PARTNERSHIP FOR COMMUNITY INTEGRATION:

OPERATIONAL PROTOCOL
FOR IOWA'S MONEY FOLLOWS THE PERSON GRANT

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Table of Contents

Page

Introduction 3

I. Overview of *the Partnership for Community Integration*...............................6

A. Case Study 6
B. Benchmarks 15

II. Demonstration Policies and Procedures 19
a. Participant Recruitment and Enrollment.......................................19
b. Informed Consent and Guardianship..23
c. Outreach/Marketing/Education...26
d. Stakeholder Involvement 29
e. Benefits and Services...30
f. Consumer Supports..36
g. Self-Direction..38
h. Quality 39
i. Housing..40
j. Continuity of Care Post Demonstration 45

III. Organization and Administration 46

A. Organizational Structure 46
B. Staffing Plan...46
C. Billing and Reimbursement Procedures 47

IV. Evaluation 48

V. Final Budget..49

Introduction

MFP's Role in Furthering Iowa's Rebalancing Goals. *The Partnership for Community Integration* proposes to assist 284 residents of Iowa's ICFs/MR in transitioning to independent settings in the community of their choice, where they will receive the enhanced services and supports they need to pursue their personal goals and to achieve a high quality of life. This initiative, made possible through a Money Follows the Person grant, complements the State's larger strategy to rebalance its systems of long term support for older Iowans and people with disabilities.

The driver for that strategy is the primary value the State of Iowa places on choice. Major milestones in the evolution of the strategy include: (a) development of Iowa's Section 1915(c) waivers and a steady and significant increase since 1982 in the number of individuals receiving HCBS services; (b) Iowa's response to the Supreme Court's *Olmstead* decision, including the issuance of Governor Vilsack's Executive Order 27 mirroring President Bush's New Freedom Initiative, and the establishment of the Olmstead Consumer Task Force; (c) adoption of case mix adjusted reimbursement for Iowa nursing homes; (d) passage of the IowaCare Act in 2005 mandating significant steps to rebalance long term care; and (e) numerous important grant-funded initiatives supporting systems transformation, including the creation of a self direction option for most waiver participants.

Iowa, like many other States, took its first steps towards rebalancing by applying for a Section 1915 waiver in 1982. The "Katie Beckett Waiver" serving an Ill and Handicapped population was followed by six other waivers over the next twenty-four years, providing HCB services to Elderly, people with MR, Physical Disabilities, AIDS, Brain Injury, and children with Serious Emotional Disorders. Presently there are about 23,000 people served by Iowa's seven waivers. The Iowa Legislature has provided consistent support over the years; recent appropriations have helped to reduce most waiver waiting lists. Enrollment has grown by 10%-12% annually since 2003, and expenditures have grown from $176 million in 2003 to $348 million in 2007, or approximately 15% annually, demonstrating Iowans' overwhelming choice to live in the community and the state's commitment to providing and promoting these options.

There are still approximately 26,000 people in nursing homes and 2100 people in ICFs/MR. Iowa has taken steps in the last five years to address the bias towards facility-based care for older Iowans by implementing case mix adjusted reimbursement, by funding case management under the Elderly Waiver, and by streamlining access to waiver services and other assistance programs for older Iowans. Nursing home occupancy is in decline and the average acuity level of nursing home residents has begun to increase.

Work continues on initiatives to support further rebalancing in the aging services system. Under Iowa's Aging and Disability Resource Center project, for example, steps have been taken to improve information and referral and provide web-based tools to assist in planning for long term support needs. In recognition of the significant gap in mental

health services for older Iowans, the Department of Human Services (DHS) has provided funding for the Iowa Coalition on Mental Health and Aging to raise awareness of mental health issues for this population and to develop recommendations to address them. However, the lack of mental health services, particularly emergency services, is only one factor putting older Iowans at risk of institutionalization. There are pervasive capacity issues across Iowa that limit access to home and community based services.

Several important initiatives have been undertaken to increase access to HCB services and to support community participation for people with disabilities of all ages. Iowa's 2005 Real Choice Systems Transformation grant provided support for a legislatively mandated, intensive year long process to develop a plan to reduce populations served by intermediate care facilities for people with mental retardation, and to increase populations served by HCBS. The Enhancing Community Options Workgroup (ECOW), a 30-member stakeholder group established by Iowa Medicaid Enterprise in collaboration with the Governor's Developmental Disabilities Council and the Iowa Association of Community Providers, submitted a comprehensive set of recommendations to DHS to reduce institutional bias and remove barriers to community living for *all* Iowans who need long term supports. Included in the draft ECOW recommendations will be (1) streamlining access to HCBS; (2) the addition to all Iowa's waivers of services critically needed to avoid institutionalization and to maintain community living; and (3) the development of transition services to assist individuals wishing to leave facilities for community living.

