MISSOURI's

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

OPERATIONAL PROTOCOL

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Money Follows the Person
MISSOURI'S OPERATIONAL PROTOCOL

I. Required Contents of the Operational Protocol

A. Project Introduction

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

How will I learn about MFP?	• Information will be provided during your annual Person Centered Planning Meeting. • Long Term Care Ombudsman and Centers for Independent Living will distribute informative information during contact with potential participants. • Informational materials will be distributed to advocacy groups, family, friends and others.
How will I be supported to plan my move to the community?	• A planning team including yourself will be organized to help plan your transition. • The team will assist you to identify the services and supports you need to live in the community. • You will have access to services for your home to make it ready for you to move in.
Where will I live?	• You will be given options and be able to visit and choose where you want to live. • Your options could include renting or owning a home, living with a family member who owns their home, living in a group home of 4 or less individuals, etc.
What type of support will I have in the community?	• You will have a service worker that will assist you to coordinate your services and supports • There will be someone you can reach 24 hours a day.
What about my safety in the community?	• The state has processes in place to help ensure that you will be safe. • Quality of Life Surveys will be done to monitor your progress. • You will have someone you can reach 24 hours a day if something is wrong.

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

Objective 1: Transition 250 individuals with disabilities or who are aging from state habilitation centers and nursing facilities to the community

Strategies:

- Through annual person centered planning meetings for people living in state habilitation centers, identify individuals who wish to transition to communities, and provide all assistance needed to implement the transition.

- Centers for Independent Living and LTC Ombudsman will assist in the identification of individuals in nursing facilities who wish to transition to communities, make referral to Division of Senior and Disability Services for eligibility determination and service authorization, and work collaboratively with DSDS to implement the transition.

Outcomes:

- A minimum of 250 individuals will choose to move from Medicaid-funded beds to communities. The state will assist any individual who wishes to transition out of a facility, whose needs can be met by the array of community-based services available in the state, regardless of whether they are part of the actual MFP demonstration.
- The need for long term beds in state-operated facilities will decrease as more individuals are served in communities.

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

Strategies:

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

Outcomes:

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

Objective 3: Improve the ability of the Missouri Medicaid Program to continue the provision of HCB LTC services to individuals choosing to transition to communities

Strategies:

- Reinvest savings from reduction need for beds in state habilitation centers into HCB services.
- Gather data on consumer satisfaction and positive outcomes to support future budget requests for continued/increased funding of HCB services.

Outcomes:

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

Objective 4: Ensure procedures are in place to provide continuous quality improvement in long term care services

Strategies:

- Quality management system for demonstration participants will be same level of quality assurance and improvement already provided under Missouri's 1915(c) HCB waivers.
- 100% of demonstration participants will have the opportunity to participate in satisfaction surveys.
- Redesign process for licensure and review of community-based providers contracting with DMRDD
- Establish a regulation for certified in-home aides employed by in-home service agencies contracting with DSDS.
- Expand College of Direct Support, a nationally recognized web-based training program for direct support professionals.

Outcomes:

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

1. Case Study

The following will address the transition process for the individuals transitioning from State Habilitation Center and Nursing Facilities.

> **State Habilitation Centers:** All people living in a State Habilitation Center will actively participate in a Person-Centered Plan (PCP). All individuals residing in a State Habilitation Center will be eligible to transition. An individual will be identified as a potential participant for MFP if they have resided inpatient for at least 6 months and are Medicaid eligible; eligibility will be determined through the annual PCP process. As part of the assessment it will be determined if the person is living in the most integrated, least restrictive environment and if the individual wishes to transition. During the annual planning process the individual/guardian will be given information about the Money Follows the Person Demonstration and will be given a choice to participate. If it is decided that the individual wants to transition a screening will be completed by the

Regional Center under the direction of the transition coordinator to determine eligibility and feasibility of transition and also if the transition would meet the MFP qualification, such as housing. A PCP is a plan in progress and is amended as the need and goals of the individual changes. The PCP is reviewed annually at the PCP meeting, as well as, quarterly and at any time the person, family or guardian may request for a change. A universal statewide transition plan, "Let's Get Moving" is in the process of being implemented for use by Regional Office staff. A copy is attached for reference (Attachment A).

The person will participate in the planning meeting with their Transition Coordinator, Habilitation Center Unit Program Supervisor, Habilitation Center Service Coordinator, Social Worker, the community agency(s) and direct care staff members who know them. They are encouraged to invite friends, relatives, and others in their circle of support, to participate in this planning meeting and subsequent meetings. The person's support team members are asked to submit information that is relevant to the development of the person-centered plan if they are unable to attend any of these meetings. Together, discussion will take place on the person's expectations, preferences, non-negotiables, timelines, projected move date, community resources which are needed, staffing needs, and any special concerns.

The person will have the right to choose if they want to self-direct their care or use provider based services. Once the individual chooses a provider, the transition meeting is scheduled. The individual will participate in the transition meeting where they will meet their Service Coordinator and representatives from the agencies that will provide community services and supports. The Transition Coordinator brings a draft of the person's Transition Personal Centered Plan to this meeting that reflects transition from habilitation center living to community living. At this meeting everybody agrees on the critical issues which still need to be addressed, the actions that the plan calls for, and the remaining timelines.

The Transition Coordinator will help make sure the individual is getting the support and services they need in the community. The Transition Coordinator, who is an employee of the Division of MRDD, works for the individual and is there to always represent his/her best interest.

The individual will work with the Transition Coordinator to schedule visits with potential residential providers and community agencies to get acquainted with potential roommates and the communities in which they reside. The number of visits will vary, depending on the individual. It will be discussed with the individual not to rush the transition process but to rather take their time deciding what provider, roommate, and community are best for them. Once services are determined the transition team will request needed services through the Regional Center. The Regional Center will work closely with the DMH/MRDD central office to assign a waiver slot and on other services as needed.

The individual will participate in the closure meeting where all assigned tasks/activities are reviewed to ensure they are either completed or there exists a clear plan for them to be completed and final preparations are made for the move.

The individual may participate in training for community staff given by the Habilitation Center staff if they want. They can share information with community staff, shop for furnishings and decorations for their new home.

Once the move has been made the individual will work with the Service Coordinator, employed by the Regional Center, to schedule the initial community Person-Centered Plan meeting. This meeting should take place approximately 30 days after the move. The new plan will be implemented within 60 days after the move. There will be six months of intense follow-up after transition. Once the participant reaches the end of the one year participation in the MFP demonstration they will continue to receive the same services they were receiving while in the demonstration. The participant will move into regular state plan and Waiver services once their year in the demonstration has been exhausted. Since a waiver slot had been reserved at the onset of the transition and services will remain the same the process will be seamless to the participant.

Individuals that have been identified as having a co-occurring diagnosis will require the Transition Coordinators at Habilitation Centers to work with Regional Center staff and also with the appropriate Community Mental Health Center to arrange for an intake evaluation and subsequently arrange for appropriate Community Psychiatric Rehabilitation (CPR) services. Most individuals will need medication services and physician consultation. Some may need additional services including but not limited to community support, psychosocial rehabilitation, counseling, and crisis intervention. Transition planning will occur in partnership with Divisions of Mental Retardation/Developmental Disabilities (DMRDD) staff. These services will be in addition to the services received through DMRDD.

Nursing Facilities: People who are elderly and those with disabilities transitioning from Nursing Facilities will require the transition coordinator or designee to facilitate planning discussions with the individual, guardian, or family member to identify needs, explore housing options, and to plan for needed supportive services. The transition coordinator will work in partnership with the nursing facilities discharge planner to plan for and secure needed items to set up a new household.

Individuals wishing to transition from nursing facilities will be identified by Centers for Independent Living (CIL) and Missouri Long Term Care Ombudsmen or by the individual/family member or guardian. A referral indicating a wish to transition will be made to the state's Division of Senior and Disability Service's (DSDS) Central Registry Unit (CRU) located within the Department of Health and Senior Services (DHSS). CRU will verify Medicaid eligibility and perform a screening to determine the feasibility of transitioning into the community. Part of the screen will be to determine if they meet the MFP qualification guidelines.

