



**ALABAMA**

**MONEY FOLLOWS THE PERSON  
REBALANCING DEMONSTRATION**

**OPERATIONAL PROTOCOL v.1.2**

**April 2013**

# ALABAMA DRAFT OPERATIONAL PROTOCOL

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## ALABAMA DRAFT OPERATIONAL PROTOCOL

### a) PROJECT INTRODUCTION

#### **(1) Organization and Administration**

**(a) Systems Assessment and Gap Analysis:** *Describe the current long-term support delivery system in the State including progress to date and “gaps” that will need to be addressed in order to “rebalance” the system.*

Much has been accomplished toward rebalancing of Alabama’s long-term support delivery system in the past decade through thoughtful planning, aggressive grant-seeking and responsiveness to the needs of Alabama’s seniors and people with disabilities. This has resulted in an institutional landscape that no longer includes any large or state-operated ICF/ID (fewer than 30 individuals now reside in small privately operated ICFs), and one that has an ever-diminishing reliance on institutions to provide services to individuals with mental illness.

The historic *Wyatt* settlement agreement in 2000 was implemented through a comprehensive consolidation plan that resulted in closure of three developmental centers and two state operated nursing homes; co-location of one psychiatric hospital with another and eventually closing the relocated hospital; and establishment of community services support teams for ICF/ID residents. Since the settlement agreement concluded, Alabama has continued its efforts. In 2009, the third and last nursing facility was closed. In March 2011, the Alabama Department of Mental Health (ADMH) announced the closure of its last and oldest developmental center, the W.D. Partlow facility in Tuscaloosa. This closure was finalized in 2011. The State has also announced plans to close two additional psychiatric hospitals by the

end of 2012. The closure of Greil Memorial Hospital in Montgomery and Searcy Hospital in Mt. Vernon will impact 292 individuals.

The State has also had experience with nursing home transition. The Alabama Department of Senior Services (ADSS) received a *Real Choice Systems Change Grant* in 2001 for Nursing Home Transition that resulted in supporting the transition of 112 people with dementia from nursing facilities. Disability Rights and Resources (formerly Independent Living Resources of Greater Birmingham) also received a *Real Choice Systems Change Nursing Home Transition Partnership Grant* that same year; Partnerships to Independence (PTI) has continued to operate since that time. To date 325 nursing facility residents have been referred to the program and 112, ages 18-101, have been assisted with transition back into the community.

In recent years, Alabama has invested in significant infrastructure with considerable capacity to continue to assist individuals with disabilities of all ages to transition from institutional settings, as described further below and in the State's Olmstead Plan, *Gateway to Community Living* (Attachment A). The goal of this MFP Rebalancing Demonstration will be to support 405 - 625 individuals to successfully transition from institutional settings to community living through continued enhancement of the State's infrastructure.

**Description of the Current LTC Support Systems:** The current LTC support system in Alabama relies largely on Medicaid funded waivers and State Plan services, augmented by other federal, state and locally funded services. The following is a brief description of the key service providers and programs that form the foundation of the LTC support system.

The **Elderly and Disabled Waiver** provides services to individuals who might otherwise be placed in nursing facilities. It is operated by the ADSS. This waiver is approved to serve 9,205

individuals. ADSS provides additional services to Alabama seniors, including Caregiver Assistance, Senior Employment and Home-Delivered Meals. ADSS is also responsible for the implementation of Aging and Disability Resource Centers (ADRC) in the state.

The **HCBS Waiver for Individuals with Intellectual Disabilities** serves individuals who meet the definition of mental retardation. It is operated by the ADMH and is approved to serve 5,260 participants. Alabama's **Living at Home Waiver**, also operated by ADMH, provides a wide array of services for individuals with a diagnosis of intellectual disability who would otherwise require more costly services in an ICF/ID. The Living at Home Waiver is approved to serve 569 participants. ADMH also provides mental health and substance abuse services to over 100,000 Alabamians.

The **SAIL Waiver** serves adults with specific medical diagnoses who are at risk of being institutionalized in nursing facilities. It is operated by the Alabama Department of Rehabilitation Services (ADRS). The SAIL Waiver is approved to serve 660 participants. Other services offered by ADRS include vocational rehabilitation, early intervention and children's rehabilitation services.

The **Technology Assisted Waiver for Adults**, operated by the Alabama Medicaid Agency (AMA), provides private duty nursing, personal care/attendant services, assistive technology, and medical supplies to individuals with disabilities who would otherwise require more costly nursing facility care. This waiver serves adults with complex medical conditions who are ventilator-dependent or who have tracheostomies. This waiver serves 40 participants.

The **HIV/AIDS Waiver** provides case management, homemaker services, personal care, respite care, skilled nursing, and companion services to individuals with a diagnosis of HIV/AIDS

and related illness who would otherwise require more costly nursing facility care. It is operated by the AMA. The waiver serves 150 individuals each year.

The **Program of All Inclusive Care for the Elderly (PACE)** provides community-based care and services to aged and disabled adults who would otherwise need nursing facility level of care. The PACE program is a capitated managed care benefit that features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with the needs of the participant. The target group for PACE is recipients that meet the nursing facility level of care, live in the community, a nursing facility or at home. PACE recipients must be 55 years of age or older, Medicare or Medicaid eligible or both, and live in a designated PACE service area.

The AMA **Home Health** program provides services to help individuals with illnesses, injuries, or disabilities to receive quality care at home, through the utilization of registered nurses, licensed practical nurses, home health aides/orderlies, physical therapists, occupational therapists, speech therapists, respiratory therapists, and medical equipment and supplies.

The **Alabama Long Term Care Ombudsman Program** enables each Area Agency on Aging to hire, at a minimum, a full-time Ombudsman to provide education and advocacy supports to individuals in long term care facilities. The Older Americans Act requires an Ombudsman program that is responsive to the needs of persons in long term care facilities.

**Major Legislative Initiatives:** The Long Term Care (LTC) Rebalancing Advisory Committee was created in 2009 by legislative action. Senate Joint Resolution (SJR) 84 (Attachment B) called for five subcommittees, each with a specific charge, as follows: a) *Needs Assessment and Services*

was charged with gathering information from consumers on the kinds of services they feel are needed that will divert or delay institutionalization and preserve or improve their quality of life; b) *Resource Development and Coordination* was charged with identifying the available services and resources within the state and presenting recommendations and approaches to providing services that are necessary to delay or divert institutionalization; c) *Single Point of Entry (SPE)* was charged with determining if a SPE is beneficial for consumers and families, and determining how the SPE should work within the state of Alabama; d) *Economic Impact* was charged with determining the financial impact of rebalancing Alabama LTC systems and making recommendations for the efficient use of available dollars; and e) *Legislative Matters* was charged with determining what steps are needed politically to facilitate long-term care policy changes within the state of Alabama. This Committee issued its findings in the *Report of the Long Term Care Rebalancing Advisory Committee* (Attachment C) in March 2010. Thus far, the State has implemented three of the five key recommendations, including continuing this Committee, implementing a PACE project, and implementing an Alabama Community Transition (ACT) waiver.

**Current Rebalancing Efforts:** *An assessment of what Medicaid programs and services are working together to rebalance the State's resources and a description of any institutional diversion and/or transitions programs or processes that are currently in operation. What additional Medicaid programs and services are needed to increase HCBS and decrease the use of institutional care?*

Alabama has developed an infrastructure that will allow the State to begin supporting transitions immediately upon an award of MFP Rebalancing Demonstration funding. In fact,

this infrastructure is already being used to assist individuals with transition to community living.

Essential components of the infrastructure include:

- The State has implemented the requirements of the MDS-Q, having established a *Local Contact Agency (LCA)* system and provided training to nursing facility staff and other stakeholders.
- Transitional Services are now available to all individuals enrolled in waiver programs who have been in the nursing facility for 90 days or more and who are expected to move into the community within 180 days. To implement Transitional Services, Alabama requested and received CMS approval to include these services as an activity within State Plan Targeted Case Management services and/or waiver amendments for Case Management offered in Alabama's HCBS waivers.
- New enrollment in the Technology Assisted (TA) Waiver continues to increase. The eligibility criteria for the TA Waiver were recently changed to accommodate a larger population of ventilator-dependent adults and address the cost-effectiveness of this waiver.
- The State has developed and begun to implement the Alabama Community Transition (ACT) Waiver to facilitate transition for individuals with disabilities currently living in nursing facilities, as described above. This waiver has a capacity to serve 200 individuals. Implemented in January 2012, ACT enrollment currently stands at three, with two more individuals in the transition process set to enroll by September 1, 2012.
- Alabama has amended each of its other HCBS waivers to reserve capacity to further facilitate transition as illustrated in the table below. We also anticipate another 20 transitions will take place to a PACE program.

**Table #1: Capacity Reserved for Transition in HCBS Waivers**

HCBS Waiver	Capacity	Slots Reserved for Transition
ELDERLY AND DISABLED	9,205	100
SAIL	660	25
INTELLECTUAL DISABILITIES	5,260	25
LIVING AT HOME WAIVER (ID)	569	25
TECHNOLOGY ASSISTED	40	5
HIV/AIDS	150	25
ALABAMA COMMUNITY TRANSITION	200	200
<b>Total</b>	<b>16,084</b>	<b>405</b>

- ADMH has announced plans to continue to downsize and close several state-operated IMDs (State Operated Psychiatric Hospitals). The AMA is working with ADMH on a transition plan for those individuals who are affected, including the development of Medicaid funded community services, such as a 1915(i) state plan amendment.
- The AMA is in the process of submitting a State Plan Amendment for a new group for Targeted Case Management. The new target group will be individuals affected by Substance Abuse. ADMH will be responsible for this new target group.

**Analysis of Gaps and Solutions:**

While Alabama has made significant strides in developing infrastructure to support transitions, gaps still remain. One such gap that continues to exist is the lack of HCBS capacity to serve individuals who have developmental disabilities without a co-occurring primary diagnosis of intellectual disability. While there are current waivers, such as the E&D waiver, for which such individuals may meet eligibility criteria, these programs were not designed for the specific needs of a DD population and often do not offer the scope of services needed to adequately support them in the community. Similarly, there have been no Medicaid waivers designed with the needs of individuals with mental illness specifically in mind. The MFP

Rebalancing Demonstration will address these gaps through the addition of new waiver and State Plan services.

Alabama has implemented the requirements of MDS-Q, but there are still significant gaps in awareness of options for individuals to transition to community settings and of the services available to individuals to support transitions. The State will address increasing awareness through:

- A planning initiative to integrate and streamline access to the HCB long term care support systems across all disability and aging populations;
- Comprehensive stakeholder training; and
- An aggressive outreach and social marketing initiative.

As in other states, housing remains one of the most significant barriers to community living in Alabama, with a deficit of some 90,000 affordable housing units across the State. The MFP Rebalancing Demonstration will undertake a comprehensive initiative to promote the availability and accessibility of housing resources.

**Potential MFP Participants:** *A description of the number of potential participants who are now living in institutions including the number of residents in nursing homes who have indicated they would like to transition into the community.*

There are currently about 14,600 individuals residing in nursing facilities in Alabama. Since the implementation of the MDS-Q protocol, 143 individuals have indicated an interest in considering home and community-based services as an alternative.

There are currently 292 individuals residing in the State-Operated Psychiatric Hospitals targeted for closure. Of these, AMA and ADMH have determined that few are currently

receiving Medicaid or are Medicaid eligible, as most are between the ages of 21-65. In addition to these two facilities, ADMH also operates the Mary Starke Harper Geriatric Psychiatry Center in Tuscaloosa, which is responsible for the provision of inpatient psychiatric services to elderly citizens throughout the state. This facility serves 113 patients, all 65 and older, many of whom have current Medicaid eligibility. It is anticipated that 30-40 individuals could be MFP participants.

**Self Direction:** *A description of any current efforts to provide individuals with opportunities to self-direct their services and supports. Would your State be developing additional opportunities for participants to self- direct?*

Alabama participated as a Cash and Counseling state to develop self-directed services, and was the first state approved to add a consumer-directed care option to the Medicaid State Plan under Section 1915(j). The program, *Personal Choices*, was designed to provide a mechanism for self-directed services that could be accessed by participants of any of the State's HCBS waivers. It was implemented in 2007. Three Alabama HCBS waivers are currently making use of the option for certain core services. In addition, the ID and LAH Waivers are providing individuals with the opportunity to self-direct core services.

As a part of the MFP Rebalancing Project, Alabama intends to expand opportunities for self-direction through the addition of self-direction in a new ACT II waiver, through an aggressive social marketing campaign to promote the use of existing self-directed options, as described under the sections on Benefits and Services and Outreach, and through an intensive formative evaluation of the choice-making process, barriers to self-direction, and comparative outcomes in key areas.

**Stakeholder Involvement:** *Describe the stakeholder involvement in your LTC system. How will you include consumers and families as well as other stakeholders in the implementation of the MFP program?*

The LTC Rebalancing Advisory Committee, created by SJR 84, is comprised of a wide array of individuals with varying interest in ensuring that individuals who are elderly and disabled receive appropriate and quality care, as well as long term-care choices. The Committee includes disability advocates, state agency representatives, advocates for the elderly, members of the legislature, and members of various provider associations. A full listing of the membership may be found in Attachment D.

The AMA has developed this application with input and feedback from the LTC Rebalancing Advisory Committee. This Committee has functioned as the MFP Planning Work Group, charged with:

- Identifying the target populations to be transitioned through the MFP Grant;
- Developing strategies to identify individuals who would be eligible for transition to the community; evaluating Alabama's current Home and Community Based Services to identify areas for expansion; and
- Engaging providers to participate in the transition process; and formulating plans of action for providing for transitioned individuals as grant eligibility expires.

As the state continues to consider options for improving long-term care delivery, the LTC Rebalancing Committee will continue to work with the Medicaid Commissioner to gather

stakeholder input on rebalancing projects and advise Medicaid on the design and implementation of any rebalancing projects.

**(b) Description of the Demo's Administrative Structure:** *Describe the Administrative structure that will oversee the demonstration. Include the oversight of the Medicaid Director, which agency will be the lead agency, all departments and services that will partner together, the administrative support agencies that will provide data and finance support and what formal linkages will be made and by what method, (i.e. Memorandum of Agreement, reorganization).*

The AMA, the Medicaid single State agency, will oversee the MFP Rebalancing Demonstration and serve as lead agency. Within AMA, the MFP program is part of the Long Term Care Division. The Director of the Long Term Care Division reports to the Deputy Commissioner for Health Systems and directly supervises the Project Director of the demonstration, who will serve as full-time staff to the project. The Alabama Medicaid Commissioner will have ultimate administrative authority related to the Grant activities.

Additional coordination with divisions internal to AMA will also be required for successful implementation of the demonstration. AMA's Information Systems Division will put information technology changes in place to track MFP participants in the eligibility and MMIS systems. Additionally, AMA's Finance Division is involved on a regular basis to assure appropriate development of cost estimates informing budget projections, as well as Maintenance of Effort (MOE) documents.

Several Operating Agencies will participate in the MFP Rebalancing Demonstration. These include the Alabama Department of Rehabilitation Services (ADRS), the Alabama

Department of Senior Services (ADSS), the Alabama Department of Mental Health (ADMH) and all entities contracting with AMA to provide PACE programs. Each Operating Agency will carry out roles and responsibilities in the implementation of the Demonstration, including:

- Tracking and status reporting of all referrals;
- Coordinating with the LCA/ADRC;
- Assigning a Transition Coordinator in a timely manner once Options Counseling has identified the appropriate service provider;
- Completing program-specific eligibility and service planning assessments as needed;
- Ensuring that an appropriate service plan and transition plan are developed and implemented;
- Verifying ongoing Medicaid eligibility of participants;
- Ensuring the presence of an effective 24/7 back-up plan is operational;
- Participating in the quality management strategies for MFP Qualified and Demonstration Services;
- Collecting and providing data required for MFP Rebalancing Demonstration operation;
- Managing waiver capacity to ensure that the allocation of slots for transition is sustained;

The AMA already maintains agreements with each of the Operating Agencies and PACE programs that will be a part of the MFP Rebalancing Demonstration service delivery system.

The agreements will be amended, as needed, to reflect the MFP agreements and requirements. The MFP Project Director will coordinate directly with the waiver managers at the Operating Agencies and the PACE programs to assure regular and ongoing communication on all aspects of the MFP demonstration.

## **(2) Benchmarks**

*Provide a list of proposed annual benchmarks that establish empirical measures to assess the State's progress in transitioning individuals to the community and rebalancing its long-term care system. These benchmarks should be measures of the progress made by the State to direct savings from the enhanced FMAP provided by this project towards the development of systems improvements and enhancing ways in which money can follow the person into the community.*

Alabama proposes five benchmarks that will demonstrate its progress toward achieving the following goals of the MFP Rebalancing Demonstration Program:

1. Increase the use of Home and Community Based Services (HCBS) and reduce the use of institutionally-based services;
2. Eliminate barriers and mechanisms in State law, State Medicaid plans, or State budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice;
3. Strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and,
4. Ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.

The following metrics will be used measure progress in each of these areas beginning in 2012 and continuing through 2016.

**Benchmark 1: Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.**

**Table #2: Projected Number of People who will Transition to the Community**

	ELDERLY	ID/DD	PHYSICAL DISABILITY	MENTAL ILLNESS	HIV/AIDS/Related Illnesses	TOTAL
<b>2013</b>	15	10	10	20	5	60
<b>2014</b>	25	20	30	20	5	100
<b>2015</b>	50	30	40	20	5	145
<b>2016</b>	35	30	30	20	5	120
<b>TOTAL</b>	125	90	110	80	20	425

**Benchmark 2: Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.**

Alabama anticipates it will increase its state Medicaid expenditures for HCBS during each calendar year of the MFP Rebalancing Demonstration. The table below displays the State’s baseline expenditures for 2012 and projected Medicaid expenditures for years 2013-2016 for community-based long-term services and supports programs. These figures include expenditures for the 1915(c) waivers, State Plan HCBS (home health, private duty nursing and Durable Medical Equipment), HCBS share of PACE and projected MFP expenditures for Qualified and Demonstration services. A more detailed breakdown may be found in Appendix 1.

