safe access into and out of and operation of the vehicle. Two quotes from certified installation technicians are required for adaptations of \$1000 or more (see Quote Form for MFP Transition Services, Appendix T). Supporting documentation includes the quotes from vendors/certified technicians. Send the completed Quote Form for MFP Transition Services to the FI and DCH MFP office via FTP. If the owner of the vehicle is not the participant, a notarized letter giving the owner's permission for the adaptation must be obtained. The notarized letter must state that the owner is required to give the participant use of the vehicle. This service does not cover repairs to the vehicle or to the adaptation once it is installed and operational.

**Rate:** Based on goals as set in ITP/ISP. Limited to a maximum of \$6,240, used during the MFP period of participation.

### Environmental Modifications (EMD)

**Description:** This service provides assistance to participants requiring physical adaptations to a qualified residence, including a qualified residence under the Housing Choice Voucher program or a community home on a case-by-case basis. This service covers basic modifications needed by a participant, i.e. ramps, widening of doorways, purchase and installation of grab-bars and bathroom modifications, to ensure health, welfare and safety and/or to improve independence in ADLs.

**How It Works:** This service must be selected and justified in the transition plan. Modifications are done to improve or maintain the independence of the participant in ADLs and ensure health, welfare and safety. Modifications are not intended for cosmetic upgrades or repairs of existing issues within the home. Two scope/bids are required for all MFP environmental modifications, but three scope/bids are recommended. Contractor scope/bids must be itemized by area modified (i.e. bathroom), itemized by task (i.e. remove toilet and install new ADA toilet) and provide a breakdown of materials and labor for each item with totals for each line of the scope/bid. Grand total of labor + materials must be included in the scope/bid. The winning scope/bid is typically the lowest bid, but not required if justification is presented and accepted for a more costly bid. Scope/bids from contractors must be based on using standard materials. Luxury materials (such as marble, brass, designer tiles, etc.) are not covered by this service. Any materials used beyond basic/standard materials must be subsidized by the property owner. If the property owner is not the participant, a notarized letter giving the owner's permission for the modifications must be obtained, except in situations where the participant is living in a property that receives federal housing or is otherwise subject to Fair Housing Act, ADA and other laws that permit the resident to make modifications that are considered 'reasonable accommodations' regardless of the property owner's permission. The notarized letter giving the owner/landlord's permission for environmental modifications (EMD) and home inspections (HIS), must give the participant the right to live in the housing/unit for an *extended period of time* after environmental modifications are completed. The *minimum extended period of time* is considered to be either the end of the lease agreement or until the participant moves out, whichever event occurs first. The notarized letter giving the owner/landlord's permission must give the participant the right to live in the housing/unit *before and after* the home inspections are conducted. The Quote Form for MFP Transition Services (Appendix T) must be completed and the winning bid indicated. Supporting documentation includes the scope/bid quotes from licensed contractors and notarized permission letters from owners/landlords. Send the completed Quote Form for MFP Transition Services and supporting documents to the FI and DCH MFP office via FTP. A home/building inspection is required before environmental modifications are started and a post-inspection is required after

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modifications are completed. Building permits must be obtained for all EMDs with scope/bid totals of \$2,500 or more.

**Rate:** Based on goals as set in the ITP/ISP. The rate is the price of the lowest scope/bid (with exceptions), limited to a maximum of \$8,000 per participant, used during the MFP period of participation.

### Home Inspections (HIS)

**Description:** Home/building inspections are required before and after MFP Environmental Modifications (MFP-EMD) are undertaken. When permission is obtained for environmental modifications, the participant and owner/landlord is advised that this service will also be provided (see description of notarized owner/landlord permission letter under EMDs). This service is used to identify and report on needed structural repairs that the owner must address before environmental modification are started. This service is also used to identify and make recommendations for appropriate and cost-effective environmental modifications before they are started. This service provides for post-inspections after modifications are complete, in order to ensure quality work and compliance with relevant building codes and standards. The inspector providing the service is not affiliated with vendors/contractors providing environmental modifications.

**How It Works:** This service must be included in the transition plan in cases where environmental modifications are selected. In spaces requiring environmental modifications for accessibility, the inspector reports on structural deficiencies and identifies repairs that are the responsibility of the property owner or landlord to address, prior to MFP environmental modifications being undertaken. In addition, the inspector makes recommendations for appropriate and cost-effective modifications and reviews proposed project scope/bids, materials and other aspects of the proposed work, providing expert opinion/advice. Following completion of the MFP environmental modifications, the inspector provides a post-inspection report on the quality of the work and compliance with relevant building codes and standards. In cases where warranty work must be done, the inspector returns to the site to provide a second post-inspection that reports on the quality of all warranty work and new non-warranty work necessary to ensure health, welfare and safety of the MFP participant. As agreed to in the notarized letter from the owner/landlord, the participant has the right to live in the housing/unit before and after the home/building inspections are conducted.

**Rate:** Based on the goals as set in the ITP/ISP, required when MFP-EMDs are selected. 1 unit = one inspection with relevant report from a qualified inspector who is not affiliated with the contractor providing the environmental modification service, billable at \$250, limited to \$1,000 per participant. Service is used during MFP period of participation.

### **Supported Employment Evaluation (SEE)**

**Description:** This service provides assistance to participants seeking career planning and supportive, customized and/or competitive employment. Participants engage in a guided/facilitated Vocational Discovery Process. Based on the Discovery Process, a Vocational Profile is completed. The Vocational Profile identifies a path to employment. These services may be procured from a qualified vocational/employment service provider. The provider assists a participant to make connections to community resources necessary to support choices for supportive, customized and/or competitive employment.

**How It Works:** As selected and justified in the transition plan, the participant identified vocational goals. Based on these identified goals, this service provides participants with additional guidance and assistance to create a path to employment. Participants are referred to qualified vocational/employment service providers to complete a Vocational Discovery Process. Based on the Discovery Process, a Vocational Profile is completed. These comprehensive services are provided by a multidisciplinary team; require multiple contacts and require coordination with community resources. Once completed, the qualified vocational/employment provider assists with rapid job development and benefits planning and referrals to a minimum of three community resources available to assist with training and vocational career development services (vocational rehab, Ticket to Work provider, One-stop career center, benefits navigator, micro-board/self-employment, etc.) necessary to support choices for supportive, customized and/or competitive employment.

**Rate:** Based on goals as set in the ITP/ISP. One unit = one complete Vocational Discovery Process with Vocational Profile and referrals to a minimum of three community resources (vocational rehab, Ticket-to-Work provider, One-stop center, benefits navigator, micro-board/self-employment, etc.), limited to \$1,500 per participant, used during the MFP period of participation.

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### MFP CBAY Demonstration Services for Youth with Mental Illness

**Table B.5.A. MFP Demonstration Services for Youth with Mental Illness**

<b>Service Title</b>	<b>Service Definition</b>	<b>Rate/Unit/Annual Caps</b>
<b>Community Transition Services</b>	Community Transition Services are: <i>non-recurring set-up expenses</i> for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.	Limited to \$5,276.16/annual cap, For members age 15 and younger at DOS, limit is \$500/ annual cap.
<b>Care Management</b>	Care Management Services assist participants in identifying and gaining access to needed MFP and other State Plan Services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.	\$721.05/monthly, \$8,652.60/ annual cap
<b>Care Management – Transition</b>	Care Management Services provided for partial month or to support the transition planning process from PRTF to community. Not billed until transition has occurred.	\$540.75/month, \$2,163.00/ annual cap
<b>Behavioral Assistance</b>	Behavioral Assistance is provided to support the individual in the community and increase the participant’s independence and control over daily life activities and events, as appropriate to the participant’s needs and as specified in the plan of care.	\$20.78/15 min, \$6,982.08/ annual cap
<b>Family Peer Support Services</b>	Family Peer Support Services are participant centered services with a rehabilitation, recovery and maintenance focus designed to promote skills for coping with and managing mental illness symptoms related to the participant’s treatment plan while facilitating the utilization of natural resources and the enhancement of community living skills and participation.	\$20.78/15 min, limited to 80 units per month, \$4,987.20 annual cap
<b>Youth Peer Support Services</b>	Youth Peer Support Services are designed to promote socialization, recovery, wellness, self-advocacy, development of natural supports, and development/maintenance of community living skills.	\$8.93/15 min, limited to 80 units per month, \$3,429.12 annual cap.
<b>Transportation</b>	Transportation Services enable participants to gain access to MFP and other community services, activities, resources and organizations typically utilized by the general population, as specified in the Individual Service Plan.	\$10.40/unit is one-way trip, not by mileage, capped at \$998.40/annually
<b>Expressive Clinical Services</b>	Expressive Clinical Services are interactive therapeutic modalities to support individualized goals as part of the plan of care. These therapeutic modalities help participants find a form of	\$28.75/15 min,, \$5,175.00 annual cap

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Service Title	Service Definition	Rate/Unit/Annual Caps
	expression beyond words or traditional therapy. They include techniques that can be used for self-expression and personal growth and aid in the healing and therapeutic process and specifically may be rendered through such modalities as: <ul style="list-style-type: none"> <li>• Art Behavioral Services</li> <li>• Dance/Movement Behavioral Services</li> <li>• Equine-Assisted Behavioral Services</li> <li>• Horticultural Behavioral Services</li> <li>• Music Behavioral Services</li> <li>• Psychodrama/Drama Behavioral Services</li> </ul>	
<b>Clinical Consultative Services</b>	Clinical Consultative Services are provided by professional experts in psychology, social work, counseling, behavior management and/or criminology. These specialized services are provided to youth who have specialized diagnoses/needs which may require an expert to differentiate assessment, treatment, or plans of care.	\$28.75/15 min., \$5,865.00 annual cap
<b>Supported Employment</b>	Supported Employment Services consist of ongoing supports that enable participants with severe emotional disturbances or mental illness for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of their serious mental illness, need supports to perform in a regular work setting.	\$10.00/15 min individual or \$5.00/15 min group, \$4,800.00 annual cap
<b>Financial Support Services</b>	Financial Support Services are services or functions that assist the family or participant to: a) manage and direct the disbursement of funds contained in the participant-directed budget; b) facilitate the employment of staff by the family or participant by performing employer responsibilities as the participant's agent, and c) perform fiscal accounting and make expenditure reports to the participant or family, Care Coordinator and state authorities.	\$75/month, \$900.00 annual cap
<b>Respite</b>	Respite Services provide safe and supportive environments on a short-term basis for participants unable to care for themselves because of the absence or need for relief of those persons who normally provide care for the participant.	\$4.00/15 min or \$128/per day, limited to no more than 4 days per month, \$3,072.00 annual cap
<b>Customized Goods and Services</b>	Customized Goods and Services are individualized supports that youth who have severe emotional disturbances or mental illness may need to fully benefit from mental health services.	\$195 monthly, \$1,500.00 annual cap

While it might be possible for a participant to receive all MFP CBAY services during the period of participation, this plan would be highly unlikely. MFP CBAY services

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provided are medically necessary and/or are identified after evaluation of the participant/family by and consultation with a multidisciplinary team. MFP CBAY Action Plans are reviewed by the multidisciplinary team and monitored monthly.

### **CBAY Service Limits (For details, see Appendix I: MFP CBAY Procedure Code and Rate Table)**

The following service limits apply to selected services available to youth with mental illness under the MFP demonstration:

- Transportation has an annual service limit of \$998.40.
- Customized Goods and Services has an annual service limit of \$1,500.00.
- Community Transition Services has an annual service limit that is dependent upon the age of the participant. Youth through age 15 are limited to \$500 per year. Youth age 16 years old and older are limited to \$5,276.16 per year. This is to be responsive to older youth/young adults who may be transitioning from a PRTF to their own home rather than their family home.
- Care Management is available in the amount of one monthly unit per participant, and is capped at \$8,652.60 annually.
- Care Management – Transition is limited to four monthly units per year and is capped at \$2,163.00 annually.
- Financial Support Services is available in the amount of one monthly unit per participant who elects to participant-direct and is capped at \$900.00 annually.
- Expressive Clinical Services and Consultative Clinical Services are limited to 8 units (15 minutes each) per day, and are capped annually at \$5,175.00 and \$5,865.00 respectively.
- Family Peer Support is limited to 80 units per month (15 minutes each) and is capped at \$4,987.20 annually.
- Youth Peer Support Services is limited to 80 units per month (15 minutes each), and is capped at \$3,429.12 annually.
- Supported Employment is limited to 32 units (15 minutes each) per day, and is capped at \$4,800.00 annually.
- Respite per diem is limited to one unit per day and Respite in 15 minute unit increments is limited to 32 per day and is capped at \$3072.00 annually.

### **Qualified HCBS Services Offered to MFP Older Adult Participants**

Older adult participants are referred through the Area Agency on Aging (AAA) Gateway network. MFP field personnel (Options Counselors) perform a screening and consent eligible MFP participants and assist them with applications to the Elderly & Disabled Waiver (CCSP or SOURCE). Persons not eligible for MFP are referred to the case management agency to have the initial assessment completed (for process detail, see *Appendix I: MFP Process Flowcharts and Text Descriptions*). The Gateway network is already established statewide and offers an extensive database of information about services for the elderly and persons with all types of disabilities.

The Elderly and Disabled Waiver program operates under a CMS home and community-based waiver (1915c). The program assists individuals of all ages who

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are elderly, blind, or physically disabled, to continue to live in their own homes and communities as an alternative to nursing facility placement. Individuals served by the programs are required to meet the same level of care for admission to a nursing facility and be Medicaid eligible or potentially Medicaid eligible and in some cases, receiving Supplemental Security Income (SSI).

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

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

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

**Organizational Structure:** The Department of Community Health Medicaid Division oversees the performance of the waiver and is responsible for provider enrollment, reimbursement, and utilization review. The Department of Human Services Division of Aging Services is responsible for the day-to-day operation of the waiver program. The Area Agency on Aging (AAA) serves as the point of contact for members, service providers, and representatives. The DHS Division of Family and Children Services determines Medicaid eligibility and member cost share (if any) for potentially Medicaid eligible members.

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

### **Qualified HCBS Services Offered to MFP Participants with Physical Disabilities/TBI**

After completing the MFP Screening Form, MFP field personnel contact Georgia Medical Care Foundation (GMCF) to conduct the waiver assessment for MFP participants with physical disabilities and/or TBI. Once the MFP participant has been approved for Independent Care Waiver Program (ICWP) Services, she/he is responsible for selecting an approved ICWP case manager.

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Up to the level of reserved capacity, there is no waiting list for MFP participants enrolled in the ICWP waiver program. When reserved capacity is exceeded, MFP uses a 'first-come-first-served' approach to service delivery. The date of the initial MFP screening will be used to prioritize the MFP waiting list. The ICWP waiver will be amended to have reserved capacity for persons transitioning inpatient facilities to the community through Money Follows the Person. DCH requests budget increases for the reserved capacity for ICWP through 2017. The ICWP program offers services to eligible Medicaid recipients who are severely physically disabled or with traumatic brain injury, between the ages of 21 and 64, and meet one of the following criteria:

- a. Are medically stable enough to leave the hospital, but cannot do so without the support services available through this program.
- b. Will be admitted to a hospital on a long-term basis without the support services available through this program.
- c. Are at immediate risk of nursing facility placement.

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

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

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

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

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

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

## **Qualified HCBS Services Offered to MFP IIDDs**

Two HCBS waivers for individuals with intellectual and developmental disabilities (IIDDs) provide for the inclusion of supports needed beyond the transition process – the New Options Waiver (NOW) and the Comprehensive (COMP) waiver. Individualized supports are identified through the person-centered planning process and included in budget and purchase planning.

Planning List Administrators and/or Case Expeditors assist and oversee elements of the transition process. The Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities (DBHDD-DDD) actively assists individuals to transition from Intermediate Care Facilities (ICFs) or State Operated Hospitals into the community. MFP supports the DBHDD-DDD transition process. Under the Interagency Agreement, there is reserved capacity for persons that transition from ICFs, under the Settlement Agreement with US Department of Justice. While transitions from ICFs under the DOJ Settlement are given first priority, MFP/IIDD participants will also be transitioned from inpatient facilities to the community. DBHDD-DDD will request appropriations needed for reserved capacity in the NOW and COMP waivers through 2017.

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

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

- Case Expeditors - in each regional office CEs are charged with actively assisting consumers toward community placement with appropriate supports.
- Intake and Evaluation- Conducts face-to-face initial screening to determine service need and preliminary eligibility (screening provides presumed eligibility or ineligibility; a comprehensive evaluation is intended to confirm

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eligibility status) of the individual for DDD services. The screener completes an *Intake Screening Summary*, which documents the individual and family circumstances related to the need for services, the services actually needed, and the timeframe in which the services are needed.

- Planning List Administrators or I & E Managers are responsible for managing the DDD Planning List. This list identifies individuals that are receiving assistance to transition from ICFs into the community.
- Support Coordination- The system of support coordination (case management) is the state's mechanism for ensuring that recipients of services are provided access to the information and services they need on an ongoing basis. This system customizes services by identifying appropriate paid, community, and natural supports, maintaining the health and safety of the consumers being transitioned, and developing appropriate goals and objectives to increase level of independence.

Individuals with intellectual and developmental disabilities who are inpatients in hospitals and nursing facilities and participants who transition from ICFs have access to services through Aging and Disability Resource Connections (ADRCs). Most ADRCs have a specialist on staff to assist with information and referral for services for IIDD. ADRC specialists are closely linked to DDD regional case expeditors.

The NOW and COMP waivers make available a wide range of quality of care and quality of life services that are sufficiently flexible to allow customization based on personal needs and preferences. These include traditional agency directed services as well as innovative, self-directed services. Both the NOW and COMP waivers offer personal choice and control over the delivery of waiver services by affording opportunities for many of the services to be available for self-direction.

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

### **Qualified HCBS Services Offered to MFP CBAY Youth with Mental Illness**

While MFP CBAY participants do not transition using qualified waiver services, they do transition using a robust set of MFP CBAY Demonstration Services (for details see Table B.5.A above).

### **State Plan and Other Local Services Offered to MFP Participants**

MFP participants receive the full range of the qualified HCBS services included in the waiver in which they are enrolled. Participants are offered MFP Demonstration Services as indicated in the Appendix B and outlined above. See also *Appendix B:*

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*MFP Transition Services Table* for a delineation of reimbursement rates and brief service descriptions. Transitioned participants receive qualified HCBS waiver services as long as they meet waiver criteria. Participants receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federal funded services, state funded programs, and local community support system funded services. See Table B.5.1 for summary of these services.

The state is seeking an enhanced match for MFP demonstration services, qualified waiver services and State Plan services provided to MFP participants.

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**Table B.5.1 Qualified HCBS Waiver Services Available to MFP Participants by Waiver**

<i>Elderly/Disabled Waivers (CCSP/SOURCE)</i>	<i>Independent Care Waiver Program (ICWP)</i>	<i>New Options Waiver (NOW) and Comprehensive Waiver (COMP)</i>
<ul style="list-style-type: none"> <li>➤ Adult Day Health</li> <li>➤ Alternative Living Services</li> <li>➤ Emergency Response Services</li> <li>➤ Enhanced Case Management</li> <li>➤ Financial Management Services</li> <li>➤ Home Delivered Meals</li> <li>➤ Home Delivered Services</li> <li>➤ Out-of-Home Respite</li> <li>➤ Personal Support Services (PSS)/(PSSX)/ Consumer Directed Services</li> <li>➤ Skilled Nursing Services</li> <li>➤ Home Health Services</li> </ul>	<ul style="list-style-type: none"> <li>➤ Adult Day Care</li> <li>➤ Behavior Management</li> <li>➤ Case Management</li> <li>➤ Consumer-Directed PSS</li> <li>➤ Counseling</li> <li>➤ Enhanced Case Management</li> <li>➤ Environment Modification</li> <li>➤ Fiscal Intermediary</li> <li>➤ Personal Emergency Monitoring</li> <li>➤ Personal Emergency Response</li> <li>➤ Personal Emergency Response Installation</li> <li>➤ Personal Support Services</li> <li>➤ Respite Services</li> <li>➤ Skilled Nursing</li> <li>➤ Specialized Medical Equipment and Supplies</li> <li>➤ Vehicle Adaptation</li> <li>➤ Adult Living Services</li> <li>➤ Home Health Services</li> </ul>	<ul style="list-style-type: none"> <li>➤ Community Residential Alternative (COMP only)</li> <li>➤ Adult Occupational Therapy Services</li> <li>➤ Adult Physical Therapy Services</li> <li>➤ Adult Speech and Language Therapy Services</li> <li>➤ Behavioral Supports Consultation</li> <li>➤ Community Access</li> <li>➤ Community Guide</li> <li>➤ Community Living Support</li> <li>➤ Environmental Access Adaptation</li> <li>➤ Financial Support Services</li> <li>➤ Individual Directed Goods and Services</li> <li>➤ Natural Support Training</li> <li>➤ Prevocational Services</li> <li>➤ Respite Services</li> <li>➤ Specialized Medical Equipment</li> <li>➤ Specialized Medical Supplies</li> <li>➤ Support Coordination</li> <li>➤ Supported Employment</li> <li>➤ Transportation</li> <li>➤ Vehicle Adaptation</li> <li>➤ Home Health Services</li> </ul>
<ul style="list-style-type: none"> <li>➤ Adult Protective Services</li> <li>➤ Caregiver Supports</li> <li>➤ Older Americans Act Services</li> <li>➤ Social Services Block Grant Services</li> <li>➤ State Funded Services</li> </ul>	<ul style="list-style-type: none"> <li>➤ Adult Protective Services</li> <li>➤ Social Services Block Grant Services</li> <li>➤ State Funded Services</li> </ul>	<ul style="list-style-type: none"> <li>➤ Adult Protective Services</li> <li>➤ State Funded Services</li> </ul>

## **B.6. Consumer Supports**

The following section identifies the organizations (state, regional and local agencies, contracted agencies, etc.) that provide MFP transition services and qualified HCB waiver services (including support coordination/case management) to MFP participants under each HCBS waiver for specific Medicaid eligible targeted MFP populations (older adults, individuals with intellectual and developmental disabilities, persons with physical disabilities and/or traumatic brain injury and youth with mental illness). It describes the work and qualifications of MFP field personnel that deliver services and how they collaborate with waiver case managers/care coordinators and support coordinators.

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

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

### **Description of Two Interagency Agreements**

As described in *B.1 Participant Recruitment and Enrollment*, the state has in place two interagency agreements for the operation of the MFP demonstration and the provision of MFP demonstration services to MFP participants for each target group. Under the Interagency Agreement with the Department of Human Services/Division of Aging Services (DHS/DAS), option counseling and transition screening services are used to assess nursing facility residents identified using the Minimum Data Set Section Q (MDSQ) as interested in information about community living. MDSQ Options Counselors (MDSQ OCs) and MFP TCs are co-located in each of the 12 regional Area Agencies on Aging/Aging & Disability Resource Connections (AAA/ADRCs). MFP field personnel (i.e. MDSQ OCs and MFP TCs) recruit elderly, blind and physically disabled participants of all ages for the Elderly and Disabled Waiver Program throughout the state. Participants with physical disabilities and/or TBI, between the ages of 21 and 64, are recruited for the Independent Care Waiver Program (ICWP) and participants with intellectual and developmental disabilities residing in nursing facilities are recruited for the waiver that is most appropriate and that meets their needs.

Under the Interagency Agreement with DBHDD, Division of Developmental Disabilities (DBHDD-DDD), individuals with intellectual and developmental disabilities who meet MFP eligibility criteria are identified from the Olmstead Planning List for transitioning into the NOW and COMP waivers. DBHDD-DDD already performs transition coordination functions in ICFs statewide; their current

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efforts are supplemented with funding from MFP to enable the state to transition IIDDs from nursing facilities into NOW/COMP waivers; provide MFP demonstration services to MFP participants transitioning into NOW/COMP waivers and receive higher FMAP on MFP and qualified HCBS services.

Under the Interagency Agreement with DBHDD, Division of Community Mental Health, Community Based Alternatives for Youth (DBHDD-DCMH MFP-CBAY), youth with mental illness who meet MFP eligibility criteria are identified in PRTFs for transitioning using a robust set of MFP Demonstration services.

To develop and manage this process, DCH:

- Determines interagency agreement scope and oversees execution of interagency agreements,
- develops and revises MFP operational policies and procedures,
- conducts programmatic reviews, monitoring, training, technical assistance, quality assurance and quality improvement activities with both agencies,
- pays all invoices submitted after review and approval of the deliverables,
- provides on-going guidance and project coordination within DCH and with the Department of Human Services and the Department of Behavioral Health and Developmental Disabilities,
- identifies appropriate information, resources and technical assistance necessary for the completion of deliverables, and
- Conducts financial and programmatic audits.

Under the two interagency agreements, agencies are responsible for:

- hiring competent and qualified personnel to deliver services as outlined under the agreements,
- offering statewide transition services to eligible inpatients who wish to transition with or without HCBS waivers,

### **Qualifications Necessary for the Delivery of MFP Demonstration Services**

Personnel delivering MFP demonstration services received initial training prior to beginning transitioning work with participants (see *Section B.3 Outreach, Marketing and Education* for a complete description of the state's staff training plan). MFP steering committee members, DCH, DHS, DBHDD and Georgia State University Georgia Health Policy Center (GSU GHPC), collaborated to develop and deliver competency-based training. Personnel delivering MFP services are required to be qualified as defined by the following competencies or KSAs (knowledge, skills and attitudes):

- MFP scope, benchmarks and eligibility criteria,
- Independent living philosophy, dignity of risk, and informed consent,
- Identify barriers to community living experienced by each population and assist participants with problem solving for barriers removal,
- Person-centered planning and circles-of-support/natural supports,
- Working MDSQ referrals and referrals from all Points-of-Entry
- Completing Screenings, Person-Centered Plans/Descriptions and Individualized Transition Plans

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- Authorizing MFP transition services, tracking expenditures and reporting,
- Complaint processes and critical incident reporting,
- Involving guardians and persons who have durable power of attorney,
- HCBS waiver eligibility, applications, service options and State Plan services,
- Identifying affordable, accessible and integrated housing,
- Collaborating with advocacy systems including Atlanta Legal Aid Society, Georgia Legal Aid, Georgia Advocacy Office and the Office of the State Long-Term Care Ombudsman
- Regional community resources by disability population,
- Local and regional, para-transit and public transportation options,
- Team approaches for working with waiver case managers and other professionals and advocates working on transitions,
- Procurement of specialized medical equipment and assistive technology for independent living,
- Customer Service and follow-up visits,
- Conducting the Quality of Life survey, and
- MFP reporting and documentation requirements, including maintaining protected health information (PHI) in accordance with HIPAA regulations.
- Experience working with older adults, people with physical disabilities and traumatic brain injury (TBI), individuals with intellectual and developmental disabilities, or youth with mental illness

### **Collaboration between MFP Personnel and Waiver Case Managers/CC/SC**

After completing the MFP Individualized Transition Plan (ITP) or Person-Centered Description with the participant, MFP field personnel (MDSQ OCs, MFP TCs, DD PLAs, CEs) play an important role in the transition process in building a collaborative relationship with waiver case managers (CMs), Care Coordinators (CCs) and/or Support Coordinators (SCs). Collaboration with CMs/CCs/SCs ensures a smooth transition to waiver services. To develop early partnerships, geographic service areas are matched based on the 12 Regional AAA/ADRC areas. After recruitment and initial screening, appropriate waiver applications are completed and referrals are made for waiver assessments. Waiver CMs/CCs/SCs are provided with information about MFP participants, including goals, disability diagnosis, functional abilities, cognitive/language function, needed personal support services, family/support network, equipment, housing, and transportation needs.

Waiver assessments are conducted by waiver assessment personnel. Beyond completing the assessment, CMs play a 'behind the scenes' role during the pre-transition period, assisting MFP field personnel with information and collaborating on the development of plans for pre and post-transition services. Before MFP participants discharge from an inpatient facility, CMs/CCs/SCs assist with plans for and establish risk management systems, including 24/7 emergency backup systems, to the extent possible. On the day of discharge, MFP field personnel work collaboratively with CM/CC/SCs to ensure a smooth transition. After discharge, the CM/CC/SC take a lead role in coordinating services, but MFP field personnel follow-up with MFP participants at least one every 30 days during the MFP period of participation to ensure that MFP demonstration services have been implemented.

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Training of MFP field personnel (MDSQ OCs, MFP TCs, DD PLAs and CEs) and waiver personnel (CMs/CCs/SCs) is critical. Personnel are trained together and trained to work collaboratively using team approaches when possible. Both MFP and waiver personnel need specialized knowledge in waiver services/options, transition, self-direction, following service budgets, procurement of specialized medical equipment and assistive technology devices, arranging for peer supports, locating housing and transportation, and obtaining other community resources.

### **MFP CBAY Care Management Services**

For MFP CBAY youth with mental illness residing in PRTFs, the hub of service planning and coordination occurs through the Child and Family Team. The youth and his/her family and the Care Coordinator who provides care management services and support comprise the core of the hub with the onus of initial planning on the Care Coordinator based on family- and youth-centered input. As the youth and family develop new skills and evolve from a point of crisis to growing stability, they take on increasing responsibility for arrangements for service planning and coordination.

MFP CBAY Care Management Services assist participants in identifying and gaining access to needed MFP and State Plan Services, as well as medical, social, educational and other services, regardless of the funding source. Care Management Services are a set of interrelated activities for identifying, planning, budgeting, documenting, coordinating, and reviewing the delivery and outcome of appropriate services for participants through a wraparound approach. Care Coordinators work in partnership with the participant and their family/caregivers/legal guardian and are responsible for assembling the Child and Family Team, including both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person-centered, build upon strengths and capabilities, and address participant health and safety issues. The role of Care Management is critical to the overall success of the planning process and program as Care Coordinators are responsible for conducting the highly individualized and highly intensive wraparound planning process, facilitating all perspectives and achieving team consensus. This service requires the individual to build strong and trusting relationships with all team members to ensure the team environment is a safe and secure place to address extremely difficult issues and foster honest communication to achieve solution oriented outcomes.

Care Management Services include the following components as frequently as necessary:

- Care Management - Transition Services may be provided to eligible individuals presently residing in an accredited Psychiatric Residential Treatment Facility (PRTF) to assist them in obtaining and coordinating services that are necessary to return them to the community. Care Management-Transition Services may be provided up to 120 days prior to transition. This service must be approved in advance and providers may not bill for this service until the date that the participant leaves the PRTF and is receiving other MFP services in a community setting.

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- Participants will be given choice of qualified providers of care management services. Care Management Services must be authorized prior to service delivery by the DBHDD and at least annually in conjunction with the ISP and any revisions.
- Comprehensive assessment and periodic reassessment of the participant to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, or other services and include activities such as: taking client history; identifying the needs, strengths, preferences and physical and social environment of the individual, and completing related documentation; gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the participant.
- Development and periodic revision of an individualized service plan (ISP), based on the assessment, that specifies the goals of providing care management and the actions to address the medical, social, educational, and other services needed by the participant, including activities that ensure active participation by the participant and others. The care plan will include a transition goal and plan. If a participant declines services identified in the care plan, it must be documented. The Care Coordinator is responsible for seeking service plan authorization through the operating agency (DBHDD) with oversight by the Medicaid Agency.
- Care Management Services encourages the use of community resources through referral to appropriate traditional and non-traditional providers, paid, unpaid and natural supports. Referral and related activities to help the participant obtain needed services, including activities that help link the eligible individual with medical, social, educational providers, and other programs or services that are capable of providing services to address identified needs and achieve goals in the care plan.
- Monitoring and follow-up activities that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the participant. Monitoring includes direct observation, and follow-up to ensure that service plans have the intended effect and that approaches to address challenging behaviors, medical and health needs, and skill acquisition are coordinated in their approach and anticipated outcome. Monitoring includes reviewing the quality and outcome of services and the ongoing evaluation of the satisfaction of participants and their families and/or caregivers/legal guardians with the ISP. These activities may be with the participant, family members, providers, or other entities, and may be conducted as frequently as necessary, and at least on an annual basis, to help determine: whether services are being furnished in accordance with the participant's service plan; whether the services in the care plan are adequate to meet the needs of the participant; whether there are changes in the needs or status of the

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participant. If changes have occurred, the individual service plan and service arrangements with providers will be updated to reflect changes.

- Care Management Services may include contacts with individuals that are directly related to the identification of the participant's needs and care, for the purposes of assisting participants' access to services, identifying needs and supports to assist the participant in obtaining services, providing Care Coordinators with useful feedback, and alerting Care Coordinators to changes in the participant's needs.
- Care Management Services also assist participants and their families or representatives in making informed decisions about the participant-direction option and assist those who opt for participant-direction with enrollment and access to this option.

When care planning progresses to readiness for the participant to graduate or age out of the program, a key deliverable of the Child and Family Team is to ensure the participant is connected to a primary care physician for integrated health planning and support in transition from MFP services and/or transition to adult community-based resources.

### **24/7 Emergency Backup**

Georgia's MFP emergency backup system serves participants through the existing HCBS waivers. As described in each 1915c waiver application, emergency backup systems are unique to each waiver, but include common elements. What follows is an abbreviated description of how 24/7 emergency backup plans are developed in service plans and how participants use them. For MFP participants who do not enter a HCBS waiver, the 24/7 backup plan is developed during the ITP planning process and is written up in the ITP (see Appendix O, Q8). The focus of the MFP 24/7 emergency backup plan for non-waiver participants is on participant health, welfare and safety and identifies such things as emergency egress from qualified housing, what to do during severe weather or power outages, and who to call about equipment failures. The TC is responsible for distributing the plan to the transition team and 'testing' the 24/7 emergency backup plan with the participant on moving day or shortly thereafter to ensure that the participant understands and is able to follow the plan. In addition, both the TC and the Home Care Ombudsman make monthly contact with the participant to resolve any problems.

### **24/7 Emergency Backup for OA and PD/TBI Participants**

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

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Health and case managers are responsible for overseeing the reporting of and response to emergency back-up needs.

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

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

Case management agencies document all emergencies. Case managers triage each incident and request additional emergency response, if needed. When there is an immediate threat to the health, safety, and/or welfare of the waiver participant, case managers may immediately (within 24 hours) relocate the member to another setting. As with critical incidents, use of the 24/7 emergency backup system is reported to waiver program manager in the appropriate waiver operating agency. The waiver program managers forward these monthly reports to the MFP TCs and TCs forward them to DCH/MFP office staff for review by the Project Director. Additionally for MFP participants, MFP field personnel (MDSO OCs, MFP TCs, DD PLAs, CEs) must complete the *MFP Sentinel Event Report* (see *Appendix AB*) for each sentinel event and forward the completed document to the MFP Project Director who along with the MFP Project Compliance Auditor investigate the event and ensure that appropriate corrective actions are taken (for additional details, see *B.2 Critical Incident Reporting Systems*).

### **24/7 Emergency Backup for IIDD**

Under the NOW and COMP waivers, DBHDD-DDD uses a standardized process for reporting and response to the need for emergency back-up. Service plans identify risks using assessment reports from the Health Risk Screening Tool (HRST). Action plans for each identified risk are prepared, with efforts to minimize risks and identify if supports interfere with what is most important to the participant. Service plans detail the provider agency's backup plans for staff coverage and capacity to provide additional staff on an intermittent basis. Service plans cover equipment and transportation failures and emergency backup plans for self-directed options. In

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these instances, the service plan also specifies an individual backup plan to address contingencies such as emergencies occurring when a support worker's failure to appear when scheduled presents a risk to the participant's health and welfare. The service plan of any waiver participant who participant-directs must include an assessment of risk and specify an individualized risk management plan. The case manager ensures that the service plan meets all requirements for waiver participants who opt for self-direction. Participants, family members of participants and/or guardians, or any other persons may initiate reports of critical incidents to case managers, providers and/or the DBHDD Investigation Section (for additional details, see B.2 Critical Incident Reporting Systems).

### **24/7 Emergency Backup for MFP CBAY Youth with Mental Illness**

MFP CBAY Care Coordinators assist each MFP CBAY Child and Family Team to identify risks to participant health, safety and welfare. Risks to health, safety and welfare are documented and address during the pre-discharge planning process in the MFP CBAY Individualized Transition Action Plan and subsequently reviewed in the post-discharge review of the action plan. For each risk identified, a plan for services and support is developed and included in the plan. The child and Family Team are assisted in planning for and developing 24/7 emergency backup plans. Together the Care Coordinator and Child and Family Team implement, monitoring and improve these 24/7 emergency backup plans.

When a MFP CBAY Care Coordinator becomes aware that a MFP participant has used the 24/7 emergency backup plan, the Care Coordinator follows-up with the Child and Family Team (parents/caregivers/participant/vendor) to see how MFP services are working and if additional MFP services are needed to reduce or prevent the use of emergency backup systems. Care Coordinators complete the MFP *Sentinel Event Report Form* (see Appendix AB) when circumstances warrant. These completed *Sentinel Event Reports* are forwarded to the MFP Project Director and MFP Project Compliance Auditor for review.

The MFP CBAY Care Coordinator is charged with the following regarding the 24/7 emergency backup plan:

- Is the system in place on the day of discharge from the PRTF?
- Does the MFP CBAY Child and Family Team know who to call based on the type of emergency experienced?
- How will MFP Care Coordinator and Child and Family Team know that the participant understands how to use the emergency system?
- Is the system in place for all critical health or supportive services and providers for MFP transition services and for waiver services?

### ***B.7 Self-Direction or Participant Direction***

This section describes the participant-directed support systems in place for MFP participants. This section begins with a description of participant-direction over MFP demonstration services, participant-centered service plan development, service plan implementation and monitoring, and participant-directed approaches, goals, and decision-making authority. For MFP participants entering HCBS waivers, each waiver provides participants with opportunities and supports for participant-direction. This section includes a description of procedures for voluntary and involuntary switches from participant-direction and describes the agencies responsible for participant counseling. This section concludes with recommendations for improvement to self-direction using the Georgia MFP demonstration, based on comments received from statewide forums with stakeholders.

#### **Participant-Directed MFP Demonstration Services**

MFP participants request MFP demonstration services based on person-centered planning as documented in the participant's transition plan (ITP/ISP/Action Plans, see *Appendix O and H*) and authorized by MFP field personnel using the *MFP Authorization for Transition Services* (see B.5 and *Appendix S*). Transition planning must include a proposed budget amount for each authorized MFP demonstration service, based on fee-for-service that does not exceed the individual service cap.

#### **Participant-Centered Service Plan Development**

The MFP Screening Form, the MFP Informed Consent and the MFP Release of Health Information identify the choices available to MFP participants (see Appendix G, D1 and D2). Likewise for MFP CBAY participants, the Freedom of Choice form verifies that the youth, family, and/or guardian has been fully informed of the services available in the PRTF setting and feasible alternatives available through MFP services. Additionally, the review of this form and the resulting signature on it attests that the participant/family has made an informed, voluntary choice.

Participant-centered service plan development for MFP services affords participants the opportunity to express their goals, resources and needs and select MFP demonstration services that can be used to address needs. Participant selection of these MFP services includes exercising decision-making in the selection of services and the determination of a budget amount for each service that stays within the individual service cap (see B.5 for details).

MFP field personnel working in concert with the participant and circle-of-support/transition team (for MFP CBAY - The Care Coordinator, in conjunction with the Child and Family Team), develops the Individualized Transition Plan (ITP/ISP/Action Plan). The transition plan is developed based upon the participant's strengths and needs and identified goals as determined by the transition team. Input of all members of the team, with special consideration given to the family's and participant's wishes, is used to identify the appropriate services and natural supports that are built into the transition plan to move the participant toward meeting their goals.

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A participant may select any willing and qualified provider to furnish MFP services included in the approved transition plan. MFP field personnel cooperate with the participant, circle-of-support, parent, and/or guardian to support the participant's right to change service providers at any time. Field personnel refer to other providers of direct services in the area. If, due to the rural nature of the area and lack of access to other providers, a parent/guardian/participant chooses the Care Management Provider to provide other services, the Care Coordinator will disclose any potential conflicts of interest including their employment by the agency that is also certified to provide other MFP and state plan services. MFP field personnel will not directly provide other MFP services.

Additionally, the State Office staff will periodically participate in transition planning meetings and review periodic reports of service encounters by client and provider to monitor the extent to which MFP field personnel/Providers are providing other services.

### **Participant-Direction under E&D and ICWP Waivers**

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

Person-centered planning is used to identify preferences and goals for inclusion in the participant's *Individualized Transition Plan (ITP)* (see *Appendix O*) including the participant's desire to participant-direct their services.

The Elderly and Disabled waiver and ICWP waiver provide for employer authority and budget authority over Personal Support Services (PSS). After being enrolled for six months in one of these waivers, the participant may select and interview PSS providers, choose qualified provider(s) and/or become the employer of record, and select a Financial Management Service (FMS). The participant then hires, trains, schedules, manages, and when necessary, discharges PSS staff. The options are similar for participants entering the NOW and COMP waivers. These waivers provide

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participants with employer authority, including a co-employer option, and budget authority, to select and manage nearly all waiver services.

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

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

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

### **Participant-Direction In NOW and COMP Waivers**

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

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

### **Voluntary and Involuntary Switches from Participant-Direction**

Participants may voluntarily choose to return to the traditional agency directed services if they determine that they lack the interest or ability to participant-direct their services. To assure that they return to the traditional waiver services while maintaining continuity of care, communication with case management personnel (CMs, CCs, SCs) is critical. Case management personnel educate participants on giving adequate notice to their worker(s). This provides case management personnel time needed to follow standard procedures to switch the option. When voluntary switches occur, the participant and/or guardian contacts the CM/CC/SC, who brokers services with a waiver enrolled provider agency selected by the participant, updates the service plan, and removes the enrollment in the Financial Management Service on the PA and service plan. The CM/CC/SC assures and monitors the health and welfare of the participant during the transition.

In the Elderly and Disabled and ICWP waivers, the participant may be involuntarily switched from participant-direction of PSS to provider-managed services for any of (but not limited to) the following reasons: 1) failure to meet responsibilities and/or identified health and safety issues for participant, 2) failure to maintain maximum control over daily schedule, 3) inability to complete accurately and timely all FMS documents, to manage budget—leading to over use of PSS budget for 2 consecutive months, 4) fraud, 5) use of state backup plan one or more times per month for 2 consecutive months, 6) not meeting the goals of the Service Plan for 2 consecutive quarters. The case manager plans and implements return to traditional services, reports health, safety, fraud, or abuse concerns to appropriate state agencies.

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

### **Education on Self-Direction**

MFP participants are provided with current information available to waiver participants through their case manager as indicated in 1915c waivers. Participants

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

### **Financial Management Agencies under Contract with the State**

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

### **Opportunities for Quality Improvements to Participant-Direction**

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

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

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

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

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

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

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

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

In an effort to address these issues, MFP is developing a Direct Services Workforce (DSW) initiative to assist waiver specialists by expanding efforts to increase the availability of providers through certification of direct support professionals and Certified Medication Aides in all waivers, as has been done with DDD programs. The DBHDD-DDD, the Governor's Council of Developmental Disabilities, and the Department of Adult and Technical Education launched a direct support professional certificate training program at four state technical colleges.

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

In August 2011, the state promulgated new 'proxy caregiver' regulations that permit direct care service workers to provide more help with medication administration and other health maintenance tasks, so long as the individual receiving services provided informed consent. These new rules promote consumer direction and offer more relief to participants and caregivers.

## **B.8 Quality Management System**

Georgia's MFP Demonstration uses existing HCBS waivers. MFP participants are afforded the same level of safeguards as those available to participants enrolled in existing waivers, as described in 1915c Appendix H; Elderly and Disabled Waiver (Number: GA.0112.90R2, Amendment Number: GA.0112.R06.00, Effective Date: 10/01/2012); the Independent Care Waiver Program (ICWP, Waiver Number: 4170.90.R2, Effective Date 4/1/2012), the New Options Waiver (NOW Waiver Number: GA.0175, Effective Date: 10/01/2012) and Comprehensive Supports Waiver Program (COMP, Waiver Number: GA.0323, Effective Date: 5/01/2012).