Individuals meeting the MFP requirements will be referred to the DSDS field office closest to the nursing facility where the individual resides. The Long Term Care Specialist (LTCS) in this office will work with their staff in assessing the individual to ensure the eligibility requirements for Home and Community Services (HCBS) are met. During this assessment a determination will be made to see if the individual qualifies for the MFP demonstration. If all eligibility requirements are met, and the participant is able to direct their own care, the participant will be given the option of selecting agency based services or self-directed services. Those who have a guardian or conservator, or who

have limitations preventing them from directing their care independently, do not have the option of self-direction.

DSDS staff will develop a service plan during their visit with the participant. Existing supports and unmet needs will be taken into consideration during the development of the plan, as well as information from relatives, friends, and other support persons. HCBS will be authorized by DSDS staff as allowable within current state guidelines. MFP participants will be provided a list of Centers for Independent Living that assist in the area they plan to transition to, and will be asked to select the CIL they would like to be involved with. Throughout the course of the demonstration, DSDS staff will work in collaboration with staff from the CIL to successfully transition the individual. An example of the transition process to be utilized by CIL staff is attached (Attachment B).

Contact information for all contracted providers will be given to the participant or their guardian to allow them to select the provider of their choice. It will be explained that persons with a guardian and/or conservator will not be eligible for self-direction. Discussion surrounding demonstration eligibility, housing and need for service will take place. The individual, their family members, guardian, or any other persons they choose to be involved in their care will be provided brochures describing available services and contact numbers to be used to notify DSDS staff of changes or the threat of harm.

DSDS staff, representatives from the CIL, friends and family members and the nursing facility discharge planner will assist the individual and/or guardian in the transition planning process. The participant may include any other persons they wish. During the planning, demographic and background information will be collected. The individual and/or guardian will be presented with information regarding available housing that is appropriate to their needs and will actively participate in choosing their home. Finance, medical and personal needs will be addressed, as well as the need for supplemental transition services such as home modifications, utility deposits, cleaning supplies and toiletries. Any behavioral issues or other pertinent needs will be provided in a case review by the nursing facility's discharge planner.

After assessing the information obtained, the CIL will assist the participant in setting a transition date. They will speak with the participant and/or guardian regarding supports that are not yet in place and whatever additional needs or concerns they may have. The CIL will aide in making arrangements for transportation on the day of discharge and will speak with the participant about ongoing follow-up. Any available supports will be encouraged to participate in the actual transition.

Following a year of participation in the MFP demonstration, the participant will seamlessly continue to receive HCBS in their home. The only service that will no longer be available to them is supplemental services, which should be exhausted by this time. The participant will move into regular state plan and waiver services, if necessary filling a waiver slot that was reserved for them at the onset of their participation in the demonstration.

MFP participants will be encouraged to be as active as possible in their transition. Following the return to the community, CIL staff will maintain contact with the

participant on at least a monthly basis for six months. If necessary or requested by the participant, more visits will be scheduled.

Attached are two model case studies, one to illustrate how a person will transition from a state habilitation center and a second to illustrate a person transitioning from a nursing facility.

(Attachment C).

2. Benchmarks

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

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

Grant Year	Aged	Physically Disabled	Individuals with MR/DD	Dual Diagnosis: MR/DD and MI	TOTAL
2007	4	4	25	5	38
2008	11	12	25	5	53
2009	11	12	25	5	53
2010	11	12	25	5	53
2011	11	12	25	5	53
TOTAL	48	52	125	25	250

- **Benchmark #2: Expenditures for HCBS during each year of the demonstration program.** The following table represents the expenditures for HCBS for all individuals including one time supplemental services. Supplemental services are for individuals who transition from nursing facility to community as part of the MFP demonstration for each state fiscal year. The supplemental services have been placed on a separate line without a trend forward The DMH and DHSS, HCBS service amounts were based on the State Fiscal Year 2007 Medicaid expenditure data and were trended forward by 4% per year for each year of the demonstration. Services included are: Aged and Disabled Waiver, AIDS Waiver, Physical Disabilities Waiver, Independent Living Waiver, MR/DD Waiver, Community Support Waiver, Adult Day Health Care, Homemaker/Respite Care, Personal Care, Target Case Management. . The state did not request a trend factor be applied to the *supplemental services* in this demonstration. Year 1 will not begin until the Operational Protocol is approved. The unusually high percentage increases over the past few years were due to Missouri's efforts to assist individuals to remain in or return to the community. Missouri

anticipates the percentage of increase to level-out since many individuals have already enrolled in HCBS programs.

	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
HCBS	$833,986,647	$867,346,113	$902,039,957	$938,121,556	$975,646,418
Supplemental	$19,200	$55,200	$55,200	$55,200	$55,200
Total	$834,005,847	$867,401,313,	$902,095,157	$938,176,756	$975,701,618

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

State Fiscal Year	MRDD Waiver Expenditures	ICF/MR expenditures
SFY 2007	73%	27%
SFY 2008	75%	25%
SFY 2009	77%	23%
SFY 2010	79%	21%
SFY 2011	81%	19%

Benchmark #4: Increase the number of public housing authorities participating and the number of housing units, housing choice vouchers, and mainstream vouchers committed to individuals who have a disability or who are aged who plan to transition from a nursing home or habilitation center to the community.
The state will work with the public housing authorities (PHA) to obtain commitments for housing units, housing choice vouchers, and mainstream vouchers for individuals who plan to transition from a nursing facility or state habilitation center. The MFP project director will attend PHA meetings throughout the state to explain MFP and how the PHA's can participate. The state will send out letters to all 131 PHA's and request for the PHA to verify their participation and number and type of housing units/vouchers they will set aside. The state plans to obtain a commitment of 100 units/vouchers the first year and an average of 50 additional unit/vouchers every year thereafter. The state plans to increase PHA participation by at least fifteen each year. There is an expectation that the more urban area PHA's will be the first on board with the highest commitment to units/vouchers. The state will monitor where housing is available in an effort to target outreach. The state will also be gathering information regarding barriers to the PHA committing.

	Year 1	Year 2	Year 3	Year 4	Year 5
Units/Vouchers	0	100	150	200	250
Participation PHA's	0	20	35	50	65

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

Percentage of all individuals receiving HCBS self-directing their care

	Percentage of MRDD and those with a co-occurring MI Self-Directing	Percentage of Nursing Facility Self-Directing
SFY 07	3%	18%
SFY 08	5%	20%
SFY 09	7%	22%
SFY 10	9%	24%
SFY 11	11%	26%

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

	MFP Participants	Number self-directing
Year 1	38	9
Year 2	91	23
Year 3	144	36
Year 4	197	49
Year 5	250	63

B. Demonstration Implementation Policies and Procedures

1. Participant Recruitment and Enrollment.

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

State Habilitation Centers: People with developmental disabilities who reside in a Missouri Habilitation Center will be considered as a possible participant. Personal Plans, which are individualized and person-centered, are prepared at the Habilitation Center during the PCP meeting on an annual basis; at this time transition into the community is discussed. The "Missouri's Guide to Home and Community Based Services" (Attachment D) will be used as an educational booklet to inform individuals of the possibility of community living and services that are available to them. This booklet was developed through a prior Real Choice Systems grant; it describes available HCBS that

will be available to participants. Individuals may also be considered if an interest to transition occurs at any point during their stay at the habilitation center.

Nursing Facilities: The CIL and Missouri Long Term Care Ombudsman currently have access to residents of nursing facilities who have physical disabilities or who are elderly and will assist in recruiting participants. Missouri state regulation requires education and distribution of the "The Guide to Home and Community Based Services," prior to or upon the admission of a nursing facility. This guide will be used by the CIL and Ombudsman in providing education during their visits or to anyone contacting them of their wish to return to the community.