**Table #3: Projected Increases in Medicaid Expenditures for HCBS 2013-2016**

	2012 (Baseline)	2013	2014	2015	2016
HOME HEALTH	\$23,269,787	\$24,203,483	\$25,145,032	\$26,007,804	\$26,770,630
DME	\$29,839,002	\$30,754,584	\$31,695,887	\$32,656,157	\$33,634,334
HIV/AIDS WAIVER	\$867,327	\$948,347	\$975,147	\$1,002,752	\$1,086,184
ID WAIVER	\$279,386,157	\$288,727,742	\$296,700,774	\$305,472,797	\$314,511,581
E&D WAIVER	\$76,883,263	\$108,144,942	\$112,171,770	\$115,074,144	\$118,511,460
TA WAIVER	\$939,571	\$967,759	\$1,116,792	\$1,146,696	\$1,117,497
LIVING AT HOME WAIVER	\$6,170,255	\$6,405,363	\$6,671,024	\$6,992,405	\$7,144,677
ACT WAIVER	\$14,615	\$615,054	\$1,215,506	\$3,135,971	\$3,096,450
SAIL WAIVER	\$5,378,835	\$5,653,377	\$5,932,759	\$6,047,573	\$6,251,985
PACE	\$1,032,300	\$1,141,929	\$1,173,827	\$1,206,682	\$1,240,523
MHS/REHB-DHR	\$47,574,071	\$49,001,294	\$50,471,333	\$51,985,473	\$53,545,037
MHS/REHB-DYS	\$14,807,437	\$15,251,660	\$15,709,210	\$16,180,486	\$16,665,901
SUBSTANCE ABUSE	\$6,159,357	\$6,344,138	\$6,534,462	\$6,730,496	\$6,932,411
MENTAL HEALTH	\$102,408,104	\$105,480,348	\$108,644,758	\$111,904,101	\$115,261,224
MENTAL HEALTH DYS	\$44,259	\$45,587	\$46,954	\$48,363	\$49,814
REHAB EARLY INTERVENTION	\$1,617,529	\$1,666,055	\$1,716,037	\$1,767,518	\$1,820,543
PRIVATE DUTY NURSING	\$5,701,275	\$5,872,314	\$6,048,484	\$6,229,938	\$6,416,836
TOTAL NONINSTITUTIONAL LTCSS	<b>\$602,093,151</b>	<b>\$651,223,976</b>	<b>\$671,969,757</b>	<b>\$693,589,356</b>	<b>\$714,057,086</b>
ANNUAL PERCENTAGE GROWTH		<b>8.16%</b>	<b>3.19%</b>	<b>3.22%</b>	<b>2.95%</b>

The projected growth will come from several sources. Key initiatives will include recruitment of eligible individuals for transition to the ACT waiver, the development of an *Alabama Community Transition II (ACT II)* waiver and recruitment of eligible individuals, the expansion of PACE services to additional areas of the State and the implementation of an *Accessible Housing Initiative*.

The ACT II waiver will target the needs of people who currently reside in a nursing facility with diagnosis of Intellectual Disabilities (ID), assessed Developmental Disabilities (DD), Mental Illness, or have a Dual Diagnosis, who wish to move to the community and receive

necessary supports. To this end this waiver will not limit the scope by targeting a specific population by diagnosis; rather this waiver will be utilized based on the appropriateness of the services offered and the expertise of the operating agency. This waiver is of particular significance in addressing systemic gaps related to a lack of Medicaid-funded services designed and available to individuals with DD and mental illnesses. This waiver will be intended to provide wrap-around supports to participants who live with their families or in their own residences. Some services may be self-directed and payment can be made to family members if the family members are qualified to provide such services.

Planning is also underway to expand PACE services beyond the single current site, including potential sites in Birmingham, Alabama's largest metropolitan area, and in Montgomery.

Alabama is also planning to further develop State Plan HCB services that will support people with mental illnesses regardless of MFP eligibility. For example, the ADMH and AMA have been examining the feasibility of implementing a 1915(i) program, with a needs based criteria requiring an individual to have a variety of combinations of risk factors and functional need for assistance with community living skills that cannot be met by outpatient clinic services. These services would be available to individuals living in IMDs and certain individuals living in nursing facilities, but also to individuals living in community settings who meet eligibility criteria.

Alabama will use the enhanced matching funds, or Rebalancing Fund, it receives when MFP participants use qualified HCBS or demonstration services to support these expanded

services in its LTC support systems. These services will strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions, and will support effective HCB services for all individuals regardless of MFP eligibility.

Administrative funding will be used to implement certain key initiatives of this project, including the housing, employment and self-determination initiatives. The experiences of the MFP programs, over time, have demonstrated these services to be essential infrastructure to facilitate and support safe and successful transitions. These building blocks must be put into place at the outset of the program in order to achieve a robust level of program recruitment and transition, which in turn will produce the enhanced funding that will eventually comprise the Rebalancing Fund.

Alabama further projects these initiatives will result in a rebalancing trend that will increase the percentage of expenditures for home and community based services in the overall Medicaid long term care expenditures, as shown below.

**Table #4: Projected Percentage of Non-Institutional Expenditures Compared To Total Long Term Care Expenditures 2013-2016**

	2012	2013	2014	2015	2016
Total Non-Institutional Expenditures	\$602,093,151	\$651,223,976	\$671,969,757	\$693,589,356	\$714,057,086
Total Long Term Care Expenditures	\$1,600,640,608	\$1,651,573,132	\$1,682,291,404	\$1,713,983,220	\$1,744,623,889
Non-Institutional % of Total LTC Expenditures	37.62%	39.43%	39.94%	40.47%	40.93%

The State also proposes three additional benchmarks by which it will measure the increase in overall community supports for community living and the use of key supports for community living, including 1) housing, 2) self-direction and 3) broad access to information through the ADRC.

**Benchmark 3: *Increase available and accessible supportive housing services statewide***

Alabama will continue its efforts to increase available and accessible supportive services to achieve a full array of health services and community supports for consumers, including those who are not MFP participants. These services will help eliminate barriers and mechanisms that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice, and strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions.

As a part of this overall effort, Alabama plans to undertake an *Accessible Housing Development Initiative* (described in full under Section (9) Housing) which will address certain needs of the state's residents who are aging and who have disabilities, regardless of their MFP participation. With MFP funds, the State plans to contract with an entity to promote the availability and accessibility of housing resources in Alabama communities, as well as provide direct housing assistance Demonstration Services to participants (further described under Section (5) Benefits). The State intends to measure indicators that would demonstrate the success of these strategies, but few numerical baseline indicators for these are currently available. This lack of information is symptomatic of a system that does not work well to meet

the needs of people with disabilities. Baseline data will therefore need to be developed at the initiation of the project. Proposed measurements include:

- An experience and satisfaction survey disseminated at the time of individual transition and on a semi-annual basis to Transition Coordinators and MFP participants. The survey will assess the accessibility and usefulness of housing resources including, for example, public housing authorities and the Accessible Housing service; satisfaction with and adequacy of the services; and the adequacy and stability of housing obtained. A baseline indicator will be established at the conclusion of the first semi-annual survey, with a target for a percentage increase per period to be developed and tracked.
- An experience and satisfaction survey, disseminated on a semi-annual basis to agencies providing HCBS to individuals with disabilities to assess accessibility and usefulness of housing resources and satisfaction with adequacy and stability of housing for the clientele served. A baseline indicator will be established at the conclusion of the first semi-annual survey, with a target for a percentage increase per period to be developed and tracked.
- An experience and satisfaction survey, disseminated on a semi-annual basis to local public housing authorities and other housing entities regarding familiarity with the needs of individuals with disabilities in their catchment areas and their interactions with MFP staff and participants. A baseline indicator will be established at the

conclusion of the first semi-annual survey, with a target for a percentage increase per period to be developed and tracked.

**Table # 5: Housing Satisfaction and Experience Surveys Completed**

Satisfaction and Experience Surveys Completed	MFP Participants	Transition Coordinators	HCBS Agencies	Public Housing Authorities	TOTAL
<b>2013</b>	60	10	150	40	260
<b>2014</b>	150	20	150	80	400
<b>2015</b>	250	30	150	90	520
<b>2016</b>	200	20	150	90	460
<b>TOTAL</b>	660	80	600	400	1740

The information collected through the surveys will also be used in future years to establish additional discrete benchmarks of progress in accessibility and utilization of housing resources by people with disabilities and as a part of a formative evaluation to increase collaborative relationships and additional infrastructure necessary to an adequate housing capacity.

In the future, Alabama intends to develop an additional baseline indicator of individuals with disabilities served in public housing. These data are not currently collected. The Demonstration will work collaboratively with HUD and the Public Housing Authorities to develop a process for data collection. Once a baseline indicator is achieved, an additional target for a percentage increase per year will be established and tracked.

***Benchmark 4: Increase in the utilization of and satisfaction with self-directed services***

Self-Directed services also serve the MFP objective of eliminating Medicaid barriers by providing ongoing flexibility in the use of Medicaid funds that enable Medicaid-eligible individuals to receive long-term care in the settings of their choice.

The State has made considerable infrastructure investments to support the availability of self-directed services in Alabama, best exemplified by the implementation of the 1915(j) state plan option for self-direction, *Personal Choices*. Despite these investments, the growth of use of these services has been slow. There was some growth seen in the past several years, but it appears to have plateaued. In 2012, a total of 94 individuals were served using the *Personal Choices* self-direction option. Potential barriers to self-direction growth include a lack of understanding of how self-directed services are implemented, including the availability of supports, and an aversion to perceived increased risk. These barriers exist, to some degree, among many stakeholder groups including potential participants, family members, some policymakers and the public.

Alabama proposes to undertake interventions to address these barriers, including:

- The development of enhanced outreach and educational materials that will be offered on multiple occasions,
- Training of key staff who deliver the materials and provide education, and
- Further development of user-friendly self-directed risk management tools.

As described in detail in Section b) (7) Self-Direction, the Demonstration will contract for assistance with the development of the supports for expanding Self-Direction. Key activities that support the proposed outcome include:

- (1) Targeted outreach will be undertaken to ensure individuals and families have a full understanding of the opportunities for self-direction, the potential benefits and the supports available to self-directing participants. MFP administrative funding will be

used to contract for development of the outreach tools to be used for this purpose. All personnel providing Options Counseling and Transition Coordination will be provided training on the use of the self-direction outreach tools.

- (2) Alabama proposes to develop a comprehensive self-directed risk management tool that is user-friendly for all population groups targeted by the MFP Rebalancing Demonstration, and to test key factors and outcomes related to their implementation.

Alabama also proposes to assess key outcomes related to the interventions (described in Section (d) Evaluation below) and to make appropriate modifications to the interventions through a formative evaluation process. Alabama proposes to include a comparative satisfaction measure that will be collected during the QoL surveys. These data will be used to develop a baseline measure to facilitate the comparison of rates of satisfaction with services between choosers and non-choosers of self-direction over the course of the MFP Rebalancing Demonstration.

Results of the anticipated positive outcomes will be used to dispel the perceptions of barriers and further promote the expansion of self-directed services. These strategies are expected to result in significant growth in the use of self-direction statewide and for both MFP and non-MFP populations as indicated in the table below.

**Table # 6: Projected Growth in Individuals Choosing Self-Directed Services**

	ELDERLY	ID/DD	PHYSICAL DISABILITY	MENTAL ILLNESS	HIV/AIDS/Related Illnesses	TOTAL
<b>2013</b>	10	10	15	5	2	42
<b>2014</b>	20	15	20	10	3	68
<b>2015</b>	30	40	50	20	5	145
<b>2016</b>	40	60	65	30	5	200
<b>TOTAL</b>	100	125	150	65	15	455

***Benchmark 5: Increases in the visibility, accessibility and utilization of the ADRC network by individuals with disabilities.***

In order to be an effective avenue for Options Counseling, outreach and marketing, the ADRC network in Alabama must achieve an optimal level of visibility and accessibility for individuals with disabilities in addition to those in the aging community. Baseline data from the most recent ADRC Semi Annual Reporting Tool (SART) for the period April-September 2012 does not currently provide adequate information to make reliable inferences regarding the number of individuals with disabilities served through ADRCs. Only four of the thirteen AAA ADRCs were reporting data to the SART during that timeframe and even among these four, it appears that data collection procedures varied substantially. All thirteen ADRCs have now been through an extensive training process on these procedures and continue to receive monitoring and technical assistance to ensure data is collected and reported in a standardized manner.

In order to measure visibility, accessibility and utilization, the MFP Rebalancing Demonstration will benchmark the following outcomes:

- The number of individuals with disabilities using ADRCs will be tracked, including number of contacts, type of contact (phone, website, walk-in, etc.), extent of contact

(information and referral, Option Counseling, etc.) and how the individuals learned of the ADRC. ADSS and AMA will continue to monitor to ensure complete and reliable data are being collected. Initial data will be obtained through the next SART report and compared with the preliminary targets, set below, for any needed adjustments. The preliminary targets are derived from data provided by the ADRC TAE and from census data.

- SART data from 2011 indicated ADRCs with 1 operating organization, such as Alabama’s current system, averaged 50.0 contacts per 1,000 in the service population. The total service population, as defined in the TAE calculations, for Alabama is 4,876,660, resulting in an expectation of approximately 244,000 contacts. Census data further suggest that there are more than 660,000 people over 60 years of age in Alabama and approximately 375,000 individuals with disabilities under age 60. Based on these data, we would hope over time to see people with disabilities less than 60 years of age represented in about 33% of ADRC contacts.

**Table # 7: Projected ADRC Contacts per Year**

	2013	2014	2015	2016
ADRC Contacts Individuals Aged 60+	—	120,000	150,000	162,667
ADRC Contacts Individuals with Disabilities Aged 60 and Under	—	30,000	50,000	81,333
Total ADRC Contacts	-----	150,000	200,000	244,000

- An experience and satisfaction survey will be disseminated at the time of individual transition and on a semi-annual basis to Transition Coordinators and MFP participants to assess satisfaction outcomes for individuals with disabilities. The baseline data will be collected through an experience and satisfaction survey during the first six months of transitions, with a target for a percentage increase per period to be developed and tracked.
- An experience and satisfaction survey will be disseminated on a semi-annual basis through agencies providing HCBS to individuals with disabilities to assess visibility, accessibility and usefulness of the ADRC and satisfaction with the services provided. A baseline indicator will be established at the conclusion of the first semi-annual survey, with a target for a percentage increase per period to be developed and tracked.
- An experience and satisfaction survey will be disseminated on a semi-annual basis to ADRCs at the Area Agencies on Aging regarding familiarity with the needs of individuals with disabilities in their catchment areas and their interactions with MFP staff and participants.

**Table # 8: ADRC Satisfaction and Experience Surveys Completed**

Satisfaction and Experience Surveys Completed	MFP Participants	Transition Coordinators	HCBS Agencies	ADRCs	TOTAL
<b>2013</b>	60	10	150	13	233
<b>2014</b>	150	20	150	26	346
<b>2015</b>	250	30	150	26	456
<b>2016</b>	200	20	150	26	396
<b>TOTAL</b>	660	80	600	91	1431

The information collected through the surveys will also be used in future years to establish additional discrete benchmarks of progress in accessibility and utilization of housing resources by people with disabilities and as a part of a formative evaluation to increase visibility, accessibility and utilization of ADRCs by individuals with disabilities.

In addition to the five benchmarks described above, Alabama will also be administering the Quality of Life survey three times to each individual participating in the Project at the following intervals: once prior to transition, one year after transition, and two-years after transition.

## **b) DEMONSTRATION IMPLEMENTATION POLICIES AND PROCEDURES**

### **(1) Participant Recruitment and Enrollment**

A flow chart outlining the overall processes for participant recruitment and enrollment for each target population may be found in Appendix 2. A narrative description is found below.

**(a) Target Populations:** *Describe the target population(s) that will be transitioned, and the recruitment strategies and processes that will be implemented under the demonstration. Specifically, please include a narrative description that addresses the issues below.*

Alabama will target two populations for transition as part of its MFP Rebalancing Demonstration. **Target Population 1** will be individuals residing in Nursing Facilities, regardless of age or type of disability. This is a diverse population in terms of the type of disability and the concomitant support needs. In addition to individuals who are elderly and/or have physical disabilities, current OBRA data indicates that there are 920 individuals living in nursing facilities

who have a diagnosis of ID and/or DD, 2,023 individuals who have a diagnosis of mental illness and 271 who have dual diagnoses of mental illness and ID/DD.

**Target Population 2** will be individuals residing in State Operated Psychiatric Hospitals who are currently receiving Medicaid or are Medicaid eligible. Due to the IMD exclusion, this group of individuals is limited to those who are aged 21 or younger or those 65 and older. The majority of these individuals (113) reside at the Harper Geriatric Psychiatry Center.

**(b) Recruitment Strategies:**

All individuals who meet MFP eligibility will be targeted for recruitment and enrollment in the MFP Rebalancing Demonstration. Participant recruitment and enrollment strategies will include a variety of activities and media. Alabama will develop an overall Outreach and Marketing Plan as described in Section 3 below to describe and operationalize its recruitment strategies for participation in the MFP Rebalancing Demonstration. Awareness and an understanding of the program among the many stakeholders will be essential to successful recruitment. As an overview, these strategies will include:

- At the outset of the implementation of the MFP Rebalancing Demonstration, a notification letter to all qualified institutions to announce the project, its goals and objectives, and the methods of communicating with facility residents;
- A multi-pronged marketing program targeting potential participants, family members and the general public;
- A training and outreach program targeting Transition Coordinators;
- A training and outreach program targeting ADRC staff and Options Counselors; and,

- A training and outreach program targeting Nursing Facility Administrators, Social Workers, MDS Coordinators and Discharge Planners.