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

### **MFP Demonstration QMS Strategy - Project Evaluation Process**

Under the MFP Demonstration, the MFP Steering Committee and the MFP Project Evaluation Advisory Team are both convened quarterly to review project evaluation data. Progress toward demonstration benchmarks is tracked and reported quarterly. An external evaluator conducts, analyzes and reports on Quality of Life survey data and demonstration service utilization. Per member pre-/post-transition cost data is tracked and reported. Semiannual reports to MPR/CMS are reviewed. A project logic model is employed to track and measure performance of the project based on outputs, outcomes and impacts. The following performance measures are tracked, analyzed, reported and results are used to make improvements to the MFP Demonstration:

- # of barriers addressed that prevent flexible use of Medicaid funds
- # of barriers to transition through a formal process, reviewed and addressed
- # of MDSQ referrals to MFP
- # of self-identified referrals to MFP
- # of outreach events targeted at potential participants and the general public
- # of attendees at outreach events
- # of meetings with professionals in nursing facilities and inpatient settings
- # of outreach contacts to nursing facility/inpatient professional organizations
- # of face-to-face meetings with potential participants in inpatient settings
- # of completed participant screenings
- # of participants signing off on transition plans (ITPs, ISP, Action Plans)
- # of MFP participants discharging into HCBS waivers
- # of participants discharging with MFP Demonstration services (no waiver services)
- # of participants choosing 'own home' as 1st housing choice
- # of tenant based rental assistance vouchers secured

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- # of housing choice vouchers secured for use by MFP participants
- # of entities approached for housing assistance for MFP participants
- # of resources/people in MFP participants' network/circle of support/transition team
- # of referrals for MFP service –Home Care Ombudsman (HCO)
- # of referrals for MFP service - Life Skills Coaching (LSC)
- # of referrals for MFP service –Peer Community Support (PES)
- # of referrals for MFP service –Supported Employment Evaluation (SEE)
- # of participants doing volunteer work or work for pay
- # of training opportunities provided to direct service workforce about MFP
- # of presentations made to providers, professionals and the public about MFP
- # of participant PMPM cost to Medicaid pre and post transition
- Strategy and procedures in place to provide quality assurance for eligible individuals receiving HCBS to increase MFP participant satisfaction
- # of Quality of Life baseline, 1<sup>st</sup> and 2<sup>nd</sup> year surveys administered
- # of Sentinel Events identified and reported
- # of Sentinel Events reviewed by MFP Project Director and Project Compliance Specialist

In addition to performance measurement, MFP QMS includes site visits by MFP office staff with field personnel. Annually, office staff randomly shadows 10% of MFP field personnel and conduct post-transition interviews with the MFP participants in an effort to identify policy and procedures that are working and procedures that need to be improved and to verify the competencies of field personnel. Document audits are conducted by MFP office staff to 1) determine that all participants meet all applicable requirements of the project, 2) ensure that satisfied requirements are appropriately documented, and 3) ensure that MFP field personnel provide services as described in the MFP Policy and Procedures Manual and Amendments. Annual document audits are based on a random sample of 20% of participant files.

### **MFP CBAY Evaluation Process**

The MFP demonstration provides MFP CBAY the opportunity to evaluate the MFP CBAY project. The MFP CBAY evaluation created the first baseline of outcomes for youth with mental illness. The baseline is used to evaluate certain performance measures as part of the state's quality assurance management strategy. Georgia applies these same performance measures to the MFP CBAY project for Youth with Mental Illness. This includes tracking and quality assurance for level of care determinations, development of plans of care, enrollment of qualified providers, provision of medically necessary, treatment plan goal-oriented service delivery, and person-centered service delivery. The DCH and DBHDD as partners have agreed to quarterly reporting and review of data related to these performance measures. The Evaluation methodology will track individual youth satisfaction and resiliency and fidelity to the Wraparound model.

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Youth will complete a Healthy Kids Survey, modules A & B at admission and every 6 months thereafter. The Evaluator will collect, analyze and report out the findings.

The components of the fidelity evaluation are outlined below in the variables description in section D.3. The CMEs will report on a CME Fidelity Report four times a year in **February** (October –January), **May** (February - April), **August** (May - July) and **November** (August - October) and move forward with the quarterly schedule. CMEs submit the Fidelity Report online to the Center for Excellence.

These documents will be reviewed by the DCH and DBHDD departments and the Quality Council. The evaluation additionally summarizes the goals and objectives of the CME's Quality Improvement Plan, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings.

The MFP Quality of Life will also be administered according to CMS guidance for youth 18 years and older.

### CBAY Evaluation Design Variables

Table B.8.1 describes specific evaluation outcome variables to be collected in State evaluation and identifies instruments, e.g. surveys, to be used.

**Table B.8.1 MFP CBAY Evaluation Variables, Process, and Method**

FIDELITY MEASURES		
Indicator	Monitor	Frequency/Measurement
1. <b>Functioning</b> – Youth will be routinely assessed by both the Child and Adolescent Functional Assessment Scales (CAFAS) and the Columbia Impairment Scale (CIS) to determine if their functioning is increasing.	CMEs are responsible for administering the CIS and for obtaining the CAFAS score from the Core Provider for the youth routinely.	The CAFAS is to be collected and reported every 90 days. The CIS is to be administered monthly to parents. Data will be collected in Synthesis. Data is reported 4x a year on the CME Fidelity Report.
2. <b>School</b> - Youth school attendance will improve during their time in Wraparound.	CMEs are responsible for tracking the school attendance of the youth monthly.	CMEs will request copies of attendance records from families for 6 months prior to Wraparound and monthly during Wraparound. Data will be collected in Synthesis. Data is reported 4x's a year on the CME Fidelity Report
3. <b>Number of Successful Dis-enrollments</b>	CMEs are responsible for tracking disenrollment.	CMEs will track the discharge of all youth and determine if they are successful or unsuccessful. This will be properly documented in Synthesis and will be reported 4xs a year on the CME Fidelity Monitoring Report.

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<p><b>4. Family Satisfaction - Provider</b></p> <p>Caregivers and youth must be satisfied with CMEs/CBAY/MFP and its Provider Network services.</p>	<p>CMEs will collect family satisfaction surveys twice a year.</p>	<p>Care Coordinators (CCs) provide the Youth Satisfaction Scale – Family (YSSF) to participant families. CCs deliver the YSSF in a sealed envelope to the CQI office for processing. QA/QI logs the data to their internal spreadsheet and then mails all surveys to DBHDD CBAY/MFP Director. The forms are delivered to UGA. UGA scans and emails the data to DBHDD. This process will happen in June and December of each year.</p>
<p><b>5. Formal/Informal/Natural Supports</b> Formal supports are described as the professionals working with the family. Informal supports are described as community resources serving on the Child and Family Team (CFT) in usually a non-paid role. These individuals may be the family members (other than the youth and parent), friends, neighbors, faith-based supports and kinship providers.</p>	<p>CMEs are responsible for tracking who participates on the child and family team monthly.</p>	<p>CMEs will track monthly the number of formal versus informal supports attending child and family team meetings each month. They will report this data 4x a year in the CME Fidelity Monitoring Report.</p>
<p><b>6. Plan of Care</b> - POCs must reference all required and applicable life domains, will include a 24 hr. Safety and Crisis Plan (SCP), will identify child/family strengths and needs, will identify formal and informal/natural/community supports, will be signed off by a the entire Child and Family Team and will acknowledge that the Child and Family Team was in attendance at the meeting and participated in the creation and/or revision of the ISP. ISP Audits are conducted by the DBHDD Child &amp; Adolescent office</p>	<p>CMEs are responsible for writing Action Plans (POCs) and Safety and Crisis Plans each month from CFTs and from Emergency CFTs. They are also responsible for submitting them to the state office within 7 days of the meeting. If there are submitted more than 15 days past the meeting or 30 days past the due date, they will not be accepted or reviewed.</p>	<p>CMEs will track monthly action and safety and crisis plans for each youth. They will track due dates, submission dates and approval/denial dates. This will be collected in Synthesis and reported 4xs a year on the CME Fidelity Monitoring Report.</p>
<p><b>7. Costs</b> - The cost of providing services for youth/families in CBAY/MFP will be less than providing services for youth/families in Psychiatric Residential Treatment Facilities.</p>	<p>CMEs will be responsible for submitting Service Authorization Requests quarterly for CBAY/MFP youth. They will monitor the cost associated with what is being spent quarterly.</p>	<p>CMEs will get Monthly Service Summaries from providers of CBAY/MFP services and Core Providers in order to gauge if costs are less than that of the institution on an individual basis.</p>

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The Center of Excellence (COE) for Child & Adolescent Behavioral Health at Georgia State University will provide supports to the Quality Improvement Process. This requires working with QA staff at each CME to generate regular fidelity reports and corrective action plans to ensure a quality data collection process. Training will be conducted through webinars and face-to-face workshops to reinforce fidelity and troubleshoot quality issues. Monthly conference calls will be held with CMEs and the COE will report process evaluation measures across all CMEs. Quality Improvement will address processes related to:

- Administering individual outcome evaluation instruments such as the Youth and Family Satisfaction with Wraparound (YSS-F), the Family Empowerment Scale (FES), the CIS, the CAFAS, and the Healthy Kids Survey.
- Fidelity to Wraparound Principles
- Frequency of adhering to principles of being community based; strength based; individualized and outcome based; collaborative and outcome based; team based; and team based and collaborative.
- Frequency and purpose of contacts with families.
- Frequency of honoring family voice and choice by allowing families to choose the location, date/time, and participants of CFTs.
- Percent of natural, informal, and formal supports present at CFTs.
- Fidelity to the Timeline
- Time from referral to first face-to-face meeting.
- Time from referral to first CFT.
- Fidelity to the Wraparound model
- Youth and family multi-agency involvement.
- Youth and family multi-services involvement.

Other evaluations of processes are captured as part of the working partnership between the DCH and the DBHDD as described in this section.

Under the Master Agreement with DBHDD-Division of Community Mental Health Services, MFP CBAY uses a contractually binding document to outline the specific services and deliverables to be provided by MFP CBAY. Specific to MFP CBAY, the Agreement specifies roles, deliverables, measures, and remediation. The agreement further outlines the collaborative nature of the two agencies' responsibilities for implementing and monitoring a quality management plan, a project evaluation plan and employing a continuous quality improvement strategy. The DBHDD-DCMH is responsible for operating a Quality Council charged with identifying opportunities for quality and system improvement. The quality mechanisms that exist already through the Master Agreement with DBHDD that is applicable to all behavioral health services funded through Medicaid will apply to MFP CBAY Youth with Mental Illness. The DBHDD Master Agreement addresses expectations of cooperation, information sharing, and operations regarding: Inspection of Work, Ownership of Work Product and Data, Safeguarding Information, DBHDD Staffing Requirements, Records and Reports, Financial Data, Statutory Compliance, Confidentiality Requirements, Notices, and Compliance with DCH Policies. The Agreement addresses systems improvement strategies specific to MFP CBAY and MFP

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demonstration services for Youth with Mental Illness. The agreement to hold monthly planning and services review meetings support a collaborative process whereby service and utilization trends are reviewed and related actions addressed; at these meetings and in between as needed, global challenges or issues for the MFP CBAY project are considered. Timelines for remediation or corrective action are outlined and where not prescribed, DCH holds the ultimate authority for establishing corrective action and related timelines. As part of these meetings and outside of the meetings as needed, DBHDD provides monthly tracking data representing the cumulative number of youth served through the program with stratification analysis. Recommendations are made as a result of data reporting findings as needed for which plans of action with assigned responsibilities for each agency are recorded and thereafter used to support tracking toward completion of recommended actions.

The DBHDD-DCMH, MFP CBAY Quality Council referenced above is comprised of child-serving agency representatives, family members, CBAY graduates, community partners, representation from the state Medicaid agency, and CBAY and now MFP providers. The Quality Council provides an official forum for evaluating the quality of services provided to youth enrolled in the waiver and in the MFP demonstration as well as the overall quality of the MFP CBAY project design. The Quality Council will review data to trend issues, prioritize and create changes as needed. The application of performance measures and project evaluation will enable the State to analyze and assess compliance and outcomes across similar populations for a greater study population while at the same time enable stratification by funding source.

### **QMS Strategy – E&D, ICWP, NOW and COMP Waivers**

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

The ICWP Advisory Council, an external review organization (the Georgia Medical Care Foundation – GMCF) and the ICWP program director monitor the quality of the ICWP waiver. The program director meets with the ICWP Advisory Council on a regular basis. Together with the External Review Organization (GMCF), they are charged with oversight of the entire ICWP waiver program. Activities of the ICWP Advisory Council include: conducting, analyzing, and reporting on participant customer satisfaction surveys; providing training, reviewing sentinel events/health and welfare of participants through risk assessment, planning and prevention; reviewing access data and reports; reviewing procedures and reports regarding person-centered planning; medical records reviews; performance reviews of case management staff; claim payment reviews; and monitoring of self-directed PSS options.

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In its role as the Operating Agency for the NOW and COMP Waiver Programs, the Department of Behavioral Health and Developmental Disabilities operates under a holistic Quality Management Plan with local components such as Regional Quality Improvement Councils that coordinate activities with an overall State QI Council. On both a local and statewide level, DBHDD uses data to identify benchmarks, track and trend activities and outcomes, and develop remediation strategies. Additionally, DBHDD contracts with an external review organization to perform provider reviews, individual reviews and satisfaction surveys, and tracks National Core Indicators. The ERO also provides technical assistance to service providers both on a routine random sample basis as well as by request, and maintains a tracking system for technical assistance and follow up to determine outcomes. Finally, DBHDD is in the process of procuring a contract for an Administrative Services Organization which will combine several data management functions that have a direct impact on the Quality Management System. Those functions include management of the service authorization system, management of an electronic clinical record system, management of service outcome data and data analytics. With those functions combined, there will be a significantly expanded potential to use various sources of data to track and trend outcomes on the individual, the service delivery and the programmatic level.

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

### **1. Level of Care (LOC) Determinations**

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

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

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

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

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

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

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

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

- Initial Application for Services data
- Date of completion of various parts of the process
- Copy of Application, Intake Screening Summary and ancillary notes and testing required to determine eligibility with schedule and completion dates

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- Initial and annual LOC assessments (with assessment reports from approved instruments) including:
  - Supports Intensity Scale
  - Health Risk Screening Tool
  - Social Work, Nursing, Psychological and Therapy Assessments
  - DMA-6 (LOC determination form)

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

Under the Master Agreement with DBHDD-DCMH, MFP CBAY, tracked Level of Care performance measures include:

- # and % of MFP CBAY participants who received a level of care determination prior to receipt of waiver/MFP services ( Note: each Waiver/MFP/program could use their own language, ex. institutional care)
- # and % of level of care determinations reevaluated within 12 months of the previous determination or to receipt of MFP CBAY services
- # and % of level of care determinations conducted by a qualified evaluator
- # and % of level of care determinations reviewed and approved by a qualified professional as specified in the MFP CBAY
- # and % of level of care determinations using the approved assessment instrument(s)

## **2. Service Plan Description and Service Delivery**

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

The Division of Aging Services (DAS) along with the DCH Utilization Review (UR) Team uses a system of monitoring the Elderly and Disabled waiver service plans statewide to ensure that service units are implemented according to service plans. DAS randomly monitors 10% of service plans for implementation and UR conducts reviews of service plan implementation with 90% of providers every two years. DAS and DCH meet quarterly to review any negative findings and trends. Plans for remediation and improvement are developed and implemented. DAS monitors 100% of statewide Area Agencies on Aging (AAA) for participant assessment/re-assessment and service plan development and implementation. DAS uses a

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discovery process with providers as well. DAS collects and analyzes service delivery information from each provider. DAS reviews 100% of service orders authorizing service types, frequency, and cost of services. DAS also collects data on the percent of service units delivered compared to service units ordered. Collected data is compiled into a report. During joint quarterly meetings, DAS provides the report to DCH, detailing statewide service delivery, including the percent of service plans reviews completed timely, percent of annual service plan reassessments completed timely, percent of service units delivered compared to service units ordered, and percent of participants offered choice between services and institutional care. AAAs that fall below a threshold of 90% compliance are required to submit an action plan detailing remediation for improvement.

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

Under the NOW and COMP waivers, support coordinators facilitate meetings with participants/representatives for the development of service plans. A random sample of service plans is reviewed by state DBHDD office staff on a quarterly basis. Weaknesses identified in service plans are noted and trended. Statewide training on service plan development and implementation is conducted by DBHDD and contracted staff. Input is sought from stakeholders including support coordination, assessment, and service provider staff regarding the content and presentation format of service plan training. Regional Office staff review five to ten percent of all service plans on a monthly basis. Audit results are shared with support coordination agencies (providers) and DBHDD, with the expectation that providers address identified issues.

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

The Web Information System (WIS) provides reports related to the management of service plans and service delivery. The "Participant ISP Expiration Report" is

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

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

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

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

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

- Convert ISP to electronic format
- Provide secure electronic signatures
- Record and track ISP due dates, meeting schedules, and dates of actual meetings

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- Sort ISP scheduling issues by:
  - Service provider, region, support coordination Agency, and support coordinator
  - Time and location of ISP meetings
  - Cancellations and reasons for cancellation
- Maintain assessment data from Supports Intensity Scale (SIS). Support coordination staff administer the SIS. The process of comparing SIS indicated supports against actual services and supports provides discovery data and results in the development of higher quality ISPs and more effective service delivery statewide.

Under the Master Agreement with DBHDD-DCMH, MFP CBAY, tracked Service Planning performance measures include:

- # and % of MFP CBAY participants whose service plans reflect needs, risks, and personal goals identified through assessment
- # and % of service plans developed with MFP CBAY participant and/or legally responsible representative according to MFP CBAY guidelines
- # and % of MFP CBAY participants whose service plans were revised annually
- # and % of MFP CBAY participants whose service plans revised were revised as needed to address changing need. ( Note : denominator = the # of participants reviewed who needed a change in their ISP to address changing need)
- # and % of MFP CBAY participants who received services specified in the service plan
- # and % of MFP CBAY participants whose records contain a signed freedom of choice form indicating choice in receiving community-based services rather than institutional care
- # and % of MFP CBAY participants whose records contain documentation that they were offered a choice of HCBS MFP CBAY providers and/or services

### 3. Identification of Qualified Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Under the Master Agreement with DBHDD-DCMH, MFP CBAY, the following Qualified Provider performance measures are tracked and reported including:

- # and % of provider applicants appropriately licensed prior to providing MFP CBAY services
- # and % of provider applicants appropriately certified prior to providing MFP CBAY services
- # and % of licensed providers that continue to meet licensing requirements

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- # and % of certified providers that continue to meet certification requirements
- # and % of MFP CBAY non-licensed/certified providers that meet waiver/MFP policy requirements prior to the provision of waiver/MFP CBAY services
- # and % of MFP CBAY non-licensed/certified providers that continue to meet MFP policy requirements
- # and % of enrolled MFP CBAY providers that comply with training requirements

### **4. Participant Health and Welfare**

Information from the MDS-HC is used to identify risks to the Elderly and Disabled Waiver participant's health and welfare. Each identified risk is included in service plan with individualized contingency plans. Under the Elderly and Disabled waiver program, each risk trigger from the *MDS-HC* is identified on the service plan with individualized service plans to minimize risks. Participants/guardians receive information about the participant's civil rights and responsibilities from case managers and providers upon admission to the waiver. They are informed of the right to be free from mental, verbal, sexual, and physical abuse, neglect, exploitation, isolation and corporal or unusual punishment and how complaints and/or concerns are reported.

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

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

Case managers also maintain a monthly provider 'complaint log.' The complaint log documents non-compliance issues that jeopardize the health and safety of participants. Action plans to remediate deficiencies are prepared and implemented by the case managers and the Area Agencies on Aging. If necessary, services are

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

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

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

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

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

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

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

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

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

Under the Master Agreement with DBHDD-DCMH, MFP CBAY, the following Health and Welfare performance measures are tracked and reported, including:

- # and % of MFP CBAY participants who receive information at admission and annually in recognizing and reporting abuse, neglect and exploitation
- # and % of all MFP CBAY sentinel event / critical incident reports following MFP CBAY policy were addressed according to MFP CBAY policy
- # and % of MFP CBAY participant unexpected or suspicious deaths reviewed by the Mortality Review Board
- # and % of MFP CBAY participants with emergency preparedness plans
- # and % of MFP CBAY participants receiving behavioral supports per MFP CBAY policy
- # and % of participants whose medication regimes is followed according to requirements

### **5. Waiver Administrative Oversight and Evaluation of QMS**

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

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

Under the Elderly and Disabled Waiver, DAS provides copies of analysis and reports to DCH. DCH conducts monitoring and analysis of the Division, the AAAs, case managers, and service provider activities. Corrective Action Plans are required whenever performance indicator variances do not meet state norms. DCH Program Integrity provides additional monitoring and investigation and reports findings to DCH. DCH and DAS meet at least quarterly to review program performance,

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monitoring reports, action plans for remediation, and opportunities for quality improvement. DCH clarifies the roles of the entities responsible for making improvements in systems performance and sets specific timelines for implementation.

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

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

Under the Master Agreement with DBHDD-DCMH, MFP CBAY, the quality mechanisms that already exist are applicable to all behavioral health services including MFP CBAY demonstration services. DCH Division of Medicaid retains ultimate administrative authority and responsibility for the operation of the MFP CBAY demonstration by exercising oversight of the performance of MFP CBAY functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

### **6. Financial Oversight of the Waivers**

For all waivers, The Department of Community Health (DCH) Medicaid Division maintains ultimate authority and responsibility for financial accountability to CMS and the executive and legislative branches of state government (for process detail related to the integration of MFP and HCBS waiver services and financial processes, see *Appendix N1: New CMS-1500 Claim Form*, *Appendix N2: FI Invoice to DCH for Payment*, *Appendix V: MFP DCH DHR Vendor Import File* and *Appendix Y: Participant Enrollment Status Change Form*).

The DHS Division of Aging Services (DAS) monitors the day-to-day operations and financial accountability for the Elderly and Disabled Waiver. DAS uses the Aging Information Management System (AIMS) to collect financial data, including monthly Service Authorizations for participant services and payment data from the DCH fiscal intermediary. This data is analyzed monthly by DAS to assure statewide program expenditures are within budget allocation. The AAAs are required to review

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expenditures versus allocation monthly. DAS uses a Client Health Assessment Tool (CHAT) to collect specific data on program activities including number of participants admitted or discharged, active participant counts and participants pending Medicaid who will retroactively impact the waiver budget. The AAAs are responsible for reviewing participant costs that are above a pre-determined threshold and requesting justification from the care coordination agency. DAS and the AAAs are responsible for reviewing the care coordination lapse report quarterly to assure expenditures are within the allocated budget.

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

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

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

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

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

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

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

### **7. Emergency Backup Systems**

Emergency backup systems are unique to each waiver; 24/7 emergency backup plans are developed and deployed based on risks assessed in service plans. Under the Elderly and Disabled Waiver Program the Division of Aging Services (DAS) and the Department of Community Health share the responsibility for overseeing the reporting of and response to emergencies and critical events. Under the Independent Care Waiver Program (ICWP), the Georgia Department of Community Health is responsible for overseeing the 24/7 emergency backup system.

Information from the MDS-HC is used to identify risks to the Elderly and Disabled Waiver Program waiver participant's health and safety. Each identified risk is included in the service plan with individualized contingency plans. This is similar in the Independent Care Waiver Program (ICWP). Participant risks are addressed with action plans using the *Care Path*. The participant's physician signs off on the

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LOC/*Care Path* plan. Under the Elderly and Disabled waiver program, each risk trigger from the *MDS-HC* is identified on the service plan with individualized contingency plans to minimize risks. Participants/guardians receive information about the participant's civil rights and responsibilities from case managers and providers upon admission to the waiver. They are informed of the right to be free from mental, verbal, sexual, or physical abuse, neglect, exploitation, isolation, and corporal or unusual punishment, and how complaints and/or concerns are reported.

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

Case management agencies document emergencies and complaints. Participants and/or guardians report incidents to case managers within three days. Case managers triage each incident and request additional emergency response, if needed. Case managers immediately report the incident to Healthcare Facility Regulation if the provider is licensed and regulated by HFR. Case managers prepare a written report of the incident and send it to HFR. Non-licensed entities are reported to DHS Adult Protective Services (APS). When there is an immediate threat to the health, safety, and/or welfare of the waiver participant, case managers immediately (within 24 hours) relocate the member to another setting. Provider agencies are responsible for conducting an investigation of critical incidents/events and reporting their findings within five working days to case management agencies and if applicable, to HFR, the Office of the State Long-term Care Ombudsman, Adult Protective Services, local law enforcement, the participant's physician, family, and/or guardian. When indicated, findings are reported to appropriate certification and/or licensing boards. It is the responsibility of the provider agency to have written policies and procedures that address steps the agency takes to prevent abuse, neglect, and exploitation; actions the agency takes when such incidents are reported; and actions the agency takes to prevent future occurrences of such incidents. During provider agency investigations of critical incidents/events, case managers may be asked to monitor the agency and participant and follow-up on discoveries/reports/allegations of abuse, neglect, or exploitation.

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

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

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

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

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

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

### **Assessment of Other Concerns/Problems**

In addition to the assessment of health and safety risks, other service delivery problems and concerns are addressed in the service plan development process. For example, the plan details the provider agency's 24/7 emergency backup plan for assuring coverage and supervision in the event that a direct staff person does not

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report for his/her shift. Necessary staff-to-consumer ratios are documented. The agency identifies its capacity to provide additional staff response when needed on an intermittent basis for contingencies such as when a waiver participant is ill and needs extra care or when an individual's behavior threatens the safety of herself or others.

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

### **Emergency Backup Plan for MFP Services**

#### **MFP Contracted Services**

For contracted services (i.e. Peer Community Support, Trial Visits, contracted Moving Services, etc.), the MFP field staff (OCs, TCs, DD PLAs, CEs, CME, SC) recruit vendors, agencies, and/or contractors to provide these services. Each needed service is included in the participant's transition plan (Individualized Transition Plan- ITP, ISP, and Transition Action Plan) and authorized using the *MFP Authorization for Transition Services*. After the service is rendered, an invoice is obtained from the vendor/agency/contractor and transmitted with required documentation to the Fiscal Intermediary (FI). The FI pays the invoice.

Contingencies for emergency backup are included in the transition plan. If the vendor, agency, or contractor cannot provide a scheduled service to the MFP participant, the vendor, agency or contractor is required to call MFP field personnel and try to reschedule the service with for the participant. If that is not satisfactory, the vendor, agency, or contractor will offer a back-up service for the originally scheduled service. In addition to arranging alternatives with the MFP participant, the vendor, agency, or contractor is expected to contact MFP field personnel with this information.

#### **MFP Fee-For-Services**

Fee-for-service purchases (such as Household Furnishings, Household Goods and Supplies, etc.) are generally made through the Fiscal Intermediary. One-time goods and/or services needed by the MFP participant are discussed during the development of the transition plan. MFP field staff (OCs, TCs, DD PLAs, CEs, CME and SC) include needed goods and/or services in the Individualized Transition Plan (ITP, Person-Centered Description, Action Plan) and authorize these services using the *MFP Authorization for MFP Services* (see *Appendix S*). The participant and MFP field staff work together to locate and determine the cost of the goods and/or services. MFP field personnel authorizing the purchase of the goods and/or services are responsible for obtaining all necessary documentation that specifies how

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authorized services meet the transition goals in the transition plan. Qualified vendors and service providers deliver the goods/services and transmits the invoice information to MFP field personnel who review the invoice and forward it to the Fiscal Intermediary using the *appropriate Vendor Import File (see Appendix V)*. A paid invoice or receipt that provides clear evidence of the purchase must be kept with the participant's transition plan and a copy sent to the FI to support all goods and/or services purchased along with the *Vendor Payment Request (see Appendix U)*. The Fiscal Intermediary also tracks the purchases. If a vendor fails to provide the purchased goods and/or services, MFP field staff authorizing the expenditure are responsible for canceling the transaction and/or obtaining a refund from the vendor. Field personnel and MFP participants must locate another vendor willing to supply the goods and/or services.

### **Quality Improvements to the Critical Incident Reporting Systems**

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

### **QMS and the Development of Personal Support Services Staff**

In an effort to increase the availability and visibility of qualified persons to render services for HCBS waiver participants who wish to self-direct PSS, MFP is developing a Direct Services Workforce (DSW) initiative to assist waiver specialists by expanding efforts to increase the availability of providers through certification of direct support professionals and Certified Medication Aides in all waivers, as has been done with DD programs.

DBHDD, the Governor's Council of Developmental Disabilities, and the Department of Adult and Technical Education, launched a direct support professional certificate training program at four state technical colleges. The very successful program has continued to expand with new classes at additional colleges being added each quarter. Reaction to the certification program has been extremely positive from participants (Direct Support Professionals) and their employers. The Division of

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Developmental Disabilities has identified desired outcomes for the Direct Support Professional Certification Program, specifying indicators and developing data collection procedures used in the measurement of these outcomes. Results are used by DBHDD and other stakeholders in decision making regarding future funding, expansion, and incentives for the certificate program.

### **B.9 Housing**

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

#### **Qualified Residences**

Under MFP, a qualified residence includes:

- a home owned or leased by the transitioning individual or the individual's family member, or
- an apartment leased to the transitioning individual, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control
- a residence, in a community-based residential setting, in which no more than four unrelated individuals reside

Georgia MFP tracks and reports on the Semiannual Report to CMS the following type of qualified residences used by participants:

- 01 – Home (owned or leased by participant or family/partner)
- 02 – Apartment (individual lease by participant or family/partner), not assisted living
- 03 – Group home or personal care home with 4 or fewer unrelated individuals
- 04 – Apartment in qualified assisted living

During the screening process, the MFP participant's housing choice is documented and tracked in the MFP Manual Tracking System. Actual use of qualified housing and county of residence is documented using the *Discharge Day Checklist* (see *Appendix R*) and is tracked in the MFP Manual Tracking System. Actual use of qualified residence at discharge is reported to CMS on the semiannual report. Housing Quality Standards (HQS) will be followed for all housing with development or rental assistance funding through the U.S. Department of Housing and Urban Development and used by MFP participants. HQS inspections will be completed by the applicable state or local entity administering the HUD funds.

#### **Qualified Residences/Providers**

MFP participants transition into existing Medicaid 1915c waiver services. HCBS waiver services will be used along with MFP transition services to help people resettle in the community. Eligible elderly, blind and physically disabled MFP

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participants or all ages can enter the Elderly and Disabled waiver program; eligible MFP participants between the ages of 21 and 64 with physical disabilities and/or TBI can enter the Independent Care Waiver Program (ICWP); and eligible participants with developmental disabilities can enter the NOW or COMP waivers. The state has processes and mechanisms in place for verifying that all qualified residences into which MFP participants may be placed will be fully licensed and/or certified, as appropriate, by state or local entity. The section describes the state's processes for ensuring that all housing providers are fully licensed and/or certified, as appropriate, by state or local entities.

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

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

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

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

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

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

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

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

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

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

DBHDD-DCMH, MFP CBAY youth with mental illness who enroll in MFP CBAY services transition from a PRTF into a qualified residence. MFP CBAY protocols for youth with mental illness assure participants have a choice among housing types as applicable. It is the responsibility of the Care Coordinator to ensure and document that the youth resides in a qualified residence. When the care plan includes transition to a qualified residence that requires licensure or other regulatory standards, it remains the Care Coordinator's responsibility to assure licenses are current, regulations are met, and these are documented in the participant's record and included in the transition plan (ITP/ISP, action plan) as needed.

Qualified housing for MFP CBAY youth with mental illness includes:

- A home owned or leased by the youth or by the youth's family
- A single-family home for which the youth or family can demonstrate ownership by deed or mortgage or signed lease in the youth's or family member's name
- An apartment with an individual lease
- A residence in a community-based residential setting

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An apartment lease must be in the youth's or family's name and the residence must have lockable entrance/exit doors that includes living, sleeping, bathing and cooking areas over which the youth and/or family has domain and control.

The residence in a community-based residential setting is considered to be a non-family residential setting in which no more than four unrelated individuals reside. Such residential settings can be Personal Care Homes (PCH), Community Living Arrangements (CLA), or Child Placement Agencies (CPA) that provide staff supervised meals, housekeeping, laundry services, transportation and semi-private sleeping rooms. They do not provide medical or nursing care as a service. These facilities are licensed and must meet design and operating standards, including minimum staff requirements.

Host Homes or Foster Care Homes are qualified residences when the youth lives with a family with one other unrelated person. State and local housing codes and quality standards remain applicable as well as any physical conditions standards of any financing source assisting in the development of the unit or providing rental assistance for the member to live in the unit.

### **Increasing Access to Affordable, Accessible and Integrated Housing**

This section describes the strategic and operational plan and collaborative partnerships between MFP and State and local housing authorities to assure and expand the availability of affordable, accessible, supportive and integrated housing (based on MFP qualified residence types).

Along with partner agencies the State Housing Finance Authority, the Department of Community Affairs (DCA), the Department of Human Services/Division of Aging Services (DHS/DAS), and The Department of Behavioral Health and Developmental Disabilities (DBHDD), DCH/Medicaid/MFP is navigating the landscape of affordable, accessible, supportive and integrated housing in an unprecedented effort to remove barriers to community living experienced by Medicaid members and MFP populations (older adult and people with disabilities). The lack of affordable, accessible, supportive and integrated housing has the potential to derail MFP resettlement efforts. But there are strategic, operational and tactical strategies for removal of barriers to housing.

Strategic approaches require collaboration among agency partners and the State Housing Finance Authority – Department of Community Affairs – to create a coordinated system that links inpatient (ICF, nursing facility, etc.) residents with available HCBS waiver services (DCH, DBHDD and DHS/DAS) in need of housing to housing agencies with housing resources. Operational and tactical approaches require relationships to be developed with local public housing authorities, local housing developers, professional management companies and other 'housers' in an effort to identify unused capacity and create additional subsidized housing options. DCH/Medicaid/MFP, DBHDD and DHS/DAS have joined the strategic efforts being led by DCA.

### **Collaboration with the State Housing Finance Authority**

The Department of Community Affairs (DCA) administers the programs of the Georgia Housing and Finance Authority, non-metro public housing authorities, and other housing organizations in an effort to coordinate resources to improve access to affordable, accessible, supportive and integrated housing. While access to home and community based services has increased, access to housing continues to be a major barrier. The success of MFP is dependent on access to affordable, accessible, supportive and integrated housing. Therefore the state is working in partnership with DCA's Strategic Housing Initiative as a member of the Steering Committee in planning and discussions, needs assessment, removing policy barriers, developing rental subsidy programs, developing state-wide referral mechanisms, and increasing access to affordable, accessible, supportive and integrated housing for HCBS waiver participants, including MFP participants.

DCA is tasked with preparing a Strategic Housing Initiative plan to address Georgia's affordable housing needs using available federal and state funds in an effort to meet the terms and conditions outlined in the *Settlement Agreement* (2010) between the State of Georgia and the US Department of Justice (DOJ). The Settlement Agreement addresses one MFP population, people with developmental disabilities. As part of a strategic interagency approach, DCA is working with MFP to meet the housing needs of all populations served by MFP. Priorities included in the DCA Housing Initiative include:

- To increase the access to MFP and Settlement Agreement populations to a continuum of housing and supportive services which address their housing, economic, health and social needs.
- To increase the access of Georgia's older adult population to a continuum of housing and supportive services which address their housing, economic and social needs.

### **The MFP Housing Manager**

The MFP Housing Manager works to expand rental subsidies and housing options for older adults and persons with disabilities. The MFP Housing Manager undertakes and tracks the following housing development goals:

- With assistance of DCA, Office of Affordable Housing and Finance Division, provide input to the Qualified Allocation Plan (QAP) in an effort to positively influence the development of affordable, accessible, supportive and integrated housing options and track the availability of and utilization of accessible units created under the QAP by county (low income housing tax credit units and units created under the 5-1-1 rule, etc).
- Seek out and build collaborative partnerships with DCA and larger metro municipalities across the State, provide input into the Annual Action Plans (AAP) for each Fiscal Years Consolidated Funds (Community Development Block Grants – CDBG and HOME Investments Partnerships), in an effort to positively influence the development of affordable, accessible, supportive and integrated housing options available to MFP participants.

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- Increase Section 8 Housing Choice Vouchers (HCVs) available to MFP participants by 20 each year, through seeking out and building partnerships with DCA and metro Public Housing Authorities across the State.
- Increase the number of project-based rental assistance (PBRA) vouchers by 40 each year through collaborative partnership with DCA Housing Initiative Steering Committee, developers and property management companies with and through the HUD Melville 811 Funding application.
- Increase the available access to rental units based on income (BOI), accessible Personal Care Homes, assisted living options, and host homes.
- Provide quarterly training/technical assistance to MDSQ Options Counselors and MFP Transition Coordinators on conducting housing searches using local tools (GA Housing Search, United Way, etc.), using local agency assistance (AgeWise, etc.), housemate/roommate match services, public housing project searches and using waiting lists.
- Increase the number of MFP participants opting to move in with a roommate or family members by 5% each year
- Increase the number of successfully completed MFP Environmental Modifications (EMDs) by 10 each year. Develop, implement and evaluate effective strategies to improve the quality of EMDs.

In addition to the above goals, the MFP Housing Manager works with DCA and other housing stakeholders to achieve the following long-range and near-term initiatives:

### **Long-range Initiatives**

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

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

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## Near-term Initiatives

- Work with DCA and metro Public Housing Authorities to discuss and strategize future plans that incorporate the following:
  - Expand rental opportunities for MFP and HCBS participants
  - Implement and expand permanent supportive housing (PSH) options
  - Expand Housing Choice Vouchers for MFP participants (see *Appendix AA: Referral for Housing Choice Voucher*)
  - Develop MOUs with Public Housing Authorities (PHAs) for rental vouchers for MFP participants
  - Create Bridge Subsidy Programs with PHAs
  - Improve access to existing rental assistance programs
  - Increase targeted outreach to Medicaid eligible older adults, people with disabilities
  - Increase Housing Education and awareness of Housing Search Tools
  - Expand home ownership and home modification programs
  - Expand funding for the Home Access (HA) Program
  - Promote home ownership for MFP participants using vouchers

## Near-Term Strategies and Activities

### **Implement and Expand HCV and Tenant-Based Rental Assistance (TBRA) Funding**

The purpose of this program is to produce funding for the production of affordable rental housing with accompanying supportive services for eligible MFP Tenants through the allocation of federal HOME and State Housing Trust Fund monies. In addition, tenant based rental assistance and Housing Choice Vouchers-HCV are available for 25% of PSHP units occupied by eligible MFP Tenants within DCA's HCV service area.

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

Low Income Housing Tax Credit/HOME Rental Housing Loan programs provide equity and low interest loans, respectively, for the production of affordable rental housing. All first floor units are accessible with 5 to 10% fully adapted for individuals with disabilities. An additional 2% are set-aside for visually/hearing challenged. The programs are competitively allocated statewide. The 2007 and 2008 Qualified Allocation Plan, which governs the allocation of both resources, includes provisions to encourage the set-aside of units for individuals with special needs. Developers must provide an agreement with a local service provider(s) for referral of potential tenants to the property. Through the MFP initiative, greater coordination between service providers and project developers must occur to enhance access to these set-aside units by MFP consumers.

### **Expand the Housing Choice Voucher (HVC) Programs**

Decatur/Dekalb Public Housing Authority administers an Housing Choice Vouchers.. To assist the MFP initiative, HA has reserved 35 Housing Choice Vouchers for use by MFP participants (see *Appendix AA: Referral for Housing Choice Vouchers*). The tenant-based rental assistance program assists households to rent safe, decent, and sanitary dwelling units in the private rental market. MFP participants are eligible for the program because most MFP participants do not have incomes that exceed 50% of the area median income as adjusted for family size. In addition, the

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

### **Create PHA Partnerships**

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

### **Create Bridge Rental Subsidy Programs**

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

### **Increase Housing Education and Access to Housing Search Tools**

The research tool available at [www.GeorgiaHousingSearch.org](http://www.GeorgiaHousingSearch.org) provides MFP participants and all Georgians with access to information about affordable rental housing opportunities, including those that have certain accessibility features. It also provides secure, behind the scenes access to additional housing information that would be beneficial to assist MFP candidates. MFP Transition Coordinators (TCs) must participate in Confidentiality Training to gain access to the secure sections of the site. MFP state staff will work with DCA, local PHAs and other state

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housing programs to educate and inform about MFP, the need for affordable, accessible and integrated housing and the need for rental subsidies (vouchers) for MFP participants.

### **Expand the Home Access (HA) (Environmental Modification) Program**

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

### **Promote Home Ownership for MFP Participants using Vouchers**

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

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

### ***B.10 Continuity of Care Post-Demonstration***

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

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

Continuity of care post-transition is assured for each demonstration participant using each of the following MFP mechanisms:

Transition screening—these processes have been adapted to gauge the likelihood of a successful transition for each MFP participant. Using the MFP Transition Screening Form (*see Appendix G: MFP Transition Screening Form*), MFP field staff (OCs, TCs, DD PLAs, CEs, and CMEs) gather information about the candidates background, personal goals, resources, and functional needs in order to assist the candidate to make an informed choice regarding options under MFP and to provide options counseling if the person chooses not to participate in the Demonstration (See B.5 for details). At the time of the screening, persons meeting MFP eligibility criteria and interested in relocation to the community are consented and provided information on HCBS waivers (the exception is MFP CBAY youth who do not enter a waiver but are provided with a robust set of MFP demonstration services (see B.5 for details). During the screening process, MFP field staff identify individuals for whom a transition is either not feasible or is medically contra-indicated and compare these findings to how far MFP, along with the waiver and state plan services, can go to accommodate the needs of the individual. The state assures that candidates for MFP are not assessed based on inappropriate criteria outside the statutory eligibility requirements as set forth in the DRA of 2006 as amended by the Affordable Care Act of 2010.

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

The results of person-centered planning are captured in the transition plan (the *Individualized Transition Plan*-ITP, ISP, or Action Plan) (see *Appendix O and H*). MFP field staff write-up and implement the transition plan, based on person-centered planning discussions with the transition team. The transition plan helps reduce the overall time needed to make a successful transition by identifying and removing barriers to resettlement and by facilitating assessment and service planning through coordination with waiver staff, waiver services, and MFP services to ensure a smooth transition and entrance into an appropriate HCBS waiver. MFP participants transitioning out of inpatient facilities receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, State funded programs, and local community funded services. The state is not seeking enhanced match for State Plan services provided to MFP participants.

Under the Interagency Agreement with DBHDD-DCMH, MFP CBAY, MFP services provide supports through a period of crisis and intense behavioral issues during which the youth meets a PRTF level of care. With MFP services and supports, the scope and intensity of MFP services for youth with mental illness are intended to assist a youth and his/her family to acquire skills that will allow behaviors to be successfully managed and keep them from escalating. Once the family unit demonstrates successful application of those skills and stability, a plan for transitioning the youth to less intense services is typically implemented.

The average length of stay for a youth has been approximately 200 days and 98% of enrolled youth are discharged within 365 days, therefore for most enrollees, the length of MFP services availability will fully satisfy the need for supports during this most critical family period.

Whatever the length of enrollment, monthly Child and Family Team Meetings facilitate the preparation and planning for discharge and modification of the individual service plan as needed to reflect the changing needs of the youth and the family.

Children and youth graduating or otherwise transitioning from services will be able to step down to Georgia's state plan Community Behavioral Health Rehabilitation Services (CBHRS). The less intense services available to a youth or young adult through CBHRS may include Community Support Services (a case-management-like service not available during MFP enrollment), Intensive Family Intervention (modeled after the adult-focused Assertive Community Treatment, but customized for children and families), and other common behavioral health services such as

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individual and family therapy. An example of the coordination expected in anticipation of transition is the CBHRS core provider would be involved in discharge planning to ease the transition. Related protocols will ensure that the Care Coordinator debriefs the CBHRS core provider as appropriate to manage the "transfer."

Additionally, it is a program policy to ensure the youth has a primary care physician and that the physician is identified in the individual service plan. This not only facilitates the coordination of medically necessary services prescribed by the physician to supplement behavioral health services, its other purposes are to involve the primary care physician in care planning, increase the likelihood of overall health and well-being of the participant, and ensure that when transition happens there is an existing infrastructure of medical support for continuity of care.

Regardless of the length of stay, all youth with mental illness will be afforded a fully developed and youth- and family-centered transition plan. For youth who have already turned 21 at initial enrollment, the MFP program for Youth with Mental Illness will afford them a full 365 days of MFP services. In these instances the 22 year old age limit will be waived in the interest of continuity of care.

When it is determined through monthly Child and Family Team meetings that the youth and family are ready to graduate from the higher intensity MFP services, the youth will soon age out, or the 365 days of MFP services are nearing their end, the team will establish a plan to transition from MFP services. The overall goal of the transition plan is that upon leaving the MFP program, young adults are connected to family, peers and caring adults; have a safe and stable place to live; know how to access community-based mental health services such as Medicaid Rehabilitation Option Services; are participating in an education or work environment; and have opportunities for family, social and civic engagement. Youth who turn 22 while participating in the MFP program will continue to receive services identified in their Individual Service Plan (ISP) for the full 365 days of MFP eligibility. These individuals will continue to be a DBHDD priority population and will be eligible for a combination of services funded through the Medicaid State Plan and state-only funding to support their transition and community sustainability when MFP services conclude.