This demonstration will transition individuals out of state Habilitation Centers and Nursing Facilities. A description of each facility is listed below:

State Habilitation Center - In the state of Missouri, as of May, 2007, there are six state Habilitation Centers: Bellefontaine, Higginsville, Marshall, Nevada, St. Louis Developmental Disability Treatment Centers, South East Missouri Residential Services. Individuals who wish to transition from any of these facilities will be considered as a potential participant. A state habilitation facility is an intermediate care facility for individuals with mental retardation; it meets the requirement of an inpatient facility under 6071(b)(3) of the Deficit Reduction Act.

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

The individual must have resided in a State Habilitation Center or a Nursing Facility no less than 6 months prior to the date of transition. For those individuals transitioning from a State Habilitation Center the MFP eligibility requirements will be determined by the transition coordinator during the PCP meeting. For those transitioning from a nursing facility, eligibility requirement will be determined by DSDS staff. Eligibility requirements will be verified in the state eligibility Family Assistance Management Information System (FAMIS) and will be monitored by the MFP project director.

Individual must have been Medicaid eligible for a month prior to the transition date to the community. For those individuals transitioning from a State Habilitation Center the MFP eligibility requirements will be determined by the transition coordinator during the PCP meeting. For those transitioning from a nursing facility, eligibility requirements will be determined by DSDS staff. Eligibility requirements will be verified in the state eligibility Family Assistance Management Information System (FAMIS) and will be monitored by the MFP project director.

If a participant completes a twelve month period of the demonstration, and then returns to an inpatient status, future participation in the MFP grant will be determined on a case by case basis. Each case will be reviewed on an individual basis; barriers will be identified that caused the first transition to be unsuccessful; a new transition plan will be developed that will address those barriers; and the current needs and wants of the individual will be considered. If a person returns to an inpatient facility at any point during the demonstration period they will continue as part of

the demonstration unless their condition or status changes to a point that will not allow them to participate. Each case will be monitored closely by the respective department state staff to assure their needs will be met at the time of discharge. Every effort will be made to allow the individual to remain in the community. Arrangements may be made to secure the individuals place of residence on a case by case basis. Waiver slots will be retained for up to 60 days if there is a professional medical opinion to indicate the person will be ready to return to the community at that time. The case will be revisited if needed at the end of the 60 days. The person's demonstration days will be cumulative over the five year demonstration period.

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

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

The Missouri Department of Mental Health has a web site www.dmh.missouri.gov which provides individuals and families a link to view Client Rights, Abuse & Neglect Definitions, and the Reporting and Investigation process which includes contact information. The DMH Client Rights Brochure is posted on the web at http://www.dmh.mo.gov/diroffice/consaff/rights.htm. The brochure on Individual Rights of Persons Receiving Services from MRDD is located at http://www.dmh.mo.gov/mrdd/consfam/indrights.pdf. DMRDD's process for informing staff, providers and individuals on reporting alleged abuse or neglect can be found at http://www.dmh.mo.gov/mrdd/consfam/a-nprocessrc.doc

Nursing Facilities: DSDS staff will distribute the "Stop Elder Abuse" brochure (Attachment F) which provides a toll free hotline number for abuse, neglect and exploitation to the individual, family and guardian. The brochure gives examples of elder abuse and warning signs to watch for if you are a guardian or family member. DSDS staff will discuss the information on the Home and Community Based Services Care Plan with the participant (Attachment G) which states participant rights and responsibilities at the time of assessment and services planning. A copy of this care plan, which contains contact information on the toll free hotline, is given to the participant.

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

All Service coordinators provide training and orientation training regarding client rights and choices annually during the re-assessment with each participant or more often if needed.

2. Informed Consent and Guardianship

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

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

Guardianship and Conservatorship are established through legal processes and are no habilitative services by definition. Missouri State Statute RSMo Chapter 475 governs the laws pertaining to guardianship. Service coordinators are responsible for assisting families in understanding the role and function of guardians and conservators. These legal processes will be discussed with families in the same manner and using the same guiding principles that all other legal services are discussed. Life planning for people with developmental disabilities will include the assessment of an individual's functional skills relative to the potential need for a guardian and/or conservator. The decision to pursue guardianship and/or conservatorship is usually a private family matter. It is only when an individual has no family to support them or when family members are unable or unwilling to be part of the individual's support network and when all other efforts to support the individual and assure their health and safety fail that the service coordinator would take a lead role in pursuing this legal process for a individual they support. The Missouri statutes recognize that individuals may be partially incapacitated, that is perfectly

able to make decisions in one area of life, while needing significant support in another. If it is determined by those who know and care about the individual that the only alternative is guardianship, then limited guardianship is always considered first. With limited guardianship, the individual retains certain legal rights and freedoms that may directly impact quality of life.

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

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

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

Individuals exercise or are assisted in exercising all rights under the Constitution of the United States and those stated in State Statute. Individuals have information on the rights and responsibilities of citizenship. Individuals are involved in any process to limit their rights and are assisted through external advocacy efforts. Individuals are entitled to due process when limitations are imposed.

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

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

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

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

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

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

Nursing Facilities: If DSDS staff become aware of a situation in which guardianship/conservatorship may be appropriate, contact is made with family members, providers, and treating professionals to verify the likelihood of need. When necessary, family members and friends are encouraged to make application for guardianship/conservatorship. However, if no appropriate individual is available, DSDS staff will contact the Public Administrator in the county in which the individual with the need for guardian/conservator resides and request they file the application. If this too is unsuccessful, DSDS staff may assist in exploring other legal services.

3. Outreach/Marketing/Education

An informational brochure is in the process of being developed; a draft of the information to be included in this brochure is included in Attachment I. This draft will be shared with and reviewed by consumer and family groups for their suggested revisions. The brochure will be used to educate facility staff, service workers, families, and potential demonstration participants. The brochure includes an overview of the demonstration, eligibility criteria, available services and contact information. The verbiage is completed, however the design is not. A provider notice will be sent out via web to all enrolled Medicaid providers to inform them about Money Follows the Person Demonstration and its requirements (Attachment J). A web page will also be developed by DMS to distribute any changes or updates to the MFP demonstration throughout the five year demonstration.

Brochures and web based information will be used to disseminate information about MFP. A grassroots approach will be used by working with the many advocacy groups, local organizations and local agencies located throughout the state. Information will be posted on the DMH's Network of Care website located at www.missouri.networkofcare.org. The entire state will be targeted for outreach.

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

The state has already initiated training regarding MFP through informational presentations with groups such as, People First, Missouri Planning Council, Statewide Independent Living Council, Nursing Home Ombudsman, Housing Task Force and others. The DMH has a quarterly transition meeting with Regional Centers and transition staff. DHSS holds monthly meetings to update regional managers of any changes in regard to programs or policies. This information is

disseminated to field staff at least quarterly during staff meetings. The project director has and will continue to identify and request to present at forums and seminars that are being held around the state by advocacy groups, organizations and community efforts surrounding activities involved with the MFP Demonstration.

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

All DHSS employees and programs have access to the State of Missouri contract for providing interpretation and translation services. Guidance and information on the current contract is always available through the Department's Office of Personnel. The Office of Personnel informs staff on a yearly basis of this policy/contract via a department-wide e-mail notice. Language Identification Cards are provided to Department employees. The Language Identification Card list the languages most frequently encountered in North America, grouped by the geographical region where they are commonly spoken. A staff person would determine the geographic region where they believe the non-English speaker may be from. The card portion for the Region is shown to the individual. The message under each language says "point to your language. An Interpreter will be called". The over-the-phone interpretation is available 24 hours a day, 7 days a week.