**(c) Selection of Service Provider:** *How will the service provider be selected and does the State intend to engage the State's Centers for Independent Living in some role in the transition process?*

Alabama will largely integrate the MFP Rebalancing Demonstration with its existing infrastructure of waiver and State Plan services, thus making available a number of options with different service packages designed to meet the diverse needs of the target populations. The State also plans to add a second transition waiver, ACT II, which will have a service package designed to address the needs of individuals with mental illness and ID/DD who transition from nursing facilities.

The selection of a service provider will be predicated on several factors:

- An assessment of each individual's needs;
- An Options Counseling process that examines the various service packages available that best meets those needs; and
- A person-centered transition planning process.

For individuals living in Nursing Facilities, each of these will be implemented through the Local Contact Agency (LCA) designated by AMA to implement the MDS-Q requirements and/or by the ADRC.

In order to implement the MDS-Q requirements and to more fully support transition from nursing facilities, AMA has designated the Operating Agency of the ACT waiver (ADRS) to

serve the LCA functions at present. Referrals from nursing facilities resulting from the MDS-Q process are made to this LCA. However, as the MFP Rebalancing Demonstration is implemented, it will be critical that other avenues for referral exist. Self-referrals and/or referrals by family members, guardians and/or advocacy groups must also have a mechanism to be addressed, particularly as the program's outreach and awareness efforts gear up and prove effective. These referrals will be addressed through the ADRC network and follow the same procedures as the LCA for MDS-Q. The AMA will ensure these processes appear seamless to referred individuals and their families. Strategies designed to achieve this will include the following:

- AMA will establish and publicize a toll-free number for interested members of the public to call for further information about the program and learn how to make or obtain a referral.
- The AMA website will host a webpage with information about the MFP Rebalancing Demonstration that will also allow for a direct on-line referral.
- Outreach materials will describe the referral process and offer a "no-wrong-door" approach. The materials will publicize the toll-free number and the webpage, but will also allow and encourage interested parties to make inquiries and/or referrals through familiar and trusted organization, such as the Independent Living Centers, Protection and Advocacy, provider organizations, the Ombudsman and others in the aging and disability resource community.
- In order to ensure these organizations are well-prepared to assist those interested in obtaining information about the MFP Rebalancing Demonstration or making a referral for

participation, extensive outreach and training will be undertaken with the aging and disability resource organizations on the program's goals, procedures, eligibility requirements and available services and on the referral process.

While these current LCA/ADRC processes, described in more detail below, are functional at this time for the purposes of the MFP Rebalancing Demonstration, the State recognizes that much remains to be accomplished in developing a "no-wrong door" single point of entry that is both highly visible and trusted across all populations who require access to the long term care support systems. Therefore, Alabama will also propose to undertake a planning initiative that will integrate and streamline access to the MFP Rebalancing Demonstration and the entire HCB long term care support systems across all disability and aging populations. A strategy for achieving this integration and for strengthening the capacity of the ADRC to provide the MFP services described in this proposal is described below.

The ADRC system that is currently in place, which is centered in the aging network and does not yet have the requisite significant connection with the disability community, will be expanded in both scope and presence, ensuring that the disability network is an integral part of the system. The assessment and Options Counseling processes will be carefully monitored and formatively evaluated for improvements, and eligibility screening and determination will be folded in to the existing information and referral capacities of the ADRC. These enhancements will also allow the ADRC to take on the LCA responsibilities at some point in the future. It is anticipated the State's Independent Living Centers, as well as other key organizations and

advocacy groups as represented in the LTC Rebalancing Advisory Committee, will play an important part in the planning and implementation for this initiative.

ADSS continues to work toward readiness for these responsibilities. The agency recently submitted an application to the Administration on Aging for funding for the *Enhanced ADRC Options Counseling Program* with a goal to coordinate and streamline programs of all aging and disability agencies in a consumer friendly, no wrong door approach, ensuring that consumers and caregivers have access to information, options counseling, and person-centered services in an integrated system supporting informed choice and independence. The project objectives are:

- 1) Strengthening and expanding Options Counseling at statewide ADRCs serving all ages, income levels, and disabilities through a coordinated effort of streamlined practices;
- 2) Agreement with AMA on guidelines and procedures to sustain ADRC activities; and
- 3) Stakeholder partnerships incorporating evidence-based programs and person-centered practices into the daily operations of all applicable programs.

Anticipated outcomes include:

- 1) Consumers and caregivers of all ages and disabilities, including veterans, will have access to consumer friendly services such as: options counseling, short-term case management, and long-term care support services;
- 2) Sustainability of ADRCs;

- 3) ADRCs will enter into partnership agreements with other state and local social service providers to streamline access to services;
- 4) Comprehensive training will be provided to all staff and stakeholder partners.

While Alabama is committed to these activities and fully confident of successful achievement of the related outcomes, it will continue to ensure the LCA process already in place will be sustained and, as needed, enhanced until the ADRC network is prepared for full implementation. In addition, as a part of its benchmark strategy described above, AMA will establish and track key indicators of progress toward ADRC readiness.

For individuals residing in State-Operated Psychiatric Facilities, the selection of a service provider will occur as part of the person-centered transition assessment and plan, during which:

- The Social Worker discusses the options with the patient whenever possible at admission.
- At the 10-day Treatment Planning Conference (TPC), with next of kin/guardian when available, the discharge options are laid out and the treatment recommendations made, and when feasible a joint decision is made.

The Treatment Team consists of, but is not limited to, patient, family member/ significant other, guardian, psychiatrist, social worker, registered nurse, therapeutic recreation representative. TPC's are held at intervals throughout the stay for continued evaluation of potential options. The Treatment Team also utilizes the assistance of the Facility Advocate

employed by the Alabama Department of Mental Health to discuss and assist the individual with community living options.

For individuals who are referred to the MFP Rebalancing Demonstration as a result of the TPC process, ADMH will ensure that all individuals are provided with overall Options Counseling that is consistent with MFP protocol.

**(c) Identification of Eligible Participants:** *The participant selection mechanism including the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence. Please include a discussion of:*

- *the information/data that will be utilized (i.e., use of MDS Section “Q” or other institutional data);*
- *how access to facilities and residents will be accomplished*

The MDS 3.0 Section Q requirement, which was effective 10/1/10, will provide one important mechanism for identification of eligible individuals. This federal regulation requires the State to have a plan for transitioning individuals from the NF to the community, as they identify such a preference through the MDS assessment process. The AMA has been designated as the lead Agency to set up processes and establish the LCAs to assist individuals to make the requested transitions. This process, which was implemented in 2012, will be a critical component in the development of the MFP demonstration design, but will be modified as needed to meet the goals of the MFP Rebalancing Demonstration.

The State's current MDS-Q process depends on nursing facilities to identify individuals who wish to transition to the community, primarily through the administration of the MDS. The MFP Rebalancing Demonstration will provide additional avenues for individuals, designees, guardians and/or family members to make referrals, as described in the section on Recruitment Strategies. All referrals received by the LCA or ADRC will be reported within two business days to the MFP Project Director who will ensure they are tracked for timely response. The AMA will also establish and publicize a toll-free number for interested members of the public to call for further information about the program and how they can refer people to it. The AMA website will host a webpage with information about the MFP Rebalancing Demonstration that will also allow for a direct on-line referral. The AMA Project Director will ensure all referrals received in this manner are routed to the appropriate LCA/ADRC for timely response.

The current process also calls for a nursing facility to complete the *Nursing Home Discharge Planning Checklist MDS 3.0 Section Q* (Attachment E) before contacting the LCA when a referral is generated as a result of the MDS administration. For the purposes of the MFP Rebalancing Demonstration, the nursing facility will be asked to provide the same information on all referrals regardless of their source. This instrument serves as a means of obtaining a preliminary baseline of information. Once the checklist is received, the LCA/ADRC will initiate a face to face visit with the individual/representative within 15 working days of receipt of the referral. During this visit, the LCA will complete the *MFP Rebalancing Demonstration Return to the Community Assessment Tool* (Attachment F) to determine appropriateness of assisting with the transition into the community and the support needs of the individual.

Based on the results, Options Counseling will be provided. An *Options Counseling Visit Summary* will be completed and provided to the individual/representative and the nursing facility staff. Within 3 days of receipt of the information, the LCA/ADRC will forward the information to the MFP Project Director with the AMA. The MFP Project Director will then refer to the appropriate agency for assignment of a transition coordinator and further assessment per each program's requirements.

If an individual does not yet appear to be an appropriate candidate for nursing facility transition within 180 days, the LCA/ADRC will assist the individual, if so desired, to develop a plan to garner the support necessary for a successful transition. Referrals can be made to the Independent Living Centers, the Area Agencies on Aging, Department of Human Resources, the Governor's Office on Disability, the Social Security Administration and the local county health department to name a few.

For individuals residing in State-Operated Psychiatric Facilities, ADMH will identify individuals through the TPC process who may benefit from community living. ADMH will complete the *Return to the Community Assessment Tool* to identify the support needs of the individual.

**(d) Options Counseling:** *The information that will be provided to individuals to explain the transition process and their options, as well as the state process for dissemination of such information.*

The State will provide Options Counseling for each person referred for transition. Options Counseling is defined by the Administration on Aging as an "interactive **decision-**

**support** process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer’s needs, preferences, values, and individual circumstances.” Options counseling will involve in-person meetings with the person referred, and may also include conversations with family members, guardians and/or other members of the person’s support network.

For individuals living in nursing facilities, Options Counseling will be provided by the designated LCA or the ADRC. For individuals residing in State-Operated Psychiatric Facilities, ADMH will complete Options Counseling as a part of the person-centered TPC.

Through the MFP Rebalancing Demonstration, the State intends to continue to pursue the expansion of capacity for ADRC Options Counseling Programs statewide. ADSS has recently submitted an application for funding for the *Enhanced ADRC Options Counseling Program* that will incorporate evidence-based programs and person-centered business practices into the daily operations of Title III and Medicaid programs. The goal is to coordinate and streamline state programs ensuring that older adults, individuals with disabilities, and family caregivers have access to options counseling, person-centered, consumer friendly information and services, both public and private, in an integrated system that offers a comprehensive set of high quality, evidence-based programs to help them remain independent and healthy in the community. The objectives in the application include strengthening and expanding the capacity of Options Counseling at ADRCs to serve people of all ages, income levels, and disabilities through a coordinated effort of streamlined practices building an infrastructure effectively serving a broad range of populations. In the process, ADSS and AMA will enter into an

agreement designating ADSS as the lead agency overseeing the ADRC Options Counseling program. Comprehensive training will be provided to all ADRC Staff and stakeholder partners.

**(e) Qualified Institutional Settings:** *The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting. If targeting certain facilities, the names of the identified facilities and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.*

All participants will transition from qualified institutional settings including skilled nursing facilities and institutions for mental diseases (IMD). For the IMDs, or State Operated Psychiatric Facilities, MFP participation will only be available to the extent medical assistance is available under the State Medicaid plan for services provided by this institution, i.e. individuals who are under 21 years old or over 65 years old and are receiving Medicaid State Plan services and meet other MFP eligibility requirements.

For individuals residing in Nursing Facilities, there will be no targeting of certain facilities or geographical considerations; the program will be statewide. For individuals residing in State Operated Psychiatric Hospitals, the primary targeted facility will be the Mary Starke Harper Geriatric Psychiatry Center in Tuscaloosa which is responsible for the provision of inpatient psychiatric services to the elderly citizens throughout the state. In addition, a few individuals residing in the other State Operated Psychiatric Hospitals may qualify for MFP Rebalancing Demonstration participation.

**(f) Minimum Residency Period:** *The minimum residency period to conform to the changes made to Section 6071 by the ACA reducing the minimum number of consecutive days to 90 in an*

*institutional setting with the statutory exception noted in the ACA; and who is responsible for assuring that the requirement has been met.*

All participants will meet the minimum residency requirement of 90 days excluding any short-term rehabilitation services funded through Medicare. The transition coordinator will be responsible for ensuring that the required residency period has been met. This will be achieved through review of data in the Medicaid MMIS, contact with qualified institutional setting staff, and physical review of individual medical records.

**(g) Verification of Medicaid Eligibility:** *The process (who and when) for assuring that the MFP participant has been eligible for Medicaid at least one day prior to transition from the institution to the community.*

Verification of Medicaid eligibility is currently completed by the Operating Agency for each waiver through access to the MMIS. For individuals living in Nursing Facilities, the LCA/ADRC will determine the individual's current Medicaid status at the nursing facility through individual/staff interviews and review of records that document Medicaid reimbursement for the individual at the facility. Once Options Counseling has been completed and a service provider selected, the Operating Agency of the selected waiver will verify Medicaid eligibility following current procedures.

For individuals residing in State Operated Psychiatric Hospitals, ADMH staff will verify Medicaid eligibility, as well as assist with Medicaid application when possible, as a part of transition planning. This planning process includes a person-centered examination of home

and community based service options. Once a service option is selected, Medicaid eligibility will be verified by the Operating Agency.

**(h) Assessment that Transition can be Accomplished through Provision of HCBS:** *The process for determining that the provision of HCBS to a participant enables that participant to be transitioned from a qualified institution. Formal Level of Care determinations are not required prior to transitioning into the MFP program for the 365-day period. States may elect to develop an assessment of eligibility that takes into consideration the readiness for an individual to transition into the community with identified transition services and appropriate long-term care services.*

For individuals residing in Nursing Facilities, the State will modify the *Local Contact Agency (LCA) Return to the Community Assessment Tool* developed as a part of its procedures to implement the MDS-Q requirements and the ACT waiver. This *MFP Rebalancing Demonstration Return to the Community Assessment Tool* will be further tested and evaluated as a part of the MFP Rebalancing Demonstration to ensure that it meets the needs of individuals with a variety of needs. In particular, Alabama will evaluate its efficacy for individuals with intellectual/developmental disabilities and mental illness, and may add a supplemental module for either or both of these populations if needed.

For individuals residing in State-Operated Psychiatric Facilities, ADMH will complete a person-centered transition assessment and plan. ADMH will also complete the *Return to the Community Assessment Tool* as a means of identifying an individual's support needs.

Once a service provider has been selected, the Operating Agency will then complete all applicable assessment processes needed to develop the plan of care.

**(i) Re-enrollment Provisions:** *The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that led to re-institutionalization in order to assure a sustainable transition.*

An MFP participant who is re-institutionalized for a period greater than 30 consecutive days will be disenrolled from the program. However, a disenrolled individual may re-enroll in the program without re-establishing the 90-day institutional residency requirements. As long as a former participant meets Medicaid waiver eligibility criteria, the participant will still be eligible for MFP services at the enhanced FMAP. However, if the former participant remains in the qualified institution beyond 90 days, the participant will be defined as a "new" participant in terms of the MFP services and the FMAP.

In order to be considered for re-enrollment, an updated assessment must be completed to determine if adequate community resources are available to meet the needs of the individual. Once the individual is assessed to be appropriate for home and community based services, a referral will be made to the appropriate case manager for development of the individualized Plan of Care that addresses any change in the status of the participant and/or any lack of necessary supports in the community. After three incidences of re-institutionalization of

30 consecutive days or longer, the re-institutionalized participant will not be considered for re-entry into the Money Follows the Person Rebalancing Demonstration.

**(j) Informed Choice Provisions:** *The State's procedures and processes to ensure those participants, and their families will have the requisite information to make informed choices about supports and services. The description shall address:*

- *How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation, including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.*
- *Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished.*

Individuals who have been identified as potential candidates for transition will be informed during Options Counseling concerning the State's protections from abuse, neglect, and exploitation, including how participants or others can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation. The information will be delivered orally and in a clearly written document by the Options Counselor who will obtain written verification the information was received and understood. This process will be repeated at the time of enrollment in the selected program and at required intervals (at least annually) according to waiver/PACE program established protocol.

## **(2) Informed Consent and Guardianship**

**(a) Informed Consent Procedures:** *Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.*

The Options Counseling process completed by the LCA/ADRC is designed to ensure the individual is aware of all aspects of the transition process, has full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Following the Options Counseling, all individuals who wish to participate in the MFP Rebalancing Demonstration (or, if appropriate, those individuals' legal guardians) will be required to sign an MFP Informed Consent form (Attachment G) indicating that they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights and responsibilities as participants. Additionally, participants and/or their family members and/or guardians will be informed about the State's protections from abuse, neglect, and exploitation

and the process for reporting critical incidents. Additional program materials to promote informed consent are under development.

Informed consent for participation in the MFP Rebalancing Demonstration may be provided by the adult participant, emancipated minors, the parents of minors, or the legal representative or surrogate decision makers who have responsibility for individual's living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent named in a health care power of attorney. In cases where there is a legal representative or surrogate decision maker, the transition coordinator will review appropriate legal documentation to ensure that the individual possesses the legal authority to make decisions dealing specifically with a participant's living arrangement and receipt of services/treatment.

Transition Coordinators will work with guardians of MFP participants to explain the program, safeguards and operating procedures. They will also work with the guardian and individual during the transition process so they fully understand their rights.

***b. Expectations of Guardianship Involvement:*** *Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf of these participants. The policy should specify the level of interaction that is required by the State.*

Guardianship practices are governed by the Code of Alabama §26-2A-78 and §26-2A-104. The laws of Alabama allow any qualified person to be appointed as the guardian over an

adult who has been declared incapacitated. The Code of Alabama, §26-2A-104 does establish priorities for who shall be appointed that infers a guardian should have a close relationship to the individual. The priorities are:

1. Any person nominated in the incapacitated person's most recent durable power of attorney;
2. The spouse of the incapacitated person or a person nominated by the spouse;
3. A parent of the incapacitated person or a person nominated by the parent;
4. A relative of the incapacitated person provided they have lived with the incapacitated person for more than six months;
5. Any person nominated by an individual who is caring for or paying for the care of the incapacitated person.