At enrollment, older youth are initially linked to agencies which provide mental health services to both children and adults. This established link will allow for service continuity for youth who age out of MFP services. If the participant had at enrollment selected a provider that offers only mental health services to children and families, the Care Coordinator will begin transition planning within six months prior to the youth's 22nd birthday. The ISP will reflect services and timeframes for transitioning youth to a provider that offers mental health services to adults.

Quality of Life Survey—results of the QoL survey assists both the MFP and waiver programs to improve the quality of their services. The QoL results help ensure that evaluative findings are used to improve overall transition services in the state. Long-range, operational changes result from QoL findings (see B.8 for details).

### **Services That Continue Beyond the Demonstration**

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

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

## **C.1 Organizational Structure**

Overall authority, administration, oversight and supervision of Georgia's MFP Rebalancing Demonstration reside in the Medicaid Division in the Department of Community Health (DCH), Aging and Special Populations section.

The MFP Project Director and DCH/MFP staff members are employed by DCH. DCH is responsible for initiating, planning, executing/ implementing, controlling/monitoring/evaluating and closing Georgia's MFP demonstration project in accordance with the approval of this operational protocol by CMS. The Project Director provides direct management of the MFP project and DCH/MFP staff members, under the supervision of the Deputy of the DCH Aging and Special Populations section.

## **Roles and Responsibilities under Interagency Agreements**

Georgia MFP currently operates through two interagency agreements – an agreement with the Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities (DBHDD-DDD) and DBHDD-DCMH, MFP CBAY, to transition individuals with developmental disabilities from inpatient facilities, (i.e. nursing facilities, hospitals, Intermediate Care Facilities-ICFs), and more recently (as of 7/1/11) an agreement with the Department of Human Services, Division of Aging Services (DHS/DAS) to transition older adults and people with physical disabilities and/or TBI from inpatient facilities.

The roles and responsibilities are similar under both agreements – both agencies conduct marketing, outreach, informed consent, information release, screening, complete waiver applications and engage participants in person-centered planning, develop transition plans and assisting with waiver applications. Both facilitate transitions into Georgia HCBS waivers.

Under the agreement with DBHDD-DDD and DBHDD-DCMH, planning list administrators, case expeditors (DD PLAs and CEs) and Case Management Entity, working in inpatient facilities (ICFs or PRTFs), facilitate the development of Person-Centered Descriptions (transitions action plans), waiver enrollment (when applicable) and discharge day planning. An Assistant Deputy Commissioner, two Transition Specialists and a Transition Consultant, employed by DBHDD-DDD, and two Transition Specialists employed by DBHDD-DCMH coordinate transition activities; including, authorizing and procurement of MFP transition services, completing the Quality of Life survey, working with FIs, complaints and critical incidents, follow-up post-transition, tracking and reporting, and they serve as liaisons to the DCH/MFP Project Director.

The DBHDD Division of Behavioral Health, Child & Adolescent Director supervises the MFP CBAY Director, and the MFP Coordinator who is supervised by the MFP CBAY Director. Partial time of other CBAY staff is allocated to supporting functions necessary for managing MFP enrollees including the Child and Adolescent Program Specialist, and the CBAY Data Coordinator. The MFP CBAY Director is the point person for the DCH MFP staff and most day-to-day operations and communications

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will flow between the MFP CBAY Director and DCH MFP staff with oversight by the DCH MFP Director and the DBHDD C&A Director. The DBHDD MFP Coordinator will support the MFP CBAY Director in MFP services operations. The Directors will meet regularly in order to carry out their oversight functions and to share information. For resumes and job descriptions of key staff for the MFP Youth with Mental Illness population, see Appendices.

Under the agreement with DHS/DAS, Long-term Care Ombudsmen (LTCO), options counselors and transition coordinators from the 12 Regional Aging and Disability Resource Connections (ADRCs) are responsible for information and referral of nursing facility residents to MFP and facilitating transitions. LTCOs are uniquely positioned to follow-up on nursing facility residents' complaints and inform residents and administrators of residents' rights, including the right to information and referral to MFP. ADRCs are the designated state referral source for MDS Section Q referrals. Options counselors work with MDS-Q referrals and assist individuals with information on a range of Long Term Support Services and, when appropriate, make referrals to MFP.

Depending on location and resource availability, options counselors and/or transition coordinators assist, guide and support participants with all aspects of MFP; including informed consent, release of information, screening, waiver applications, convening the transition team, person-centered planning, completing the ITP, authorizing and procurement of MFP transition services, housing searches, completing the QoL survey, discharge day planning, working with FIs, complaints and critical incidents, follow-up post-transition, tracking and reporting.

A Long-term Care Ombudsmen supervisor, a Lead Transition Specialist and a Lead MDSQ Options Counselor, employed by DHS/DAS, provide services under the agency agreement. The LTCOs report to the LTCO supervisor. In addition to coordinating the activities of MDSQ OCs and MFP TCs, the Leads are responsible for reporting, training and technical assistance. The LTCO supervisor and Leads serve as liaisons to the MFP Project Director.

Per an agreement with the DCH/MFP, Fiscal Intermediaries (FIs) provide services to MFP participants during their period of MFP participation. Because MFP demonstration services are non-traditional Medicaid services and do not continue after the MFP period of participation, Fiscal Intermediaries are needed to make funds available for procurement of these services. Once MFP services are authorized, the FI sets up an account under the participant's name. FIs pay invoices once required documentation is received. FIs then invoice DCH/MFP. DCH/MFP verifies invoices and reimburses FIs using demonstration grant funds.

Under a contract with Georgia State University, Georgia Health Policy Center (GSU GHPC) the MFP project conducts limited project evaluation activities. Under the contract, the GSU GHPC evaluation consultant assists with the design and application of the project logic model and performance measures, designs, conducts, analyzes and reports results of Quality of Life survey analysis, PM pre-/post-transition cost studies and MFP demonstration service utilization to the MFP

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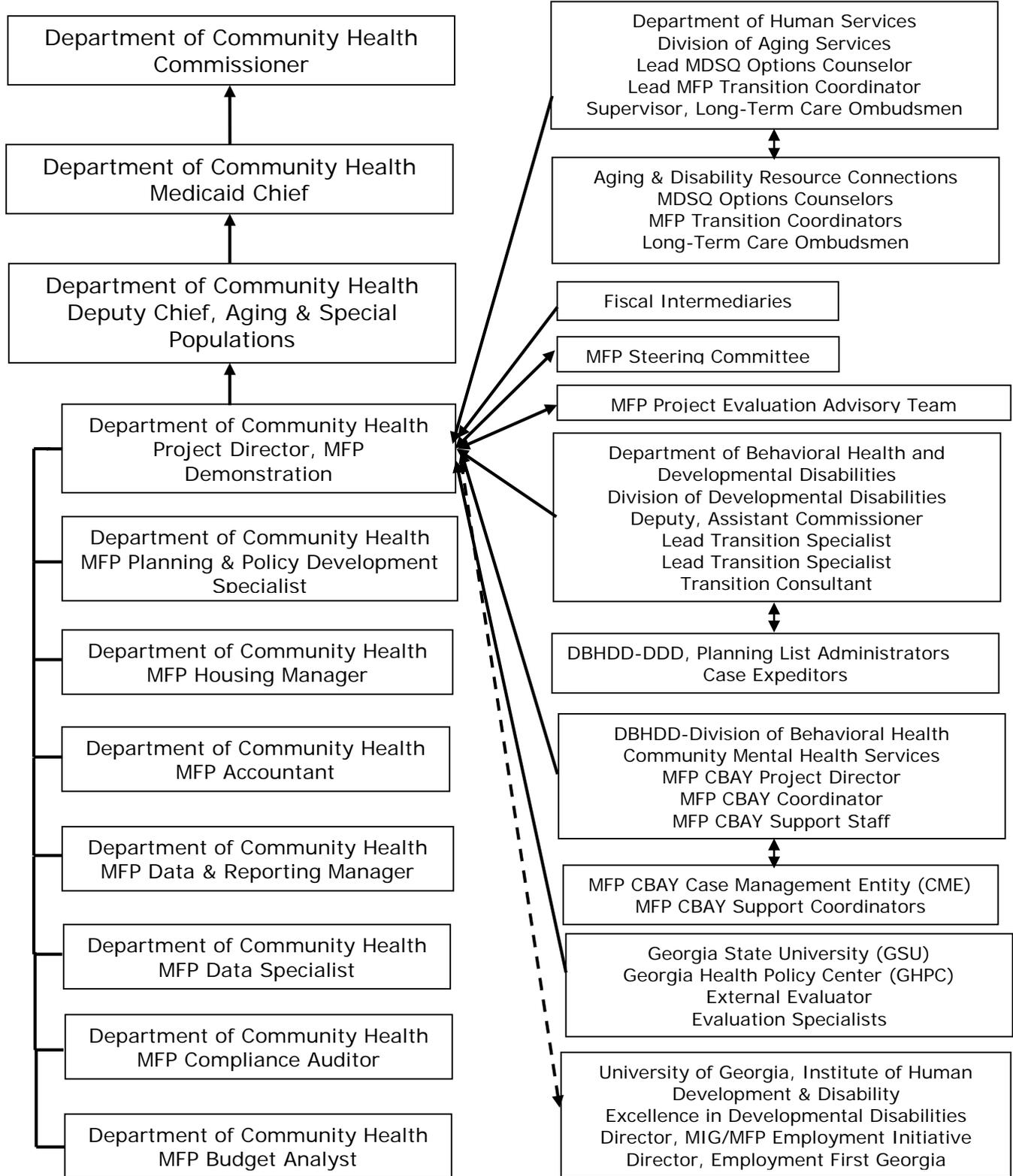
Project Director and MFP Project Evaluation Advisory Team in an effort to improve the project.

DCH/MFP has participated in training offered by the Medicaid Infrastructure Grant (MIG) with the University of Georgia, Institute of Human Development and Disability. An agreement/MOU for an employment initiative and supported employment services for MFP participants will be developed.

This section describes the roles and responsibilities of State Agencies under Interagency Agreements and contracts with other governmental agencies and private contractors involved in the implementation, daily operations and evaluation of the MFP Demonstration. Table C.1.1 captures the relationships of these entities to the project.

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**Table C.1.1 Georgia’s MFP Demonstration Organizational Chart**



## **C.2 Staffing Plan**

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

The MFP grant funding enables Georgia to further enhance its Olmstead Initiatives. As described throughout this Operational Protocol amendment, Georgia MFP currently operates through two interagency agreements – an agreement with the Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities (DBHDD-DD) to transition individuals with developmental disabilities from Intermediate Care Facilities (ICFs), and an agreement with the Department of Human Services, Division of Aging Services (DHS/DAS) to transition older adults and people with physical disabilities and/or TBI from nursing facilities. The roles and responsibilities of field personnel under the interagency agreements have been described elsewhere. This section describes the roles and responsibilities of the full-time project director and all project staff located within the Department of Community Health. This section also includes the roles and responsibilities of evaluation contractor.

The MFP Project Director and DCH/MFP project team members are employees of DCH, and as such are responsible for carrying out the responsibilities residing in DCH and for interagency coordination in the implementation of the demonstration project, under the supervision of the Deputy of DCH Aging and Special Populations section. Beginning with the Project Director, each DCH/MFP project team member's responsibilities are listed below. For the resume of the project director, see *Appendix J1: MFP Project Director*.

Under the direction of the Deputy Chief of Aging & Special Populations, the MFP Project Director:

- Oversees the Project Plan, Operational Protocol and Policies and Procedures
- Secures necessary resources (budget, personnel, equipment, etc.) to carry out project and achieve project goals, outcomes and impact
- Develops project team member position descriptions, hires, manages, develops and evaluates team members
- Leads project team, convenes team meetings, and sequences overall project tasks and activities
- Convenes Steering Committee and Evaluation Advisory Workgroup quarterly meetings, stakeholder forums and project working groups on an ad hoc basis
- oversees development, execution and monitoring of interagency agreements
- oversees development, execution and monitoring of the all project contracts and provider agreements (i.e. Fiscal Intermediaries, External Evaluator) and uses the RFP process, as needed, to hire contractors to complete tasks
- reviews and approves all interagency agreement and contractor deliverables, completes report cards and approves payments

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- develops/negotiates Memorandums of Understanding (MOUs) with entities as necessary to implement project goals and agenda
- identifies appropriate information, resources, and technical assistance necessary for partnering agencies and awarded contractors to complete assigned tasks
- receives and assesses input for revisions requested by Steering Committee members, internal and external stakeholders and team members
- oversees all revisions to project scope, Project Plan/Operational Protocol and Policies and Procedures
- conducts periodic programmatic reviews/audits of vendors, monitoring, quality assurance, and quality improvement
- monitors grant expenditures and prepares and submits project budgets
- works with appropriate Medicaid staff to establish prior authorization limits, and sets reimbursement rates, as needed
- conducts periodic reviews of consumer Quality of Life survey data and results of project evaluation studies to understand customer experience and share with staff for continuous quality improvements.

The Planning and Policy Development Specialist performs complex and comprehensive research for project planning and develops and revises the Operational Protocol and Policies and Procedures.

The MFP Planning and Policy Development Specialist:

- develops and revises as needed, project work breakdown structure based on scope, tracks project tasks and activities using Gantt Charts, prepares Project Dashboards, monitors and reports deviations from the project plan,
- develops and revises as necessary, project operational protocol, policies and procedures manual, and all forms for conducting project operations
- Works with team members to carry out project scope and activities and attends meetings,
- Assists with project communications with external and internal stakeholders, convenes steering committee meetings, stakeholder forums, working groups, as needed/ad hoc, to develop strategic, operational and tactical plans, refine and revise operational protocol, and policies and procedures
- Develops economic demographic, business and sociological forecasts to support development of project strategic, operational and tactical plans and consults on development of project budgets
- Coordinates project evaluations to provide continuous and systematic feedback and monitoring of benchmarks, goals and initiatives
- Prepares, delivers and evaluates training for contractors, as needed, with assistance of internal and external stakeholders
- Prepares and distributes project outreach and marketing materials, consumer materials and other reports or publications used to demonstrate and report on project outcomes and impacts
- Other duties as assigned

The Housing Manager develops, executes and reports on a comprehensive plan to increase affordable and accessible housing options available to MFP target

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populations (i.e. older adults and participants with physical and developmental disabilities).

The MFP Housing Manager:

- Conducts and coordinates outreach to public and private housing professionals to identify and access available housing options for MFP participants in accordance with MFP Benchmark #5
- Serves as expert and organization resource on affordable and accessible housing for project populations
- Conducts research, analysis and evaluation of barriers to housing experienced by project participants
- Leads state- level team in the development of a housing strategic plan based on promising and evidence-based practices related to the MFP project
- Reviews, selects and implements strategies that build housing capacity and increase available funding and housing resources for MFP participants
- Participates as part of DCH/LTSS/MFP in policy and procedure development related to housing for MFP participants
- Develops and implements standards and procedures for efficient use of available housing resources
- Designs and maintains a system to provide continuous and systematic assessment of programs and initiatives related to locating and sharing information on approved housing for the MFP target populations
- Represents DCH/Medicaid/MFP on housing development teams, proposes drafts, and review of current policies related to housing for MFP participants and other duties as assigned

The Data and Reporting Manager analyzes and reports project quantitative data; makes and reviews recommendations for technology solutions for automating data extraction and analysis processes, and integrates data in federal reporting.

The Data and Reporting Manager:

- Designs (charts, tables, graphs, etc), implements and validates solutions for extraction and integration of data to support analysis and federal reporting
- Provides interpretation of data, identifies quality issues and makes recommendations for technology solutions for automating analysis and reporting
- Provides interpretation of data necessary for project Plan and initiatives
- develops and implements a system to maintain, coordinate and provide continuous and systematic assessment of data received from outside sources
- Serves on development teams, proposes drafts, reviews and recommends changes to policy and procedures
- Other duties as assigned.

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Under the direction of the DCH Finance Unit, the MFP Accountant and MFP Budget Analyst prepare financial reports necessary for the operation and reporting of the demonstration.

The MFP Accountant:

- provides monthly and quarterly federal reports for submission to CMS
- Initiates payments to vendors when approved by DCH/MFP program staff
- Other financial duties as assigned and as needed by MFP project staff

The MFP Budget Analyst:

- Prepares budget forecasts
- Tracks and reports on rebalancing funds
- Other financial duties as assigned and as needed by the MFP project director or MFP staff

The Project Data Specialist (position under review to re-allocate as program specialist) manages, organizes and tracks project specific participant data using a master tracking spreadsheet and uses GAMMIS to manage changes in participants Medicaid status.

The Project Data Specialist:

- Receives, organizes and tabulates MFP participant discharge forms/data
- Uses GAMMIS to close out institutional Medicaid and enroll MFP participants in Community Medicaid
- Verifies participants' qualified waiver claims, adjusts claims if necessary based on appropriate FMAP
- monitors, tracks and reports MFP demonstration and supplemental services to DCH Accounting for reimbursement
- monitors and tracks participants' critical incident and status change reports
- creates ad hoc reports for project management
- Serves on development teams, proposes drafts, reviews and recommends changes to policy and procedures
- Other duties as assigned.

The MFP Compliance Auditor is responsible for the review of quality management systems data and continuous quality improvement.

The MFP Compliance Auditor:

- conducts periodic programmatic reviews/audits of vendors,
- conducts monitoring, quality assurance, and quality improvement
- conducts analysis on critical events and reviews critical incident discovery reports
- other duties as assigned

### **Contractor Roles and Responsibilities**

Fiscal Intermediaries (FIs) provide services to MFP participants per agency agreements. Because MFP demonstration and supplemental services are non-traditional Medicaid services and do not continue after the 365 days of MFP, Fiscal Intermediaries are needed to 'front monies' for procurement of these services. Once MFP services are authorized, FIs 'charge up' participant's accounts. FIs pay invoices once required documentation is received. FIs then invoice DCH/MFP. DCH/MFP verifies invoices and reimburses FIs using demonstration grant funds. There are two financial management agencies enrolled with the Georgia Medicaid Program. However, any willing and capable provider is eligible to enroll at any time. Stakeholder feedback indicates that there may be other providers interested in enrolling in this service.

Under a contract with Georgia State University, Georgia Health Policy Center (GSU GHPC) the MFP project conducts limited project evaluation activities. Under the contract, the GSU GHPC evaluation consultant designs, conducts, analyzes and reports results of studies to the MFP Project Director and MFP Advisory Team Workgroup in an effort to improve the project.

Under the contract, GSU GHPC engages in the following evaluation activities and conducts and reports on the following evaluation studies:

1. Evaluation Advisory Team – convened quarterly to review evaluation reports, provide input and make recommendations for improvement to project activities, services, policies and procedures.
2. Project Logic Model – revised annually to reflect changes in project scope, horizontal and vertical integration and to track project outputs, outcomes and impacts.
3. Conducts Quality of Life Surveys – conducts 1<sup>st</sup> and 2<sup>nd</sup> year follow-up Quality of Life (QoL) surveys.
4. Develops and adds a minimum of 10 questions to the Quality of Life Survey – added questions identify barriers to health, welfare and safety experienced by MFP participants residing in community settings.
5. Analysis of Quality of Life Survey data – performs quantitative, qualitative and matched analysis (baseline to 1<sup>st</sup> year follow-up) in an effort to understand the outcomes and impacts of the project and offer data that can be used by the project staff, Steering Committee and Evaluation Advisory Team to make and implement project improvements. Provides quarterly report of analysis.
6. MFP Demonstration Service Analysis – performs quantitative analysis on MFP demonstration and supplemental service utilization. Provides quarterly report of analysis.
7. Other analysis as directed by the Project Director and Evaluation Advisory Team.

### **C.3 Billing and Reimbursement Procedures**

This section describes procedures for manual processing of MFP Demonstration service invoices (for process detail, see *Appendix I: MFP Flowcharts and Text Descriptions*), and monitoring procedures in place to ensure against duplication of payment and fraud.

Under the interagency agreement with the Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities (DBHDD-DDD) provides initial funding to vendors for MFP demonstration services. Vendors render these demonstration services to MFP participants (transitioning from ICFs). Once delivered, vendors submit 'paid' invoice(s) and receipts to DDD/MFP Transition Specialist within DBHDD-DDD. The DDD/MFP Transition Specialist then submits the invoice(s), vendor import files and supporting documentation to the FI for reimbursement (see *Appendix V: MFP Vendor Import File*). The FI verifies invoices against authorizations to ensure that reimbursement does not exceed account balance and reimburses DBHDD-DDD.

Under the interagency agreement with DBHDD-DCMH, MFP CBAY claims for MFP CBAY Demonstration services are billed through GAMMIS effective September 30, 2014.

The MFP program office performs the accounting and tracking necessary to report on budget and expenditures for DCH Finance Office who in turn completes the periodic MFP reporting and billing to CMS.

Under the interagency agreement with the Department of Human Services, Division of Aging Services (DHS/DAS), MFP TCs authorize FIs to fund an account under the participant's name. TC's authorize services (see *Appendix S: MFP DCH DHS Authorization for Services* and *Appendix B: MFP Transition Services Table, MFP 3 Digit Service Code*). MFP TCs enlist vendors to provide demonstration services. Vendors render services to participants and obtain documentation of services rendered. Vendors then submit invoice(s) and accompanying documents to MFP Transition Coordinators (MFP TCs). MFP TCs submit receipts, vendor import files (see *Appendix V: MFP Vendor Import File*) and supporting documentation directly to a Fiscal Intermediary for reimbursement. The FI verifies invoice(s) against authorizations to ensure that reimbursement does not exceed account balance and the FI then reimburses either the vendor directly or the MFP TC's agency (if and when a purchase card was used).

FIs submit to the DCH/MFP office a monthly invoice(s) that includes the actual billing period, the total amount of demonstration services and the total amount of supplemental services provided (supplemental services include the total amount of Community Transition Financial Service, the FI's processing fee). In addition to the monthly billing invoice(s), FIs submit vendor import file reports that include participant name, vendor name, service date, 3 digit MFP service code, Category of Service (waiver information), Medicaid Identification Number, Date of Birth, and billing amount (per person, per service).

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DCH/MFP reviews and verifies the accuracy of information received from FIs. DCH/MFP submits all financial documents to DCH Accounting for reimbursement on a monthly basis. Provided all financial documents have been received and verified for accuracy and completeness, FIs are reimbursed either by paper check or electronic funds transfer (see *Appendix O: MFP Invoice DCH Payment to FI*).

Additionally reviews and verifications are performed on MFP participant's qualified waiver service claims. DCH queries and checks edits and audit processes for providers of services, members' eligibility and MFP enrollment spans (to prevent overlapping spans), tracks MFP span for enhanced match not to exceed the MFP period of participation, and reference data (i.e. procedure codes, rates and limitations) during the adjudication process for validation to allow claims to process and pay providers. Claims pay as approved, suspend, or be denied based on MFP and waiver service reimbursement validation processes (see *Appendix O: FI Invoice to DCH for Payment*, *Appendix S: Authorization for MFP Services*, *Appendix V: MFP DCH DHR Vendor Import File* and *Appendix Y: Participant Enrollment Status Change Form*).

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

***E. Final Project Budget – Submitted under Separate Cover***

## APPENDICES

### ***Appendix A1: MFP Steering Committee Members by Organization***

#### **MFP Steering Committee Members by Organization – Rev June 2012**

AAA Gateway ADRC, Atlanta Regional Commission, MFP TC  
AAA/ Gateway ADRC, Atlanta Regional Commission, MDSQ OC  
AADD, Unlock the Waiting Lists  
AARP Georgia, ASD Advocacy  
Advocate, ADAPT Atlanta, Chair of Fundraising Comm.  
Advocate, ADAPT Atlanta, GA Voices that Count/People First  
Advocate, Peer Support Network  
Aging Services of Georgia  
Area Agency on Aging of Northwest Georgia  
Area Agency on Aging of Northwest Georgia, (Rome) Director  
Area Agency on Aging, CSRA  
Atlanta Housing Authority, VP of Corporate Planning Strategy and Planning  
Atlanta Legal Aid Society, Disability Rights Project, Staff Attorney  
Atlanta Legal Aid Society, Disability Rights Project, Staff Paralegal  
Atlanta Regional Commission - AAA/ADRC  
Attorney, Metro Fair Housing  
B&B Care Services, Inc  
BAIN CIL-NF Transition Coordinator  
Brain Injury Peer Visitor Association  
BSITFC Spinal Cord Injury Task Force Staff  
BSITFC Spinal Trust Fund, Executive Director  
Council on Aging, Director  
CSRA GA Legal Svs, LTC Ombudsman  
CSRA Office of Georgia Legal Services Program, LTC Ombudsman  
CSRA-AAA Gateway Administrator  
DAS MFP Transition Specialist  
DAS MDSQ Options Counselor Specialist  
DBHDD DD, Residential Specialist MFP  
DBHDD DD, Specialist  
DBHDD, Director of Finance  
DBHDD, Division of DD, Transition Specialist  
DBHDD, Division Olmstead Coordinator  
DBHDD-DD, PLA/CE  
DCH, Recovery  
DCH, Accounting & Finance  
DCH, Accounting & Finance  
DCH, Chief, Medicaid  
DCH, Deputy Chief, Medicaid, Director Aging & Special Needs  
DCH, Dir. Member Services and Policy (Eligibility Determination)  
DCH, Medicaid, MFP Planning and Policy Development Specialist  
DCH, Medicaid, MFP Data and Reporting Manager  
DCH, Medicaid, MFP Project Director  
DCH, Medicaid MFP, Data Specialist  
DCH, Medicaid, CCSP Waiver Specialist  
DCH, Medicaid, ICWP Program Specialist  
DCH, Medicaid, DD Waivers Program Specialist  
Department of Community Affairs, Rental Assistance Division  
Department of Community Affairs, Disability Housing Coordinator

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Department of Labor  
DFCS, Regional X Supervisor ABD Waivers  
DHS DAS AAA  
DHS, DAS, AAA demo NH diversion grant  
DHS, DAS, CCSP Program Manager  
DHS, DAS, Financial Services  
DHS, DAS, Financial Services  
DHS, DFCS, Regional ABD Supervisor, SW Georgia  
DHS, Division of Aging Services, ADRC Specialist  
DHS, Division of Aging Services, Livable Communities Specialist  
DHS, Office of Regulatory Services  
Director of Public Policy, AADD  
Director of Resident Services, Habitat of GA  
Director, Division of Aging Services  
Director, Russell Professional Group LLC  
Disability Advocate, CRC  
Disability Connections CIL, Peer Supporter  
Disability Connections, Executive Dir  
Disability Connections, NH Transition Coordinator  
Disability Connections, Program Dir, Tools for Life (AT)  
Disability Link Northwest, IL Counselor  
disABILITY Link, ICWP Service Coordination  
disABILITY Link, IL Program Coordinator  
Disability Resource Center CIL, ED  
Disability Solutions, Owner/Licensed Contractor  
Division of Aging Services, Program Integrity  
ED, BAIN CIL  
ED, disABILITY LINK - Northwest  
ED, Disability Resource Center  
ED, Multiple Choices CIL  
Family member of participant  
Friends of Disabled Adults & Children FODAC, President  
Fulton Co Dept of Housing and Community Development  
GA State, Community Health & Fiscal Management  
Georgia Advocacy Office, Executive dir  
Georgia Brain and Spinal Injury Trust Fund, Director of Data & Public Policy  
Georgia Council on Aging - Advocate  
Georgia Health Care Association  
Georgia Legal Service Program, Coordinator, CSRA Ombudsman Program  
Georgia Legal Services Program  
Georgia Medical Care Foundation  
Georgia Office of Civil Rights (OCR), Regional Civil Rights Counsel,  
Georgia State University, Health Policy Center, MFP Evaluator  
Georgia State University, Health Policy Center, MFP Evaluator  
Georgia Voices that Count/Coordinator Ga Peer Support Pjt  
Georgia Medial Care Foundation GMCF  
Governor's Council on DD, Program Director  
Governor's Council on Developmental Disability, Executive Director  
IL Specialist, disABILITY Link NW, Rome CIL  
IL Specialist, Disability Resource Center

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LIFE CIL, Executive Director  
LIFE CIL, Nursing Home Transition Coordinator  
LTCC Atlanta  
LTCC, CSRA  
MFP Participant  
Metro Fair Housing, President Board of Directors  
Middle GA AAA ADRC, MFP TC  
National Ataxia Foundation, Greater Atlanta Ataxia Group  
National Seating and Mobility  
NW GA AAA/ADRC, MFP TC  
Office of Civil Rights  
Owner, Creative Consulting Services, Inc  
PC, Employment Initiatives, The GAO  
PC, ICWP, disABILITY Link, Decatur  
People First Georgia  
Regional CMS, CS, Sam Nunn Building  
Regional CMS/CMCHO, Sam Nunn Building  
Resident Services & Grants Coordinator, Columbus HA  
Residential Specialist, DBHDD DDD  
Shepherd Center, Brain Injury Services  
Shepherd Center, Case Manager, Shepherd Care  
Shepherd Center, Director of Advocacy  
Shepherd Center, VP Marketing  
Side by Side Brain Injury Clubhouse, Work Unit Coordinator  
State Action Plan Coordinator, BSITF  
State Board of Workers Compensation  
State Long Term Care Ombudsman  
Statewide Independent Living Council, Director  
The Arc of Georgia  
UGA, Institute for Human Development & Disability, UCEDD  
UHS -- Pruitt, NH Corporation, Staff  
UHS -- Pruitt, Regional Director  
VA - Community Nursing Home Program Supervisor  
Visiting Nurse Health Systems/CCSP  
[Visiting Nurse Health System/CCSP](#)  
Visiting Nurse Health System/CCSP  
Walton Options for Independence CIL, IL Counselor  
Walton Options for Independent Living CIL, ED  
Walton Options for Independent Living CIL, Program Manager  
Walton Options, Advocacy Coordinator

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## Appendix A2: MFP Referral Form



### Money Follows the Person Referral Form

Date of referral (mm/dd/yyyy): \_\_\_\_\_

Person making referral: \_\_\_\_\_

Agency making referral: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Person Referred-Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_

Inpatient Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Admission Date to inpatient facility (mm/dd/yyyy): \_\_\_\_\_

Anticipated Referral: CCSP  SOURCE  ICWP  Date Referred: \_\_\_\_\_  
NOW  COMP  \_\_\_\_\_  Date Referred \_\_\_\_\_

Currently on wait list for: CCSP  SOURCE  ICWP   
NOW  COMP  \_\_\_\_\_

Interested Parties:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP: \_\_\_\_\_

Pertinent Information: \_\_\_\_\_

Return completed referral by **Email** to: [gamfp@dch.ga.gov](mailto:gamfp@dch.ga.gov); or by **Fax** to: 404-463-2889; or **mail** to:

Money Follows the Person (MFP)  
Georgia Department of Community Health/Medicaid Division  
2 Peachtree St. NW, 37<sup>th</sup> Floor  
Atlanta, GA 30303  
Website: [dch.georgia.gov/mfp](http://dch.georgia.gov/mfp)

For questions or assistance making a referral, contact the MFP Project Director at: 404-651-9961. For question or assistance making a MDS Section Q referral, contact the Aging & Disability Resource Connection (ADRC) at 1-866-552-4464, Local Contact - \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Appendix A3: MFP CBAY Enrollment Packet



### MFP CBAY Treatment Choice Form

#### **What is a Psychiatric Residential Treatment Facility?**

Psychiatric Residential Treatment Facility (PRTF) services are designed to be short term interventions that stabilize targeted behaviors. Your child will be placed in a residential facility outside of the home. A facility will typically provide services such as therapy, psychological assessments, and on-site educational programs. Day to day operations of a residential facility follow a strict, regimented, structured schedule. The facility is also responsible to work with the family to develop a transition plan into the community once treatment goals and objectives are met and level of care criteria are no longer appropriate.

#### **What is MFP CBAY (Money Follow the Person Community Based Alternatives for Youth)**

MFP CBAY is a waiver designed to provide psychiatric residential treatment facility-level community based services in the home through an individualized Wraparound planning process. A Care Management Entity (CME) of your choice will help you prioritize your family's needs through a child and family team process designed to build on your family strengths. These strengths are used to meet developed goals and objectives while building on your already existing natural and community support system. This process is an alternative to PRTF to build supports in the family's home and community so the family can remain together.

This process's values include:

- **Voice** – The child and family are active partners in making treatment decisions.
- **Team** – The approach must involve a team consisting of members of those social systems (family, school, community, neighbors, church) who are most important to the child.
- **Community Based** – Mental health treatment success is best achieved in the community in which the child lives.
- **Culturally Competent** – The process must be built on each family's unique values, preferences, and strengths.
- **Individualized** – Every child has different needs and abilities and treatment plans reflect this. As part of this, you, as the parent/guardian, have the right to have a choice of the services and service providers that you receive.
- **Strengths Based** – Mental health treatment success can be best achieved if we focus not only on the problems of a child and family but also what is going well and is healthy about the family.
- **Natural Supports** – The use of informal community supports such as neighbors, church or friends is important to the success of children.
- **Continuity of care** – Unconditional commitment to continue to help the families through whatever services are necessary to meet treatment goals.
- **Collaboration** – The child is best treated if all the important systems in her life are working together towards similar goals.
- **Flexible Resources** – It is important to be able to flex resources towards what the team believes is most important to the mental health needs of the child.

Along with this process, you will have access to additional support services.

**Outcome based services** – Goals and services must be measured and treatment adjusted to improve outcomes. You will be interviewed every three months by family support staff and university staff to collect the information needed to evaluate if you are receiving the services you need and are satisfied with everything you are receiving. These services include:

- Respite
- Waiver Transportation
- Care Management
- Family Peer Support Services
- Financial Support Services
- Expressive Clinical Services
- Clinical Consultation Services
- Youth Peer Support Services
- Community Transition
- Customized Goods and Services
- Supported Employment
- Behavioral Assistance

Participation in MFP CBAY demonstration services is voluntary and you may choose to discontinue services at any time.

Based on the above information, I, \_\_\_\_\_,

Parent/guardian of \_\_\_\_\_, formally request

- Psychiatric Residential Treatment Facility Services       MFP CBAY Services with my chosen CME being:
- View Point Health (formerly GRN)
  - Lookout Mountain Care Management Entity

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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MFPNA CBAY1

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## MFP CBAY Unified Release of Information

Participant First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Section A1: Use or Disclosure of Health/Education Information**      **Section A2: Use or Disclosure of Health/Education Information**

<p>By signing this form, I authorize the disclosure of my individually-identifiable health/education information <b>by</b> the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Juvenile Court</li> <li><input type="checkbox"/> Care Management Entity (specify) _____</li> <li><input type="checkbox"/> Department of Juvenile Justice</li> <li><input type="checkbox"/> Department of Family and Children Services</li> <li><input type="checkbox"/> Mental Health Provider(s) (specify): _____</li>   <li><input type="checkbox"/> School(s) (specify): _____</li> <li><input type="checkbox"/> Wraparound Evaluation Team</li> <li><input type="checkbox"/> Medical Provider (specify): _____</li> <li><input type="checkbox"/> Other organizations providing services to you and your family (specify) _____</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p>By signing this form, I authorize the disclosure of my individually-identifiable health/education information <b>to</b> the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Juvenile Court</li> <li><input type="checkbox"/> Care Management Entity (specify) _____</li> <li><input type="checkbox"/> Department of Juvenile Justice</li> <li><input type="checkbox"/> Department of Family and Children Services</li> <li><input type="checkbox"/> Mental Health Provider(s) (specify): _____</li>   <li><input type="checkbox"/> School(s) (specify): _____</li> <li><input type="checkbox"/> Wraparound Evaluation Team</li> <li><input type="checkbox"/> Medical Provider (specify): _____</li> <li><input type="checkbox"/> Other organizations providing services to you and your family (specify) _____</li> <li><input type="checkbox"/> Other _____</li> </ul>
---	---

**Section B: Scope & Use of Disclosure**

Information that may be used or disclosed based on this authorization is as follows (check one):

- All health information about me, including medical records created or received by the Provider. This information may include, if applicable:
  - Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse, mental health disorders, educational issues/needs, legal issues/needs and/or social/recreational issues/needs.
  - Services provided by the above agencies during the period of this release
  - Services provided by the above agencies prior to this release
  - Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
  - Privileged communications between me and a psychiatrist, psychologist, licensed marriage & family counselor, or licensed professional counselor or between them concerning my communications with them.
- All health information about me as described in the preceding checkbox, excluding the following: \_\_\_\_\_
- Specific health information **including only** the following: \_\_\_\_\_
- All education information about me, including education records. This information may include, if applicable: report cards, attendance, discipline, IEP, 504 plan, evaluation

**Section C: Purpose of Use or Disclosure**

The purpose for this disclosure is (check one):

- Specifically, the following \_\_\_\_\_
- The youth chooses not to disclose the purpose. NOTE: This box may NOT be checked if the information to be disclosed pertains to alcohol or drug abuse information.

**Section D: Expiration**

NOTE: If an expiration event is used, the event must relate to the youth or the purpose for the disclosure

Event \_\_\_\_\_

Consent for Release of Health Information expires 12 months from the date it was signed. Consent for Health Information must last no longer than "reasonably necessary to serve the purpose for which consent is given". 42 CFR 2.31 (a)(9)

**Section E: Other Important Information**

1. I understand that the System of Care agencies cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a youth in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2).
2. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain services.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the System of Care in reliance on this authorization before written notice of revocation is received.
4. I understand that educational records are confidential under state and federal law and by signing this Unified Release of Information, I am authorizing the release of educational records.

<b>Date</b>	<b>Signature of Participant</b>
<b>Date</b>	<b>Signature of Parent/Legal Guardian</b>
<b>Date</b>	<b>Signature of Witness (Title):</b>

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MFPNA CBAY2



## **MFP CBAY Overview and Consent**

### **Introduction**

Community-based Alternatives for Youth (MFP CBAY), serves children and youth ages 5 through 17 and youth or young adults ages 18 through 21 with serious emotional and behavioral disturbances who have a primary diagnosis of mental illness as identified in the DSM-IV and who are placed, or at risk of placement, in a Psychiatric Residential Treatment Facility will be served by the program as close to their natural home settings as possible. MFP CBAY uses a systems approach that targets youth served by multiple agencies, striving to coordinate, blend, and braid programs and funding to create a comprehensive behavioral system that ensures youth are placed in and remain in intensive residential treatment only when necessary and that a coordinated system of services at the community level is available. The state's entire system relative to youth is being transformed to ensure that evidence-based practices, as well as an array of quality services, are available, integrated, and supported throughout Georgia. Moving forward the youth previously enrolled and active by September 30<sup>th</sup>, 2012, will be sustained in the program until they graduate or age out of the program. The Money Follows The Person (MFP) Rebalancing Demonstration grant will support funding for MFP CBAY youth eligible for MFP services.

### **Evaluation Component**

If you choose to participate in the MFP CBAY demonstration project there will be an on-going evaluation component conducted through your CME (Care Management Entity) and the Georgia State University staff. Your participation is entirely voluntary, and you can withdraw your consent at any time without penalty. If you choose to participate, you will be expected to complete the evaluation tools as requested. These results will be anonymous. You will be asked to complete the following evaluation tools by the respective organization:

- WFI-4 (Wraparound Fidelity Index)
- YSSF (Youth Satisfaction Survey Family)
- CANS (Child and Adolescent Needs and Strengths)
- CIS (Columbia Impairment Scale)
- CHKS (California Healthy Kids Resiliency Survey)
- FES (Family Empowerment Scale)
- MFP QOL (MFP Quality of Life Survey – for participants 18 to 21 years of age)

The evaluations will be completed either by phone or in person. Staff may explain the evaluation instrument and assist you in understanding the questions that are asked, however, your answers are confidential and you should not be persuaded to answer any question a certain way. Participation in this project does not involve any risk or stresses.

If you have any questions regarding the evaluation component, please contact Linda Henderson-Smith at 404-657-6087 or by email at [lyhenderson@dbhdd.ga.gov](mailto:lyhenderson@dbhdd.ga.gov).

***I have read and understand the above information.***

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MFP\_CBAY\_Enrollment\_Packet\_REVISED\_041014 MFPNA CBAY3

# Georgia MFP Operational Protocol Version 1.6



## Instructions for Completing Minimum Data Set (MDS)

**What is the MDS?** The MDS (Minimum Data Set) is required data collected for each youth for the National Evaluation submitted to MFP CBAY staff on a quarterly basis.

**Who should fill out the MDS?** The care provider who completed the PRTF application is responsible for completing the MDS. After APS notifies MFP CBAY staff of an approval referral, MFP CBAY staff will then email the care provider requesting the completed MDS form. Service **cannot** be authorized without this document.

**When should the MDS be completed?** The MDS is completed at intake, every 3 months thereafter, and at discharge.

**Where is the MDS kept?** The MDS form is kept in each client's folder in a locked designated cabinet.

**What guidelines should be followed in completing the MDS?** Please see the following chart below for additional assistance with completing the MDS form.

- Make sure completed dates are entered in required fields.
- Check for accuracy of information.
- Make sure family understands what information/questions are being asked.
- Complete all fields!

Data	Instructions
Medicaid ID#	Enter participant's Medicaid Id # <b>Format:</b> 12 digits (ex: 111565656565)
CID Eligibility #	Enter CID # received from CBAY MFP staff <b>Format:</b> 9 digits (ex: 3001111111)
Record Trail	Select collection period for participant's data
Date of data collection	Enter date data was collected <b>Format:</b> mm/dd/yyyy (ex: 11/07/2009)
Enrollment #	Enter # of times participant has enrolled in the program
Demographic & Family Data Section	
Data	Instructions
Date of Birth	Enter participant's DOB <b>Format:</b> mm/dd/yyyy (ex: 10/15/1993)
Gender	Select participant's gender
Race	Check participant's race
Ethnicity	Check participant's ethnicity
Current Caregiver	Check participant's current caregiver
Current living arrangement and/or residential placement	Check participant's current arrangement
Total annual family income in the past year	Enter income <b>Format:</b> \$##,### (ex: \$20,000)
Would youth be Medicaid eligible for non-waiver home-based services	Check Yes or No
Health & Health Care History Section	
Data	Instructions
DSM-IV Diagnosis: Primary	Enter participant's diagnosis <b>Format:</b> ###.## (ex: 321.23)
DSM-IV Diagnosis: Secondary	Enter participant's diagnosis <b>Format:</b> ###.## (ex: 321.23)
Age at first receipt of mental health services	<b>Format:</b> ## (ex: 12)
# of PRTF admissions to date:	Enter total # of participant's PRTF admissions <b>Format:</b> ## (ex: 10)
Date of first ever PRTF admission	Enter date of participant's 1 <sup>st</sup> PRTF admission

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Date of admission at most recent PRTF stay	<b>Format:</b> mm/yyyy (ex: 12/2006) Enter date of participant's most recent PRTF admission <b>Format:</b> mm/yyyy (ex: 12/2006)
Date of exit at most recent PRTF stay	Enter date of participant's recent PRTF exit <b>Format:</b> mm/yyyy (ex: 12/2006)
Date of first admission to waiver services	MFP CBAY staff will enter this date at intake. Enter MFPCBAY approval date when completing follow-up <b>Format:</b> mm/dd/yyyy (ex: 10/15/2006)
Date of discharge/enrollment from the waiver services	Enter date if participant is being discharged from MFP/CBAY <b>Format:</b> mm/yyyy (ex: 12/2006)
Common Functional Assessment Items Section	
Data	Instructions
Days in PRTF	<b>Format:</b> ### (ex: 115)
Days in psychiatric hospital	<b>Format:</b> ### (ex: 15)
Days in out-of-home placements	<b>Format:</b> ## (ex: 0)
# of unexcused absences from school in the past 6 months	<b>Format:</b> ### (ex: 10)
# of excused absences from school in the past 6 months	<b>Format:</b> ### (ex: 15)
School absences severity	Check participant's severity level
Severity of substance abuse use	Check participant's severity level
Number of arrests in the past 6 months	Enter total # of participant's arrest <b>Format:</b> ## (ex: 10)
Any involvement with law enforcement in the past 6 months?	Select Yes or No
Has the youth been involved with Child Protective Services in the past 6 months?	Select Yes or No

## Changes to MDS

There have been changes to the Minimum Data Set Form (MDS). **ALL** MDS data submitted must be as complete as possible, each time it is submitted.

MDS changes include:

- CID Eligibility # has been added.
- Record Trail: Additional monthly follow-up boxes have been added.
- Enrollment # will always be 1 for each youth unless they have been discharged previously.
- In the Environmental Variables & Common Functional Assessment Items sections, all fields are for data collection in the **past 6 months** unless otherwise denoted.
- Received psychosocial rehabilitation services' in the Environmental Variables section has been changed to 'Received core/specialty services'.
- A non-applicable (N/A) section has been added to the Environmental Variables section. Please use this section if the data is not applicable to the youth in question. Also, rather than leaving information blank, please write N/A for any other data fields that do not apply to the youth.