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

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

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

There is no cost sharing requirements for home and community based services. Individuals will be notified of cost sharing responsibilities for other Medicaid State Plan services using the states current method of notification for any Medicaid eligible individual. Eligibility and cost sharing issues will be addressed and discussed with the DMH participants during the personal centered planning meeting. DSDS staff will notify participants of cost sharing responsibilities during the initial assessment and care planning meeting. Individuals who are participating in the Money Follows the Person Grant will be required to meet the current eligibility requirements, there will

be no new eligibility requirement changes for the Money Follows the Person Demonstration Grant. Recipients will also be notified of Medicaid eligibility and cost sharing through the "Medicaid and You" (Attachment K) brochure and the "Recipient Handbook" (Attachment L).

4. Stakeholder Involvement

The success of this project is contingent on multiple stakeholder collaborations that include individuals with disabilities and their families, state agencies, legislators, community providers, consumer advocacy groups, and others. For true rebalancing of the systems to occur, key stakeholders need to be engaged in discussions regarding issues such as bed/institutional closure and conversion of institutional resources to support Home and Community Based services. The Missouri DMS the single state agency responsible for the administration of Missouri's Medicaid Program, will have overall responsibility for administration of this project. DMS and project partners will support the ongoing collaboration and participation of multiple stakeholders in the design and implementation of this project through the Missouri Personal Independence Commission (PIC).

The Personal Independence Commission was established by former Governor Bob Holden in April, 2001. The Commission's primary responsibility is to monitor Missouri's implementation of Title II of the ADA, with guidance provided by the U.S. Supreme Court in *Olmstead* and subsequent cases. Commission members include the following: The Directors of the Departments of Social Services, Mental Health, Health and the Commissioner of the Department of Elementary and Secondary Education or their designees (4 members); ten (10) members who are appointed by the Governor and include persons with disabilities or family members of persons with disabilities, or who represent a wide variety of disability and elderly groups; four (4) members from the Missouri General Assembly, (two are appointed by the President Pro Tem of the Senate and two are appointed by the Speaker of the House of Representatives); and the Missouri Lieutenant Governor, for a total of 19 members.

The Executive Director of the Governor's Council on Disability serves as primary staff support to the Commission. The Personal Independence Commission is charged with the following responsibilities:

1. To examine whether existing programs and services provide individuals with disabilities who may be eligible for community-based treatment with appropriate information regarding this option
2. To facilitate communication and collaboration between state agencies and the disability community in accomplishing the objectives of the Home and Community-Based Services and Consumer-Directed Care Commission of 2000 and the Personal Independence Commission, and to include representatives from the areas of housing and transportation in its discussion;
3. To monitor and assess continuing development of the process to transition institutionalized individuals with disabilities eligible for community-based treatment into appropriate community settings;
4. To monitor and assess implementation of the process to transition eligible institutionalized individuals with disabilities to community-based treatment settings;

5. To recommend modifications or changes that may be needed to improve existing home and community-based services and consumer-directed care programs;
6. To recommend potential means of expanding home & community-based services or consumer-directed care programs;
7. To meet at least biannually;
8. To submit a report to the Governor and General Assembly by October 31 of each year, containing specific recommendations for any changes necessary to further the effort to assist eligible persons remaining in or moving to community-based settings or to assist persons to live more independently.

The Personal Independence Commission developed a comprehensive guide to home and community-based services in Missouri. The guide is posted on the state's website, and is available in electronic and hard copy. Missouri Nursing Homes are required to provide this to new residents and families, upon admissions to a Medicaid-certified bed. The Personal Independence Commission has also developed a guide to Missouri housing resources. The Personal Independence Commission has quarterly informative presentations from various groups to keep the commission informed of best practices as well as innovative approaches to independent living services. At the close of each meeting time is allotted to allow public testimony for those concerned about pending legislation or current regulation impacting their ability to live and work independently to have their voice heard.

While the Personal Independence Commission is required to meet only semi-annually, this group generally meets on a quarterly basis. Money Follows the Person has been a regular agenda topic since December, 2006, and will continue to be on the agenda throughout the agenda. PIC members provided input during development of the operational protocol, and facilitated access to and input from a wide variety of other stakeholders. The PIC will monitor Missouri's implementation of the Money Follows the Person Demonstration, and will provide input to the state over the life of the demonstration. The Operational Protocol is viewed as a "work in progress" and will continue to evolve as changes are made to Missouri's long term care system, through budget appropriations, legislation, and other initiatives that will lead to better access to and higher quality of home and community-based services.

Current membership includes the following individuals:

Lieutenant Governor Peter D. Kinder, Chair (represented by Deputy Lt. Governor Eric Feltner). The Lt. Governor is the senior advocate for Missouri, and has the Office of Advocacy and Assistance for the Elderly is located within his office. The Lt. Governor's office coordinates activities with the Long Term Care Ombudsman program, and acts as a clearing house for information pertaining to, or of interest to the elderly. In addition, Lt. Governor Kinder chaired the Mental Health Task Force, appointed by Governor Matt Blunt. The Mental Health Task Force submitted a report of recommendations to improve quality and safety of mental health services in late 2006, following public hearings around the state, and continues to monitor the department's implementation of the recommendations.

Kirsten Dunham, Co-Chair: Ms. Dunham is employed by Paraquad, one of Missouri's 22 Centers for Independent Living. She has been a leader in Missouri in advocating for the rights of individuals with disabilities, and supporting initiatives that enable all Missourian's to live with freedom and dignity.

State agency representatives include Brenda Campbell, Director of the Division of Senior and Disability Services (DHSS), Sandra K. Levels, Director of Program Management, Division of Medical Services (DMS), C. Jeannie Loyd, Assistant Commissioner of the Division of Vocational Rehabilitation (DESE) and Bernie Simons, Director of the Division of MR/DD (DMH).

Other PIC members include a wide variety of individuals who have a disability, who have a family member with a disability, and others who have a long history of advocacy for persons with disabilities and the elderly.

Attachment M is an organizational chart including how stakeholders will influence the project. Attached to the Organizational Chart is a list of the stakeholders that are part of the MFP Demonstration.

In addition to individuals with disabilities and advocates who are members of the PIC, other numerous state individual advocacy organizations and associations will be involved in discussions regarding overcoming barriers to transitioning individuals to the community. Consumers are required participants in many of the State's councils, task forces and planning meetings

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

If during an assessment the individual expresses a wish to transition into the community the provider will be responsible for notifying the transition coordinator at the Habilitation Center, or the Center for Independent Living for those transitioning from a nursing facility to begin the transition process. If anytime during a patients stay in an institution the individual wishes to transition the proper entity will be notified.

Individuals will be responsible for notification of changes in living situation, problems that are occurring with service providers or staff, changes in support or service needs, changes in health, inpatient hospitalizations or any service interruptions. This may be done by the person, a family member, guardian, provider or anyone else that is closely involved with the individual. Once the service coordinator receives this information they will coordinate with all parties to make whatever arrangements necessary, such as change services, moving arrangements, guardian consent, or whatever actions are needed based on the situation.

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

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

5. Benefits and Services

The delivery mechanism for the grant participants will be fee-for-service. The Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period will be Medicaid State Plan, and waiver services. Appendix C-3 of the HCBS Waivers specifies provider qualification criteria. The State has a provision built into the current MR/DD and Independent Living 1915(c) waivers that reserves capacity for individuals transitioning from ICF/MR and Nursing Facilities. Reserved slots will be held at the onset of transition into the community; once they reach the end date of grant participation they will enter into the saved slot. The same process will be used for those waivers that do not have reserved slots. The project director will work in collaboration with the DMH and DHSS on monitoring this process. If it appears that waivers are reaching maximum capacity the waiver(s) may be amended to include more slots. The state will assure the process will be seamless to the participant by having a slot available at the onset of participation. The services provided during the grant will continue to be provided once the one year period is over, with the exception of supplemental services used during the demonstration for moving costs, housing related expenditures, etc. as designated by the MFP guidelines for supplemental enhancements for those participants transitioning out of nursing facilities. The below chart identifies the qualified HCBS for individuals participating in the MFP demonstration. There are no HCBS demonstration services. There is a one time supplemental service available for a person transitioning from a nursing facility described below. An individual may only participate in one waiver at a given time, but may be moved from one waiver to another during the one year demonstration based on their needs.