As the ECOW was working in the fall of 2006, CMS issued the first round RFP for Money Follows the Person funding. DHS perceived an immediate opportunity to address one of the most significant elements of institutional bias in its disability services system--its high reliance on intermediate care facilities to provide services to people with mental retardation. *The Partnership for Community Integration*, Iowa's MFP proposal to CMS, has thus been incorporated seamlessly into the State's rebalancing efforts. *The Partnership for Community Integration* addresses several significant barriers faced by residents of ICFs/MR: (1) a lack of awareness of, or even misinformation about, community living alternatives; (2) the scarcity of assistance from trained professionals in planning for and accomplishing successful transitions; and (3) an underdeveloped HCBS provider network; (4) the absence of critical services such as crisis intervention and behavioral supports; and (5) inflexibility in program funding, which makes it difficult for many individuals, particularly in rural areas, to find the supports they need.

The design of Iowa's MFP proposal incorporates processes and program initiatives intended to address these four central issues, contributing in a substantial and permanent way to system rebalancing:

1. *Awareness of community living alternatives*. Families are frequently driven to place loved ones in ICFs/MR for lack of any apparent alternative, and once those loved ones are secure and have access to intensive services by trained staff, family concerns and fears about the loss of safety and services constitute the single

biggest barrier to community transitions. MFP's aggressive marketing, outreach and education component will raise awareness of that option.

2. *Transition assistance*. The development of transition services and the formalization of the transition process, coupled with community outreach to publicize their availability, is intended to raise the confidence of families that they will be able to navigate the transition planning process successfully.
3. *Resources for HCBS network capacity building.* Iowa's MFP will allocate an additional $60 million to home and community based services for people requiring an ICF/MR level of care. These resources will constitute a powerful incentive to community providers to expand services, and to ICF/MR providers (with appropriate technical assistance) to diversity their service offerings. MFP will also enhance opportunities for staff training to meet the needs of program participants.
4. *Critical services.* Enhancement of MR and BI Waiver service menus to include additional supports for individuals with mental illness or behavioral issues is widely regarded as one of the most important steps the State of Iowa could take to expand community living options.
5. *Flexibility in service management through self direction.* All MFP program participants will have access to the Consumer Choices Option, which is Iowa's self direction option.

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 ICF/MR settings into qualified community settings.

Continuity of services after an individual completes his or her demonstration year will be guaranteed through access to Iowa's MR, Brain Injury or other appropriate waiver. Sufficient waiver slots have been set aside for the first demonstration year to accommodate people transitioning from ICFs/MR, (IME routinely designates 100 slots annually for individuals transitioning from ICFs/MR) and IME anticipates no difficulty in addressing the needs of MFP participants in future years. Should any shortfall become apparent, DHS will work with the Legislature to ensure the availability of slots and to add important services to the waivers to support successful community living. Any savings accruing to Iowa as a result of the enhanced FMAP will be used to provide these additional services, which, are proposed to be available to all MR and BI waiver participants, not just MFP participants.

As described elsewhere in this Operational Protocol, MFP will not only establish the structures and processes necessary to provide meaningful choices to residents of ICFs/MR, but also, by injecting $61 million into home and community based services, it will build the capacity of Iowa's network of community providers to serve all target populations in need of long term supports.

MFP is one of many past, present and probably future initiatives aimed at rebalancing. Funding from the 2005 Real Choice Systems Transformation grant is being used to support several important and complementary projects, such as the design of a Medicaid-

funded transportation brokerage system, the establishment of a statewide, web-based database of affordable and/or accessible housing, an electronic medical records system, and a plan for a revised approach to reimbursement for services to people needing an ICF/MR level of care. Iowa has just received a 2007 Real Choice Systems Transformation grant to collaborate with CMS in the development of a State Profile tool to measure progress towards rebalancing. DHS will collaborate with the Iowa Department of Elder Affairs (the recipient of the grant) in assessing the effectiveness of the strategies adopted to date, and the identification of what else needs to be done, to eliminate barriers to community living

The Operational Protocol. This Operational Protocol was developed on the basis of recommendations from the Partners Group and its five Subcommittees: Social Marketing, Transition Process, Services and Supports, Housing and Workforce. In total, over 70 people contributed their ideas, their experience and their analysis of the challenges posed by this project. The Partners Group consisted of representatives from consumers and family members, advocates, ICF/MR administrators and staff, community providers, direct care workers, State agencies, case managers, and counties.