Further, Alabama law requires the Guardian must become or remain personally acquainted with the ward and maintain contact with the ward, and must report to the Court the condition of the ward as often as the Court may order.

For purposes of enrollment in the MFP Rebalancing Demonstration, it is the expectation that guardians will have a known relationship with the individual, interact with the individual on an ongoing basis and have recent knowledge of the individual's welfare if the guardian is making decisions on behalf of the participant. The LCA/ADRC will document guardianship status and obtain information about the level of interaction between the guardian and individual over the past twelve months. The LCA/ADRC will make contact with the guardian to ensure there is adequate information to provide informed consent as described in the preceding paragraphs,

including whether the guardian appears to have knowledge of the individual's current needs sufficient to participate in the evaluation of appropriateness of the proposed services. Where necessary, the LCA/ADRC will facilitate an expanded discussion of needs and benefits to assist the guardian. At all times, the LCA/ADRC will promote the maximum participation of the individual in the decision-making process. An MFP Rebalancing Demonstration policy is under development to indicate the level of interaction required by the State to accept guardian election of MFP participation.

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

*Submit the State's outreach, marketing, education, and staff training strategy.*

*a. The information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);*

During the first year of planning and operation, the MFP Rebalancing Demonstration will develop a comprehensive statewide outreach/marketing and education strategy and develop appropriate and accessible brochures and transition guides for distribution to residents of eligible institutions, family members, social workers, providers, municipal agents, senior centers, AARP, nursing facility administrators, advocacy organization, etc. Examples of information to be communicated will include the following:

- Real life stories about people who moved from institutions to the community;
- Eligibility requirements;
- Processes for selection and enrollment;

- Target populations;
- Institutions identified for outreach;
- Qualified Residences;
- Services and supports available under MFP, including Transition Coordination, Transitional Assistance, Housing Accessibility Services and Housing Coordination Services;
- Consumer supports;
- Participant responsibilities during the demonstration including participation with data Collection;
- Participant rights, including how to report abuse and neglect;
- Contact information for additional information; and,
- What happens if a participant has to go back into the institution?

The MFP Rebalancing Demonstration will also ensure development of coordinated outreach materials explaining self-directed services, as further described below in the section entitled Self-Direction.

All materials will be reviewed by the Long Term Care Rebalancing Advisory Committee, approved by the Medicaid Commissioner and submitted to CMS prior to use.

**b. Media:** *Types of media to be used;*

Alabama will undertake a multi-media approach to raise general awareness about the MFP Rebalancing Demonstration and to assist with the appropriate referral of persons in institutions to the program.

**c. Target Areas:** *Specific geographical areas to be targeted;*

The outreach and social marketing campaign will be implemented on a statewide basis.

**d. Dissemination Locations:** *Locations where such information will be disseminated;*

Information will be disseminated in many locations and venues according to the strategic outreach and marketing plan to be developed, and may include:

- Newspapers: A press release will offer the press general information about transition options and the MFP Rebalancing Demonstration, including contact information at the state and local levels to obtain more information;
- Information on the AMA website, including fact sheets;
- Alabama Connects, the State's ADRC web portal;
- Fact sheets will be developed to provide general information about the Demonstration;
- Print materials providing general information about MFP will be available at numerous locations statewide, including:
  - Qualifying institutions;
  - Churches;
  - Independent Living Centers and Area Agencies on Aging; community-based organizations providing information and referral;
  - Advocacy organizations, including the Alabama Disabilities Advocacy Program;
  - Alabama Bar Association; and,
  - Professional organizations for social workers, personal care assistants, physicians, nurses, and providers.

**e. Training and Education Plans:** *Staff training plans, plans for State forums or seminars to educate the public;*

A complete training and education plan will be developed. The training and education plan will be an integral part of the overall outreach and marketing plan. Key components of the plan will include:

- Two MFP Program Specialists, tasked with organizing and delivering much training and education throughout the State, as specified in the Outreach and Marketing Plan. Alabama has provided training to nursing facility staff, MDS Coordinators and other stakeholder on transition procedures as a part of the implementation of the MDS-Q and the ACT waiver, but recognizes a need to provide this training on an ongoing basis.
- Training developed and implemented for all Transition Coordinators, the Ombudsman staff, and ADRC staff throughout the State.

The MFP Specialists will research and identify all other potential venues or providing training to various stakeholders, including conferences such as the annual Health and Human Services Conference sponsored by the ADSS.

**f. Materials for Individuals with Special Needs:** *The availability of bilingual materials/interpretation services and services for individuals with special needs;*

All outreach materials will be made accessible to individuals through a variety of methods. This will include bilingual materials and interpretation services.

**g. Cost Sharing Responsibilities:** *A description of how eligible individuals will be informed of cost sharing responsibilities.*

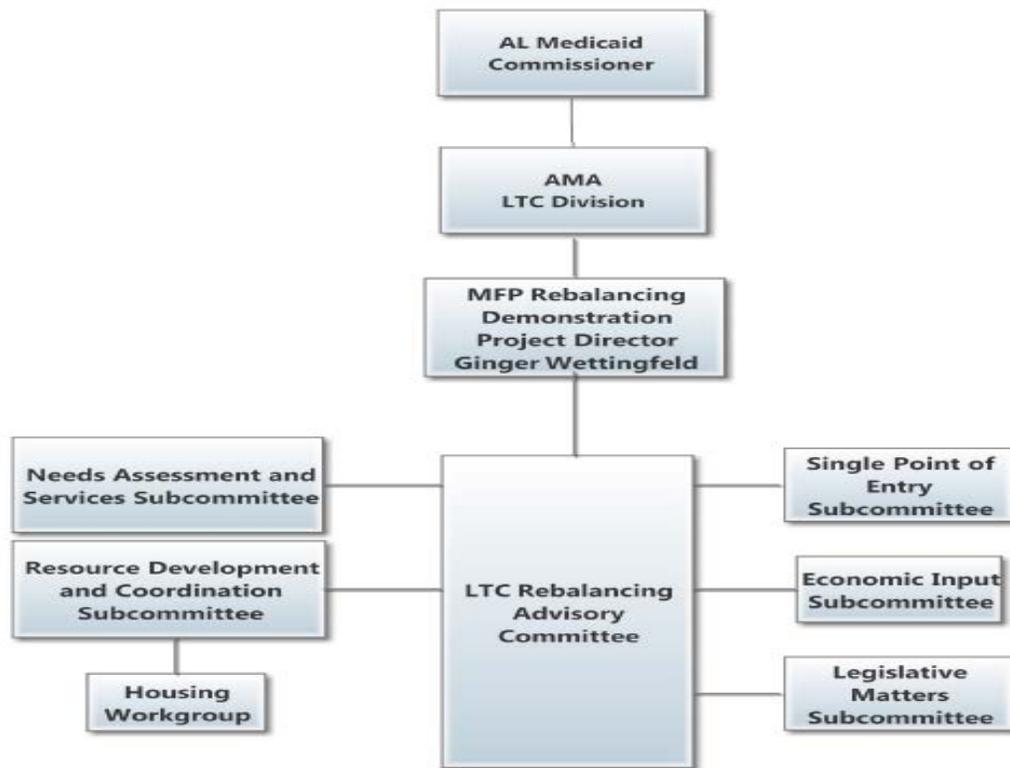
Eligible individuals will be informed of cost-sharing responsibilities through Options Counseling and through written program materials. Once the service provider is selected, individuals will be again informed as to cost-sharing responsibilities as a part of the waiver enrollment process.

**(4) Stakeholder Involvement**

*Describe how the State will involve stakeholders including consumer representatives in the Implementation Phase of this demonstration, and how these stakeholders will be meaningfully involved throughout the life of the demonstration grant.*

**a. Stakeholder Organizational Chart:** *A chart that reflects how the stakeholders relate to the organizational structure of the grant and how they influence the project.*

The Stakeholder Organizational Chart may be found on the next page.



**b. - e. Descriptions of Stakeholder Roles, Responsibilities and Activities**

*A brief description of how consumers will be involved in the demonstration. A brief description of community and institutional providers’ involvement in the demonstration; a description of the consumers’ and community and institutional providers’ roles and responsibilities throughout the demonstration; and, the operational activities in which the consumers, community, and institutional providers are involved.*

The LTC Rebalancing Advisory Committee serves as the primary vehicle to ensure stakeholder involvement in the MFP Rebalancing Demonstration. The Committee is comprised of a wide array of individuals with varying interest in ensuring that individuals who are elderly

and disabled receive appropriate and quality care, as well as choices about long term-care. Stakeholders representing consumers, community, and institutional providers are all members of the LTC Rebalancing Advisory Committee. This Committee includes disability advocates, state agency representatives, advocates for the elderly, members of the legislature, and members of various provider associations. As described under the Systems Readiness and Gap Analysis in Section a)(1)(a), this Committee has legislatively prescribed responsibilities for advising the AMA on long term care and rebalancing initiatives.

The LTC Rebalancing Advisory Committee has also functioned as the MFP Planning Work Group, charged with:

- Identifying the target populations to be transitioned through the MFP program;
- Developing strategies to identify individuals who would be eligible for transition to the community;
- Evaluating Alabama's current Home and Community Based Services to identify areas for expansion; and,
- Engaging providers to participate in the transition process; and formulating plans of action for providing for transitioned individuals as grant eligibility expires.

As the state continues to consider options for improving long-term care delivery, the LTC Rebalancing Advisory Committee will remain as an advisory body for the AMA as prescribed in SJR 84. This Committee will receive ongoing reports as to the implementation of the Demonstration and its outcomes, barriers encountered and other information for review,

discussion and feedback. It will continue to work with the Medicaid Commissioner to gather stakeholder input on rebalancing projects and advise Medicaid on the design and implementation of any rebalancing projects.

## **(5) Benefits and Services**

**a. Description of Service Delivery System:** *Provide a description of the service delivery system(s) used for each population that the State will serve through the Money Follows the Person Rebalancing Demonstration. Include both the delivery mechanism and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration. For all HCBS demonstration services and supplemental demonstration services State must detail the plan for providers or the network used to deliver these services.*

Each member of the target populations will have the opportunity to receive waiver and/or State Plan services that best fit their individual needs based on an individualized assessment and Options Counseling. Participants will be enrolled in the program or services for which they meet eligibility criteria, including level of care, such that termination of the demonstration will not impact continuation of services.

Each of the waiver programs is administered by the AMA and delivered through an operating state agency as described under Systems Readiness and Gap Analysis. The E&D waiver operates within a cost settlement model, while the remaining waivers are fee for service. The operating agencies contract with a provider network across the state, including Area Agencies on Aging, local and county level mental health and developmental disability

planning councils known as 310 Boards, county health departments and regional offices of ADRS. These entities, in turn, contract with local service providers including private for profit and nonprofit agencies.

The PACE program is administered by AMA and operated locally by private providers contracted by AMA. It is a capitated managed care program. Currently there is one PACE program in operation in Mobile, AL, with potential for two more to open in other areas of the State.

**b. Service Packages:** *List the service package that will be available to each population served by the Demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). Do not include acute care service or institutional services that will be paid for through the regular Medicaid program.*

The following table provides a list of the service packages available under each of the waivers in which an MFP participant may enroll, depending on his or her needs. In addition, participants will have access to State Plan services for which they meet eligibility criteria. As the table demonstrates, the State has in place many service packages that will enable it to meet the needs of the diverse populations transitioning through the MFP Rebalancing Demonstration.

The table provides an overview of the various services available to MFP participants, depending on the service type they choose to enroll in based on their individual needs and as identified through Options Counseling. Appendix 3 provides a more detailed breakdown of the

individual benefits packages that will be available to MFP enrollees in each of the waivers, including unit of service definitions, rates and specific eligibility criteria. Appendix 3 also provides a summary of eligibility criteria for populations who may access each of the waivers.

**Table # 9: Overview of Benefits Packages**

Service	E&D	SAIL	ID	LAH	HIV	TA	ACT
Case Management	√	√*	√**	√**	√*	√**	√*
Homemaker Services	√				√		
Personal Care	√	√	√	√	√		√
Personal Assistance Service		√					
Adult Day Health	√						√
Respite Care (Skilled and Unskilled)	√				√		√
Adult Companion Services	√		√		√		√
Home Delivered Meals	√						√
Residential Habilitation			√				
Residential Habilitation – Other Living Arrangement			√				
Residential Habilitation – In Home				√			
Day Habilitation			√	√			
Day Habilitation with Transportation			√	√			
Prevocational Services			√	√			
Supported Employment			√	√			
Individual Job Coach			√	√			
Individual Job Developer			√	√			
Occupational Therapy			√	√			
Speech and Language Therapy			√	√			
Physical Therapy			√	√			
Behavior Therapy			√	√			
In-Home Respite Care			√	√			
Out-of-Home Respite Care			√	√			
Institutional Respite Care			√	√			

Service	E&D	SAIL	ID	LAH	HIV	TA	ACT
Personal Care on Worksite			√	√			
Personal Care Transportation			√	√			
Environmental Accessibility Adaptations			√	√			
Specialized Medical Equipment			√	√			
Medical Supplies			√	√		√	
Skilled Nursing			√	√			√
Private Duty Nursing						√	
Crisis Intervention			√	√			
Community Specialist			√	√			
Peer Support Specialist							
Crisis Intervention			√	√			
Personal Emergency Response System		√					√
Minor Assistive Technology		√					
Assistive Technology		√				√	√
Evaluation for Assistive Technology		√					
Assistive Technology Repairs		√					
Personal Care/Attendant Services						√	
Transitional Assistance							√
Home Modifications							√
Medical Equipment Supplies and Appliances							√
Housing Accessibility Services	√	√	√	√	√	√	√
Housing Coordination Services	√	√	√	√	√	√	√

\* Service Includes Transitional Assistance

\*\* Targeted Case Management (a covered service under the Medicaid State Plan) which includes Transitional Services

Participants may alternatively be enrolled in the PACE program if it is better suited to their needs and is available in the geographical area in which the individual will live. The service package for the PACE program includes Primary Care (including doctor and nursing services); Hospital Care; Medical Specialty Services; Prescription Drugs; Dentistry; Nursing Home Care; Personal Care; Physical Therapy; Adult Day Care; Nutritional Counseling; Laboratory/X-ray Services; Social Services, and Transportation.

**Qualified, Demonstration and Supplemental Services:** *In a chart, divide the service list(s) into Qualified Home and Community-Based Program Services, HCBS demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. If any qualified Home and Community-based Services are not currently available to Medicaid recipients in the State (and are, therefore, not included in the State’s maintenance of effort calculations), provide a detailed account of when and how they will be added to the Medicaid program. For HCBS demonstration services and supplemental demonstration services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.*

**Table # 10: Qualified, Demonstration and Supplemental Services**

Program	Qualified	Demonstration	Supplemental
E&D	Case Management Homemaker Services Personal Care Adult Day Health Respite Care (Skilled and Unskilled) Adult Companion Services Home Delivered Meals	Transitional Assistance  Housing Accessibility Services  Housing	

Program	Qualified	Demonstration	Supplemental
		Coordination Services	
SAIL	Case Management * Personal Care Personal Assistance Service Personal Emergency Response System Minor Assistive Technology Assistive Technology Evaluation for Assistive Technology Assistive Technology Repairs	Transitional Assistance  Housing Accessibility Services  Housing Coordination Services	
ID	Targeted Case Management** Residential Habilitation Residential Habilitation – Other Living Arrangement Day Habilitation Day Habilitation with Transportation Prevocational Services Supported Employment Individual Job Coach Individual Job Developer Occupational Therapy Speech and Language Therapy Physical Therapy Behavior Therapy In-Home Respite Care Out-of-Home Respite Care Institutional Respite Care Personal Care on Worksite Personal Care Transportation Environmental Accessibility Adaptations Specialized Medical Equipment Medical Supplies Skilled Nursing Crisis Intervention Community Specialist Adult Companion Services	Transitional Assistance  Housing Accessibility Services  Housing Coordination Services	
LAH	Targeted Case Management** Residential Habilitation – In Home	Transitional Assistance	

Program	Qualified	Demonstration	Supplemental
	Day Habilitation Day Habilitation with Transportation Prevocational Services Supported Employment Individual Job Coach Individual Job Developer Occupational Therapy Speech and Language Therapy Physical Therapy Behavior Therapy In-Home Respite Care Out-of-Home Respite Care Personal Care on Worksite Personal Care Transportation Environmental Accessibility Adaptations Specialized Medical Equipment Medical Supplies Skilled Nursing Crisis Intervention Community Specialist Adult Companion Services	Accessible Housing Assistance Services	
TA	Targeted Case Management** Private Duty Nursing Personal Care/Attendant Services Medical Supplies Assistive Technology	Transitional Assistance	
HIV	Case Management * Homemaker Services Personal Care Respite Care Skilled Nursing Companion Services	Transitional Assistance  Accessible Housing Assistance Services	
ACT	Case Management Transitional Assistance Personal Care Homemaker Services Adult Day Health Home Delivered Meals Respite Care (Skilled and Unskilled)	Housing Accessibility Services  Housing Coordination Services	

Program	Qualified	Demonstration	Supplemental
	Skilled Nursing Adult Companion Services Home Modifications Assistive Technology Personal Emergency Response Systems (PERS) Installation/Monthly Fee Medical Equipment Supplies and Appliances		
PACE	HCBS Portion of Services	Transitional Assistance  Housing Accessibility Services  Housing Coordination Services	

\* Service Includes Transitional Services

\*\* Targeted Case Management (a covered service under the Medicaid State Plan) which includes Transitional Services

### **Transition Coordination**

All MFP participants will be offered Transition Coordination, which is defined as service coordination provided to individuals in an eligible institution to assist them to develop and implement a person-centered plan for transitioning to the community with appropriate services and supports for up to 180 days prior to the move. For individuals who select and are eligible for a waiver program, Transition Coordination is currently available as a Qualified Service as a function of case management services provided to all waiver participants. For individuals who enroll in PACE programs, Transitional Assistance is provided by the designated PACE case

manager. A Transition Coordinator is assigned upon selection of the service provider by the participant as depicted in the flow charts in Appendix 2.