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## Minimum Data Set Form

Medicaid ID #:	CID Eligibility #:	Record Trail: <input type="checkbox"/> Baseline <input type="checkbox"/> Discharged <input type="checkbox"/> 3-Month <input type="checkbox"/> 6-Month <input type="checkbox"/> 9-Month <input type="checkbox"/> 12-Month <input type="checkbox"/> 15-Month <input type="checkbox"/> 18-Month	
Date of data collection: / /	Enrollment #: _____		
<b>DEMOGRAPHIC &amp; FAMILY DATA</b>			
Date of Birth (mm/dd/yyyy): / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		
Race:	<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other		
Ethnicity:	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic		
Current Caregiver: <input type="checkbox"/> Biological parent <input type="checkbox"/> Step-parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Live-in friend/relative <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other			
Current living arrangement and/or residential placement: <input type="checkbox"/> Family or relative's home <input type="checkbox"/> Foster care home <input type="checkbox"/> Therapeutic foster care <input type="checkbox"/> Detention/jail <input type="checkbox"/> Other residential setting			
Total annual family income in the past year: \$	Would youth be Medicaid eligible for non-waiver home-based services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Guardian Name:	Guardian Phone:		
County where Youth will be living:	County of Residence:		
Address where Youth will be living during CBAF MFP Project:			
<b>HEALTH &amp; HEALTH CARE HISTORY</b>			
DSM-IV Diagnosis: Primary	DSM-IV Diagnosis: Secondary		
Age at first receipt of mental health services:	# of PRTF admissions to date:		
Date of first ever PRTF admission (mm/yyyy): /	Date of admission at most recent PRTF stay (mm/yyyy): /		
Date of exit at most recent PRTF stay (mm/yyyy): /	Date of first admission to waiver services (mm/dd/yyyy): / /		
Date of discharge/enrollment from the waiver services (mm/yyyy): /			
<b>ENVIRONMENTAL VARIABLES</b>			
	<b>YES</b>	<b>NO</b>	<b>N/A</b>
Diverted from the PRTF (Only at Intake)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transitioned from PRTF (Only at Intake)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had ever moved in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever been in foster care in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received vocational counseling/ employment services in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had contact with unemployment office in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had contact with any special education program in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received core/specialty services in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received supported employment services in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>COMMON FUNCTIONAL ASSESSMENT ITEMS</b>			
Days in PRTF in the past 6 months :	Days in psychiatric hospital in the past 6 months :	Days in out-of-home placements in the past 6 months :	
# of unexcused absences from school in the past 6 months : _____	# of excused absences from school in the past 6 months : _____		
School absence severity : <input type="checkbox"/> Youth attends school regularly <input type="checkbox"/> Some attendance problems, but generally attends <input type="checkbox"/> Problems with school attendance (missing 2 days each week) <input type="checkbox"/> Generally truant or refusing to go to school		Severity of substance abuse use: <input type="checkbox"/> No <input type="checkbox"/> Mild/occasionally <input type="checkbox"/> Moderately <input type="checkbox"/> Severe	
Number of arrests in the past 6 months: _____	Any involvement with law enforcement in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the youth been involved with Child Protective Services in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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## **MFP CBAY Referral Form**

Date of referral (mm/dd/yyyy): \_\_\_\_\_

Person making referral: \_\_\_\_\_

Agency making referral: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Person Referred-Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_

Inpatient Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Admission Date to inpatient facility (mm/dd/yyyy): \_\_\_\_\_

Anticipated Referral: CCSP  SOURCE  ICWP  Date Referred: \_\_\_\_\_  
NOW  COMP  CBAY  Date Referred \_\_\_\_\_

Currently on wait list for: CCSP  SOURCE  ICWP   
NOW  COMP  CBAY

Interested Parties:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Street: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ ZIP: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Street: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ ZIP: \_\_\_\_\_

Pertinent Information: \_\_\_\_\_

Return completed referral form by Email to: [cbayreferrals@dhc.state.ga.us](mailto:cbayreferrals@dhc.state.ga.us) Or mail completed form to:

**Community Based Alternatives for Youth (CBAY)**  
**Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)**  
2 Peachtree St. NW, 23rd Floor  
Atlanta, GA 30303  
Attention: MFP CBAY Referral

For questions or assistance making a MFPCBAY referral, contact Dr. Linda Henderson-Smith at 404-657-6087.



## Money Follows the Person Informed Consent for Participation

I, \_\_\_\_\_, (print name) voluntarily agree to be screened and assessed as part of my application for participation in the Money Follows the Person (MFP) project<sup>i</sup>. MFP Field Personnel will determine my appropriateness for the project. If approved for the MFP project, my participation may be in segments or consecutive days, but for a total period not to exceed 365 calendar days<sup>ii</sup>.

By signing this Informed Consent, I agree to participate in all aspects of the MFP project, including completing the *Quality of Life Survey*. My responses to the *Quality of Life Survey* and other program information will be shared with the Centers for Medicare and Medicaid Services (CMS) as well as Georgia and national evaluators.

I have been given information about the MFP project; a copy of the MFP Brochure and a copy of the *Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia* booklet. I understand the MFP project guidelines including enrollment requirements. I understand that MFP one-time transitional services are provided under the MFP demonstration project.

I understand that if I qualify for and am enrolled in an appropriate waiver program, waiver services will continue for as long as I need them and I continue to meet eligibility requirements. If I am no longer eligible for the Medicaid waiver program, I will be provided with other service options that may assist me in a community setting. I understand that certain circumstances will make me ineligible for a waiver and for MFP. If the total cost of providing my care under the waiver exceeds the cost of providing care in an inpatient facility, I will become ineligible for the waiver and for the MFP project. If my condition improves and I don't continue to meet the waiver Level of Care criteria, I will become ineligible for the waiver program and may become ineligible for the MFP project.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by Responsible Party, State Relationship and Authority to Sign

\_\_\_\_\_  
MFP Field Personnel Sign

\_\_\_\_\_  
Date

<sup>i</sup> Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter. 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 304

<sup>ii</sup> If the MFP participant needs to be readmitted to an inpatient facility for a period of 30 days or less, the participant remains enrolled in the MFP demonstration. As soon as the participant's condition stabilizes, the participant can return to the community and resume services. When an MFP participant is readmitted into an inpatient facility for a period of time greater than 30 days (31 days or longer), the participant is suspended from the MFP demonstration and is considered an institutional resident. However, the suspended MFP participant will be re-enrolled, prior to the completion of 365 days, back into the demonstration without re-establishing the 90-day institutional residency requirement. The individual is considered an MFP participant when discharged from the inpatient facility, and is eligible to receive MFP services for any remaining days up to 365. MFP field personnel determine if any changes to the participant's Individualized Transition Plan are needed to prevent a re-admission to an inpatient facility. If the participant is readmitted to an inpatient facility for a period of longer than six months, the participant will be re-evaluated like a "new" MFP participant.

# Georgia MFP Operational Protocol Version 1.6



## MFP Release of Health Information (MFP RHI)

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Georgia and Federal law concerning the privacy of such information. Failure to provide *all* information requested may invalidate this Authorization.

### USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the release, use or disclosure of my health information as follows:

Member Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Health Plan Name: \_\_\_\_\_

Persons/Organizations authorized to receive, use or disclose the information <sup>i</sup> are:

- MFP Field Personnel \*
- Waiver assessment/case management staff \*
- My Representative (Legal, etc.) \*
- MFP service providers (Peers, Ombudsman, etc.) \*

*\* Personnel located in Georgia and in the state to which you are transitioning.*

Purpose of requested use or disclosure: <sup>ii</sup> for screening and assessment and participation in MFP. This Authorization applies to the following information (select **only one** of the following):<sup>iii</sup>

- All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: \_\_\_\_\_

- Only the following records or types of health information (including any dates). This may consist of psychotherapy notes, if specifically authorized:

\_\_\_\_\_  
\_\_\_\_\_

### EXPIRATION

All information I hereby authorize to be obtained from this inpatient facility will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for: (PLEASE CHECK ONE)

- ninety (90) days unless I specify an earlier date here: \_\_\_\_\_
- one (1) year
- the period necessary to complete transactions related to my participation in Money Follows the Person on matters related to services provided to me through Money Follows the Person.

*I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.*

# Georgia MFP Operational Protocol Version 1.6



## MFP Release of Health Information (MFP RHI)

### NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: \_\_\_\_\_

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.<sup>iv</sup>

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.<sup>v</sup>

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

\_\_\_\_\_  
Signature of Member or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Representative, State Relationship or Basis of Authority

<sup>i</sup> If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

<sup>ii</sup> The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

<sup>iii</sup> This form may not be used to release both psychotherapy notes and other types of health information (see 45 CFR § 164.508(b)(3)(ii)). **If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.**

<sup>iv</sup> Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR § 164.508(d)(1), (e)(2)).

<sup>v</sup> If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. **Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.**

# Georgia MFP Operational Protocol Version 1.6

## Appendix AA: Referral for Housing Choice Voucher Program



### MFP Referral Letter for



### Decatur Housing Authority Sec 8/HCV Program

Georgia Department of Community Health • Medicaid Division • Money Follows the Person  
Two Peachtree Street, NW • 37<sup>th</sup> Floor • Atlanta, GA 30303 • 404-651-9961

Date of Referral Letter Submission: \_\_\_\_\_

This letter serves as official correspondence for the MFP direct referral process for the Decatur Housing Authority (DHA), *Housing Choice Voucher Program*.

The MFP participant (print name), \_\_\_\_\_, is being referred for application to the DHA *Housing Choice Voucher Program* by MFP field personnel (print name), \_\_\_\_\_.

The Decatur Housing Authority has entered into an agreement to assist MFP participants with a rental assistance voucher upon approval of the DHA *Application for Housing Choice Voucher Rental Assistance*. The Department of Community Health in partnership with the Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Department of Human Services, Division of Aging Services (DHS/DAS) will provide the MFP participant with MFP transition services, Medicaid Home and Community services (waiver services) and State Plan services for which they are eligible and that are appropriate to meet their needs, including non-Medicaid federally funded services, state funded programs and local community funded services. DCH and Decatur Housing Authority, *Housing Choice Voucher Program* will collaborate to ensure that the MFP participant has the best opportunity for successful outcomes in the community.

The MFP participant/family has been screened, selected and referred by MFP field personnel and is hereby requesting an application for participation in the *DHA Housing Choice Voucher Program* in Dekalb county. The participant's screening is complete. The participant's Pre-ITP is in the process of being completed with an anticipated discharge date of: \_\_\_\_\_.

#### MFP Participant Information (Print)

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Medicaid ID#: \_\_\_\_\_ SSN: \_\_\_\_\_ -- \_\_\_\_ --

# in Household (include PCA if applicable) \_\_\_\_\_

#### Signature of MFP Participant Requesting Application \_\_\_\_\_

By signing, I understand and agree to the terms and expectations set forth in this official MFP referral for the *DHA Housing Choice Voucher Program*. Based on this official correspondence, I am hereby requesting a *DHA Application for Housing Choice Rental Assistance* for the number of household members listed above.

#### MFP Field Personnel Information

Note: the *Application for Housing Choice Rental Assistance* will be mailed to designated MFP field personnel. When field personnel receive the *Housing Choice Voucher Application* packet, **she/he and the MFP participant have 14 business days to complete and mail the application back to Decatur Housing Authority**, to the person at DHA the application was mailed from.

#### MFP Field Personnel Contact (print address for all correspondence)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

**Note: Complete and send this MFP referral letter to the DCH/MFP office by File Transfer Protocol, attention:**  
MFP Housing Manger, DCH  
2 Peachtree Street NW, 37<sup>th</sup> Floor, Atlanta, Georgia 30303

**Appendix AB: MFP Sentinel Event Report Form (Revised)**



**MFP Sentinel Event Reporting Form**

**MFP Field Personnel:** using the text boxes provided, complete this form when an MFP participant experiences a critical incident or sentinel event listed. An individual is considered a MFP participant if (s)he or a parent/legal guardian has signed the *MFP Consent for Participation* form.

Date of Report:                      Waiver Name:                      - Or  Check for MFP CBAY  
Case Mgr/Care or Service Coordinator Name:                      Phone:

Participant First Name:                      Participant Last Name:  
Participant Medicaid ID#:                      Participant Date of Birth:  
Participant Address:                      Participant City:                      Zip:                      County:  
Participant Phone Number:                      Other Contact Name:                      Other Phone:  
Provider (if applicable):  
Name of the Inpatient Facility Admitted to: (or n/a ):  
Address of the Inpatient Facility Admitted to: (or n/a ):  
Date of Incident:                      Location of Occurrence:

Type of Critical Incident/Sentinel Event: (Check only one. Each event requires a separate report.)  
 Abuse,  Neglect,  Exploitation,  \*\*\*Hospitalization: Admit Date: \_\_\_\_\_,  
 Emergency Room Visit,  \*\*\*Death,  \*\*\*Death due to abuse, neglect, or exploitation,  
 \*\*\*Death due to a breakdown in the 24/7 back-up system,  Involvement with Criminal Justice  
System,  Medication Administration Error,  Other (specify): \_\_\_\_\_

\*\*\*NOTE: These sentinel events also require the submission of the *MFP Participant Status Change Form (see Appendix Y)*.

Brief summary of event:

Q1. What did the participant report (or check for NA )?

Q2. What were the adverse outcomes related to the event/injuries (describe in detail)?



## MFP Sentinel Event Reporting Form

Q3. Who witnessed to the event (list name and contact information)?

Q4. What action was taken by MFP field personnel at time of event (Discovery)?

Q5. MFP Field Personnel Action Plan (Do) - What will field personnel do to prevent this from happening in the future?

Q6. MFP Field Personnel Process improvement (Check) - What MFP processes were instituted to evaluate the effectiveness of the action plan and reduce risk to the participant?

Q7. What are the follow-up time frames (Act/Monitor) for evaluating effectiveness of the processes?

Q8. Who was notified about the event?

	Name	Date	Time
Field Personnel Supervisor:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Physician:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Guardian/Family:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
MFP Project Director:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Agency Name:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Agency Name:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
MFP Field Personnel Name:		Phone:	Email:

MFP Field Personnel Signature: \_\_\_\_\_

**Note:** Send this completed form to the appropriate coordinating agency and then to DCH MFP by FTP.

Appendix AC: MFP Letter of Denial, Suspension or Termination



MFP Letter of Denial, Suspension or Termination

To: \_\_\_\_\_ Date: \_\_\_\_\_

Your participation in Money Follows the Person (MFP) has been given careful consideration. In accordance with Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter. 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 304, this letter is to inform you of a change in your participation.

A. Denied – According to the Georgia Money Follows the Person Policy and Procedures Manual Chapter 601.2, 601.4, 601.7 and 602.2, you have been determined ineligible and are being denied participation in MFP because:

- checkbox You have not resided in an inpatient facility (hospital, nursing facility, ICF/IDD, PRTF) for at least 90 consecutive days; short-term rehabilitative stays do not count. (D1)
checkbox You have not been receiving Medicaid benefits for inpatient services provided by an inpatient facility. (D2)
checkbox You do not require institutional level of care provided by an inpatient facility. (D3)
checkbox You did not transition into a qualified residence. (D4)
checkbox You did not cooperate in the transition planning process (describe process/steps and non-participation): \_\_\_\_\_ (D5)

B. Suspended – According to the Georgia Money Follows the Person Policy and Procedures Manual Chapter 604.6, you have been temporarily suspended from participation in MFP because:

- checkbox You have been readmitted to an inpatient facility for a period of thirty-one (31) days or more, but less than 6 months.

C. Terminated – According to the Georgia Money Follows the Person Policy and Procedures Manual Chapter 601.2, 601.4, 601.7, 602.2, 604.6, and Chapter 605.6 and 605.7, you have been determined no longer eligible and are being terminated because:

- checkbox You have been readmitted to an inpatient facility for a period of 6 months or more. (T1)
checkbox You are no longer receiving Medicaid benefits. (T2)
checkbox You have moved to a non-qualified residence. (T3)
checkbox You no longer meet institutional level of care criteria. (T4)
checkbox You have informed us that you no longer wish to participate in MFP. (T5)
checkbox You have moved outside of the service area for the State of Georgia. (T6)
checkbox You are a MFP CBAY participant and have been readmitted to an inpatient facility for 31 days or more. (T7)

MFP Field Personnel Signature

MFP Field Personnel (Print Name)

Telephone Number

If you disagree with this decision, you may request a fair hearing. Your request should be sent to the following address:

# Georgia MFP Operational Protocol Version 1.6



## MFP Letter of Denial, Suspension or Termination

To: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

### **NOTICE OF YOUR RIGHT TO A HEARING**

To request a hearing, you must ask for one in writing. Your request for a hearing must be *received* by the Department of Community Health within 30 calendar days from the date of this letter. You must include a copy of this *MFP Letter of Denial, Suspension or Termination*. Your request should be sent to the following address:

Department of Community Health  
Legal Services Section  
2 Peachtree Street, NW, 40<sup>th</sup> Floor  
Atlanta, GA 30303-3159

If this action is sustained by a hearing decision, you may be held responsible for the repayment of continued services that were provided during the appeal.

The Office of State Administrative Hearings will notify you of the time, place, and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member speak for you. You may also ask a lawyer for help. You may be able to get legal help at no cost. If you want a lawyer to help, you may call one of these numbers:

**Georgia Legal Services Program**

800-498-9469 (statewide legal services, except for the counties served by Legal Aid)

**Georgia Advocacy Office**

800-537-2329 (statewide advocacy for persons with disabilities or mental illness)

**Atlanta Legal Aid**

404-377-0701 (DeKalb/Gwinnett Counties)

770-528-2565 (Cobb County)

404-524-5811 (Fulton County)

404-669-0233 (S. Fulton/Clayton County)

**State Ombudsman Office**

866-552-4464

**Appendix AD: MFP Enrollment End Letter**



**Money Follows the Person  
Enrollment End Letter**



**DATE**

**PARTICIPANT NAME**

**PARTICIPANT ADDRESS**

**PARTICIPANT CITY, STATE ZIP**

Dear **PARTICIPANT NAME**,

On **DATE**, you discharged from an inpatient facility into the community using Money Follows the Person (MFP). Participation in MFP is limited to 365 calendar days. Your 365 days of enrollment in MFP will end on **DATE**.

You will continue to receive waiver services through the Medicaid HCBS Waiver, **NAME OF WAIVER**, so long as you continue to meet eligibility criteria for that waiver. Please contact **NAME OF WAIVER CASE MANAGER** at **CASE MANAGER PHONE NUMBER** if you have any questions regarding your waiver services.

In the near future, you will be contacted by a representative from the Georgia State University, Georgia Health Policy Center. This representative will be calling to conduct a follow-up to the **Quality of Life** survey you responded to before you left the inpatient facility. Your responses to the survey questions are extremely important to the success of Money Follows the Person, and we appreciate your time and your feedback about the MFP transition services you received.

Thank you for participating in Money Follows the Person. If you have any questions about this letter, you may contact MFP field personnel at the number below, or you may call the MFP State Office at the Georgia Department of Community Health Medicaid Division at 404-651-9961.

Sincerely,

\_\_\_\_\_  
MFP Field Personnel Print Name

\_\_\_\_\_  
Contract Phone #



## Money Follows the Person (MFP) Community Based Alternatives for Youth (CBAY) Enrollment End Letter

---

**DATE**

**PARTICIPANT NAME**

**PARTICIPANT ADDRESS**

**PARTICIPANT CITY, STATE ZIP**

Dear **PARTICIPANT NAME**,

On **DATE**, you discharged from a Psychiatric Residential Treatment Facility (PRTF) into the community using Money Follows the Person (MFP), Community Based Alternatives for Youth (CBAY). Participation in MFP CBAY is limited to 365 calendar days. Your 365 days of enrollment in MFP CBAY will end on **DATE**.

If you are between the ages of 18 and 21, you will be contacted by a representative from Georgia State University, Georgia Health Policy Center. This representative will be calling to conduct a follow-up to the **Quality of Life** survey you responded to before you left the Psychiatric Residential Treatment Facility (PRTF). Your responses to the survey questions are extremely important to the success of MFP CBAY, and we appreciate your time and your feedback about the services you received.

Thank you for participating in MFP CBAY. If you have any questions about this letter, you may contact MFP CBAY field personnel listed below, or you may contact the state offices of MFP CBAY at:

Community Based Alternatives for Youth  
Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)  
2 Peachtree St., NW, 23<sup>rd</sup> Floor  
Atlanta, GA 30303

Sincerely,

\_\_\_\_\_  
MFP CBAY Representative - Print Name

\_\_\_\_\_  
Contact Phone #

## Appendix AE: MFP Participant Complaint Form



### Money Follows the Person Participant Complaint Form



**MFP Field Personnel:** using the text boxes provided, 1) enter the participant's identifying information 2) summarize the issues and enter the action plan/process improvement/follow-up time frames, and 3) in the table provided, enter the vendor's information and identify the service that is the focus of the complaint using the drop down menu. Complete a separate form for each complaint and for each service.

1) Participant First Name:	Participant Last Name:
Participant Medicaid ID#:	Date of Birth (mm/dd/yyyy):
Address:	City:                      Zip:                      County:
Participant Phone Number:	Other Contact Name:
Other Contact Phone Number:	
Discharge Date (mm/dd/yyyy):	Waiver Name:              Or <input type="checkbox"/> Check for MFP CBAY
MFP Field Personnel Name:	Phone:
Date of Complaint (mm/dd/yyyy):	Name of Person Completing Form:

**Brief Summary of Complaint/Issues to Resolve:**

**Q1. Action Plan - What will be done to resolve the complaint and who will do what?**

**Q21. Process Improvement - What was instituted to evaluate the action plan and reduce risk to the participant?**

**Q3. Act/Monitor – What are the follow-up time frames for evaluating effectiveness of process?**

**Q4. Enter vendor name and contact information and use the drop down menu to select the service that is the focus of the complaint -**

Vendor Name and Contact Information	MFP Transition Service
Vendor Name and Contact Information	MFP CBAY Transition Service

**Note:** Send the completed form to the DCH MFP Office via FTP or by fax to the MFP Project Director at 770-408-5883.

**Appendix AF: MFP HCO Payment Request Form**



**Home Care Ombudsman Payment Request**

**MFP Home Care Ombudsman (HCO) Services Rendered for:**

Participant Name:	Participant/Contact Phone:
Participant Address:	Participant City /Zip /County

<b>Home Care Ombudsman Complete:</b>	
Participant Medicaid ID#:	Participant Date of Birth:
Discharge Date:	Anticipated MFP End Date:

**PAYMENT INSTRUCTION**

HCO Name:	HCO Phone:
MAIL CHECK TO (if different):	Tax ID, FEIN or SS#:
Address:	City/State/Zip

**DESCRIPTION OF MFP HOME CARE OMBUDSMAN (HCO) SERVICES**

Service Dates and Description	Billed Amount
<b>Total Check Amount</b>	

**HC Ombudsman note:** Check the appropriate box below to indicate how services were provided and documented -

- telephone call – contact must be documented in case notes, no participant signature required on this form
- in-person (face-to-face) – contact must be documented in case notes, participant signature required on this form

By signing this form, I attest that services were delivered/received consistent with the Individualized Transition Plan (ITP) or Person Centered Description and MFP Authorization for Services. I understand that Medicaid is the payer of last resort.

\_\_\_\_\_  
**MFP Participant Signature** **Date**

\_\_\_\_\_  
**Home Care Ombudsman Signature** **Date**

MFP Field Personnel (Print Name): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**HC Ombudsman note:** send this completed form to MFP field personnel via fax or file transfer protocol (FTP).

**MFP Field Personnel note:** once verified, send this completed form to the Fiscal Intermediary by FTP. Send this completed form to DCH MFP office by FTP.

Appendix AG: MFP Homecare Ombudsman Brochure

## Money Follows the Person (MFP)

Money Follows the Person is a demonstration program through the Georgia Department of Community Health. MFP helps individuals move from living in a facility to living in the community. Each MFP participant has a right to be treated with dignity and respect, and to participate fully in decisions about his or her life, services, and supports.

### What we do

Long-Term Care Ombudsmen and Home Care Ombudsmen:

- Advocate for individuals who receive long-term services and supports
- Keep communication confidential
- Ask what the MFP participant wants
- Ask for permission from the MFP participant to take action
- Advocate for the MFP participant's wishes
- Empower the MFP participant to become his or her own advocate and problem solver

Long-Term Care Ombudsmen serve residents of nursing homes, personal care homes and assisted living communities. Long-Term Care Ombudsmen assist all residents while they live in the facility.

A Home Care Ombudsman assists MFP participants in the community.

### How HCO works

- Make regular contact with each MFP participant – face to face and phone contact
- Check on the health, safety and adjustment to living in the community
- Serve participants in all parts of the state

### Examples of how HCOs help

- Talk with service provider to fix problems, such as a worker not showing up
- Help to get a needed ramp
- Advocate to add more services when needed



## Home Care Ombudsman Services Benefit

MFP includes as one of the benefits the Home Care Ombudsman service for the 365 days of participation

## Stopping Home Care Ombudsman Services

Each participant has the option to:

- Stop visits and telephone calls – just by letting the Home Care Ombudsman know
- Restart the service – just call the Home Care Ombudsman

**H.C.O.** Call 1-866-552-4464  
**HOME CARE OMBUDSMAN**

The Home Care Ombudsman Program is authorized through the Money Follows the Person demonstration project. The Long-Term Care Ombudsman Program is authorized by the Older Americans Act and Georgia law. The Office of the State Long-Term Care Ombudsman operates as a separate office within the Georgia Department of Human Services, Division of Aging Services (DAS). You may also reach your HCO or LTCO by calling the state office at phone number **1-866-552-4464**.



## MFP in a Personal Care Home

For each MFP participant who chooses to live in a personal care home:

- The Long Term Care Ombudsman that serves the residents of that personal care home will serve the MFP participant
- The ombudsman makes routine and unannounced visits quarterly and is available more frequently when needed



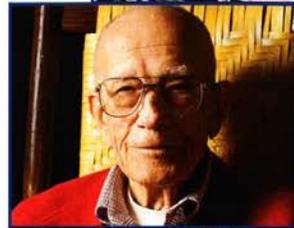
**H.C.O.**  
HOME CARE OMBUDSMAN

A Guide to  
**HOME  
CARE  
OMBUDSMAN**

**Contact:**  
**1-866-552-4464**

**Each participant has a right to be treated with respect, and to participate fully in decisions about his or her life, services and supports.**

VARIETY OF NEEDS & AGES SERVED



**A Guide to  
HOME  
CARE  
OMBUDSMAN**

YOUR HCO IS:  
\_\_\_\_\_  
AND MAY BE REACHED AT:  
\_\_\_\_\_

**Online:**  
[www.georgiaombudsman.org](http://www.georgiaombudsman.org)

Office of the State  
Long-Term Care Ombudsman



2 Peachtree Street, N.W.,  
33rd Floor  
Atlanta, GA 30303  
1-866-552-4464  
Fax (404) 463-8384



**Call 1-866-552-4464**

**H.C.O.**  
**HOME CARE OMBUDSMAN**

**Contact:**  
**1-866-552-4464**

# Georgia MFP Operational Protocol Version 1.6

## Appendix B: MFP Transition Services Rate Table (Revised with Service Caps)

Appendix B: MFP Services and Rate Table Revised 031015

Transition Service Name	Procedure Code	Modifiers	MFP 3 Digit Service Code	Rate	Description (for full description, see MFP Policy & Procedures Manual Chapter 603)	Maximum Cost Per Service
Peer Community Support	T2038	Q2, U1	PES	Based on goals as set in the ITP/ISP. 1 unit = one quarter hour contact, billable in quarter-hour increments, at \$12.50 per unit, used during the MFP period of participation. Rate includes all costs associated with delivery of service.	This service provides for face-to-face visits before, during and after transition, from a qualified and where available, a certified peer supporter for the purpose of discussing transition experiences, problem solving and building connections to individuals and associations in the community. A case note is required to document each contact. ***	\$2,000
Trial Visit- Personal Support Services (PCH/CRA)	T2038	Q2, U2	PSS	Based on goals as set in the ITP/ISP. 1 unit of personal support = the current rate provided by the appropriate waiver. 1 unit of residential services = 1 day at \$65 per day. In NOWCOMP, 1 unit of CLSS/CRA = 1 day at \$156, used during the MFP period of participation.	This service provides a brief period of personal support services or residential services during a trial visit to the community before transitioning. The purpose of this service is to give the participant an opportunity to manage and direct Personal Support Services (PSS) staff, interact with staff in the personal care home or community residential alternative and/or assist the owner/vendor to identify, develop and improve the PSS staff skills necessary to accommodate the needs of the participant. On a case-by-case basis, this service can be used post-discharge by a participant who's PSS services are arranged but delayed. ***	\$1,044
Household Furnishing	T2038	Q2, U3	HHF	Based on goals as set in the ITP/ISP. This service is used during the MFP period of participation.	This service provides assistance to participants requiring basic household furnishings to help them transition back into the community. This service provides initial set-up assistance with a qualified residence. ***	\$1,500
Household Goods and Supplies	T2038	Q2, U4	HGS	Based on goals as set in the ITP/ISP. This service is used during the MFP period of participation. \$200 of the amount authorized can be used for a one-time purchase of groceries.	This service provides assistance to participants requiring basic household goods (see Appendix P). This service is intended to help the participant with the initial set-up of their qualified residence. ***	\$750
Moving Expenses	T2038	Q2, U6	MVE	Based on goals as set in the ITP/ISP. Service is to be used during the MFP period of participation.	This service may include rental of a moving van/truck or trailer and staff or the use of a moving or delivery service to move a participant's household goods and furniture to a qualified residence. Although this service is intended as a one-time set-up service to help establish a qualified residence, under certain circumstances it may be used throughout a participant's period of participation. ***	\$850
Utility Deposits	T2038	Q2, U6	UTD	Based on goals as set in the ITP/ISP. Service is to be used during the MFP period of participation.	This service is used to assist participants with required utility deposits for a qualified residence. On a case-by-case basis, this service can be used to pay past-due utility bills in order to re-connect utilities to a qualified residence. ***	\$500
Security Deposits	T2038	Q2, U7	SCD	Based on goals as set in the ITP/ISP. Service is used during the MFP period of participation.	This service is used to assist participants with housing application fees and required security deposits for a qualified residence. ***	\$1,000
Transition Support	T2038	Q2, U8	TSS	Based on goals as set in the ITP/ISP. Limited to use during the participant's 365 days of MFP.	This service provides assistance to help participants with unique transition expenses (obtaining documentation, accessing paid roommate match services, etc.) This service provides funding for needs that are unique to each participant, but necessary for a successful transition. ***	\$600
Transportation	T2038	Q2, U9	TRN	Based on goals as set in the ITP/ISP. 1 unit = a one-way trip. Service is designed to supplement existing public and private transportation with one-way or round trips. Service is used during the MFP period of participation and is limited to \$500 per participant.	This service assists participants with transportation needed to gain access to community services and resources (i.e. housing). This service is used when other forms of transportation are not otherwise available. This service does not replace the Medicaid non-emergency transportation (for medical appointments) or emergency ambulance services. ***	\$500
Life Skills Coaching	T2038	Q2, U10	LSC	Based on goals as set in the ITP/ISP. 1 unit = one half- hour of contact training/coaching or group/individual training activities, billable at \$25 per half-hour. Service is used during the MFP period of participation. Rate includes all costs associated with the delivery of service.	This service provides for life skills coaching and independent living skills training. Participants must be assisted to: 1) complete an individualized training needs assessment (ITNA), 2) complete the necessary hours of customized training focused on skill development, lead by a qualified trainer/coach 3) participate in individual and group activities designed to reinforce skill development, and 4) evaluate the impact of the training. This service requires structured, instructor-lead, customized training/coaching based on the results of the ITNA. The trainer/coach documents training/coaching with a case note and reports the results of the evaluation. ***	\$1,500
<b>Not to Exceed Per Participant</b>						<b>\$10,244</b>

# Georgia MFP Operational Protocol Version 1.6

Appendix B: MFP Services and Rate Table Revised 031015

Transition Service Name	Procedure Code	Modifiers	MFP 3 Digit Service Code	Rate	Description (for full description, see MFP Policy & Procedures Manual Chapter 603)	Maximum Cost Per Service
Skilled Out-of-Home Respite	T2038	Q2, U11	SOR	Based on goals as set in the ITP/ISP. 1 unit = \$134.17 per day. Limited to use during the MFP period of participation.	This service provides a brief period of support or relief for caregivers or family members caring for an elderly or disabled individual. This service is used during the participant's 365 days of MFP. The respite is done at a GA qualified nursing facility or community respite provider approved through a Georgia waiver program. On a case-by-case basis this service can be used by a participant who is waiting for environmental modifications to be completed to their qualified residence. ***	\$1,880
Caregiver Outreach & Education	S5110	Q2, U12	COE	Based on goals as set in the ITP/ISP. 1 unit = one half-hour of contact caregiver training, billable at \$25 per half-hour, delivered by a qualified caregiver specialist, used during the MFP period of participation. Rate includes all costs associated with delivery of service.	This service provides outreach, information, referral and education to caregivers who support MFP participants. This service includes; 1) an assessment that identifies sources of a caregiver's stress, 2) consultation and education with a qualified, trained caregiver specialist to develop a Caregiver Support Plan with strategies to reduce caregiver stress and 3) assistance to identify and obtain local services and resources to meet the caregiver's needs. The qualified caregiver specialist documents activities with case notes. This service is not provided in order to educate paid caregivers. ***	\$1,000
Home Care Ombudsman	T2038	Q2, U13	HCO	Based on goals as set in the ITP/ISP. 1 unit = one quarter-hour contact at \$37.50, billable in quarter-hour increments, used during the MFP period of participation. Rate includes all costs associated with delivery of service.	This service provides regular monthly contacts made by a qualified home care ombudsman who is not a state employee, for review of a transitioned participant's health, welfare and safety, provides advocacy for participants to respond to and resolve complaints related to MFP and waiver services and how these services are provided. Service is limited to participants who transition into a qualified residence (see Appendix A for details). Three face-to-face contacts are required, the first F2F contact must be completed within 30 days of discharge, additional monthly contacts (F2F or phone contacts) can be arranged as needed. A case note is required to document each contact. ***	\$1,800
Equipment, Vision, Dental and Hearing Services	T2038	Q2, U14	EQS	Based on goals as set in the ITP/ISP. Service is used during the MFP period of participation. Except for items listed in PPM 603.17, DME covered by the participant's DME benefit and obtained using MFP funds must have either a GAMMIS claim denial or a Prior Authorization denial.	Service provides equipment, vision, dental, hearing aids and related services and certain types of assistive technology and services that are not otherwise covered by Medicaid or Medicare. Except for items listed in PPM 603.17, all DME obtained using MFP funds must have either a GAMMIS claim denial or a Prior Authorization denial. Items and services obtained must be justified in the ITP/ISP and be necessary to enable participants to interact more independently and/or reduce dependence on physical supports and enhance quality of life. Covers normal charges associated with one vision examination and one pair of basic prescription glasses. Covers normal charges for one dental exam, xrays, cleaning and/or minor restoration. Covers normal charges for hearing aids and related services. Two quotes are required for purchase of a single piece of equipment or a service costing \$1000 or more. ***	\$4,000
Specialized Medical Supplies	T2038	Q2, U15	SMS	Based on goals as set in the ITP/ISP. Used during the MFP period of participation. Except for items listed in PPM 603.18, specialized medical supplies covered by the participant's DME benefit and obtained using MFP funds must have either a GAMMIS claim denial or a Prior Authorization denial.	Service includes various specialized medical supplies that enable MFP participants to maintain or improve independence, health, welfare and safety and reduce dependence on the physical support needed from others. The service includes incontinence items, diapers/adult briefs, special clothing, disposable liners/pads, food supplements, diabetic supplies and other supplies that are identified in the approved in the ITP/ISP and that are not otherwise covered by Medicaid or Medicare (see 603.18 for more information). Ancillary supplies necessary for the proper functioning of approved supplies are also included in this service. Two quotes are required for the single purchase of specialized medical supplies costing \$1000 or more. ***	\$1,000
Vehicle Adaptations	T2038	Q2, U16	VAD	Based on goals as set in the ITP/ISP. Price of the lowest quote, used during the MFP period of participation.	This service enables individuals to interact more independently, enhancing their quality of life and reducing their dependence. Limited to participant's or the family's privately owned vehicle and includes such things as driving controls, mobility device carry racks, lifts, vehicle ramps, wheelchair tie-downs and occupant restraint systems, special seats and other interior modifications for access into and out of the vehicle as well as to improve safety while moving. Two quotes are required for adaptations costing \$1000 or more. ***	\$6,240
Environmental Modification	T2038	Q2, U17	EMD	Based on goals as set in the ITP/ISP. Price of the lowest quote (with exceptions), used during the MFP period of participation.	This service provides assistance to participants requiring physical adaptations to a qualified residence, including qualified residences under the Housing Choice Voucher or Other Housing Subsidy program or a community home on a case-by-case basis. This service covers basic modifications needed by a participant to ensure health, welfare and safety and/or to improve independence in ADLs. Two scope/bids are required. Total scope/bids of \$2,500 or more, require building permits. The MFP Home Inspection Service must be completed prior to beginning the environmental modifications and after modifications are completed to ensure participant health, welfare and safety and quality work. ***	\$8,000
Home Inspection	T2039	Q2, U18	HIS	Based on goals as set in the ITP/ISP. 1 unit = one inspection with relevant report from a qualified inspector, billable at \$250 per inspection. Used during the MFP period of participation.	This service provides for home/building inspections, required before and after MFP Environmental Modifications (MFP-EMD) are undertaken. This service is used to identify and report on needed structural repairs to a qualified residence that must be addressed prior to beginning environmental modifications and to identify and make recommendations for appropriate and cost-effective environmental modifications before they are started. This service also provides for post-inspections after modifications are complete, in order to ensure quality work and compliance with relevant building codes and standards. The inspector providing the service is not affiliated with the contractors providing the environmental modifications. ***	\$1,000
Supported Employment Evaluation	S5110	Q2, U19	SEE	Based on goals as set in the ITP/ISP. 1 unit = one complete Vocational Discovery Process with Vocational Profile and referrals to a minimum of three community resources, used during the MFP period of participation.	This service provides assistance to participants seeking career planning and supportive, customized and/or competitive employment. Participants engage in a guided/facilitated Vocational Discovery Process. Based on the Discovery Process, a Vocational Profile is completed. The Vocational Profile identifies a path to employment. These services may be procured from a qualified vocational/employment service provider. The provider is required to assist the participant to make connections to a minimum of three unique community resources necessary to support choices for supportive, customized and/or competitive employment. ***	\$1,500
<b>Maximum Post-transition Cost per Participant</b>						<b>\$26,420</b>
***MFP services are approved in the participant's transition service plan and authorized by MFP field personnel. **Q2-demonstration procedures/service; U-Medicaid Level of Care (1 thru 20), as Defined by Georgia Medicaid (DCH)						

## Appendix C: MFP Tri-Fold Recruiting Brochure

### What is Person-Centered Planning?

Transition plans work best when you fully participate in planning your own life. With person-centered planning, you will be asked to talk about your goals, needs, resources, personal experience and motivation to relocate.

Everyone depends on others at times. Through the MFP project, you will learn who these important people are and build new relationships with people who share goals that are important to you.

### What are Home Modifications?

You may need assistance to live independently in your own home. Home modifications may include the installation of ramps or grab bars or widening doorways. Money Follows the Person includes financial help for eligible older adults and persons with disabilities to make these changes to existing structures. Contact your MFP Transition Coordinator for more details.

### What is Self-Direction?

Self-direction means that informed consumers make choices about the home- and community-based services they receive. They can assess their own needs, determine how and by whom those needs should be met and monitor the quality of services received.

This document was developed under grant CFDA 93.779 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Money Follows the Person is a 10 year demonstration grant (Award #1LICMS030163) funded by CMS in partnership with the state of Georgia Department of Community Health. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the federal government.

**Money Follows the Person Project**  
Georgia Department of Community Health  
Two Peachtree Street, NW, 37th Floor  
Atlanta, GA 30303  
Email: [gamfp@dch.ga.gov](mailto:gamfp@dch.ga.gov)  
[dch.georgia.gov/mfp](http://dch.georgia.gov/mfp)

# Money Follows the Person



866-55-AGING (866-552-4464);  
888-454-5826  
Email: [gamfp@dch.ga.gov](mailto:gamfp@dch.ga.gov)



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH





*"MFP is the best thing the State has ever done."*

Cathy, MFP participant

*"[I'm] happy to be independent, and the MFP program is the best program in Georgia."*

Brenda, former MFP participant

## What is Money Follows the Person?

If you have lived in an inpatient facility, a hospital, nursing facility or an intermediate care facility (for people with developmental disabilities) for at least 90 consecutive days and would rather live in your own home, apartment or group setting, you may be eligible for home- and community-based services (HCBS) through Georgia's Medicaid programs.

Money Follows the Person (MFP) can assist with home- and community-based services. It is a grant offered through the Centers for Medicare and Medicaid Services (CMS) and the Georgia Department of Community Health (DCH).

## Who will help me relocate?

If you want to move into your own place (home, apartment or group setting), you can take advantage of MFP and HCBS. Through MFP, you will learn the skills you need and get the information and help you need to move to the community.

## What MFP services are available?

- Peer community support
- Trial visits to the community
- Household furnishings (limited)
- Household goods and supplies
- Moving expenses
- Utility and security (rent) deposits
- Transition supports
- Transportation
- Life skills coaching
- Skilled out-of-home respite
- Caregiver outreach and education
- Community Ombudsman
- Equipment, vision, dental and hearing services
- Specialized medical supplies
- Vehicle adaptations
- Environmental modifications
- Home inspection
- Supported employment evaluation

## Who do I contact?

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

- The Department of Human Services, Aging and Disability Resource Connection at **866-55-AGING** (866-552-4464)
- The Office of the Long Term Care Ombudsman at **888-454-5826**
- The Georgia Department of Community Health, Money Follows the Person project at **404-651-9961**

## What are the goals of MFP?

1. To increase the use of home- and community-based, rather than institutional long-term care services;
2. To eliminate barriers in state law, state Medicaid Plan and state budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible persons to receive support for long-term services in a setting of their choice;
3. To increase the ability of the state to continue to provide home- and community-based services to eligible people who choose to transition from an institution to a community setting.



[dch.georgia.gov/mfp](http://dch.georgia.gov/mfp) | Email: [gamfp@dch.ga.gov](mailto:gamfp@dch.ga.gov)

## Appendix D1: MFP Informed Consent



### Money Follows the Person Informed Consent for Participation

I, \_\_\_\_\_, (print name) voluntarily agree to be screened and assessed as part of my application for participation in the Money Follows the Person (MFP) project<sup>1</sup>. MFP Field Personnel will determine my appropriateness for the project. If approved for the MFP project, my participation may be in segments or consecutive days, but for a total period not to exceed 365 calendar days<sup>1</sup>.

By signing this Informed Consent, I agree to participate in all aspects of the MFP project, including completing the *Quality of Life Survey*. My responses to the *Quality of Life Survey* and other program information will be shared with the Centers for Medicare and Medicaid Services (CMS) as well as Georgia and national evaluators.

I have been given information about the MFP project; a copy of the MFP Brochure and a copy of the *Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia* booklet. I understand the MFP project guidelines including enrollment requirements. I understand that MFP one-time transitional services are provided under the MFP demonstration project.

I understand that if I qualify for and am enrolled in an appropriate waiver program, waiver services will continue for as long as I need them and I continue to meet eligibility requirements. If I am no longer eligible for the Medicaid waiver program, I will be provided with other service options that may assist me in a community setting. I understand that certain circumstances will make me ineligible for a waiver and for MFP. If the total cost of providing my care under the waiver exceeds the cost of providing care in an inpatient facility, I will become ineligible for the waiver and for the MFP project. If my condition improves and I don't continue to meet the waiver Level of Care criteria, I will become ineligible for the waiver program and may become ineligible for the MFP project.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**If signed by Responsible Party, State Relationship and Authority to Sign**

\_\_\_\_\_  
MFP Field Personnel Sign

\_\_\_\_\_  
Date

<sup>1</sup> Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter. 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 304

<sup>11</sup> If the MFP participant needs to be readmitted to an inpatient facility for a period of 30 days or less, the participant remains enrolled in the MFP demonstration. As soon as the participant's condition stabilizes, the participant can return to the community and resume services. When an MFP participant is readmitted into an inpatient facility for a period of time greater than 30 days (31 days or longer), the participant is suspended from the MFP demonstration and is considered an institutional resident. However, the suspended MFP participant will be re-enrolled, prior to the completion of 365 days, back into the demonstration without re-establishing the 90-day institutional residency requirement. The individual is considered an MFP participant when discharged from the inpatient facility, and is eligible to receive MFP services for any remaining days up to 365. MFP field personnel determine if any changes to the participant's Individualized Transition Plan are needed to prevent a re-admission to an inpatient facility. If the participant is readmitted to an inpatient facility for a period of longer than six months, the participant will be re-evaluated like a "new" MFP participant.

