

Money Follows the Person



Operational Protocol

Grant # 1LICMS030163

Georgia Department of Community Health
Atlanta, Georgia

Revised June 2012
Version 1.4

Table of Content

Money Follows the Person-Operational Protocol
 Georgia Department of Community Health
 Grant # 1LICMS030163

PROJECT INTRODUCTION..... 7
 Goals and Objectives of Georgia’s MFP Demonstration..... 11

A.2 BENCHMARKS 16
 Table A.2.1 MFP Transitions by Target Group 16
 Table A.2.2 Total Georgia Medicaid HCBS Spending 17
 Table A.2.3 MFP Transition Tracking System 18
 Table A.2.4 Long-Term Support Services- Rebalance Spending Process 19
 Table A.2.5 Baseline Count of Housing 20

B.1 Participant Recruitment and Enrollment..... 22
 MFP Demonstration ‘Eligible Individual’ Defined..... 22
 Georgia’s Plan for Providing MDSQ Option Counselors and MFP Transition
 Coordinators, DD Planning List Administrators and Case Expeditors 23
 To Recruit Older Adults and Persons with Physical Disabilities and TBI..... 23
 To Recruit Persons with Developmental Disabilities (DD) 23
 Procedures for Recruiting, Screening and Enrolling Potential Participants 24
 Procedures for Denial or Termination of MFP Participants..... 25
 Procedures for Transition Planning with Participants..... 25
 Procedures for Transitions with MFP Transition Services only..... 26
 Waiting Lists for MFP Services..... 26
 MFP Re-enrollment Process..... 27
 MFP Re-enrollment Process for Former MFP Participants 27
 Money Follows the Person Recruiting Text..... 28

B.2 Informed Consent, Guardianship, Grievance/Complaint and Critical Incident
 Reporting Systems 30
 How Guardians are Appointed in Georgia 30
 Informed Consent and Involving Guardians in MFP Transitions 31
 Informed Consent for Older Adults and Persons with Physical Disabilities/TBI. 32
 Informed Consent for Persons with Developmental Disabilities 33
 Grievance and Complaint Processes for Older Adults and Persons with Physical
 Disabilities/TBI 33
 Grievance and Complaint Processes for Persons with DD 35
 Critical Incident Reporting Systems 37
 Critical Incident Reporting Systems for All Populations 38

B.3 Outreach, Marketing, Education and Training 40
 Outreach, Marketing, and Education Efforts 40
 The Expanded Role of Long-term Care Ombudsmen (LTCO) 41
 MFP Targeted Outreach and Marketing 43
 Outreach to Older Adults 44

Outreach to Persons with Physical Disabilities/TBI 44

Outreach to Persons with Developmental Disabilities..... 44

MFP Outreach and Recruiting using HCBS Booklets 44

MFP Informational Recruiting Brochure..... 45

Effective Use of the MFP Website: dch/georgia.gov/mfp 46

DCH/MFP Competency-Based Training (CBT) Plan..... 47

Additional Education and Training that includes MFP 48

B.4 Stakeholder Involvement..... 49

MFP Working Groups and Initial Design of the MFP Demonstration 49

Stakeholder Forums and the Development of the Operational Protocol 50

Targeted Outreach and Recruiting 50

 Table B.4.1 Customer/Consumer Forum Involvement/Demographics 51

 Table B.4.2 Steering Committee Stakeholder Forum Demographics 52

 Table B.4.3 Current MFP Steering Committee Members by Category/Group. 53

Stakeholder Forums used to Develop the Operational Protocol 53

Systematic Data Collection 53

Analysis, Reporting and Development of the Operational Protocol..... 53

Ongoing and Future Stakeholder Involvement..... 54

B.5 Benefits and Services..... 55

MFP Service Delivery to Older Adults and Participants with Physical Disability/TBI 55

Delivery of MFP Services to Participants with Developmental Disabilities..... 56

Delivery of Qualified HCBS Waiver Services to MFP Participants..... 56

Person-Centered Planning and Individualized Transition Plans under MFP 57

The Expanded Role of Long-Term Care Ombudsman (LTCO) 58

Current MFP Demonstration and Supplemental Services 58

Peer Community Support (PES) 58

Trial Visits-Personal Support Services (PSS)..... 59

Household Furnishings (HHF) 60

Household Goods and Supplies (HGS) 60

Moving Expenses (MVE) 61

Utility Deposits (UTD) 62

Security Deposits (SCD) 62

Transition Support (TSS) 62

Transportation (TRN) 63

Life Skills Coaching (LSC) 64

Skilled Out-of-Home Respite (SOR) 65

Caregiver Outreach & Education (COE)..... 65

Community Ombudsman (COB)..... 66

Equipment,, Vision, Dental, and Hearing Services (EQS) 66

Specialized Medical Supplies (SMS)..... 68

Vehicle Adaptations (VAD) 69

Environmental Modifications (EMD)..... 69

Home Inspections (HIS) 70

Supported Employment Evaluation (SEE) 71

Qualified HCBS Services Offered to MFP Older Adult Participants 71

Qualified HCBS Services Offered to MFP Participants with Physical
Disabilities/TBI 73

Qualified HCBS Services Offered to MFP Participants with Developmental
Disabilities 74

State Plan and Other Local Services Offered to MFP Participants 76

 Table B.5.1 Qualified HCBS Waiver Services Available to MFP Participants by
 Waiver 77

B.6. Consumer Supports 78

 Description of Two Interagency Agreements 78

 Qualifications Necessary for the Delivery of MFP Demonstration and
 Supplemental Services under Interagency Agreements 79

 Collaboration between MFP Personnel and Waiver Case Managers, Care
 Coordinators and/or Support Coordinators 80

 24/7 Emergency Backup..... 81

 24/7 Emergency Backup for Older Adults and Persons with Physical Disabilities
 and/or TBI 81

 24/7 Emergency Backup Persons with Developmental Disabilities 82

B.7 Self-Direction or Participant Direction..... 83

 Self-Direction for Older Adults and Persons with Physical Disabilities/TBI 83

 Self-Direction for Persons with Developmental Disabilities 84

 Procedures for Voluntary and Involuntary Switches from Self-Direction 84

 Education on Self-Direction..... 85

 Financial Management Agencies under Contract with the State..... 86

 Opportunities for Quality Improvements to Self-Direction 86

B.8 Quality Management System..... 88

 1. Level of Care (LOC) Determinations 89

 2. Service Plan Description and Service Delivery..... 91

 3. Identification of Qualified Providers 93

 4. Participant Health and Welfare 96

 5. Waiver Administrative Oversight and Evaluation of QMS 99

 6. Financial Oversight of the Waivers 100

 7. Emergency Backup Systems 102

 Emergency Backup Plan for MFP Services 105

 MFP Contracted Services 105

 MFP Fee-For-Services..... 106

 Quality Improvements to the Critical Incident Reporting Systems 106

 QMS and the Development of Qualified Personal Support Services Staff 106

B.9 Housing..... 108

 Qualified Residences 108

 Qualified Residences/Providers..... 108

 Increasing Access to Affordable, Accessible and Integrated Housing..... 111

 Collaboration with the State Housing Finance Authority 112

 The MFP Housing Manager 112

Long-range Initiatives 113

Near-term Initiatives 114

Near-Term Strategies and Activities 114

 Implement and Expand Section 811 Project Rental Assistance (PRA) Funding 114

 Expand Low Income Housing Tax Credit/HOME Rental Housing Loan Programs..... 114

 Expand the Housing Choice Voucher (HVC) Programs 115

 Create PHA Partnerships 115

 Create Bridge Rental Subsidy Programs..... 115

 Increase Housing Education and Access to Housing Search Tools 116

 Expand the Home Access (HA) (Environmental Modification) Program 116

 Promote Home Ownership for MFP Participants using Vouchers 116

B.10 Continuity of Care Post-Demonstration 117

 Services That Continue Beyond the Demonstration 118

C.1 Organizational Structure..... 119

 Roles and Responsibilities under Interagency Agreements 119

 Table C.1.1 Georgia’s MFP Demonstration Organizational Chart 121

C.2 Staffing Plan 122

 Contractor Roles and Responsibilities 125

C.3 Billing and Reimbursement Procedures 127

D. Independent Evaluator – Not Applicable 128

E. Final Project Budget – Submitted under Separate Cover 128

Revised Appendices..... 129

 Appendix A1: MFP Steering Committee Members by Organization 129

 Appendix A2: Checklist for Transition to the Community 132

 Appendix A3: Checklist for Transition to the Community - DD..... 136

 Appendix AA: Referral for Housing Choice Voucher Program 141

 Appendix AB: MFP Sentinel Event Report Form 142

 Appendix AC: MFP Denial/Termination Letter 144

 Appendix AD: MFP Enrollment End Letter 146

 Appendix AE: MFP Right To Appeal Letter 147

 Appendix AF: MFP Participant Complaint Form 148

 Appendix B: MFP Transition Services Table 149

 Appendix C: MFP Brochure 151

 Appendix D1 MFP Authorization for Use of Information..... 153

 Appendix D2: MFP Informed Consent..... 155

 Appendix E: Home and Community Services Booklet (excerpts) 156

 Appendix F: AAA Gateway Network and Affiliated Agency..... 163

 Appendix G: MFP Screening Form..... 169

 Appendix H: MFP Participant Transition Planning Guide (pages 1-11) 176

 Appendix J: MFP Project Director Resume..... 182

 Appendix M: Self-Direction in HCBS Waivers-Crosswalk 185

Appendix N: CMS 1500 Claim Form 198
Appendix O: Example Invoice from FI to DCH..... 199
Appendix P: MFP Household Goods and Supplies Worksheet 200
Appendix Q1: MFP Individualized Transition Plan (ITP)..... 202
Appendix Q2: MFP Guidelines for Completing the ITP..... 216
Appendix R: MFP Discharge Day Checklist 221
Appendix S: MFP Authorization for Services..... 222
Appendix T: Quote Form for EQS, EMD and/or VAD 223
Appendix U: MFP Vendor Payment Request 224
Appendix V: MFP Vendor Import File..... 225
Appendix W: Monthly Report of Persons Served 226
Appendix X: MFP Request for Additional MFP Services..... 227
Appendix Y: MFP Enrollment Status Change..... 228
Appendix Z: MFP Referral Form..... 229

PROJECT INTRODUCTION

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

Georgia has long demonstrated a commitment to providing care systems that enable its citizens to receive compassionate care in settings that are appropriate to individual needs and independence, steadily increasing its funding for home and community based services (HCBS). While 27% of the state's long-term care budget was expended on HCBS in SFY 2005, by SFY 2011 that share had risen to 45% (see Table A.2.2 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 2016. Through MFP, Georgia has achieved 2 - 3% growth in annual spending on Home and Community-Based Services (HCBS).

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.

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. Georgia MFP currently operates through two interagency agreements – an agreement with DBHDD-DD to transition individuals with developmental disabilities from Intermediate Care Facilities (ICFs), and beginning in July 2011 an agreement with DHS/DAS to transition older adults and people with physical disabilities from nursing facilities.

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 into Georgia HCBS waivers.

Under the agreement with DBHDD-DD, 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-DD is responsible for:

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

Working from ICFs, 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 DHS/DAS, options counselors and transition coordinators working from the 12 Regional Aging and Disability Resource Connections (ADRCs) facilitate transitions from nursing facilities. ADRCs are designated by DCH as the Local 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. 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 Transition Coordinators. .

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

- Hiring MFP Field Personnel, i.e. MDSQ Options Counselors (OCs) and MFP Transition Coordinators (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 and supplemental 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, Options Counselors perform the following functions:

- Screen interested, 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 an Enhanced Services Program database, with 24,000 listings, to search state-wide for 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.

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

- 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, 100 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 an additional 100 slots per year for MFP participants with 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-DD, the State has a yearly appropriation for an additional 150 waiver slots in COMP 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 Federal dollars for provision of direct services to participants/members.

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

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

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

Goals and Objectives of Georgia's MFP Demonstration

Georgia's MFP Demonstration addresses the long-term services and support needs of three specific populations: older adults, persons with developmental disabilities, persons with physical disabilities and/or traumatic brain injury (TBI)-(see *Section A.2 Benchmarks* for more detail). The Operational Protocol illustrates Georgia's

commitment to rebalancing long-term support services (LTSS), to person-centered planning, self-direction, quality assurance and continuous quality improvement, and to transparency and openness in program development, implementation and evaluation.

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

- The Elderly and Disabled Waiver Program, 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 care services.

In an effort to provide additional alternatives to institutional stays, Georgia's MFP project will use the state's home and community-based Medicaid waivers and MFP demonstration and supplemental services to transition Medicaid eligible, qualified individuals residing in an institutional setting for a minimum of 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. The state is not seeking enhanced match for State Plan services provided to MFP participants.

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

- Transition 2,142 individuals to community settings,
- By CY2016, achieve 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 the building HCBS infrastructure and transition services, to assist individuals to transition into a community setting.

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

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

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

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

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

MFP funds transition services (see *Appendix B: MFP Transition Services Table*) to help people 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 Options Counselors, Transition Coordinators, LTC/Community Ombudsman, CIL Transition Counselors and Peer Supporters receive training together. Applying a team approach to training improves coordination between systems.

MFP developed a collaborative referral network by building on the Aging and Disability Resource Connections (ADRC) 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 has resulted in a transparent, easily accessible and open system for obtaining information and referral to MFP, long-term care information and

resources, knowledge of where to go for assistance and how to obtain basic information. These processes have strengthened the coordinating systems for planning and service delivery and unify referral processes across all waivers.

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

Planning for MFP takes into account available resources and the responsibility to provide 'choice' to Medicaid beneficiaries eligible for long-term support services. For the state to facilitate the movement of individuals from institutional settings to community-based settings, requests for appropriations for waiver 'slots' will be made for each budget period. 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 CCSP, ICWP, NOW, and COMP waiver programs, the state assures that transitioning participants enter these waivers immediately upon discharge from the institution.

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.

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.

Because MFP participants enter an appropriate HCBS waiver on the day of discharge from the nursing facility or institution, they have been 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, the Department of Community Health (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, 7) risk management processes, 24/7 emergency backup and critical incident reporting systems.

Additionally, MFP Field Personnel/Facilitators (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 day 365 after leaving the institution. See Appendix AB: *MFP Sentinel Event Form* and Appendix AF: *MFP Participant Complaint Form* for the reporting tools. All MFP Field Personnel/Facilitators 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/Facilitator, Ombudsman or DCH/MFP staff member. *Sentinel Event Forms and Participant Complaint Forms* are reviewed by DCH/MFP staff and reported to CMS. The MFP Evaluation Advisory Team is charged with analysis of critical incidents and complaints and recommending changes that will reduce critical incidents and complaints. LTCO services to MFP participants include resolution of concerns and complaints. LTCOs make aggregated data about LTCO activities available to DCH/MFP for the purpose of developing and implementing quality improvement plans.

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:

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

This population benchmark target for the MFP project will allow DCH to transition 2,142 participants from institution care to community-based settings. Focus will be placed on three specific populations:

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

Table A.2.1 MFP Transitions by Target Group

Calendar Year	Older Adults	Developmental Disabilities	Physical Disability/TBI	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
Projected 2012	50	150	75	275
Projected 2013	50	150	75	275
Projected 2014	50	150	75	275
Projected 2015	50	150	75	275
Projected 2016	50	150	75	275
Totals	421	1136	585	2142

2. Georgia has increased 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 nursing homes and Intermediate Care Facilities (ICFs).

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 CY2012 – CY2016
- 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

	HCBS Expenditures	Transition Expenditures (MFP)	Total HCBS Expenditures	% Increase in HCBS
Actual 2010	\$801,738,252	\$6,115,062	\$807,853,314	
Actual 2011	\$820,388,057	\$16,189,468	\$836,577,525	3%
Projected 2012	\$954,317,756	\$22,428,008	\$976,745,764	14%
projected 2013	\$973,404,111	\$27,203,634	\$1,000,607,745	2%
Projected 2014	\$992,872,194	\$28,170,167	\$1,021,042,361	2%
Projected 2015	\$1,012,729,638	\$29,172,464	\$1,041,902,102	2%
Projected 2016	\$1,039,566,973	\$30,211,904	\$1,069,778,877	3%

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.

For the purpose of this benchmark, a successful transition is considered to be (1) a Medicaid eligible older adult or person with a disability, (2) who may or may not be eligible for HCBS waiver services, (3) who transitions to a qualified community-

based residence and (4) who resettles in the community for a minimum of 365 days, 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 can be tracked:

- Number of completed transition screenings
- Number of completed Individualized Transition Plans (ITPs/ISPs)
- Number of MFP participants discharged from institutions, entering waivers
- Number of completed transitions (365 days in the community)

A MFP tracking system is under development to track successful transitions. Key stakeholders from DCH, DHS/DAS, 12 regional Aging and Disability Resource Connections, DBHDD and key internal and external stakeholders are participating in the development. The 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 MDSQ Options Counselors, Transition Coordinators, Long-Term Care Ombudsman and unique transition services. Under the transition program in place prior to MFP, the state had contracted with a private vendor to screen likely candidates for transitioning from nursing facilities. Currently, potential candidates are identified through the use of the Minimum Data Set, Section Q (MDSQ). The screening process includes an interview to explain the transition process and provide information on home and community based 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. The numbers are projected 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 DD)	4	126	97%	367	66%	327	-12%
Completed ITPs/ISPs	22	204	89%	298	32%	299	0%
Transitioned/Discharge to HCBS Waiver	22	198	89%	249	20%	286	13%
Completed 365 days of MFP	0	22	100%	184	88%	237	22%
Performance Indicators (2012 – 2016)	Projected CY 2012	Projected CY2013	Projected CY2014		Projected CY2015	Projected CY2016	% Increase
Completed Transition Screenings (not DD)	327	392	471		565	678	20%
Completed ITPs/ISPs	278	320	368		423	486	15%
Transitioned/Discharge to HCBS waiver	275	303	333		366	403	10%
Completed 365 days of MFP	275	301	316		332	349	5%

The MFP Transition Tracking System allows the state to track, analyze, and report on the performance of the system. For example, the tracking system is used to measure how much of each output is needed to produce one successful transition. In other words, once data is collected for each output indicator for a calendar year and the number of successfully resettled participants is known for that calendar year, analysis of output indicators will reveal how many of each were needed to produce one successful outcome measure- a transition of at least 365 days. System outputs can be adjusted to produce desired outcomes. Transition Tracking System data continues to be collected, analyzed, trended and reported to the MFP Evaluation Advisory Team.

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

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

As indicated in the table below:

- DCH anticipates an overall expenditure increase in LTC 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 Support Services- Rebalance Spending Process

	HCBS Expenditures with 440	Transition Expenditures (MFP)	Institutional Costs (COS 110 and 160)	Rebalancing %
Actual 2010	\$801,738,252	\$6,115,062	\$1,030,426,149	44%
Actual 2011	\$820,388,057	\$16,189,468	\$1,015,048,007	45%
Projected 2012	\$954,317,756	\$22,428,008	\$1,030,273,727	49%
Projected 2013	\$973,404,111	\$27,203,634	\$1,045,727,833	49%
Projected 2014	\$992,872,194	\$28,170,167	\$1,056,185,111	49%
Projected 2015	\$1,012,729,638	\$29,172,464	\$1,061,466,037	50%
Projected 2016	\$1,039,566,973	\$30,211,904	\$1,066,773,367	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 partner 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 Medicaid members and MFP populations (older adult and people with disabilities). The lack of housing options has the potential to curtail MFP resettlement efforts, but strategies are being used to address barriers.

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 system that links institutional (ICF, nursing facility, etc.) residents with MFP and HCBS waiver services in need of housing to housing agencies with available housing resources. Relationships developed with local public housing authorities, local housing developers, professional management companies and other housing agencies will be developed 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:

- Number and location of MFP participants returning to live with family members (discharge day list)
- Number and location of MFP participants returning to home owned by participant
- Numbers selecting this option as 1st Choice during the planning phase

Table A.2.5 Baseline Count of Housing

Housing Choice	DAS Regions	Preferred Housing Count		Grand Total
		01 - Own Home	02 - Fam home	
Calendar Year				
CY2008	Central Savannah River		1	1
CY2008 Total			1	1
CY2009	Atlanta	3	17	20
	Central Savannah River	3	6	9
	Middle GA		1	1
	NE GA	1	1	2
	NW GA		2	2
	Three Rivers		1	1
	(blank)	1		1
CY2009 Total		8	28	36
CY2010	Atlanta	7	23	30
	Central Savannah River		6	6

	Coastal GA	1	2	3
	GA Mountains	2	4	6
	Middle GA	1	3	4
	SW GA	1	4	5
	Three Rivers		1	1
	(blank)		1	1
CY2010 Total		12	44	56
CY2011	Atlanta	5	16	21
	Central Savannah River	4	10	14
	Coastal GA	3	3	6
	GA Mountains	1	3	4
	Middle GA	1	2	3
	NE GA	1		1
	River Valley	1	2	3
	Southern GA	5		5
	Three Rivers	1	3	4
	(blank)	2	2	4
CY2011 Total		24	41	65
CY2012	Atlanta	1	3	4
	Central Savannah River	1	5	6
	Coastal GA	1	2	3
	GA Mountains	1	2	3
	Heart of GA	1	1	2
	Middle GA	1	1	2
	NE GA	1	1	2
	NW GA	2		2
	River Valley	1		1
	Southern GA	1		1
	SW GA	1	2	3
	Three Rivers		1	1
	(blank)	2	3	5
CY2012 Total		14	21	35
Grand Total		58	135	193

During CY2012, baseline data will be collected and trended and projections will be made for grant years 2013 – 2016. Results will be reported at Quarterly MFP Steering Committee meetings.

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. The MFP recruiting brochure is included (see *Appendix C1: MFP Tri-Fold Recruiting Brochure and Appendix Z: MFP Referral Form*). The brochure text contains specific information about MFP and is distributed as described later in this section.

MFP Demonstration ‘Eligible Individual’ Defined

- 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; 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 options 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 resides in a qualified residence beginning on the initial date of participation in the demonstration project
- 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).

Georgia's Plan for Providing MDSQ Option Counselors and MFP Transition Coordinators, DD Planning List Administrators and Case Expeditors

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 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). MDSQ OCs and MFP TCs recruit elderly, blind and physically disabled individuals or all ages for the Elderly and Disabled Waiver Program throughout the state of Georgia. MDSQ OCs and MFP TCs recruit individuals between the ages of 21 and 64 with physical disabilities and/or TBI for the Independent Care Waiver Program (ICWP). OCs and TCs recruit participants with developmental disabilities residing in nursing facilities for the waiver that is most appropriate and that meets their needs.

MFP has served participants with developmental disabilities since the beginning of the demonstration (see *Section A: Introduction/Goals* for more details) under an interagency agreement with the Department of Behavioral Health and Developmental Disabilities/Division of Developmental Disabilities (DBHDD-DD). Planning List Administrators and Case Expeditors recruit individuals located in ICFs throughout the state for the New Options Waiver and Comprehensive Waiver Programs (NOW and COMP).

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), Options Counselors (OCs) receive MDS Section Q referrals from Medicaid nursing facilities state-wide. OCs follow-up on MDSQ referrals and OCs and TCs follow-up on referrals from points-of-entry, with 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.

As State Long-Term Care Ombudsman work 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. MFP staff members take referrals over the phone. Division of Aging Services (DAS) staff take referrals from all points-of-entry into the long-term support services system.