Each Subcommittee attempted to anticipate every conceivable programmatic issue within its purview in the development of this Protocol, and the overall management of the project by Iowa Medicaid Enterprise (IME) has been immeasurably strengthened by their work. However, everyone who had a hand in this effort acknowledges that the answers to the big questions are unknown: Who of Iowa's 2,100 residents in ICFs/MR will express the desire to move to more independent settings? What will be their communities of choice? What kind and intensity of supports will they need, and have all of these been anticipated? Can a largely rural State that has depended on facility-based services ramp up to meaningful choices for its citizens in community supports, housing and daily activities?

The experiences of consumers and providers, as implementation of the grant proceeds, will generate important information about what works and what doesn't. IME will continue to consult with the Partners Group over the next four years, and fully expects the Protocol to be modified as necessary in response to emerging conditions.

I. Overview of the *Partnership for Community Integration*

A. Case Study

This case study is fictitious but based on experiences which have either been commonly encountered by staff at Iowa's ICFs/MR as they assisted hundreds of residents in transitioning to community settings over the past several years, or are unique challenges with implications for various components of Iowa's Operational Protocol. One of the biggest barriers to transitioning has consistently been the opposition of parents, guardians and legal representatives, and the process of marketing MFP has therefore been thought through in great detail.

Background. John Smith, age 24, has lived in the ICF/MR for ten years. He has a diagnosis of moderate mental retardation and qualifies for an ICF/MR level of care. John needs reminders to take his medication every day and at the prescribed times but accomplishes his personal care independently. When John has difficulty communicating his thoughts, and when he becomes frustrated, scared or does not want to do something, his behavior can escalate to the point he is a danger to himself or others with aggressive physical actions and verbal outbursts.

Until the age of 14, he lived with his parents in Manchester (Delaware County), a two hour drive from the ICF/MR. When he entered adolescence, his behavioral issues became extremely challenging for his parents, who were both working and had difficulty finding safe supervision for John during working hours. John's only sibling, an older sister, was away at college and could offer only limited help. John's aggressive outbursts were most common at school but also occurred at home and with his respite workers. When the situation became increasingly difficult, John's parents asked the county's targeted case manager to help them find an out-of-home placement for him in the Manchester area, either in a small, four-bed community ICF/MR or in residentially based supported community living. They were unsuccessful, and became exhausted and fearful that John would hurt someone, and that then they would have to quit their jobs for lack of an alternative way to provide care. When John eventually struck a teacher who was trying to prevent him from self injury, the Smiths became distraught and decided that placement in the ICF/MR two hours away from their home was their only option.

Over the next ten years, they became very satisfied with the services John received, and relieved that there were no more worries about his safety or the safety of others. They learned very early on that John's behavioral outbursts had been diagnosed as symptoms of an anxiety disorder, co-occurring with his MR, and saw that John benefited significantly from medications. His aggressive outbursts, initially frequent and severe, subsided. ICF/MR staff informed them that many individuals with MR have co-occurring mental health conditions that go undiagnosed and untreated. They were impressed at the skills demonstrated by ICF/MR staff in behavioral intervention, and felt confident that John was happy there. Because John had been overweight for a number of years, staff encouraged him to choose healthy snacks and to get physical exercise. He had lost some weight and appeared healthier. He developed better skills in social interaction and particularly enjoyed the company of two other residents of approximately the same age, named Joe and Mike.

Iowa's Resource Centers and many community ICFs/MR have taken steps to facilitate the re-integration of residents into the community. Each individual has a discharge plan based on an assessment of the resident's needs and the barriers he or she would face upon return to the community. Staff at John's ICF/MR have always believed him to be an excellent candidate for transition to a more integrated setting. They have tried over the years to discuss John's discharge plan with his parents, but have been met with great skepticism. The plan would entail moving John to a house or apartment in the community and providing services under Iowa's MR waiver. John's parents share their concerns about the lack of crisis intervention services under the waiver, and that they

have heard stories from other parents that community provider staff in their area still lack training in dealing with the behavioral issues of people in community living situations.