## Appendix D2: MFP Release of Health Information (MFP RHI)



### MFP Release of Health Information (MFP RHI)

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Georgia and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

#### USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the release, use or disclosure of my health information as follows:

Member Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Health Plan Name: \_\_\_\_\_

Persons/Organizations authorized to *receive, use or disclose* the information <sup>i</sup> are:

- MFP Field Personnel \*
- Waiver assessment/case management staff \*
- My Representative (Legal, etc.) \*
- MFP service providers (Peers, Ombudsman, etc.) \*

*\* Personnel located in Georgia and in the state to which you are transitioning.*

Purpose of requested use or disclosure: <sup>ii</sup> for screening and assessment and participation in MFP. This Authorization applies to the following information (select **only one** of the following):<sup>iii</sup>

- All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] **Except:** \_\_\_\_\_

- Only** the following records or types of health information (including any dates). This may consist of psychotherapy notes, if specifically authorized:

\_\_\_\_\_  
\_\_\_\_\_

#### EXPIRATION

All information I hereby authorize to be obtained from this inpatient facility will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for: (PLEASE CHECK ONE)

- ninety (90) days unless I specify an earlier date here: \_\_\_\_\_
- one (1) year
- the period necessary to complete transactions related to my participation in Money Follows the Person on matters related to services provided to me through Money Follows the Person.

*I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.*

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## MFP Release of Health Information (MFP RHI)

### NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: \_\_\_\_\_

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.<sup>iv</sup>

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.<sup>v</sup>

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

\_\_\_\_\_  
Signature of Member or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Representative, State Relationship or Basis of Authority

<sup>i</sup> If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

<sup>ii</sup> The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

<sup>iii</sup> This form may not be used to release both psychotherapy notes and other types of health information (see 45 CFR § 164.508(b)(3)(ii)). **If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.**

<sup>iv</sup> Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR § 164.508(d)(1), (e)(2)).

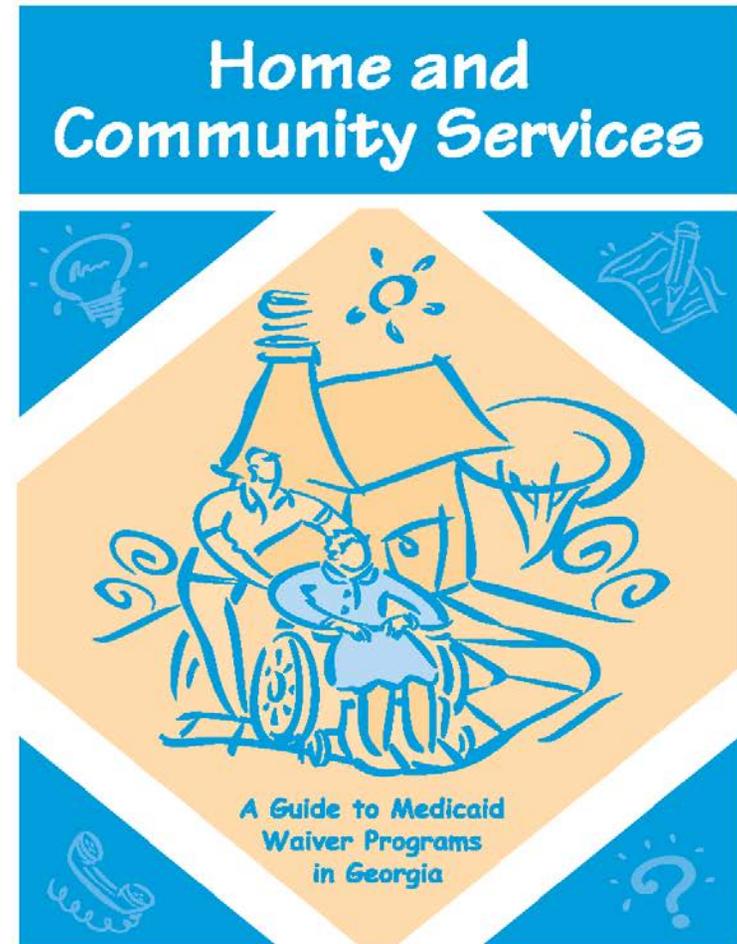
<sup>v</sup> If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. **Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.**



**Appendix E2: Home and Community Services Booklet (excerpts)**



A Publication of  
The Georgia Department of Community Health  
404-656-6862  
ofreeman@dch.ga.gov





## Booklet Order Form Home and Community Services A Guide to Medicaid Waiver Programs in Georgia

Date: \_\_\_\_\_

Name of Facility/Individual: \_\_\_\_\_

Address: (Street Address Only—No P.O. Boxes)  
\_\_\_\_\_  
\_\_\_\_\_

Total Number of Booklets Request: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

RE: If you are a Nursing/ICF-MR facility, refer to section 802 of the Nursing Facility Services manual for ordering.

Fax to/Mail to:  
Company: DCH/Long Term Care Unit

Fax Number: 404-656-8366

Mail to Attention: \_\_\_\_\_

## Helpful Telephone Numbers and Web Sites



To find out more about Medicaid eligibility, contact your county DFCS office. Look in the government pages of your telephone book for **Department of Family and Children Services**.

To locate a **county health department**, call **404-657-2700** or look in the government pages.

To locate the **Area Agency on Aging** that serves your community, call **404-657-5258**.

To locate a **Social Security Administration office** near you, call **1-800-772-1213**.

For questions about your **Medicaid card**, call **770-570-3373** or **866-211-0950**.

To learn more about your nursing home rights and options, contact the **Long Term Care Ombudsman** at **888-454-5826**.

To learn more about **Georgia Medicaid**, stop by your local library and log onto the Internet. The web site address is **[www.ghp.georgia.gov](http://www.ghp.georgia.gov)**.





- If you receive payments from any other type of insurance or health-related benefit, you must inform your caseworker of these payments within 10 days. These payments may come from private health, dental or vision insurance; Medicare; CHAMPUS; or any payment for an accident or injury. Be sure to report any of these sources of insurance to your caseworker when you apply for Medicaid. You must also report any money you have received or may receive in the future from an injury or accident caused by another person or liable party.



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of Family and Children Services (DFCS) office within 10 days after you have received a notice about eligibility or services.

- You have a right not to be discriminated against because of political beliefs, religion, disability, race, color, sex, national origin or age. If you are applying for someone else, these rights and responsibilities apply to that person. To report eligibility or provider discrimination, call 1-800-533-0686.



## Your Responsibilities

- You are responsible for providing true and complete information about your circumstances, including your income, the size of your family, your current address, and other information that helps Medicaid decide whether or not you continue to be eligible for Medicaid services.
- You are responsible for reporting changes in your circumstances. If your income, resources, living arrangements, family size, or other circumstances change, they could affect your eligibility. It is your responsibility to let your caseworker or the Social Security Administration (SSA) know about these changes within 10 days of the change.



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Georgia has several home and community-based waivers. Some of the waiver program services are: assistance with daily living activities (bathing, dressing, meals, housekeeping), help with arranging medical or support services and relief for caregivers. This booklet describes waiver programs for people who are elderly, physically disabled, have mental retardation or who have a developmental disability. For information about other waiver programs for children, such as the Deeming (Katie Beckett) or Model waivers, call the Georgia Health Partnership at 770-570-3373 (Metro Atlanta) or 866-211-0950 (Statewide).



Although different waiver programs offer different services, they have some things in common. Each program is designed to help people who qualify for institutional care remain in the community or return to the community from nursing homes, hospitals or ICF-MRs. Each program also requires that people be eligible for Medicaid. To qualify for a waiver program, you can have higher income and resources than permitted in the regular Medicaid program.

- Non-emergency transportation (to get to and from medical appointments if you don't have any other means of transportation)
- Medical equipment and supplies prescribed by a doctor for use in your home (such as wheelchairs, crutches or walkers)
- Home health services ordered by a doctor and received in your home (such as part-time nursing, physical therapy or home health aides)
- Hospice care services provided by a Medicaid hospice provider

Some other services covered by Medicaid include:

- Case management
- Diagnostic, screening and preventive services
- Laboratory services
- Medicare cost sharing
- Mental health clinic services
- Orthotics and prosthetics (artificial limbs and replacement devices)
- Podiatry services
- Therapy services (physical, occupational and speech)
- County Public Health Departments
- Dialysis and services for end-stage renal (kidney) disease





## What Other Services Does Medicaid Cover?

It's always a good idea to ask your doctor or pharmacist whether Medicaid covers the specific service or item you need. There are some limits to these services, and some may require you or your doctor to get permission first. (This is called prior approval.)

Following are basic Medicaid services. Additional services are offered by each of the waiver programs. Your caseworker can provide more information about other available services.

In general, Medicaid covers these services:

- Doctors' and nurses' office visits (when you visit a doctor or nurse for check-ups, lab tests, exams or treatment)
- Prescription drugs
- Inpatient hospital services (room and board, drugs, lab tests and other services when you have to stay in the hospital)
- Outpatient hospital services (services you receive in a hospital, even though you do not stay in the hospital overnight)
- Nursing facilities (nursing homes)
- Emergency ambulance services
- Emergency dental care for adults; comprehensive dental care for individuals under age 21



## What is Medicaid?

**Medicaid** is a medical assistance program that helps many people who can't afford medical care pay for some or all of their medical bills. If you apply and are approved for Medicaid, you will receive a plastic Medicaid card in the mail. Medicaid will pay participating doctors, pharmacists, hospitals or other providers for your care.

**If you or someone in your family needs health care, you should apply for Medicaid even if you are not sure whether you qualify or if you have been turned down in the past.**



## How to Apply for Medicaid Home and Community-Based (waiver) Services

If you are interested in a waiver program, contact the agency listed. If you qualify, someone will guide you through the next steps of the Medicaid application process. You will be notified within 90 days or less whether you are eligible for waiver services. If you are told that you do not qualify, you can ask for a hearing. If you are eligible for waiver services, you will be advised about when services will begin.





## Medicaid Home and Community-Based (waiver) Programs

Waiver programs help people who are elderly or have disabilities and need help to live in their home or community instead of an institution such as a nursing home or ICF-MR. Each program offers several "core" services:



- service coordination (help with managing care needs and services)
- personal support (assistance with daily living activities, i.e. bathing, dressing, meals and housekeeping)
- home health services (nursing, home health aide, and occupational, physical and speech therapy)
- emergency response systems
- respite care (caregiver relief)

Additional services are available under each program. Following are brief descriptions of the home and community waivers. Sometimes waiver services are added or changed. The agencies that handle the waiver programs can provide more detailed information about covered services.

condition, the acuity level of care to be administered and the required number of one-on-one hours the member will need. An overall evaluation of nursing treatments and frequency, therapy services and frequency, equipment needs and skilled nursing care needs are other components considered in determining the level of day care service required: Skilled Nursing, Physical therapy, Speech therapy, Transportation, Social work, Child life specialist.

Registered dietitian services are included in the Day care facility services.

The children are classified as requiring Level I or Level II services:

### Level I - Low Tech Services

- Requires nursing treatments every 4 - 6 hours
- Therapy services 1 - 2 times per week
- Minimum equipment needs

### Level II - High Tech Services

- Nursing Treatments every 1 - 3 hours
- Therapy services 3 - 5 times per week
- Maximum equipment needs

Applications to the program are completed by the individual Medically fragile daycare center that are enrolled in the GAPP Program. The center has to be approved by the Department of Community Health, Health Improvement and Wellness Unit.

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### Appendix F:AAA Gateway Network, Georgia Cares and Affiliated Agencies

Planning & Service Area	Area Agency on Aging Director, Address & Phone Number	GeorgiaCares Program Coordinator Address & Phone #	Counties Served
<p>Atlanta Regional Commission (ARC)</p> <p><b>(REGION 3)</b> Katrina Wilder Regional Coordinator 404-657-5275</p>	<p>Kathryn Lawler AAA Director <a href="mailto:KLawler@atlantaregional.com">KLawler@atlantaregional.com</a> Atlanta Regional Commission 40 Courtland Street, NE Atlanta, Georgia 30303 <b>Ph No. 404-463-3235</b> <b>Fax No. 404-463-3264</b></p> <p><b>AgeWise Connection</b> <b>404-463-3333 or 1-800-676-2433</b></p> <p>Sue Burgess - Supervisor <i>(cc for SHIP &amp; SMP)</i> <a href="mailto:sburgess@atlantaregional.com">sburgess@atlantaregional.com</a> Ph No: 404-463-1936</p> <p>Cara Pellino – Supervisor <i>(cc for SHIP &amp; SMP)</i> <a href="mailto:cpellino@atlantaregional.com">cpellino@atlantaregional.com</a> Ph No: 404-463-3218</p> <p><b>Kristie Sharp</b> Volunteer Coordinator Ph No. 404-463-0437</p>	<p><b>Lisa Federico</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:lfederico@atlantaregional.com">lfederico@atlantaregional.com</a> Ph. No. 404-463-3522 Fax No. 404-463-3264</p> <p><b>Gia Brunson</b> GeorgiaCares Counselor <a href="mailto:gbrunson@atlantaregional.com">gbrunson@atlantaregional.com</a> Ph. No. 678-515-9662</p> <p><b>Monica Gilbert</b> GeorgiaCares Counselor <a href="mailto:mgilbert@atlantaregional.com">mgilbert@atlantaregional.com</a> 678-515-9663</p> <p><b>GeorgiaCares Contact #:</b> 404-463-3350</p>	<p>Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale (10 counties)</p>

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Planning & Service Area	Area Agency on Aging Director, Address & Phone Number	GeorgiaCares Program Coordinator Address & Phone #	Counties Served
<p>Central Savannah River Area (CSRA)</p> <p><b>(REGION 8)</b>                      Katrina Wilder                      Regional Coordinator                      404-657-8779</p>	<p>Jeanette Cummings                      AAA Director  <a href="mailto:jcummings@csrarc.ga.gov">jcummings@csrarc.ga.gov</a>                      Central Savannah River Area RDC                      3023 River Watch Pkwy Ste A Bldg 200                      Augusta, Georgia 30907-2016                      Ph No. 706-210-2013</p> <p><b>Ph No. 706-210-2018 (AAA Gateway)</b>  <b>Ph No. 706-210-2000 (RDC Main)</b>  <b>Fax No. 706-210-2006</b>  <b>Toll Free Nu. 1-888-922-4464</b></p> <p><b>Vacant - Supervisor</b>                      Elder Rights Coordinator  <a href="mailto:lpivey@csrarc.ga.gov">lpivey@csrarc.ga.gov</a>                      Same address                      Ph. No. 706-650-5693</p> <p><b>Wallace White</b>                      Aging Services Program Manager  <a href="mailto:wwhite@csrarc.ga.gov">wwhite@csrarc.ga.gov</a>                      Same address                      Ph. No. 706-650-5693                      Cell 706-951-2605</p> <p><b>Jackie Harris</b>                      Contracts Manager  <a href="mailto:jharris@csrarc.ga.gov">jharris@csrarc.ga.gov</a></p>	<p><b>Kerrie Sirmans</b>  <b>GeorgiaCares Coordinator</b>                      3023 River Watch Pkwy Ste A, Bldg 200                      Augusta, Georgia 30907-2016                      Ph. No. 706-210-2029                      Fax No. 706-210-2024  <a href="mailto:ksirmans@csrarc.ga.gov">ksirmans@csrarc.ga.gov</a></p> <p><b>GeorgiaCares Contact #: 706-210-2029</b></p>	<p>Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes                      (14 counties)</p>

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Planning & Service Area	Area Agency on Aging Director, Address & Phone Number	GeorgiaCares Program Coordinator Address & Phone #	Counties Served
<p>Three Rivers (Southern Crescent AAA)</p> <p><b>(REGION 4)</b> Katrina Wilder Regional Coordinator 404-657-5275</p>	<p>Joy Y. Shirley AAA Director <a href="mailto:jvshirley@threeriversrc.com">jvshirley@threeriversrc.com</a> P.O. Box 1600 13273 Ga. Hwy. 34 East Franklin, Georgia 30217 Ph No: 678-552-2853</p> <p><b>Gateway/ADRC Ph No. 678-552-2838 or 1-866-854-5652 Fax No. 706-675-9210 or 770-854-5402</b></p> <p><b>Tonya Jones</b> Volunteer Coordinator Ph. No. 770-254-4501 <a href="mailto:ttjones@threeriversrc.com">ttjones@threeriversrc.com</a></p>	<p><b>Belinda Jones</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:bjones@threeriversrc.com">bjones@threeriversrc.com</a> 13273 GA Hwy 34 East PO Box 1600 Franklin, Georgia 30217 Ph. No. 678-552-2839 Fax No. 770-854-5402</p> <p><b>Linda Smith</b> GeorgiaCares Counselor Ph. No. 678-552-2851</p> <p><b>GeorgiaCares Contact #: 706-675-9031</b></p>	<p>Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup, Upson (10 counties)</p>
<p>Coastal Regional Commission</p> <p><b>(REGION 12)</b> Elaine Popham Regional Coordinator 912-449-4996 (office) 912-281-3829 (cell)</p>	<p>Dionne Campbell Lovett AAA Director <a href="mailto:dlovett@crc.ga.gov">dlovett@crc.ga.gov</a> Ph No. 912-437-0840 Coastal Regional Commission AAA 1181 Coastal Drive SW Darien, GA 31305 Ph No. 912-437-0800</p> <p><b>Fax No. 912-262-2313 Info Link 1-800-580-0860</b></p> <p><b>Pamela Rogers, Contracts Administrator</b> <a href="mailto:progers@crc.ga.gov">progers@crc.ga.gov</a> Ph No. 912-437-0842</p>	<p><b>Evelyn Gay</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:egay.savannah@glsp.org">egay.savannah@glsp.org</a> Ph No. 478-982-3421 Cell 478-494-3421 Fax No. 478-982-4130</p> <p><b>Wynette Sellers, Staff</b> GeorgiaCares Counselor <a href="mailto:wsellers@crc.ga.gov">wsellers@crc.ga.gov</a> Ph No. 912-262-2865</p> <p><b>GeorgiaCares Contact #: 912-262-2864</b></p>	<p>Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh (9 counties)</p>

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Planning & Service Area	Area Agency on Aging Director, Address & Phone Number	GeorgiaCares Program Coordinator Address & Phone #	Counties Served
<p>Northwest Ga. Regional Commission (Coosa Valley)</p> <p><b>(REGION 1)</b> Katrina Wilder Regional Coordinator 404-657-8779</p>	<p>Debbie Studdard AAA Director <a href="mailto:dstuddard@nwgrc.org">dstuddard@nwgrc.org</a> AAA Director Northwest Georgia AAA #1 Jackson Hill Drive Rome, GA 30161-1793</p> <p><b>Ph No. 706-295-6485, 706-295-6348 or 706-802-5506</b> <b>Fax No. 706-802-6665</b> <b>Screening 1-800-759-2963</b></p> <p><b>Karen Nelson – ADRC Supervisor</b> <a href="mailto:knelson@nwgrc.org">knelson@nwgrc.org</a></p> <p><b>Angie Ashmore – Supervisor</b> <a href="mailto:aashmore@nwgrc.org">aashmore@nwgrc.org</a></p>	<p><b>Kerry DeFoe</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:kdefoe@nwgrc.org">kdefoe@nwgrc.org</a> same address Ph. No: 706-295-6485 Cell No: 770-881-0171</p> <p><b>Mandy Burchett - Staff</b> GeorgiaCares Counselor <a href="mailto:mburchett@nwgrc.org">mburchett@nwgrc.org</a> Ph No: 706-295-6348 <b>GeorgiaCares Contact #: 706-622-3635</b></p>	<p>Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield (15 counties)</p>
<p>Legacy Link (Georgia Mountains)</p> <p><b>(REGION 2)</b> Katrina Wilder Regional Coordinator 404-657-8779</p>	<p>Pat Viles Freeman AAA Director <a href="mailto:pvfreeman@legacylink.org">pvfreeman@legacylink.org</a> 4080 Mundy Mill Road (NEW) Oakwood, GA 30566</p> <p>Mailing Address: (NEW) P.O. Box 1480 Oakwood, GA 30566</p> <p><b>Ph No.770-538-2650</b> <b>Fax No. 770-538-2660</b> <b>Screening 1-800-845-5465</b></p> <p><b>Diane Currans – Supervisor</b> Gateway Manager/ADRC Specialist Ph. No. 770-538-2654 <a href="mailto:mcurrans@legacylink.org">mcurrans@legacylink.org</a></p>	<p><b>Barbara Hilber</b> <b>GeorgiaCares Coordinator</b> same address <a href="mailto:bhilber@legacylink.org">bhilber@legacylink.org</a> Ph. No. 678-677-8540 Fax No. 770-538-2660</p> <p><b>Moira J. Todd, Counselor</b> <a href="mailto:mjtodd@legacylink.org">mjtodd@legacylink.org</a> Ph: 770-538-2702</p> <p><b>Joan Knight, Counselor</b> <a href="mailto:jdknight@legacylink.org">jdknight@legacylink.org</a></p> <p><b>GeorgiaCares Contact #: 770-538-2650</b></p>	<p>Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White (13 counties)</p>

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<p>Heart of Georgia Altamaha Regional Commission</p> <p><b>(REGION 9)</b> Elaine Popham Regional Coordinator 912-449-4996 (office) 912-281-3829 (cell)</p>	<p>Gail Thompson AAA Director <a href="mailto:thompson@hogarc.org">thompson@hogarc.org</a> Heart of Georgia Altamaha RDC 331 West Parker St. Baxley, GA 31513-0674 <b>Ph No. 912-367-3648 or 1-888-367-9913</b> <b>Fax No. 912-367-3640 or 912-367-3707</b></p> <p><b>Linda Hunter</b> <a href="mailto:hunter@hogarc.org">hunter@hogarc.org</a></p>	<p><b>Don Gay, Sr.</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:dgay@glsp.org">dgay@glsp.org</a> Aging Disability Advocacy Group, Inc. 6250 Elam Rd Garfield, GA 30425 Ph. No. 478-982-8526 Cell 706-871-0241 Fax No. 478-982-4130</p> <p><b>GeorgiaCares Contact #: 478-982-8526</b></p>	<p>Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox (17 counties)</p>
<p>River Valley AAA (Formerly Lower Chattahoochee)</p> <p><b>(REGION 6)</b> Donna Walker Regional Coordinator 404-657-5315</p>	<p>Tiffany Ingram AAA Director <a href="mailto:tingram@rivervalleyrcaaa.org">tingram@rivervalleyrcaaa.org</a> River Valley AAA 1428 Second Avenue P. O. Box 1908 Columbus, GA 31902-1908 <b>Ph No. 706-256-2910</b> <b>Fax No. 706-256-2908</b> <b>Toll Free: 1-800-249-7468</b></p> <p><b>Ilona Preattle, ADRC</b> <a href="mailto:ipreattle@rivervalleyrcaaa.org">ipreattle@rivervalleyrcaaa.org</a> 706-256-2918</p>	<p><b>Shameika Averett</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:saverett@rivervalleyrcaaa.org">saverett@rivervalleyrcaaa.org</a> Same address Ph. No. 706-256-2917 Fax No. 706-256-2908</p> <p><b>GeorgiaCares Contact #: 706-256-2917</b></p>	<p>Chattahoochee, Clay, Crisp, Dooley, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster (16 counties)</p>

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Planning & Service Area	Area Agency on Aging Director, Address & Phone Number	GeorgiaCares Program Coordinator Address & Phone #	Counties Served
<p>Middle Georgia Regional Commission</p> <p><b>(REGION 7)</b> Elaine Popham Regional Coordinator 912-449-4996 (office) 912-281-3829 (cell)</p>	<p><b>Julie Hall, Interim Director</b> <b>(Effective 6/30/14)</b> AAA Director <a href="mailto:jhall@mg-rc.org">jhall@mg-rc.org</a> Middle Georgia RDC 175 Emery Highway Ste C Macon, GA 31217-3699 <b>Ph No. 478-751-6466</b> <b>Fax No. 478-752-3243</b> <b>Toll free: 1-888-548-1456</b></p>	<p><b>Butch Swinney</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:bswinney@mg-rc.org">bswinney@mg-rc.org</a> Same address Ph. No. 478-751-6489 Cell 478-714-2309 Fax No. 478-752-3243</p> <p><b>GeorgiaCares Contact #: 478-751-6489</b></p>	<p>Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson (11 counties)</p>
<p>Northeast Georgia</p> <p><b>(REGION 5)</b> Katrina Wilder Regional Coordinator 404-657-8779</p>	<p>Peggy Jenkins AAA Director <a href="mailto:pjenkins@negro.org">pjenkins@negro.org</a> Northeast Georgia RDC 305 Research Drive Athens, GA 30605-2795 <b>Ph No. 706-369-5650</b> <b>Fax No. 706-369-5792</b> <b>Toll free: 1-800-474-7540</b></p> <p>Athens Community Council on Aging 135 Hoyt Street Athens, GA 30601-2646 Ph No. 706-549-4850 Fax No. 706-549-7786</p> <p><b>Erin Beasley – Supervisor</b> <a href="mailto:ebeasley@accaging.org">ebeasley@accaging.org</a></p> <p><b>Anne Hansen – AAA</b> <a href="mailto:ahansen@dhr.state.ga.us">ahansen@dhr.state.ga.us</a></p>	<p><b>Jessica Bankston</b> <b>(Last Day 11/7/14 until 2/9/15)</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:jbankston@accaging.org">jbankston@accaging.org</a> 63 Lee Street Winder, GA 30680 Ph. No. 678-963-5199 Athens Office: 706-549-4850 Cell No.: 239-470-4202</p> <p><b>Marie White, Interim Coordinator</b> <b>(Started 10/1/14)</b> <a href="mailto:mwhite@accaging.org">mwhite@accaging.org</a> Ph. No. 706 549 4850 Located in Athens Mon 8am-4:30pm, Tues. 8am-3pm, Wed. 12noon-5pm, Thurs. 8am-2pm, Fri. 12noon-5pm</p> <p><b>Shannon (Intern)</b> <a href="mailto:gcintern@accaging.org">gcintern@accaging.org</a> Mon., Tues., Thurs. from 9am-4:30pm.</p> <p><b>GeorgiaCares Contact #: 678-963-5199</b></p>	<p>Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton (12 counties)</p>

## Georgia MFP Operational Protocol Version 1.6

Planning & Service Area	Area Agency on Aging Director, Address & Phone Number	GeorgiaCares Program Coordinator Address & Phone #	Counties Served
<p>Southwest Georgia (SOWEGA)</p> <p><b>(REGION 10)</b> Donna Walker Regional Coordinator 404-657-5315</p>	<p>Kay Hind AAA Director <a href="mailto:kay.hind@sowegacoa.org">kay.hind@sowegacoa.org</a> Southwest Georgia COA 335 West Society Ave Albany, GA 31701-1933 <b>Ph No. 229-432-1124</b> <b>Fax No. 229-483-0995</b> <b>Toll Free 1-800-282-6612</b></p> <p><b>Debbie Blanton, Assistant Director/Supervisor</b> <a href="mailto:debbie.blanton@sowegacoa.org">debbie.blanton@sowegacoa.org</a> 229-432-1124</p>	<p><b>Brian Ramey</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:Brian.Ramey@sowegacoa.org">Brian.Ramey@sowegacoa.org</a> 335 West Society Ave. Albany, GA 31701 Ph. No. 229-432-1124 Ext. 183 Fax No. 229-438-0408</p> <p><b>GeorgiaCares Contact #: 229-432-1124</b></p>	<p>Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth (14 counties)</p>
<p>Southern Georgia</p> <p><b>(REGION 11)</b> Donna Walker Regional Coordinator 404-657-5315</p>	<p>Wanda Taft AAA Director <a href="mailto:wtaft@sgrc.us">wtaft@sgrc.us</a> Southeast Georgia RDC 1725 S. GA Pkwy, West Waycross, GA 31503 <b>Ph Nu. 912-285-6097</b> <b>Fax Nu. 912-285-6126</b> <b>Toll Free: 1-888-732-4464</b></p> <p><b>Bridget Delaney – Supervisor</b> <a href="mailto:jbdelaney@sgrc.us">jbdelaney@sgrc.us</a> Ph. No. 912-287-5888</p>	<p><b>Linda Gail</b> <b>GeorgiaCares Coordinator</b> <a href="mailto:lgail@sgrc.us">lgail@sgrc.us</a> Same address Ph No. 912-285-6124 or 912-285-6118 Fax No. 912-337-1196</p> <p><b>Cecelia Nelson - Staff</b> <a href="mailto:cjnelson@sgrc.us">cjnelson@sgrc.us</a></p> <p><b>GeorgiaCares Contact #: 912-338-5945</b></p>	<p>Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware (18 counties)</p>

## Georgia MFP Operational Protocol Version 1.6

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Planning & Service Area	Area Agency on Aging Director, Address & Phone Number	GeorgiaCares Program Coordinator Address & Phone #	Counties Served
DAS GeorgiaCares Program	<p>2 Peachtree Street, NW 33<sup>rd</sup> Floor Atlanta, GA 30303 Fax No. 404-657-5285</p> <p><b>Cheryl Harris, Access to Services Manager</b> <a href="mailto:charris@dhr.state.ga.us">charris@dhr.state.ga.us</a> Ph. No. 404-657-5325 BB 404-783-8913</p> <p><b>Christine J. Williams</b> State SHIP Coordinator <a href="mailto:cjwilliams@dhr.state.ga.us">cjwilliams@dhr.state.ga.us</a> Suite 33-101 Ph. No. 404-657-5347</p>	<p><b>Patsy McDoodle</b> Program Consultant <a href="mailto:plmcdood@dhr.state.ga.us">plmcdood@dhr.state.ga.us</a> Suite 33-202 Ph. No. 404-657-1516</p> <p><b>Isaac Long</b> Program Consultant <a href="mailto:iclong@dhr.state.ga.us">iclong@dhr.state.ga.us</a> Suite 33-212 Ph. No. 404-232-7876 BB: 404-807-4952</p> <p><b>Carline Robertson</b> State SMP Coordinator <a href="mailto:cdrobertson@dhr.state.ga.us">cdrobertson@dhr.state.ga.us</a> Suite 33-203 Ph. No. 404-657-5318</p> <p><b>David Watkins</b> Volunteer Coordinator <a href="mailto:dawatkins@dhr.state.ga.us">dawatkins@dhr.state.ga.us</a> Suite 33-204 Ph. No. 404-657-5253 Cell: 404-388-8095</p> <p><b>Vacant</b> Business Operations Generalist Suite 33-205 Ph. No. 404-232-1667</p>	Statewide

# Georgia MFP Operational Protocol Version 1.6

## Appendix G: MFP Transition Screening Form



### MFP Transition Screening Form

Participant FName: \_\_\_\_\_ MI: \_\_\_ LName: \_\_\_\_\_

1. Do you want to live somewhere other than this facility?  Yes  No

Screening Type/Date (Check one box) <input type="checkbox"/> Initial F2F Screening _____ (mm/dd/yyyy) <input type="checkbox"/> F2F Re-screening _____ (mm/dd/yyyy) Screener's Name: _____ Screener's Contact: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity: <input type="checkbox"/> Not Hispanic, Latino, Spanish <input type="checkbox"/> Mexican, Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another (Print Origin): _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black, African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other (Print): _____	MFP Target Population (Check one box): <input type="checkbox"/> OA-Older Adult (65+) <input type="checkbox"/> PD-Physical Disability <input type="checkbox"/> TBI-Traumatic Brain Injury <input type="checkbox"/> DD-Developmental Disability	Primary Disability (Check only one): <input type="checkbox"/> D1-Cognitive (TBI, DD, dementia) <input type="checkbox"/> D2-Hearing (deaf/HoH/H loss) <input type="checkbox"/> D3- Mental/SPMI <input type="checkbox"/> D4- Physical (mobility, stamina) <input type="checkbox"/> D5- Vision (Blind/Low Vision) <input type="checkbox"/> D6- N/A <input type="checkbox"/> D7- DNK <input type="checkbox"/> D8- Refused
Date of Initial MFP referral: _____ (mm/dd/yyyy) Date of Waiver Referral: _____ (mm/dd/yyyy)	Referral Source: <input type="checkbox"/> RS1-Inpatient Facility <input type="checkbox"/> RS2-MDSQ <input type="checkbox"/> RS3-Self <input type="checkbox"/> RS4-Family Member <input type="checkbox"/> RS5-CIL, LTCO <input type="checkbox"/> RS6-AAA/ADRC <input type="checkbox"/> RS7-Waiver Case Mgr <input type="checkbox"/> RS8-Personal Care Home <input type="checkbox"/> RS9-Assisted Living Facility <input type="checkbox"/> RS10-Legal Representative <input type="checkbox"/> RS11-Other (specify): _____		Waiver Referral: <input type="checkbox"/> CCSP <input type="checkbox"/> SOURCE <input type="checkbox"/> ICWP <input type="checkbox"/> NOW <input type="checkbox"/> COMP <input type="checkbox"/> Other Waiver (specify): _____ <input type="checkbox"/> No Waiver Referral	Refused/ineligible: <input type="checkbox"/> in NF < 90 days <input type="checkbox"/> no Medicaid <input type="checkbox"/> didn't transition to qualified residence <input type="checkbox"/> didn't cooperate in planning process <input type="checkbox"/> no longer wished to participate <input type="checkbox"/> Other (specify): _____
Primary Language: <input type="checkbox"/> American Sign Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Korean <input type="checkbox"/> Other (specify): _____			<input type="checkbox"/> Deaf or Hard of Hearing Requires Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: _____	

**Personal Data:**

2. First Name: \_\_\_\_\_ MI: \_\_\_ Last Name: \_\_\_\_\_

3. Date of Birth (mm/dd/yyyy) \_\_\_\_\_ SSN: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

4. Medicaid # \_\_\_\_\_ Medicare # \_\_\_\_\_

5. Inpatient Facility Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Facility Street Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

**MFP field personnel note:** All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via **FTP**.  
 DCH MFP Transition Screening Form\_Revised\_041014

# Georgia MFP Operational Protocol Version 1.6



## MFP Transition Screening Form



Participant FName: \_\_\_\_\_ MI: \_\_\_ LName: \_\_\_\_\_

6. Discharge Planner/Contact FName: \_\_\_\_\_ LName : \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

7. Marital Status:  Single  Mar  Div  Widowed  Sep  Other: \_\_\_\_\_  
(if applicable) Spouse Name and address: \_\_\_\_\_  
\_\_\_\_\_

8. Are you a veteran?  Yes  No. Did you serve during wartime?  Yes  No

9. Do you have a guardian?  Yes  No. If yes, list name and contact:  
\_\_\_\_\_

(Screener note: Ask the person who they would like to include in the screening process—family members, friends, etc. If person has a guardian, stop the interview and reschedule the screening when these persons can participate).

### Background Data:

10. What were the reasons you entered this facility? \_\_\_\_\_  
\_\_\_\_\_

11. How long have you lived here at this facility? \_\_\_\_\_ years \_\_\_\_\_ months  
(Screener note: to qualify for MFP, the person must have resided in an inpatient facility for a minimum of 90 consecutive days, short term rehab stays do not count).

(Screener note: At this point in the screening interview, introduce, review and obtain signature on *Authorization for Release of Information and Informed Consent for MFP*).

12. Do you have any family living in this area?  Yes  No  
If yes, list name, phone number and address:  
\_\_\_\_\_  
\_\_\_\_\_

13. Are there family member(s) or friend(s) that would be interested in your move to the community?  Yes  No

14. May we contact these family member(s) or friends(s) to meet with you and us to discuss your move to the community?  Yes  No  
If yes, please provide their name(s) and telephone number(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MFP field personnel note:** All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via FTP.  
DCH MFP Transition Screening Form\_Revised\_041014

# Georgia MFP Operational Protocol Version 1.6



## MFP Transition Screening Form

Participant FName: \_\_\_\_\_ MI: \_\_\_\_ LName: \_\_\_\_\_

### Housing Section:

15. Where did you live before you came here? \_\_\_\_\_

Screener note: after the person answers, code the response by checking the box below-  
 01-own home,  02-family home,  03-apt/house leased by participant,  04-apt leased/assisted living,  05-group home/PCH,  06-Other (specify) \_\_\_\_\_

16. What Georgia County did you live in before you came here? \_\_\_\_\_

17. Do you want to return to (living situation in Q15)?  Yes  No

18. If yes, what prevents you from returning to (living situation in Q15)? \_\_\_\_\_

19. Do you have a home to move back into?  Yes  No

If yes, the address (street, city, zip, county) of your home: \_\_\_\_\_

20. (If applicable) Does anyone live in your home?  Yes  No

If yes, what are their names and relationship to you? \_\_\_\_\_

(Screener note: discuss MFP qualified housing. Tell the candidate that while MFP will assist the person to locate qualified housing, the MFP project does not cover the cost of rent or utilities and that to participate in MFP, the person must enter qualified housing).

21. Which type of qualified housing are you interested in and why? \_\_\_\_\_

Screener note: after the person answers, code the response by checking the box below-  
 01-own home,  02-family home,  03-apt/house leased by participant,  04-apt leased/assisted living,  05-group home/PCH,  06-Other (specify) \_\_\_\_\_

22. What Georgia County do you prefer to live in? \_\_\_\_\_

23. Do you have someone you want to live with?  Yes  No

If yes, list contact information \_\_\_\_\_

### Waiver Service History:

24. Did you receive services in your home before coming here?  Yes  No

If yes, what services: \_\_\_\_\_

25. Are you currently on a waiver waiting list for home & community based services?  Yes  No If so, which waiver? \_\_\_\_\_

26. Do you have a letter or contact information from the waiver?  Yes  No

If yes, where is the letter or contact information and who can bring these to you? \_\_\_\_\_

**MFP field personnel note:** All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via FTP.  
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# Georgia MFP Operational Protocol Version 1.6



## MFP Transition Screening Form



**Participant FName:** \_\_\_\_\_ **MI:** \_\_\_ **LName:** \_\_\_\_\_

**Financial Data:**

(Screener note: Review facility records to obtain or confirm this information. The signed informed consent will allow you to obtain and review inpatient facility records).

**27. Income and Resources:**

SOURCE	MONTHLY AMOUNT	PAYEE
<input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> SS Retirement		
<b>PENSION BENEFITS</b>		
<b>TRUST PROCEEDS</b>		
<b>INHERITANCE</b>		
<b>VETERAN'S COMPENSATION</b>		
<b>CASH</b>		
<b>CHECKING ACCOUNT</b>		
<b>SAVINGS ACCOUNT</b>		
<b>SAVINGS ACCOUNT (DESIGNATED BURIAL)</b>		
<b>CEMETERY PLOT</b>		
<b>RAILROAD RETIREMENT</b>		
<b>LIFE INSURANCE</b>		
<b>CERTIFICATE OF DEPOSIT</b>		
<b>OTHER (SPECIFY)</b>		

**MFP field personnel note:** All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via **FTP**.  
 DCH MFP Transition Screening Form\_Revised\_041014

# Georgia MFP Operational Protocol Version 1.6



## MFP Transition Screening Form

Participant FName: \_\_\_\_\_ MI: \_\_\_\_ LName: \_\_\_\_\_

28. Who is paying for your stay here? \_\_\_\_\_

29. Are you Medicaid eligible, but subject to transfer of asset penalty?  
 Yes  No  DNK (Do Not Know) (Screener note: check facility records)

### Health Care Needs:

30. How would you describe your primary disability or limitation? \_\_\_\_\_

Screener note: After the person provides a primary disability, confirm that the response fits into one of the following categories and check the box:  D1- Cognitive (TBI/DD, dementia),  D2- Hearing (Deaf/HoH/Hearing loss),  D3- Mental Health/SPMI,  D4- Physical (Mobility/Dexterity/Stamina),  D5- Vision (Blind/Low Vision),  D6- Not Applicable,  D7- DNK,  D8- Refused

31. Who is your doctor here at this facility? \_\_\_\_\_

32. Do you have a primary care doctor or clinic in the community?  Yes  No

If yes, list contact information? \_\_\_\_\_

33. Do you need help taking your daily medications?  Yes  No

Describe assistance needed: \_\_\_\_\_

34. What specialized medical equipment (DME) and assistive technology devices do you use?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

35. Which equipment or devices need to be obtained because you don't own them or they need to be replaced?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MFP field personnel note:** All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via FTP.  
DCH MFP Transition Screening Form\_Revised\_041014

# Georgia MFP Operational Protocol Version 1.6



## MFP Transition Screening Form

Participant FName: \_\_\_\_\_ MI: \_\_\_ LName: \_\_\_\_\_

### 36. Functional Needs -

See KEY below for instructions to complete:

Function: Ask, "Do you need help with (activities below)? (observe person doing activity when possible)"	Impairment: If assistance needed, check yes	Unmet Need: Ask: Do you have an unmet need for help with (activities) _____ in the community?	Comments: Identify sources of assistance in the community, resources, assistive technology, DME used. Describe special needs and circumstances that should be taken into account when developing a plan for services and supports
1. Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Grooming	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Transferring	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Contenance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Managing Money	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Telephoning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Preparing Meals	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Housework	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Outside Home	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Routine Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Special Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Being Alone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>KEY</b> Assistance Needed in the Community Ask: <b>Do you need help with (activities listed above #1-15)?</b> When appropriate, observe the person in the activity.		<b>Unmet Need for Care</b> – when person returns to the community Ask: <b>When you return to the community, do you have an unmet need for someone to help you with _____ (activities listed above #1-15)?</b> If participant has assistance of family/friend/caregiver or assistive device, the answer would be <b>NO</b> . If participant <b>has no assistance</b> , the answer would be <b>YES (there is an unmet need for care)</b> . Note observations.	

**MFP field personnel note:** All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via FTP.  
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## MFP Transition Screening Form

Participant FName: \_\_\_\_\_ MI: \_\_\_ LName: \_\_\_\_\_

37. Home Community Based Service (HCBS) referral to:

- CCSP (AAA/Gateway)
- SOURCE (SOURCE Case Management)
- Independent Care Waiver (ICWP) (GMCF)
- NOW/COMP Waiver (DBHDD-DDD/MFP Office)
- No Waiver Referral Made (specify reason) \_\_\_\_\_
- State Plan Services (list) \_\_\_\_\_
- Non-Medicaid Services (specify) \_\_\_\_\_

38. Date of referral to HCBS waiver \_\_\_\_\_ (mm/dd/yyyy).

39. Date HCBS waiver application submitted: \_\_\_\_\_ (mm/dd/yyyy)

40. Date HCBS waiver assessment completed: \_\_\_\_\_ (mm/dd/yyyy)

41. I DO NOT wish to participate in MFP:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### Document Checklist:

(Screener note: attach the following documents. Send these copies and copy of completed *MFP Transition Screening Form* with referral for HCBS waiver).

- Copy of *MFP Informed Consent for Participation*
- Copy of *Authorization for Use or Disclosure of Health Information*
- Copy of Medication Administration Record (MAR) or list of current medications
- Copy of State Medicaid Card
- Copy of Medicare Card
- Copy of Social Security Card
- Copy of Legal documents that cover guardianship (on file at institution)
- Copy of Documents that cover Power of Attorney (on file at institution)
- Nursing Home Face-Sheet
- Other (Specify) \_\_\_\_\_

Notes: \_\_\_\_\_

### MFP Field Personal Contact Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**MFP field personnel note:** the *MFP Transition Screening Form* must be submitted even when the person being screened refuses participation or is found to be ineligible. If the person refuses participation, be sure Question 41 is signed.