All providers have received notification of this addition to the definition of case management. As a part of this Operational Protocol, each Operating Agency will ensure the designation of an adequate number of case managers who will act as Transition Coordinators. These designated individuals will receive comprehensive training and ongoing support as a part of the overall MFP Rebalancing Demonstration Outreach / Marketing / Education plan.

### **Demonstration Services**

Demonstration services to be offered will include: 1) Transitional Assistance for those programs in which transitional services are not already included as qualified HCBS services, 2) Housing Coordination Services and 3) Housing Accessibility Services.

**Transitional Assistance** services and expenses consist of the following items, when appropriate and necessary for the participant's discharge from a nursing facility and safe transition to the community:

1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

4. Household services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; and,
5. Moving expenses.

To qualify for payment as Transitional Assistance, expenses must be authorized and included in the participant's service plan; incurred within 60 days before a participant's discharge from a nursing facility or hospital or another provider-operated living arrangement; and necessary for the participant's safe transition to the community. Transitional Assistance Services cannot exceed \$1,500 without prior approval from AMA. Transitional assistance does not include expenses for monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes; or that are not necessary for the participant's safe transition to the community.

**Housing Coordination Services** will include assistance to a participant with locating accessible and affordable housing that will meet an individual's needs. This will be provided through services of a Housing Coordinator who will assist in facilitating applications for housing assistance for MFP Rebalancing Demonstration participants, providing information on available and accessible housing to MFP participants and working collaboratively with Transition Coordinators and individuals to develop plans for accessible housing supports, including assistance in developing accessibility of a selected residence through assessment and development of a person-centered accessibility plan.

To qualify for payment as Housing Coordination Services, expenses must:

- Be authorized and included in the participant's service plan;

- Incurred within 60 days before and 120 days after a participant's discharge from a nursing facility or hospital or another provider-operated living arrangement; and,
- Necessary for the participant's safe transition to the community.

The approved unit rate for Housing Coordination Services is \$13.95 per 15 minute unit. Housing Coordination Services do not include expenses for monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes; or that are not necessary for the participant's safe transition to the community.

**Accessible Housing Assistance Services** will include the following:

1. Where not available in the program service package as a Qualified Service, Assistive Technology Evaluation. This is an evaluation of the needs of an individual, including a functional evaluation of how the technology will enhance the functioning and independence of the individual, including:
  - Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing a device or piece of equipment;
  - Coordinating and using appropriate allied health therapies with devices under an appropriate individualized plan;
  - Training or technical assistance for an individual with a disability, or his or her family members, guardians, advocates, rehabilitation professionals, direct support staff/personal care assistants, or other authorized representatives; and,

- A service that expands access to technology, including e-mail and Internet, to persons with disabilities.
2. Where not available in the program service package as a Qualified Service, Assistive Technology and Environmental Adaptations that will make the home accessible and increase independence. Assistive Technology Device is defined in federal law as “any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain or improve functional capabilities of individuals with disabilities (Assistive Technology Act of 2004, 29 USC 3002). Within the purposes of the law is the statement: “Access to such devices can also reduce expenditures associated with...rehabilitation and training, health care, employment, residential living, independent living, recreation opportunities and other aspects of daily living” (ibid, USC 3001). The increasing availability of a vast array of assistive and environmental “smart” technologies and the concept of “smart homes” must change how supports are provided. These technologies offer great opportunities to increase the independence and autonomy of the individual, improve health status, enhance and redistribute the role of direct support staff and reduce lifelong costs of health care services and long term supports. Examples of Assistive Technology include:
- Power and manual wheelchairs, scooters, canes, walkers, and standing devices
  - Augmentative communication devices (speech generating devices), voice amplifiers and speech recognition devices;

- Durable medical equipment and medical supplies, such as lifts, shower chairs and incontinence supplies;
- Orthotics and prosthetics such as ankle/foot orthoses (AFOs), hearing aids and artificial/electric larynxes;
- Accessibility adaptations to the home, workplace, and other places, such as ramps, stair glides, lifts, grab bars, flashing smoke detectors, lever doorknobs and environmental controls systems, including those with remote monitoring contracts;
- Special equipment to help people work, study, engage in recreation, such as enlarged computer keyboards, reachers, amplified telephones, enlarged telephone keys, magnifiers, and, voice recognition software; and,
- Remote supervision technology and personal emergency response systems that will increase autonomy, ensure safety and reduce the need for in-person staff supports. Technological devices and electronic applications that are easy for people with disabilities to use and support their independence in daily living, healthy lifestyles and wellness. Examples include desktop, “pocket PC” and phone devices that are equipped with applications such as appointment management, menu planning, and incentivized walking routes specifically designed for the target population; and the use of biometric kiosk and “wrist band” device monitoring systems to track health indicators accurately, and in some cases enable people to self-monitor their own health.

To qualify for payment as Accessible Housing Assistance Services, expenses must be authorized and included in the participant's service plan; incurred within 60 days before and 120 days after a participant's discharge from a nursing facility or hospital or another provider-operated living arrangement; and necessary for the participant's safe transition to the community. Accessible Housing Assistance Services cannot exceed \$2,500 without prior approval from AMA. Accessible Housing Assistance Services do not include expenses for monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes; or that are not necessary for the participant's safe transition to the community.

**Other Services to be Examined:** The State is also examining additional Medicaid-funded service packages for individuals with mental illness. MFP Rebalancing Demonstration participants would, in some cases, also qualify for these programs. For example, the ADMH and AMA have been examining the feasibility of implementing a 1915(i) program, with a needs based criteria requiring an individual to have a variety of combinations of risk factors and functional need for assistance with community living skills such that those needs cannot be met by outpatient clinic services. These combinations of risk factors and functional need for assistance must be primarily due to a chronic mental illness and the individual must meet the criteria for Seriously Mentally Ill Adults/Elderly (SMI) as defined in the Alabama Department of Mental Health's Mental Illness Contract Service Delivery Manual and does not meet the criteria established for 1915 (b) and (c) Waiver services. These services would be available to an individual who is at least 19 years of age and does not require acute inpatient psychiatric

hospitalization (inpatient level of care). Residency requirements would include having been a resident in an inpatient psychiatric hospital bed for over one year or a resident in an inpatient psychiatric hospital bed for at least 90 consecutive or cumulative days in the last 12 months, whose clinical status is unlikely to change. Additional eligibility criteria are under development. Individuals living in IMDs as well as certain individuals living in nursing facilities could be included in this population.

Alabama also intends to evaluate the potential for adding a demonstration employment service that would augment those currently available in some, but not all, of the waiver programs. This MFP demonstration service would enhance employment opportunities for all individuals under the age of 65 who are transitioning from institutions to the community, and would emphasize an **Employment First** policy. Employment First states focus policies, practices and strategies on integrated community integrated employment at prevailing wages and benefits as the desired outcome for all individuals with disabilities. Employment First is about raising expectations and centers on holding individuals with disabilities to the same employment standards, responsibilities, and sets of expectations as any working-age adult.

This initiative will require significant interagency collaboration among the various agencies, including AMA, ADRS and ADMH. While the State is not yet prepared to implement a carefully-crafted employment demonstration service at this time, the LTC Rebalancing Committee will be tasked with developing a proposed strategy for ensuing years of the MFP Rebalancing Demonstration. A staff person will be funded at ADRS to work with the Committee and lead the strategy development, provide assistance to individuals transitioning through the

MFP Rebalancing Demonstration and provide training and technical assistance to Transition Coordinators.

### **(6) Consumer Supports**

*Describe the process and activities that the state will implement to ensure that the participants have access to the assistance and support that is available under the demonstration including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services.*

**a. Educational Materials:** *A description of the educational materials used to convey procedures the State will implement in order for demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available;*

Alabama will provide each potential MFP Rebalancing Demonstration participant with a packet of materials that includes a description of procedures for obtaining needed assistance and support. Alabama will also educate LCA, ADRC and Transition Coordinators in the procedures and expectations for providing this information and materials. Transition Coordinators will also receive training in assisting participants to develop Back-up Plans as described below.

**b. Description of 24-hour Back-up Systems:** *A description of any 24-hour backup systems accessible by demonstration participants including critical services and supports that are available and how the demonstration participants can access the information (such as a toll free*

telephone number and/or website). Include information for back-up systems including but not limited to:

- *Transportation;*
- *Direct service workers;*
- *Repair and replacement for durable medical and other equipment (and provision of loan equipment while repairs are made); and,*
- *Access to medical care: individual is assisted with initial appointments, how to make appointments and deal with problems and issues with appointments and how to get care issues resolved.*

The case management systems for the waiver and PACE programs provide the foundation for 24/7 back-up for critical services. Each program has procedures in place for ensuring a timely and effective response to unmet needs. In addition, for the purposes of the MFP Rebalancing Demonstration, Transition Coordinators and case managers will assist all transitioning individuals with the development an emergency back-up plan that will identify the arrangements that have been made for the provision of services and/or supplies in the absence of critical planned services and supports. The Back-up plan will describe the alternative service delivery methods that will be used under the following circumstances:

- 1) If the primary employees fail to report for work or otherwise cannot perform the job at the time and place required;
- 2) If the participant experiences a personal emergency; or
- 3) If there is a community-wide emergency (e.g., requiring evacuation).

The personal emergency portion of the Back-up plan will allow the participant to identify circumstances that would cause an emergency for him based upon his unique needs. This plan must be updated at enrollment in the waiver and again no later than six months after transition. This procedure, as a minimum requirement, does not vary by population or by the selected service in which an individual enrolls. Once enrolled in the waiver or PACE program, the designated case manager is available to assist the individual in situations in which emergency back-up may be required.

As described further in Section b) (7) on Self Direction, individuals who choose to self-direct their services will use an additional comprehensive risk identification and planning tool, which will be tested for effectiveness, ease of use and outcomes.

**c. Complaint and Resolution Process:** *A copy of the complaint and resolution process when the back-up systems and supports do not work and how remediation to address such issues will occur.*

The AMA has procedures in place to process complaints and achieve resolutions. MFP Rebalancing Demonstration participants have the right to participate in these well-established grievance and appeals processes.

The first line of resolution for any issue is the Transition Coordinator or assigned case manager. The participant, responsible party, and/or knowledgeable others should be instructed to notify the case manager if back-up systems and supports do not work, services are not initiated as planned, the participant's condition changes or changes are needed in the plan of care when problems are identified or reported. The case manager is responsible for

investigating all complaints that any participant reports and taking appropriate action to remediate the problems.

The second line of resolution is the Operating Agency, which must have in place a procedure for reporting to a designated agency staff by the Transition Coordinator or assigned case manager of issues and complaints that have not been resolved within 30 days from the date the complaint was received, or in the event the nature of the issue represents an imminent threat to the health and safety of the individual, an immediate report is to be made.

A Grievance/Complaint is to be filed and maintained in a Grievance and Complaint File until resolved. A report of all Grievances and Complaints received and status of resolution will be forward to the AMA LTC/QA division by the tenth day of the month following the end of the fiscal year quarter. The AMA LTC/QA division will review the report and may request additional information as needed to ensure adequate resolution to all complaints. The division may also undertake its own investigation if circumstances so warrant.

## **(7) Self-Direction**

*Provide a description of the self-direction opportunities under the demonstration before the Institutional Review Board (IRB) approval.*

Self-direction options will be available in the Demonstration. Individuals who enroll in the E&D, SAIL or ACT waivers may choose to self-direct certain services through the 1915(j) *Personal Choices* program. Availability is currently limited to specific geographic areas for the E&D and SAIL waivers, while self-directed services are available statewide for the ACT waiver.

The targeted geographic areas for the E&D Waiver are the following ten counties: Baldwin, Bibb, Escambia, Fayette, Greene, Hale, Lamar, Mobile, Pickens and Tuscaloosa. The targeted geographic areas for SAIL Waiver are the following seven counties in West Alabama: Bibb, Fayette, Greene, Hale, Lamar, Pickens, and Tuscaloosa. The State continues to plan to expand the service areas for *Personal Choices*.

In addition, self-direction of certain services will be available to individuals participating in the ID, LAH or ACT II waiver as indicated in the table on the following page. Sub-Appendix I; Self-Direction is also attached as Attachment H.

**Table # 11: Availability of Self-Directed Services**

Waiver	Optional Services That May Be Self-Directed	Availability
E&D	Personal Care, Homemaker Unskilled Respite Adult Companion	Available in the pilot counties
SAIL	Personal Care Personal Assistance	Available in the pilot counties, with plans to expand to statewide availability by the end of 2012.
ACT	Personal Care Homemaker Unskilled Respite Adult Companion	Statewide
ID	Personal Care RN/LPN Community Specialist	Statewide
LAH	Personal Care RN/LPN Community Specialist	Statewide

The State proposes to develop, implement and evaluate additional and/or enhanced supports in order to promote self-direction. Alabama will undertake an initiative to

substantially increase the use of self-directed services, developing and testing strategies to reduce and eliminate barriers to self-direction. Through a formative evaluation process (described in Section d) Evaluation), Alabama proposes to evaluate key desired outcomes related to the interventions. Primary barriers to be addressed will include a 1) a lack of awareness of the benefits of self-directed services and the supports available to those who select them, which precludes informed decision-making, and 2) a perception of increased risk when self-directing. Targeted outreach will be undertaken to ensure individuals and families have a full understanding of the opportunities for self-direction, the potential benefits and the supports available to self-directing participants.

Currently, all individuals who enroll in E&D, SAIL, ACT, LAH and ID waivers are expected to be offered self-direction as an option. For the MFP Rebalancing Demonstration, all transitioning individuals will be informed of the options for self-direction during Options Counseling and during enrollment in the selected program to enable informed decision-making. MFP administrative funding will be used to contract for development of the outreach tools to be used for this purpose, which will supplement the outreach tools (described in Section b)(3) Outreach/Marketing/Education). In order to devise the tools, the contractor will partner with AMA and the Operating Agencies using the 1915(j) *Personal Choices* option to examine the use of current outreach materials and make improvements based on the results. The development of the tools will be coordinated with the MFP Outreach tools developed by the ADRC.

All personnel providing Options Counseling and Transition Coordination will be provided training on the use of the self-direction outreach tools. Formal feedback on the ease of use and efficacy will be solicited at key points to determine if any additional enhancements are needed.

The *Personal Choices* program risk management strategies include certain tools that were designed to assist individuals to identify potential risks, including the need for back-up assistance in case primary supports fail. Alabama proposes to further develop these one and two page tools into a more comprehensive self-directed risk management tool that is user-friendly for all population groups targeted by the MFP Rebalancing Demonstration, and to test key factors and outcomes related to their implementation.

Current protocol includes a Self-Assessment that asks participants to indicate their understanding and ability to implement each of the roles and responsibilities detailed in the *Personal Choices* Roles and Responsibilities tool. Depending on the responses, the Counselor and participant formulate a plan for ensuring the participant can effectively manage each of the roles and responsibilities. Other potential strategies may include additional training and/or the use of an informal or formal representative. The Health and Safety Planning Checklist lists many common risk factors, ranging from physical and cognitive disabilities to social issues such as isolation. For each identified risk, the participant is alerted to the nature of the potential risk and prompted with examples to develop a plan to mitigate that potential risk. These tools will be expanded and reformatted into a workbook that will be available in hard copy and as an interactive electronic document. The products will be tested and modified as needed over the course of the project and additional products designed if a need is identified.

**a. Voluntary Disenrollment Procedures:** *Describe how the State accommodates a participant who voluntarily terminates self-direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method.*

For those individuals who self-direct under *Personal Choices*, a program participant may elect to discontinue participation in the *Personal Choices* program at any time. The following procedures ensure continuity of services and participant health and welfare during the transition, and provide safeguards to ensure that the reasons for disenrollment are not related to abuse or similar concerns and that services are not interrupted during the transfer from *Personal Choices* to the participant's traditional waiver program. It is the responsibility of the participant to initiate voluntary disenrollment by notifying the Counselor of such a decision. The participant may notify the Counselor of his desire to dis-enroll by phone or e-mail. The Counselor will document in the participant's record the date of notification by the participant of their decision to dis-enroll. The Counselor will begin the disenrollment process within 5 business days from the date of notification. A face-to-face contact is required to discuss the following:

- To provide an opportunity for the Counselor to determine if the participant's health, safety, and welfare has been jeopardized during their enrollment;

- To minimize unnecessary dis-enrollment if the Counselor can identify and resolve any problems that would enable continued enrollment and satisfaction with the program or confirm that the reasons for disenrollment cannot be resolved;
- To obtain the signature of the participant to attest to his desire to dis-enroll;
- To explain the processes and timeline for transfer back to the traditional service delivery option;
- To ascertain the participant's choice of direct service providers;
- To discuss the conversion of the individual budget back to traditionally authorized services and make necessary decisions related to accumulated funds.

From the receipt of the request for voluntary disenrollment, the timeline for transfer from *Personal Choices* to the traditional waiver, when the participant's health and safety is not in jeopardy, may be from fifteen to forty-five days. The Counselor will have 5 days to begin the process of disenrollment and have an additional 10 days to complete the transition back to the traditional waiver program. The timeline may be extended up to 45 days if requested by the participant.