To Recruit Persons with Developmental Disabilities (DD)

DBHDD-DD/MFP State staff coordinate recruitment with Planning List Administrators (PLAs) and Case Expeditors (CEs) in ICFs and State Operated

Hospitals to screen residents 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. DBHDD collaborates with DHS/DAS, OCs and TCs to identify and recruit participants with developmental disabilities currently residing in nursing facilities, who meet eligibility criteria. DBHDD-DD/MFP State Staff assist and oversee elements of the transition process.

Procedures for Recruiting, Screening and Enrolling Potential Participants

MDSQ OCs, CEs and PLAs have experience in screening and referring to specialized services and supports for a specific target population and have excellent professional communication skills. Under the two Interagency Agreements, MDSQ OCs, CEs and PLAs use (but will not be limited to) the following strategies to recruit:

- obtain referrals from point-of-entry systems,
- obtain referrals from nursing facilities through MDS Section Q,
- obtain DD referrals from the "Olmstead List"
- obtain referrals from participants, family members, caregivers, or guardians,
- make initial contact with participants,
- observe candidates in the institutional setting for needs, strengths, limitations and document service needs,
- while candidate is in the facility, 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*),
- while candidate is in the facility, 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: Authorization for Use or Disclosure of Health Information and Appendix D2: MFP Consent for Participation*),
- 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 D1*),
- while participant is in the facility, 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,
- while in the nursing facility during the screening and enrollment process, the FACE sheet is obtained and reviewed to establish the original admission date

to the nursing facility. Medicaid status is reviewed using the Georgia Medicaid Management Information System (GAMMIS) "Member" information.

- In ICFs, the screening and enrollment process is completed by PLAs and CEs
- In nursing facilities, once screening is completed and the participant has been assisted with the waiver application, the MFP facilitator (OC or TC) begins the transition planning process..

Procedures for Denial or Termination of MFP Participants

If a participant signs informed consent (see *Appendix D2: MFP Informed Consent*), is screened and is found to be ineligible for the MFP Demonstration, MFP facilitators 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 waiver applications are completed, a transition planning team is convened and planning for transition begins. Under the two Interagency Agreements, MFP field personnel (i.e. OCs, TCs, PLAs and CEs) use (but will not be limited to) the following strategies to develop Individualized Transition Plans – ITPs for MFP older adults and participants with physical disabilities/TBI and Person Centered Descriptions (PCDs) for MFP participants with developmental disabilities:

- ensure person-centered planning is conducted consistent with best practices
- assist the MFP participant to convene a transition team that includes (but is not limited to) the following; participant, circle-of-friends/circle-of-support, family members, social worker/discharge planner and MFP TC
- ensure that the results of person-centered planning are written in the *Individualized Transition Plan (ITP)* (see *Appendix Q1: Individualized Transition Plan and Appendix Q2: MFP Guidelines for Completing the ITP*) or the Person-centered Description (PCD) and that all members of the transition team are aware of and complete their assigned duties.
- Work with transition team to match participant needs to MFP transition services available (see *Appendix B: MFP Services Table*)
- Work with transition team to match participant needs to HCBS waiver services and community resources, ensuring effective use of each type of service
- educate and inform MFP participants about self-direction options under the waiver programs
- educate and inform MFP participants about peer community supporters 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 waiver's Transition Team and case manager to ensure the waiver assessment and service plans are completed
- assist participants in securing personal identification documents
- assist participants in locating a qualified residence,
- assist participants to identify and use local transportation options.

Using a transition team approach, TCs meet with participants, families/friends, discharge planners (Social Workers and Administrators), waiver case managers (when available), and peer supporters to create and implement transition plans agreed upon by participants/guardians. Transition plans are developed using person-centered planning and circles-of-support. Resources for transition are identified including assistance with SSDI/SSI. Transition plans 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, MFP participants enter a HCBS waiver upon discharge from the nursing facility/ICF. In some cases, MFP participants choose to transition without waiver services. Transitioning without waiver services is not recommended. The informed consent (see *Appendix D2: Informed Consent for Participation*) requires participation with all aspect of MFP, including MFP Screenings, HCBS waiver applications and waiver assessments are required to be completed prior to transitioning to the community/discharging from the facility. In addition, there are MFP participants who desire to transition to the community using MFP transition services, but who do not meet HCBS waiver eligibility criteria for any waiver. Notwithstanding these policies, participants are free to choose to transition to the community using MFP transition 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 365 days of MFP under this Medicaid aid category. MFP facilitators are required to inform MFP participants that the consequences for transitioning without HCBS waiver services include being placed on a HCBS waiver waiting list should the participant desire to entry into a waiver after discharge to the community.

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.

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 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 365 days, 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.

MFP Re-enrollment Process for Former MFP Participants

Georgia will re-enroll former MFP participants who have been re-institutionalized after completing their initial 365 days 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 post-MFP waiver Plan of Care/Services Plan. The Plan of Care/Services Plan will be reviewed by the MFP facilitator (OC or TC) and the waiver case manager/care coordinator before re-enrolling the participant into the MFP demonstration.

The following protocol will be included in the policy for re-evaluating the former MFP participant's Individualized Transition Plan (ITP) and waiver Plan of Care/Services Plan:

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

- Document how the ITP and Plan of Care/Services Plan was not supported by the delivery of quality services.

The former MFP participant may be re-enrolled for another 365 days of MFP, once the reasons for re-institutionalization have been determined using the protocol above, and changes are made to the MFP ITP and waiver Plan of Care/Services Plan that consider the possible causes for the reinstitutionalization. Georgia will track, trend and report an annual summary of the numbers of re-enrollments for a second 365-day MFP period and the causes of re-institutionalization.

Money Follows the Person Recruiting Text

Georgia Money Follows the Person helps people living in nursing homes and Intermediate Care Facilities (ICFs) for people with developmental disabilities to transition and resettle into qualified residences in the community. If you have lived in a nursing home or ICF for at least 90 consecutive days, you may be eligible for the MFP demonstration and home and community-based services (HCBS) through Georgia's Medicaid programs.

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

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

MFP participants 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
- Community Ombudsman Visits
- Equipment, Vision, Dental and Hearing Services
- Specialized Medical Supplies

- Vehicle Adaptations
- Environmental Modifications for Accessibility
- Home Inspections
- Supported Employment Evaluation

Persons eligible for MFP will not be referred to a waiver program waiting list. 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. Transitioned individuals enter an appropriate waiver program and receive waiver services as long as they meet the institutional level of care criteria for these services.

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

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

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

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

How Guardians are Appointed in Georgia

A candidate/facility resident is assumed to be competent and able to consent to participation in the MFP Demonstration, unless the candidate/facility resident has been deemed incapacitated by a court and a legal guardian has been appointed. If the candidate/facility resident 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 (see *Appendix D2*) and move forward with screening and transition planning using person-centered approaches.

In cases where the participant 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 D2*). The MFP facilitator informs the guardian of MFP transition services and planning processes and includes 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 transition personnel (MDSQ OCs, MFP TCs, DD PLAs, DD CEs) before signing the *Authorization for Release of Information and Informed Consent Form* (see *Appendix D1 and D2*); opportunities to discuss waiver options and MFP field personnel/facilitators (i.e. MDSQ OCs, MFP TCs, DD PLAs and/or CEs) 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*, institutionalized persons, family members, caregivers, friends and/or guardians will be provided with easy to use, understandable information, or information in alternative formats, about MFP and core waiver services, eligibility criteria, how to apply and what to expect (see *Appendix C: MFP Brochure* and *Appendix E: Home and Community-Based Services: A Guide to Medicaid Waiver Programs in Georgia*; and *Appendix H: MFP Transition Planning Guide*). Information about MFP is provided along with core waiver services through statewide Point-of-Entry partners including: AAA/Gateway networks, Aging and Disability Resource Centers (ADRCs), Centers for Independent Living (CILs), provider networks, and regional DBHDD service councils and providers. Potential MFP candidates have opportunities to receive and discuss information with MFP Field Personnel/Facilitators (i.e. MDSQ OCs, MFP TCs, DD PLAs and/or CEs) during face-to-face meetings and follow-up discussions. Once institutionalized persons have received information about MFP and have indicated interest in MFP/transitioning, consent and release of information are obtained from the MFP candidate 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 plans (see *Appendix Q1 and Q2*), 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 chose to transition to community living. One strategy used by transition personnel (MDSQ OCs, MFP TCs, DD PLAs, DD CEs) 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 often been enough to move the transition process forward. If not, a Long-Term Care Ombudsman (LTCO) is called in to assist at the request of the participant. For example, if a person in a

nursing facility or ICF 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, 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 resettlement to the community, MFP TCs and LTCO 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/PCD and waiver Plan of Care/Service Plan. When resettled 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 TCs 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.

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 waiver services along with information on their rights and responsibilities, MFP candidates are consented using a standardized *Authorization for Use or Disclosure of Health Information and MFP Consent for Participation* (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 written service plan. The Freedom of Choice forms, signed during initial face-to-face assessments, are maintained for a minimum of three years by the case management agency.

Informed Consent for Persons with Developmental Disabilities

For individuals residing in ICFs, 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/waiver service plan. At these planning meetings, MFP candidates from the Olmstead Planning List are consented using a standardized *Authorization for Use or Disclosure of Health Information and MFP Consent for Participation* (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 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.

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

During initial face-to-face screenings with the MDSQ OC or the MFP TC, MFP participants will be informed about grievance and complaint procedures related to MFP services. MFP participants contact their MDSQ OC, MFP TC, LTCO, DHS/DAS/MFP staff or the DCH/MFP office staff to report a complaint regarding MFP. The *MFP Participant Complaint Form* (see *Appendix AF*) is used to report a complaint. The 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. 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. The Project Director follows-up with MFP TCs, 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, MFP TCs provide 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 AE: Notice of Right to Appeal a Decision*).

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 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 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) are provided to participants along with procedures for reporting complaints.

Complaints or grievances are initially addressed by the case manager. Allegations of abuse, neglect and exploitation must be reported to either the DCH Healthcare Facility Regulation Division or Adult Protective Services (APS) if the participant resides in a non-institutional setting, as required by law. In an effort to ensure that participants and/or caregivers receive consistent and objective treatment when grievances are reported, case managers immediately intervene to work with the participants and 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 in order to address all relevant details associated with the complaint. If the problem cannot be resolved, a grievance committee is convened to address the concerns and a solution is recommended within seven days.

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

Waiver program managers will forward these monthly reports to the MFP Project Director when these reports involve MFP participants.

When applicable, complaints/grievances are referred to the Office of State Long-Term Care Ombudsman as well as the DCH Healthcare Facility Regulation Division, the agency which gives the license/permit to operate. Waiver participants and caregivers are informed by case management that the filing of complaints is not a prerequisite or substitute for a Fair Hearing. If the grievance process is unable to resolve the differences, the participant/caregiver is provided with information on initiating a request for fair hearing with the state agency.

Grievance and Complaint Processes for Persons with DD

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

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

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

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

Improvement Committee's records, and a copy is sent to the complainant. In all investigated complaints, the staff employs the investigatory method deemed most suitable to determine the facts.

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

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

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

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

Within ten working days of the filing of the request for review, the Director or his/her designee issues a disposition of the appeal. This decision of the Director or his designee is based upon a review of the request for review and the documents forwarded by the Regional Coordinator; no evidentiary hearing is conducted by the Director or his designee. In the decision, the Director or his/her designee may affirm, reverse, or modify the Regional Coordinator's rejection or other decision, or s/he may return the case to the Regional Coordinator. If the Director or his designee returns the case to the Regional Coordinator, the Director or his/her designee specifies the matters to be addressed in the further proceedings and the

period within which those proceedings shall be concluded. In no event is the period for completing the further proceedings, including the reviewer's submission of an additional report, the Regional Coordinator's issuance of another rejection or other decision, and the Director's or his/her designee's issuance of a decision, more than 14 working days. The original of the Director's or his/her designee's decision is filed in the Director's records, and copies are sent to the Regional Coordinator and to the complainant. The decision of the Director is final. However, this process is not a prerequisite or substitute for a Fair Hearing.

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

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

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

Critical Incident Reporting Systems

Georgia's MFP critical incident reporting systems serves participants through the existing HCBS waivers, including the Elderly and Disabled Waiver Program, the Independent Care Waiver Program (ICWP) and the NOW and COMP Waiver

Programs. This section describes how critical incidents are reported and investigated and the processes for receiving and reviewing critical incident reports, assuring follow up is implemented, and how incident reports are used for program improvements.

Critical incidents are defined in each 1915c waiver application and include factors that threaten or result in failure to maintain a safe and humane environment for consumers. Chief among those factors that are defined as critical incidents are allegations of abuse, neglect, exploitation, medication errors, deaths, allegations of criminal activity, unexpected absences from residential facilities, and injury to participants. Under state law, all health care providers and their staff/volunteers are mandated reporters of abuse, neglect, and/or exploitation. These incidents are reported to waiver program managers at the operating agency (DHS, DBHDD, or DCH). For incidents involving MFP participants, TCs and CEs complete an *MFP Sentinel Event report* and submit it to the DCH MFP Office (see *Appendix AB: MFP Sentinel Event Form*).

Critical Incident Reporting Systems for All Populations

Under the Elderly and Disabled Waiver Program, the Department of Human Services (DHS) and DCH share the responsibility for overseeing the reporting of and response to critical events. Under the DD waiver programs, 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
- Notification, as appropriate (including written notifications where required), of tofamily, 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 MDSQ OCs, MFP TCs and DD CEs using the *MFP Sentinel Event report*. The completed form is submitted to the DCH MFP office and reviewed by the MFP Project Director (see *Appendix AB: MFP Sentinel Event Form*). OCs, TCs and CEs are required to report on the following critical incidents experienced by MFP participants: abuse, neglect, exploitation, hospital/nursing facility/ICF admissions, ER visits, deaths, involvement with criminal justice system, and medication administration errors. 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. OCs, TCs and CEs are required to institute process improvement and evaluate the effectiveness of such processes in an effort to reduce risk to participants.

MFP Sentinel Events (SEs) are categorized according to critical incident type and maintained on a project SE log. Notes summarize and document the SE and the action plan in the log. All SEs are reviewed immediately by the MFP 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 related to the reduction of SEs.

B.3 Outreach, Marketing, Education and Training

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

Outreach, Marketing, and Education Efforts

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 3.0 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 with Georgia's 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 connect interested individuals with MFP, or if the information seeker doesn't meet MFP eligibility criteria, OCs refer to other LTSS 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 have access to a well-developed and constantly updated resource database that includes LTSS and other home and community-based resources. This extensive database places ADRC OCs and MFP TCs in an ideal position to provide comprehensive MFP and LTSS 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. 65% of Medicaid nursing homes have made MDS Section Q referrals. 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)

Residents who wish to relocate from a nursing home frequently tell their local long-term care ombudsman (LTCO). The resident may already have indicated this desire during the MDS 3.0 Section Q interview. When problems occur in the resident's plans to relocate, 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.

Though LTCOs have historically supported MFP policy and have participated in the demonstration project in three of the twelve LTCO regions in Georgia, LTCOs have not been formally utilized in the process across the state. With MDS 3.0 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.

Through Area Agencies on Aging (AAAs), the Georgia LTCO Program contracts with 13 local LTCO programs to provide services to residents in skilled nursing facilities across the state. LTCOs are trained and directed by the State Long-Term Care Ombudsman at the Department of Human Services, Division of Aging Services. 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 skilled nursing facilities. LTCOs are needed to:

- Provide options counseling and education about the MDS 3.0 Section implementation, MFP process,
- 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 nursing 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 3.0 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 skilled nursing facility to the community.

- LTCOs will support residents by providing counseling and education about the MFP process and other living options to residents, family, and facility staff as noted in the budget section of this narrative. As LTCO and the ADRC staff, acting as the LCA, gain more experience with MDS 3.0 section Q and requests to participate in MFP, LTCOs will likely be required to provide education and counseling as well as complaint resolution services to more residents.
- LTCOs will work to resolve complaints associated with MDS 3.0 Sec. Q implementation including referrals to the MFP program and the LCA. Collaboration between the LTCO program, the ADRCs as the LCA and the state Medicaid agency administering the grant will be important for the success of the demonstration.

The involvement of LTCOs in the MFP process will improve the overall effectiveness of the Georgia MFP demonstration grant. As Georgia strives to meet its goals of 2,222 MFP participants transitioned by 2016, LTCOs will be in a position to assist with educating 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, the LTCO will receive concerns from all parties and work with necessary entities on behalf of the resident to remove barriers and ensure the resident has access to available benefits and services. Regardless of the source of a complaint, the LTCO will take direction from the resident, thus ensuring an individualized relocation plan and improving the resident's chances of successful relocation.

As Section Q implementation 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 the LCA, improve accountability by nursing home staff, and provide all parties with an additional resource during relocation.

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, the state is focused on developing systematic outreach through all points-of-entry and Information & Referral networks.

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

MFP Targeted Outreach and Marketing

Targeted outreach will proceed through a proactive process of face-to-face communication, relationship building, presentations, informational forums, interagency meetings, training presentations, marketing and outreach materials (*Appendix C: MFP Tri-Fold Recruiting Brochure and Appendix E: Home and Community Services, A Guide to Medicaid Services in Georgia 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.

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

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

Outreach to Persons with Physical Disabilities/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 Persons with Developmental Disabilities

DD/MFP Planning List Administrators and Case Expeditors expand on the outreach, marketing, and education efforts of DBHDD, the state's DD Council, People First Georgia, the Association of Retarded Citizens, Community Service Boards, regional and local service provider networks.

MFP Outreach and Recruiting using HCBS Booklets

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 ICFs, 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
- 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-DD Regional Transition Staff recruit participants in targeted locations (nursing homes, ICFs, 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, DD Regional transition staff, peer support networks, 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 discharge planners' and social workers' offices, AAAs, ADRCs, CILs, SOURCE network offices, senior centers, county health departments, targeted community organizations, nursing facility staff and administrators, and hospital discharge planners. Inpatient facility partners 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: dch/georgia.gov/mfp

The creation of a link to the Georgia Money Follows the Person Demonstration project on the DCH website demonstrates to potential participants, their communities and families, that the project is state and federally sanctioned. Topics covered on the site are the same as topics covered in the MFP Informational Brochure to ensure consistency of information and to provide the ability to easily navigate and locate information about MFP and HCBS Waivers. Information about Demonstration activities are regularly updated. The site 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 wavier specialists, DHS/DAS, and DBHDD stakeholders, collaborated to develop competency-based training and delivered training sessions in 2008 - 2011. MDSO Options Counselors (OCs) and MFP Transition coordinators (TCs) received initial training in July 2011. In addition to core competency training for OCs and TCs, 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 MDSO
- Dignity of risk, independent living philosophy, CILs, and dependency,
- 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 (ITP),
- 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:

- 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,
- Assisting participants to locate and use local and regional transportation,
- Team approaches for working with waiver case managers, professionals and advocates working on resettlement,
- Authorizing MFP service expenditures, reporting and documentation,
- Procurement of specialized medical equipment and assistive technology,
- 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.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) provides on-going and systematic cross-waiver trainings through its regional offices. MFP state staff work with DBHDD staff to develop MFP training materials that can be delivered along with existing training. DBHDD offers specific training on transitioning within hospitals, designed to help professionals make appropriate referrals and provide pre-transition services. DBHDD 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 prior to implementation, 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 state decided 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 and supplemental services for 365 days post-discharge. Waiver services would continue to be provided after the MFP demonstration ended.

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 Commissioners from the Department of Mental Health, Developmental Disabilities and Addictive Disorders (MHDDAD), Department of Human Resources (DHR) and the Chief of Medicaid. 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 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

Currently, the QMS/Project Evaluation working group/advisory team meets during regularly scheduled quarterly meetings and includes former MFP participants, consumers and HCBS waiver participants, professional advocates, service providers, DCH, DHS/DAS and DBHDD-DD staffers. As recently as May – July 2011, the Training working group was reconvened to develop and revise Core and Specialized Competency-Based Training for MDSQ OCs and MFP TCs. Members of the Training working group include consumers, HCBS waiver participants, professional advocates, service providers, DCH, DHS/DAS and DBHDD-DD staffers. The Housing working group will be reconvened and will meet on a quarterly basis.

Stakeholder Forums and the Development of the Operational Protocol

To obtain broad stakeholder involvement in the design of the Operational Protocol, a series of stakeholder forums were convened. 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 MFP Operational Protocol. Eight stakeholder forums were convened in five different regions of the state. During these stakeholder forums, participants were asked to engage in various types of activities (i.e. idea generation and consensus building) and focused discussions. As is the case with participation/action research methods, several steps were 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.

Table B.4.1 Customer/Consumer Forum Involvement/Demographics

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

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

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
Category				
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 make up 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.

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 used to 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.

Analysis, Reporting and Development of the Operational Protocol

Facilitators worked together to analyze stakeholder input in a process referred to as content analysis. This involved sifting and sorting comments and preparing topical summaries. Summaries were revised based on reviews with stakeholders. Using the summary reports, system requirements were generated for the MFP Operational Protocol. These requirements can be found throughout the sections of the MFP OP. System requirements became the basis for designing the MFP OP. The MFP OP was

reviewed by steering committee members on April 8, 2008, at a forum in Macon, Georgia. The protocol was subsequently revised and represented the ideas and views of all stakeholders (customers/consumers/professionals/advocates) regarding the development and operation of the MFP demonstration.

The most recent revisions to the Operational Protocol are being sent to current MFP Steering Committee members for review and comment. The protocol will include revisions based on input from Steering Committee members in an effort to continue to improve project implementation and operation of the MFP demonstration.

Ongoing and Future Stakeholder Involvement

Ongoing stakeholder involvement continues using similar methods. The MFP Housing work group has undertaken several initiatives to increase access to affordable, accessible, and integrated housing. 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.

Steering committee sessions continue to be open to the general public in an effort to maintain transparency. In addition to work groups, the MFP steering committee and MFP Evaluation Advisory work group both meet on a quarterly basis, to review implementation and provide guidance on demonstration evaluation.

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

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

B.5 Benefits and Services

This section describes 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 supplemental and demonstration service.

As was discussed in Section *B.1 Participant Recruitment and Enrollment*, DCH has an Interagency Agreement in place with the Department of Human Services/Division of Aging Services (DHS/DAS) for option counseling and transition services. MDSQ OCs and MFP TCs recruit elderly, blind and physically disabled participants of all ages for the Elderly and Disabled Waiver Program and participants with physical disabilities and/or TBI between the ages of 21 and 64 for the Independent Care Waiver Program (ICWP). MDSQ OCs and MFP TCs recruit participants with developmental disabilities residing in nursing facilities for a waiver that is most appropriate and that meets their needs. The Interagency Agreement with DHS/DAS for MDSQ OCs, MFP TCs and Long-Term Care Ombudsman services is funded using 100% MFP grant funds (administrative).

Under an Interagency agreement with the Department of Behavioral Health and Developmental Disabilities/Division of Developmental Disabilities (BDHDD-DD), options counseling and transition coordination services are provided to ICF residents by Planning List Administrators (PLAs) and Case Expeditors (CEs). PLAs and CEs identify and recruit ICF residents for MFP and the New Options Waiver (NOW) or the Comprehensive Waiver Program (COMP). 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 services to MFP participants are authorized by MFP facilitators (MDSQ OCs, MFP TCs, PLAs, and/or CEs) and tracked by the FI and DCH. Interagency agreements require DHS/DAS and DBHDD to maintain documentation and a tracking mechanism that ensures accountability for utilization of MFP services.