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

Program Name	Administration	Overview
		some home modification or equipment can also be provided if cost effective; limitation on total hours of personal care

Supplemental Services: After an individual is found eligible for the MFP demonstration, the CIL selected to assist in transition is responsible for identifying the need for supplemental services. As a Medicaid enrolled provider, the CIL will submit an itemized prior authorization request to the DSDS Program Oversight Unit for review and approval. If DSDS staff determines the requested services are appropriate for participant needs and qualify for reimbursement, they will prior authorize up to, but not more than $2400 per participant. The CIL may bill for reimbursement of Medicaid supplemental services anytime during the year of MFP participation through use of a procedure code and modifier. If, during the course of the demonstration, it is determined the individual needs additional supplemental services, a prior authorization may be requested as long as the total amount per participant does not exceed the $2400 limit. Supplemental Services will include home modifications, deposits, household items, cleaning supplies, toiletries, furniture, groceries and other items as identified on an as needed basis.

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

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

State Plan Service Overview

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

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

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

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

Individualized Supported Living (ISL): A non-facility form of residential habilitation that provides support and training services to an individual in the individual's own residence. Individuals may live alone or with their families or may share living arrangements with others. When living arrangements are shared, no more than 3 individuals with disabilities may reside together and qualify for ISL services.

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

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

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

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

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

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

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

6. Consumer Supports

Missouri's Guide to Home and Community Based Services booklet will be used as a tool to inform the participant about available services. The Missouri Medicaid/MC+ Fee-For-Service Recipient Handbook and the Medicaid and You brochure will also be provided to each participant. Education will be provided by the MRDD transition coordinator during the person centered planning process. For residents in nursing facilities, DSDS staff will discuss options during their face to face visit for assessment and care planning. Transitioning guides, such as the Division of MRDD's Let's Get Moving transition process, and the transition processes developed by participating agencies such as the Independent Living Centers will be used by staff

to educate participant. Going through the transition processes will act as a check list of areas to discuss with the participant.

The Following website provides educational information for those individuals transitioning out of a Habilitation Center: http://www.dmh.mo.gov/mrdd/progs/fiscal.htm.

Emergency back-up plans will be developed on an individual basis by the individual with a fall back plan if the system fails. Addressed in the following the back-up procedures and policies for State Habilitation Centers and Nursing Facilities.

State Habilitation Centers: Division of MRDD participants who are self-directed are required to identify the demographics of their emergency/back-up plan in their person center plan. Back up plans include a description of the risks faced when emergencies, such as lack of staff arises. The back up plan also identifies what must be done to prevent risks to health and safety: how people, should respond when an emergency occurs; and who should be contacted and when. Back up plans must list at least two individuals who will provide support when regular staff is not available. The Missouri Independence Plus Initiative participant workbook will be used by the Division of MRDD Regional Centers for individuals transitioning out of Habilitation Centers as a guide to direct participants in developing a back-up system that is appropriate for their needs and also what to do in case the back-up plan fails. If the individualized back up system does not work, and it is not an emergency requiring 911 assistance, the participant should inform their regional center service coordinator immediately. If it is after regular working hours, they should still call the local regional center. They will either be connected to an answering service that will contact staff or they will receive instructions regarding how to contact the on call staff directly. The service coordinator will explain how the after hours answering service works at the regional center during the transition process. All contact information will be listed in the participant's back-up plan.

Nursing Facilities: Providers are required by state regulation to ensure back-up services are available to individuals they provide services to. See Appendix A(e) for more information. At the time of the DSDS assessment and service planning, the participant is given contact information regarding who to call in the event of service delivery failure or to inquire about the need for additional services, etc. Participants have additional resources available through local Centers for Independent Living. If unable to obtain assistance through the CIL or if unable to contact the indicated DSDS staff, they may call the toll free hotline number maintained by DSDS' Central Registry Unit (CRU). CRU staff will assist in any way possible, including contacting local DSDS field staff if appropriate. In situations in which the participant is in immediate danger, they may be advised to call 911 for emergency assistance.

7. Self-Direction (See Appendix A)

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

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

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

8. Quality

The state will integrate the MFP demonstration into existing 1915(c) HCBS waivers. The MFP program will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waivers during the transition and during the 12 month demonstration period in the community. Attached is a copy of two of the most current Appendix H's of the HCBS waivers (Attachment O).

Missouri Division of MRDD, Division of CPS, and Department of DHSS each have established Quality Management systems. The following is a brief overview of these systems:

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

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

Assuring Health and Safety: The Division of MRDD employs case managers at its 11 regional centers around the state. These case managers, and some employed by Missouri Senate Bill 40 County Boards, provide case management for individuals served by the division including waiver participants. They are responsible for determining waiver eligibility, facilitating person centered planning, authorizing necessary services, and frontline monitoring. In addition, the DMH has a critical event or incident reporting system, an Office of Individual Affairs that receives and resolves complaints, a Licensure and Certification Unit, a Contract Unit, and a centralized investigation unit. Each regional center has quality assurance staff that are responsible for working with providers to ensuring corrective action is taken as required and for encouraging quality enhancement and assuring the health and safety of individuals they serve. In addition, the Division of MRDD is working toward a plan for home and community-based contractors to be accredited by either the Council on Quality Leadership (CQL) or Commission on Accreditation of Rehabilitation Facilities (CARF).

The Division of Senior and Disability Services serves as the State Unit on Aging and carries out the mandates of the State regarding investigation and intervention in cases of adult abuse, neglect, and financial exploitation, and provides oversight to programs and services for seniors and adults with disabilities. The Division Bureaus are responsible for providing program oversight and has a Central Registry Unit for receiving reports of adult abuse, neglect and exploitation, distribution for investigation, and tracking status. Participant care plans are reviewed at least annually by Division staff and as part of the review process staff ask specific questions regarding the quality and continuity of services received. When a problem is detected, the Division staff assists in the resolution of the problem and in cases of abuse, neglect, or exploitation would investigate and take action to protect the health and welfare of the participant. Attachment P contains a statement of Assurances regarding necessary safeguards to protect the health and welfare of recipients under the Aged and Disabled Waiver.

The Division of CPS conducts certification and monitoring of community agencies that provide services for people with psychiatric disabilities. This includes conducting ***pre-surveys*** for each agency being monitored (e.g. data is collected on incidents, injuries and complaints); ***surveys*** to determine compliance with certification standards (e.g. interviews with individuals and staff; review of personnel and clinical records); and ***post-surveys*** to inform the agency of the findings, including deficiencies and recommendations for program improvement.

Quality Management Improvements in process: The primary system gaps relate to improvements in quality management systems that track and share individual outcomes/satisfaction and information related to quality of services. This issue is currently being addressed through the various existing transformation efforts which are exploring the use of information technology systems to improve tracking and reporting. For example, the Division of MRDD is exploring the development of "provider report cards" as an approach to supporting improved choice related to quality services. The Division of MRDD is exploring the feasibility of national accreditation for all home and community based providers. In 2003 CMS awarded a Quality Assurance/Quality Improvement grant to the DHSS. One large part of the effort is conducting a comprehensive Individual Satisfaction Survey of roughly 10% of the people served by DHSS. The purpose of this survey is to assess the individuals' general satisfaction with the services they receive. The survey tool chosen for this project is the Participant Experience Survey (PES) developed by the MEDSTAT group. Through this project we will expand upon the current DHSS initiative and explore the use of the *PES* as a tool to evaluate individual satisfaction outcomes for demonstration participants. We would survey an individual after he/she has been transitioned for six months and again 12 months later. The results would be compared to the two years of data collection from the larger sample to track and trend responses.