For those individuals who self-direct services under the ID or LAH waivers, any participant who is self-directing his or her services may request to discontinue this model at any time by contacting the case manager or the FMSA, either of which will notify the Operating Agency immediately. The case manager will provide the participant with free choice of providers who will take over delivering the services. If appropriate and desired by the participant, the staff which has been providing the services may be employed by the provider

agency which is selected. The transfer will be as fast as can be arranged depending on the circumstances: if the participant's staff can be employed by an agency to continue the service, this will be done within two weeks. If all new staff needs to be recruited, vetted, hired and trained prior to employment, the process may take a month or more. During that time the original backup plan will need to be implemented, and other providers within the county may also be asked to help staff the participant's needs.

The circumstances under which a participant chooses to voluntarily terminate his use of the self-direction model will always be assessed, first by the case manager, then as needed, by the regional office or advocacy section, as a routine component of trying to improve the service delivery system.

**b. Involuntary Dis-enrollment from Self-Direction:** *Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition.*

At any time that it is determined that the health, safety and well-being of the participant is compromised by continued participation in the *Personal Choices* program, the participant may be returned to the traditional waiver program. The Counselor and Case Manager will work together to immediately take action to have traditional waiver services restarted for those participants whose health and safety are at imminent risk. Participants who are not in immediate jeopardy will be given an advance notice in writing of their return to the traditional waiver service. Although the decision to involuntarily dis-enroll the participant from the

*Personal Choices* program may be appealed, the participant will begin to receive traditional waiver services until a decision is made on their appeal. The participant/representative has 15 days from the date of notification of disenrollment to file a request for an informal review of this decision. The operating agency, depending upon the traditional waiver the participant is enrolled in, will make a decision within 30 days from receipt of the request for an informal review. If the informal review decision is unfavorable, the participant may appeal the decision within 60 days from the date of the written decision to dis-enroll the participant from the *Personal Choices* Program based in accordance with established Medicaid Fair Hearings Policy.

For self-directed services under the ID and ACT waivers, similar disenrollment procedures are followed. Any participant who is self-directing his or her services may request to discontinue this model at any time by contacting the case manager or the FMSA, either of which will notify the Operating Agency immediately. The case manager will provide the participant with free choice of providers who will take over delivering the services. If appropriate and desired by the participant, the staff which has been providing the services may be employed by the provider agency which is selected. The transfer will be as fast as can be arranged depending on the circumstances: if the participant's staff can be employed by an agency to continue the service, this will be done within two weeks. If all new staff needs to be recruited, vetted, hired and trained prior to employment, the process may take a month or more. During that time the original backup plan will need to be implemented, and other providers within the county may also be asked to help staff the participant's needs.

The circumstances under which a participant chooses to voluntarily terminate his use of the self-direction model will always be assessed, first by the case manager, then as needed, by the regional office or advocacy section, as a routine component of trying to improve the service delivery system.

In all cases, program participants may be involuntarily disenrolled from the program for the following reasons:

1. Health, Safety and Well-being: At any time that the Counselor, the traditional waiver case manager, or the operating agencies determine that the health, safety and well-being of the program participant is compromised or threatened by continued participation in the *Personal Choices* program, the participant will be disenrolled.
2. Change in Condition: if the participant's ability to direct his/her own care diminishes to a point where they can no longer do so and there is no responsible representative available to direct the care, then the individual will be involuntarily disenrolled from the program.
3. Misuse of Monthly Allocation: If the *Personal Choices* participant/representative chooses the cash option and uses the monthly budgeted allocation to purchase items unrelated to personal care needs, fails to pay the salary of an employee, or fails to pay related state and federal payroll taxes, the participant/representative will receive a written warning notifying them that exceptions to the agreed upon conditions of participation are not allowed. The participant will be permitted to

remain on the *Personal Choices* program, but will be assigned to a Financial Management Services Agency (FMSA), who will provide bookkeeping services for the participant. The participant/representative will be notified in writing that further failure to misuse funds allocated through the *Personal Choices* program will result in involuntary disenrollment from the program.

4. Under-utilization of Budget Allocation: The FMSA is responsible for monitoring on a monthly basis the use of funds received on behalf of program participants. If the participant is underutilizing the monthly allocation or is not using the allocation according to their Personal Support Plans, the FMSA and Counselor will discuss the issues of utilization with the participant/representative. If the health and safety of the participant may be in jeopardy because of under-utilization of the budget allocation, the participant will be returned to traditional waiver services.
5. Failure to Provide Required Documentation: If a program participant/representative fails to provide required documentation of expenditures and related items as prescribed in the *Personal Choices Roles and Responsibility* tool, a written reminder will be sent from the FMSA to the participant/representative. If the participant/representative continues to fail to provide required documentation after a written notice is given, the individual will be disenrolled from the program. The participant/representative will receive written advance notification of disenrollment and the reasons for the actions. After disenrollment, the participant/representative cannot utilize funds allocated by the *Personal Choices* program.

Procedures to assure the continuity of care for an individual who is involuntarily disenrolled are the same as for voluntary disenrollments.

**c. Goal for Participation in Self-Direction:** *Specify the State’s goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration’s self-direction opportunities.*

The State’s goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration’s self-direction opportunities is 106. This number represents a rate of approximately 25% of the individuals projected to transition through the MFP Rebalancing Demonstration.

#### **(8) Quality**

*Provide a description of the State’s quality Improvement system (QIS) for demonstration participants during the demonstration year and a description of what system they will be transitioned to after the 365-day demonstration period.*

**a. Assurances for 1915(c) waiver or HCBS SPA Quality:** *If the State plans to integrate the MFP demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration 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 waiver application during the transition and during the 12 month demonstration period in the community. The state need not provide documentation of the*

*quality management system already in place that will be utilized for the demonstration.*

*However, rather provide assurances in the OP that:*

- *This system will be employed under the demonstration; and*
- *The items in section (C) below are addressed.*

*In addition, the state should provide a brief narrative regarding how the existing waiver QIS is already or will be modified to ensure adequate oversight/monitoring of those demonstration participants that are recently transitioned.*

Alabama's project design will largely integrate the MFP Rebalancing Demonstration into existing 1915(c) waivers and HCBS SPA (PACE). The State provides assurances that the same QIS systems will be employed under the demonstration and that the items in section (c) below are addressed.

The State's QA/QI processes will be adapted to incorporate components to track customer satisfaction and indicators of improved quality of life for all individuals that transition out of nursing facilities into qualified community settings.

**b. Assurances for 1915(b), State Plan Amendment (SPA) or an 1115 waiver Quality:** *If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community. The state must provide a*

*written narrative in this section of the OP regarding how the proposed service delivery structure (1915(b), State Plan Amendment, or 1115) will address the items in section (c) below.*

The State does not plan to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year.

**c. Waiver Assurances articulated in version 3.5 of the 1915(c) HCBS waiver application:** *The Quality Improvement System under the MFP demonstration must address the waiver assurances articulated in version 3.5 of the 1915(c) HCBS waiver application and include:*

- *Level of care determinations;*
- *Service plan description;*
- *Identification of qualified HCBS providers for those participants being transitioned;*
- *Health and welfare;*
- *Administrative authority; and*
- *Financial accountability.*

The State has developed a QIS for its waiver programs that addresses each of the waiver assurances articulated in version 3.5 of the 1915(c) HCBS waiver application. A summary is provided below. The full Long-Term Care Waiver Quality Assurance Manual is provided in Attachment I.

**Waiver Quality Management Plans:** AMA LTC Division is responsible for collecting data from the OA quarterly and annually regarding the quality of services provided from various sources for the waiver programs. The Quality Framework is used as a guide to assess seven Program Design Focus areas from samples of waiver participants, case management and direct

service providers' records, on-site home visits when deemed necessary, and onsite visits to adult day health facilities. In addition, participant satisfaction surveys and complaints and grievances logs are reviewed quarterly. Adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants' satisfaction with resolutions.

Data are collected through annual record reviews and the review of the OA which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. More specifically, a sample of all participants approved is conducted to ensure that the processes and instruments described in the approved waiver are applied in determining the Level of Care. Additionally, a sample of the waiver population is chosen for record review to ensure coordination of care, quality of care, outcomes and billing accuracy. A sample of personnel records of Case Managers and other employees is reviewed to ensure that basic and continuing education requirements are met. Home visits may be made to ensure quality of care, health and safety, ongoing needs of the client are being met, and to gain input about the quality of the services received.

Remediation for non-compliance issues identified during data collection is handled by requesting the entity involved to submit a plan of correction within 15 days of notification. If the problem is not corrected, the entity is monitored every three months. After the third request for a plan of correction, and if the entity continues to be non-compliant, a letter to terminate the Memorandum of Agreement will be issued. The collected data are reported quarterly and annually to each Operating Agency. AMA LTC Division will evaluate reports and

make recommendations for improvements to the program. The AMA LTC Division will determine if changes are to be made to the program. In order to measure and improve performance, data are collected, reviewed and reported using the seven focus areas of the Quality Framework. In addition, quality indicators from adverse responses to surveys and/or complaints received are tracked to resolution. Adverse responses are also re-tracked with targeted surveys to determine participants' satisfaction with resolutions.

**PACE QAPI:** The operating PACE program in Mobile has developed a QAPI plan that addresses all of the assurances articulated in version 3.5 of the 1915(c) HCBS waiver application. The 2011 QAPI Plan may be found in Attachment J.

**Quality Assurance for Demonstration Services:** The state assures CMS it will implement a comprehensive quality management approach for Demonstration Services that will utilize critical processes of discovery, remediation and systems improvement. The QA processes will be integrated into the existing quality management design described above. AMA will ensure that an adequate sample of MFP Rebalancing Demonstration participants is reviewed as a part of its quarterly and annual data collection from the Operating Agencies. These reviews will address the quality of Demonstration Services and other programmatic considerations which may impact the delivery of these services, which may include policies and procedures, contracts with subcontractors, on-going training of subcontractors, quality assurance system, and billing and service provision. Home visits made to ensure quality of care, health and safety, ongoing needs of the client are being met, and to gain input about the quality of the services received, will also include an adequate sample of MFP Rebalancing Demonstration participants. Likewise,

AMA will ensure that procedures for participant satisfaction surveys will include a sample of these participants. Remedial actions for any identified concern will be tracked to resolution.

On a quarterly basis, the Project Director will oversee a review and analysis of these data and take needed actions for remediation and improvement of Demonstration Services and any other emerging issues based on the results. These processes will complement and be integrated with the quality improvement strategies for 24/7 back-up, risk assessment/mitigation and critical incident reporting and follow-up described below.

**Quality Improvement for Additional MFP Quality Requirements:**

- **24/7 Back-Up:** AMA and the Operating Agencies will, as a part of each program’s quality management strategy, monitor responsiveness and timeliness related to consumer needs for emergency back-up. The Operating Agency will be responsible for ensuring ongoing collection of the data, acting upon identified issues as they occur if remediation is warranted, and instituting improvement strategies if trends emerge. The AMA will review the data on at least a quarterly basis to assess whether any additional remedial or improvement action is needed.
- **Risk Assessment/Mitigation:** Each Operating Agency will follow the respective risk assessment and mitigation processes as described in the waiver and PACE documents. These processes will be further informed and augmented by risk identification in the Return to Community Assessment Tool, and in subsequent risk mitigation planning in the transition plan developed by the individual and significant others with the Transition Coordinator. For the MFP Rebalancing Demonstration participants, the MFP Project Director will ensure a

sample of transition plans are reviewed for thoroughness and quality on at least a quarterly basis and determine any corrective actions or overall program modifications that may be needed.

- **Critical Incident Reporting and Follow-up:** Each Operating Agency will follow the respective critical incident reporting and follow-up as described in the waiver and PACE documents. The Operating Agencies will forward reports of all critical incidents of MFP participants to the AMA MFP Project Director within one business day for review. The MFP Project Director will monitor to ensure that adequate follow-up is completed on a timely basis. At least quarterly, AMA will complete an analysis of critical incidents to determine overall trends and/or service provider trends, how these compare to the larger populations served by each service provider and determine any corrective actions or overall program modifications that may be needed.

**d. Description of quality assurance process for SDS:** *If the State provides supplemental demonstration services (SDS), the State must provide:*

- *A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,*
- *A description of the remediation and improvement process.*

The State does not plan to offer any supplemental demonstration services at this time.

## **(9) Housing**

**a. Qualified Residences;** *Describe the State’s process for documenting the type of residence in which each participant is living. The process should categorize each setting in which an MFP participant resides by its type of “qualified residence” and by how the State defines the supported housing setting, such as:*

- *Owned or rented by individual,*
- *Group home,*
- *Adult foster care home,*
- *Assisted living facility, etc.*

*If appropriate, identify how each setting is regulated.*

Alabama proposes to offer participants in the MFP Rebalancing Demonstration the broadest range of qualified housing permissible. The State’s definition of qualified residences for MFP participants include the following:

- A home owned or leased by the individual or the individual's family member, for which there are no regulatory requirements;
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control, for which there are no regulatory requirements;
- An apartment within an assisted living facility provided all criteria in the paragraph above are also met. Assisted living facilities are regulated through the Alabama Department of Public Health (ADPH);

- A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside, i.e. Adult Family Foster Care or Community Group Home. Group homes and foster homes are subject to regulation by state agencies, including ADMH, ADPH and the Department of Human Resources (DHR).

Information on the type of qualified residence that the individual chooses must be verified and approved by the MFP Project Office prior to discharge. Approval will be given in writing and will become part of the participant's file.

**b. Capacity of Qualified Residences:** *Describe how the State will plan to achieve a supply of qualified residences so that each eligible individual or the individual's authorized representative can choose a qualified residence prior to transitioning. Explain how the State will plan to address any identified housing shortages for persons transitioning under the MFP demonstration grant, including:*

- *Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions;*
- *Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet these needs; and,*
- *Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants.*

As evidenced in the continuing Mathematica evaluation series, housing has been the primary barrier faced by MFP states. Alabama has a strong track record in partnering with

housing programs to address the needs of individuals with disabilities. For example, Alabama received one of the earliest *Home of Your Own* grants, partnering with the Alabama Housing Finance Authority to provide individuals with developmental disabilities and their families with opportunities to purchase homes. Since then, and over the past decade, there have been several additional initiatives related to coordination between the Alabama Housing Finance Authority (AHFA) and State service agencies. The most significant of these was the temporary commitment of 100% of the tax credits offered to homebuilders and contractors who would incorporate housing for people with disabilities into their projects. This initiative served to support the deinstitutionalization of almost 1,000 people from the State's facilities for people with mental retardation and mental illness. Another effort undertaken by AHFA in collaboration with the disability community is Access Alabama. This program makes mortgages more affordable for low to moderate-income home buyers who have disabilities or family members with disabilities. Alabama's 18-member coalition, led by AHFA, was one of only 10 states and the District of Columbia chosen by Fannie Mae to offer this pilot program. In connection with AHFA's Mortgage Revenue Bond Program, Access Alabama provides 30-year fixed-rate loans, increased down payment assistance, budget counseling and financial crisis intervention.

AMA and other stakeholders have also been engaged in a coordinated effort with HUD Office in Alabama. In 2012, HUD's State Field Office Director and Director of Public Housing initiated a stakeholder Round Table discussion designed specifically to identify common interests, mutual opportunities and complementary resources that can be effectively leveraged

and to determine strategies for partnering to more effectively to assist persons with disabilities to transition from residential settings to more community-based, independent living arrangements. Real life profiles of such individuals were fully discussed and the roles each stakeholder examined toward developing an individual plan framework, to better facilitate a more successful transition to independent living for persons with disabilities.

Yet, with all of these initiatives, accessible and affordable housing remains a primary barrier to community living for individuals with disabilities. Recent data indicate a deficit of some 90,000 affordable housing units across the state, a situation that becomes even more critical in the rural areas of the State. The MFP Rebalancing Demonstration will build on the efforts and relationships described above to achieve an adequate supply of qualified residences for MFP participants through coordinated program strategies that will include:

- A Housing Workgroup will be created within the LTC Rebalancing Advisory Committee. Staff support will be provided by one of the AMA MFP Program Specialists to develop partnerships and design a strategic plan.
- AMA will work with HUD and the local Public Housing Authorities to share education and resources. For example, there are several areas in the State that were awarded Non-Elderly Disabled (NED) Housing Vouchers which must be used for individuals with disabilities. AMA will work with these entities to ensure the necessary connections are made to facilitate access to these vouchers.
- AMA will form a partnership with the Alabama Housing Trust Fund, recently created by legislative action.

- Project funding will be used to support a comprehensive Housing Accessibility Initiative. Five Housing Specialists will be strategically positioned across the State. These personnel will be tasked with outreach in their catchment areas to:
  - Identify and catalog all housing resources; to act as liaison with Public Housing Authorities for the purposes of facilitating applications for housing assistance for MFP Rebalancing Demonstration participants as well as promoting understanding of the needs of seniors and individuals with disabilities;
  - Provide training and technical assistance to Transition Coordinators in accessing housing resources;
  - Provide education and technical assistance to MFP participants and other individuals with disabilities and seniors in accessing housing resources; and
  - Actively participate in planning and resource coalitions in the catchment area to ensure the needs of individuals with disabilities and seniors are incorporated.

Transition Coordinators will receive ongoing training and technical assistance from the Housing Specialists in resource development and access strategies in order to assist individuals to locate available, affordable and accessible housing. One Housing Coordinator will also be funded to provide planning, direction, oversight and direction of the work of the Housing Specialists, to coordinate with other statewide housing initiatives and coalitions and to ensure coordination with AMA staff and the LTC Rebalancing Committee Housing Workgroup.