MFP Service Delivery to Older Adults and Participants with Physical Disability/TBI

MFP demonstration and supplemental services are delivered using fee-for-service mechanisms, based on person-centered approaches. In brief, the fee-for-service process includes the following steps –

1. Participant is provided with information about MFP and HCBS (*Appendix C, E*)
2. Participant meets MFP eligibility criteria
3. Participant is screened and signs Consent and Release of Information (*Appendix G, D1, D2*)

4. Participant is assisted in convening transition team (circle-of-friends) and is assisted to complete an Elderly & Disabled or ICWP waiver application
5. Participant is assisted with completion of the MFP Individualized Transition Plan (*Appendix Q1, Q2*)
6. Participant selects MFP services for transition from menu of available MFP services (*Appendix B*)
7. Participant is assessed for and selects waiver and state plan services
8. MFP field personnel/facilitators (OC/TC) authorize MFP services (*Appendix S*)
9. Participant discharges from the institution and enters waiver (*Appendix R*)
10. Vendor(s) are identified and provide quotes (where required) (*Appendix T*)
11. Vendor delivers services and completes documents necessary for reimbursement through Fiscal Intermediary (FI) (*Appendix U*)
12. MFP field personnel authorize payment from FI to vendor (*Appendix V*)
13. DCH accounting uses MFP grant funds to reimburse FI (*Appendix O*)

Delivery of MFP Services to Participants with Developmental Disabilities

The process for the delivery of MFP services to participants with developmental disabilities is similar, but reimbursement procedures are handled through the Office of Developmental Disabilities within DBHDD. Essentially, DBHDD uses state general revenues to provide 'up-front' funding to vendors for MFP services. The DBHDD/MFP reimbursement process includes the following steps –

1. Planning List Administrators or Case Expeditors provide participants information about MFP, waiver and state plan services (*Appendix C, E*)
2. Participant is in the ICF and meets MFP and waiver eligibility criteria
3. Participant signs MFP Consent and Release of Information (*Appendix D1, D2*)
4. Participant is assisted in convening transition team (circle-of-family/friends) and is assisted to complete a waiver application for the New Options Waiver (NOW) or Comprehensive (COMP) waiver
5. Participant is assisted with completion of the Person-Centered Description
6. Participant selects MFP, waiver and state plan services and selects a vendor for the delivery of all services
7. MFP/DD staff authorize MFP services (*Appendix S*)
8. Participant discharges from the institution and enters waiver
9. Vendor delivers services and provides DBHDD-DD with service invoice and supporting documents (*Appendix U*)
10. MFP/DD staff submit invoice and documents to FI (*Appendix V-DD*)
11. FI reimburses DBHDD-DD
12. DCH accounting uses MFP grant funds to reimburse FI (*Appendix O*)

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. MFP participants remain eligible for HCBS waivers after the 365 day MFP demonstration period 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.

Person-Centered Planning and Individualized Transition Plans under MFP

Once MFP candidates have been identified, recruited, and have completed informed consent, MDSQ OCs or MFP TCs complete the *MFP Transition Screening Form* (see *Appendix G*) 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). MDSQ OCs and MFP TCs use person-centered planning to identify preferences and goals that are included in the *Individualized Transition Plan (ITP)/DD-Person-Centered Description* (see *Appendix Q1 and Q2*). During the pre-transition period, MFP participants are linked with community resources, including housing and transportation, and Peer 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. Facilitators (OCs, TCs, PLA, and CEs) assist the participant to identify personal and community resources and to select MFP services that match needs and remove barriers. Facilitators assist participants to select and make referrals to an appropriate waiver, review functional independence, discuss needed assistance with ADLs/IADLs, personal support services 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 *Individualized Transition Plan (ITP)* and later are used in the participant's service plan. Facilitators refer the participant to the appropriate waiver and make contact with the appropriate waiver case management agency (once selected). Facilitators (OCs, TCs, PLAs, or CEs) coordinate meetings and face-to-face waiver assessment interviews between the participant and the waiver assessment team.

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

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

assessment information, information from the MFP screening will be used to develop the waiver service plan.

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

Under MFP, LTCOs participate in transition planning while the participant remains in the long-term care facility, if requested. The LTCO post-transition services are offered to all MFP participants in the Elderly and Disabled and ICWP Waiver programs, with the exception of those transitioning into a licensed group setting (ombudsmen make regularly scheduled visits to these locations). When this MFP service is selected, LTCOs make periodic contact with participants 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 and supplemental 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.

There are several MFP services that provide supports to participants that are the same as or similar to services included within the E&D, ICWP, NOW, and COMP waivers. In the event that MFP funding is available to cover these items, MFP services are authorized to be used before waiver services. By accessing MFP services before waiver services, participants may be able to preserve or prolong waiver benefits with an annual or lifetime maximum and that may be needed after the MFP demonstration period has ended.

Peer Community Support (PES)

Description: 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.

How It Works: Peer supporters are typically individuals who 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), connect with community services and network with individuals and associations, before, during and after transitions. 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 the 365 day demonstration period. Qualified peer supporters have experience in providing peer support, may or may not be certified through the Georgia Peer Support Network (<http://www.disabilitylink.org/docs/psp/peersupport.html>) and attend a one-day MFP orientation. A case note is required to document each contact.

Rate: one unit = one hour contact, billable in quarter-hour increments, at \$50 per unit/hour; a maximum of 40 units/hours, for a total not to exceed \$2,000, ends on day 365 of the demonstration period. 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 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-transition by a participant who's PSS services are arranged but delayed.

How it works: Participants may wish to try Personal Support Services (PSS) on a trial basis before leaving an inpatient facility. The purpose of this service is to give participants an opportunity to learn how to manage and direct PSS staff. Participants transitioning to residential settings such as a Personal Care Home (PCH) or Community Residential Alternative (CRA) may wish to gain experience working with staff on care/services routines or may need to assist the PCH owner or CRA vendor to develop PSS staff skills necessary to accommodate the needs of the participant. This service may also be used to provide for temporary PSS for participants who have transitioned, but who's PSS services do not begin in the first 24 hours after discharge. In some cases, the nursing facility will arrange for assistance during this period of time (discharge until the beginning of waiver PSS). In some cases, arrangements can be made with family and friends for natural supports during this period. When other arrangements cannot be made, the participant can use Trial Visits-PSS. The purpose of the service is to provide PSS to assist the participant post-discharge, until waiver PSS begins. This service may be particularly helpful for participants who have limited natural supports from family and friends.

PSS Rate: This service pays for 1 unit of personal support = the current rate provided by the appropriate waiver. This service is limited to 74 hours for ICWP and 55 hours for CCSP and SOURCE. Service ends on day 365 of the MFP demonstration period. 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. The maximum number of trial PSS hours available will vary by waiver, but cannot exceed \$1044 per member. Based on reimbursement rates published on January 2012, ICWP participants can receive a maximum of 74 hours and CCSP and SOURCE participants can receive a maximum of 55 hours. 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.

PCH/CLA Rate: This service pays for 1 unit of residential services to be provided through an enrolled waiver Personal Care Home at the rate of \$65 per day and limited to 6 days. In NOW/COMP, 1 unit of CLSS/CRA = 1 day at \$156, limited to 6 days. Not to exceed \$1044 per participant. Service ends on day 365 of the MFP demonstration period.

Household Furnishings (HHF)

Description: This service provides assistance to participants requiring basic household furnishings (e.g., bed, table, but not limited to items listed) to help participants transition back into the community. This service is intended to help the participant with the initial set-up of their qualified residence.

How It Works: During planning, 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. Remaining furniture needs are detailed with the participant and included in the ITP/ISP along with a plan for locating and pricing the needed items. Household furnishings are items such as: table, chairs, bed, desk, dressers, or large appliances (such as a washer and dryer) that are needed in a house or apartment and necessary to allow the participant to set up a home.

Rate: This service provides a maximum of \$1,500 per participant to be used during the 365 day demonstration period.

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. This service may include a one-time purchase of groceries (up to \$200) to assist a participant with setting up their qualified residence.

How It Works: During planning, 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. Remaining needs for household goods are detailed with the participant and included in the ITP along with a plan for locating and pricing the needed items. Household goods and supplies are items such as 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. This service can also be used to provide a one-time purchase of groceries for setting up the participant's qualified residence. Alcohol and tobacco products cannot be purchased with these funds. This service does not provide for items such as televisions, stereos, DVD players, or purely decorative items (such as vases, wall art, etc.). Items such as a personal computer or laptop may be purchased if needed by the participant for health and welfare purposes: connecting with disability support groups, making medical appointments, purchasing supplies or groceries, searching for and arranging transportation services, accessing weather alert information, attending classes, conducting employment searches or activities, etc. Items like computers cannot be purchased for recreational and/or entertainment use – MFP funds are intended to enhance the participant's health and well-being, and purchase decisions are driven by need, not want. 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. While this service is intended as a one-time start up service to help the participant establish a qualified residence, these funds may be used throughout the year in certain circumstances. If household goods and supplies are not identified during the initial ITP meeting, requests for additional furnishings are made to the DCH MFP office along with appropriate justification, using the *MFP Request for Additional Services* and *MFP Authorization for Services* forms.

Rate: Limited to a maximum of \$750 per participant, to be used during the 365 day demonstration period. The purchase of groceries is limited to a one-time purchase not to exceed \$200.

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. 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 the 365 day demonstration period.

How It Works: During 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. This service can then be arranged to obtain a truck rental, 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, either from storage, the home of a family or friend, or from the place of purchase.

Rate: Limited to \$850 per participant during the 365 day demonstration period.

Utility Deposits (UTD)

Description: 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 the qualified residence.

How It Works: These funds can be used to turn on electricity, gas, water, telephone, and 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: Limited to \$500 per participant- ends on day 365 of the MFP demonstration period.

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: These funds can be used to pay the security deposit (flat fee, first and last month's rent, etc.) and/or application fees required to secure a rental unit that meets qualified residence criteria.

Rate: Limited to \$1,000 per participant- ends on day 365 of the MFP demonstration period.

Transition Support (TSS)

Description: 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.

How It Works: These funds may be used to help participants resolve transition barriers that are unique to each participant. For example, a participant may need to obtain a birth certificate or other necessary

documentation that requires a fee, or the participant may need assistance to pay a rental unit application fee. Such needs are determined with the participant during planning. The participant is assisted to resolve the identified issues. In some instances, participants may have a need for additional funding in one of the other MFP transition services categories. For instance, a participant may have a past due electric bill that must be paid in order to have electricity turned on. If the amount of the past due electric bill and deposit depletes the funding available in the Utility Deposits category, the participant has no funds left to pay deposits for water, sewage, gas, etc. The participant will need additional funds to cover the deposits necessary to have utilities turned on. Funds in the Transition Support category can be used for this purpose. Note that these funds are to be used in this manner only when doing so directly supports the participant's transition. These funds cannot be used to purchase more items than might otherwise be obtained, such as purchasing more than the category limit on Household Furniture or Household Goods. Participants are assisted to carefully develop a budget for obtaining those items and stay within the existing budget. In addition, these funds cannot be used for categories where funding still remains. Expenses in this category must be authorized by DCH on a case-by-case basis, and unauthorized purchases, or purchases that violate the guidelines within other service categories, will not be reimbursed. **Rate:** Limited to \$600 per participant – ends on day 365 of the demonstration period.

Transportation (TRN)

Description: 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.

How It Works: This service does not replace Non-Emergency Transportation (NET) or emergency ambulance services. Transportation funds can be used for trips related to transition, such as making trial visits to the community, viewing housing options and personal care homes to find a suitable, qualified residence, obtaining needed documents such as personal identification, and for going home on the day of discharge.

Rate: one unit = a one-way trip, up to \$500 (when necessary), service is designed to cover the cost of multiple one-way or round trips totaling no more than \$500, can be a pre and post-transition, ends on day 365 of the demonstration period.

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, 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, didactic, instructor-lead, customized training/coaching based on the results of the ITNA.

How It Works: This service requires an ITNA and the development, delivery and evaluation of customized, trainer-lead training by a qualified trainer/coach. This 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 a facilitator (MDSQ OC, MFP TC, PLA or CE). The service is authorized for 60 units or 30 hours of contact 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 attend a one-day MFP orientation. 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: One unit = one half- hour of contact training/coaching or group/individual training activities, billable at \$25 per half-hour, to a maximum of 60 units or 30 hours training/coaching, delivered by a qualified trainer/coach, limited to \$1,500 per participant, ends on day 365 of the demonstration period.

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 individual. This service will pay for up to 14 days during the MFP 365 day demonstration. 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.

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

Rate: One unit = \$134.17 per day, limited to 14 units or \$1,878.38 per member, ends on day 365 of the demonstration period.

Caregiver Outreach & Education (COE)

Description: 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.

How It Works: 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 on topics including adult day services, assistive technologies, counseling services, assistance for planning for the future, psycho-emotional issues and coping skills, direct care (i.e. activities for daily living, safe transfers, bathing, other issues unique to the participant's needs), communication skills, caregiver self care, financial assistance and/or legal advice, circle-of-support/informal networks, managing/maintaining in-home support service, 24 hour supervision, respite, palliative and hospice care, assisting participants to manage chronic health conditions and secondary conditions related to disability. Caregiver education may be available through local agencies.

Rate: 1 unit = one half- hour of contact caregiver training, billable at \$25 per half-hour, to a maximum of 40 units or 20 hours training/coaching, delivered by a qualified caregiver specialist, limited to \$1,000 per participant, ends on day 365 of the demonstration period. Rate includes all costs associated with delivery of service.

Community Ombudsman (COB)

Description: This service provides periodic, face-to-face (F2F) contacts made by a certified community ombudsman, 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 (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.

How It Works: This service provides a periodic, face-to-face (F2F) contact for review of transitioned participants' health, welfare and safety; Community Ombudsmen make visits and phone calls to participants to discuss any issues related to the MFP and HCBS services they are receiving. Community Ombudsmen are certified 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)Minimum contacts occur during the first 30 days post-transition, at 6 months and again at 11 months 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 365 day demonstration period.

Rate: one unit = one hour contact at \$150 per hour, billable in quarter-hour increments at \$37.50, limited to \$1,800 per participant, ends on day 365 of the demonstration period.

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 Medicaid. 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 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. Three quotes are required for purchase of a single piece of equipment costing \$1000 or more.

How It Works: As justified in the participant's ITP/ISP, these funds can be used to obtain equipment, vision, dental and hearing services, durable medical equipment, adaptive or assistive technology devices, 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 dental work 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. When equipment, vision, dental, hearing and/or AT devices and services are not covered by state plan Medicaid or the DME program, it is not necessary to submit a claim and receive a denial, before obtaining items under this service. However a citation from the DME manual must be included in the ITP/ISP indicating the item or service is not covered. 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. The following items do not require denial of coverage documentation:

- Environmental Control Systems/equipment (e.g. devices used by participants to control lights, heat, ventilation and air conditioning, door openers for participant use)
- 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)
- 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, tripp 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
- Prescription eye glasses, exam and fitting
- Dental exam and cleaning
- 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

Three quotes are required for the purchase of a single piece of equipment that costs \$1000 or more. 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.

Rate: Limited to \$4,000 per participant - ends on day 365 of the MFP demonstration period.

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 needed from others. The service includes incontinence items, food supplements, special clothing, bed wetting protective chucks, diabetic supplies and other supplies that are identified in the approved Individualized Transition Plan (ITP) and/or the Individual Service Plan (ISP) and that are not otherwise covered by Medicaid. Ancillary supplies necessary for the proper functioning of approved supplies are also included in this service.

How It Works: Specialized Medical Supplies (SMS) are identified in the approved Individualized Transition Plan (ITP) and/or the Individual Service Plan (ISP). When SMS are not covered by state plan Medicaid or the DME program, 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 ITP/ISP that the SMS is not covered. Citations should come from Part II Policies and Procedures manual for Durable Medical Equipment (DME). The following items do not require State Plan denial of coverage documentation:

- Incontinence items (e.g. diapers, pads and adult briefs)
- Diabetic supplies (not covered by Medicaid, syringes, etc.)
- Chucks (used to line the bed for incontinent persons)
- Catheter Condoms
- 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
- Ancillary supplies necessary for the proper functioning of approved devices
- Infection control supplies, such as non-sterile gloves, aprons, masks and gowns, when services are provided by an individual caregiver, not from an agency.

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. No items should be billed to DCH/MFP or a Fiscal Intermediary prior to delivery to the MFP participant.

Rate: Limited to \$1,000 per participant - ends on day 365 of the MFP demonstration period.

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 while moving. Three quotes are required for adaptations of \$1000 or more.

How It Works: Three quotes are required for adaptations of \$1000 or more. 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. Three quotes must be obtained for all vehicle adaptations. If the owner of the vehicle is not the participant, a notarized letter giving the owner's permission for the adaptations must be obtained. This service does not cover repairs to the vehicle or to the adaptations once they are installed and operational.

Rate: There is a maximum of \$6,240 available during the 365 day demonstration period.

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. Two scope/bids are required, three scope/bids are recommended. 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.

How It Works: This service can be used to pay for such things as ramps, structural changes such as widening doorways, the purchase and installation of grab-bars and bathroom modifications. These modifications are done to improve or maintain the independence of the participant in ADLs and to 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. A home/building inspection is required before environmental modifications are started and a post-inspection is required after modifications are completed. Building permits must be obtained for all EMDs with scope/bid totals of \$2,500 or more.

Rate: price of the lowest scope/bid (with exceptions), limited to a maximum of \$8,000 per participant, ends on day 365 of the demonstration period.

Home Inspections (HIS)

Description: 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 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 vendors/contractors providing environmental modifications.

How It Works: In spaces requiring environmental modifications for accessibility, the inspector reports on structural deficiencies and identifies repairs that are the responsibility of the property owner to complete, 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.

Rate: 1 unit = one inspection with relevant report from a qualified inspector, billable at \$250, limited to \$1,000, ends on day 365 of the MFP demonstration period.

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: Supported Employment services are promoted to MFP participants throughout all phases of the transition process, but specifically during the ITP/ISP process in which the participant identifies vocational goals. Based on these identified goals, this service is authorized to provide 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: 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, ends on day 365 of the demonstration period.

Qualified HCBS Services Offered to MFP Older Adult Participants

Older adult participants are referred through the Area Agency on Aging (AAA) Gateway network. Gateway staff perform the screening and refer to the case management agency to have the initial assessment completed (for process detail, see *Appendix I: MFP Process Flowcharts and Text Descriptions*). The Gateway

network is already established statewide and offers an extensive database of information about services for the elderly and persons with all types of disabilities.

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

Up to the level of reserved capacity, there is no waiting list for MFP participants enrolled in the ICWP waiver program. When reserved capacity is exceeded, MFP uses a 'first-come-first-served' approach to service delivery. The date of the initial MFP screening will be used to prioritize the MFP waiting list. The ICWP waiver will be amended to have reserved capacity of 100 slots per year for persons transitioning from long-term care facilities to the community through Money Follows the Person. DCH requests budget increases for the additional slots needed for reserved capacity for ICWP through 2016.

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.

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 Participants with Developmental Disabilities

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

Planning List Administrators and/or Case Expeditors assist and oversee elements of the transition process. The Department of Behavioral Health and Developmental Disabilities (DBHDD) actively assists individuals to transition from ICFs or State Operated Hospitals into the community. MFP supports the DBHDD transition process. Under the Interagency Agreement, there is reserved capacity of 150 waiver slots per year for persons that transition under the Settlement Agreement with US Department of Justice from ICFs. While transitions from ICFs under the DOJ Settlement are given first priority, MFP/DD participants will be transitioned from nursing facilities to the community as a second priority. DBHDD will request appropriations for slots needed for reserved capacity in the NOW and COMP waivers through 2016.

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

The DD 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 developmental disabilities. 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 are charged with actively assisting consumers toward community placement with appropriate supports.

- Intake and Evaluation- Conducts face-to-face initial screening to determine service need and preliminary eligibility (screening provides presumed eligibility or ineligibility; a comprehensive evaluation is intended to confirm eligibility status) of the individual for DD services. The screener completes an *Intake Screening Summary*, which documents the individual and family circumstances related to the need for services, the services actually needed, and the timeframe in which the services are needed.
- Planning List Administrators or I & E Managers are responsible for managing the DD 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.

Participants who transition from ICFs also have access to services through Aging and Disability Resource Centers (ADRCs). Most ADRCs have a DD specialist on staff to assist with information and referral for services. ADRC-DD specialists are closely linked to DD 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. These programs are separate home and community-based waivers for people with developmental disabilities such as autism, cerebral palsy, or epilepsy that require the level of care provided in an Intermediate Care Facility (ICF). 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.

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 and Supplemental Services as indicated in the Appendix B and outlined above. See also *Appendix B: 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 not seeking enhanced match for State Plan services provided to MFP participants

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

B.6. Consumer Supports

The following section identifies the organizations (state, regional and local agencies, contracted agencies, etc.) that provide pre-transition and transition services (including case management) to MFP participants under each HCBS waiver for three specific Medicaid eligible targeted populations (older adults, persons with developmental disabilities, persons with physical disabilities and/or traumatic brain injury). It describes the work and qualifications of personnel that deliver options counseling and transition coordination 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 three specific Medicaid eligible populations who are currently residing in an institutional 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 provision of LTSS options counseling, pre-transition and transition 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 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). 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. MDSQ OCs and MFP TCs recruit participants with physical disabilities and/or TBI, between the ages of 21 and 64 for the Independent Care Waiver Program (ICWP). MDSQ OCs and MFP TCs recruit participants with developmental disabilities residing in nursing facilities for the waiver that is most appropriate and that meets their needs.

Interagency Agreement--For DD populations transitioning into the NOW and COMP waivers, the current Interagency Agreement with the Department of Behavioral Health and Developmental Disabilities (DBHDD) was expanded to support the current efforts to transition individuals with DD through MFP. DBHDD already performs transition coordination functions in ICFs statewide; their current efforts are supplemented with funding from MFP to enable the state to transition DD

participants from nursing facilities into NOW/COMP waivers; provide MFP demonstration and supplemental services to MFP participants transitioning into NOW/COMP waivers and receive higher FMAP on MFP and qualified HCBS services.

To develop and manage this process, DCH:

- Determines interagency agreement scope and oversees execution of both 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 older adults and adults and children with physical disabilities/TBI and developmental disabilities who wish to transition with or without HCBS waivers,

Qualifications Necessary for the Delivery of MFP Demonstration and Supplemental Services under Interagency Agreements

Personnel delivering MFP demonstration and supplemental 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 and referrals from all Points-of-Entry
- Completing Screenings and Individualized Transition Plans/Person-Centered Descriptions
- 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 and people with physical disabilities and traumatic brain injury (TBI), and/or developmental disabilities

Collaboration between MFP Personnel and Waiver Case Managers, Care Coordinators and/or Support Coordinators

After completing the MFP Individualized Transition Plan (ITP) or Person-Centered Description with the participant, MFP 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 MDSQ OCs, MFP TCs, DD PLAs and/or CEs with information and collaborating on the development of plans for pre and post-transition services. CMs/CCs/SCs assist with plans for and establish risk management systems, including 24/7 emergency backup systems. MFP personnel follow-up with MFP participants at 30 days to ensure that service plans have been implemented.

Training of MFP 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.

24/7 Emergency Backup

Georgia's MFP emergency backup system will serve 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.