During the assessment process and development of the service plan, DSDS staff will discuss with the participant, guardian or family member what supplemental services are required to transition them into the community. DSDS staff will work collaboratively with the Center for Independent Living and other appropriate agencies in the area to which the participant is transitioning in order to ensure that their needs are met and barriers to residing in the community are addressed. DSDS staff, taking into consideration the recommendation of the agencies involved in the transition, will give final approval of all funds and services. Throughout the duration of the demonstration period, contact will be maintained with the participant at least monthly for the first six months by the CIL to ensure the service plan continues to adequately meet their needs and that their quality of life in the community meets their expectations. The

monthly visits will be extended beyond the six months if there is a need or if requested by the person, family or guardian. DSDS will track how Supplemental Demonstration services were used and their effectiveness in supporting successful transitions.

9. Housing

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

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

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

- **Division of MRDD Waiver Individualized Supported Living (ISL) and Personal Assistant Services:** ISL services provides support and training services to an individual in the individual's own residence. Individuals may live alone or with their families or may share living arrangements with up to 2 other unrelated individuals.

- **DHSS In-home Services:** DHSS supports the provision of in-home services to individuals in a variety of living arrangements, including but not limited to, their own homes, homes of family members or senior housing units. These home and community-based services are provided through both State Plan and Aged and Disabled Waivers.

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

At the policy level, the Department of Economic Development coordinates and prepares the State of Missouri Consolidated Plan for HUD. The plan recognizes the need for increasing affordable housing options for individuals with disabilities and their families. The Plan established four priorities for the 2003-2007 planning cycle: *Increase funding for the Missouri Housing Trust Fund and assure that a portion of those funds serve people with disabilities; Implement housing rehab activities to assist individuals in maintaining their home; Increase the supply of affordable housing; and Increase awareness of ADA laws.*

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

The state will contact Public Housing Authorities (PHA) and request to present at meetings. The MFP project director will send out letters to all 131 public housing agencies requesting verification of participation. In the request the state will encourage PHAs to commit a number of vouchers to individuals who are transitioning out of nursing facilities and habilitation centers. A draft copy of the letter of request is attached (Attachment Y).

The Missouri Planning Council will be partner to the state in addressing housing issues. In its' five year plan, the Council identified objectives that included increasing the number of accessible and affordable housing options and increasing the number of individuals with a home of their choice. One of the past projects supported by the Council was the Home of Your Own (HOYO) project. The state will continue to collaborate with the planning council to support efforts for people to become home owners. The HOYO program has helped over 30 Missourians with developmental disabilities to obtain homes throughout the state.

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

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

10. Continuity of Care Post the Demonstration.

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

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

Missouri does not anticipate having any State Plan Amendments during the first year of the demonstration because participant transition and community support needs can be met through existing HCB program services. Future state plan amendments may be necessary as a result of legislative or budget initiatives.

C. **Organization and Administration**

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

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

The Missouri Department of Mental Health was first established as a cabinet-level state agency by the Omnibus State Government Reorganization Act, effective July 1, 1974. The Department of Mental Health (DMH) is organizationally comprised of three program divisions that serve approximately 150,000 Missourians annually, along with six support offices. DMH makes services available through state-operated facilities and contracts with private organizations and individuals. The Division of Mental Retardation and Developmental Disabilities (MRDD), established in 1974, serves a population that has developmental disabilities such as mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such

conditions must have occurred before age 22, with the expectation that they will continue. To be eligible for services from the Division, persons with these disabilities must be substantially limited in their ability to function independently. The Division improves the lives of persons with developmental disabilities through programs and services to enable those persons to live independently and productively. In 1988, the Division began participation in the Medicaid home and community-based waiver program, designed to help expand needed services throughout the state. In addition, six habilitation centers and 11 regional centers serve individuals with developmental disabilities. DMH will be responsible for transitions of individuals with MRDD and those with co-occurring MI. Attachment (Y) is a map of Missouri showing the regions of the state that the regional centers operate.

Missouri Revised Statutes Chapter 205 Section 968 authorizes Missouri counties to establish boards and to assess a local tax to provide services to individuals with developmental disabilities. Counties with such taxes may fund residential and other services, in addition to sheltered workshop programs. Eighty-five (85) Missouri counties have County Boards for Developmental Disabilities, also known as "SB 40 Boards." County DD Boards are an important part of the community system of services for people with developmental disabilities. County DD Boards may use their local public funding to leverage federal Medicaid reimbursement for service coordination (targeted case management) and/or waiver services. Over 30% of County DD boards have formed a partnership with the state to provide TCM services but this number is growing due to additional state support provided to county DD boards in the division's FY08 budget. Over 65% of County DD Boards use local public funds to purchase and/or provide MRDD waiver services. In counties where the County DD Board provides service coordination, residents may choose a case manager either from the County Board or from the Division of MRDD Regional Center. Likewise, when County DD boards also offer MRDD waiver services, individuals qualifying for MRDD waiver services have a freedom of choice from among all providers serving the county in which they wish to reside.

The Mental Health Commission, and a Mental Health Task Force, appointed by Governor Matt Blunt during 2006, have both recommended the Division of MRDD continue to explore public private relationships for the provision of service coordination and supports for individuals with developmental disabilities. To this end, the Division of MRDD will begin to change its' Regional Center structure over the next five years, as County Boards begin to increase their capacity to provide service coordination.

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

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

and many rural areas throughout Missouri, many with branch offices, for statewide access in all 115 Missouri counties.

The Personal Independence Commission is the lead stakeholder organization to provide guidance and oversight of the Money Follows the Person Demonstration. The organizational chart referenced under the stakeholders section outlines organization of the MFP Demonstration. The Personal Independence Commission's primary responsibility is to monitor Missouri's implementation of Title II of the ADA, with guidance provided by the U.S. Supreme Court in *Olmstead* and subsequent cases.

The Project Director is an employee of the state's Department of Social Services, Division of Medical Services. A resume as well as the Department of Social Services, Division of Medical Services Organizational chart is attached (attachment S)

The number of key staff is assigned and paid for by the grant is four: The Project Director, Transition Service Coordinator, and two Support Staff.

The Project Director is a Department of Social Services full time employee, the Transition Service Coordinator will be using 30% of his time in Money Follows the Person Grant activities, support staff for the Transition Service Coordinator will spend 10 % of their time, and support staff for the Project Director will spend 50% of their time on the Money Follows the Person grant.

Money Follows the Person Project Director will be responsible for implementation of the demonstration. Julie Ousley fills the position as Project Director; a high-level unclassified administrative position within the Department of Social Services, Division of Medical Services responsible for planning, coordinating, and directing unique Medicaid programs. The MFP Projector Director position is a full time (100 percent level of effort) position. This position will closely coordinate with MFP project liaisons within the DMH and the DHSS. Fred Fridlington, MRDD Project Liaison will fill the role of statewide transition coordinator for the Division of MRDD, overseeing all transitions from State Habilitation Center into communities. Mr. Fridlington will oversee the work of the Transitional Coordinators, Placement Coordinators, and other division staff located throughout the state, with day-to-day responsibilities for transitions. Mr. Fridlington is a member of the DMH MRDD Executive Team, reporting to the director of the DMRDD and coordinating closely with the division's six Regional Center Directors. A second support may be hired, if needed, after the demonstration is implemented.

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

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

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

The only staff that is not currently hired is a support staff for the project director. Filling the support staff position will be made once implementation of the demonstration begins.

Julie Ousley, Project Director	Hired
Fred Fridlington, Transition Coordinator	Hired
Nancy Schetzler, Transition Coordinator support staff	Hired
Project Director Support Staff	Upon Implementation, if needed

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

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

D. Evaluation

The overall goal of the Money Follows the Person Rebalancing Project (MFP) is to support and assist persons with disabilities or who are aging to make the transition from large institutions to smaller, quality community settings that can meet their individual support needs and preferences. This project will enhance existing state efforts to reduce the use of institutional, long-term care services and increase the use of home and community based programs.