## **(10) Continuity of Care Post-Demonstration**

*To the extent necessary to enable a State initiative to meet the demonstration requirements and accomplish the purposes of the demonstration, provide a description of how the following waiver provisions or amendments to the State plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care:*

Alabama's MFP Rebalancing Demonstration has been designed to rely on, as well as to expand and enhance existing infrastructure. As such, continuity of care will be provided through the State's Home and Community-Based (Section 1915(c)) waivers and State Plan Services. Individuals will continue to be served through these waivers in the post-demonstration period as long as they continue to meet the eligibility criteria. After the MFP Demonstration period, if an individual no longer meets the institutional level of care requirement or medical necessity due to a change in status, the individual would not be eligible to participate in any of the Medicaid 1915(c) waiver programs. However, if the individual meets Medicaid financial eligibility and the functional eligibility criteria for Alabama's State Plan services, then the state will assist that individual in the enrollment of one of those programs. If Medicaid financial eligibility is not met, the individual will be referred to the ADRC for assessment of eligibility for other services and further Options Counseling.

**Research and Demonstration (Section 1115)** – *for participants eligible for the research and demonstration waiver services provide evidence that:*

- i. Slots are available under the cap;*
- ii. A new waiver will be created; or*

iii. There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver.

Section 1115 waivers will not be utilized for the MFP Demonstration.

**Home and Community-Based (Section 1915(c))** – for participants eligible for “qualified home and community-based program” services, provide evidence that:

- i. capacity is available under the cap;
- ii. A new waiver will be created; or
- iii. There is a mechanism to reserve a specified capacity for people via an amendment to the current 1915(c) waiver.

The existing ACT waiver, which is devoted to transition, will be an ongoing program not subject to discontinuation of MFP funding. AMA has also amended each of the other existing HCBS waivers to reserve a specified capacity for individuals who transition from institutions. The numbers of slots reserved per waiver for transition are found in the table below. This number (405) does not include the expected number of individuals who will transition to the PACE program, which is projected to be 20.

**Table # 12: Transition Capacity per HCBS Waiver**

HCBS Waiver	Transition Slots
Elderly and Disabled	100
SAIL	25
Intellectual Disabilities	25
Living at Home Waiver (ID)	25
Technology Assisted	5
HIV/AIDS	25
Alabama Community Transition	200
<b>Total</b>	<b>405</b>

**Managed Care/Freedom of Choice (Section 1915(b))** – *for participants eligible for managed care/freedom of choice services, provides evidence that:*

- i. 1915(b) waivers and managed care contracts are amended to include the necessary services*
- ii. Appropriate HCBS are ensured for the eligible participants; or*
- iii. A new waiver will be created.*

Section 1915(b) waivers will not be utilized for the MFP Demonstration.

**State Plan and Plan Amendments** - *for participants eligible for the State plan optional HCBS services, provide evidence that there is a mechanism where there would be no disruption of services when transitioning eligible participants from the demonstration program.*

MFP Balancing Demonstration participants who select the PACE program will be required to meet the eligibility criteria for enrollment. Individuals will continue to be served in the PACE program in the post-demonstration period as long as they continue to meet the eligibility criteria and continue to live in a geographic location where a PACE program is available. If a PACE enrollee moves during the Demonstration or afterwards, the individual will be referred to the ADRC for assessment of eligibility for other services and further Options Counseling.

### **C) PROJECT ADMINISTRATION**

*Provide a description of the day to day organizational and structural project administration that will be in place to implement, monitor, and operate the demonstration.*

The MFP Rebalancing Demonstration will be operated under the auspices of the AMA, the single State Medicaid Agency. The Medicaid Commissioner oversees both the Medicaid State Plan services and home and community-based waivers. This oversight includes ensuring the waivers specify licensure and/or certification requirements for providers of waiver services, which address qualifications of direct care staff, maintenance of clinical and other records, supervision, treatment planning and evaluation of the provision of service. Providers are monitored by the Operating Agencies to ensure continued compliance with regulatory requirements. AMA staff conduct further compliance review monitoring to ensure waiver requirements are being met. AMA and the Operating Agencies conduct provider meetings to issue updated information and new training based on issues identified through the monitoring process and to address provider concerns. AMA also conducts annual training with each Operating Agency's staff, and additionally as needed to enhance education and performance.

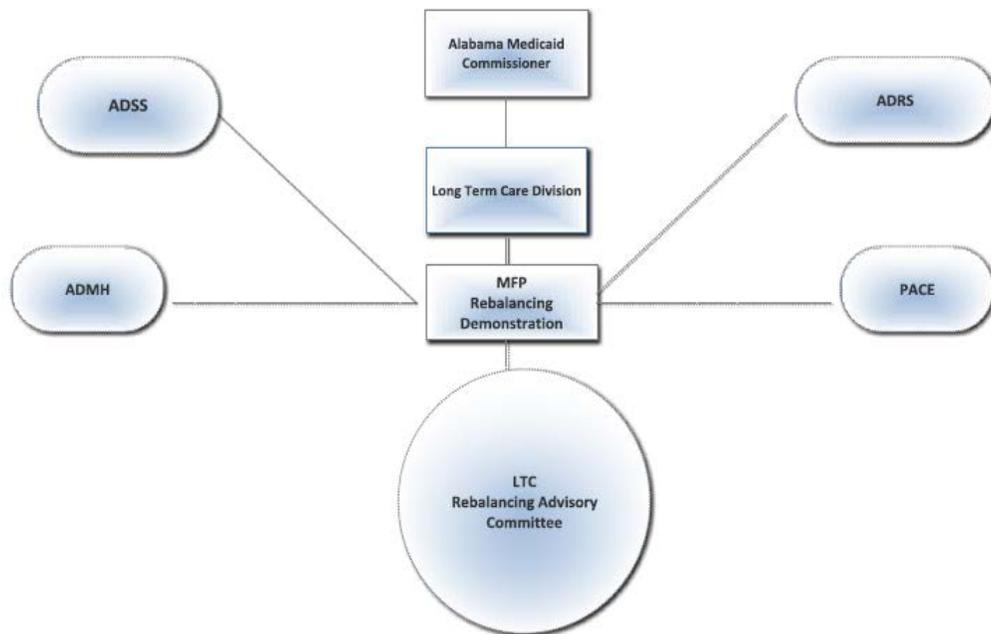
Primary responsibility for the day to day operations of the Demonstration will be housed in the AMA Long Term Care Division. A full time Project Director will be assigned within the Long Term Care Division to direct and coordinate the activities within the AMA related to the Demonstration as well as oversee and coordinate Demonstration activities of the Operating Agencies and all Demonstration contractual relationships.

- 1. Organizational Chart:** *Provide an organizational chart that describes the entity that is responsible for the day-to-day management of this grant and how that entity relates to all other departments, agencies and service systems that will provide care and supports and*

*have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.*

The organizational chart in Attachment O represents the AMA, the entity responsible for the day-to-day management of the MFP Rebalancing Demonstration.

The chart below further illustrates how the AMA relates to all other departments, agencies and service systems that will provide care and supports and interface with the eligible beneficiaries under the MFP Rebalancing Demonstration, including the Operating Agencies of the waivers, the PACE program and the stakeholder representative LTC Rebalancing Advisory Committee.



**2. Staffing Plan:** *Provide a staffing plan that includes:*

**a. Project Director:** *A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director's resume or Job Description including performance evaluation criteria. CMS will have input into the approval of the person hired. At any time, CMS feels that the individual is not performing up to our expectations, CMS may request that a new Project Officer be assigned.)*

Ginger Wettingfeld, Deputy Director, Long Term Care Division, will be the primary agency staff member to direct the MFP Rebalancing Demonstration. The state provides assurance that 100% of her time will be dedicated to being the Money Follows the Person Project Director. Her resume may be found in Attachment K.

**b. Dedicated Staff:** *The number and title of dedicated positions paid for by the grant and a justification of need. Please indicate the key staff assigned to the grant, if they have been identified.*

The Long Term Care Director, Ozenia Patterson, is the immediate supervisor of the Project Director and will devote 20% of her time to oversight and monitoring of the MFP Rebalancing Project. All MFP transitions will occur to one of Alabama's existing waivers. As the director of LTC, Ms. Patterson is ultimately responsible for the activities for all of the waivers including MFP clients. Given the level of her responsibility over the function of the LTC Waivers, the state feels it is reasonable that she would spend 20% of her time overseeing the waiver programs in addition to MFP activities.



**d. Roles and Responsibilities:** *Brief description of role/responsibilities of each position.*

**Project Director:** Ginger Wettingfeld, Deputy Director, Long Term Care Division, will be the primary agency staff member to direct the MFP Rebalancing Demonstration. The state provides assurance that 100%\_of her time will be dedicated to being the Money Follows the Person Project Director. The Project Director's functions for the Demonstration will include:

- Oversee daily activities of the Demonstration;
- Manage program budgets and financials for MFP;
- Coordinate with Finance for appropriate matching activities;
- Coordinate and monitor Operating Agency activities;
- Coordinate with Quality Assurance;
- Oversee the activities and provide supervision to key project staff;
- Research other states' initiatives, policies, and procedures relative to long term care services as they support the goals and objectives of the MFP Rebalancing Demonstration;
- Develop, implement, and manage new grant proposals related to long term care services as they support the goals and objectives of the MFP Rebalancing Demonstration, including: collaboration with federal grantor staff and state operating agencies; technical assistance for RFP process, personal service contracts and provider agreements;
- Complete grant financial and progress reports, and consumer/provider education;
- Assist the Director to develop the program and administrative budgets;

- Work closely with all LTC Units, Medicaid staff, other state agencies, advocacy groups, provider and associations in coordinating the long term care rebalancing efforts related to the elderly and disabled populations as this support the goals and objectives of the MFP Rebalancing Demonstration; and,
- Review federal and state legislative mandates to determine the impact of existing policies as they support the goals and objectives of the MFP Rebalancing Demonstration.

**Long Term Care Director:** The Long Term Care Director will provide oversight and monitoring for the MFP Rebalancing Project, supervision of the Project Director, and will ensure coordination and integration of the initiative with overall long term care planning and services.

**MFP Program Specialists:** The scope of work for the MFP Program Specialists will be to analyze and interpret data, assess federal and state regulations, rules and provider contracts for use in developing and managing the MFP Rebalancing Demonstration's strategic plan. The job description below lists the essential functions of the position and is not intended to include every job duty and responsibility specific to the position. The MFP Program Specialists may be required to perform other related duties not listed on the supplemental job description provided that such duties are characteristic of that classification.

As directed by the Project Director, the MFP Program Specialists will:

- Assist with project management;
- Serve as liaison as assigned to the LCA/ADRC and Operating Agencies for all MFP referrals and enrollees;

- Serve as the liaison and staff support to the Housing Workgroup of the LTC Rebalancing Advisory Committee and assist in the development and implementation of the MFP Housing strategic plan. Provide oversight, monitoring and reporting for the implementation of the Accessible Housing Assistance Service; *and/or*, serve as the liaison and staff support to the Employment Workgroup of the LTC Rebalancing Advisory Committee and assist in the development and implementation of the MFP Employment strategic plan. Provide oversight, monitoring and reporting for the implementation of planned employment initiatives, including recommendations for addition of employment-related demonstration services;
- Assist in the research and development of draft protocols and outreach materials;
- Coordinate education, outreach and training activities for staff, other agencies, advisory councils and community providers;
- Make formal presentations to appropriate state bureaus, inpatient facilities, community agencies, advisory and planning councils to build strong collaborations, to implement and improve policies and protocols;
- Analyze and interpret reports from the Operating Agencies and other relevant reports; make recommendations for improvement to the Project Director;
- Consult with associated groups and agencies to ensure coordination in the development and implementation of the project's strategic plan;
- Provide information to inpatient facilities about the goals and expectations of the project;

- Produce regular reports as required by the MFP grant and the Project Director; and,
- Perform other duties as required by the Project Director.

The IT/MMIS Programmer position will be dedicated to MFP/LTC activities and serve as a liaison between the LTC division and IT. This person will also have the ability to make IT changes in the system to support MFP and other LTC support systems activities. In addition, the IT/MMIS Programmer would handle all administrative paperwork and reviews related to IT changes for MFP/LTC.

**e. In-Kind Support:** *Identify any positions providing in-kind support to the grant.*

No specific in-kind support will be provided; however, each Operating Agency will designate staff to participate in MFP Rebalancing activities and provide management of MFP related operation within their organization.

**f. Contractual Support:** *Number of contracted individuals supporting the grant.*

The Demonstration will contract with an entity or entities to provide the services of five Housing Specialists contracted to provide services to individuals transitioning and training and technical support to Transition Coordinators as described in section, and one Housing Coordinator to oversee and manage the work of the Housing Specialists.

The Demonstration will also contract for assistance with the development of the supports for expanding Self-Direction, the implementation of the Self-Direction evaluation and the administration of the MFP QoL. Funding will support the MFP Rebalancing related work of the Principal Investigator, assigned research staff, the program administrator and a to be determined number of interviewers.

Additional funding will be used to support the work of the contractors for the outreach/marketing and employment initiatives respectively.

**g. Staffing Timeline:** *Provide a detailed staffing timeline.*

The Project Director, Ginger Wettingfeld, has been identified and is in place. The request for the IT/MMIS Programmer position has been completed and submitted for approval. MFP specialists will be obtained from the current MA I registry or via contract with outside firm. Given the current fiscal environment of the state, using a contractor appears to be more feasible at this time. It is anticipated that these positions will be filled within 90 days of project approval.

**h. Supervision of Demonstration Staff:** *Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.*

The Director of the Long Term Care Division, in concert with the Deputy Commissioner for Health Services, will be responsible for the assessment of performance of the Project Director. The direct supervision for the MFP Specialists and responsible for assessment of their performance will be the Project Director.

**3. Billing and Reimbursement Procedures:** *Describe procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.*

The State of Alabama assures the financial accountability and integrity of MFP payments through the following activities:

The AMA serves as the administering agency for MFP services and for all waivers subsumed in the MFP demonstration. The Long Term Care Division monitors payments for all MFP and waiver services. MFP participants will be assigned a unique living arrangement code in the claims payment system (MMIS) which will allow for payment, reporting, and tracking of qualified, demonstration and supplemental HCB services. The code will also allow for collection of specific data ensuring individuals meet the eligibility criteria and will provide data to be used in the analysis of the success of the transition process. Specific data will include length of time institutionalized, length of time in community living, and costs of the transition plan.

The Fiscal Agent Liaison Division/Contract Monitoring Unit monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews and targeted reviews of claims are performed when potential system errors are identified. The Medicaid Management Information Systems (MMIS) performs validation edits and audits to ensure program compliance. Audits check for duplicate services, service limitations and related services are compared to Medicaid policy and guidelines.

Monthly reports of expenditures are received by the waiver coordinator in order to monitor irregular expenses. The CMS 372 report is generated annually which records cost effectiveness and cost comparisons. Provider records are audited annually or more frequently at the discretion of the Medicaid Agency.

The entity responsible for conducting the periodic independent audit of the waiver program as required by the Single State Audit Act is the Alabama Department of Examiners of Public Accounts.

#### **d) EVALUATION**

*Although not required as a component of the MFP demonstration, States may propose to evaluate unique design elements from their proposed MFP program. If these activities are undertaken by the State, the following information must be provided to CMS:*

*1. Evaluator – If an evaluator has been identified, name the evaluator and provide a resume of the principle investigator in an indexed appendix. Provide a description of the process that will be used to secure an evaluator if one has not yet been identified. Also, provide a description of how the State will assure that the evaluator will possess the necessary expertise to conduct a high quality evaluation. Provide a brief description of the organizational and structural administration that will be in place to implement, monitor and operate the evaluation.*

Alabama will contract with a qualified entity for purposes of project evaluation, as described below.

#### **Evaluation Process Overview and Focus Areas:**

The evaluation component of the MFP Rebalancing Demonstration will have two areas of focus.

**National MFP Evaluation:** The first area of focus will be coordination with the National MFP Evaluation, including the administration of the MFP-QoL. The required MFP-QoL surveys will be accomplished through in-person interviews with participants using survey and data collection instruments provided by the national MFP evaluator. The survey measures quality of life in seven domains: living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall living satisfaction, and health status.

These “face-to-face” surveys are to be conducted at three points in time for each individual within 30 days prior to transition but not later than ten days after discharge from an institution (baseline survey), about 11 months after transition and about 24 months after transition. Individuals may choose to enroll in the MFP Demonstration but may decline to participate in the survey process. If an individual does not participate in the baseline survey, post-transition surveys are not conducted. It is estimated that there will be 1,275 surveys that need to be conducted during the course of the MFP Rebalancing Demonstration. This number may vary based on the total number of individuals who transition.

AMA will work with the contractor to define the job description, qualifications and the screening mechanism for interviewers including background checks. In addition, procedures will be established to ensure:

1. Training, monitoring and supervision of interviewers;
2. Inter-rater reliability for individual survey staff;
3. A process of making appointments to conduct survey;
4. A process of documenting when individuals decline to participate in the surveys;
5. Communication barriers that require interpreters;
6. Data collection;
7. Data entry, including percent of accuracy and how it is to be obtained;
8. A process for returning all completed surveys, data files and related materials with the submission of the billing invoice for the completed QoL surveys in batches.

Alabama is requesting to be reimbursed in the amount of \$125.00 per survey, due to the largely rural nature of the State, the geographic distances that must be covered and the rising costs of fuel.

**Evaluation of Self-Directed Services:** The second area of focus will be an evaluation of key issues related to the use of self-directed services in the State, including both MFP and non-MFP participants.