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

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 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 personnel (MDSQ OCs, MFP TCs, DD PLAs, CEs) must complete the *MFP Sentinel Event Report* (see *Appendix AB*) for each event and forward the completed document to the MFP Project Director who will investigate the event and take appropriate corrective action.

24/7 Emergency Backup Persons with Developmental Disabilities

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

B.7 Self-Direction or Participant Direction

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

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

Participants, family members and caregivers receive their initial information about self-direction options during initial screenings conducted by MFP field personnel (MDSQ OCs, MFPTCs, .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 services needs, housing needs, accessibility needs, and transportation needs. The *MFP Transition Screening Form* also gathers information about the participant's health, therapies, specialized medical equipment and assistive technology needs, and community resettlement needs for basic household goods and furnishings (see *Appendix G*). The *MFP Transition Screening Form* information is used to make a referral to an appropriate HCBS waiver and make contact with waiver case managers, advising them of the member's desire to self-direct care. 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 Q1 and Q2*) including the participant's desire to self-direct their care.

The Elderly and Disabled waiver and ICWP waiver provide for employer authority and budget authority over PSS. 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 discharges PSS staff. The options are similar for participants entering the NOW and COMP waivers. These waivers provide participants with employer authority, including a co-employer option, and budget authority, to select and manage nearly all waiver services.

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

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

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

Self-Direction for Persons with Developmental Disabilities

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

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

Procedures for Voluntary and Involuntary Switches from Self-Direction

Participants may voluntarily choose to return to the traditional agency directed services if they determine that they lack the interest or ability to self-direct their services. To assure that they return to the traditional waiver services while maintaining continuity of care, communication with 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 self-direction to provider-managed services for any of (but not limited to) the following reasons: 1) failure to meet responsibilities and/or identified health and safety issues for participant, 2) failure to maintain maximum control over daily schedule, 3) inability to complete accurately and timely all FMS documents, to manage budget—leading to over use of PSS budget for 2 consecutive months, 4) use of state backup plan one or more times per month for 2 consecutive months, 5) not meeting the goals of the Service Plan for 2 consecutive quarters. The case manager plans and implements return to traditional services, reports health, safety, fraud, or abuse concerns to appropriate state agencies.

When removal from the self-directed option occurs, the participant return to the traditional agency directed option without loss, reduction or interruption of services. A switch from self-directed services does not terminate the participant from the waiver program. The case manager maintains communication with the participant to ensure a smooth transition from one service option to the other and educates the participant (or guardian) on how to give adequate notice to the employees. This provides the case manager with time needed to follow standard procedures to switch the self-directed option, broker services with a waiver enrolled provider agency, remove the FMS services, and update the participant's service plan to reflect the change. The 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 self-directed services and returns the participant to the traditional agency-directed option. However, participants can always appeal any reduction in services or any termination of services. Providing initial enrollment criteria are met, after one year from the date of the re-entry into the traditional option, participants may be eligible to re-enter the self-directed services option.

Education on Self-Direction

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

entering the NOW and COMP waivers will receive the *Handbook on Participant Direction*.

Financial Management Agencies under Contract with the State

There 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 Self-Direction

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

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

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

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

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

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

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

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

In an effort to address these issues, MFP 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. The DBHDD, the Governor's Council of Developmental Disabilities, and the Department of Adult and Technical Education launched a direct support professional certificate training program at four state technical colleges.

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

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.R05.01, Effective Date: 10/01/07); the Independent Care Waiver Program (ICWP, Waiver Number: 4170.90.R2, Effective Date 4/1/2012), the Mental Retardation Waivers (MRWP/NOW, Waiver Number: GA.12.01.00, Effective 10/01/07) and Comprehensive Supports Waiver Program (CHSS/COMP, Waiver Number: GA.10.00.00, Effective 10/01/07).

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

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

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

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

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

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

1. Level of Care (LOC) Determinations

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

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

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

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

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

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

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

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

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

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

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

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

2. Service Plan Description and Service Delivery

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

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

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

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

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

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

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

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

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

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

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

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

- Convert ISP to electronic format
- Provide secure electronic signatures
- Record and track ISP due dates, meeting schedules, and dates of actual meetings
- Sort ISP scheduling issues by:
 - Service provider, region, support coordination Agency, and support coordinator
 - Time and location of ISP meetings
 - Cancellations and reasons for cancellation
- Maintain assessment data from Supports Intensity Scale (SIS). Support coordination staff 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.

3. Identification of Qualified Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Participant Health and Welfare

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

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

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

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

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

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

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

The case manager meets with the participant no less than once a month. Case managers are trained to observe and document critical incidents and report them to the contracting agency nurse. The nurse does a face to face assessment to determine impact on participant health and safety. Case 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.

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

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

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

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

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

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

5. Waiver Administrative Oversight and Evaluation of QMS

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

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

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

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

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

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

6. Financial Oversight of the Waivers

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

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

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

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

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

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

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

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

7. Emergency Backup Systems

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

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

Information from the MDS-HC is used to identify risks to the Elderly and Disabled Waiver Program waiver participant's health and safety. Each identified risk is included in the service plan with individualized contingency plans. This is similar in the Independent Care Waiver Program (ICWP). Participant risks are addressed with action plans using the *Care Path*. The participant's physician signs off on the LOC/*Care Path* plan. Under the Elderly and Disabled waiver program, each risk trigger from the *MDS-HC* is identified on the service plan with individualized contingency plans to minimize risks. Participants/guardians receive information about the participant's civil rights and responsibilities from case 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.

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

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

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

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

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

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

Assessment of Other Concerns/Problems

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

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

Emergency Backup Plan for MFP Services

MFP Contracted Services

For contracted services (i.e. Peer Community Support, Trial Visits, contracted Moving Services, etc.), the MFP field staff (OCs, TCs, DD PLAs, CEs) recruit vendors, agencies, and/or contractors to provide these services. Each needed service is included in the participant's Individualized Transition Plan (ITP) and authorized using the *MFP Authorization for Pre and Post-Transition Services*. After the service is rendered, 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 the participant and try to reschedule the service with the participant. If that is not satisfactory to the participant, the vendor, agency, or contractor will offer a back-up service for the originally scheduled service. In addition to arranging alternatives with the MFP participant, the vendor, agency, or contractor is expected to contact the Transition Coordinator with this information.

MFP Fee-For-Services

Fee-for-service purchases (such as Household Furnishings, Household Goods and Supplies, etc.) are 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) include needed goods and/or services in the Individualized Transition Plan (ITP)/Person-Centered Description 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. The MFP field staff authorizing the purchase of the goods and/or services is responsible for obtaining all necessary documentation that specifies how authorized services meet the transition goals in the transition plan. MFP field staff obtains and delivers the goods/services and transmits the invoice information 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 to TC/CE* (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 staff 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 MR/DD Service Areas. Human Rights Committees are groups of local citizens who provide independent oversight as a local intermediary structure in matters related to the rights of citizens with developmental disabilities who reside in the state of Georgia. Examples of types of issues/concerns to be reviewed by HRCs include: mistreatment, abuse, neglect, exploitation, misuse of pharmaceuticals, restraints and behavioral programs and interventions. Volunteer membership includes medical professionals, pharmacist/medication experts, self advocates, other advocates, parents, other family members, law enforcement personnel, business people, and representatives of faith-based organizations. Issues heard by HRCs receive follow-up with documentation of resolution. Division of DD staff communicates with local HRC leadership on a monthly basis. The Division of DD uses HRC information as discovery, to track trends monthly, and to respond systemically with remediation and quality improvement as needed. The Division of DD communicates with region staff monthly regarding issues and concerns identified through the HRCs.

QMS and the Development of Qualified Personal Support Services Staff

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 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 type of qualified residence using the following:

- 01 – Home owned by participant
- 02 – Home owned by family member
- 03 – Apartment leased by participant, not assisted living
- 04 – Apartment leased by participant, assisted living
- 05 – Group home of no more than 4 people

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

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

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

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

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

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

Front line staff (support coordinators) complete site visits on all residential settings prior to participants moving into any setting. Sites may not be occupied until all requirements are satisfied. Support coordinators document and report 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.

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 institutional (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 lead 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. Once hired, the MFP Housing Manager will undertake and track 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.
- 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 will work 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.

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 Section 811 Project Rental Assistance (PRA) 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, project based rental assistance (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 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 (MDSO 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 provides MFP participants and all Georgians with access to information about affordable rental housing opportunities, including those that have certain accessibility features. It also provides secure, behind the scenes access to additional housing information that would be beneficial to assist MFP candidates. MFP Transition Coordinators (TCs) must participate in Confidentiality Training to gain access to the secure sections of the site. MFP state staff will work with DCA, local PHAs and other state housing programs to educate and inform about MFP, the need for affordable, accessible and integrated housing and the need for rental subsidies (vouchers) for MFP participants.

Expand the Home Access (HA) (Environmental Modification) Program

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

Promote Home Ownership for MFP Participants using Vouchers

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

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

B.10 Continuity of Care Post-Demonstration

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

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

Transition screening—these processes will be adapted to gauge the likelihood of a successful transition for each MFP participant. Using the MFP Transition Screening Form (*see Appendix G: MFP Transition Screening Form*), MFP field staff (OCs, TCs, DD PLAs, CEs) gather information about the candidates background, personal goals, resources, and functional needs in order to closely match the person to the most appropriate HCBS waiver. During the screening process, MFP 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.

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. 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 *Individualized Transition Plan* (ITP) (see *Appendix Q1 and Q2*). MFP field staff write-up and implement the ITP, based on person-centered planning discussions with the transition team. The ITP 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 nursing homes or ICFs receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, State funded programs, and local community funded services. The state is not seeking enhanced match for State Plan services provided to MFP participants.

Quality of Life Survey—results of the QoL survey 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.

Services That Continue Beyond the Demonstration

The state assures that HCBS waiver services continue to 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, consumer input, and appropriation of funds by the General Assembly will also impact on continuation of MFP services beyond the demonstration period.

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

C.1 Organizational Structure

Overall authority, administration, oversight and supervision of Georgia's MFP demonstration program reside in the Medicaid Division in the Department of Community Health (DCH), 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-DD) to transition individuals with developmental disabilities from 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 nursing 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 assist with waiver applications. Both facilitate transitions into Georgia HCBS waivers.

Under the agreement with DBHDD-DD, planning list administrators and case expeditors (DD PLAs and CEs), working in ICFs, facilitate the development of Person-Centered Descriptions (transitions plans), waiver enrollment and discharge day planning. An Assistant Deputy Commissioner, two Transition Specialists and a Transition Consultant, employed by DBHDD-DD, coordinate transition activities with DD PLAs and CEs and manage certain transition activities; including, authorizing and procurement of MFP transition services, completing the QoL 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.

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.

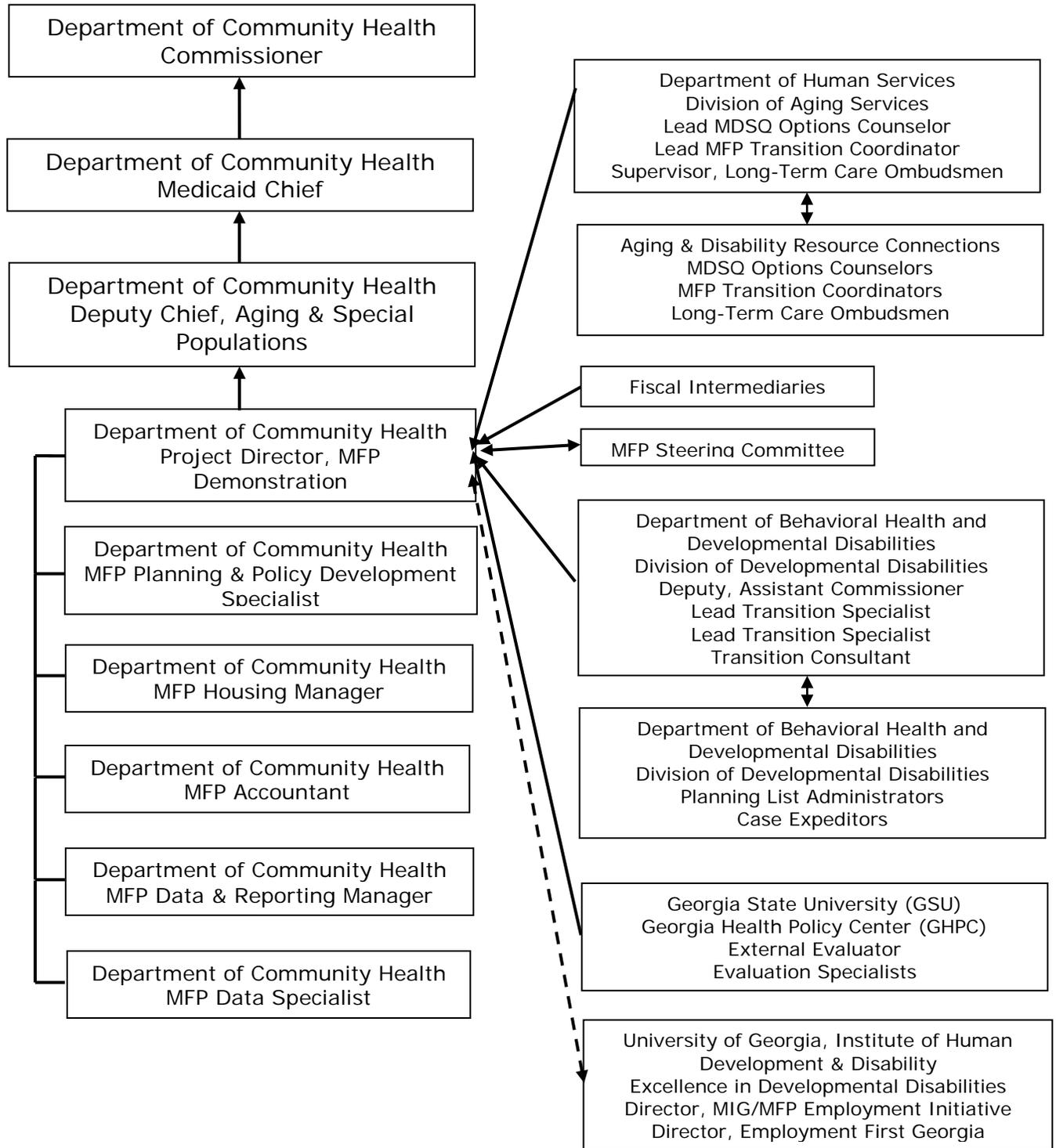
Fiscal Intermediaries (FIs) provide services to MFP participants per agency agreements. Because MFP demonstration and supplemental services are non-traditional Medicaid services and do not continue after the 365 days of MFP, Fiscal Intermediaries are needed to 'front monies' for procurement of these 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.

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.

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.

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

- 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.

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

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.

Under the direction of the DCH Finance Unit, the Accountant prepares financial reports necessary for the operation 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 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.

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 1st and 2nd 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 1st 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.

C.3 Billing and Reimbursement Procedures

This section describes procedures for manual processing of MFP Demonstration and Supplemental 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-DD) 'fronts' initial funding to vendors for MFP demonstration services. Vendors render these demonstration services to MFP participants with developmental disabilities (transitioning from ICFs). Once delivered, vendors submit 'paid' invoice(s) and receipts to DD/MFP Transition Specialist within DBHDD-DD. The DD/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-DD.

Under the interagency agreement with the Department of Human Services, Division of Aging Services (DHS/DAS), MFP TCs authorize FIs to 'charge up' participant's accounts by authorized service (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).

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 a total of 365 days, and reference data (i.e. procedure codes, rates and limitations) during the adjudication process for validation to allow claims to process and pay providers. 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.

D. Independent Evaluator – Not Applicable

E. Final Project Budget – Submitted under Separate Cover

Revised 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

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

LIFE CIL, Executive Director
LIFE CIL, Nursing Home Transition Coordinator
LTCO Atlanta
LTCO, 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

Appendix A2: Checklist for Transition to the Community



CHECKLIST FOR TRANSITION TO THE COMMUNITY

(For Use with Participants Transitioning to CCSP/SOURCE or ICWP)

Rev_071212



Resident Name: _____ Medicaid #: _____ DOB: _____

Current Location: _____ Best Contract Phone #: _____

Current Address: _____ City: _____ Zip: _____

Step	Responsible Person	Action Step/Notes	Results
1. Participant is identified as eligible for screening.	<ul style="list-style-type: none"> Referral Source Options Counselor-OC/ Transition Coordinator-TC 		
2. Ensure participant has expressed a desire to leave the institution.	<ul style="list-style-type: none"> Participant OC/TC 		
3. All applicable consent and release forms obtained and signed. <ul style="list-style-type: none"> MFP Consent For Participation Authorization for Use or Disclosure of Health Information Verification of guardianship obtained if applicable.	<ul style="list-style-type: none"> Participant OC/TC 		
4. Initial face-to-face screening form completed using <ul style="list-style-type: none"> MFP Screening Form Participant is eligible based on eligibility criteria. <ul style="list-style-type: none"> Has lived in a nursing facility for at least 90 consecutive days At least one day of stay was paid by Medicaid Meets institutional level of care Will resettle into qualified housing 	<ul style="list-style-type: none"> Participant OC/TC 		
5. Provide participant with copies of the <i>Home and Community Services: A Guide to Medicaid Waiver Programs in Georgia</i> , and a <i>MFP Brochure</i> .	<ul style="list-style-type: none"> Participant OC/TC 		



CHECKLIST FOR TRANSITION TO THE COMMUNITY

(For Use with Participants Transitioning to CCSP/SOURCE or ICWP)
Rev_071212



Resident Name: _____ Medicaid #: _____ DOB: _____

Step	Responsible Person	Action Step/Notes	Results
6. If referred to a waiver, <i>MFP Transition Screening Form</i> and attachments are complete to determine appropriate waiver referral and then sent to assigned waiver program for pre-screen.	<ul style="list-style-type: none"> • OC/TC 		
7. The participant accepts waiver recommendation.	<ul style="list-style-type: none"> • Participant • OC/TC 		
8. Establish and convene the transition team (includes the participant's circle-of-support/friends) and identified current stakeholders with the participant to complete person-centered planning using MAP, PATH or similar to establish long and short-term goals. At a minimum, the team should identify individualized support needs for qualified residence type/living arrangements, personal assistance, DME/AT, transportation, community integration and a personal care physician (PCP) and pharmacy.	<ul style="list-style-type: none"> • Participant • Circle of Support • OC/TC 		
9. The support network assists the participant/family in choosing and verifying services from a list of MFP transitional services and providers, if applicable. Conduct a housing search using tools available including www.georgiahousingsearch.org	<ul style="list-style-type: none"> • Participant • Transition Team/Circle of Support • OC/TC • Waiver CC/CM 		
10. Once determined eligible for a waiver, continue person-centered planning meetings with participant, family/friends and support/transition team to develop <i>Individualized Transition Plan</i> (ITP) Part A MFP Services, Part B waiver services and Part C State Plan Services (if applicable).	<ul style="list-style-type: none"> • Participant • Transition Team • OC/TC • Waiver CC/CM 		



CHECKLIST FOR TRANSITION TO THE COMMUNITY

(For Use with Participants Transitioning to CCSP/SOURCE or ICWP)
Rev_071212



Resident Name: _____ Medicaid #: _____ DOB: _____

Step	Responsible Person	Action Step/Notes	Results
11. Arrange pre-transition visit of participant to community setting. Review potential qualified residences and identify community transportation options.	<ul style="list-style-type: none"> • Participant • OC/TC • Waiver CC/CM 		
12. Process <i>MFP Authorization for Transition Services</i> . Arrange for vendors to provide pre-transition services. *Note: Will appear as needed throughout the billing process	<ul style="list-style-type: none"> • OC/TC • Vendor • DCH/MFP 		
13. Initiate pre-transition services. Vendors submit <i>Request for Vendor Payment</i> along with documentation of delivery of goods/services to OC/TC. OC/TC must submit <i>Vendor Import File</i> monthly to the Fiscal Intermediary (FI) and DCH/MFP office with all documentation. *Note: Will appear as needed throughout the billing process	<ul style="list-style-type: none"> • OC/TC 		
14. <i>Quality of Life (QOL)</i> survey completed 30 days to two weeks prior to discharge.	<ul style="list-style-type: none"> • Participant • OC/TC 		
15. Date established for participant discharge from institution.	<ul style="list-style-type: none"> • Participant • OC/TC • Waiver CC/M 		



CHECKLIST FOR TRANSITION TO THE COMMUNITY

(For Use with Participants Transitioning to CCSP/SOURCE or ICWP)
Rev_071212



Resident Name: _____ Medicaid #: _____ DOB: _____

Step	Responsible Person	Action Step/Notes	Results
16. When discharge date established: A) Terminate institution enrollment and change Medicaid eligibility. B) Supply change of address for social security benefits C) Provide copy of discharge paperwork to DCH/MFP D) DCH/MFP forwards discharge documents to DCH/Member Services for changes to SUCCESS	<ul style="list-style-type: none"> • Participant • OC/TC • DCH/MFP • DCH/ Member Services 		
17. <i>Discharge Day Checklist</i> is complete.	<ul style="list-style-type: none"> • OC/TC 		
18. OC/TC contacts DCH/ MFP office via secure e-mail with completed discharge documents / information – <ul style="list-style-type: none"> • DMA - 59 with the last date of institutional care indicated, • DMA - 6 OR Level of Care document, • Communicator indicated slot date for waiver admission (used only for non-SSI participants) 	<ul style="list-style-type: none"> • OC/TC • DCH/ Member Services • DCH/ MFP 		
19. DCH/MFP enrolls participant into MFP assignment plan and enters waiver.	<ul style="list-style-type: none"> • DCH /MFP • MMIS 		
20. Waiver services begin. OC/TC follow-up visits scheduled.	<ul style="list-style-type: none"> • Participant • Waiver CC/CM • Waiver Service Providers • OC/TC 		
21. Coordinate and/or arrange for the 2 nd Quality of Life (QoL) survey to be completed between 11 and 12 months post-discharge (resettlement).	<ul style="list-style-type: none"> • OC/TC • QoL Surveyor • Participant 		

Appendix A3: Checklist for Transition to the Community - DD

Division of Developmental Disabilities
 Department of Behavior Health Developmental Disabilities
DISCHARGE CHECKLIST FOR TRANSITION TO COMMUNITY PLACEMENT

For Individual: _____

SS#: _____

Discharge From: _____

DOB: _____

Step	Responsible Person	Action Step	Results
1. Complete and submit to appropriate region a Medicaid waiver application, and all supporting required documentation for individuals on transition including verification of legal guardianship if applicable.	DD Chief		
2. Review Medicaid application and determine waiver eligibility. Send out waiver award letter and another letter with information on support coordination. (The choice of Support Coordination Agency will be made at the Transition meeting.)	Regional I&E Manager		
3. Confirm current Medicaid code, waiver eligibility and MFP eligibility as well as documentation of individual financial resources (1 month in ICF/MR, SNF or private nursing home, Medicaid eligible).	DD Chief/ Hospital Patient Accounts		
4. Ensure that each individual on Transition list has a Hospital Planning List Administrator.	Hospital Case Expediter		
5. Convene the support team and identified current stakeholders with the individual/family to review and update person-centered plans to determine individualized support needs including living arrangements, staffing needs, medical supports, employment opportunities, and educational arrangements if applicable (Person-Centered Descriptions).	Hospital Planning List Administrator		