The purpose of this proposal is to evaluate the effectiveness of the State of Missouri's Money Follows the Person Project and, if needed, provide information for program improvement. This program evaluation will examine points throughout the transition process from large institutions to community settings. These stages include but are not limited to: how the 250 persons in the project are selected as participants; the type funding they will receive; the type residence they will occupy; the support services they will receive; and their satisfaction with these services.

1. EVALUATOR

Evaluator Name: Robert F. Doljanac, Ph.D.
Title: Research Associate
Agency: University of Missouri – Kansas City Institute for Human Development

Dr. Doljanac had an integral role in the development of the evaluation plan. Dr. Doljanac worked closely with Julie Ousley, MFP Project Director, in the Division of Medical Services. He also collaborated closely with Thomas McVeigh, Associate Director, Program Development and Chris Rinck, Director of Applied Research, both at the University of Missouri – Kansas City Institute of Human Development. A resume for Dr. Doljanac is included in the Appendices.

2. EVALUATION DESIGN

Hypotheses, Outcome Measures, Data Sources, & Analysis Methods:

Hypothesis #1: The recruitment and transition planning processes developed and implemented for MFP will result in an increase in persons living in the community who have disabilities and those who are aging.

The MFP demonstration will enhance existing efforts to transform the long-term support system that provides services and supports for people with disabilities. For the State of Missouri to successfully implement the Money Follows the Person Project, the state will work to eliminate barriers that prevent individuals currently residing in state institutions and private nursing facilities from accessing needed long-term community support services and improve the ability of the Missouri Medicaid program to continue provision of home and community based long-term care services to individuals who choose to transition from institutional to community settings following this demonstration. To support these outcomes, the state will evaluate the overall recruitment, planning, and transitioning processes for MFP participants.

Target Groups: Persons participating in the MFP project will be followed to identify exemplary practices as well as barriers to successful transitions. Evaluation methods described below will focus on each of the three subgroups that include:

- People with developmental disabilities transitioning from habilitation centers,
- People with co-occurring developmental and mental health disabilities transitioning from habilitation centers, and
- The elderly and those with disabilities transitioning from nursing facilities.

The evaluation is organized within 6 areas related to a number of important transition practices as follows:

Area #1: Establishment of practices and policies to screen, identify, and assess persons who are candidates for transitioning into the community through the MFP project.

Outcome Measures:

- Changes in relevant policies and procedures related to screening, identification, assessment, and transition planning.
- Number of eligible MFP participants who choose to participate in relation to those who actually transition.

Data Source:

- The Missouri DSS (MO HealthNet Division), Missouri DMH, and Missouri DHSS will provide the Institute of Human Development (Evaluation Agency) with a listing of current policies and procedures related to screening, identification, assessment, and transition planning. Policies and procedures will be identified for each of the three primary target groups. Key informant interviews will be conducted on an annual basis to track and identify changes, modifications, and additions to these policies and practices.

- Data on the numbers of potential and actual participants in MFP will be obtained from the Missouri DMH and DHSS. This information will be inputted into a database developed and maintained by the MO HealthNet Division. This dataset will identify, a). The number of persons who express an interest in transitioning and who are referred for transition supports and, b). The number of individuals who actually transition. The evaluation will examine the reasons for non-transition for identified individuals.

Analysis: Summary reports will be prepared that list the number of identified potential candidates for transitioning into the community and the number who successfully transitioned. The report will also delineate some of the reasons why individuals decided not to participate or were unsuccessful in accomplishing their transitions. In addition, the report will describe any changes in practices related to screening, identification, assessment, and transition planning that may have taken place.

Area #2: Development of flexible financing strategies or other budget transfer strategies that allow "money to follow the person".

Outcome Measures:

1. Changes in State practices and policies that support the smooth transitioning of money from the institutional long term support budgets to community budgets.
2. Changes in the balance of long term care funding between institutional and home and community based services
3. Increases in the number of persons and amount of supplemental service funding received by persons under the MFP program

Data Source:

1. The Missouri DSS (MO HealthNet Division), Missouri DMH, and Missouri DHSS will provide the Institute of Human Development (Evaluation Agency) with a listing of current policies and procedures related to flexible financing and budget transfer strategies. Policy information will be gathered from the DMH and DHSS websites. If necessary, key informant interviews will be conducted on an annual basis to track and identify changes, modifications, and additions to these policies and practices.

2. Data on the amount of funding for institutional and home and community based services as well as the number of persons funded under the Medicaid waiver program in Missouri will be obtained from the state Departments of Social Services, Mental Health and Health and Senior Services.

3. Data on the amount of funding for supplemental services as well as the number of persons funded under the supplemental services provision for MFP in Missouri will be obtained from the state Departments of Social Services, Mental Health and Health and Senior Services.

Analysis: Relevant policy and program reports will be reviewed and monitored to determine if funding policy changes have occurred and the degree to which rebalancing was achieved. Funding amounts and the numbers receiving services will be summarized.

Area #3: Availability and accessibility of supportive services for MFP participants. Supportive services include a full array of health services, 'one time' transitions services, adaptive medical equipment, housing and transportation.

Outcome Measures:
1. Level of consumer involvement in planning transitions and delivery of services
2. Number of MFP participants who choose to self-direct
3. Types of housing selected by participants in MFP
4. Types and amount of transition services, including supplemental services, used by MFP participants
5. Number of public housing authorities supporting and number of housing vouchers committed to individuals participating in MFP

Data Source:
1. Through participant level surveys/interviews we will identify the level of consumer involvement in and satisfaction with transition planning and services.

2. Database will be developed by the MFP staff that identifies the type funding the person receives to support these services (e.g. Medicaid waiver, state plan services). Also listed in this database will be the initial type housing participants live in upon re-entering the community (e.g. unit with an individual lease, community based group setting, family home) and any housing transition services that participants receive (e.g. security deposits, home modifications, furnishings). Information will be inputted into the database at the time of transition and updated as needed on a continuous basis.

3. Data on the types of housing selected by participants in MFP will be obtained through DMH and DHSS.

4. Data on the types and amount of transition services will be obtained through DMH and DHSS

5. Data on the number of housing authorities and vouchers will be obtained from the MFP Directors

Analysis: Data will be summarized and reported on a 6 month basis. Summary information will include frequency of various types of services, supports, and living arrangements.

Area #4: Actions to develop an available and trained workforce to provide support for participants in MFP. These state actions will act to increase the quality and quantity of direct care workers.

Outcome Measures:

1. Number of individuals trained and certified through the Missouri College of Direct Support.

Data Source:
1. A database will be developed to contain the number of persons enrolled and participating in the College of Direct Support Training Curriculum, the number who completed at least thirteen courses, and the number who have reached the certification level. The individuals completing this curriculum will also be recorded in a database for monitoring.

Analysis: Data will be summarized on a 6 month basis to report the number of persons taking, the number who have completed the courses, and the number who have reached certification level.

Hypothesis #2: The development and use of the MFP quality monitoring system will insure that needed services are identified and delivered to participants.

This system will also help insure that participants are satisfied with their services and supports and continue to reside in community settings. This system will result in participants transitioning into the community and continuing to live in community based settings.

Area #5: Development of policies and practices to improve quality management systems to monitor services and supports provided to participants in the MFP Project.

Outcome Measures:
1. Level of satisfaction with home and community based services including living arrangements
2. Changes in quality of life

Data Source:
1. The state of Missouri in partnership with the IHD evaluation team will develop and implement a quality of life survey/interview that meets CMS established guidelines.
2. Participants from each target group who have agreed to transition to the community will be selected to participate in the survey/interview on service satisfaction and quality of life. This survey/interview will be conducted by identified individuals for each MFP participant prior to their leaving their current living setting and at intervals identified by CMS after leaving. Additional questions related to the transition process may also be included (e.g. level of consumer involvement in planning transitions).