**MFP field personnel note:** All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via FTP.  
DCH MFP Transition Screening Form\_Revised\_041014

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***Appendix H: MFP CBAY Procedure Manual (Removed for Revision)***

# Georgia MFP Operational Protocol Version 1.6

## **Appendix I: MFP CBAY Procedure Code and Rate Table (New)**

**MFP CBAY GAMMIS PROCEDURE CODE AND RATE TABLE**

Service Name	Procedure Code	Rate / Unit	Annual Service Limits Per Year Participant	Applicable Edits/Audits
<b>Care Management</b>				
Care Management	T2022	\$721.05/month	12 units, \$8,652.60	1 per month; need to establish hierarchy in relation to other Medicaid Case Management services
Care Management - Transition	T2025	\$540.75/month	4 Units, \$2,163.00	1 per month; Allowed for same or overlapping PRFT/Institutional Claim DOS
<b>Supported Employment</b>				
Supported Employment, Individual	T2019	\$10.00 / 15 min unit	\$4,800.00/ yr.	Supported Employment cannot be reimbursed if the member has received Task-Oriented Services under COS 440, H2025 U4 U7 or H2025 U5 U7, for same or overlapping DOS.
Supported Employment, Multi Disc Team	T2019 HT	\$10.00 / 15 min unit	\$4,800.00/ yr.	
Supported Employment, Group	T2019 HQ	\$5.00 / 15 min unit	\$4,800.00/ yr.	
Supported Employment, Job Development	T2019 UK	\$500 / job		
<b>Community Transition Services</b>				
Community Transition Services	T2038	Claim / Actual Cost	\$5,276.16/ yr	Age-related edit: For members age 15 and younger at DOS, this limit is \$500/yr
Community Transition Services - Self Directed	T2038 UC	Claim / Actual Cost	\$5,276.16/ yr	

# Georgia MFP Operational Protocol Version 1.6

<b>Youth Peer Support Services</b>				
Youth Peer Support Services	T2025 UC	\$8.93 / 15 min	\$3,429.12	
<b>Customized Goods and Services</b>				
Customized Goods and Services	T2028	Claim / Actual Cost	\$1,500.00 / year cap	
Customized Goods and Services, Self-Directed	T2028 UC	Claim / Actual Cost	\$1,500.00 / year cap	
<b>Clinical Consultative Services</b>				
Practitioner Level 3, In Clinic	H2019 U3 U6	\$28.75 / 15 min	\$5,856.00 / year	Maximum of 2 hours per day of any combination
Practitioner Level 3, In Clinic, Client Present	H2019 HR U3 U6	\$28.75 / 15 min	\$5,856.00 / year	
Practitioner Level 3, In Clinic, Client not Present	H2019 HS U3 U6	\$28.75 / 15 min	\$5,856.00 / year	
Practitioner Level 3, In Clinic, Collateral Contact	H2019 UK U3 U6	\$28.75 / 15 min	\$5,856.00 / year	
Practitioner Level 3, Out of Clinic	H2019 U3 U7	\$28.75 / 15 min	\$5,856.00 / year	
Practitioner Level 3, Out of Clinic, Client Present	H2019 HR U3 U7	\$28.75 / 15 min	\$5,856.00 / year	
Practitioner Level 3, Out of Clinic, Client Not Present	H2019 HS U3 U7	\$28.75 / 15 min	\$5,856.00 / year	
Practitioner Level 3, Out of Clinic, Collateral Contact	H2019 UK U3 U7	\$28.75 / 15 min		

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Practitioner Level 3, Mult Disciplinary Team	H2019 HT U3	\$28.75 / 15 min	\$5,856.00 / year	
Practitioner Level 4, In Clinic	H2019 U4 U7	\$23.56 / 15 min	\$5,856.00 / year	
Practitioner Level 4, In Clinic, Client Present	H2019 HR U4 U7	\$23.56 / 15 min	\$5,856.00 / year	
Practitioner Level 4, In Clinic, Client Not Present	H2019 HS U4 U7	\$23.56 / 15 min	\$5,856.00 / year	
Practitioner Level 4, In Clinic, Collateral Contact	H2019 UK U4 U7	\$23.56 / 15 min	\$5,856.00 / year	
Practitioner Level 4, Out of Clinic	H2019 U4 U7	\$23.56 / 15 min	\$5,856.00 / year	
Practitioner Level 4, Out of Clinic, Client Present	H2019 HR U4 U7	\$23.56 / 15 min	\$5,856.00 / year	
Practitioner Level 4, Out of Clinic, Client not Present	H2019 HS U4 U7	\$23.56 / 15 min	\$5,856.00 / year	
Practitioner Level 4, Out of Clinic, Collateral Contact	H2019 UK U4 U7	\$23.56 / 15 min	\$5,856.00 / year	
Practitioner Level 4, Multi Disciplinary Team	H2019 HT U4	\$23.56 / 15 min	\$5,856.00 / year	
<b>Expressive Clinical Services</b>				
Practitioner Level 3, In Clinic	H2019 U3 U6	\$28.75 / 15 min	\$5,175.00 / year	Maximum of 2 hours per day of any combination
Practitioner Level 3, In Clinic, Client Present	H2019 HR U3 U6	\$28.75 / 15 min	\$5,175.00 / year	

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Practitioner Level 3, In Clinic, Client not Present	H2019 HS U3 U6	\$28.75 / 15 min	\$5,175.00 / year
Practitioner Level 3, In Clinic, Collateral Contact	H2019 UK U3 U6	\$28.75 / 15 min	\$5,175.00 / year
Practitioner Level 3, Out of Clinic	H2019 U3 U7	\$28.75 / 15 min	\$5,175.00 / year
Practitioner Level 3, Out of Clinic, Client Present	H2019 HR U3 U7	\$28.75 / 15 min	\$5,175.00 / year
Practitioner Level 3, Out of Clinic, Client Not Present	H2019 HS U3 U7	\$28.75 / 15 min	\$5,175.00 / year
Practitioner Level 3, Out of Clinic, Collateral Contact	H2019 UK U3 U7	\$28.75 / 15 min	\$5,175.00 / year
Practitioner Level 3, Mult Disciplinary Team	H2019 HT U3	\$28.75 / 15 min	\$5,175.00 / year
Practitioner Level 4, In Clinic	H2019 U4 U7	\$23.56 / 15 min	\$5,175.00 / year
Practitioner Level 4, In Clinic, Client Present	H2019 HR U4 U7	\$23.56 / 15 min	\$5,175.00 / year
Practitioner Level 4, In Clinic, Client Not Present	H2019 HS U4 U7	\$23.56 / 15 min	\$5,175.00 / year
Practitioner Level 4, In Clinic, Collateral Contact	H2019 UK U4 U7	\$23.56 / 15 min	\$5,175.00 / year
Practitioner Level 4, Out of Clinic	H2019 U4 U7	\$23.56 / 15 min	\$5,175.00 / year

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Practitioner Level 4, Out of Clinic, Client Present	H2019 HR U4 U7	\$23.56 / 15 min	\$5,175.00 / year	
Practitioner Level 4, Out of Clinic, Client not Present	H2019 HS U4 U7	\$23.56 / 15 min	\$5,175.00 / year	
Practitioner Level 4, Out of Clinic, Collateral Contact	H2019 UK U4 U7	\$23.56 / 15 min	\$5,175.00 / year	
Practitioner Level 4, Multi Disciplinary Team	H2019 HT U4	\$23.56 / 15 min	\$5,175.00 / year	
<b>Waiver Transportation</b>				
Transportation	T2003	\$10.40 / 1 Way	\$998 / yr. cap	
Transportation, Self-directed	T2003 UC	\$10.40 / 1 Way	\$998 / yr. cap	
<b>Family Peer Support Services</b>				
In Clinic	H2014 U6	\$20.78 / 15 min	\$4,987.20/ yr. cap	
In Clinic, Client Present	H2014 HR U6	\$20.78 / 15 min	\$4,987.20/ yr. cap	
In Clinic, Client Not Present	H2014 HS U6	\$20.78 / 15 min	\$4,987.20/ yr. cap	
Out of Clinic	H2014 U7	\$20.78 / 15 min	\$4,987.20/ yr. cap	
Out of Clinic, Client Present	H2014 HR U7	\$20.78 / 15 min	\$4,987.20/ yr. cap	
Out of Clinic, Client Not Present	H2014 HS U7	\$20.78 / 15 min	\$4,987.20/ yr. cap	
Multi-Disciplinary Team	H2014 HT	\$20.78 / 15 min	\$4,987.20/ yr. cap	
Self-Directed, Client Present	H2014 UC HR	\$20.78 / 15 min	\$4,987.20/ yr. cap	

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Self-Directed, Client Not Present	H2014 UC HS	\$20.78 / 15 min	\$4,987.20/ yr. cap	
<b>Respite</b>				
Respite	S5150	\$4.00 / 15 min	\$3,072.00/ yr. cap	Limited to no more than four days per month.
Respite, Self- Directed	S5150 UC	\$4.00 / 15 min	\$3,072.00/ yr. cap	
Respite	S5151	\$128 / per diem	\$3,072.00/ yr. cap	
Respite, Self- Directed	S5151 UC	\$128 / per diem	\$3,072.00/ yr. cap	
<b>Behavioral Assistance</b>				
In Clinic	H2015 U6	\$20.78 / 15 min	\$6,982.08/ yr. cap	
In Clinic, Client Present	H2015 HR U6	\$20.78 / 15 min	\$6,982.08/ yr. cap	
In Clinic, Client Not Present	H2015 HS U6	\$20.78 / 15 min	\$6,982.08/ yr. cap	
In Clinic, Collateral Contact	H2015 UK U6	\$20.78 / 15 min	\$6,982.08/ yr. cap	
Out of Clinic	H2015 U7	\$20.78 / 15 min	\$6,982.08/ yr. cap	
Out of Clinic, Client Present	H2015 HR U7	\$20.78 / 15 min	\$6,982.08/ yr. cap	
Out of Clinic, Client Not Present	H2015 HS U7	\$20.78 / 15 min	\$6,982.08/ yr. cap	
Out of Clinic, Collateral Contact	H2015 UK U7	\$20.78 / 15 min	\$6,982.08/ yr. cap	
In Clinic, Multi - Family Group	H2015 HQ U6	\$20.78 / 15 min	\$6,982.08/ yr. cap	
In Clinic, Multi - Family Group, Client Present	H2015 HQ HR U6	\$20.78 / 15 min	\$6,982.08/ yr. cap	

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In Clinic, Multi - Family Group, Client Not Present	H2015 HQ HS U6	\$20.78 / 15 min	\$6,982.08/ yr. cap	
Out of Clinic, Multi-Family Group	H2015 HQ U7	\$20.78 / 15 min	\$6,982.08/ yr. cap	
Out of Clinic, Multi-Family Group, Client Present	H2015 HQ HR U7	\$20.78 / 15 min	\$6,982.08/ yr. cap	
Out of Clinic, Multi-Family Group, Client not Present	H2015 HQ HS U7	\$20.78 / 15 min	\$6,982.08/ yr. cap	
Multi-Disciplinary Team	H2015 HT	\$20.78 / 15 min	\$6,982.08/ yr. cap	
<b>Financial Support Services</b>				
Financial Support Services	T2040 UC	\$75.00 /month	\$900.00/ yr. cap	

(FROM APPENDIX D from Part II Policies & Procedures for MFP CBAY 1/2015 from DCH)

## **Appendix J: MFP Project Director Resume**

PAMELA RENEE JOHNSON

**State of Georgia  
Department of Community Health (DCH)  
Medicaid Division / Aging and Special Populations  
April 2012 – Present**

### **Program Director-Money Follows the Person**

Under the direction of the Deputy Chief of Aging & Special Populations, the MFP Project Director:

- Oversees the Project Plan, Operational Protocol and Policies and Procedures
- Secures necessary resources (budget, personnel, equipment, etc.) to carry out project and achieve project goals, outcomes and impact
- Develops project team member position descriptions, hires, manages, develops and evaluates team members
- Leads project team, convenes team meetings, and sequences overall project tasks and activities
- Convenes Steering Committee and Evaluation Advisory Workgroup quarterly meetings, stakeholder forums and project working groups on an ad hoc basis
- oversees development, execution and monitoring of interagency agreements
- oversees development, execution and monitoring of the all project contracts and provider agreements (i.e. Fiscal Intermediaries, External Evaluator) and uses the RFP process, as needed, to hire contractors to complete tasks
- reviews and approves all interagency agreement and contractor deliverables, completes report cards and approves payments
- develops/negotiates Memorandums of Understanding (MOUs) with entities as necessary to implement project goals and agenda
- identifies appropriate information, resources, and technical assistance necessary for partnering agencies and awarded contractors to complete assigned tasks
- receives and assesses input for revisions requested by Steering Committee members, internal and external stakeholders and team members
- oversees all revisions to project scope, Project Plan/Operational Protocol and Policies and Procedures
- conducts periodic programmatic reviews/audits of vendors, monitoring, quality assurance, and quality improvement
- monitors grant expenditures and prepares and submits project budgets
- works with appropriate Medicaid staff to establish prior authorization limits, and sets reimbursement rates, as needed
- conducts periodic reviews of consumer QoL survey data and results of project evaluation studies to understand customer experience and share with staff for continuous quality improvements.

**Department of Behavioral Health and Developmental Disabilities (DBHDD)  
Office of Prevention Services and Programs  
Travis Fretwell, Director (404) 657-6604  
October 2007 – April 2012**

**Project Administrator-Strategic Prevention Framework, State Incentive Grant (SPF SIG)**  
As a Coordinator I provide daily management of all aspects of the federally funded Strategic Prevention Framework (SPF SIG) State Plan in addition to convening an Advisory Council, and Epidemiological Workgroups. Lead state bidding process to solicit eligible contractors for

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PAMELA RENEE JOHNSON

technical assistance/process and outcome evaluation, development of budgets for state contracts and monitoring implementation of prevention initiatives and corrective action based on state protocols, programs and practices. This position requires recruiting, hiring directing and evaluation of personnel, as well as, excellent community involvement skills and the ability to anticipate problems and work with the team and community to proactively address issues of capacity and outcomes.

## **Department of Community Health (DCH)**

**Argartha Russell, Unit Manager, Health Improvement & Wellness (404) 463-1160  
December 2006-September 2007**

## **Strategic Development Coordinator**

Recruited as Project Coordinator for “Money Follows the Person” a Medicaid waived research and demonstration project; later assigned to monitor coordinated health services under a newly funded Disease Management Program (DSM), meeting with vendors (APS Healthcare and United Healthcare), monitoring excel reports and resolving complaints and grievances from Medicaid patients, physician (providers) and other stakeholders.

**Morehouse School of Medicine/Community Health & Preventive Medicine,  
Mary Langley, Ph.D., Director (404) 752-1503 or (752-1600)  
October 1996 – December 2006**

## **Program Manager**

Responsible for the administration of the work plan designed to manage the state contract with Mental Health and Developmental Disabilities and Morehouse School of Medicine (MSM). Provided training in core prevention education for Prevention Providers and preparation of consultant contracts for external trainers. Facilitated training in research-based prevention curricula approved by Substance Abuse Mental Health Services Administration. As Program Manager, I was responsible for meeting planning and focus group facilitation as needed. Monitored compliance with state policies and guidelines.

## **Public Health Summer Fellows Program (PHSF) Coordinator**

As Coordinator was administratively responsible for the Cooperative Agreement among the Centers for Disease Control, Emory University and Morehouse School of Medicine’s public health summer research based initiative. Managed day to day program activities and expenditures, planned program activities for 12-15 students and Mentors, hired and supervised program personnel, developed the Advisory Council, monitored the qualitative evaluation process and prepared the budget, progress reports, year-end reports and continuation proposals.

## **Georgia Outreach Parent Advocacy Network (GOPAN)**

Responsible for recruitment of parents in both rural and urban counties throughout Georgia to share in an initiative designed to create a resource and advocacy network throughout the State. Parent groups were convened to define issues that concerned their community in order to improve outcomes for children.

## **Carter Presidential Center/The Atlanta Project**

**Doug Greenwell, Ph.D., Director (404) 206-5002 or 1(800) 367-5  
Cluster Coordinator March 1993-September 1996**

Provided leadership for collaborations among community based organizations in College Park, East Point and Hapeville (South Fulton County) to focus on common areas of concern such as

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PAMELA RENEE JOHNSON

health, education, economic development and public safety. Successfully completed neighborhood leadership training for community organizations and assisted community leaders with the development of a strategic plan. Collaborated with other Coordinators to engage the larger community in volunteer and advocacy efforts by establishing networks and partnerships among non-profit and for profit groups within the community.

**State of Georgia/Fulton County Department of Family and Children Services  
Senior Case Worker 1986-2003**

Responsible for efficient and respectful delivery and documentation of income-based eligibility programs for recipients of Medicaid, Aid to Families with Dependent Children (now TANF) and Food Stamps. Later employed as Child Support Recovery Agent and PEACH Jobs Employment Counselor.

**Education:**

MPA, Public Administration /Policy (2003) Clark Atlanta University, Atlanta, Georgia  
Pi Alpha Alpha National Honor Society (2001-2003)  
BS, Education, (1975) Ohio State University, Columbus, Ohio  
Diploma, Glenville High School, (1970) Cleveland, Ohio

**Special Skills:** Facilitator/Trainer, Grant Review, Contract Monitoring

**Appendix L: Aging and Disability Resource Connections**

<b>Planning &amp; Service Area</b>	<b>ADRC Name, Address &amp; Phone</b> Revised 04/2014
<p><b>Atlanta Region</b></p> <p>Cherokee Clayton Cobb DeKalb Douglas Fayette Fulton Gwinnett Henry Rockdale</p>	<p><b>Atlanta Regional Commission</b></p> <p>40 Courtland Street, N.E. Atlanta, GA 30303-2538 Phone: 404-463-3333 <b>Toll Free: 800-676-2433</b> Website: <a href="http://www.agewiseconnection.com">www.agewiseconnection.com</a></p>
<p><b>Central Savannah River Area</b></p> <p>Burke Richmond Columbia Screven Glascock Taliaferro Hancock Warren Jefferson Washington Jenkins Wilkes Lincoln McDuffie</p>	<p><b>Central Savannah ADRC</b></p> <p>3023 Riverwatch Parkway Suite A, Bldg 200 Augusta, GA 30907-2016 Phone: 706-210-2018 <b>Toll Free: 888-922-4464</b> Website: <a href="http://www.csrardc.org">www.csrardc.org</a></p>
<p><b>Coastal Area</b></p> <p>Bryan Bulloch Camden Chatham Effingham Glynn Liberty Long McIntosh</p>	<p><b>Coastal ADRC</b></p> <p>127 F Street Brunswick, GA 31520 Phone: 912-262-2862 <b>Toll Free: 800-580-6860</b> Website: <a href="http://www.coastalgeorgiardc.org">www.coastalgeorgiardc.org</a></p>
<p><b>Georgia Mountains</b></p> <p>Banks Dawson Forsyth Franklin Habersham Hall Hart Lumpkin Rabun Stephens</p>	<p><b>Georgia Mountains ADRC</b></p> <p>Physical Address: 508 Oak St., Ste 1, 30501 Mailing Address: P. O. Box 2534 Gainesville, GA 30503-2534 Phone: (770)538-2650 <b>Toll Free: 800-845-5465</b> Website: <a href="http://www.legacylink.org">www.legacylink.org</a></p>

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<b><i>Planning &amp; Service Area</i></b>	<b><i>ADRC Name, Address &amp; Phone</i></b> Revised 04/2014
Towns Union White	
<b>Heart of Georgia Altamaha</b> Appling Montgomery Bleckley Tattnall Candler Telfair Dodge Toombs Emanuel Treutlen Evans Wayne Jeff Davis Wheeler Johnson Wilcox Laurens	<b>Heart of Georgia Altamaha ADRC</b> Physical Address: 331 West Parker Street Baxley , GA 31513-0674 Phone: (912)367-3648 <b>Toll Free: 888-367-9913</b> Website: www.georgiaadrc.com
<b>Middle Georgia</b> Baldwin Peach Bibb Pulaski Crawford Putnam Houston Twiggs Jones Wilkinson Monroe	<b>Middle Georgia ADRC</b> Physical Address: 175 Emery Highway , Suite C Macon , GA 31217-3679 Phone: (478)751-6466 <b>Toll Free: 888-548-1456</b> Website: www.georgiaadrc.com
<b>River Valley</b> Chattahoochee Quitman Clay Randolph Crisp Schley Dooley Stewart Harris Sumter Macon Talbot Marion Taylor Muscogee	<b>River Valley ADRC</b> 1428 Second Avenue PO Box 1908 Columbus, GA 31902-1908 Phone: 706-256-2900 <b>Toll Free: 800-615-4379</b> Website: <a href="http://www.lcrdcaaa.org">www.lcrdcaaa.org</a>

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<b><i>Planning &amp; Service Area</i></b>	<b><i>ADRC Name, Address &amp; Phone</i></b> Revised 04/2014
Webster	
<b>Northeast Georgia</b> Barrow Newton Clarke Oconee Elbert Greene Walton Jackson Jasper Madison Morgan	<b>Northeast Georgia ADRC</b> 305 Research Drive Athens, GA 30610 Phone: 706-583-2546 <b>Toll free: 800-474-7540</b> Website: <a href="http://www.negrdc.org">www.negrdc.org</a>
<b>Northwest Georgia</b> Bartow Murray Catoosa Paulding Chattooga Pickens Dade Polk Fannin Walker Floyd Whitfield Gilmer Gordon Haralson	<b>Northwest Georgia ADRC</b> Physical Address: 1 Jackson Hill Dr. Rome, GA 30161 Mailing Address: PO Box 1798 Rome, GA 30162-1798 Phone: 706-802-5506 <b>Toll Free: 888-759-2963</b> Website: <a href="http://www.northwestga-aaa.org">www.northwestga-aaa.org</a>
<b>Southern Georgia</b> Atkinson Cook Bacon Echols Ben Hill Irwin Berrien Lanier Brantley Lowndes Brooks Pierce Charlton Tift Clinch Turner	<b>Southern Georgia ADRC</b> 1725 South Georgia Parkway, West Waycross, GA 31503-8958 Phone: 912-287-5888 <b>Toll Free: 888-732-4464</b> Website: <a href="http://www.segardc.org">www.segardc.org</a>

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<b><i>Planning &amp; Service Area</i></b>	<b><i>ADRC Name, Address &amp; Phone</i></b> Revised 04/2014
Coffee Ware	
<b>Southwest Georgia</b>  Baker Lee Calhoun Miller Colquitt Mitchell Decatur Seminole Dougherty Terrell Early Thomas Grady Worth	<b>SOWEGA ADRC</b>  1105 Palmyra Road Albany, GA 31701-1933 Phone: 229-432-0994 <b>Toll free: 800-282-6612</b> Website: <a href="http://www.sowegacoa.org">www.sowegacoa.org</a>
<b>Three Rivers</b>  Butts Pike Carroll Spalding Coweta Troup Heard Upson Lamar Meriwether	<b>Three Rivers ADRC</b>  Physical Address: 13273 Hwy. 34 East Franklin, GA 30217 Mailing Address: PO Box 1600 Franklin, GA 30217-1600 Phone: 706-407-0033 <b>Toll Free: 866-854-5652</b> Website: <a href="http://www.scaaa.net">www.scaaa.net</a>

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## Appendix M: Self-Direction in HCBS Waivers-Crosswalk

Appendix\_M\_Self\_Direction\_CrossWalk\_HCBSWaivers\_rev\_102408.xls

<b>Appendix M: Self-Direction Crosswalk for HCBS Waivers</b>				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
<b>I. Participant-Centered Service Plan Development</b>				
<b>a. Responsibility for Service Plan Development.</b>	P. 86, Other--Support Coordinator--assisted by Eval Team, RN, LSW, psychologist or behavioral specialist, OT, PT, SLP. Each member must also be a qualified mental Retardation Professional	P. 82, Same	P. 51, Registered Nurse Care Coordinator, licensed to practice in State, Case Manager, (does not need to be RN or LSW)	P. D-1:1, RN, MD, OD, Case mgr, Social worker-- P. D-1:2, Two options--trad PSS and CD-PSS.
<b>b. Service Plan Development Safeguards.</b>	P. 87, Yes--Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the	P. 82, Same	P. 51, same	P. D-1:1, same
<b>c. Supporting the Participant in Service Plan Development.</b>	P. 97, Yes--Support Coordinator discusses svcs options, tells member can choose individuals who will participate in the formal ISP meeting, discusses choices waiver options, providers	P. 82, Same	P. 51-52, same, Nurse Care Coordinator develops Svcs plan on initial visit reviewed every 6 months	P. D-1:2, similar--Case mgr develops Plan of care w/ member/ rep. Member/rep sign MOU, Plan of Care, Employer Agreement Forms and Care Path plans. CM monitors w/ annual reassessment of Plan of care
<b>d. Service Plan Development Process--who develops, who participates, assessments used, needs, goals, prefs, health status, who does what, how ISP is updated</b>	Yes--P. 88-89, Assessments done by each member of I&E team--social, nursing and behavioral reports, uses Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), I&E Team members, participant, family, support coordinator, peer supporter, rep from each provider org providing svcs, ISP includes Person-Centered Process, Personal Focus for member goals, scope of services, svcs summaries, signature page. ISP QA process, Options for Participant-Directed svcs, budet amount, FSS rate, 24/7 emergency bkup, risk mgt plan. Updated anually, denials and Fair Hearings	P. 83-84, Same	P. 52, similar, RN Care coordinator develops, approved by consumer's physician or licensed Nurse Practitioner. Use MDS-HC, Determination of Need-Revised (DON-R), Geriatric Depression Scale, Beck Depression Inventory or Cornell Scale, Environmental Assessment, Caregiver Burden Inventory, Mini Mental Status Exam. Review at 6 months	P. D-1:3, similar, agency conducts assmt using Participant Assessment Form (PAF), those entering PSS-CD-assmt with Consumer Directed Skills Inventory. CM, member/ rep, advocate, agency develop Plan of care. Care Path is implemented and reviewed quarterly, annually. Monthly checks by CM. CM & agency oversite Care Plan

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Appendix\_M\_Self\_Direction\_CrossWalk\_HCBSWaivers\_rev\_102408.xls

<b>Appendix M: Self-Direction Crosswalk for HCBS Waivers</b>				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
e. Risk Assessment and Mitigation	P. 89-90, Individual Svs Plan Page 10, HRST, Action plans for each indentified risk, efforts to minimize risks and identify if those supports interfere with what is most important to the individual, details provider agency's backup plans for staff coverage, capacity to provide additional staff on intermittent basis, covers assistive tech, self-direct emergency bkup	P. 85, same	P. 53, Use MDS-HC triggers, CMs observations, identifies on Plan of Care with individualized contingency plans, 24/7 emergency phone contacts to case coordinator and to provider, providers required to provide bkup and instruct direct care staff. For self-directed bkup--Client must id 2 individual emergency bkup plans for staff on shows, plans for natural disasters, power outages, interruptions in routine care, wkrs must agree to plan. For Agency-24.7 agency on-call backup mandated.	P. D-1:4, 1) Use Participant Assessment Form (PAF) with agency nurse interview, 2) address risks in Care Path and w/ action plan. 3) CM provide list of providers to client. 4) Providers required to have emergency bkup. 5) members have emergency bkup from circle of support
f. Informed Choice of Providers	P. 90, sign Freedom of Choice form, Waiver <b>participant chooses a Support Coordinator</b> from the enrolled Support Coordination Agencies. Support Coordinator assists member to choose his or her providers of services, also get list of peer supporters families available to assist in the decision-making proces. MHDDAD conducts provider fairs for members and families to help them choose. Member can receive Support Coordination for up to 6 months prior to community placement	P. 85-86, same	P. 53, similar, Care Coordination Agency provides member list of enrolled providers. <b>No freedom to select Care Coordinator.</b> Make selection or if no opinion, provider assigned by rotation, or based on special need. Choice documented in plan.	P. D-1:5, Contracting Agency (GMCF) sends approval letter and list of approved ICWP Case Mgrs. 2) Member selects CM. 3) CM provide list of providers to member. 4) CM provides info and training to member/ rep under Consumer Directed Option
g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency	P. 91, Copies of ISP available for review at MHDDAD regional offices and at Support Coordination agencies, in participants charts maintained by provider. DCH Program Integrity Unit completes planned and unplanned reviews. Requests for reviews come from members, family, anysource, DHR or other state agencies. During reviews, care plans and svcs records are reviewed for appropriateness of svcs re: ISP and prior authorization, adequacy or docs of svcs provided and billed to Medicaid. Funds may be recouped by Medicaid/DCH. Monthly meeting for svcs reviews by	P. 86, same	P. 54, similar, DCH does periodic Utilization Reviews of member svcs, Provider reviewed as often as appropriate on-site. UR audit member Level of Care and Placement Instrument is signed, dated, certified, by physician. Provider care plans complete, documented svcs, appropriated billed to Medicaid	P. D-1:5, CM submits initial Care Path (Plan of Care) quarterly reviews and annual reviews to contracting agency. Waiver Pgm staff meet monthly to review members records with contracting agency. Issues are addressed, policy changes implemented. Approximately 10% records reviewed annually.

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Appendix\_M\_Self\_Direction\_CrossWalk\_HCBSWaivers\_rev\_102408.xls

<b>Appendix M: Self-Direction Crosswalk for HCBS Waivers</b>				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
b. Monitoring Safeguards	P. 93, Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant	P. 88, same	P. 55 same	P. D-2:2, same
<b>III. Overview of Self-Direction</b>				
a. Description of Self-Direction—opportunities, how members access, entities that support	P.94-95, <b>Independence Plus:</b> SC inform, train on benefits, risks, responsibilities to those who elect. SC responsible for changing ISP, grievance process, freedom of choice of providers, rights, reassessments and review schedules, info on Individual Advocacy mediation. Voluntary and involuntary moves. Expenditure safeguards. 1) employer authority-decision making over PAS staff. 2) Co-employer w/ traditional agency (employer of record). 3) Member can opt for <b>Budget Authority over ALL waiver svcs</b> . Budgets developed from assessments, SIS. Statically determine participants total waiver allocation. Assessment guides svcs and supports in ISP. Participant/rep and SC determine which svcs are participant-directed and which are provider-managed. FMS-process payroll, withholding, fining and payment of taxes and insurance, technical assistance & training, track report on income, disbursements and balances of funds, pay invoices. Provide statements twice monthly. DCH monitors FSS. Family may provide PAS but not if legal representative, i.e.can't do both.	P. 89-90, same	P. 56-59, <b>No Independence Plus, LIMITED:</b> RN Care Coordinator assess members ability, must have no cog, no communication and no behavioral deficits and must express interest in PSS-CD, member must be able to do tasks. 2) <b>Care coordinator informs of PSS-CD option for EMPLOYER authority, but Care Coordinator brokers ALL other waiver svcs</b> , 3) Care coordinator educates, mentors, coaches member in employer tasks management of PSS budget. 4) FMS-member can select, FMS trains/provides technical employment support, provides payroll, accounting, budget, worker tax/insurance activities, assures that designated consumer-directed budget for PSS are paid.	P. E-1:1, <b>No Independence Plus, LIMITED:</b> 1) Nurse describes CD Option during assmt, determines if member can self-direct. CM completes Consumer Directed Members Skills Inventory. 2) CMs must pass cert. test, then provide info and training to member/rep on <b>EMPLOYER authority</b> . 3) Member (Employer/ rep) signs MOU, Plan of Care and agrees to perform all required tasks, selects fiscal agent. 4) Fiscal agent provides training and TA, handles annual budget, billing and reports, bkgroud cks on potential employees up to 5 each yr. 5) Training on CD Option in offered yearly in addition to CM training of member
b. Participant Direction Opportunities: Select one				
b1. Participant--Employer Authority. Appendix E-2, item a. Decision making authority over PAS staff, may be common law				

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Appendix\_M\_Self\_Direction\_CrossWalk\_HCBSWaivers\_rev\_102408.xls

<b>Appendix M: Self-Direction Crosswalk for HCBS Waivers</b>				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
<b>b2. Participant--Budget Authority. Appendix E-2, item b. Has decision making authority over a budget for services.</b>				
<b>b3. Both Authorities</b>	P. 95, Both, Budget Authority over all waiver services	P. 91, Both	P. 57, Both, budget authority only over PSS budget	P. E-1:4, Both, budget authority only over PSS
<b>c. Availability of Participant Direction by type of Living Arrangement: Check all that apply</b>				
<b>c1. own home or home of family member</b>	P. 95, Yes	P. 91, Yes	P. 57, Yes	P. C-3: 17, Yes
<b>c2. other community-based living w/ 4 or fewer persons</b>	P. 96, NO	P. 91, Yes, Community Residental Alternative Svs, Community Living /support Svs. Limit of 4	P. 57 NO	P. E-1: 5, NO
<b>c3. leased apartment</b>	P. 96, Yes, included in 'own home'	P. 91, Yes	P. 57, Yes, like own home	Yes, similar to own home
<b>d. Election of Participant Direction: select one</b>				
<b>d1. every participant can elect to direct, alternatives available for those who</b>	P. 96, Yes	P. 91, Yes		
<b>d2. may direct some or all of services, alternatives available, subject to following criteria</b>			P. 57 Yes, LIMITED: PSS-CD- must have received PSS for 6 months, willing, no cog impairment, no behavior problems, MOU, required docs to FMS	P. E-1:5. Yes: LIMITED to- assessed by agency nurse, using Participant Assessment Form (PAF), 1) Cognitive intact, 2) must communicate verbally or AAC, 3) willingness, 4) control of daily schedule, 5) no behavioral problems, 6) stay w/l budget, 7) can make informed choice to select option

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<b>e. Information Furnished to Participant about benefits, responsibilities and liabilities of self-direction, who furnishes this info, how and when is info provided</b>	P. 96, 1) I&E team-provide info to all who apply, highlight differences between participant-directed and provider-managed, benefits, risks, responsibilities, provided verbally and in writing. 2) Support Coordinators--provide info while waiting for waiver svcs to begin, verbally and in writing, assist informed decision making, train. 3) <i>NOW Handbook on Participant Direction</i> .	P. 92, same, <i>COMP Handbook</i>	P. 58-59, Similar 1) Case mgr provide info to member/family/rep, 2) member gets waiver brochure, also in waiver admissions pkt, 3) RN care coordinator responsible for informed consent--reviews <i>Consumer-Directed Option Employer Manual</i> , trains, mentors, educates member/family/rep, 4) RN Care Coordinator role expands to support broker--conducts assessment, implementation, review of Care Plan, 5) FMS provides info, handles billing, tax, worker verification, information, training tech assistance 6) RN Care coordinator handles voluntary involuntary terminations	P. E-1:6, similar 1) CM provides info, trains, 2) info from nurse during assessment about consumer directed option, 3) members signs MOU (informed consent), Plan of Care and , 4) member/rep responsible for compliance with Plan of Care, member has Employer Authority, must select FMS
<b>f. Participant direction by representative: Select one</b>				
<b>f1. State doesn't provide for direction by rep</b>				
<b>f2. State does provide for direction by rep</b>	P. 97, Yes	P. 92, Yes	P. 59, Yes	P. E-1:7, Yes
<b>f2a. May be directed by legal rep of participant</b>	P. 97, Yes	P. 92, Yes	P. 59, Yes	P. E-1:7, Yes
<b>f2b. May be directed by non-legal rep chosen by member, specify policy and safeguards</b>	P. 97, Yes, Adults can, 1) Support Coordinators--inform participant of option, assist in choosing an appropriate rep, conducts annual review. 2) rep must follow requirements related to direction of waiver svcs, sign document of their commitment Work with SC to develop ISP and budget. 3) Community Guide--direct assistance to the rep on ISP and budget. Rep	P. 92, Yes, Same	P. 59-60, Yes, similar: non-legal rep freely chosen by client, strong commitment to assume rights, risks, responsibilities, no mental/cog/com deficits can do tasks, 2) Safeguards--provide rep training, RN Care Coordinator is broker, monitors monthly, rep can't provide PSS svcs	P. E-1:7, Yes, similar, a) rep not paid to direct & manage svcs, b) legal guardian not paid to direct & manage, c) employee can't serve as rep, d) ICWP only provides svcs for qualified members
<b>g. Participant-Directed Services: Check all that apply: Employer Authority, Budget Authority</b>				
	P. 97 Community Living Support--Yes/Yes	P. 93 Yes/Yes	P. 60 PSS, PSSX, PSS-CD, Yes/Yes-budget limited to PSS	P. E-1:8, Consumer Directed PSS--Employer Authority. Financial Support Svcs--Budget Authority
	Community Guide--Yes/Yes	Yes/Yes		
	Community Access--Yes/Yes	Yes/Yes		

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	Supported Employment--Yes/Yes	Yes/Yes		
	Respite--Yes/Yes	Svs not listed		
	P. 98 Natural Support Training--Yes/Yes	Svs not listed		
	Individual Directed Goods and Svs--	Svs not		
	Specialized Medical Equipment--Yes/Yes	Yes/Yes		
	Vehicle Adaption--Yes/Yes	Yes/Yes		
	Environmental Access Adaptions--Yes/Yes	Yes/Yes		
	Adult Physical Therapy--Yes/Yes	Yes/Yes		
	Adult Occupational Therapy--Yes/Yes	Yes/Yes		
	Adult Speech/Language Therapy--Yes/Yes	Yes/Yes		
	Behavioral Supports Consultation--	Yes/Yes		
	Transportation--Yes/Yes	Yes/Yes		
	Specialized Medical Supplies--Yes/Yes	Yes/Yes		
<b>h. Financial Management Services: Select one</b>				
<b>h1. Yes, svs through 3rd party, specify whether government and/or private entities furnish these svs</b>	P. 98, Private Entities.	P. 93, Private Entities	P. 60, Private Entities	P. E-1:8, Private Entities
<b>h2. No, svs not furnished, standard Medicaid payment mech are used.</b>				
<b>i. Provision Financial Management svs: covered as Demo Svs or as administrative activity</b>	P. 50, Svs is included in approved waiver. There is no change in service specifications.	P. 49, 94, FMS covered as waiver	P. 61, 42, FMS covered as waiver svs (see appendix C-1/C-3),	P. E-1:8, FMS covered as waiver svs called Financial Support Svs (FSS).
<b>i.i.Types of entities</b>	P. 51, Agency, Fiscal Intermediary, Approved by IRS, licensed for GA	P. 49, Agency	P. 42, Agency, same	P. E-1:8, Agency, same
<b>i.ii. Payment of FMS</b>	P. 51 Limit: One unit per month per member, Provider managed,	P. 49, same	??	??
<b>i.iii. Scope of FMS, check all that apply: Support when participant is employer</b>				
<b>*assist w/ citizenship status</b>	P. 51, Yes, criminal bkground, age verification	P. 49, Yes, same	P. 42, Yes, but LIMITED, up to a max of 5 workers per calander yr. pre member, added checks at member's	P. E-1:3, Yes, but LIMITED, up to a max of 5 workers per calander yr. pre member, added

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*collect process timesheets	P. 51, Yes	P. 50, Yes, same	P. 42, Yes, same	P. E-1:3, Yes
*process payroll, withholding, filing and payment of taxes and insurance	P. 51, Yes	P. 50, Yes, same	P. 42, Yes, same	P. E-1:3, Yes
*Other				P. E-1:3, supply fax
i.iii. Scope of FMS, check all that apply: <b>Supports for participant budget authority:</b>				
*maintain separate account for each participant's self-direction budget	P. 51, Yes	P. 49, Yes	P. 42, Yes	P. E-1:9,
*Track and report participant funds, disbursements and the	P. 51, Yes	P. 50, Yes	P. 42, Yes	P. E-1:9,
*process and pay invoices for goods and services approved in the svcs plan	P. 51, Yes	P. 49, Yes	P. 42, Yes	P. E-1:9,
*provide participant with periodic reports of expenditures and the status of the self-directed budget	P. 51, Yes	P. 50, Yes	P. 42, yes	P. E-1:9,
*other svcs and supports, specify	P. 52, Yes, provide startup training and technical assistance to members, reps, others as required.	P. 89, same	P. 42, same	P. E-1:9,
*receive and disburse funds for the payment of participant-directed svcs under agreement with the Medicaid agency or	P. 51, Yes	P. 49, Yes	P. 42, yes	P. E-1:9,
*other, specify	None	None	toll free telephone line for TA, fax, internet access	
i.iv. Oversight of FMS Entities				
* how is performance monitored and assessed, including integrity of the financial transactions	No info	No info	P. 42, Entity completes a Readiness Review by the DCH, must demo ability to perform functions prior to enrollment	P. E-1:9, DCH Program Integrity unit conducts reviews of FMS once per year, financial transactions are in accordance with employer timesheets, requirement met for fiscal responsibilities
* who is responsible for this monitoring	P. 52, Dept. of Community Health, Division of Medical Assistance	P. 50, same	P. 42, DCH provider enrollment unit, Program Specialist, contracting agency	P. E-1:9, DCH Program Integrity unit
* how frequent is performance assessed	P. 52. Annually	P. 50, same	P. 42, Annually	P. E-1:9, Annually
<b>j. Information and Assistance in Support of Participant Direction: check each that applies</b>				

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j1. As Case Mgt Activity, specify	P. 100, Yes, Case Mgt Activity- Support Coordinators--inform about participant-direction options, assess participant for option, inform participant that rep may assist, inform rep about freedom of choice, assist w/ emergency backup plan, risk management agreement, arrange for Community Guide svcs, change/update ISP, assist participant to recognize and report critical events, provide training and technical assistance, monitor ISP services, participant direction services,	P.95, same	P. E-1:10, Yes, Case Mgt Activity-1) CM develops Plan of Care, provides training, info, enroll member in FMS, monitors timesheets hrs submitted monthly, monitors svcs, care, safety, assist with MOU. 2) Agency approves Plan of Care, forwards units and \$ to FI/FMS, communicates with CM. 3) FI/FMS-disburses, monthly reports, to member and agency, handles taxes. 4) member/rep set rates for PSS, submits timesheets, hire, fire, train. 5) DCH and agency review bi-monthly reports to ensure payments are made P. E-1:11, Waiver svcs called Consumer Directed Option PSS
j2. As Demo Svcs Coverage, Specify	P.100, Community Guide-peer support for member	P. 96, Community Guide	
j3. As Admin Activity, Specify, who, how, when, what			P. 62-63, <b>As Administrative Activity--</b> 1) RN Care Coordinator/ Support Broker informs, trains, coaches, 2) PSS-CD budget developed with client based on Care Plan; 3) State staff provide TA, 4) Care coordinators get no added compensation, 5) Care coordinator assess risk on on-going basis, 6) Care Coordinators define, ID and investigate critical incidents. 7) 24/7 bkup--Client must id 2 individual emergency bkup plans for staff on shows, plans for natural disasters, power outages, interruptions in routine care, wkers must agree to plan. 8) 24.7 agency on-call backup mandated. 9) FMS-conducts criminal bkground cks, gathers I-9s, W-
k. Independent Advocacy: select one			

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k1. Yes, independent advocacy is available to persons who direct their svcs	P. 101, Yes, but advocates don't provide other direct services, preform assessments, conduct waiver monitoring, oversight or fiscal functions that directly impact participants. Assist with mediation, conflict resolution, problem solution in respect to any waiver svcs	P. 96, Yes, same			
k2. No, no independent advocacy is available			P. 63 NO	P. E-1:11, NO	
I. Voluntary Termination of Participant Direction: Describe how this happens, how State ensures continuity of svcs and health and welfare	P. 102, Participant/rep contacts Support Coordinator, revise the ISP, link participant with svcs providers, void FSS, assure health and welfare during transition, monitor	P. 97, same	P. 64, same	P. E-1:11, similar, member contacts CM and agency.	
m. Involuntary Termination of Participant Direction: Specify circumstance under which this happens	P. 102, 1) failure to meet responsibilities or because or identified health and safety issue for participant, 3) inability to complete accurately and timely all FSS docs, to manager budget, 4) maltreatment of participants and occurrence of high-risk situations. 5) unreported fraud and misuse of funds. SC plans and implements return to provider-managed svcs, reports health , safety or abuse concerns or fraud to appropriate state agencies, ensuring continuity in svcs.	P. 97, same	P. 64-65, Similar: 1) behavior places client at risk, 2) failure to maintain max control over daily schedule, 3) over PSS budget 2 consecutive months, 4) used state backup plan one or more times per month for 2 consecutive months, 5) goals of PSS in Care Plan unmet for 2 consecutive quarters, 6) returned to Traditional PSS, 7) can re-enroll after 1 yr	P. E-1:12, same as Elder and Disabled Waiver.	
n. Goals for Participant Direction:	P. 102, Budget Authority Only or Budget Authority/ Employer Authority	P. 98 same	P. 65 Budget Authority Only or Budget Authority/ Employer Authority	P. E-1:13, Employer Authority Only	
Year 1		105	65	25	24
Year 2		325	110	50	30
Year 3		590	175	75	50
Year 4		1070		100	76
Year 5		1942		100	100
<b>E.1. Participant–Employer Authority</b>					
a1. Participant Employer Status: Check each that applies					

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*Participant/Co-Employer-- participant is selecting and managing workers who provide svcs. Agency is common law employer of participant- selected/recutited staff and performs necessary payroll and human resouces functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies with choice that	P. 95, 103 Both types	P. 98, Both types	P. 65 NO	P. E-2:1, NO
* Participant/Common Law Employer--participant is common law employer of workers. An IRS approved Fiscal/Employer Agent functions as the participant's agent for payroll and HR functions as required by federal and state law, What supports are available to assist participants in employer-	P. 95, 103 Both types	P. 98, Both types	P. 65, Yes	P. E-2:1, Yes
<b>a2. Participant Decision Making Authority-Participant exercises the following Authorities:</b>				
* Recruit staff	P. 103, Yes	P. 98, Yes	P. 66, Yes	P. E-2:1, Yes
* Refer staff to agency for hiring (Co-employer)	P. 103, Yes	P. 98, Yes	P. 66, NO	P. E-2:1, NO
* Select staff from worker registry	P. 103, NO	P. 98, NO	P. 66, NO	P. E-2:1, NO
* Hire staff (common law employer)	P. 103, Yes	P. 98, Yes	P. 66, Yes	P. E-2:1, Yes
* Verify staff qualifications	P. 103, Yes	P. 98, Yes	P. 66, Yes	P. E-2:1, Yes
* Obtain criminal history and /or background investigation of staff, specify how the costs of such investigation s are	P. 103, Yes	P. 98, Yes	P. 66, Yes	P. E-2:1, Yes, costs covered through Fiscal Intermediary fees
* Specify additional staff qualifications based on participant needs and preferences	P. 103, Yes, See Apendix C-1/C-3	Not checked	P. 66, Checked	P. E-2:1, Yes
* Determine staff duties consistant with the services specifications	P. 103, Yes, See Apendix C-1/C-3	P. 98, Yes	P. 66, Yes	P. E-2:1, Yes