Protocol: Transition and Post-Transition Procedures for Assisting Individuals on the DD Transition List
 Attachment A
 Revised 8/29/2011; 9/28/2011; 2/24/2012

Page 1 of 5 Pages

Division of Developmental Disabilities
 Department of Behavior Health Developmental Disabilities
DISCHARGE CHECKLIST FOR TRANSITION TO COMMUNITY PLACEMENT

<p>6. Within 30 days of PCD meeting, disseminate updated person centered description information to division (for uploading on K Drive) individual's family and to potential providers for review.</p>	<p>Hospital Planning List Administrator/ DD State Case Expediter</p>		
<p>7. With the assistance of the support network the individual/family chooses the service provider(s) and informs the Region. (This includes scheduling visits to potential homes.)</p>	<p>Hospital Planning List Administrator</p>		
<p>8. As soon as a provider has been selected, schedule and conduct transition meeting utilizing the Guidelines for Transitional Planning and the Person Centered Description. During this meeting w/provider, a reasonable discharge date must be set & documented with assignments and dates of needed tasks to meet the d/c date. Review financial records, burial information and other Medicare Part A, B, or D information for eligibility. Review all medications, ensure that meds are on community formulary, and appropriate informed consent for psychotropic medication is completed. Ensure hospital staff has completed SIS (SIS must be current within 120 days of beginning of service). Review need for ERR and provider begins development of ERR. Required documentation to Division for community allocation. Review need for start-up and begin development of start-up request.</p>	<p>Hospital Planning List Administrator</p>		
<p>9. Develop any MFP demonstration and transition services (for MFP eligible participants) and/or start-up requests and submit to Transition Coordinators (Sally Carter, Bobbie Davidson, & Jenny Weismann). The completed Transition Agreement form and Transition Fund Request Forms are due to the</p>	<p>HPLA/Provider</p>		

Protocol: Transition and Post-Transition Procedures for Assisting Individuals on the DD Transition List
 Attachment A
 Revised 8/29/2011; 9/28/2011; 2/24/2012

Page 2 of 5 Pages

Division of Developmental Disabilities
 Department of Behavior Health Developmental Disabilities
DISCHARGE CHECKLIST FOR TRANSITION TO COMMUNITY PLACEMENT

applicable Regional Office within 10 business days from the date of the Transition Meeting.			
10. As soon as meeting transition meeting is completed the information and date is entered into the CIS. The Transition Planning Guideline document must be uploaded into CIS within 10 business days from the transition meeting date.	Hospital Case Expediter		
11. Request completion of Regional pre-placement site approval.	Hospital Planning List Administrator		
12. When home is selected, verify status of provider number and/or HFR status for site as indicated. Request expedited process if necessary.	Hospital Case Expediter		
13. Request approval for out of Region placement (if applicable).	Regional Service Administrator-DD (HPLA, HCE)		
14. Schedule and conduct the ISP meeting. Provider completes ERR and submits request, if needed with ISP. If ERR is needed for behavioral issues, a temporary BSP must be submitted with package.	Hospital Planning List Administrator/ Provider		
15. At the ISP meeting (usually held 30 days prior to discharge) complete and/or update all required assessments including HRST , nursing, social work, and psychological and submit to I&E LOC Nurse. In addition, 30 days prior to discharge complete and submit DMA-6 and the top section of the MAO to I&E LOC Nurse. If the discharge does not occur, the ISP and assessments will need to be amended.	DD Chief		
16. When Hospital Planning List Administrator (PLA) notifies the I & E office that the ISP and assessments are complete, the Intake & Evaluation (I&E) office will acknowledge receipt of Individual Service Plan (ISP) and notify the PLA of approval	I & E Manager		

Protocol: Transition and Post-Transition Procedures for Assisting Individuals on the DD Transition List
 Attachment A
 Revised 8/29/2011; 9/28/2011; 2/24/2012

Page 3 of 5 Pages

Division of Developmental Disabilities
 Department of Behavior Health Developmental Disabilities
DISCHARGE CHECKLIST FOR TRANSITION TO COMMUNITY PLACEMENT

within 2 weeks; approves the DMA6, MAO , and forward the approval to PLA and Provider. (An Exceptional Rate Request and/or Waiver of Standards Request (if applicable) are sent to the Division of DD for approval).			
17. Ensure that the individual has an appointment with the primary care physician within one month after discharge. In addition, the name, address and phone number of the dentist and other required medical specialists should be identified and entered in CIS.	Hospital Case Expediter/ PLA		
18. A. On the day of discharge if MFP Eligibility Criteria has been determined, the following information must be submitted to: Tiffany Butler, Sally Carter, Bobbie Davidson: 1) Physical address for the residence the person is moving, 2) DMA 6, 3) DMA 59, & 4) MAO Communicator B. If ineligible for MFP, the hospital should provide the agency provider the relevant documents listed above for follow-up with DFCS office for the Medicaid category changes.	Hospital Contact Individual		
19. Provide the following to the community provider on day of discharge: individualized information from hospital record, current Medicaid card/Medicare Card/Plan, 5 day supply of medications, prescription(s) for an additional 30 days, a copy of the informed consent for psychotropic medication, adaptive equipment in good repair, clothes packed in a suitcase with inventory, personal belongings packed with inventory, Spending money (if available) and current financial statement , contact information for friends from the hospital and decision tree of	DD Chief/Hospital Contact Individual		

Protocol: Transition and Post-Transition Procedures for Assisting Individuals on the DD Transition List
 Attachment A
 Revised 8/29/2011; 9/28/2011; 2/24/2012

Page 4 of 5 Pages

Division of Developmental Disabilities
 Department of Behavior Health Developmental Disabilities
DISCHARGE CHECKLIST FOR TRANSITION TO COMMUNITY PLACEMENT

names and numbers of hospital staff to contact in case of questions.			
--	--	--	--

20. Submit the Day of Discharge Checklist within 3 days of discharge to Tiffany Butler, Division of DD			
21. After approval of all necessary documentation the Regional Office staff (OA) creates and enters the Prior Authorization(s) with a copy to provider.	I&E Manager/OA		
22. After Discharge: If medical and/or behavioral issues are present, the Hospital PLA and appropriate I & E staff, make joint visits until a PA is created, the individual is admitted into a Support Coordination Service, and a Support Coordinator is identified. The PLA completes a monitoring report. The Hospital PLA and the assigned Support Coordinator will make at least one joint visit to the home and ensure continuity of care. PLA will ensure that SC has copy of PCD/ISP.	Support Coordination Agency, Hospital PLA, and I & E staff		
23. Upload completed Discharge Checklist into CIS	Hospital CE		

Protocol: Transition and Post-Transition Procedures for Assisting Individuals on the DD Transition List
 Attachment A
 Revised 8/29/2011; 9/28/2011; 2/24/2012

Page 5 of 5 Pages

Appendix AA: Referral for Housing Choice Voucher Program



Georgia Money Follows the Person Referral Letter for the Decatur Housing Authority Housing Choice Voucher Program



Georgia Department of Community Health • Medicaid Division • Money Follows the Person
Two Peachtree Street, NW • 37th 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 the MFP Transition Coordinator (TC 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 the MFP Facilitator and is hereby requesting an application for participation in the *DHA Housing Choice Voucher Program* in Dekalb county. The MFP participant's screening is complete. The participant's 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 Facilitator Information

Note: the *Application for Housing Choice Rental Assistance* will be mailed to designated MFP facilitator (TC, OC, CE, PLA). When the MFP facilitator receives the Housing Choice Voucher Application packet, **she/he and 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 Facilitator 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 secure email to gamfp@dch.ga.gov, by File Transfer Protocol or **by mail to:**

MFP Housing Manger, Money Follows the Person
DCH, 2 Peachtree Street NW, 37th Floor, Atlanta, Georgia 30303
(404) 651-9961

Appendix AB: MFP Sentinel Event Report Form



MFP Sentinel Event Form



MFP Facilitator (OC, TC, PLA, CE): complete this form when an MFP participant experiences a sentinel event. An individual is considered an MFP participants if (s)he or their guardian has signed the *MFP Consent for Participation* form.

Date of Report: **Waiver CM/CC/SC Name:** **CM/CC/SC Phone:**
Participant First Name: **Participant Last Name:**
Participant Medicaid #: **Participant Date of Birth:**
Name & Address of Nursing Facility/Hospital/ICF Admitted to: (or n/a):
Participant Address: **Participant City:** **State:** **Zip:**
Participant Phone Number: **Other Contact Name:** **Other Phone:**
Provider (if applicable):

Date of Incident:

Location of Occurrence:

Type of Sentinel Event: (Check only one)

- Abuse, Neglect, Exploitation, Hospital/Nursing Facility/ICF Admit,
- Emergency Room Visit, Death, Involvement with Criminal Justice System,
- Medication Administration,
- Other (specify) _____

Detailed summary of event:

Adverse outcomes related to the event: (Any injuries?) Describe in detail.

Witnesses to the event:

Action taken by MFP Facilitator at time of event (Discovery):

MFP/DCH_Sentinel_Event_Form_Revised_061212



MFP Sentinel Event Form



MFP Facilitator Action Plan (Do): (What can be done by MFP Facilitator to prevent this from happening in the future?)

MFP Facilitator Process improvement (Check): (What MFP processes were instituted to evaluate the effectiveness of the action plan and reduce risk to the participant?)

Define follow-up time frames (Act/Monitor) for evaluating effectiveness of processes.

Notification:

	Name	Date	Time
MFP Facilitator 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		
DCH/MFP Office Staff:			
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		
OC/TC/CE Name:	Phone:	Email:	
OC/TC/CE Signature: _____		Date:	

Notice: Send this completed *MFP Sentinel Event Form* to the DCH/MFP Office by secure email via File Transfer Protocol.

MFP/DCH_Sentinel_Event_Form_Revised_061212

Appendix AC: MFP Denial/Termination Letter



Money Follows The Person Notice Of Denial Or Termination Letter



To: _____

Date: _____

Your participation in Money Follows the Person (MFP) has been given careful consideration.

A. 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, and the Georgia Money Follows the Person Policy and Procedures Manual Chapter 600, Section 600.6, Chapter 602, Section 602.5, Chapter 604, Section 604.2, Chapter 605, Section 605.1 and based on initial screening, you have been determined **ineligible** for MFP because:

- You have not resided in an inpatient facility (hospital, nursing facility, ICF) for at least 90 consecutive days, short-term rehabilitative stays do not count.
- You have not been receiving Medicaid benefits for inpatient services provided by an inpatient facility.
- You do not require the level of care provided in an inpatient facility.
- You did not transition into a qualified residence.

B. 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, and the Georgia Money Follows the Person Policy and Procedures Manual Chapter 600, Section 600.6, Chapter 602, Section 602.5, Chapter 605, Section 605.1, you have been determined **no longer eligible** for MFP because:

- You are no longer receiving Medicaid benefits.
- You have moved to a non-qualified residence.
- You no longer meet institutional level of care criteria.
- You have informed us that you no longer wish to participate in MFP.
- You have moved outside of the service area for the State of Georgia.

MFP Facilitator Signature

MFP Facilitator (Print Name)

Telephone Number

If you disagree with this decision, you may request a fair hearing. Your request for a hearing must be received by the Department of Community Health within 30 calendar days from the date of this letter. Your request should be sent to the following address:

Department of Community Health
Legal Services Section
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159

MFP_Denial_Term_Letter_Rev_072412



Money Follows The Person Notice Of Denial Or Termination Letter



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 Notice of Denial letter from the Money Follows the Person Transition Coordinator. Your request should be sent to the following address:

Department of Community Health
Legal Services Section
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159

If you want to keep your services, you must send a written request for a hearing to the Department of Community Health. Your request for a hearing must be *received* by the Department within 30 calendar days from the date of this letter. 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

888-454-5826 (Nursing Homes or Personal Care Homes)

MFP_Denial_Term_Letter_Rev_072412

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 a nursing home or other long-term care facility into the community through 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 long-term care facility. Your responses to the survey questions are extremely important to the success of the Money Follows the Person program, and we appreciate your time and your feedback about the MFP services you received.

Thank you for participating in Money Follows the Person. If you have any questions about this letter, you may contact your MFP Facilitator 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 Facilitator Print Name

Contract Phone #

MFP ENROLLMENT END LETTER_rev_072512

Appendix AE: MFP Right To Appeal Letter



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. Your request for a hearing must be received by the Department of Community Health within 30 calendar days from the date of this letter.

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 Notice of Right to Appeal a Decision letter from the Money Follows the Person Transition Coordinator. Your request should be sent to the following address:

Department of Community Health
Legal Services Section
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159

If you want to keep your MFP transition services, you must send a written request for a hearing to the Department of Community Health. Your request for a hearing must be *received* by the Department within 30 calendar days from the date of this letter. 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

888-454-5826 (Nursing Homes or Personal Care Homes)

MFP Transition Coordinator/CE Signature

MFP TC/CE (Print Name)

Telephone Number

MFP_Right_to_Appeal_Decision_MFP_Svs_Revised_060612

Appendix AF: MFP Participant Complaint Form



MFP Participant Complaint Form



Use this form to report a complaint regarding a MFP service delivered to a participant. Complete separate form for each complaint.

Participant First Name: _____ Participant Last Name: _____
 Participant Medicaid #: _____ Participant Date of Birth: _____
 Participant Address: _____ City: _____ Zip: _____
 Participant Phone Number: _____ Other Contact Name: _____ Other Phone: _____
 Date of Discharge from NF/Institution: _____ Waiver: _____
 MFP Facilitator Name: _____ Phone: _____ Email: _____
 Date of Complaint: _____ Name of Person Completing Complaint Form: _____

Summary of Complaint/Issues to Resolve:

Action Plan:

Process Improvement (what was instituted to evaluate the action plan and reduce risk to the participant?)

Define follow-up time frames (Act/Monitor) for evaluating effectiveness of process:

If applicable, complete information and select the MFP service that is focus of complaint:

Vendor	MFP Transition Service
--------	------------------------

Note: (1) Send this completed *Participant Complaint Form* to the DCH/MFP Office via File Transfer Protocol.

MFP/DCH_Participant_Complaint_Form_rev_062612

Appendix B: MFP Transition Services Table

Appendix B: MFP Services Table Revised 072312

Medicaid Rate	Pre-Transition Service	Procedure Code	Modifiers	MFP 3 Digit Service Code	Rate	Description	Maximum Cost per Service	Transition Financial Service
Enhanced	Peer Community Support	T2038	Q2, U1	PES	1 unit = one hour contact, billable in quarter-hour increments, at \$50 per unit/hour; a maximum of 40 units/hours, for a total not to exceed \$2,000, ends on day 365 of the demonstration period. 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	
Enhanced	Trial Visit- Personal Support Services (PCH/CRA)	T2038	Q2, U2	PSS	1 unit of personal support = the current rate provided by the appropriate wavier. Limited to 74 hours for ICWP and 55 hours for CCSP and SOURCE or 1 unit of residential services = 1 day at \$65 per day, limited to 6 days. In NOW/COMP, 1 unit of CLSS/CRA = 1 day at \$156, limited to 6 days. Not to exceed \$1044 per member, ends on day 365 of the MFP demonstration period.	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-transition by a participant who's PSS services are arranged but delayed. ***	\$1,044	
Enhanced	Household Furnishing	T2038	Q2, U3	HHF	Limited to \$1,500 per participant - ends on day 365 of the MFP demonstration period.	This service provides assistance to participants requiring basic household furnishings (e.g., bed, table, but not limited to items listed) to help participants transition back into the community. This service is intended to help the participant with the initial set-up of their qualified residence. ***	\$1,500	
Enhanced	Household Goods and Supplies	T2038	Q2, U4	HGS	Limited to a maximum of \$750 per participant, to be used during the 365 day demonstration period. The purchase of groceries is limited to a one-time purchase not to exceed \$200.	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. This service may include a one-time purchase of groceries (up to \$200) to assist a participant with setting up their qualified residence. ***	\$750	
Enhanced	Moving Expenses	T2038	Q2, U6	MVE	Limited to a maximum of \$850 per participant - to be used during the 365 day demonstration period.	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. 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 the 365 day demonstration period. ***	\$850	
Enhanced	Utility Deposits	T2038	Q2, U6	UTD	Limited to \$500 per participant- ends on day 365 of the MFP demonstration period.	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	
Enhanced	Security Deposits	T2038	Q2, U7	SCD	Limited to \$1,000 per participant- ends on day 365 of the MFP demonstration period.	This service is used to assist participants with housing application fees and required security deposits for a qualified residence. ***	\$1,000	
Enhanced	Transition Support	T2038	Q2, U8	TSS	Limited to \$600 per participant - ends on day 365 of the demonstration period.	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	
Enhanced	Transportation	T2038	Q2, U9	TRN	1 unit = a one-way trip, up to \$500 (when necessary), service is designed to cover the cost of multiple one-way or round trips totaling no more than \$500, can be a pre and post-transition, ends on day 365 of the demonstration period.	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	
Enhanced	Life Skills Coaching	T2038	Q2, U10	LSC	1 unit = one half-hour of contact training/coaching or group/individual training activities, billable at \$25 per half-hour, to a maximum of 60 units or 30 hours training/coaching, delivered by a qualified trainer/coach, limited to \$1,500 per participant, ends on day 365 of the demonstration period. 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 up to 30 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, didactic, 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 training/coaching evaluation. ***	\$1,500	
Not to exceed							\$10,244	\$1,844

Appendix B: MFP Services Table Revised 072312

Medicaid Rate	Post-Transition Service	Procedure Code	Modifiers	MFP 3 Digit Service Code	Rate	Description	Maximum Cost per Service	Financial Service Fee total
Enhanced	Skilled Out-of-Home Respite	T2038	Q2, U11	SCR	1 unit = \$134.17 per day, limited to 14 units or \$1,878.38 per member - ends on day 365 of the MFP demonstration period.	This service provides a brief period of support or relief for caregivers or family members caring for an elderly or disabled individual. This service will pay for up to 14 days during the MFP 365 day demonstration. 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. ***	\$1,878	
Enhanced	Caregiver Outreach & Education	S5110	Q2, U12	COE	1 unit = one half-hour of contact caregiver training, billable at \$25 per half-hour, to a maximum of 40 units or 20 hours, delivered by a qualified caregiver specialist, limited to \$1,000 per participant, ends on day 365 of the demonstration period. 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	
Enhanced	Community Ombudsman	T2038	Q2, U13	COB	1 unit = one hour contact at \$150 per hour, billable in quarter-hour increments at \$37.50, limited to \$1,800 per participant, ends on day 365 of the demonstration period. Rate includes all costs associated with delivery of service.	This service provides periodic, face-to-face (F2F) contacts made by a certified community ombudsman, 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 (as defined under DRA of 2006 and ACA 2010). Three face-to-face contacts are required, additional contacts (F2F or phone contacts) can be arranged as needed. A case note is required to document each contact. ***	\$1,800	
Enhanced	Equipment, Vision, Dental and Hearing Services	T2038	Q2, U14	EQS	Limited to \$4,000 per participant - ends on day 365 of the MFP demonstration period.	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 Medicaid. 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 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. Three quotes are required for purchase of a single piece of equipment costing \$1000 or more. ***	\$4,000	
Enhanced	Specialized Medical Supplies	T2038	Q2, U15	SMS	Limited to \$1,000 per participant - ends on day 365 of the MFP demonstration period.	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, food supplements, special clothing, bed wetting protective chucks, diabetic supplies and other supplies that are identified in the approved Individualized Transition Plan (ITP) and/or the Individual Service Plan (ISP) and that are not otherwise covered by Medicaid. Ancillary supplies necessary for the proper functioning of approved supplies are also included in this service. ***	\$1,000	
Enhanced	Vehicle Adaptations	T2038	Q2, U16	VAD	Price of the lowest quote, limited to \$6,240 per member-ends on day 365 of the MFP demonstration period.	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 while moving. Three quotes are required for adaptations of \$1000 or more. ***	\$6,240	
Enhanced	Environmental Modification	T2038	Q2, U17	EMD	Price of the lowest quote, limited to \$8,000 per member-ends on day 365 of the MFP demonstration period.	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. Two scope/bids are required, three scope/bids are recommended. 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	
Enhanced	Home Inspection	T2039	Q2, U18	HIS	1 unit = one inspection with relevant report from a qualified inspector, billable at \$250, limited to \$1,000, ends on day 365 of the MFP demonstration period.	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 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 vendors/contractors providing the environmental modifications. ***	\$1,000	
Enhanced	Supported Employment Evaluation	S5110	Q2, U19	SEE	1 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, ends on day 365 of the demonstration period.	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. ***	\$1,500	
Maximum Post-transition cost							\$26,418	\$4,765

***MFP service procedures are based on authorized and approved services as specified in the participant's service plan. ** Q2-HCFA/ORD demonstration project procedures / service; U-Medicaid Level of Care (1 thru 20), as Defined by Georgia Medicaid (DCH)

Appendix C: MFP 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: gamfmp@dch.ga.gov
dch.georgia.gov/mfp

Money Follows the Person



866-55-AGING (866-552-4464);
888-454-5826
Email: gamfmp@dch.ga.gov





"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 | Email: gamfp@dch.ga.gov

Appendix D1 MFP Authorization for Use of Information



MFP Authorization For Use Or Disclosure of Health Information

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 use or disclosure of my health information as follows:

Member Name: _____

Medicaid #: _____

Health Plan Name: _____

Persons/Organizations authorized to *receive, use or disclose* the information ⁱ are:

- Options Counselors/ MFP Transition Coordinators/ Case Expeditors
- Waiver assessment/case management staff
- Representative (Legal, etc.)
- MFP service providers (Peers, Ombudsman, etc.)

Purpose of requested use or disclosure: ⁱⁱ for screening and assessment and participation in the MFP Project.

This Authorization applies to the following information (select **only one** of the following):ⁱⁱⁱ

- 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 nursing facility/institution 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 all transactions related to my participation in the Money Follows the Person Project on matters related to services provided to me through the Money Follows the Person Project.

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.



MFP Authorization For Use Or Disclosure of Health Information

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.^{iv}

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.^v

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

ⁱ If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

ⁱⁱ 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.

ⁱⁱⁱ 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.

^{iv} 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)).

^v 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 D2: 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) projectⁱ. The MFP Transition Coordinator/Case Expediter 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 daysⁱⁱ.