The Principal Investigator will be Rebecca Wright, MSW, LCSW. Ms. Wright has substantial experience in the design and evaluation of services to individuals with disabilities and, in particular, with self-directed services. She has an extensive background in aging and disability services both in Alabama and across the nation. She co-led the State's initial Olmstead planning process with the Director of Long Term Care for the Medicaid Agency, and coordinated the development of three successful grants in the Real Choice Systems Change offerings. The centerpiece of these was designed to infuse infrastructure to support self-determination across the Medicaid Agency and the State's three largest waiver programs, including the Elderly and Disabled waiver. Ms. Wright worked with ADSS to design successful Cash and Counseling application that addressed individual budgets, quality assurance processes, person-centered planning and risk management, and served as technical advisor to this three-year project. In the process, Ms. Wright served as the primary author of the Personal Choice Program, the first 1915(j) to be approved by CMS.

In addition, Ms. Wright worked closely with the State of Texas Department of Aging and Disability Services (DADS) to implement and evaluate a self-directed agency with choice service

model (Service Responsibility Option) within a Medicaid entitlement program that served over 100,000 people statewide. Roles include developing outreach, education and training materials and providing training to DADS staff, providers and consumers. In the process, Ms. Wright worked with a group of stakeholders to lead the development of a set of tools to be used by people who are self-directing to take an active part in personal risk identification and mitigation and to evaluate their results. These tools and the quality management system were featured in a CMS publication about quality in self-directed services. The outcome of the project was that the Service Responsibility Option was expanded to most of the waivers statewide in Texas.

In addition to her work in the area of self-direction, Ms. Wright has led and participated in many program evaluations, including for example an evaluation of Alabama's original Family Support Projects, an evaluation of Texas Long Term Care Regulatory program, and an evaluation of Peer Supports as a potential reimbursable waiver service in Georgia. Most recently, Ms. Wright collaborated with Dr. Erik Carter to complete a longitudinal evaluation of a three year congregational inclusion project for people with developmental disabilities in New York. Ms. Wright's full resume may be found in Attachment L.

**2. Evaluation Design:** *Provide a description of the State's evaluation design. The description should include the following:*

**a. Demonstration Hypotheses:** *A discussion of the demonstration hypotheses that will be tested;*

Alabama proposes to examine the barriers to self-direction and develop and test strategies to reduce and eliminate them. Primary barriers to be addressed will include: 1) a lack of

awareness of the benefits of self-directed services and the supports available to those who select them, which precludes informed decision-making, and 2) a perception of increased risk. The hypotheses include: 1) increased understanding of the benefits of self-direction and the supports available will result in increased usage of self-directed options; 2) MFP participants who choose self-directed services will report increased satisfaction with services over participants who do not choose self-direction and 3) MFP participants who choose self-directed services will have reduced rates of re-institutionalization than participants who do not choose self-direction.

**b. The outcome measures that will be included to evaluate the impact of the demonstration;**

In addition to the benchmark to increase availability of self-directed services and Alabama's stated goals for increased use of self-direction, the State will include the following outcome measures:

1. Comparisons of rates of reported increased understanding of the potential benefits of self-directed services and the supports available to facilitate participation between choosers and non-choosers of self-direction;
2. Comparisons of rates of increased understanding of the supports available for risk management between choosers and non-choosers of self-direction;
3. Comparison of rates of satisfaction with services between choosers and non-choosers of self-direction; and,
4. Comparisons of rates of re-institutionalization between choosers and non-choosers of self-direction.

**c. Data Sources:** *The data source that will be utilized;*

There will be several data sources that will inform the evaluation. First, a participant-level survey will be designed to complement the QoL that will be administered at the same time as that instrument and by trained interviewers. This complementary instrument will be designed to obtain information from MFP participants as to their baseline knowledge and perceptions of self-direction, the factors they considered when offered the option of self-direction at the time of Options Counseling, and again at the time of enrollment in the selected program if self-direction was available. Questions will probe whether the Options Counseling process influenced their decision. The questions will further probe whether individuals had an understanding of the potential benefits of self-directed services and the supports available to facilitate participation as well as the understanding of the supports available for risk management.

Results from the QoL, assuming availability from Mathematica, will be used as the source of satisfaction data. If this is not acceptable, the evaluation team will develop and implement a quality of life survey/interview that will meet CMS established guidelines. MMIS and MFP Rebalancing Demonstration data reported by the Operating Agencies will be used to determine rates of re-institutionalization.

**d. Data Collection:** *An analysis of the methods used for data collection;*

Alabama proposes to administer the surveys at the same time as the QoL for purposes of cost effectiveness and to reduce intrusion on the time and attention of participants. Other

data will be obtained on a quarterly basis from the MMIS and quarterly reports from the Operating Agencies.

**e. Variables:** *The control variables (independent variables) that will be used to measure the actual effects (dependent variables) of the demonstration;*

Control variables for analyzing data will include a comparison group of individuals who did not select self-direction. Cost, service use and quality of life data will be compared between these participants and MFP participants who choose self-direction.

**f. Method to Isolate Effects of Demonstration:** *The method that will be utilized to isolate the effects of the demonstration from other state initiatives and state characteristics (e.g. per capita income and/or population);*

The evaluation will make every effort to isolate the effects of the demonstration from other state initiatives or intervening factors. Since all MFP participants will be offered the enhanced information on self-directed options, using a control group will not be feasible for the first hypothesis that individuals who are well-educated about self-direction will be more likely to select this option. For this hypothesis, the evaluation will use two methods to attempt to isolate the effects. The first method will be obtaining customer input by questioning participants as to their assessment of the impact of the outreach and education. This will be complemented by a trend-line analysis over time in which successive enhancements and subsequent outcomes are plotted. The evaluation will obtain the assistance of a subgroup of the Long-Term Care Rebalancing Advisory Committee, including managers of the MFP

Operating Agencies, to help identify any intervening happenstances that may have impacted the process and these will also be plotted on the trend line for analysis.

For the second hypothesis, that MFP participants choosing self-directed services will report increased satisfaction with services over participants who do not choose self-direction, it will be possible to have a comparison group. The comparison groups will be analyzed by certain self-reported variables in addition to reported satisfaction with services.

For the third hypothesis, that MFP participants who choose self-directed services will have reduced rates of re-institutionalization than participants who do not choose self-direction, MMIS and data reported by the Operating Agencies will allow the evaluation to compare this outcome across the two comparison groups.

**g. Other Information:** *Any other information pertinent to the State's evaluative or formative research via the demonstration operations;*

Not applicable.

**h. Interim Evaluation Findings:** *Any plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction.)*

Interim evaluation findings will be reported in quarterly and annual progress reports and shared.

**3. Variables** – *Describe the demographic, health care, and functional outcome variables you propose to collect in the demonstration. Provide a copy in an indexed appendix to the*

*application. Describe the instruments and provide a rationale for their use in the evaluation including reliability, validity and appropriateness for use on the study population.*

- Unique ID;
- Age / Date of Birth / Gender;
- Eligibility Group;
- Rates of re-institutionalization;
- Service utilization patterns and costs post transition;
- Length of stay in the institution prior to transition;
- Satisfaction as reported through the QoL or other standardized tool if needed; and
- Measures of understanding of self-direction options. This tool is to be developed as a part of the MFP Rebalancing Demonstration and will be predicated on existing reliable and valid methodology for assessing comprehension.

A copy of this information may be found in Appendix M.

**4. Process Evaluation** – *Please describe how process measures will be evaluated. Include a description of how infrastructure changes will be evaluated as well as any pilot programs.*

AMA is committed to formative learning and procedures for this process in order to make modifications that can improve self-directed outcomes on an ongoing basis. For the purposes of this project, we will build a formative evaluation plan that includes reporting to the Long-Term Care Rebalancing Advisory Committee and obtaining stakeholder feedback and input. Key process measure to be evaluated will include:

- Timeliness in which key evaluation findings are translated to needed improvements in the processes to promote self-direction, and
- Involvement of an appropriate stakeholder group in the review of evaluation findings and the proposed interventions as they are developed.

### e) BUDGET

The following budget corresponds to the 424a budget period of January 2013-December 2013.

A budget narrative follows the presentation of the overall budget below:

<b>Personnel</b>			
	Project Director	\$66,825	
	LTC Director	\$15,117	
	IT/MMIS Programmer	\$75,000	\$156,942
<b>Fringe Benefits</b>			
	Project Director	\$24,115	
	LTC Director	\$5,140	
	IT/MMIS Programmer	\$25,000	\$54,255
<b>Contractual Costs</b>			
	MFP Program Specialist Staffing	\$120,984	
	Self-Direction Initiative	\$108,333	
(Shown separately on MFP form)	Self-Direction Initiative Evaluation	\$50,000	
	Outreach and Marketing	\$200,000	
	Housing Initiative	\$315,400	
	Employment Initiative	\$114,600	
(Shown separately on MFP form)	QOL Survey	\$10,000	\$919,317
<b>Indirect Charges</b>			
	10% of Wages	\$15,694	\$15,694
<b>Travel</b>			
	<b>Instate:</b> 1,625 miles/month x 12 @ .555	\$10,823	
	Per Diem	\$3,800	
	<b>Out of State:</b>		
	2013 HCBS Conference 4 @ \$2500 each	\$10,000	

	2013 MFP Conference 4 @ \$2500 each	\$10,000	\$34,623
<b>Supplies</b>			
	General Supplies for 4 ppl	\$8,000	
	Startup Supplies	\$3,650	
	Printing/Copying	\$1,700	
	Postage/Mailing	\$1,200	\$14,550
<b>Equipment</b>			
	3 Computers @ 3500 each	\$11,500	\$11,500
	<b>Total Administrative Budget (100%)</b>	<b>\$1,206,881</b>	
<b>Other</b>			
(Shown separately on MFP form)	Routine Administrative (50%)	\$58,034	
	Qualified HCBS Services	\$2,477,332	
	Demonstration HCBS	\$206,850	
	<b>Total MFP Budget for 2013</b>	<b>\$3,949,097</b>	

## Administrative Budget Presentation

### I. Personnel

**Project Director (1.0 FTE)    \$66,825**

The Project Director will be responsible for oversight of all daily MFP activities, including program budget and financial management for MFP and supervision of all key MFP project staff. The Project Director will collaborate with federal grantor staff and state operating agencies, provide technical assistance for MFP processes, and participate in the development and procurement of personal service contracts and provider agreements. The Project Director will also assist the Division Director with the development of program and administrative budgets and will work closely with all LTC units and other Medicaid staff as this relates to MFP implementation, administration and coordination.

**Long Term Care Director (.2 FTE) \$15,117**

The Long Term Care Director will provide oversight and monitoring for the MFP Rebalancing Project, supervision of the Project Director, and will ensure coordination and integration of the initiative with overall long term care planning and services.

**IT/MMIS Programmer (1.0 FTE) \$75,000**

The IT/MMIS Programmer will primarily serve as a liaison between the LTC division and IT department. This person will be responsible for making changes in the IT system as required to facilitate the technological requirements of the MFP operational plan. In addition, the IT/MMIS Programmer will be responsible for the coordination of all administrative paperwork and reviews pertaining to IT changes required under MFP/LTC.

**II. Fringe Benefits**

Fringe benefits are claimed for the AMA positions according to the standard rates for each classification. The total amount for 2013 is \$54,255.

**III. Contractual Costs**

**MFP program Specialist Staffing: \$120,984**

AMA will contract for the services of two FTE MFP Program Specialists, who will be responsible for assisting the Program Director with carrying out the day to day operations of the MFP Demonstration and assisting in the development and implementation of the MFP Housing strategic plan. They will serve in a liaison role between the LCA/ADRC and a variety of operating agencies, including Employment and Housing Workgroups, advisory councils, community agencies, state bureaus, and outside inpatient facilities, among others. They are responsible for making

presentations, analyzing and interpreting reports, and coordinating the education, outreach and training of staff. MFP Program Specialists may also perform other duties as required by the Project Director. The total amount for these FTE, including in-state travel, is \$120,984.

Alabama also proposes to use administrative funding to implement the key initiatives of this project, including the housing, employment and self-determination initiatives. The experiences of the MFP programs over time have demonstrated these to be essential infrastructure to facilitate and support safe and successful transitions. These initiatives must be put into place at the outset of the program in order to achieve a robust level of program recruitment and transition. Rebalancing Funds are not available at the outset of the Demonstration and it would not be likely the State would generate an amount sufficient to support these projects in the absence of the infrastructure the initiatives will provide. These contractual costs include:

**Self-Direction Initiative: \$108,333**

The Demonstration will also contract for assistance with the development of the supports for expanding Self-Direction. Funding in the first period is requested in the amount of \$108,333 to support the MFP Rebalancing related work of the Principal Investigator, assigned research staff and the program administrator to provide oversight and monitoring. This contractual arrangement supports the outcomes specified in Benchmark 4: Increases in the availability of self-directed services (i.e., progress directed either by the State to expand the opportunities for Medicaid eligible persons beyond those in the MFP transition program to

directly, or through representation, to express preferences and desires to self-direct their services and supports). Key activities that support the proposed outcome include:

(1) Targeted outreach will be undertaken to ensure individuals and families have a full understanding of the opportunities for self-direction, the potential benefits and the supports available to self-directing participants. MFP administrative funding will be used to contract to develop the outreach tools to be used for this purpose. All personnel providing Options Counseling and Transition Coordination will be provided training on the use of the self-direction outreach tools.

2) Alabama proposes to develop a comprehensive self-directed risk management tool that is user-friendly for all population groups targeted by the MFP Rebalancing Demonstration, and to test key factors and outcomes related to their implementation.

**Outreach and Marketing: \$200,000**

The Demonstration will contract for development and implementation of the outreach/marketing at an estimated cost of \$200,000 for staff, materials and supplies and production of the outreach and marketing materials.

**Housing Initiative: \$315,400**

Funding is requested for the Demonstration to contract with an entity or entities to develop community housing resources, beginning in January 2013 and continuing for the balance of the first funding period. Housing remains one of the most significant barriers to community living, with a deficit of some 90,000 affordable housing units across the State. The MFP Rebalancing Demonstration proposes to undertake a comprehensive initiative to promote

the availability and accessibility of housing resources. Five Housing Specialists will be strategically positioned across the State. These personnel will be tasked with a variety of administrative tasks, including outreach in their catchment areas to identify and catalog all housing resources; to act as liaison with Public Housing Authorities for the purposes of facilitating applications for housing assistance for MFP Rebalancing Demonstration participants as well as promoting understanding of the needs of seniors and individuals with disabilities; to provide training to Transition Coordinators in accessing housing resources; to provide education and technical assistance to MFP participants and other individuals with disabilities and seniors in accessing housing resources; and to actively participate in planning and resource coalitions in the catchment area to ensure the needs of individuals with disabilities and seniors are incorporated. Transition Coordinators will receive ongoing training and technical assistance from the Housing Specialists in resource development and access strategies in order to assist individuals to locate available, affordable and accessible housing. One Housing Coordinator will also be funded to provide planning, direction, oversight and direction of the work of the Housing Specialists, to coordinate with other statewide housing initiatives and coalitions and to ensure coordination with AMA staff and the LTC Rebalancing Committee Housing Workgroup.

The above services are administrative in nature and intended as community resource development and training that will benefit the long-term care system as a whole. The amount requested is \$315,400. The AMA will also contract with the same entity or entities to provide the direct participant-specific Housing Coordination Services as described in Section (5)

Benefits. These services will be reimbursed as a Demonstration service. It is estimated that 50 participants will make use of the service at an average cost of \$892 per person.

**Employment Initiative: \$114,600**

The Demonstration will contract for a position to work with the LTC Rebalancing Committee and lead the strategy development for employment services, provide assistance to individuals transitioning through the MFP Rebalancing Demonstration and provide training and technical assistance to Transition Coordinators. The cost is projected at \$114,600 for one FTE to be devoted to this project, including statewide travel, materials and supplies.

**IV. Indirect Charges**

\$15,694 is requested for Indirect Charges. This figure was arrived at using 10% of wages (excluding Fringe Benefits) per the RFP instruction.

**V. Travel**

Travel costs for the MFP Demonstration Project are calculated based upon state travel rates. These are: (1) mileage at .555 cents per mile, (2) per diem at \$11.25 for less than 12 hours, \$30.00 for more than 12 hours, and \$75.00 for overnight stays. Out-of-state travel is reimbursed at cost with receipts.

To facilitate outreach, marketing, promotion, administration and coordination of the MFP Demonstration Project, in-state travel is budgeted for the Project Director at 1250 miles per month during 2013 in her efforts related to the management of the MFP Project, and 375 miles per month for the LTC Director.

Out-of-state travel for 2013 covers the costs of airfare, overnight per-diem rates and lodging for the Project Director, LTC Director and two MFP Specialists. These costs enable their participation in both the MFP and HCBS annual conferences.

## **VI. Supplies**

\$3,650 will be used to purchase startup supplies. In subsequent years, general office supplies to support 5 MFP employees will be purchased on an as-needed basis utilizing the \$8000 appropriated. Postage/mailing costs are anticipated to be \$1,200. Printing and copying of program materials is estimated at \$1,700.

## **VII. Equipment**

In 2013, \$11,500 dollars will be utilized to purchase three computers and associated software for 3 MFP employees. These computers are expected to cost \$3500 each.

**2. Administrative Budget** – *Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Please indicate any administrative fund request to be reimbursed fully through the grant. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.*

**Routine Administrative Costs:** \$58,034

Alabama is requesting administrative funding for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration, in the amount of \$58,034.

**QOL Survey: \$10,000**

Alabama is also requesting costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS for the administration of the QoL in the amount of \$10,000 for the period of September 2102-December 2013, with a projected number of 80 surveys to be completed during this timeframe. This amount reflects a requested rate of reimbursement for QoL administration of \$125 per survey. This request is based on the statewide implementation plan, the largely rural nature of the State and significant geographic distances across the State and the rising costs of fuel and other travel costs.

**3. Evaluation Budget** – *Please include annual estimated costs of the evaluation activities the State is proposing.*

The estimated annual cost for the evaluation of the Self-Direction Initiative is \$50,000. This figure includes the costs associated with data collection and entry, and analysis and report preparation.