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* Determine staff wages and benefits subject to applicable State limits	P. 103, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Schedule staff	P. 103, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Orient and instruct-staff in duties	P. 104, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Supervise staff	P. 104, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Evaluate staff Performance	P. 104, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Verify time worked by staff and approve time sheets	P. 104, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Discharge staff (common law employer)	P. 104, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Discharge staff from providing services (co-employer)	NO	NO	NO	NO
* Other (specify)				
<b>b. Participant-Budget Authority: Complete when the demo offers the budget authority opportunity as in E1b</b>				
<b>b1. Participant Decision Making Authority. Check all that apply:</b>				
* Reallocate funds among services included in the budget	P. 104, Yes	P. 99, Yes	P. 66, NO	P. E-2:1, NO
* Determine the amount paid for services within the State's established limits	P. 104, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Substitute service providers	P. 104, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Schedule the provision of services	P. 104, Yes	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Specify additional service providers qualifications	P. 104, Yes, See Appendix C-1/C-3	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Specify how services are provided	P. 104, Yes, See Appendix C-1/C-3	P. 99, Yes	P. 66, Yes	P. E-2:1, Yes
* Identify service providers and refer for provider enrollment	P. 104, Yes	P. 99, Yes	P. 67, NO	P. E-2:1, Yes
* Authorize payment for demonstration goods and services	P. 104, Yes	P. 99, Yes	P. 67, Yes	P. E-2:1, NO
* Review and approve provider invoices for	P. 104, Yes	P. 99, Yes	P. 67, Yes	P. E-2:1, Yes
* Other (specify)				

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<p><b>b2. Participant-Directed Budget, methods described to establish the amount of the participant-directed budget for goods and svcs over which the participant has authority, including the method used to estimate costs and how this is applied consistently to each participant. Is this info available to the public?</b></p>	<p>P. 105, <b>budget statistically determined based on SIS assessment.</b> After budget, next services and supports are determined as the ISP is developed. Which services are participant-directed or provider-managed is determined by participant, rep and SC. The amount of the participant-directed budget is the waiver allocation remaining after any costs from provider-managed services. FMS funds are included, but cannot be rate adjusted and are not subject to participant-direction. Same method for all participants. Available for public inspection, forums, meetings, MHDDAD website, written doc</p>	<p>P. 100, same</p>	<p>P. 67, similar--<b>budget determined by MDS-HC</b> to create Care Plan and calculate the number of PSS svcs units. Care Coordinator/ broker uses Medicaid reimbursement rates to calculate monthly PSS-CD budget base on svcs units needed. FMS monthly fees are paid from this budget.</p>	<p>P. E-2:1, similar, agency nurse assess using DMA-6, PAF, NH and Hosp. Level of Care Criteria. <b>Agency and Case mgr develop Plan of Care, determine number of PSS hours member needs.</b> If additional hours are needed, file addendum and Prior Authorization and Agency determines justification. Total cost cannot exceed 5% above NH cost of care</p>
<p><b>b3. Informing Participant of Budget Amount: Describes how State informs each participant of the amount of the self-directed budget and the procedures by which the participant may request an adjustment in the budget amount</b></p>	<p>P. 105, Support Coordinator informs. ISP review to change. If need for increased intensity of svcs, I&amp;E manager may approve time-limited increase. If need is greater, participant is referred to Comprehensive Supports Waiver Program. Participant may request Fair Hearing if denied increase or budget is reduced.</p>	<p>P. 100, same</p>	<p>P. 67, Similar--RN Care Coordinator establishes budget for PSS-CD. Changed only after changing Care Plan, adjustment made by Care Coordinator/ support broker. Member controls schedule, freq, time of day, days per week.</p>	<p>P. E-2:2, 1) GMCF calculates budget based on Plan of Care, documented on Prior Authorization Form (DMA-80). Sends to CM. CM provides copy to member. 2) Adjustments require CM to file DMA-80, justification. Nurse reviews and approves/denies, sends note to CM. CM provides member copy. Fair Hearing???</p>
<p><b>b4. Participant Exercise of Budget Flexibility. Select one:</b></p> <p>* participant has authority to modify the svcs included in the self-directed budget w/o prior approval. Specify how changes in the self-directed budget are documented, including updating the svcs plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change</p>	<p>P. 106, NO</p>	<p>P. 101, NO</p>	<p>P. 68, NO</p>	<p>P. E-2:3, NO</p>

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<p>* Modifications to the participant-directed budget must be preceded by a change in the service plan</p> <p>b5. Expenditure Safeguards have been established for prevention of the premature depletion of the participant-directed budget or budget under-utilization and the entity responsible for implementing these safeguards;</p>	<p>P. 106, Yes</p> <p>P. 106, 1) FMS provides twice monthly declining balance report, notifies member/family/rep or the potential for premature depletion at 6 months. 2) DHR regional DD analysts review expenditures and notify the state agency of any identified issues or concerns, discussed at regular meetings of DHR, MHDDAD with support coordinators. 3) Support Coordinators--assists with budget management, including underutilization, arranges for assistance from Community Guide Services to provide direct assistance, if needed.</p>	<p>P. 101, Yes</p> <p>P. 101, same</p>	<p>P. 68, Yes</p> <p>P. 68, 1) Care coordinator authorizes PSS payments monthly using <i>Service Authorization Form</i>. 2) changes to budget require changes to Care Plan first. 3) FMS provides monthly reports of expenditures, over/under utilization to member and Care Coordinator/ support broker. 4) Care coordinator monitors during interm calls and quarterly F2F visits</p>	<p>P. E-23, Yes</p> <p>P. E-23, similar 1) Members PSS hours submitted to CM, FI, member, and DCH. 2) Case mgr works with member to assure they are w/ budget. 3) FI provides DCH report on each members remaining annual budget, DCH reviews to determine over/under utilization</p>



**Appendix N2: Example Invoice from FI to DCH**

**INVOICE**

Fiscal Agent Company Name  
Address  
City, ST ZIP

**DATE:**  
**INVOICE #**  
**FOR:** Transition expenses

**Bill To:**  
DCH, MFP Accountant  
2 Peachtree Street, NW, 34th Fl  
Atlanta, GA 30303

Period Date	Description of Service	Amount
	Enhanced Transition Services	
	Admin Fees	
	<b>TOTAL</b>	<b>\$ -</b>

**BILLING INQUIRIES SHOULD BE  
DIRECTED TO:**

-

**THANK YOU FOR YOUR BUSINESS!**

# Georgia MFP Operational Protocol Version 1.6

## Appendix O: MFP Individualized Transition Plan (Revised)



### MFP INDIVIDUALIZED TRANSITION PLAN (ITP)

**Participant FName:** \_\_\_\_\_ **MI** \_\_\_\_\_ **LName:** \_\_\_\_\_

#### Individualized Transition Plan (ITP)

#### 1. MFP PARTICIPANT INFORMATION

Participant First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy) \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medicaid ID # \_\_\_\_\_ Medicare # \_\_\_\_\_

Inpatient Facility Name and Address: \_\_\_\_\_

City, Zip and County: \_\_\_\_\_

This is an (check only one):  Initial ITP –OR--  Updated ITP Date: \_\_\_\_\_

#### 2. IMPORTANT PLANNING DATES

Projected Discharge/Move-out Date: \_\_\_\_\_ Actual Discharge/Move-out Date: \_\_\_\_\_

#### 3. Waiver Name (if known) \_\_\_\_\_

Waiver Case Manager/Care Coordinator Name \_\_\_\_\_

CM/CC Phone \_\_\_\_\_ Email \_\_\_\_\_

#### 4. HOUSING CHOICE/LIVING ARRANGEMENTS

Check if participant will live with family. Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Check if participant has someone that she/he wants to live with.

Name \_\_\_\_\_

Contact Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

#### Check the housing choice expressed by the participant/family. Is housing choice needed?

Check Housing Choice	Participant / Family Has? Y/N	Participant / Family Needs? Y/N
<input type="checkbox"/> 01- Home owned by participant		
<input type="checkbox"/> 02- Home owned by family member		
<input type="checkbox"/> 03- Apt/house leased by participant, not assisted living		
<input type="checkbox"/> 04- Apartment leased by participant, assisted living		
<input type="checkbox"/> 05- Group home of no more than 4 people/ PCH		

(Continue narrative on back or add additional pages as needed)

**Note to field personnel:** All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed ITPs to DCH MFP via **FTP**.

# Georgia MFP Operational Protocol Version 1.6



## MFP INDIVIDUALIZED TRANSITION PLAN (ITP)

**Participant FName:** \_\_\_\_\_ **MI** \_\_\_\_\_ **LName:** \_\_\_\_\_

**Note:** If “Participant/Family Needs” is marked “Y”, describe problem/issue, strategies for resolving, and tasks that must to be done to secure choice:

\_\_\_\_\_

Discuss and identify needed MFP transition services and complete the following:

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

\_\_\_\_\_

### 5. PERSONAL GOALS/ DESIRED COMMUNITY OUTCOMES

Personal Goals/ Desired Community Outcomes	Barriers to Achieving Goals/Needs	Plan/Resources for Barrier Removal

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

\_\_\_\_\_

### 6. HEALTH AND NUTRITION GOALS:

List Health Related Needs	Who can help? What resources are available to help?	Health Improvement Goal

(Continue narrative on back or add additional pages as needed)

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## MFP INDIVIDUALIZED TRANSITION PLAN (ITP)

**Participant FName:** \_\_\_\_\_ **MI** \_\_\_\_ **LName:** \_\_\_\_\_

Ex: Rx med supply, specialized medical supplies, skin care/wounds, bowel/bladder program, etc.

List Nutrition Related Needs	Who can help? What resources are available to help?	Nutrition Improvement Goal

Ex: diet and restrictions, food preferences, preparation strategies, food supplies, etc.

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

### 7. SENSORY/COMMUNICATION GOALS

Includes – vision, hearing, dental, mobility, speech/language and general communication goals.

Sensory/Communication Goals	Barriers to Achieving Goals/Needs	Plan/Resources for Barrier Removal

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

(Continue narrative on back or add additional pages as needed)

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# Georgia MFP Operational Protocol Version 1.6



## MFP INDIVIDUALIZED TRANSITION PLAN (ITP)

**Participant FName:** \_\_\_\_\_ **MI** \_\_\_\_ **LName:** \_\_\_\_\_

### 8. 24/7 EMERGENCY BACKUP PLANS:

List Risks to Health/Safety	Describe Plan to Address Risk	Emergency Backup Plan

Ex: natural disasters, power outages, PSS doesn't show up, equipment failures, falls/injuries, etc.

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

### 9. SOCIAL/RECREATIONAL GOALS

Activity Goals	Barriers/Needs	Plan

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

(Continue narrative on back or add additional pages as needed)

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# Georgia MFP Operational Protocol Version 1.6



## MFP INDIVIDUALIZED TRANSITION PLAN (ITP)

**Participant FName:** \_\_\_\_\_ **MI** \_\_\_\_\_ **LName:** \_\_\_\_\_

### 10. HOUSEHOLD/PERSONAL CARE GOALS (from Screening-Q36/DON-R)

Goals	Barriers/Needs	Plan

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

### 11. ASSISTIVE TECHNOLOGY (AT) AND/OR DURABLE MEDICAL EQUIPMENT (DME) USE AND NEEDS (from Screening, use Q34 and Q35)

Assistive Tech/DME Needs	Who can help/Resources?	Plan (who does what)

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

(Continue narrative on back or add additional pages as needed)

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# Georgia MFP Operational Protocol Version 1.6



## MFP INDIVIDUALIZED TRANSITION PLAN (ITP)

**Participant FName:** \_\_\_\_\_ **MI** \_\_\_\_\_ **LName:** \_\_\_\_\_

### 12. COMMUNITY ACCESS/TRANSPORTATION GOALS

Goals	Barriers/Needs	Plan

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

### 13. EMPLOYMENT GOALS – supported, customized, competitive and/or self-employment or volunteer/work without pay (complete if applicable)

Goals	Barriers/Needs	Plan

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_ ; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

(Continue narrative on back or add additional pages as needed)

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# Georgia MFP Operational Protocol Version 1.6



## MFP INDIVIDUALIZED TRANSITION PLAN (ITP)

**Participant FName:** \_\_\_\_\_ **MI** \_\_\_\_ **LName:** \_\_\_\_\_

### 14. OTHER ISSUES (Unique to Participant and Necessary for Transition)

Goal/Issue	Barriers/Needs	Plan/Resource

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Needed MFP Service: \_\_\_\_\_; Calculate Budget \_\_\_\_\_

Provide justification for MFP Services (Include in Part A): \_\_\_\_\_

### 15. INCOME and RESOURCES – Create a budget for community living

Budget Categories	Monthly Amounts/Costs	Notes
<b>Monthly Income (all sources)</b>		
<b>Housing (rent, utilities) costs</b>		
<b>Food costs</b>		
<b>Debts</b>		
<b>Medical, health care, prescription drugs costs</b>		
<b>Personal items, movies, entertainment costs, etc.</b>		
<b>Transportation costs</b>		
<b>Other</b>		
<b>Other</b>		
<b>Other</b>		

(Continue narrative on back or add additional pages as needed)

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# Georgia MFP Operational Protocol Version 1.6



## MFP INDIVIDUALIZED TRANSITION PLAN (ITP)

**Participant FName:** \_\_\_\_\_ **MI** \_\_\_\_\_ **LName:** \_\_\_\_\_

**PART B: WAIVER and OTHER SERVICES:**

Use the table below to list the generic types of waiver services that will be needed by the participant/recommended by the team.

GENERIC WAIVER and/or OTHER SERVICE (i.e. Personal Support Services)	RATIONALE (describe how service will work with MFP services to support participant in the community)

**TRANSITION PLAN ASSIGNMENTS:**

Assignment	Person Responsible	Projected Date of Completion	Actual Date of Completion

**Recommended Assignments: Who will assist with the following -**

- Conduct Housing Searches; Arrange Environmental Modifications/Home Inspections
- Arrange Community Transportation Services/Travel Training
- Resolve any Legal Issues; Arrange for security and utility deposits; household goods
- Arrange Peer Support/Independent Living Skills Training/Life Skills Coaching
- Arrange Counseling/Behavioral Health Needs
- Schedule Home Care Ombudsman Visits; Arrange Caregiver Outreach and Training
- Locate Community Pharmacy for Refills of Rx Medications
- Locate Primary Care Physician/Clinic; Schedule Medical/Dental/Specialist Appointments
- Complete Waiver Enrollment; Select Case Mgt/Care Coordinator, Service Providers
- Complete Quality of Life Survey
- Referrals for Durable Medical Equipment and Assistive Technology

(Continue narrative on back or add additional pages as needed)

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# Georgia MFP Operational Protocol Version 1.6

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## **Appendix P: MFP Household Goods and Supplies Worksheet**

### **Appendix P: Startup Household Goods and Supplies Worksheet**

<b>ITEMS</b>	<b>OWNS/FAMILY</b>	<b>DOLLAR GENERAL</b>	<b>WALMART</b>	<b>DOLLAR TREE</b>	<b>BIG LOTS</b>	<b>TARGET</b>
<b>Kitchen</b>						
Dishes						
Silverware						
Kitchen Knives						
Glasses						
Cups						
Tea Pitcher						
Tupperware						
Pots/Pans						
Cookie Sheet						
Cooking Utensils						
Can Opener						
Measuring Cups						
Salt/Pepper Shakers						
Pot Holders/Mitt						
Kitchen Trash Can						
Kitchen Towels						
Dish Cloths						
Dish Drainer						
Ice Trays						
<b>Cleaning</b>						
Paper Towels						
Laundry Detergent						
Round Laundry Basket						
Bleach						
All Purpose Cleaner						
Pine Cleaner						
Glass Cleaner						
Dish Liquid						
Glade Spray						
Lysol						
Broom						
Mop						
Mop Bucket						
Dust Pan						

MFP\_Household\_Goods\_Supplies\_Revised\_010412

**Appendix Q: MFP DESKAIDS & Workworks for Everyone Employment Manual**

 <h2 style="display: inline;">Recommending a Waiver for Transition</h2> 				
 Participant Profile	CCSP	SOURCE	ICWP	NOW/COMP
	<ul style="list-style-type: none"> <li>Elderly or has disability (no age limit) and who meets an intermediate nursing home level of care</li> </ul>	<ul style="list-style-type: none"> <li>Elderly or has disability (no age limit) and who meets an intermediate nursing home level of care</li> <li>Must be receiving SSI or Public Law Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>More severe physical disability or traumatic brain injury (TBI), aged 21 to 64, meets skilled nursing facility or hospital level of care</li> <li>Generally younger and desires to live independently</li> </ul>	<ul style="list-style-type: none"> <li>Developmental disability before age 21, such as intellectual disability and/or a closely related condition and who meets ICF/ID institutional level of care</li> </ul>

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[dch.georgia.gov/mfp](http://dch.georgia.gov/mfp) - Waiver\_Determn\_Recommend\_Deskaid\_rev\_09\_2013

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Application Steps	Referral for CCSP contact...	Referral for SOURCE contact...	Referral for ICWP contact...	Referral for NOW/COMP contact...
<b>1. Initial Telephone Screening</b>	Aging & Disability Resource Connection (ADRC)	SOURCE Case Management Agency	Georgia Medical Care Foundation (GMCF) – ask for ICWP Team	DBHDD Regional Office – face-to-face screening based on completed application
<b>2. Face-to-Face Assessment</b>	CCSP Care Coordination Agency	SOURCE Case Management Agency	GMCF – ask for ICWP Assessment Team	DBHDD Regional Office
<b>3. Level of Care (LOC) Determination</b>	CCSP Care Coordination Agency	GMCF – SOURCE Case Management Agency gathers information	GMCF – ask for ICWP Assessment Team	DBHDD Regional Office
<b>4. LOC Form Name</b>	Appendix E/5588	Appendix F	DMA – 6	DMA – 6
<b>Obtain form from</b>	CCSP Care Coordination Agency	SOURCE Case Management Agency	Nursing Facility Social Worker, Discharge Planner or DON	DBHDD Regional Office
<b>5. Case Management</b>	CCSP Care Coordination Agency	SOURCE Case Management Agency	ICWP Case Management Agency	DBHDD Regional Office

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 <b>Benefits and Services for MFP Participants by Waiver</b> 		
Elderly/Disabled Waivers (CCSP/SOURCE)	Independent Care Waiver Program (ICWP)	New Options Waiver (NOW) and Comprehensive Waiver (COMP)
<ul style="list-style-type: none"> <li>• Adult Day Health</li> <li>• Alternative Living Services</li> <li>• Emergency Response Services</li> <li>• Enhanced Case Management</li> <li>• Financial Management Services for Consumer Directed PSS</li> <li>• Home-Delivered Meals</li> <li>• Home-Delivered Services</li> <li>• Out-of-Home Respite Services</li> <li>• Personal Support Services (PSS)/ (PSSX)/ Consumer Directed Services</li> <li>• Skilled Nursing Services</li> <li>• Home Health Services</li> </ul> 	<ul style="list-style-type: none"> <li>• Adult Day Care</li> <li>• Behavior Management</li> <li>• Case Management</li> <li>• Consumer-Directed PSS</li> <li>• Counseling</li> <li>• Enhanced Case Management</li> <li>• Environmental Modification</li> <li>• Financial Management Services for Consumer Directed PSS</li> <li>• Personal Emergency Monitoring</li> <li>• Personal Emergency Response</li> <li>• Personal Emergency Response Installation</li> <li>• Personal Support Services</li> <li>• Respite Services</li> <li>• Skilled Nursing</li> <li>• Specialized Medical Equipment and Supplies</li> <li>• Vehicle Adaptation</li> <li>• Adult Living Services</li> <li>• Home Health Services</li> </ul>	<ul style="list-style-type: none"> <li>• Community Residential Alternative (COMP only)</li> <li>• Adult Occupational Therapy Services</li> <li>• Adult Physical Therapy Services</li> <li>• Adult Speech and Language Therapy Services</li> <li>• Behavioral Supports Consultation</li> <li>• Community Access</li> <li>• Community Guide</li> <li>• Community Living Support</li> <li>• Environmental Access Adaptation</li> <li>• Financial Support Services</li> <li>• Individual Directed Goods and Services</li> <li>• Natural Support Training</li> <li>• Prevocational Services</li> <li>• Respite Services</li> <li>• Specialized Medical Equipment</li> <li>• Specialized Medical Supplies</li> <li>• Support Coordination</li> <li>• Supported Employment</li> <li>• Transportation</li> <li>• Vehicle Adaptation</li> <li>• Home Health Services</li> </ul>
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# Georgia MFP Operational Protocol Version 1.6



## Services for MFP Participants



**Medicaid State Plan Services for MFP Participants**  
 Search for providers using <https://www.mmis.georgia.gov/portal/> or MFP Participants call: 1-866-211-0950

 <ul style="list-style-type: none"> <li>• Ambulance Services</li> <li>• Diagnostic, Screening and Preventive Services (County Health Departments)</li> <li>• Dialysis Services</li> <li>• Durable Medical Equipment Services</li> <li>• Family Planning Services</li> <li>• Health Check (Early and Periodic Screening, Diagnosis and Treatment)</li> </ul>	<ul style="list-style-type: none"> <li>• Health Insurance Premiums Paid for Medicare Part A, Part B and Part D</li> <li>• Home Health Services (nursing, home health aide, and occupational, physical and speech therapy)</li> <li>• Hospice Services</li> <li>• Inpatient and Outpatient Hospital Services</li> <li>• Laboratory and Radiological Services</li> <li>• Medicare Crossovers – Medicaid payment for certain services not paid by Medicare</li> <li>• Mental Health Clinic Services</li> <li>• Non-Emergency Transportation Services</li> </ul>	<ul style="list-style-type: none"> <li>• Oral Surgery</li> <li>• Orthotic and Prosthetic Services</li> <li>• Pharmacy Services</li> <li>• Physician Services (Primary Care, Specialists and Physician Assistant Services)</li> <li>• Podiatric Services</li> <li>• Psychological Services (Behavioral Health Services)</li> <li>• Rural Health Clinic/Community Health Center Services</li> <li>• Surgical Services</li> <li>• Vision Care Services</li> </ul>
<p><b>Other Community Services For MFP Participants May Be Available Through...</b></p>		
<ul style="list-style-type: none"> <li>• Adult Protective Services – call 1-866-55AGING (1-866-552-4464) – Press “2”</li> <li>• Older Americans Act (Title III) Services; Social Services Block Grant Services; and Community Services Block Grant – <a href="http://aging.dhs.georgia.gov/programs-and-services">http://aging.dhs.georgia.gov/programs-and-services</a></li> <li>• Dept. of Behavioral Health &amp; Developmental Disabilities (DBHDD) Regional Offices – <a href="http://dbhdd.georgia.gov/regions">http://dbhdd.georgia.gov/regions</a></li> </ul>	<ul style="list-style-type: none"> <li>• Area Agencies on Aging (AAAs) – <a href="http://aging.dhs.georgia.gov/local-area-agencies-aging-aaas">http://aging.dhs.georgia.gov/local-area-agencies-aging-aaas</a></li> <li>• Aging &amp; Disability Resource Connections (ADRCs) – <a href="http://www.georgiaadrc.com/">http://www.georgiaadrc.com/</a></li> <li>• Brain &amp; Spinal Injury Trust Fund Commission – <a href="http://www.ciclt.net/sn/cilt/bsitf/default.aspx?ClientCode=bsitf">www.ciclt.net/sn/cilt/bsitf/default.aspx?ClientCode=bsitf</a></li> </ul>	<ul style="list-style-type: none"> <li>• Centers for Independent Living (CILs) – <a href="http://www.silcga.org/resources/find-cil-locations-in-georgia">http://www.silcga.org/resources/find-cil-locations-in-georgia</a></li> <li>• Community Service Boards (CSBs) – <a href="http://www.qacsb.org/">http://www.qacsb.org/</a></li> <li>• Friends of Disabled Adults and Children – <a href="http://www.fodac.org/">www.fodac.org/</a></li> <li>• Goodwill Industries Inc. – <a href="http://locator.goodwill.org/">http://locator.goodwill.org/</a></li> </ul>

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# Georgia MFP Operational Protocol Version 1.6



## Housing Searches & Resources



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

MFP Housing Type	Searchable Resource	
Housing Choice Vouchers – Tenant Based	Decatur Housing Authority – Voucher Administrator – contact Kimberly Daly, (404) 270-2133, <a href="mailto:kda@decaturha.org">kda@decaturha.org</a>	<p><b>1 Network</b> – Discuss housing needs and available budget. Network! Network! Network! Assist participants to tell family, friends, neighbors, etc. that they are looking for housing. Find out if family members have housing that can be modified to meet the needs of the participant. Review listings in local community publications, newspapers, etc. Depending on the situation, discuss housemate and roommate situations. Has the participant considered renting with a roommate?</p> <p><b>2 Rental Housing</b> – Assist participants to use available search tools to search for rental housing; <a href="http://www.georgiahousingsearch.org">www.georgiahousingsearch.org</a> (this resource can be searched by telephone at 877-428-8844; it can assist with locating Low Income Tax Credit units by entering "\$0.00 in the lower rent range), use ADRC resource at <a href="http://www.georgiaservicesforseniors.org">www.georgiaservicesforseniors.org</a>, and search for affordable (non-subsidized) and subsidized housing Based on Income (BOI). Assist participants to locate housing authorities, identify themselves as "at risk for institutional placement," make application and get on waiting lists.</p> <p><b>3 Group Living Situations</b> – Depending on the situation, assist participants to consider group living situations. Assist participants to locate Assisted Living Facilities, qualified Personal Care Homes (PCHs), or Community Living Arrangements (CLAs).</p>
TBRA – Housing Voucher – Tenant Based	Department of Community Affairs – Voucher Administrator <a href="http://www.dca.ga.gov">www.dca.ga.gov</a> or contact: <a href="mailto:HOMETBRA@dca.ga.gov">HOMETBRA@dca.ga.gov</a> or call (404) 982-3581, TTD (404) 679-4915 TBRA <a href="http://www.dca.ga.gov/housing/SpecialNeeds/programs/tbra.asp">http://www.dca.ga.gov/housing/SpecialNeeds/programs/tbra.asp</a>	
HUD 811 Program – Project Based	Department of Community Affairs – Voucher Administrator, contact Pat Brown, at <a href="mailto:patrick.brown@dca.ga.gov">patrick.brown@dca.ga.gov</a> or <a href="http://www.dca.ga.gov">www.dca.ga.gov</a> for application information	
Public Housing & Other Resources	<a href="http://www.hud.gov/offices/pih/pha/contacts/states/ga.cfm">www.hud.gov/offices/pih/pha/contacts/states/ga.cfm</a> /Public Housing <a href="http://211online.unitedwayatlanta.org/search.aspx">http://211online.unitedwayatlanta.org/search.aspx</a> /Shelter/Housing <a href="http://www.hud.gov/offices/hsg/sfh/hcc/hcs.cfm?&amp;webListAction=search&amp;searchstate=GA">http://www.hud.gov/offices/hsg/sfh/hcc/hcs.cfm?&amp;webListAction=search&amp;searchstate=GA</a>	
HUD Approved Housing Counseling		
Low-Income Housing Tax Credit (LIHTC)	<a href="http://lihtc.huduser.org">http://lihtc.huduser.org</a>	
Affordable (subsidized/ Based on Income)	<a href="http://www.hud.gov/offices/pih/pha/contacts/states/ga.cfm">http://www.hud.gov/offices/pih/pha/contacts/states/ga.cfm</a> <a href="http://www.hud.gov/apps/section8/step2.cfm?state=GA%2CGeorgia">http://www.hud.gov/apps/section8/step2.cfm?state=GA%2CGeorgia</a> <a href="http://rdmfhrentals.sc.gov.usda.gov/RDMFHRentals/select_state.jsp">http://rdmfhrentals.sc.gov.usda.gov/RDMFHRentals/select_state.jsp</a> <a href="http://www.nahma.apartmentsmart.com/">http://www.nahma.apartmentsmart.com/</a>	
Housemate Match Services	Marcus Jewish Center of Atlanta, 678-812-4000	
Affordable (non-subsidized/ Market-Rate)	<a href="http://www.forrent.com">www.forrent.com</a> <a href="http://www.lowincomeapartmentfinder.com">www.lowincomeapartmentfinder.com</a> <a href="http://www.affordablehousingonline.com">www.affordablehousingonline.com</a>	

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[dch.georgia.gov/mfp](http://dch.georgia.gov/mfp) - Housing\_Searches\_Resources\_Deskaid\_rev\_09\_2013



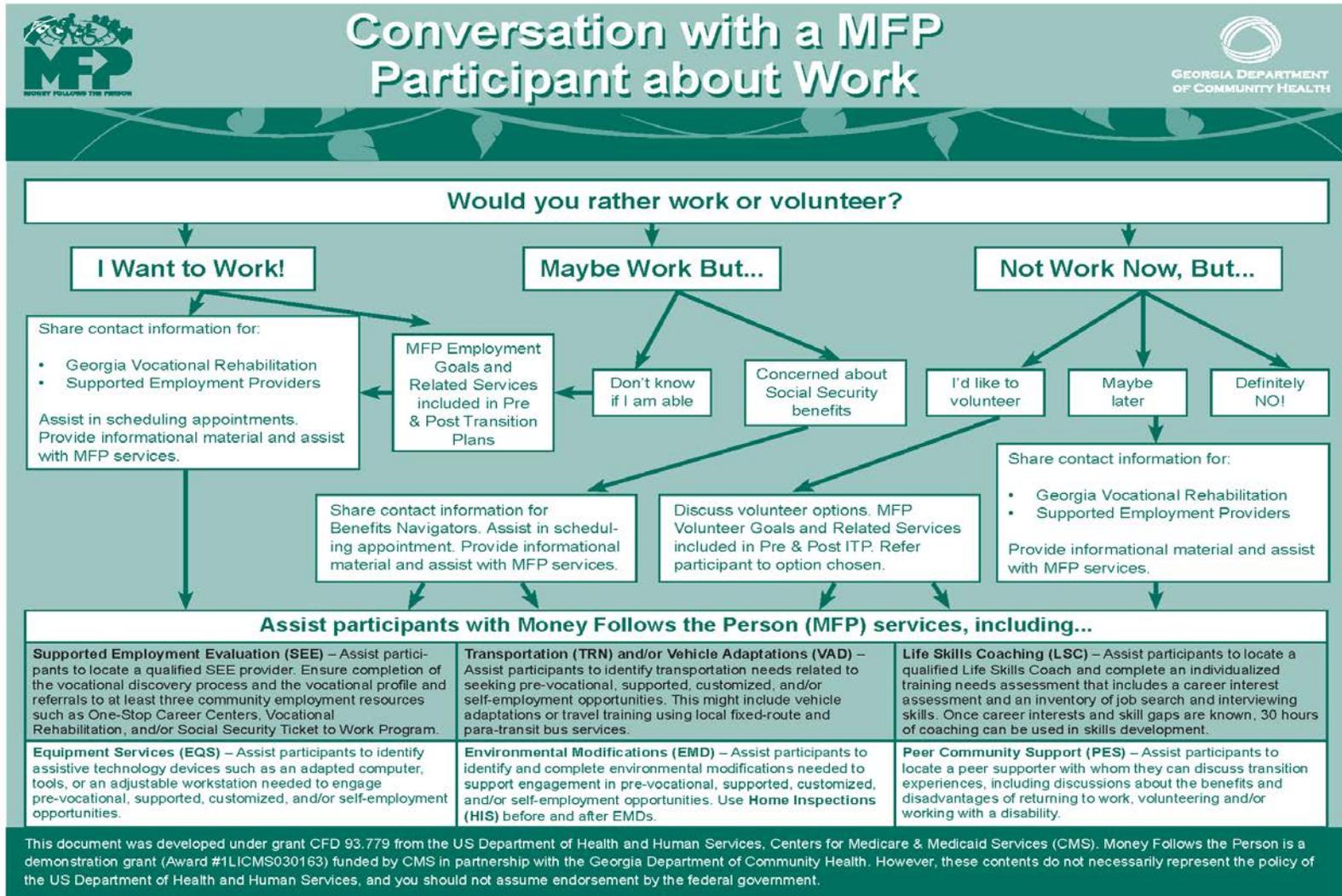
## Subsidized Housing Searches & Accessibility Reviews



Subsidized Housing Searches		Accessibility Reviews – Will the participant need assistance to:	
<p><b>What is needed to apply for subsidized housing?</b></p> <ul style="list-style-type: none"> <li>• State ID or Passport</li> <li>• Birth Certificate or Proof of Citizenship</li> <li>• Verification of income</li> <li>• Some management companies may ask for additional information</li> </ul>		<input type="checkbox"/> Enter and leave the residence, using a ramp or zero-step entrance?	
<p><b>How is rent determined in subsidized housing?</b></p> <p>A Public Housing Authority (PHA) using an awarded <b>Housing Choice Voucher (HCV)</b> calculates the maximum amount of housing assistance allowable. The maximum housing assistance is generally the lesser of the payment standard minus 30% of the family's monthly adjusted income or the gross rent for the unit minus 30% of monthly adjusted.</p> <p><b>Tax Credit Program</b> income limits are similar.</p> <p><b>Examples of deductions that can reduce rent:</b></p> <ul style="list-style-type: none"> <li>• Elderly or Disabled Deduction</li> <li>• Medical Expenses &amp; Disability Assistance Equipment Deduction</li> <li>• Child Care &amp; Dependent Expenses</li> </ul>		<input type="checkbox"/> Climb/descend interior stairs, using railings and grab bars, etc.?	
<p><b>Know Your Rights</b></p> 	<p>Georgia Commission on Equal Opportunity <a href="http://gceo.state.ga.us/">http://gceo.state.ga.us/</a></p> <p>File a Fair Housing Complaint <a href="http://gceo.state.ga.us/to-file-a-complaint/">http://gceo.state.ga.us/to-file-a-complaint/</a></p> <p>Metro Fair Housing <a href="http://www.metrofairhousing.com/">http://www.metrofairhousing.com/</a></p>	<input type="checkbox"/> Move around inside the residence, wheelchair access, needs wider doorways, hallways, etc.?	<input type="checkbox"/> Use the bathroom facilities, tub/shower transfer bench/chair or roll-in shower, knee space under sinks, access to storage?
		<input type="checkbox"/> Use the bed/bedroom, transfers to/from the bed with lift, lowered shelves and clothing racks, dressing and grooming aids, etc.?	<input type="checkbox"/> Use the laundry facilities, access to the washer/dryer?
		<input type="checkbox"/> Clean and maintain the home, sweeping, dusting, mopping, etc.?	<input type="checkbox"/> Control the environment (open/close doors, windows, turn lights on/off, control AC/Heat fans, control TV, etc., make/take phone calls, answer doorbell)?
		<input type="checkbox"/> Get around the neighborhood during the day/after dark, use sidewalks, lights, crosswalks?	

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# Georgia MFP Operational Protocol Version 1.6



[dch.georgia.gov/mfp](http://dch.georgia.gov/mfp) - Employment\_WorkandBenefits\_Deskaid\_rev\_09\_2013

# Georgia MFP Operational Protocol Version 1.6



## How Employment May Impact MFP Participants' Social Security Benefits



	<b>MFP Participants with SSI... SSI – Supplementary Security Income</b>	<b>MFP Participants with SSDI... SSDI – Social Security Disability Insurance</b>
<b>Medical Coverage</b>	<b>Usually Medicaid</b>	<b>Medicare is Primary and Medicaid is Secondary</b>
<b>Effects of Earned Income on Cash Benefits</b>	<p style="text-align: center;"><b>Gradual Reduction in Relation to Earnings</b></p> <ul style="list-style-type: none"> <li>Monthly SSI cash benefit checks reduced in relation to earned income; as earnings increase, SSI decreases</li> <li>After the first \$85 of earned income, SSI check is reduced by \$1 for every \$2 earned</li> </ul>	<b>All or Nothing</b>
<b>Effects of Earned Income on Medical Benefits and HCBS Waiver Services</b>	<ul style="list-style-type: none"> <li>Even if SSI cash benefits end, a participant may keep free Medicaid coverage until going over the "threshold limit" (in Georgia \$28,547 yr. for family of one)</li> <li>If free Medicaid coverage ends, participants can purchase coverage through the state's Medicaid Buy-In program. For information on the program, call 404-651-9982 or complete the application at <a href="http://www.gmwd.org">www.gmwd.org</a></li> <li>HCBS waiver services continue as long as full Medicaid coverage continues</li> </ul>	<ul style="list-style-type: none"> <li>After beginning work, Medicare coverage stays in effect for at least 7½ years</li> <li>If Medicare ends, participants may purchase Medicare coverage.</li> <li>HCBS waiver services continue as long as full Medicaid coverage continues</li> </ul>
<b>Examples of Work Incentives Available to Manage Benefits</b>	<ul style="list-style-type: none"> <li>Impairment Related Work Expense (IRWE)</li> <li>Plan for Achieving Self-Support (PASS)</li> <li>Property Essential to Self-Support (PESS)</li> <li>Student Earned Income Inclusion</li> <li>Blind Work Expenses</li> <li>Expedited Reinstatement (benefits quickly reinstated)</li> </ul>	<ul style="list-style-type: none"> <li>Trial Work Period</li> <li>Impairment Related Work Expense (IRWE)</li> <li>Expedited Reinstatement (benefits quickly reinstated if necessary)</li> </ul>
<b>Information and Resources</b>	<ul style="list-style-type: none"> <li>Participants should consult with experts on benefits issues to fully understand the impact of earnings on their benefits</li> <li>Benefits Navigation and Work Incentives Planning &amp; Assistance – <a href="https://gvra.georgia.gov/benefits">https://gvra.georgia.gov/benefits</a> and <a href="http://www.bpaoga.com">www.bpaoga.com</a></li> <li>Georgia One-Stop Career Centers; Find the center nearest you – <a href="http://wfa.cybernetixs.com/">http://wfa.cybernetixs.com/</a></li> <li>Georgia Vocational Rehabilitation – 404-232-7800; <a href="https://gvra.georgia.gov/vocational-rehabilitation-program">https://gvra.georgia.gov/vocational-rehabilitation-program</a></li> <li>Social Security Ticket to Work Call Center – 866-968-7842 / 866-833-2967 (TTY/TDD); <a href="http://www.choosework.net">www.choosework.net</a></li> <li>Georgia Medicaid Buy-In information at 404-651-9982 or <a href="http://www.gmwd.org">www.gmwd.org</a></li> </ul>	

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## **MONEY FOLLOWS THE PERSON**

Employment Services & Support:  
An Orientation Manual for Field Personnel

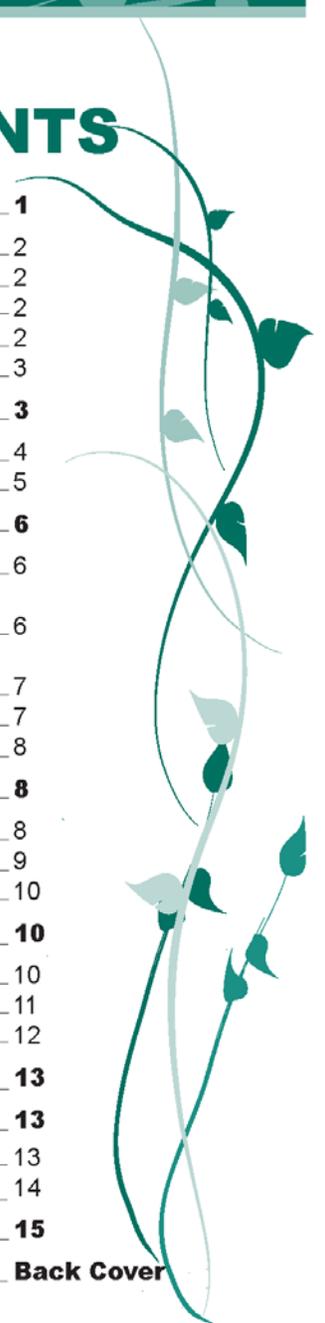
October 2013





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### INTRODUCTION

Older adults and people with disabilities have been “placed” in institutions sometimes against their will. A recent US Supreme Court decision (*Olmstead v LC*, 1999) requires an end to this practice. Money Follows the Person (MFP) is a rebalancing demonstration grant project funded by the federal Centers for Medicare & Medicaid Services (CMS) with the intent of shifting Medicaid long-term services and support (LTSS) from institutional care to Home and Community-Based Services (HCBS) in an effort to end unnecessary institutionalization of older adults and people with disabilities. The goals of MFP are to provide Medicaid-eligible participants comprehensive services and support using MFP services and HCBS waivers in settings of their choice; to increase use of HCBS waiver services; to encourage self-direction of personal support services; to increase the capacity of Georgia to provide HCBS; and, to eliminate barriers that prevent or restrict the flexible use of Medicaid funds. Along with community integration and independent living, there is a renewed focus on assisting participants with employment-related services and support to empower them to take responsibility for using all of their abilities to produce a life of quality for themselves and their families.

*This manual addresses one topic – employment as an option for participants served by MFP field personnel.*

Field personnel are responsible for providing information regarding how to access MFP employment-related services to prepare MFP participants for employment and/or **pre-vocational\*** and volunteer opportunities.

Throughout this manual, the phrase **pre-vocational\*** is set off by an asterisk. This is intentional and meant to bring attention to a very important consideration. For decades, people with disabilities have been told that they must be ready to work, implying that they required a great deal of upfront, intense services that focused on readiness, rather than natural supports, essential job matching and assistance with employer negotiations. While it's critical to think of the supports each person will need to be successful, the Centers for Medicare & Medicaid Services (CMS), along with advocates and policy makers across the country, have found that **pre-vocational\*** services should be focused, time-limited and aimed at finding a real job. For purposes of this manual, please refer to the CMS guidance text below whenever **pre-vocational\*** is referenced.

Pre-vocational\* services are not an end point, but a time-limited service for the purpose of helping someone obtain competitive employment. The full text of the Updates to the §1915 (c) Waiver Instructions and Technical Guide regarding employment and employment-related services can be found in the Technical Guide Version 3.6 (CMCS Informational Bulletin, Sept. 16, 2011; [http://www.ct.gov/dds/lib/dds/community/employment\\_informational\\_bulletin.pdf](http://www.ct.gov/dds/lib/dds/community/employment_informational_bulletin.pdf))



## EVERYONE CAN WORK!



*Aging and disability are universal human experiences. If you live long enough, you will experience them. Older adults and people with disabilities have a right to exercise citizenship, enjoy independence and be productive. (Conversations on Citizenship & Person-centered Work; edited by John O'Brien and Carol Blessing; 2011 Inclusion Press. [www.inclusion.com/bkcitizenship.html](http://www.inclusion.com/bkcitizenship.html)). Each MFP participant can work if he or she chooses to; MFP offers information and services related to this choice.*

### Benefits and Values of Work

Having a job or an occupation is an important determinant of self-esteem. It provides a vital link between the participant and society and enables people to exercise their citizenship, contribute to society and achieve personal fulfillment. To meet MFP eligibility criteria ([dch.georgia.gov/mfp](http://dch.georgia.gov/mfp)), most participants live just above or at the federal poverty level. Working may raise participant's income enough to help them create a new life in the community. While work is important for many reasons including financial gain, it may also help participants regain independence, maintain well-being, and develop feelings of dignity and worth.

The best place for learning work and other skills is the very environment in which the skill is required. If participants receive the services and support that assist them in learning skills on the job and in retaining jobs, they benefit from integration and inclusion rather than enduring segregation and exclusion. (Association of People Supporting EmploymentFirst, Establishing a National EmploymentFirst Agenda, October 2009, [www.apse.org/policy/positions.cfm](http://www.apse.org/policy/positions.cfm)).