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 a hospital, nursing home or ICF, 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

Date **MFP Facilitator Sign**

ⁱ 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

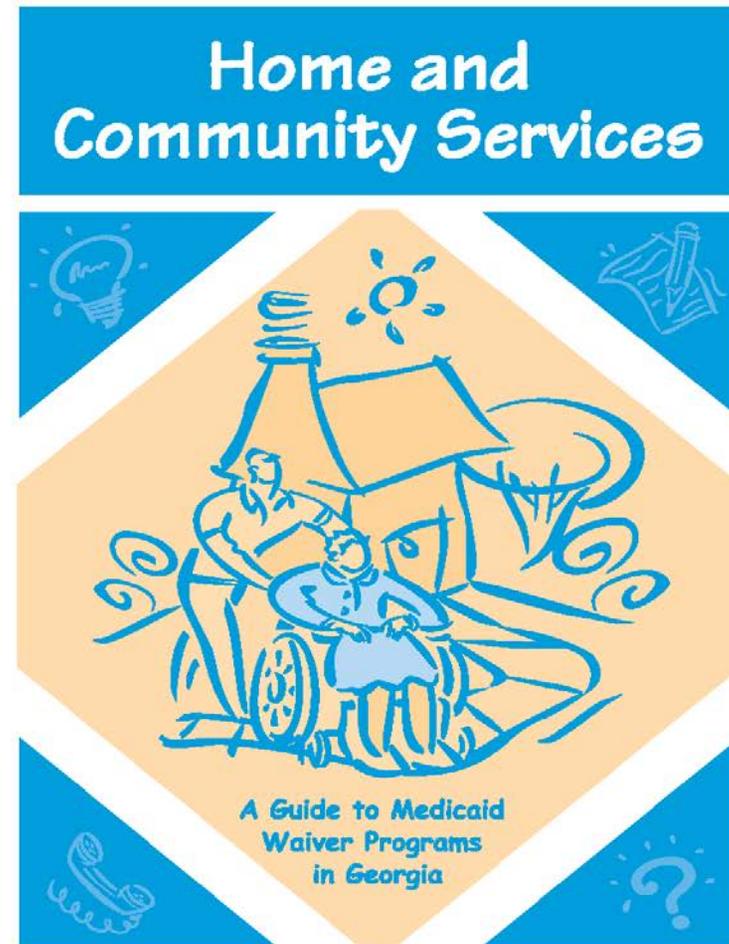
ⁱⁱ If the MFP participant needs to be readmitted to an inpatient facility for a period of 30 days or less, the participant remains enrolled in the MFP demonstration. As soon as the participant's condition stabilizes, the participant can return to the community and resume MFP and waiver services. When 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 discharged from the MFP demonstration and is considered an institutional resident. However, the discharged 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 demonstration participant when discharged from the inpatient facility and is eligible to receive MFP services for any remaining days up to 365. The MFP Transition Coordinator determines if any changes to the participant's Individualized Transition Plan are needed to prevent a re-admission to an inpatient facility. If the participant readmitted to an inpatient facility for a period of longer than six months, the participant will be re-evaluated like a "new" MFP participant.

MFP Informed Consent_Revised_072512

Appendix E: 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**.





- 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.

HOME AND COMMUNITY SERVICES



Table of Contents

Home and Community Services	1
What is Medicaid?	3
How to Apply for Medicaid Home and Community-based (waiver) Services	3
Medicaid Home and Community-based (waiver) Programs.....	4
■ Elderly and Disabled Waiver	6
■ SOURCE	8
(Service Options Using Resources in a Community Environment)	
■ Independent Care Waiver Program (ICWP)	13
■ Mental Retardation, Developmental Disabilities &.....	15
Addictive Diseases (MRDDAD)	
■ Money Follows the Person (MFP)	17
■ Georgia Pediatric program (GAPP)	
Medical Day Care Services - Waivered Service	20
What Other Services Does Medicaid Cover?	22
What's Not Covered?	24
Your Rights and Responsibilities	24
Telephone Numbers and Web Sites.....	Inside back cover

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.





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.

Appendix F:AAA Gateway Network and Affiliated Agency

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>Atlanta Region</p> <p>Cherokee Clayton Cobb DeKalb Douglas Fayette Fulton Gwinnett Henry Rockdale</p>	<p>Cathie Berger, AAA Director Atlanta Regional AAA 40 Courtland Street, N.E. Atlanta, GA 30303-2538 (404) 463-3100 Fax: (404) 463-3264 Aging Connection: 1-800-676-2433 or (404) 463-3333</p> <p>Email: cberger@atlantaregional.com</p> <p>Website: aginginfo@atlantaregional.com</p>	<p>Charles C. Krautler, Executive Director Atlanta Regional Commission 40 Courtland Street, N.E. Atlanta, GA 30303-2538 (404) 463-3100 Fax: (404) 463-3105</p> <p>Email: ckrautler@atlantaregional.com</p> <p>Fulton County</p>
<p>Central Savannah River Area</p> <p>Burke Columbia Glascok Hancock Jefferson Washington Jenkins Lincoln McDuffie</p> <p>Richmond Screven Taliaferro Warren</p> <p>Wilkes</p>	<p>Jeanette Cummings, AAA Director Central Savannah River AAA 3023 Riverwatch Parkway Suite A, Bldg 200 Augusta, GA 30907-2016 (706) 210-2013 Director Direct Line (706) 210-2000 Aging Program Fax: (706) 210-2006 Aging Connection: 1-888-922-4464</p> <p>E-mail: jcummings@csrarc.ga.gov Website: www.csrarc.ga.gov</p>	<p>Andy Crosson, Executive Director Central Savannah River Area Regional Commission 3023 Riverwatch Parkway Suite A, Bldg 200 Augusta, GA 30907-2016 (706) 210-2000 Fax: (706) 210-2006</p> <p>E-mail: acrosson@csrarc.ga.gov</p> <p>Richmond County</p>

Planning & Service Area	AAA Director Name of AAA Address, Phone & E-Mail	Executive Director Name of Agency Address, Phone & E-Mail
<p>Coastal Georgia</p> <p>Bryan Bulloch Camden Chatham Effingham Glynn Liberty Long McIntosh</p>	<p>Dionne Campbell (Interim AAA Director) Coastal Georgia AAA 127 F Street Brunswick, GA 31520 (912) 262-2822 Fax: (912) 262-2313 Information Link: 1-800-580-6860</p> <p>Email: dcampbell@crc.ga.gov</p> <p>Website: www.crc.ga.gov</p>	<p>Allen Burns, Executive Director Coastal Regional Commission of Georgia 127 F Street Brunswick, GA 31520 (912) 262-2800 Fax: (912) 262-2313</p> <p>Email: aburns@crc.ga.gov</p> <p>Glynn County</p>
<p>Georgia Mountains</p> <p>Banks Dawson Forsyth Franklin Habersham Hall Hart Lumpkin Rabun</p> <p>Stephens Townsend Union White</p>	<p>Pat Freeman, AAA Director Legacy Link AAA P. O. Box 2534 Gainesville, GA 30503-2534 (770)538-2650 Fax: (770)538-2660 Intake Screening: 1-800-845-5465</p> <p>Physical Address: 508 Oak St., Ste 1, 30501</p> <p>E-mail: pvfreeman@legacylink.org</p> <p>Website: www.legacylink.org</p>	<p>Pat Freeman, Executive Director The Legacy Link, Inc. P.O. Box 2534 Gainesville, Georgia 30503-2534 (770) 538-2650 Fax: (770) 538-2660</p> <p>E-mail: pvfreeman@legacylink.org</p> <p>Hall County</p>

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>Heart of Georgia Altamaha</p> <p>Appling Montgomery Bleckley Tattnall Candler Telfair Dodge Toombs Emanuel Treutlen Evans Wayne Jeff Davis Wheeler Johnson Wilcox Laurens</p>	<p>Gail Thompson, AAA Director Heart of Georgia Altamaha AAA 331 West Parker Street Baxley, GA 31513-0674 (912)367-3648 Fax: (912)367-3640 or (912)367-3707 Toll Free: 1-888-367-9913</p> <p>E-mail: thompson@hogarc.org</p> <p>Website: www.hogarc.org</p>	<p>Alan R. Mazza, Executive Director Heart of Georgia Altamaha Regional Commission 5405 Oak Street Eastman, Georgia 31023-6034 (478) 374-4771 Fax: (478) 374-0703</p> <p>E-mail: mazza@hogarc.org</p> <p>Dodge County</p>
<p>Middle Georgia</p> <p>Baldwin Peach Bibb Pulaski Crawford Putnam Houston Twiggs Jones Wilkinson Monroe</p>	<p>Geri Ward, AAA Director Middle Georgia AAA 175 Emery Highway, Suite C Macon, GA 31217-3679 (478)751-6466 Fax: (478)752-3243 Toll free: 1-888-548-1456</p> <p>E-mail: gward@mg-rc.org</p> <p>Website: www.mg-rc.org</p>	<p>Ralph Nix, Executive Director Middle Georgia Regional Commission 175 Emery Highway, Suite C Macon, GA 31217-3679 (478) 751-6160 Fax: (478) 369-6517</p> <p>E-mail: rnix@mg-rc.org</p> <p>Bibb County</p>

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>Northeast Georgia</p> <p>Barrow Clarke Elbert Greene Jackson Jasper Madison Morgan</p> <p>Newton Oconee Oglethorpe Walton</p>	<p>Peggy Jenkins, AAA Director Northeast Georgia AAA 305 Research Drive Athens, GA 30610 (706)369-5650 Fax: (706)425-3370 Toll free: 1-800-474-7540</p> <p>E-mail: pjenkins@negrc.org</p> <p>Website: www.negrc.org</p>	<p>James R. Dove, Executive Director Northeast Georgia Regional Commission 305 Research Drive Athens, GA 30605 (706) 369-5650 Fax: (706) 369-5792</p> <p>E-mail: jdove@negrc.org</p> <p>Clarke County</p>
<p>Northwest Georgia</p> <p>Bartow Catoosa Chattooga Dade Fannin Floyd Gilmer Gordon Harralson</p> <p>Murray Paulding Pickens Polk Walker Whitfield</p>	<p>Debbie Studdard, AAA Director Northwest Georgia AAA P.O. Box 1798 Rome, GA 30162-1798 (706) 295-6485 Fax: (706) 295-6126 Toll Free: 1-888 -732-4464 Screening Fax: (706) 802-5506</p> <p>Physical Address: 1 Jackson Hill Dr. 30161</p> <p>E-mail: dstuddard@nwgrc.org</p> <p>Website: www.nwgrc.org</p>	<p>William R. Steiner, Executive Director Northwest Georgia Regional Commission P.O. Box 1793 Rome, GA 30162-1793 (706) 295-6485 Fax: (706)295-6126</p> <p>E-mail: wsteiner@nwgrc.org</p> <p>Floyd County</p>

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>River Valley</p> <p>Chattahoochee Quitman Clay Randolph Crisp Schley Dooley Stewart Harris Sumter Macon Talbot Marion Taylor Muscogee Webster</p>	<p>Tiffany Ingram, AAA Director River Valley AAA 1428 Second Avenue P.O. Box 1908 Columbus, GA 31902-1908 (706)256-2910 Fax: (706)256-2908 Toll Free: 1-800-615-4379</p> <p>E-mail: t Ingram@rivervalleyrcaaa.org</p> <p>Website: www.rivervalleyrc.org</p>	<p>Patti Cullen, Executive Director River Valley Regional Commission 1428 Second Avenue P.O. Box 1908 Columbus, GA 31902-1908 (706) 256-2910</p> <p>E-mail: pcullen@rivervalleyrc.org</p> <p>Muscogee County</p>
<p>Southern Georgia</p> <p>Atkinson Cook Bacon Echols Ben Hill Irwin Berrien Lanier Brantley Lowndes Brooks Pierce Charlton Tift Clinch Turner Coffee Ware</p>	<p>Wanda Taft, AAA Director Southern Georgia AAA 1725 South Georgia Parkway, West Waycross, GA 31503-8958 (912)285-6097 Fax: (912)285-6126 Toll Free: 1-888-732-4464</p> <p>E-mail: wtaft@sgrc.us</p> <p>Website: www.sgrc.us</p>	<p>John L. Leonard, Executive Director Southern Georgia Regional Commission 327 West Savannah Avenue P.O. Box 1223 Valdosta, GA 31603-1223 (229) 333.5277 Fax: (229) 333-5312</p> <p>E-mail: jleonard@sgrc.us</p> <p>Ware County</p>

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>Southwest Georgia</p> <p>Baker Lee Calhoun Miller Colquitt Mitchell Decatur Seminole Dougherty Terrell Early Thomas Grady Worth</p>	<p>Kay Hind, AAA Director SOWEGA AAA 1105 Palmyra Road Albany, GA 31701-1933 (229)432-1124 Fax: (229)483-0995 Toll free: 1-800-282-6612</p> <p>E-mail: khhind@dhr.state.ga.us</p> <p>Website: www.sowegacoa.org</p>	<p>Kay Hind, Executive Director SOWEGA Council on Aging, Inc. 1105 Palmyra Road Albany, GA 31701-1933 (229) 432-1124</p> <p>E-mail: khhind@dhr.state.ga.us</p> <p>Dougherty County</p>
<p>Three Rivers</p> <p>Butts Pike Carroll Spalding Coweta Troup Heard Upson Lamar Meriwether</p>	<p>Joy Shirley, AAA Director Southern Crescent AAA P.O. Box 1600 Franklin, GA 30217-1600 (706)407-0016 or (678)552-2853 Fax: (706) 675-9210 or (770)854-5402 Toll Free: 1-866-854-5652</p> <p>Physical Address: 13273 Hwy. 34 East</p> <p>E-mail: jyshirley@threeriversrc.com</p> <p>Website: www.scaaa.net</p>	<p>Lanier E. Boatwright Jr., Executive Director Three Rivers Regional Commission 120 North Hill Street P.O. Box 818 Griffin, GA 30224-0818 (770) 227-6300 Fax: (770) 227-6488</p> <p>E-mail: lboatwright@threeriversrc.com</p> <p>Spalding County</p>

Appendix G: MFP Screening Form



Money Follows the Person (MFP) Transition Screening Form



Participant Name: _____

(Screener note: Establish rapport before beginning the screening process).

1. Do you want to live somewhere other than this facility? Yes No

Screening Type/Date: (Check only 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: _____		Date of Initial MFP referral: _____ (mm/dd/yyyy) Date of Referral To Waiver: _____ (mm/dd/yyyy)		Referral Source: <input type="checkbox"/> Nursing Facility <input type="checkbox"/> MDSQ <input type="checkbox"/> Self <input type="checkbox"/> Family Member <input type="checkbox"/> AAA, CIL, LTCO, etc. <input type="checkbox"/> ADRC <input type="checkbox"/> Waiver Case Mgr <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Legal Representative <input type="checkbox"/> Other: (specify) _____		Notes:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian or Pacific Is. <input type="checkbox"/> Hispanic <input type="checkbox"/> Latino <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____	Population (Check only one): <input type="checkbox"/> Older Adult (60+) <input type="checkbox"/> Physical Disability <input type="checkbox"/> TBI <input type="checkbox"/> DD <input type="checkbox"/> Other (specify): _____		Referral to: <input type="checkbox"/> CCSP <input type="checkbox"/> SOURCE <input type="checkbox"/> Independent Care Waiver (ICWP) <input type="checkbox"/> NOW/COMP <input type="checkbox"/> State Plan Service <input type="checkbox"/> Non-Medicaid HCBS <input type="checkbox"/> Other (specify): _____		Refused/ineligible: <input type="checkbox"/> in NF < 90 days <input type="checkbox"/> no Medicaid <input type="checkbox"/> didn't meet LoC <input type="checkbox"/> costs > than NF <input type="checkbox"/> insufficient community svcs <input type="checkbox"/> didn't locate qualified residence <input type="checkbox"/> didn't want to participate <input type="checkbox"/> changed mind <input type="checkbox"/> family/guardian refused permission <input type="checkbox"/> Other: _____	
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: _____ Contract: _____			

(Screener Note: List persons participating in the screening or attach sign-in sheet).

Personal Data:

2. Medicaid # _____ Medicare # _____

3. First Name: _____ MI: _____ Last Name: _____

4. SSN: _____ -- _____ -- _____ Date of Birth (mm/dd/yyyy) _____

5. Facility Name and Address: _____

City: _____, Zip: _____ Phone: _____

6. Discharge Planner/Contact: _____ Phone : _____



**Money Follows the Person (MFP)
Transition Screening Form**



Participant Name: _____

7. Marital Status: Single Mar Div Widowed Sep Other: _____

8. Spouse Name and address: _____

9. Are you a veteran? Yes No. Did you serve during wartime? Yes No

10. Do you have a guardian: Yes No If yes, list name and contact information:

(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:

11. Where did you live before you came here? _____

12. What were the reasons you entered this facility? _____

13. How long have you lived here at this facility? _____ years _____ months

(Screener note: to qualify for MFP, the person must have resided in the nursing facility/institution for a minimum of 90 consecutive days).

14. Do you have any family living in this area? Yes No

If yes, list name, phone number and address:

15. Do you have a close relationship with family member(s) or friend(s) that can assist you: Yes No

(Screener note: At this point in the interview, introduce, review and obtain signature on *Authorization for Release of Information* and *Informed Consent for MFP*).

16. May we contact a family member(s) or friends(s) to meet with you and us to discuss your move into the community? Yes No

17. If yes, please provide their name(s) and telephone number(s): _____

18. Do you have a home to move back into? Yes No

If yes, the address of your home: _____



**Money Follows the Person (MFP)
Transition Screening Form**



Participant Name: _____

19. If applicable, does anyone live in your home? Yes No

What are their names and relationship to you? _____

(Screener note: introduce MFP qualified housing options. Tell the candidate that while MFP will assist the person to locate qualified housing, the MFP program does not cover the cost of rent or utilities and that to participate in MFP, the person must enter one of the following types of qualified housing--

- A home owned or leased by the individual or the individual's family member,
- An apartment with an individual lease, with lockable entry door, that includes living, sleeping and bathing and cooking areas over which the individual or the individual's family have domain and control, or
- A residence, in a community based residential setting, in which no more than 4 unrelated individuals reside)

20. Which type of qualified housing are you interested in and why? _____

21. Do you have someone you want to live with? Yes No
If yes, list contact information _____

22. Did you receive services in your home before coming to (name of facility)?
 Yes No If yes, what service(s): _____

23. Are you currently on a waiver waiting list for home & community based services?
 Yes No If so, which waiver? _____

24. Do you have a letter or contact information from the waiver? Yes No
If yes, where is the letter or contact information and/or who can bring these to you? _____

(Screener note: contact the waiver program manger for this information).



**Money Follows the Person (MFP)
Transition Screening Form**



Participant Name: _____

Financial Data:

(Screener note: Review facility records to obtain or confirm this information. The signed informed consent should allow you to obtain these records).

25. Income and Resources:

SOURCE	MONTHLY AMOUNT	PAYEE
<input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> SS Retirement		
PENSION BENEFITS		
TRUST PROCEEDS		
INHERITANCE		
VETERAN'S COMPENSATION		
CASH		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
SAVINGS ACCOUNT (DESIGNATED BURIAL)		
CEMETERY PLOT		
RAILROAD RETIREMENT		
LIFE INSURANCE		
CERTIFICATE OF DEPOSIT		
OTHER (SPECIFY)		



**Money Follows the Person (MFP)
Transition Screening Form**



Participant Name: _____

26. Who is paying for your stay here at (this facility)? _____

27. Are you Medicaid eligible, but subject to transfer of asset penalty?
 Yes No Don't Know (Screener note: check facility records)

Health Care Needs:

28. Disability/Diagnoses (include Self-Reported Diagnoses): _____

29. Who is your doctor here at (name of facility)?

30. Do you have a primary care doctor in the community? Yes No

If yes, what is her/his name and contact information? _____

31. Do you need help taking your daily medications? Yes No

Describe assistance needed: _____

32. What specialized medical equipment (DME) and assistive technology devices do you use?

33. Which equipment or devices need to be obtained because you don't own them or they need to be replaced?



**Money Follows the Person (MFP)
Transition Screening Form**



Participant Name: _____

34. 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. Continence	<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	
KEY Assistance Needed in the Community Ask: Do you need help with _____ (activities listed above #1-15)? When appropriate, observe the person in the activity.		Unmet Need for Care – when person returns to the community Ask: When you return to the community, do you have an unmet need for someone to help you with _____ (activities listed above #1-15)? If participant has assistance of family/friend/caregiver or assistive device, the answer would be NO . If participant has no assistance , the answer would be YES (there is an unmet need for care) . Note observations in case comments.	



**Money Follows the Person (MFP)
Transition Screening Form**



Participant Name: _____

35. Home Community Based Service (HCBS) referral to:
- CCSP (AAA/Gateway)
 - SOURCE (SOURCE Case Management)
 - Independent Care Waiver (ICWP) (GMCF)
 - NOW/COMP Waiver (Regional DBHDD or DBHDD-DDD/MFP Office)
 - State Plan Services (list) _____
 - Non Medicaid HCBS (specify) _____

36. Date of referral to waiver _____ (mm/dd/yyyy).

37. Date HCBS application submitted: _____ (mm/dd/yyyy)

38. Date HCBS waiver assessment completed: _____ (mm/dd/yyyy)

39. 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 Screening Form with referral to AAA/Gateway and/or GMCF).

- 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: _____

OC/TC Name: _____ Date: _____

OC/TC Phone: _____ Email: _____

Note to OC/TC: the *MFP 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 39 is signed.

Send this completed *MFP Screening Form* to the DCH/MFP Office by File Transfer Protocol (FTP).

Appendix H: MFP Participant Transition Planning Guide (pages 1-11)



Money Follows the Person

Participant Transition Planning Guide

for returning to the community
2012

MFP Participant Name: _____

Anticipated Discharge Date: _____



Money Follows the Person (MFP) Contact Information

If you are an older adult or a person with a physical disability or acquired brain injury and want more information about MFP, contact:

The Department of Human Services, Aging and Disability Resource Connections (ADRCs) at **866-55-AGING** (866-552-4464)

The Georgia Department of Community Health (DCH), Money Follows the Person (MFP) at **404-657-9323** or **404-651-6889**

The Office of the Long-Term Care Ombudsman at **888-454-5826**

Website:
dch.georgia.gov/mfp

E-mail:
gamfp@dch.ga.gov

If you are a person with a developmental disability and want more information about MFP, contact the Department of Behavioral Health and Developmental Disabilities (DBHDD), Regional Office nearest you:
Region 1 DBHDD Office (Rome):
706-802-5272

Region 2 DBHDD Office (Augusta):
706-792-7733

Region 3 DBHDD Office (Tucker):
770-414-3052

Region 4 DBHDD Office (Thomasville):
229-225-5099

Region 5 DBHDD Office (Savannah):
912-303-1670

Region 6 DBHDD Office (Columbus):
706-565-7835

Transition Guide Icons

The following icons will help remind you to take action or call attention to important activities and information:

-  Information
-  Medical Equipment and Supplies
-  Assignment
-  Daily Support
-  Moving
-  Self-Direct
-  Affordable Housing
-  Community Activities
-  Transportation Options

Would you like to return to your home or community?

Money Follows the Person could be your answer!



If You:

- Are Medicaid-eligible and have lived for at least three months in a nursing facility or an Intermediate Care Facility (ICF); AND
- Have a strong desire to live in the community

Read on:

This booklet will help you understand the services and support that are available through *Money Follows the Person* (MFP) to help you successfully move back into your home or a qualified residence in the community. In addition, this booklet contains information that you will need to move into the community.

MFP offers you support so you are not alone in the transition process. You will get help to plan your short-term and long-term goals, help with services and support you need to make your move and follow-up visits for the first year of living in the community. A number of people will be available to assist you. Options Counselors (OCs) and MFP Transition Coordinators (TCs) will help with planning and coordinate the services you need to move.