Identification of John as a Candidate for MFP Participation. The Smiths become aware in the fall of 2007 that Iowa is planning implementation of a $60 million Money Follows the Person grant. Their first concern is whether the State will force John to leave the ICF/MR; they are determined to resist any discussion of transition for fear that if the move is a failure they will have no option left but to assume responsibility for his care. In June 2008, they receive a letter from the Iowa Department of Human Services (DHS) notifying them that under Iowa's *Partnership for Community Integration*, the State will offer transition assistance and enhanced services to interested residents of ICFs/MR and their families/guardians/legal representatives. The letter invites family members to attend an upcoming meeting in the county to learn about this option, and provides the name of the transition specialist in their region.

Although the letter stresses that no resident will be forced to transition, John's parents are alarmed and contact the Delaware County Central Point of Coordination (CPC) for disability service. The CPC has received information about MFP from DHS at various CPC meetings and conferences. The CPC has also just been notified in writing by DHS that communications are being sent out to the contacts of record for ICF/MR residents from Delaware County. The CPC shares information about MFP with the Smiths, reinforces that participation in MFP is an option, and encourages attendance at a community meeting in Manchester. The Smiths do so, if only to reassure themselves that John does not have to participate in MFP.

The meeting is run by the regional transition specialist, and a number of community providers are also present. A young woman with MR talks a little about her move to the community from one of the Resource Centers, and her parents share their story about the evolution of their feelings about her move, from skepticism to gradual acceptance, and eventually enthusiasm for her successful adaptation to community living. She has learned how to ride the bus, has a job laundering towels for a local beauty salon, and enjoys bowling. Her family is now able to spend much more time with her, because she lives in the same community and it is easy for them to help her attend family gatherings or celebrations.

The community providers talk about their work with the transition specialist to identify service gaps locally, and about the new services they are prepared to offer which will be paid for under the grant. Several of these new services will become permanent additions to Iowa's MR and BI Waivers if the Legislature agrees. The remarks of greatest interest to the Smiths concern the requirement under the grant that people who transition are assured continuity of service after the period of the grant ends. Written materials about MFP are distributed, and the transition specialist describes how the process works. The Smiths learn that the next parents' advisory group meeting at the ICF/MR will offer additional information, and they make it a point to attend.

At this second meeting, they happen to meet the parents of both of the young men with whom John has become friends. These parents have become interested in the idea of transitioning, and have been talking to Joe and Mike about whether they would like to move in together in an apartment in Waterloo, where Joe's family lives, and which is about a half hour's drive from Vinton, where Mike's family lives. Waterloo is also about a half hour west of Manchester. Joe and Mike like the idea of moving. Their families have already been in contact with a transition specialist, who has begun to set up a planning team for each of them.

The Smiths become very concerned about John's reaction to separation from his friends, and the suggestion is then made that he make the move with them. An ICF/MR staff person informs the Smiths that transition planning for the three men can be coordinated, explains the close working relationship that ICF/MR staff have with regional transition specialists around the State, and makes specific suggestions about how the individual needs of the three young men might be met in the community.

The Smiths hesitantly agree to explore the option, and sign an informed consent form provided by the ICF/MR, with the understanding that this is only for the purposes of information gathering. They are given a packet of materials. It details John's rights and responsibilities under MFP, and includes a series of consent forms that will have to be signed by them at each critical step in the process, ensuring their control in the decision-making process. John then becomes a candidate for transition under MFP.

Preliminary Planning. Once the informed consent form is signed, the ICF/MR staff person begins to follow MFP transition procedures. She notifies the regional transition specialist for Waterloo, whose territory also includes Manchester. She begins to assemble a referral packet for the specialist, which includes the informed consent form, the current discharge plan, documentation of John's legal status under the guardianship of his parents, John's most recent diagnostics and medical and dental records, his current program plan, and his social history. She also takes steps to ensure that the teams ("IDTs") that are being established to help Joe and Mike plan for their transitions are informed that a third ICF/MR resident may be interested in moving to the community with them.

The transition specialist verifies through the ISIS system (the State's electronic information system which tracks enrollment and service management for people receiving long term, Medicaid-funded supports) that John is Medicaid eligible and has resided in the ICF/MR for at least six months.

In a couple of days, the transition specialist calls the Smiths and offers to meet with them either in Manchester or, preferably, at the ICF/MR with John. The Smiths, who are both still working, set up a Saturday appointment at the ICF/MR. At the first meeting, they are joined by the ICF/MR social worker and a direct care worker who knows John well. The transition specialist has reviewed John's referral packet, and gets to know him and his parents. He asks John about the things he does and does not enjoy, including being with his friends, and John's responses are affirmed by the direct care worker. Everyone listens

to the things that worry John's parents about the idea of his moving into an apartment, and their description of an ideal environment for John. John agrees with his parents' description of an ideal environment, and says he wants to live with his friends from the ICF/MR, in a house or apartment that they would share.