Analysis: This Survey will be given to participants prior to their leaving the institution and after transitioning to the community. Project evaluators will input and analyze the responses and data. These pre and post scores will be compared and reported in a summary manner using a within Analysis of Variance. Independent variables will include age, agency, and other relevant variables. There will be no control group. No names will be linked to the data provided for analysis. This will minimize the time needed to obtain needed SSIRB approvals. Results will be disseminated through an annual summary report.

Area #6: As part of the state commitment to have persons live in community settings, persons eligible to participate in MFP and who decline or cease participation will be evaluated to determine the reasons for their decisions.

Outcome Measures:
1. Rates of re-institutionalization and reasons cited

Data Source: Data will be gathered from the project database on the number of MFP participants who choose to return to institutional facilities and the reasons behind their leaving community based services. This data will be used to identify problems in the MFP project and support ongoing quality improvements. Relevant data regarding persons who re-institutionalize will be collected by case managers/service coordinators at the time of reentry and sent to the MFP Coordinator for inclusion in the database maintained by the project.

Analysis: The results from this survey will be summarized and presented on an annual basis to participating state agencies. This summary will include frequencies on the number of persons returning to institutional facilities and an analysis of the reasons for their return.

Control Variables:
Control variables for analyzing data will be the three target groups (MRDD, MRDD and MI, and Aging).

Methods to Isolate Effects of Demonstration From Other Initiatives:
Data on the number of persons who moved from long term institutions to community settings for the 5 years prior to MFP will be obtained. These numbers will be compared to the number of eligible persons who move to the community under the MFP Project.

State policies and procedures will also be monitored for changes that would affect persons continuing to live in long term institutional settings. Nursing homes will be monitored for closings or other changes that might change their populations.

Other Pertinent Information: NA

Reporting of Interim Evaluation Findings:
Summary reports will be developed and presented to relevant state of Missouri personnel and the PIC on a semiannual basis.

3. VARIABLES

Data will be collected on the following variables in relation to each evaluation area.

Area #1:
- Unique ID
- Age / Date of Birth / Gender
- Eligibility: MRDD, MRDD-MI, Aging
- Length of stay in institution
- Participate in MFP
- If no, reason for non-participation
- What services or practices helped in the planning process
- What practices could be improved and how

Area #2:
- Number of persons funded under Medicaid waiver program

- Funding for institutional and home and community based services
- What policies support the development of flexible financing strategies
- What policies could be improved and how

<u>Area #3:</u>

- Level of consumer involvement in transition process
- Type and amount of funding received
- Initial type community housing
- Use of transition services and how used
- Services that are self-directed
- What services or practices helped in the transition process
- What practices could be improved and how

<u>Area #4:</u>

- Data on the number of persons enrolled in certification training
- Number who have completed courses
- Number who have certification of completion

<u>Area #5:</u>

- Survey/interview completed while living in institutional setting
- Survey/interview completed after living in the community

<u>Area #6:</u>

- Number of persons participating in MFP living in the community who return to institutional settings
- Reason for return to institutionalized setting

4. PROCESS EVALUATION

Process evaluation has been incorporated under several of the evaluation areas to monitor and improve the MFP Project. This overall process will include evaluations of the recruitment and transition process, the services and supports provided in the community and living arrangements.

<u>Analysis</u>: Comparisons will be made between the various groups to determine if there are differences in how the MFP Project is being experienced. Summaries within groups will also be reported. Reports will be presented on a semi-annual basis.

	Area #1: The MFP Project will establish practices and policies to screen, identify, & assess persons who are transitioning into the community through the MFP Project			
	Outcome	Data Elements for Measure	Information / Data Source(s)	Entity / Agency providing dat
a.	Changes in policies & procedures relevant to persons in each target group	Related policies and procedures	Interviews and Dept. Policy Reports	Dept. of Mental Health MRDD & CPS Dept. of Health and Senior Services
b.	Number in each target group who choose to participate and those who actually transition	• Numbers identified • Numbers who transition • Reasons for non-transition	Annual reviews, referrals, and interviews	Dept. of Mental Health MRDD & CPS Dept. of Health and Senior Services

5. EVALUATION OVERVIEW

	Area #2: Development of flexible financing strategies or other budget transfer strategies that allow "money t			
	Outcome	Data Elements for Measure	Information / Data Source(s)	Entity / Agency providing data
a.	Changes in policies & procedures relevant to budgeting & finance strategies for persons in each target group	Policies and procedures on funding	State departmental web site / Key informants /Policy reports	Dept. of Mental He Dept. of Health and Senior Services
b.	Changes in the balance of long term care funding between institutional and home and community based services	• Long term care funding • Institutional funding	State budget reports	Dept. of Mental He Dept. of Health and Senior Services
c.	Increases in the number of persons funded under the Medicaid waiver program	Number of persons receiving Medicaid waiver funding	State data reports	Dept. of Mental He Dept. of Health and Senior Services
d.	Increases in the amount of funding for supplemental services received by persons in the MFP Project	Supplemental services funding	State budget reports	Dept. of Mental He Dept. of Health and Senior Services

	Area #3: Availability and accessibility of supportive services for MFP Project Participants			
	Outcome	Data Elements for Measure	Information / Data Source(s)	Entity / Agency providing da
a.	Level of involvement of consumers in the MFP Project in transition planning and delivery of services for each target group	Individual responses to survey/interview questions	Consumer satisfaction survey (TBD)	To be determined

b.	Types of housing selected by MFP participants for each target group	Type housing selected and received	MFP Data Files	Department of Mental Health Department of Health and Senior Services
	• Apt. or Unit with an individual lease			
	• Community Based Residential Setting			
	• Home Owned or Leased by Individual or Family			
c.	Number of MFP participants who self-direct services for each target group	Number of persons self-directing services	MFP Data Files	Department of Mental Health Department of Health and Senior Services
d.	The number of public housing authorities agreeing to participate in the MFP Project	Number of PHA's agreeing to participate in the MFP Project	Letters of Agreement	MFP Project Director
e.	The number of housing vouchers committed to individuals participating in the MFP Project	Number of housing vouchers committed to participates in the MFP Project	Letters of Agreement	MFP Project Director
f.	Types and amount of transition services, including supplemental services	Transition Services	MFP Data Files	Department of Mental Health Department of Health and Senior Services

	Area #4: The State of Missouri will take actions to develop a trained workforce for MFP Project participants a enter the community after the MFP Project			
	Outcome	Data Elements for Measure	Information / Data Source(s)	Entity / Agency providing data
a.	The number of direct care workers taking CDS courses	Number enrolled CDS learners in MO	CDS reports	CDS Coordinato
b.	The number of direct care workers completing certification requirements through the CDS	Number CDS learners receiving certificates	CDS reports	CDS Coordinato
c.	Policy changes that will call for state-wide implementation of the CDS	Policies & Procedures	Interviews & Dept. Policy Reports	Mo CDS Statewic Steering Committe

	Area #5: Development of policies & practices to improve quality management systems to monitor services a provided to participants in the MFP Project			
	Outcome	Data Elements for Measure	Information / Data Source(s)	Entity / Agency providing data
a.	Level of satisfaction with home and community based services including living arrangements	Individual responses to survey/interview questions	MFP Participants	To be determined

b.	Changes in quality of life	Individual responses to survey/interview questions	MFP Participants	To be determined

	Area #6: As part of the state commitment to have persons live in community settings, persons eligible to par who decline or cease participation will be evaluated to determine the reasons for their decisions.			
	Outcome	Data Elements for Measure	Information / Data Source(s)	Entity / Agency providing data
a.	Rates of re-institutionalization	• Persons returning • Reasons for return	Records and interviews	The Departments of Mental Health and Health and Senior Services

E. Final Budget

The following information is attached as listed.

Appendix C
Medicaid Program Expenditure Report, Other Narrative Explanations (Attachment V)
Money Follows the Person Combined DMH/DHSS Budget Table (Attachment W)
MFP MOE Forms 64 (Attachment X)