What's Inside

Are You Interested in Moving?..... 6
 The Choice is Yours 6
 Some Simple Ground Rules 7

What are Medicaid Home and Community-Based Programs?..... 8
 Documents You Will Need 8

What MFP Services Do You Need? 9
 Assignment: MFP Services 13

Identify Who Will Assist You 14
 Your Transition Team 14
 Circle of Friends/Circle of Support 15
 Peer Supporters 15
 Advocacy Partners 16
 Providers 16
 Court-Appointed Guardian 16

Complete Your Individualized Transition Plan..... 17
 Assignment: Complete Your Self-Assessment 17
 Personal Finances and Budget Worksheet 20

Apply for a Home and Community-Based Service Waiver 24
 What Will My Waiver Case Manager Do? 28
 Assignment: Apply for a Waiver 28

Locate Appropriate Housing..... 30
 Assignment: Complete the Housing Needs Assessment 32
 Conduct a Housing Search 37
 Affordable (Non-Subsidized) Housing Resources 38
 Affordable (Subsidized) Housing Resources 39
 Housemate and Roommate Match Services 40
 Public Housing and Housing Choice Vouchers 41

Identify Daily Health Services, Supplies and Equipment You Need..... 43
 Assignment: Complete Healthcare and Nutrition Worksheet 44

Identify Daily Support You Need..... 48
 Assignment: Complete the Personal Support Services Log 49
 24/7 Emergency Backup Service Plans 51
 Independent Living Skills Training 53

Do You Want To Self-Direct?..... 54
 Assignment: Self-Direction 59

Identify Transportation Options 59
 Assignment: Complete Transportation Planning Worksheet 60

Complete Community Activities 65
 Assignment: Complete Social & Recreational Planning Worksheet 66
 Training, School and Employment 68

Moving Day (Discharge Day) and Beyond 70
 Your First Year in the Community 71
 Your Waiver Services Continue After MFP 72
 Assignment: Complete Discharge Day Planning Worksheet 73
 Short-Term Hospitalizations or Nursing Facility/Rehab Stays 76

Quick Reference Guide to Resources..... 78
 Centers for Independent Living (CIL) 78
 Area Agency on Aging (AAA) 81
 Aging and Disability Resource Connections (ADRC) 85
 SOURCE Providers 88
 Startup Household Goods & Supplies 96
 Startup Household Goods & Supplies Worksheet 97
 Documents Needed for Housing Searches 100
 Benefits and Services for MFP Participants by Waiver 102
 Health and Emergency Resources 104
 Emergency Food Resources 107
 Durable Medical Equipment and Assistive Technology Equipment
 and Services 108
 Environmental Modification Services 110
 Legal Services 113
 Additional Transportation Resources 114
 Training and Employment Resources 115

Are You Interested in Moving?

In 1999, the United States Supreme Court issued a landmark decision in *Olmstead v. L.C.* recognizing that “unjustified institutional isolation of persons with disabilities is a form of discrimination” under the Americans with Disabilities Act (ADA). As a qualified Medicaid-eligible person, you should know that *Olmstead v. L.C.* gives you the choice to return to the community from a nursing facility, hospital or Intermediate Care Facility (ICF). You now have a choice of where you want to live – you can stay in the nursing facility, hospital or ICF or you can return to your community. Georgia is implementing the *Olmstead* agreement in part by using the MFP Demonstration, a \$93 Million Grant awarded to Georgia Department of Community Health (DCH) to transition eligible participants through 2020. The MFP Grant was awarded by the Centers for Medicare & Medicaid Services (CMS) to DCH, Medicaid Division, Aging and Special Populations Unit.

6

The Choice is Yours



The first step is to express interest in *Money Follows the Person* (MFP) to one of the contacts listed on page 2, or by notifying the social worker at your nursing facility or Intermediate Care Facility (ICF). The social worker will coordinate a visit from an Aging and Disability Resource Connections (ADRC) Options Counselor or MFP Transition Coordinator. The Options Counselor or Transition Coordinator will review MFP with you and tell you how it works. If you are interested, you will sign the *MFP Consent for Participation* and you will complete the *Authorization for Use of Health Information*. Next, you will be screened for entry into the program. During the screening, you will be asked questions to get a better picture of your goals, needs and resources. Once the screening is complete, the Options Counselor and/or Transition Coordinator will help you complete the *Quality of Life Survey*. If you decide not to participate, there will be no penalty or loss of any current benefits.

Some Simple Ground Rules

MFP offers transition services to qualified, Medicaid-eligible older adults, adults and children with all types of disabilities. An ADRC Options Counselor or MFP Transition Coordinator will assist you in understanding the information and help you choose the services and support you need to live in the community.

There are many factors that determine how long it will take to make your move to the community. Some of these factors include identifying your goals and resources, locating housing, identifying and obtaining the health services and equipment you need, identifying the daily support services you need and identifying transportation options. **The most important factor will be how actively involved you are in the transition process.**

The transition process is based on trust. You must be honest with your Transition Coordinator and each member of your transition team at all times during the transition process. Dishonesty can cause difficulties which can slow down or stop the process. Your transition team members (see *Identify Who Will Assist You*, page 14) are there to help you leave the nursing facility or ICF, not to judge you.

For more information on your rights and responsibilities, ask for a copy of the booklet called *Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia*.

7

What are Medicaid Home and Community-Based Programs?

Documents You Will Need

You will need your Medicaid card. Usually, Medicaid pays for your stay in the nursing facility unless you have private insurance or someone is paying for your stay. If you do not have your Medicaid card yet, you should apply. Ask the social worker at your nursing facility or ICF to help you get your Medicaid card. Medicaid will pay for participating doctors, pharmacists, hospitals and other providers of your care in the community.

In addition to the MFP services listed on pages 9 – 12, you may be eligible for a variety of Home and Community-Based Services, also known as waiver services. These services help people with basic needs. Each waiver program (see *Apply for a Home and Community-Based Service Waiver*, page 24, for details) offers several core services including service coordination, personal support services, home health services, emergency response systems and respite care for care givers.

MFP participants typically enter a Medicaid waiver program immediately upon discharge from the nursing facility or institution. To ease your move into the community, waiver services and MFP transition services are combined. For example, waiver services do not include funds for making security and utility deposits. MFP funds can be used for this purpose.

In addition, MFP can provide basic household furnishings (e.g., bed, table) and basic household goods and supplies (e.g., cookware, toiletries) to participants who need these items to set up their qualified residence. These items are not usually provided by waiver services, but MFP provides these items to assist participants to move into the community.

After you leave the facility, you will receive 365 days of MFP transition services. After your MFP transition services end, you will continue receiving home and community-based waiver services, Medicaid State Plan services, state funded programs and local community services that you are qualified to receive.

What MFP Services Do You Need?



The next step is to consider what services and support you need to relocate to the community. Review the following list of 14 MFP transition services and check the box beside the services you may need.

Service	Service Description/Allowable Cost
<input type="checkbox"/> Peer Support	Peer Supporters may have transitioned out of nursing facilities themselves or they may have experience helping others to resettle. They can assist you to connect to agencies, individuals and associations in your local community. This service is limited to \$1,200.
<input type="checkbox"/> Trial Visit- Personal Support Services	This service provides a brief period of personal support services or residential services (such as a personal care home) during a trial visit to the community before you transition. The purpose of this service is to give you an opportunity to manage and direct Personal Support Services staff and/or interact with staff in a personal care home. This service is limited to \$1,044.
<input type="checkbox"/> Household Furnishings	You may be in need of basic household furnishings such as a bed, table, chair, dresser, appliance, etc. You can use this service to obtain basic household furnishings to set-up your qualified residence. This service is limited to \$1,500.
<input type="checkbox"/> Household Goods and Supplies	You may need basic household goods (e.g., cookware, toiletries). This service is limited to \$750. You can use this service to help you obtain basic goods and supplies that are needed to set-up your qualified residence. You can also use this service for a one-time \$200 purchase of groceries.
<input type="checkbox"/> Moving Expenses	When you leave the nursing facility or ICF, you may need assistance to move your belongings. This service is limited to \$750 and can be used to cover the cost of a moving service or the rental of a moving van or trailer.

What MFP Services Do You Need?

Service	Service Description/Allowable Cost
<input type="checkbox"/> Utility Deposit	You may have to make a utility deposit. This service is limited to \$500 and can be used to make utility deposits for phone, electric, water and gas.
<input type="checkbox"/> Security Deposit	You may need to make a security deposit on a qualified residence. This service is limited to \$1,000 and can be used for housing application fees and deposits for rentals.
<input type="checkbox"/> Transition Support	As you begin the process of planning and making your move into the community, you may find that you have unique service needs such as obtaining documentation or accessing paid roommate match services, etc. This service is limited to \$600 and can be used for unique expenses needed to transition. These expenses must be authorized on a case-by-case basis. Check with your MFP Transition Coordinator for details.
<input type="checkbox"/> Transportation	You may need assistance to get around the community in search of housing and other services required for transition. This service is limited to \$500 and can be used to pay for transportation when public and/or para-transit are not available. This service does not replace Medicaid non-emergency transportation (for medical appointments) or ambulance services.
<input type="checkbox"/> Skilled Out-of-Home Respite	Once you are discharged from the nursing facility or ICF, your caregivers and/or family members may need a brief period of support or relief from providing your care. This service will pay for up to 14 days of skilled respite during the MFP 365 day period. The respite must be provided at a Georgia qualified nursing facility or community respite provider approved through a Georgia waiver program. This service is limited to \$1,878.

10

Service	Service Description/Allowable Cost
<input type="checkbox"/> Long-Term Care Ombudsman	A Long-Term Care Ombudsman is available to assist you with problems or concerns you have with the MFP process while you are still in the nursing home as you prepare to transition to the community.
<input type="checkbox"/> Community Ombudsman	A community ombudsman is available to contact you to review your health, welfare and safety and to advocate for you if you encounter any problems with MFP services during the 365 days you are in the MFP program. This service is available to participants entering the Community Care Services Program (CCSP) , Service Options Using Resources in the Community Environment (SOURCE) Program , and the Independent Care Waiver Program (ICWP) for transitioning into a home or apartment. This service is limited to \$1,800.
<input type="checkbox"/> Equipment and Supplies	If you need Assistive Technology and services, supplies or equipment that are not covered by your Medicaid Health Insurance plan, you can use this service to obtain these devices and services. This service is limited to \$5,000 and might include bath chairs, communication systems, specialized or customized wheelchair accessories, environmental control systems, and/or computer access devices that will help you live more independently, enhance your quality of life and reduce your dependence on others. You will need to be evaluated for some of these devices before you leave your current facility. You need time to learn to use them before you move to your new community. This may be difficult because these items can't be ordered until you have a discharge date. Second, in most cases Medicaid must deny coverage for the item before you can use this service to obtain it. Ask for assistance.

11

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

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

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 M: Self-Direction in HCBS Waivers-Crosswalk

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
i. Participant-Centered Service Plan Development				
a. Responsibility for Service Plan Development.	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. Service Plan Development Safeguards.	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
c. Supporting the Participant in Service Plan Development.	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
d. Service Plan Development Process--who develops, who participates, assessments used, needs, goals, prefs, health status, who does what, how ISP is updated	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

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
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 participant chooses a Support Coordinator 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. No freedom to select Care Coordinator. 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 svs records are reviewed for appropriateness of svs re: ISP and prior authorization, adequacy or docs of svs provided and billed to Medicaid. Funds may be recouped by Medicaid/DCH. Monthly meeting for svs reviews by	P. 86, same	P. 54, similar, DCH does periodic Utilization Reviews of member svs, 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 svs, 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.

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
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
III. Overview of Self-Direction				
a. Description of Self-Direction—opportunities, how members access, entities that support	P.94-95, Independence Plus: 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 Budget Authority over ALL waiver svcs . 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, No Independence Plus, LIMITED: 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) Care coordinator informs of PSS-CD option for EMPLOYER authority, but Care Coordinator brokers ALL other waiver svcs , 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, No Independence Plus, LIMITED: 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 EMPLOYER authority . 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				

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
b2. Participant--Budget Authority. Appendix E-2, item b. Has decision making authority over a budget for services.				
b3. Both Authorities	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
c. Availability of Participant Direction by type of Living Arrangement: Check all that apply				
c1. own home or home of family member	P. 95, Yes	P. 91, Yes	P. 57, Yes	P. C-3: 17, Yes
c2. other community-based living w/ 4 or fewer persons	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
c3. leased apartment	P. 96, Yes, included in 'own home'	P. 91, Yes	P. 57, Yes, like own home	Yes, similar to own home
d. Election of Participant Direction: select one				
d1. every participant can elect to direct, alternatives available for those who	P. 96, Yes	P. 91, Yes		
d2. may direct some or all of services, alternatives available, subject to following criteria			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

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
e. Information Furnished to Participant about benefits, responsibilities and liabilities of self-direction, who furnishes this info, how and when is info provided	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
f. Participant direction by representative: Select one				
f1. State doesn't provide for direction by rep				
f2. State does provide for direction by rep	P. 97, Yes	P. 92, Yes	P. 59, Yes	P. E-1:7, Yes
f2a. May be directed by legal rep of participant	P. 97, Yes	P. 92, Yes	P. 59, Yes	P. E-1:7, Yes
f2b. May be directed by non-legal rep chosen by member, specify policy and safeguards	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) <i>Community Guide--direct assistance to the rep on ISP and budget. Rep</i>	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
g. Participant-Directed Services: Check all that apply: Employer Authority, Budget Authority				
	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		

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
	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		
h. Financial Management Services: Select one				
h1. Yes, svs through 3rd party, specify whether government and/or private entities furnish these svs	P. 98, Private Entities.	P. 93, Private Entities	P. 60, Private Entities	P. E-1:8, Private Entities
h2. No, svs not furnished, standard Medicaid payment mech are used.				
i. Provision Financial Management svs: covered as Demo Svs or as administrative activity	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).
i.i. Types of entities	P. 51, Agency, Fiscal Intermediary, Approved by IRS, licensed for GA	P. 49, Agency	P. 42, Agency, same	P. E-1:8, Agency, same
i.ii. Payment of FMS	P. 51 Limit: One unit per month per member, Provider managed,	P. 49, same	??	??
i.iii. Scope of FMS, check all that apply: Support when participant is employer				
*assist w/ citizenship status	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

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
*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: Supports for participant budget authority:				
*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
j. Information and Assistance in Support of Participant Direction: check each that applies				

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
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
j2. As Demo Svcs Coverage, Specify	P.100, Community Guide-peer support for member	P. 96, Community Guide		P. E-1:11, Waiver svcs called Consumer Directed Option PSS
j3. As Admin Activity, Specify, who, how, when, what			P. 62-63, As Administrative Activity-- 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				

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers					
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c	
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	
l. 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
E.1. Participant–Employer Authority					
a1. Participant Employer Status: Check each that applies					

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
*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
a2. Participant Decision Making Authority-Participant exercises the following Authorities:				
* 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

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
* 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. Participant-Budget Authority: Complete when the demo offers the budget authority opportunity as in E1b				
b1. Participant Decision Making Authority. Check all that apply:				
* 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)				

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
<p>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?</p>	<p>P. 105, budget statistically determined based on SIS assessment. 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--budget determined by MDS-HC 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. Agency and Case mgr develop Plan of Care, determine number of PSS hours member needs. 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>b3. Informing Participant of Budget Amount: Describes how State informs each participant of the amount for the self-directed budget and the procedures by which the participant may request an adjustment in the budget amount</p>	<p>P. 105, Support Coordinator informs. ISP review to change. If need for increased intensity of svcs, I&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>b4. Participant Exercise of Budget Flexibility. Select one:</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>

Appendix_M_Self_Direction_CrossWalk_HCBSWaivers_rev_102408.xls

Appendix M: Self-Direction Crosswalk for HCBS Waivers				
MFP Requirements	New Options Waiver (NOW) 1915c	COMP 1915c	Elderly & Disabled Waiver	ICWP 1915c
<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 N: CMS 1500 Claim Form

1500 HEALTH INSURANCE CLAIM FORM												
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05												
PICA										PICA		
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <input type="checkbox"/>	2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE (MM DD YY)	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No. Street)	8. PATIENT STATUS (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
14. DATE OF CURRENT ILLNESS (First symptom or injury/accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? \$ CHARGES	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER	24. A. DATE(S) OF SERVICE From To	25. FEDERAL TAX I.D. NUMBER	
26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For gov. plans use box)	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$	31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #	34. SIGNATURE	35. DATE	36. NPI	37. NPI	

Appendix O: 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	
TOTAL		\$ -

BILLING INQUIRIES SHOULD BE DIRECTED TO:

-

THANK YOU FOR YOUR BUSINESS!

Appendix P: MFP Household Goods and Supplies Worksheet

Appendix P: Startup Household Goods and Supplies Worksheet

ITEMS	OWNS/FAMILY	DOLLAR GENERAL	WALMART	DOLLAR TREE	BIG LOTS	TARGET
Kitchen						
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						
Cleaning						
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 P: Startup Household Goods and Supplies Worksheet

ITEMS	OWNS/FAMILY	DOLLAR GENERAL	WALMART	DOLLAR TREE	BIG LOTS	TARGET
Dust Cloths						
Toilet Brush						
Trash Bags						
Light Bulbs						
Bedroom						
Blanket						
Sheet Set						
Pillow						
Alarm Clock						
Toilet Tissue						
Tissues						
Bathroom						
Bath Towels						
Hand Towels						
Wash Cloths						
Shower Curtain						
Shower Hooks						
Small Trash Can						
Toiletries						
Shampoo						
Soap						
Lotion						
Toothpaste						
Mouthwash						
Razors						
Hand Soap (Pump)						
Other						
Speaker Phone/big #						
Coasters						

Grand Total: All Stores
(Cheapest Prices)

MFP_Household_Goods_Supplies_Revised_010412

Appendix Q1: MFP Individualized Transition Plan (ITP)



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

1. MFP PARTICIPANT INFORMATION

Participant First Name: _____ MI: __ Last Name: _____

Medicaid # _____ Medicare # _____

Date of Birth: _____

Facility Name: _____

Facility Location: _____

Individualized Transition Plan (ITP) date: _____

This ITP is an Initial ITP –OR– Updated ITP (check only one).

Projected move to housing type:

- 01 - Home owned by participant
- 02 - Home owned by family member
- 03 – Apartment leased by participant, not assisted living
- 04 - Apartment leased by participant, assisted living
- 05 – Group home of no more than 4 people/ PCH

Prepared by: _____
(TC Name and Contact information)

2. IMPORTANT PLANNING DATES

Projected Discharge/Move out Date: _____

Actual Discharge/ Move out Date: _____

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

3. HOUSING CHOICE/LIVING ARRANGEMENTS:

Indicate housing choice priority (1, 2, 3 etc) and describe tasks that must be done to secure choice:

____ OWN HOME- _____

____ WITH FAMILY/FRIENDS- _____

____ RENTAL UNIT- _____

____ QUALIFIED GROUP HOME- _____

(Continue narrative on back or add additional pages as needed)

4. HOUSING – IDENTIFY PROBLEMS/ISSUES AND STRATEGIES FOR ADDRESSING/RESOLVING PROBLEMS/ISSUES (describe in detail):

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

5. PERSONAL GOALS/ DESIRED OUTCOMES (describe in detail based on Person-Centered Planning process):

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

6. HEALTH AND NUTRITION GOALS (describe in detail based on Person-Centered Planning process or indicate N/A):

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

7. 24/7 EMERGENCY BACKUP PLANS (describe in detail based on Person-Centered Planning process):

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

8. VISION/HEARING/DENTAL/MOBILITY GOALS (describe or indicate N/A):

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

9. **COMMUNICATION GOALS** (describe or indicate N/A

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

10. **SOCIAL/RECREATIONAL GOALS** (describe or indicate N/A

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.

DCH/MFP Individualized Transition Plan (ITP)_Revised_061112

Page 5 of 14



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

11. SELF-CARE (DOMESTIC/ PERSONAL) GOALS (describe or indicate N/A):

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

12. ASSISTIVE TECHNOLOGY (AT) AND/OR DURABLE MEDICAL EQUIPMENT (DME) USE AND NEEDS (describe or indicate N/A):

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) FOR OBTAINING NEEDED AT AND DME:

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

13. COMMUNITY ACCESS GOALS – IDENTIFY AND DESCRIBE GOALS, INCLUDING PROBLEMS/ISSUES AND BARRIERS & TO OBTAINING COMMUNITY SERVICES:

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE COMMUNITY ACCESS GOALS:

14. EMPLOYMENT GOALS – IDENTIFY AND DESCRIBE PRE-VOCATIONAL (training, volunteer), SUPPORTED EMPLOYMENT, CUSTOMIZED AND/OR COMPETITIVE EMPLOYMENT GOALS:

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

15. **TRANSPORTATION– IDENTIFY COMMUNITY TRANSPORTATION GOALS (describe or indicate N/A)**

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

16. **FINANCIAL GOALS: (describe and complete Question #22 Income & Resources-Budget for Community Living)**

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

17. **LEGAL ISSUES** (describe or indicate N/A):

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO RESOLVE LEGAL ISSUES:

18. **FRIENDS/FAMILY/GUARDIAN INVOLVEMENT ISSUES** (describe or indicate N/A)

IDENTIFY RESOURCES NEEDED AND AVAILABLE (PERSONAL/FAMILY, MFP/WAIVER, COMMUNITY SERVICES) TO RESOLVE ISSUES:

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.

DCH/MFP Individualized Transition Plan (ITP)_Revised_061112

Page 9 of 14



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

19. PART A: MFP PRE AND POST-TRANSITION SERVICES

Use the table below to list the MFP Pre-and Post-Transition Services selected by the participant /team along with the justification for each. The MFP participant initials each choice.

MFP PRE-TRANSITION SERVICE	RATIONALE (provide justification for why this MFP service is needed to support successful living in the community)	MFP PARTICIPANT INITIAL

MFP POST-TRANSITION SERVICE	RATIONALE (provide justification for why this MFP service is needed to support successful living in the community)	MFP PARTICIPANT INITIAL

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.



INDIVIDUALIZED TRANSITION PLAN (ITP)

Participant Name: _____



21. FOLLOW UP PLANS:

22. INCOME AND RESOURCES-Budget for Community Living:

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.

DCH/MFP Individualized Transition Plan (ITP)_Revised_061112

Page 12 of 14



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

23. PART B: WAIVER SERVICES (identify or indicate N/A):

Use the table below to list the generic types of waiver services that may be needed by the participant/recommended by the team.

GENERIC WAIVER SERVICE (i.e. Personal Support Services)	RATIONALE (describe how service will work with MFP services to support participant in the community)

24. PART C: STATE PLAN SERVICES (identify or indicate N/A):

Use the table below to list additional services that may be needed by the participant /recommended by the team.

OTHER SERVICE	RATIONALE (describe how service will work with MFP services to support participant in the community)

(Continue narrative on back or add additional pages as needed)

Note to TCs: Send this completed ITP to the DCH/MFP Office via **File Transfer Protocol**.

Appendix Q2: MFP Guidelines for Completing the ITP



MFP Guidelines for Completing the ITP



- AN INDIVIDUALIZED TRANSITION PLAN (ITP) will be completed prior to all moves associated with transitions from nursing facility/institutional settings to community settings.
- The ITP is completed after the MFP participant signs the *MFP Informed Consent*. Person-directed planning is undertaken to complete the ITP. Person-directed planning meetings include the MFP participant, family members, friends, care givers, guardian (if applicable), the MDSQ Options Counselor (MDSQ OC) and/or MFP Transition Coordinator (MFP TC), the nursing facility/institutional discharge planner, and/or waiver case manager, care coordinator, support broker and other appropriate facility staff.
- The MFP facilitator (MDSQ OC, MFP TC) is responsible for facilitating Person-Centered Planning and the subsequent development and writing of the ITP, including the documentation in the plan and monitoring the outcomes. A complete ITP includes the participant's goals/desired outcomes, choices of living arrangements, preferences, strengths, barriers to transition, MFP Service needs in Part A, Waiver Service needs in Part B and State Plan Services in Part C.
- The MFP facilitator will distribute a copy of the ITP showing specific transition assignments to all persons having an assignment to complete. The ITP is distributed prior to discharge to assure timely implementation.
- The MFP participant, friends, family members and appropriate transition planning members receive a copy of the ITP.
- The Department of Community Health (DCH), MFP Office receives a copy of the completed ITP within three (3) business days of completion.
- The entire transition team reviews the ITP two to four weeks before the discharge date from the nursing facility/institution. The MFP facilitator updates the ITP with any changes in status. Updates to the ITP are documented and DCH/MFP office receives a copy of the updated ITP within three (3) business days of the completed update.