### Positive Attitudes

*Attitudes that distort our relationships and interactions with older adults and people with disabilities are forms of prejudice that can become devastating for those to whom they are directed. Unsupportive attitudes lead to isolation and segregation of people and may hurt their pride and damage their confidence. Such attitudes may be more disabling than any result of aging or disability. These attitudes often reduce expectations of the participant's ability to perform at work, to socialize, and to live as independently as possible (Self-Advocates Becoming Empowered – SABE – Declaration of Self-Determination; November 1, 1997; [sabeusa.org/user\\_storage/File/sabeusa/Position%20State-ments/39\\_%20Self-Determination.pdf](http://sabeusa.org/user_storage/File/sabeusa/Position%20State-ments/39_%20Self-Determination.pdf)).*

### Positive Expectations

*When people are not treated fairly, there is no reason to expect them to behave normally. People do perform better when good performance is expected. Research has demonstrated the power of holding positive expectations of others. Positive expectations lead to the achievement of expected outcomes ([www.psychologytoday.com/blog/cutting-edge-leadership/200904/pygmalion-leadership-the-power-positive-expectations](http://www.psychologytoday.com/blog/cutting-edge-leadership/200904/pygmalion-leadership-the-power-positive-expectations)).*





## MFP Employment Services & Support 2013

To develop positive expectations concerning employment, follow five basic guidelines:

1. Focus and build on the participant's strengths, not weaknesses.
2. Express positive expectations about the participant's abilities.
3. Listen and pay attention to the participant.
4. Emphasize the participant's citizenship duties and responsibilities.
5. Have confidence in your own ability to help the participant solve problems. (Adele Patrick; Institute on Human Development and Disability, University of Georgia at Athens; 2012. [www.ihdd.uga.edu/](http://www.ihdd.uga.edu/))



### Words Matter

*Words reflect and influence attitudes and expectations. Language can play a significant role in creating and maintaining attitudinal barriers that are harmful to participants. Words indicate how we feel and think and they perpetuate belief systems. Your words and the manner in which you deliver them affect whether or not a participant feels respected.*

Older adults and people with disabilities are people first and our language should reflect that. "People-first" language is an objective way to acknowledge personal characteristics and to communicate and report about them ([www.peoplefirst.org/](http://www.peoplefirst.org/)). It is a respectful way of communicating and ends negative stereotypes while creating a climate in which a person can exercise his/her citizenship and make decisions about the future.

Using labels to describe a person identifies the person as the label. Saying a person has a disability rather than a person is disabled sounds like a subtle difference but the first reference suggests a person first who has a disability and the second suggests that the disability is who the person is. Finally, use the participant's name, when appropriate, and always refer to the participant rather than to a paper case or some other personal characteristic. (*Shaping Attitudes Through Person-First Language*; The University of Kansas Life Span Institute, Research and Training Center on Independent Living; Lawrence, KS. 1984. [www2.ku.edu/~lsi/news/featured/guidelines.shtml](http://www2.ku.edu/~lsi/news/featured/guidelines.shtml))



### MFP EMPLOYMENT-RELATED SERVICES AND SUPPORT

As soon as possible and appropriate in the pre-transition planning process, field personnel can begin to assess whether or not the participant wishes to work or engage in pre-vocational\* (e.g. training) or volunteer activities after transition into the community. Discuss the following MFP services with the participant and if the participant indicates interest, include justification for them in the Pre-ITP:

- **Life Skills Coaching (LSC)** – for development of pre-vocational\* activities and employment or volunteer-related tasks. Assist participants to locate a qualified Life Skills Coach and complete an individualized training needs assessment that includes a career interest assessment and an inventory of job search and interviewing skills. Once career interests and skill gaps are identified, 30 hours of coaching can be used in skills development.



- **Equipment, Vision, Dental and Hearing Services (EQS)** – includes equipment needed for pre-vocational\* activities, employment and/or volunteer activities, assistive technology, and services that are not otherwise covered by Medicaid such as an adjustable workstation, adapted computer, monitor, keyboard or mouse and/or tools needed for training, customized or self-employment.
- **Transportation (TRN) and/or Vehicle Adaptations (VAD)** – might include vehicle adaptations to a vehicle owned by the participant or family member or travel training using local fixed-route, para-transit bus service, dial-a-ride and/or other local transportation services. Assist participants to identify transportation needs and resources related to engaging in pre-vocational\* activities (e.g. training), employment or volunteering.
- **Supported Employment Evaluation (SEE)** – includes career planning services for employment, the Vocational Discovery Process and Vocational Profile and referrals to community employment resources.

In the post-transition planning process (e.g., the Post-ITP) after the participant has transitioned to the community, MFP field personnel complete (when applicable) Q10 Employment Goals within 30 days of transition. To complete Q10, field personnel facilitate a discussion of the participant's pre-vocational\* goals, employment and/or volunteer goals, identify barriers and needs and include a plan to achieve each goal. This plan includes specific references to MFP services and how they are used to achieve each goal.

In the event that MFP employment-related services were not included in the Pre-ITP, they must be included in the Post-ITP, *Part A: Request for Additional MFP Transition Services* with a statement of justification for each service. Field personnel complete *Part B: Other Services* when the participant is referred to pre-vocational\* activities, employment and/or volunteer resources in the community. Field personnel include any employment-related tasks for transition team members (circle of support) on the *Post-ITP-Discharge Transition Plan Assignments* page (<http://dch.georgia.gov/documents/mfp-forms>, see *MFP Pre- Post Individualized Transition Plan*).

## FACILITATING EMPLOYMENT-RELATED CHOICES



As you facilitate the discussion of employment-related choices, consider the following:

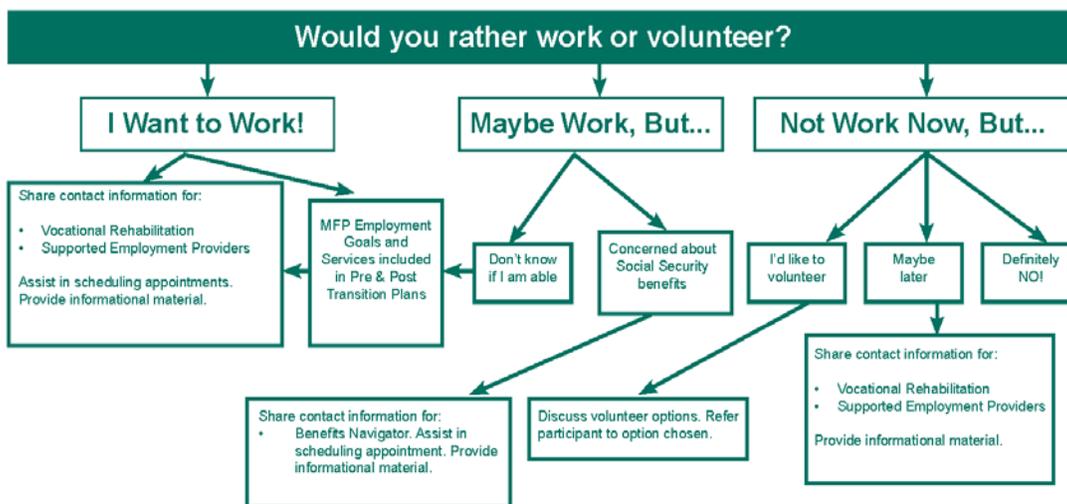
- Working-age participants must be supported to pursue a lifestyle of work!
- Presume that participants want to work.
- The decision to transition out of an inpatient facility precedes the decision to engage in employment-related services and activities.
- The participant chooses pre-vocational\* activities, work, or volunteer activities.
- Field personnel help participants assess whether pre-vocational\* options, work or volunteerism is the best fit for them.



- Work is not optional for participants who are capable of working and who rely on public assistance to sustain themselves. (Adele Patrick; Institute on Human Development and Disability, University of Georgia at Athens; 2012. [www.ihdd.uga.edu/](http://www.ihdd.uga.edu/))

Use the following diagram as a guide to focus discussions with participants about employment-related options:

## CONVERSATIONS WITH PARTICIPANTS ABOUT WORK



### Supported Employment Services

- Discovery and Vocational Profile
- Person-Centered Career Planning
- Customized Employment
- Self-Employment Assistance
- Identification of Needed Supports

### Vocational Rehabilitation Services

- Counseling & Guidance
- Work Adjustment Training
- Post-secondary Support
- Vocational & Technical Training
- Supported Employment
- On-the-Job Training
- Work-readiness Training
- Deaf, Blind & Deaf/Blind Services

### MFP Employment-Related Services

- Life Skills Coaching (LSC)
- Peer Community Support (PES)
- Transportation (TRN) and/or Vehicle Adaptation (VAD)
- Equipment, Vision, Dental & Hearing Services (EQS)
- Supported Employment Evaluation (SEE)

(Adele Patrick; Phillip Chase and Doug Crandell; Institute of Human Development and Disability, University of Georgia at Athens; 2012. [www.ihdd.uga.edu/](http://www.ihdd.uga.edu/))



## FIVE COMPONENTS OF EMPLOYMENT CHOICE



Adele Patrick; Phillip Chase and Doug Crandell; Institute of Human Development and Disability, University of Georgia at Athens; 2012. [www.ihdd.uga.edu/](http://www.ihdd.uga.edu/)

### RAPID ENGAGEMENT

- Quickly begin to learn about the participant and work on the Pre-Transition Individualized Transition plan (Pre-ITP).
- Develop the Post-Discharge Individualized Transition Plan (Post-ITP), include employment-related MFP services selected by the participant/transition team.
- Assist the participant in achieving the desired employment goals quickly.

### MFP SUPPORTED EMPLOYMENT EVALUATION (SEE) AND THE VOCATIONAL DISCOVERY PROCESS

“Discovery consists of looking at the same thing as everyone else and thinking something different.”  
(Albert Szent-Gyorgyi, Hungarian physiologist.)

MFP offers all participants the Supported Employment Evaluation (SEE) service. This service provides assistance to participants seeking career planning and supported-employment, customized-employment, self-employment and/or competitive employment. Participants engage in a guided/facilitated Vocational Discovery Process. Based on the Discovery Process, a Vocational Profile is completed with the assistance of a qualified employment specialist; the Vocational Profile identifies a path to employment. These services are procured from a qualified vocational/employment service specialist/provider who is required to assist the participant to make connections to a minimum of three unique community resources necessary to support choices for supported, customized or competitive employment.

Field personnel assist participants to locate a qualified SEE provider. They also ensure completion of the vocational discovery process and the vocational profile and referrals to at least three community employment resources – see section on *Employment Service Providers* in this manual for more information on locating qualified SEE providers.

#### The Vocational Discovery Process:

- Is *not* a planning process; it is an information gathering activity that pinpoints who the participant is and his/her ideal conditions of employment.
- Explores the life of the participant to gain necessary information and perspective to help determine his/her wishes, values, and interests.
- Recognizes that each participant has many assets, traits, and abilities and disability is only one of these.





- Forms a guide for job development and a foundation for person-centered career planning.
- Supports utilizing involvement and interaction with the participant in natural settings rather than in test settings.
- Provides a complete picture of a participant, rather than looking at one or two skill areas in the context of a segregated program.
- Focuses on the participant rather than job openings as the starting point for the employment process.
- Involves getting to know participants beyond how they are seen by teachers, service providers, counselors, and other paid staff.

For more on the vocational discovery process, see Dave Hammis and Cary Griffin; *Discovering Personal Genius*. [www.griffinhammis.com/training.asp](http://www.griffinhammis.com/training.asp).

## PERSON-CENTERED CAREER PLANNING AND THE TRANSITION PLANNING PROCESS



- Organizes truly individualized, natural, and creative supports and relies on the participant's strengths and preferences to achieve meaningful goals.
- Creates a team of people (circle of support) who know and care about the participant.
- Involves a transition team who works together to develop and share a dream for the participant's future, and to organize and provide the supports necessary to make that dream real.
- Reduces emphasis on the service system as much as possible.
- Creates an umbrella under which all planning for services and supports occurs.
- Focuses on the identification of the participant's/family's goals and needs and includes a plan to achieve desired life outcomes.
- Is based on what is most important to and for the participant/family as identified by the participant/family and the people who know and care about the participant.

## NATURAL SUPPORTS



- Natural support is any help, including relationships and interactions that allow a participant to get and keep a community job that is consistent with the typical work routines and social interactions of other employees. We all need natural supports in our environments.



- Natural support refers to using things that are available in the environment.
- Using natural supports also means relying on the same things that other people rely on – each other.

## LONG-TERM SUPPORTS



- A participant receiving MFP-supported employment evaluation (SEE) services must be assisted to make connections to community employment services and supports necessary for long-term employment retention.
- Reliable employment-related services and support in the community must be provided throughout the longevity of a participant's employment tenure.
- Ongoing support is the unique characteristic of supported employment that makes it possible for participants to maintain employment and is provided both at and away from the job site.
- These supports may be telephone calls, periodic onsite visits, or a combination of both types of contact.

## THREE COMMUNITY EMPLOYMENT SERVICE OPTIONS



Doug Crandell; Institute of Human Development and Disability, University of Georgia at Athens; 2012.  
[www.ihdd.uga.edu/](http://www.ihdd.uga.edu/)

## SUPPORTED EMPLOYMENT

Participants with severe disabilities receive supports which help them learn skills on-the-job and which help them keep their jobs.

Supported employment means:

- **Inclusion** – Participants are integrated into and are active members of the work environment. This involves such things as having friends, going to parties, chit-chat with co-workers at breaks, being on the bowling team. It means doing things that everyone does and being like everyone else.
- **Real Money For Real Work** – Participants who receive supported employment services are paid on the same pay scale as others who are doing the same job.
- **Choice** – Participants have a right to choose where they work, with whom they work, and what sort of job they would like to have. We can find ways to “listen” to those who have even the most severely limited communication skills.



- **Individualization** – All people are different. Capabilities of participants are not similar just because participants have similar disabilities. We all have unique personalities, skills, needs and desires.
- **On-Going Support** – On-going support is provided on an “as-needed” basis in the least invasive way possible. On-going support may include co-worker support, productivity aids and many other forms of “natural” supports as well as support from the job coach.

## CUSTOMIZED EMPLOYMENT



- Individualizing the employment relationship between employees and employers in ways that meet the needs of both.
- Is based on an individualized assessment of the strengths, needs and interests of the participant.
- Revealing multiple employment directions rather than a job description during the discovery process; vocational interests and revealed skills are used to create employment in the community.

### Fundamental principles of customized employment:

- Recognizes the participant as the source of information for exploring potential employment options through a person-centered process.
- Negotiates specific job duties and employer expectations with employers.
- Negotiates individualized jobs based on the needs, strengths and interests of the participant.
- Negotiates, amends and adapts the relationship between the employer and the participant for the participant.
- Meets the unique needs of the participant and employer.
- Offers any needed representation to assist participants in negotiating with employers.
- Occurs in integrated environments in the community alongside people who do not have disabilities.
- Results in a customized job that meets the participant’s employment needs, conditions necessary for his/her success, and business needs for valued contributing employees.





- Results in at least minimum wage compensation.
- Creates employment through self-employment and/or business ownership.
- Facilitates a mixture of supports and funding sources.
- Provides supports as needed to maintain employment.

## SELF-EMPLOYMENT



- Is recognized as a viable employment option for MFP participants.
- Minimizes the fears of the prospective business-owner, as well as those of the rehabilitation and local small business development professionals who assist the participant.
- Does not require that a participant “get ready” to own a business if a customized approach is used.
- Focuses on the talents and interests of the participant and identification of his/her personal assets.
- Uses a strength-based rather than a deficit-based outlook.
- Customizes supports.

## OVERVIEW OF WORK INCENTIVES

For more information on Social Security Disability Insurance Work Incentives Program, see <http://www.socialsecurity.gov/disabilityresearch/wi/generalinfo.htm>



## SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

- **Trial Work Period** – Nine months, not necessarily consecutive, during which a participant may earn any amount of money without losing SSDI as long as he/she continues to have a disability and reports the work activity.
- **Extended Period of Eligibility** – For 36 consecutive months, after the trial work period is completed and the participant continues to have a disability, he/she can receive an SSDI check for each month that earnings are below a certain amount.



- **Medicare Continuation** – Medicare health insurance can continue for seven years and nine months – sometimes longer – after a successful trial work period if the participant continues to have a disability.
- **Impairment-Related Work Expense** – This is a documented disability-related expense that is absolutely necessary for performance of a job. The Social Security Administration (SSA) deducts the cost of these expenses from gross earnings before determining eligibility for cash payments. Examples of these types of expenses may include wheelchairs, assistive technology or other specialized work-related equipment and certain special transportation costs.
- **Medical Recovery During Vocational Rehabilitation** – SSDI eligibility may continue if the participant has medically recovered from disability but is actively participating in a vocational rehabilitation program that will likely lead to self-support.
- **Ticket to Work** – While actively participating in the Ticket to Work program, a participant can get the help needed to find an appropriate job and can safely explore work options without losing SSDI benefits. While using the ticket:
  - The participant has access to “expedited reinstatement of benefits” – an easy return to benefits if the participant has stopped working.
  - The participant can continue to receive health care benefits.
  - The participant will not receive a continuing disability review.
  - The participant can still use other SSA programs and work incentives for the transition into work.

For more information, contact Social Security Ticket to Work Call Center – 866-968-7842 / 866-833-2967 (TTY/TDD); [www.chosework.net](http://www.chosework.net)

## SUPPLEMENTAL SECURITY INCOME (SSI)



For more information on Supplemental Security Income Work Incentives Program, see <http://www.socialsecurity.gov/disabilityresearch/wi/generalinfo.htm>

- **Ticket to Work** – Similar to the SSDI work incentive. See the description above.
- **1619A and 1619B** – Two different programs to help the participant keep Medicaid benefits while he/she tries to become self-supporting.
- **Student Earned Income Exclusion** – A student participant, up to 22 years of age who is disabled or blind and regularly enrolled in school, is allowed to earn income that is not counted for SSI income purposes.



- **Plan for Achieving Self-Support** – This is a document that the participant writes to set aside income or resources to reach a work goal. For example, the participant could set aside money to go to school, start a business or pay for work expenses such as transportation to and from work or attendant care. SSA does not count money set aside under this plan to determine the SSI payment amount.
- **Impairment-Related Work Expense** – This is a documented disability-related expense that is absolutely necessary for the participant to perform a job. Examples may include wheel chairs, assistive technology or other specialized work-related equipment and certain special transportation costs. An SSI beneficiary may recover the cost of these expenses through higher SSI payments. Additionally, this work incentive can also be used to establish eligibility for initial SSDI disability status.
- **Blind Work Expense** – For a participant who has blindness, this is a documented expense incurred because of disability and absolutely necessary to perform a job. Examples may include adaptive devices or guide dogs. Like an impairment related work expense, the participant may be able to recover 100 percent of those expenses through increased SSI cash payments.

## MEDICAID BUY-IN



For information on the Georgia Medicaid Buy-In program, call 404-651-9982 or complete the application at [www.gmwd.org](http://www.gmwd.org). Find information about the Medicaid Buy-in Program provided by the Benefits Navigator Program of Atlanta at [www.bpaoga.com/](http://www.bpaoga.com/)

If the participant's SSI cash benefits end after returning to work, the participant may keep free Medicaid coverage until going over the "threshold limit" in Georgia of \$28,547 a year for a family of one. If free Medicaid coverage ends, participants can purchase coverage through the state's Medicaid Buy-In program. Effective March 3, 2008, a participant is eligible for Georgia's Medicaid Buy-In program for workers with disabilities if he/she:

- Meets the citizenship and residency requirements for Medicaid eligibility.
- Is at least 16 years of age and under age 65.
- Is disabled based on the SSA definition of disability.
- Has earned income from employment or self-employment.
- Has disability income between \$600 and \$699 per month.
- Has earned income less than 300% of the Federal Poverty Level (FPL) based on family size.
- Has resources or assets less than \$4000 for a participant or \$6000 for a couple.



## INFORMATION AND RESOURCES/BENEFITS NAVIGATION

Encourage participants to consult with experts on benefits issues to fully understand the impact of earnings on their benefits.

- For personalized Benefits Navigation and Work Incentives Planning and Assistance (WIPA), visit: <https://gvra.georgia.gov/benefits> and/or: <http://www.bpaoga.com/>. 
- The WIPA programs at the Georgia Vocational Rehabilitation Agency service specific counties. Please see each website above to determine which organization provides the WIPA supports in each county. Be prepared to ask for the *Benefits Planning Query* (BPQY). Directions are below:
  - All Social Security Administration (SSA) offices nationwide including the agents at the toll-free number 800-772-1213 can process a request for a BPQY.
  - If the participant is interested in getting a BPQY, assist them to call their local Social Security office or 800-772-1213 and ask for it. It is mailed to the participant's address as shown on SSA's records. A signed consent is required only if the BPQY is sent to someone other than the participant; the participant's Representative Payee or the participant's Authorized Representative. Two signed Consent for Release of Information (SSA-3288) forms must include the Social Security Number (SSN) or the Claim Number of the worker under whose work record the benefits are paid. (The Claim Number appears on the beneficiary's Medicare card.)
- If you are assisting the participant to obtain information from SSA, you must have the MFP participant/beneficiary sign two Consent for Release of Information (SSA-3288) forms referenced above.
- If you or the participant don't know how to reach the SSA office, call 800-772-1213 or go to the Social Security website at [www.socialsecurity.gov](http://www.socialsecurity.gov) and click on the "Find your nearest Social Security office" item on the left side of the home page. Follow the instructions on this page and you will be provided with information about the field office that is responsible for the participant's record.

## EMPLOYMENT SERVICE PROVIDERS

### GEORGIA VOCATIONAL REHABILITATION AGENCY (GVRA)



- GVRA helps participants with disabilities to become fully productive members of society by achieving independence and meaningful employment.



- Regional and unit office staffs provide services to eligible participants who can, will and want to work.
- Services necessary to meet a carefully determined work goal may include:
  - Counseling & Guidance
  - Post-secondary Support
  - Supported Employment
  - Work Readiness Training
  - Work Adjustment Training
  - Vocational & Technical Training
  - On-the-Job Training
  - Deaf, Blind & Deaf/Blind Services



Most funding for community employment services is available through GVRA. Services may be initiated by contacting appropriate GVRA staff found through <http://www.vocrehabga.org/contact1.html>.

## GEORGIA NETWORK OF SUPPORTED EMPLOYMENT PROVIDERS

When an MFP participant chooses work or is unsure of her/his ability to work, the participant has the right to choose referral to a Supported Employment Provider or the Georgia Vocational Rehabilitation Agency.

*WorkWorks for Everyone* (Medicaid Infrastructure Grant) maintains a website with an area designated for Georgia MFP field personnel. Within this area, MFP field personnel can access approved Supported Employment Providers by region, county and/or city. They will also be able to determine if the provider primarily serves participants with developmental disabilities, participants with mental illnesses and participants with any disabilities. The *WorkWorks for Everyone* website is currently being developed ([www.gasupportedemployment.com](http://www.gasupportedemployment.com)).

It is important to ask potential supported employment providers some basic questions:

- Do you currently use a person-centered career planning process?
- What are your employment success statistics (i.e., length of time from referral to first day on the job, average wages per hour for persons severed, retention/how long do people stay on their jobs at your agency, access to benefits such as paid leave, and health care).
- What types of employers do you work with?
- Does your staff have the knowledge, skills and abilities to develop and support customized employment options?
- Do you currently work with anyone you've supported in self-employment?

Doug Crandell; Institute of Human Development and Disability, University of Georgia at Athens; 2012. [www.ihdd.uga.edu/](http://www.ihdd.uga.edu/).



## VOLUNTEER OPPORTUNITIES



Volunteer jobs (similar to pre-vocational\* services) are not required before a person starts a real job of their choosing for real pay. However, volunteer work is rewarding and beneficial to many people, both with and without disabilities. Field personnel are encouraged to become knowledgeable about volunteer opportunities in the communities where they serve transitioning participants. An excellent site to find volunteer opportunities and assist with matching participants who desire to volunteer may be found at *VolunteerMatch* ([www.volunteermatch.org/search](http://www.volunteermatch.org/search)). At this site, you will be asked to identify a city. For example, 1133 volunteer opportunities were found in the Atlanta area; 85 in Augusta; 42 in Rome; 91 in Athens; 90 in Savannah; and 35 in Valdosta.

As field personnel experience success in matching participants with volunteer opportunities, informational listings at the *WorkWorks for Everyone* website will include additional volunteer opportunities.



For questions regarding this publication or for more information about the Georgia MFP rebalancing demonstration project, contact:

Pam Johnson, Project Director  
Georgia Money Follows the Person  
[pajohnson@dch.ga.gov](mailto:pajohnson@dch.ga.gov)  
404-651-9961

R.L. Grubbs, Policy Specialist  
Georgia Money Follows the Person  
[rgrubbs@dch.ga.gov](mailto:rgrubbs@dch.ga.gov)  
404-657-9323

Georgia Department of Community Health  
Medicaid Division, Aging & Special Populations  
37<sup>th</sup> Floor  
2 Peachtree Street, NW  
Atlanta, GA 30303



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

## DISCLAIMER

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## Appendix R: MFP Discharge Day Checklist



### MFP DISCHARGE DAY CHECKLIST



<b>Discharge Date:</b> _____		MFP Field Personnel Print Name: _____		Phone #:
<b>MFP Participant Housing at Discharge</b>				
Participant Name:		Medicaid ID#		Date of Birth:
New Address:		City:	Zip:	County:
Phone Number(s): _____ ;		<b>MFP Target Population</b> (check only one): <input type="checkbox"/> OA (65+yoa) <input type="checkbox"/> PD <input type="checkbox"/> TBI <input type="checkbox"/> DD <input type="checkbox"/> MI		
<b>Housing Type:</b> <input type="checkbox"/> 01-Home owned by Participant <input type="checkbox"/> 02-Home owned by Family Member <input type="checkbox"/> 03-Apt/House Leased by Participant, Not Assisted Living <input type="checkbox"/> 04-Apt. Leased by Participant, Assisted Living <input type="checkbox"/> 05-Group Home of No More Than 4 People/PCH <input type="checkbox"/> <b>Lives with family (check for yes)</b>				
<b>Housing Subsidy:</b> If H3-Apt/House Leased by Participant, check box for housing subsidy used: <input type="checkbox"/> HS1- Sec8 HCV, <input type="checkbox"/> HS2-Project Based Rental Assistance/ Based On Income, <input type="checkbox"/> HS3- Low Income Housing Tax Credit, <input type="checkbox"/> HS4- Other Subsidy (specify) _____ <input type="checkbox"/> HS5-No Subsidy/Market Rate				
<b>Services at Discharge: Item Key: N=Needed; O=Ordered; S = Secured; N/A=Not Applicable</b>				
Items (provide items for all that apply):				
_____ Environmental Modifications; _____ Home Inspections; _____ Security Deposit; _____ Utility Deposits: _____				
_____ Household items: _____; _____ Kitchen: _____; _____ Bath: _____; _____ Bed: _____				
_____ Food & Nutrition: _____				
_____ Health & Hygiene: _____				
_____ RX Medications _____				
_____ Medical Services/DME Equipment: _____				
_____ Assistive Technology Devices: _____				
_____ Life Skills Coaching/ Socialization: _____				
_____ Financial: _____				
_____ Transportation: _____				
_____ Other (list) _____				
Waiver:	SSI Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Waiver Case Mgr/CC/SC Name:	Phone:	
Waiver services ordered at discharge:				
_____				
_____				
Are providers identified to begin services upon discharge?: <input type="checkbox"/> Yes <input type="checkbox"/> No* If no, explain:				
Name of Community Pharmacy:		Name of Community Doctor/Clinic:		
24/7 Emergency plan reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:				
Identify participant's unmet needs upon discharge and the plan to meet these unmet needs: (attach additional sheets as needed)				
<b>Follow-up Visits/Quality Management</b>				
<b>Home Visits:</b> Provide schedule for follow-up visits:				
<input type="checkbox"/> Field Personnel/TC: 1 <sup>st</sup> Scheduled Visit to review ITP: _____; 2 <sup>nd</sup> Visit, If Scheduled: _____				
<input type="checkbox"/> Waiver Case Mgr, <input type="checkbox"/> Care Coordinator, <input type="checkbox"/> Support Coordinator, <input type="checkbox"/> PLA Name: _____ Phone: _____				
1 <sup>st</sup> Scheduled visit: _____; 2 <sup>nd</sup> Visit, If Scheduled: _____				
<input type="checkbox"/> HC Ombudsman Name: _____ Phone: _____ 1 <sup>st</sup> Scheduled F2F visit (or NA): _____				
<input type="checkbox"/> Peer Supporter Name: _____ Phone: _____ 1 <sup>st</sup> Scheduled F2F visit (or NA): _____				
<b>Quality of Life Survey:</b> <input type="checkbox"/> Baseline Survey - <input type="checkbox"/> Completed <input type="checkbox"/> Scheduled: _____ <input type="checkbox"/> Rescheduled: _____ <input type="checkbox"/> NA				
<b>Participant Tracking</b>				
<input type="checkbox"/> MFP Field Personnel Signature: _____				Date Sent to coordinating agency: _____



## Appendix T: Quote Form for MFP Transition Services (Revised)



### Quote Form For MFP Transition Services

Notice to MFP field personnel: complete this *Quote Form* for equipment, vision and/or dental services costing \$1000 or more, all environmental modifications and all vehicle adaptations. In the table provided, list the licensed contractors or vendors and the amount of each quote. Check the quote selected. If a quote is selected that is not the lowest quote, provide a justification for the selected quote. MFP field personnel sign the form and attach supporting documentation. For assistance in locating licensed contractors Certified in Aging-in-Place (CAPS), contact DCH MFP Housing Manager.

Participant First Name: \_\_\_\_\_ Participant Last Name: \_\_\_\_\_  
 Participant Medicaid ID #: \_\_\_\_\_ Participant Date of Birth: \_\_\_\_\_  
 Inpatient Facility Name or NA: \_\_\_\_\_  
 Participant Address: \_\_\_\_\_ Participant City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
 Participant Phone Number: \_\_\_\_\_ Other Contact Name: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
 Date(s) of ITPs/Planning Meetings: \_\_\_\_\_ COS Waiver Name: \_\_\_\_\_

Vendor Name/Phone	MFP Transition Service	MFP 3 Digit Service Code	Quoted Amount	Accepted Quote
				<input type="checkbox"/>
				<input type="checkbox"/>

Total \$'s Authorized: \_\_\_\_\_

**Justification for selection of quote that is not the lowest:**

- Maximum allowed cost for Equipment, Vision, Dental and/or Hearing Services (EQS) is \$4,000 during the MFP period of participation. Service must be justified in the ITP/ISP. Two quotes must be obtained before a purchase can be authorized for a single piece of equipment costing \$1000 or more, or for vision, dental or hearing services costing \$1000 or more.
- Maximum allowed cost for Environmental Modifications (EMD) is \$8,000 during the MFP period of participation. Service must be justified in the ITP/ISP Two itemized scope/bids are required, before Environmental Modifications are authorized. Building permits are required for EMDs totaling \$2,500 or more. The Home Inspection service (HIS) must be completed before beginning environmental modifications and after environmental modifications are completed to ensure quality work and compliance with relevant building codes and standards. Environmental modifications can be made to rental property for participants who have a Housing Choice Voucher or other housing subsidy.<sup>1</sup>
- Maximum allowed cost for Vehicle Adaptations (VAD) is \$6,240 during the MFP period of participation. Service must be justified in the ITP/ISP Two quotes must be obtained before Vehicle Adaptations can be authorized.<sup>2</sup>

Owner/Landlord Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
 MFP Field Personnel Name: \_\_\_\_\_  
 Region/Office: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Authorizing Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Note:** (Step 1) Send completed *Quote Form* to FI via **File Transfer Protocol (FTP)**. (Step 2) Send to the DCH MFP Office via FTP.

<sup>1</sup> If the owner/landlord is not the MFP participant, a notarized document must be obtained from the owner/landlord giving permission for environmental modifications and home inspections. The notarized document must state that the owner/landlord gives the participant the right to live in the modified housing/unit for an *extended period of time* (i.e. the end of the lease or when the participants moves out, whichever comes first) after the modifications are complete. Further, the owner/landlord must allow the participant to live in the housing/unit before and after the home inspections are conducted.

<sup>2</sup> For vehicle adaptations, a notarized document must be obtained giving the owner's permission. It must include a statement giving the participant use of the vehicle.

## Appendix U: MFP Vendor Payment Request



### MFP Vendor Payment Request

MFP Services – OR –  MFP CBAY Services Rendered for:

Participant Name:	Participant/Contact Phone:
Participant Address:	Participant City /Zip /County

<b>MFP Field Personnel Complete:</b>	
Participant Medicaid ID#:	Participant Date of Birth:
Discharge Date:	Anticipated MFP End Date:

#### PAYMENT INSTRUCTION

Vendor Name:	Vendor Phone:
MAIL CHECK TO (if different):	Vendor Tax ID, FEIN or SS#:
Vendor Address:	Vendor City/State/Zip

#### DESCRIPTION OF MFP TRANSITION SERVICES

Description of Services	Billed Amount
<b>Total Check Amount</b>	

By signing this form, I attest that services were delivered/received consistent with the transition/ services plan (i.e. ITP, ISP) and *MFP Authorization for Services*. I understand that Medicaid is the payer of last resort.

Signature	Relationship (Participant, Parent/Legal Guardian)	Date
-----------	---	------

Vendor Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Fax or mail to MFP Field Personnel (Print Name): \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Vendor note:** send completed form (signed by participant or parent/legal guardian), along with invoice and receipts to MFP field personnel listed above by fax, mail or via file transfer protocol (FTP).

**MFP Field Personnel:** once verified, send this completed form along with invoice and receipts to the FI by FTP and send completed form and required documentation to the appropriate coordinating agency by FTP.





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## Appendix W: Monthly Update QoL Survey Blue Form

\*Please fill in the necessary data for **[MONTH YEAR]**

Cumulative numbers from the beginning of your MFP program until the date indicated below	Baselines	One Year Follow-Ups	Two Year Follow-Ups
<u>Completed</u> from start of program until <b>[END OF PREVIOUS MONTH]</b>	All baselines completed in your state since beginning an MFP program	All One Year Follow-Up surveys (11 months after transitioning) completed in your state since beginning an MFP program	All Two Year Follow-Up surveys (24 months after transitioning) completed in your state since beginning an MFP program
<u>Refused</u> from start of program until <b>[END OF PREVIOUS MONTH]</b>	All beneficiaries who transitioned into the community, but refused to take the survey after the transition	All MFP-enrolled beneficiaries who completed the baseline survey, but refused to take the follow-up survey 11 months after transitioning	All MFP-enrolled beneficiaries who completed the baseline survey, but refused to take the follow-up survey 24 months after transitioning
<u>Missed</u> from start of program until <b>[END OF PREVIOUS MONTH]</b>	All beneficiaries who transitioned into the community, but were not administered the survey due to factors such as (but not limited to): <ul style="list-style-type: none"> <li>• Interviewers were unable to locate the beneficiary</li> <li>• Interviewers were unable to reach the beneficiary within 15 attempts</li> <li>• Beneficiary's paperwork was misplaced</li> <li>• An interviewer forgot</li> </ul>	All MFP-enrolled beneficiaries who completed the baseline survey, but were not administered the follow-up survey due to factors such as (but not limited to): <ul style="list-style-type: none"> <li>• Interviewers were unable to locate the beneficiary</li> <li>• Interviewers were unable to reach the beneficiary within 15 attempts</li> <li>• Beneficiary's paperwork was misplaced</li> <li>• An interviewer forgot</li> </ul>	All MFP-enrolled beneficiaries who completed the baseline survey, but were not administered the follow-up survey due to factors such as (but not limited to): <ul style="list-style-type: none"> <li>• Interviewers were unable to locate the beneficiary</li> <li>• Interviewers were unable to reach the beneficiary within 15 attempts</li> <li>• Beneficiary's paperwork was misplaced</li> <li>• An interviewer forgot</li> </ul>
<u>Lost</u> (died, out of state, etc.) from start of program until <b>[END OF PREVIOUS MONTH]</b>	All beneficiaries who transitioned into the community, but died or moved out of state before a baseline was administered within the appropriate time frame.	All MFP-enrolled beneficiaries who completed the baseline survey, but died or moved out of state before the 11-month follow-up survey was administered within the appropriate time frame.	All MFP-enrolled beneficiaries who completed the baseline survey, but died or moved out of state before the 24-month follow-up survey was administered within the appropriate time frame.
<u>Completed</u> from start of program until <b>[END OF THIS MONTH, LAST YEAR]</b>	All baselines completed in your state from the beginning of the program to the end of this month last year.		
<u>Completed</u> from start of program until <b>[END OF THIS MONTH, TWO YEARS AGO]</b>	All baselines completed in your state from the beginning of the program to the end of this month two years ago.		

\*\*Just to clarify, the last two rows of the table asks for the **cumulative number** of completed baselines from the beginning of your MFP program until **THE END OF THIS MONTH, LAST YEAR** and the **cumulative number** of completed baselines from the beginning of your MFP program until **THE END OF THIS MONTH, TWO YEARS AGO**. This information is necessary for us to track the percentage of completed first year follow-ups and second year follow-ups.

## Appendix X: MFP Request for Additional MFP Services (Revised)



### Request for Additional MFP Transition Services

**MFP Field Personnel note:** Complete this form - 1) if the initial budget for the transition service(s) was inadequate AND the service funding cap has not been reached, and/or 2) the transition service was not initially identified during transition service planning (i.e., after discharge to the community, the need for the additional transition service(s) listed below became apparent). The MFP participant initials each additional service and/or additional amounts authorized.

**Participant First Name:** \_\_\_\_\_ **Participant Last Name:** \_\_\_\_\_  
**Participant Medicaid ID#:** \_\_\_\_\_ **Participant Date of Birth:** \_\_\_\_\_  
**Participant Address:** \_\_\_\_\_  
**Participant City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **County:** \_\_\_\_\_ **Waiver Name:** \_\_\_\_\_  
**Participant Phone Number:** \_\_\_\_\_ **Other Contact Name:** \_\_\_\_\_ **Other Phone:** \_\_\_\_\_  
**Date of ITP/ISP:** \_\_\_\_\_ **Date of Discharge:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

MFP TRANSITION SERVICE CODE	*RATIONALE (provide justification - describe need for additional service(s) or additional amount authorized, for successful community living)	**INITIAL AMOUNT AUTHORIZED	***ADDITIONAL AMOUNT AUTHORIZED	MFP PARTICIPANT INITIAL

\*When additional transition services are identified after discharge to the community, the planning document (ITP/ISP) must be updated to reflect these changes.

\*\*Initial Amount Authorized plus \*\*\*Additional Amount Authorized together cannot exceed individual MFP service caps; see Appendix B: MFP Services and Rate Table.

**MFP Field Personnel Name:** \_\_\_\_\_

**Region/Office:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Field Personnel note:** Send this completed form to the FI and DCH/MFP Office via **File Transfer Protocol (FTP)**. Submit completed reimbursement documentation (i.e. updated ITP, *Vendor Import File*, etc.) to Fiscal Intermediary via **FTP** and to DCH/MFP Office by **FTP**.

## Appendix Y: MFP Participant Status Change Form (Revised)



### MFP Participant Status Change Form

**MFP Field Personnel:** complete the text boxes and check boxes provided to identify changes in the status of an MFP participant.

**Participant First Name:** \_\_\_\_\_ **Participant Last Name:** \_\_\_\_\_  
**Participant Medicaid ID#:** \_\_\_\_\_ **Participant Date of Birth:** \_\_\_\_\_  
**Participant Phone Number:** \_\_\_\_\_ **Other Contact Name:** \_\_\_\_\_ **Other Phone:** \_\_\_\_\_  
**Original Date of Transition/Discharge (mm/dd/yyyy):** \_\_\_\_\_ **Waiver:** \_\_\_\_\_ **- OR -  MFP CBAY**

Check Type(s) of Status Change and add Dates	Check Reason – Select Only One Reason per Type
<input type="checkbox"/> Participant was <u>admitted to an inpatient facility</u> (i.e. participant was <u>reinstitutionalized</u> <sup>1</sup> ) <b>Admission Date:</b> _____ <b>Discharge Date:</b> _____	<input type="checkbox"/> Acute care hospital stay, followed by long term rehabilitation (01) <input type="checkbox"/> Deterioration in cognitive functioning (02) <input type="checkbox"/> Deterioration in health (03) <input type="checkbox"/> Deterioration in mental health (04) <input type="checkbox"/> Loss of housing (05) <input type="checkbox"/> Loss of personal care giver (06) <input type="checkbox"/> By request of participant or guardian (07) <input type="checkbox"/> Lack of sufficient community services (08)
<input type="checkbox"/> Participation <u>Ended</u> or was <u>Suspended</u> <sup>2</sup> <b>Date participation ended:</b> _____ <b>Or Date participation was suspended:</b> _____	<input type="checkbox"/> Completed MFP period of participation (01) <input type="checkbox"/> Suspended eligibility (02) <input type="checkbox"/> Reinstitutionalized (03) <input type="checkbox"/> Died (04) – <b>Date</b> _____ <input type="checkbox"/> Moved (provide new address below) (05) <input type="checkbox"/> No longer needed services (06) <input type="checkbox"/> Other (07) Specify: _____
<input type="checkbox"/> Participant <u>reactivated/re-enrolled</u> <b>Date participation began</b> <sup>3,4</sup> : _____	<b>New Project End Date:</b> _____
<input type="checkbox"/> Participant <u>moved</u> (fill in new address) <b>Date moved:</b> _____	<b>New Street Address:</b> _____ <b>New City:</b> _____ <b>New Zip:</b> _____ <b>New County:</b> _____ <b>Check type of qualified residence used after move:</b> <input type="checkbox"/> Home owned by participant (01) <input type="checkbox"/> Home owned by family member (02) <input type="checkbox"/> Apt. leased by participant, not assisted living (03) <input type="checkbox"/> Apt. leased by participant, assisted living (04) <input type="checkbox"/> Group home/PCH with no more than 4 unrelated people (05) <input type="checkbox"/> Participant lives with family members (check for yes)

**Notes:**  
MFP Field Personnel Name: \_\_\_\_\_  
Region/Office: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_ **Note:** Send completed form to the appropriate coordinating agency via File Transfer Protocol.

<sup>1</sup> When a MFP participant is readmitted (reinstitutionalized) into an inpatient facility for a period of 30 days or less, the participant remains enrolled in MFP. The reinstitutionalization must be reported with the admission and discharge dates. A reason must be provided for the reinstitutionalization.

<sup>2</sup> When a MFP participant is readmitted into an inpatient facility for a period of time greater than 30 days (31 days or more), the participant is considered suspended from MFP. During the suspension, MFP field personnel are required to continue monthly contact with the participant and report the participant's status. The suspended participant will be reactivated or re-enrolled prior to the completion of the MFP period of participation, back into MFP without re-establishing the 90-day institutional requirement.

<sup>3</sup> Upon discharge from the inpatient facility, the MFP participant resumes their period of participation for any remaining days up to the maximum of 365 days. No inpatient days are counted toward the total of the 365 days of MFP. MFP field personnel revise the ITP prior to discharge back into the community.

<sup>4</sup> When an MFP participant is suspended for 6 months or longer, the participant must be re-evaluated like a 'new' participant.

MFP\_Participant\_Status\_Change\_Form\_Revised\_031015 MFP14 CBAY13

**Appendix Z: MFP Notice of Right to Appeal a Decision**



**Money Follows the Person**  
**Notice of Right to Appeal a Decision**

To: \_\_\_\_\_

Date: \_\_\_\_\_

**If you disagree with a decision regarding your MFP transition services, you have a right to appeal the decision. You may request a fair hearing.**

**NOTICE OF YOUR RIGHT TO A HEARING**

To request a hearing, you must ask for one in writing. Your request for a hearing must be *received* by the Department of Community Health within 30 calendar days from the date of this letter. With your written request, you must include a copy of this Notice of Right to Appeal a Decision. Your written request should be sent to the following address:

Department of Community Health  
Legal Services Section  
2 Peachtree Street, NW, 40<sup>th</sup> Floor  
Atlanta, GA 30303-3159

If this action is sustained by a hearing decision, you may be held responsible for the repayment of continued services that were provided during the appeal.

The Office of State Administrative Hearings will notify you of the time, place, and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member speak for you. You may also ask a lawyer for help. You may be able to get legal help at no cost. If you want a lawyer to help, you may call one of these numbers:

**Georgia Legal Services Program**

800-498-9469 (statewide legal services, except for the counties served by Legal Aid)

**Georgia Advocacy Office**

800-537-2329 (statewide advocacy for persons with disabilities or mental illness)

**Atlanta Legal Aid**

404-377-0701 (DeKalb/Gwinnett Counties), 770-528-2565 (Cobb County)

404-524-5811 (Fulton County), 404-669-0233 (S. Fulton/Clayton County)

**State Ombudsman Office**

866-552-4464 (Nursing Homes or Personal Care Homes)

\_\_\_\_\_  
MFP Field Personnel Signature

\_\_\_\_\_  
MFP Field Personnel (Print Name)

\_\_\_\_\_  
Telephone Number