Guidelines and examples for completing the ITP:

1. Enter the requested participant information. Enter the requested facility name and location. Enter the date the ITP was prepared. Check the appropriate box for the stage of the ITP (initial or updated). Enter the type of qualified residence/living arrangement the participant desires to enter. Enter the MFP facilitator's name and contact information.
2. Enter the projected discharge/move out date and actual discharge/move out date.
3. Housing Choice/Living Arrangement: Include qualified residence preference with priority and type of living arrangement (i.e. quieter environment; closer to friends and



MFP Guidelines for Completing the ITP



family; opportunity for greater independence in activities of daily living; family setting; person/friends/family assistance, access to public transit and paratransit, access to community services, healthcare services, pharmacy and shopping and entertainment). The TC facilitates a discussion of potential qualified residence types and living arrangements.

4. Housing – Identify problems/issues and strategies for addressing and resolving housing-related problems/issues. The MFP participant may have lived for several months or years at the facility and may need assistance with independent living skills, budgeting, problem solving, searching for housing, locating transportation, locating a pharmacy, a personal care physician, shopping, social and recreation activities in the community. The person might be leaving a close friend behind or might want to join a roommate in a community. A MFP peer supporter can assist the participant to do a housing search and look at housing options. The housing search process is also a great time to work out community transportation issues. Unpaid utility bills and other budget issues are discussed.
5. Personal Goals/Desired Outcomes from Transition: Conduct Person-Centered Planning sessions with the transition team/circle of support. Based on the results of Person-Centered Planning, list the participant's short-term and long-range goals. Describe the participant's personal assets/strengths. List barriers to resettlement identified by the participant, family and transition team. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to remove listed barriers. The MFP participant will need to be introduced to older adults and/or persons with similar disabilities living successfully in the community. In this section, include transition activities to assist the person in adjusting to resettlement. For example, if separating from a close friend, there may need to be a plan for the person to make contact with the friend either by phone or by personal visit, or by email/mail, etc. Such an approach recognizes the importance of the MFP participant's existing support network while assisting the person to make new relationships in the community.
6. Health/Nutrition Goals: List health and nutrition goals; recommended medical follow-up; allergies; current medications/dosages, self-administration of meds; lifting/positioning needs; type of diet; dietary restrictions (food allergies, low cholesterol etc.); food intake/preferences; food preparation strategies and dietary restrictions. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve goals.
7. 24/7 Emergency Backup Plan: identify risks to the MFP participant's health, welfare and safety based on resettlement choice of residence type. For each identified risk to health and safety in the preferred community living environment, develop an individualized contingency plan for emergency back-up. The ITP must include plans for equipment failures, transportation failures, natural disasters, power outages and interruptions in routine care. This information should be gathered and put into a notebook (or something similar) so that the participant will be able to access it in time of emergency. In the notebook or similar, provide the participant with 24/7 emergency phone contacts for case manager and/or care coordinator and service providers. Vendors/agencies are required to



MFP Guidelines for Completing the ITP



provide 24/7 backup for direct care staff and to instruct direct care staff on participant needs and preferences. MFP participants using participant-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 routine care staff doesn't show up.

8. Vision/Hearing/Dental/Mobility Goals: List vision, hearing and personal mobility goals of the participant, and the impact of current functioning on activities of daily living (ADLs); list need for visual exam, prescription glasses, dental exam/cleaning/dental work, hearing assessment, hearing aid, durable medical equipment for mobility that the participant is currently using or that is needed to maximize current functioning. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available (i.e. FODAC) to assist the participant to achieve vision, hearing, dental and personal mobility goals for independence. If this area does not apply to the participant, check the N/A checkbox.
9. Communication Goals: List the communication goals of the participant, the methods that participant uses to communicate (verbal, non-verbal, uses gestures, communication board, AAC device, assistive telephone technology, TTY, etc.); any specific signals a person may give to communicate (ex. "whine" means doesn't feel well; "hand to head" means headache, etc.). List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve communication goals. If this area does not apply to the participant, check the N/A checkbox.
10. Social/Recreational Goals: List the participant's leisure and recreation interests/preferences and goals. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve social and recreational goals. If this area does not apply to the participant, check the N/A checkbox.
11. Self Care (Domestic and Personal) Goals: List the participant's self care routines, goals, interest in self-directing personal services and supports, the degree of personal independence; amount/type of assistance needed for activities of daily living in personal care (eating, dressing, hygiene, etc.); and domestic skills (meal preparation, laundry, budgeting, etc.). List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve self care goals, including self-direction of personal services and supports. If this area does not apply to the participant, check the N/A checkbox.
12. Assistive Technology (AT) and/or Durable Medical Equipment (DME) Use and Needs: What assistive technology devices and DME is the participant currently using to maintain the current level of functioning? What is the availability of the devices/DME? Will DME and AT devices move with the person or will they need to be procured using MFP funds and/or Medicaid for DME? Has the participant with complex rehabilitation technology needs been referred to an appropriate wheelchair/seating clinic for assessment? List personal assets/strengths, resources offered by friends and family, MFP/waiver/state plan



MFP Guidelines for Completing the ITP



services and community programs and services available to assist the person with assistive technology (including *Tools for Life* and/or *FODAC* resources) and DME equipment and supply needs and vendor/supplier for each. If this area does not apply to the participant, check the N/A checkbox.

13. Community Access Goals: List the independent living community skills, strengths or degree of independence in use of money to purchase services; travel; use of community facilities and services; basic safety awareness/skills. Identify the community services that the participant will most likely benefit from and any barriers to obtaining these services. List personal assets/strengths, resources offered by friends and family, MFP/waiver services and community programs and services available to assist the person to achieve higher degrees of independent living community skills.
14. Employment Goals: list pre-vocational, supported-employment and/or competitive or customized employment goals, interests, skills, and attitudes; list type of work experience and career interests; list barriers and resources to gainful employment. List personal assets/strengths, resources offered by friends and family, MFP Supportive Employment Evaluation services and supported employment waiver services along with community programs and services available to assist the person to achieve employment goals. If this area does not apply to the participant, check the N/A checkbox.
15. Transportation Needs and Barriers to Access: List the transportation needs the participant may have. Is accessible public transit and/or para-transit available/needed? Is travel training needed? Is a wheelchair accessible personal van needed, does the person need someone to ride with her/him or is the participant independent? List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve independent transportation goals. If this area does not apply, check N/A checkbox.
16. Financial Goals: Are the appropriate people aware of and familiar with the SSI/SSDI/SS retirement transfer issues and the involvement DCH MFP in Atlanta? The DCH MFP will terminate the institutional enrollment and change the participant's eligibility status from institutional to community Medicaid. Are there any outstanding financial issues? What about unpaid utility bills? If unpaid utility bills from the past are preventing the person from transitioning, consult with the county DFCS office for programs to assist the participant to pay off these old utility bills. List the participant's financial goals. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to resolve financial issues and achieve financial goals. Assist the person to develop a budget for community living (see #22 Income and Resources-Budget for Community Living). Establish how the MFP participant will pay for rent, utilities, food, transportation, medicines, recreation, etc.
17. Legal Issues: Are there legal issues to consider? List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to resolve these legal issues. If this area does not apply to the participant, check the N/A checkbox.



MFP Guidelines for Completing the ITP



18. Family/Guardian Involvement Issues: Who is involved and what is the relationship? How often does contact occur; type of contact (phone calls, visits, etc.); person's response to interaction with family/guardian. Does the participant want to terminate guardianship? List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to resolve family/guardian involvement issues. If this area does not apply, check the N/A checkbox.
19. Part A: MFP Pre- and Post-Transition Services: List the MFP Pre-and Post-Transition Services selected by the participant/team in the Table provided. Under "Rationale" provide the justification for each service selected. Why is the services needed? How will it be used to support successful living in the community? How much will it cost? Are the costs within the maximum allowed for the service? The participant initials each MFP service selected.
20. Transition Plan/Assignments: Identify pre/post-discharge or follow-up activities that need to occur for a smooth transition and continuity of care and services. Include specific names of persons (when possible) that are assigned to implement the ITP.
21. Follow-up Plan: Specify what follow-up is to be given, when and by whom.
22. Income and Resources-Budget for community living: Based on the information obtained about the participant's Income and Resources from the MFP Screening Form, discuss and develop a budget for community living with the transition team. Use the space provided to develop a preliminary community living budget.
23. Part B Waiver Services: Using the table provided, identify generic waiver services provided under the waiver. Under "Rationale" describe how the waiver services will work with MFP services to support the participant in the community. Why is the services needed? How will it be used? If this area does not apply, check the N/A checkbox.
24. Part C Other Services: Using the table provided, identify State Plan and/or Other Services selected by the participant and the team. Under "Rationale" describe how State Plan and/or Other Services will work with MFP services to support the participant in the community. Why is the services needed? How will it be used? If this area does not apply to the participant, check the N/A checkbox.
25. ITP Signature Page: Each member of the transition team signs the signature page.

Note: the participant's learning style/preferences (what works best with this participant) should be incorporated in each domain as applicable. **Note to TCs: Send the completed ITP to the DCH/MFP Office via File Transfer Protocol.**

Appendix R: MFP Discharge Day Checklist



MFP Discharge Day Checklist



Revised 061112

OC/TC/PLA/CE Name/Phone #:			Date:
MFP Participant Information			
Name:			Date of Birth:
New Address:			Phone Number
City:	Zip:	County:	Change Of Address Notification To: <input type="checkbox"/> DFCS <input type="checkbox"/> Social Security <input type="checkbox"/> Other(Please List)
<input type="checkbox"/> Home owned by Participant <input type="checkbox"/> Home owned by Family Member <input type="checkbox"/> Apartment Leased by Participant, Not Assisted Living <input type="checkbox"/> Apt. Leased by Participant, Assisted Living <input type="checkbox"/> Group Home of No More Than 4 People/PCH <input type="checkbox"/> Lives with family (check for yes)			
Individualized Transition Plan (ITP)			
Item Key: N=Needed; O=Ordered; S = Secured; N/A=Not Applicable			
Items (provide items for all that apply):			
Home: _____ Modifications: _____ Security Deposit: _____ Utility Deposits: _____; _____ Other: _____			
Household Items: _____ Kitchen: _____; _____ Bath: _____; _____ Bed: _____			
Food & Nutrition: _____			
Health & Hygiene: _____			
RX Medications: _____			
Medical Services/DME Equipment: _____			
Assistive Technology Devices: _____			
Life Skills/ Socialization: _____			
Financial: _____			
Transportation: _____			
Other:(list) _____			
Waiver:	Waiver Case Manager/Care Coordinator/Planning List Admn:		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:			
24/7 Emergency plan reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No* If no, explain:			
Please identify participant's needs upon discharge and the plan to meet the participant's need: (attach additional sheets as needed)			
Follow-up Visits/Quality Management			
Home Visits: Please provide schedule for follow up visits.			
<input type="checkbox"/> Transition Coordinator: 1 st Scheduled Visit: _____; 2 nd Scheduled Visit: _____			
<input type="checkbox"/> Waiver Case Mgr /Care Coord/Support Coord/PLA Name: _____ Phone: _____			
1 st Scheduled visit: _____; 2 nd Scheduled Visit: _____			
<input type="checkbox"/> Community Ombudsman Name: _____ Phone: _____ Email: _____			
1 st Scheduled F2F visit (or n/a): _____; 2 nd Scheduled F2F Visit: _____			
<input type="checkbox"/> County DFCS Office Contact: _____ Phone: _____ Email: _____			
Quality of Life Survey: <input type="checkbox"/> Initial; <input type="checkbox"/> 2 nd Survey; <input type="checkbox"/> Completed: <input type="checkbox"/> Scheduled: <input type="checkbox"/> Rescheduled: _____			
Participant Tracking			
<input type="checkbox"/> This report sent to DCH/MFP Office by secure email to gampf@dch.ga.gov attention: _____ <input type="checkbox"/> This report faxed to client's Case Manager/Care Coordinator			Date:
By: _____		Title: _____	

DCH/MFP Discharge Day Checklist 061112

Appendix S: MFP Authorization for Services



MFP Authorization for Pre and Post-Transition Services



MFP Facilitator (OC, TC, PLA, CE): complete the following to authorize MFP services.

Participant First Name: _____ Participant Last Name: _____
 Participant Medicaid #: _____ Participant Date of Birth: _____
 Participant Address: _____ Participant City: _____ State: _____ Zip: _____
 Participant Phone Number: _____ Other Contact Name: _____ Other Phone: _____
 (Anticipated) Transition Date: _____ COS Waiver Type: _____
 CHECK ONLY ONE: this is a(n) Initial Authorization Revised Authorization

Vendor	Pre Transition Services	\$'s Authorized

Total Pre-Transition \$'s Authorized:

(Pre-transition services are not to exceed \$10,244.00 in the 365 day demonstration period).

Vendor	Post Transition Service	\$'s Authorized

Total Post-Transition \$'s Authorized:

Post-Transition services are not to exceed \$26,418 in the 365 day demonstration period.

MFP Facilitator (OC, TC, PLA, CE) Name: _____

Office Location: _____ Phone: _____ Email: _____

Authorizing Signature: _____ Date Signed: _____

Notice: (Step 1) Send this completed *Authorization* to Fiscal Intermediary via **File Transfer Protocol (FTP)**. (Step 2) Send this complete *Authorization* to the DCH/MFP Office via **File Transfer Protocol**.

MFP Authorization for Transition Services_Revised_062112

Appendix T: Quote Form for EQS, SMS, EMD and/or VAD



Quote Form for Equipment, Vision, Dental, and/or Hearing Services, Specialized Medical Supplies, Environmental Modification and/or Vehicle Adaptations

Notice to MFP Facilitator: complete this *Quote Form* for equipment, supplies, vision and/or dental services costing \$1000 or more, all environmental modifications and/or all vehicle adaptations for MFP participants.

Participant First Name: _____ Participant Last Name: _____
 Participant Medicaid #: _____ Participant Date of Birth: _____
 Nursing Facility/Hospital Name: _____
 Participant Address: _____ Participant City: _____ Zip: _____ County: _____
 Participant Phone Number: _____ Other Contact Name: _____ Other Phone: _____
 Date(s) of ITP/Planning Meetings: _____ COS Waiver Name: _____

Vendor Name/Phone	Post Transition Service	MFP 3 Digit Service Code	Quoted Amount	Check Accepted Quote
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

Total \$'s Authorized:

- Maximum allowed cost for Equipment, Vision, Dental and/or Hearing Services (EQS) is \$4,000 in the 365 day demonstration period. Three 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 Specialized Medical Supplies is \$1,000 in the 365 day demonstration period. Three quotes must be obtained before a purchase can be authorized for a single supply costing \$1000 .
- Maximum allowed Cost for Vehicle Adaptations (VAD) is \$6,240 in the 365 day demonstration period. Three quotes must be obtained before Vehicle Adaptations can be authorized.¹
- Maximum allowed Cost for Environmental Modifications (EMD) is \$8,000 in the 365 day demonstration period. Two itemized scope/bids are required, three itemized scope/bids are recommended before Environmental Modifications are authorized. Building permits are required for EMDs totaling \$2,500 or more. A Home Inspection (HIS) must be completed before the 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. ¹

Owner Name: _____ Phone: _____
 Address: _____ City: _____ Zip: _____ County: _____
 MFP Facilitator Name: _____
 Region/Office: _____ Phone: _____ Email: _____

Authorizing Signature: _____ Date Signed: _____

¹ Environmental Modifications and Vehicle Adaptations must include a notarized document giving the owner's permission for services, if the owner is not the MFP participant.

Notes to MFP Facilitators: (Step 1) Send this completed *Quote Form* to Fiscal Intermediary via File Transfer Protocol (FTP). (Step 2) Send this completed *Quote Form* to the DCH/MFP Office via File Transfer Protocol (FTP).
 MFP_Quote_Form_EQS_SMS_VehAD_EnvMods_Revised_062112

Appendix U: MFP Vendor Payment Request



MFP Vendor Payment Request

MFP Services Rendered for:

Participant Name:	Participant/Contact Phone:
Participant Address:	Participant City/State/Zip

MFP Facilitator Use Only	
Participant/Member Medicaid #:	Participant/Member Date of Birth:
Date of Transition (Discharge Date):	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
Total Check Amount	

By signing this form, I attest that services were delivered and received consistent with the Individual Transition Plan (ITP) or Person Centered Description (PCD) and MFP Authorization for Services. I understand that Medicaid is the payer of last resort.

MFP Participant Signature **Date**

Vendor Signature **Date**

Fax or mail to MFP Facilitator Name: _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Note to Vendor: send this completed form, signed by participant (or legal guardian), along with invoice and receipts to MFP Facilitator listed above by fax, mail or via file transfer protocol.

Note to MFP Facilitator: once verified, send this completed form along with invoice and receipts to the Fiscal Intermediary by **File Transfer Protocol**. Send this completed form and required documentation to the DCH/MFP office by **File Transfer Protocol**.

DCH/MFP Vendor Payment Request To TC_Revised_061112

Appendix W: Monthly Report of Persons Served

Monthly Report of Persons Served Monthly Report of Completed QoL Surveys Monthly Update of MFP HCV Program Participation

Monthly Report of Persons Served

Under the Interagency Agreement, The Department of Human Services/Division of Aging Services (DHS/DAS) is responsible for preparing and submitting a report to DCH monthly by the 15th of the month, for the previous month; with the data listed below for each individual referred, screened and transitioned. DHS/DAS submits the requested data in the requested format for this report.

- Person's First and Last Name; Date of Birth; Medicaid ID Number
- Target Population (as per *MFP Transition Screening Form*)
- Number of contacts by referral source, date received and date of response
- Type of referral (as per *MFP Transition Screening Form*)
- Dispensation of referral (MDSQ Referrals, Received Options Counseling, Referred to MFP, Referred to Other Sources, etc.)
- Number and type of Outreach Events
- Number of contacts that resulted in referrals to resources other than MFP
- Nursing Facility/Institution Name (facility participant transitioned from)
- Date of completed screening (actual face-to-face screening completion date)
- Date of completed Individualized Transition Plan/Person-Centered Description (ITP/PCD)
- Date of referral to waiver by COS
- Date of waiver approval (date participant is accepted into waiver, service start date, by COS)
- Date of discharge (actual date participant was discharged from the facility)
- Participant Status – deceased, ineligible for MFP, refused MFP, etc.
- Type and Date of Sentinel Event (as per *Sentinel Event Form*), re-institutionalizations, deaths, participant status changes, status changes associated with Sentinel Events
- Number of Successful Transitions by Population and Waiver COS
- Pre-transition services authorized – total amount authorized to date for all pre-transition services
- Pre-transition service expenditures – total amount spent to date for all pre-transition services
- Post-transition services authorized – total amount authorized to date for all post-services
- Post-transition service expenditures – total amount spent to date for all post-transition services
- Date of 30 day follow up (actual face-to-face follow-up completed)

Monthly Report: Completed QoL Surveys

- Date of baseline Quality of Life Survey
- Completed MFP Quality of Life Survey (must be submitted as an Excel file to the MFP Office via secure FTP transmission. The survey software provided by MPR will produce the file in the proper format).

Monthly Update of MFP Housing Choice Voucher (HCV) Program Participation

TCs submit the following information on each MFP HCV participant:

- Last Name, First Name; SSN (last 4 digits)
- MFP Facilitator Name and Contact Information
- Preferred County of Residence
- Date *MFP Referral Letter for Housing Choice Voucher Program* (see Appendix AA) faxed to DCH MFP office
- Date Completed HCV application sent to appropriate PHA/DCA Regional Office
- Date of HCV Voucher Briefing with Participant
- Date of HQS Inspection of Qualified Residence
- Date of Passed Inspection/HAP Contract Begins with Participant

MFP Monthly Report of Participants Served_061112

Appendix X: MFP Request for Additional MFP Services



Request For Additional MFP Transition Services



MFP Facilitator (OC, TC, PLA, CE): To obtain approval for additional MFP Transition Services, complete the following form. Services listed on this form must be needed by the participant and not initially identified in the ITP/PCD by the team. The MFP participant initials each additional service.

Participant First Name: _____ **Participant Last Name:** _____
Participant Medicaid #: _____ **Participant Date of Birth:** _____
Participant Address: _____
Participant City: _____ **State:** GA **Zip:** _____ **Waiver Name:** _____
Participant Phone Number: _____ **Other Contact Name:** _____ **Other Phone:** _____
Date of ITP: _____ **Date of Discharge:** _____ **Date of Request:** _____

MFP TRANSITION SERVICE	RATIONALE (provide justification for why this MFP service is needed to support successful living in the community)	MFP PARTICIPANT INITIAL

MFP Facilitator Name: _____

Region/Office: _____ **Phone:** _____ **Email:** _____

Notice: (Step 1) Send this completed *Request for Additional MFP Services* to the DCH/MFP Office via **File Transfer Protocol**. Contact the DCH/MFP Office regarding the dispensation of this request. (Step 2) If approved by DCH/MFP Office, submit completed reimbursement documentation (i.e. updated ITP, *Vendor Import File*, etc.) to Fiscal Intermediary via **File Transfer Protocol** and to DCH/MFP Office by **File Transfer Protocol**.

<p>For DCH/MFP Office Use Only Additional MFP Services Authorized: <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:</p>

MFP_Request_for_Additional_MFP_Services_Revised_061112

Appendix Z: MFP Referral Form



**Money Follows the Person
Referral Form**



Date (mm/dd/yyyy): _____

Person making referral: _____

Agency making referral: _____ Phone Number: _____

Person Referred-Name: _____ Phone Number: _____

Date of Birth (mm/dd/yyyy): _____ Age: _____

Institution/Nursing Facility: _____

Address: _____

City: _____ ST: _____ ZIP: _____ County: _____

Contact Person: _____ Phone Number: _____

Admission Date to Nursing Facility (mm/dd/yyyy): _____

Anticipated Referral CCSP SOURCE ICWP Date Referred: _____
 NOW COMP C-BAY Date Referred _____

Currently on wait list for: CCSP SOURCE ICWP
 NOW COMP C-BAY

Letter or contact info from the waiver: Yes No

Case Manager if assigned _____ Phone Number: _____

Interested Parties:

Name: _____ Relationship: _____
 Street: _____ Phone Number: _____
 City _____ ST _____ ZIP: _____

Name: _____ Relationship: _____
 Street: _____ Phone Number: _____
 City _____ ST _____ ZIP: _____

Pertinent Information: _____

Money Follows the Person (MFP)
 Department of Community Health
 Medicaid Division, Aging & Special Populations
 2 Peachtree St. NW, 37th Floor
 Atlanta, GA 30303

Email: gamfp@dch.ga.gov Website: dch.georgia.gov/mfp
 Phone: 404-656-6862

MFP Referral Form rev 061712