The social worker then reviews John's current program and his discharge plan, and the transition specialist describes the ways in which John's needs could be met in Waterloo. He describes what the State of Iowa is trying to do under MFP, and the work being done by regional transition specialists to build the capacity of communities to support people's independence and participation in work, school and recreation. Finally, he reviews the materials that the Smiths received at their last visit to the ICF/MR, explaining the process and the rights and responsibilities of consumers and their family members and/or guardians.

The transition specialist has already completed this initial step with John's two friends and their families, and has initiated the planning process for them. He suggests that if John's parents sign a consent form to initiate transition planning, he can begin to contact providers in Waterloo. He also begins to work with all three residents and their family members to help them plan how they will share the decision making process needed in order to become successful roommates. This includes how to solve problems and define the tasks each is expected to carry out when living together. An Interdisciplinary Team (IDT) with representatives of community providers will be pulled together for each man to develop a transition plan and a plan of service. The Smiths agree to this next step. The transition specialist asks John whom he would like to help him plan his move to Waterloo. John wants the ICF/MR social worker, his direct care worker, his two friends, and his parents to help. The specialist asks if he can pull in some people from Waterloo, including a county service coordinator and a provider of supported community living (SCL) services, and John agrees. The specialist provides John's parents with the web sites and contact information for SCL providers in Waterloo, and asks that they work with John to choose one for the IDT. John's parents say that they want the provider who will be serving Joe and Mike to participate in John's IDT.

The transition specialist notifies the local DHS Income Maintenance worker to initiate the necessary paperwork to enroll John in MFP, and also the County CPC. The transition specialist not only serves as the initial point of contact for the Smiths, but will assume full responsibility for case management after John has moved to Waterloo. A targeted case manager will transition John to the MR waiver on the 366th day after transition, and will continue to work with John from that point on. The Supported Community Living (SCL) service provider who will provide services to Joe and Mike is contacted by the transition specialist about doing the same for John, with the understanding that John will nevertheless be able to choose his providers.

The SCL provider informs the transition specialist that Joe, as a wheelchair user, will need accessible housing, which is in short supply in Waterloo. The provider assumes that resources for home modifications will be necessary. The transition specialist agrees that this needs to be taken into account in the joint planning for the three men's transitions.

While the transition specialist is ultimately responsible for ensuring that the men have a choice of qualified housing, the suggestions for sites can come from a number of sources. Joe's family has taken an active interest in finding a place for him and his friends, and the three families spend a lot of time talking to the men about what kind of neighborhood they would like and the things that are important to them. The SCL provider, who has helped many individuals find appropriate housing in Waterloo and neighboring communities, also has suggestions. Although the Iowa Finance Authority's web-based Housing Registry is still in development in 2008, it will soon provide a database on affordable, accessible units. For now, the IDTs for the three men work closely with them on the issue of where to live.

Transition Planning Process. The IDT has its first meeting with John at the ICF/MR. The three friends confirm that they would like to live together in Waterloo, near Joe's parents. The IDT asks questions about whether John would like a job or would like to volunteer, what he likes to do with his leisure time, what new things he would like to learn how to do, whether he wants to join a church, etc. John says he wants to work because he likes to see people every day. The ICF/MR social worker, who has known John for five years, shares information about John's skills and abilities, and John and the team talk about the kinds of work and work environments that would be a good match. The team discusses transportation options with John. John says he used to like to ride his bike, but was afraid to ride it on the street.

The transition specialist explains that there are two ways that John can get what he needs in the community. He can work with an agency that provides the supports he needs to live in the community, and he can rely on that agency to make sure that someone is there when he needs help. Alternatively, he can "self direct" some of the services he needs. Iowa allows people using HCBS waiver services to hire their own help for services that do not require a licensed professional, and to purchase goods and products that are important to independent living. Iowa's "Consumer Choice Option" (CCO) is available to MFP participants. In John's case, for example, he can use money from his individual budget to take part in a fitness program, where he can ride an exercise bike, and to pay for the bus to and from there, which can help him to stay healthy and reduce the risk of social isolation. John eventually chooses to self direct some, but not all of his unlicensed services with the help of his sister, who now lives in Independence, twenty miles west of Manchester. His sister wants to become trained to serve as his Independent Support Broker (ISB). She understands John's interest in finding a job where he can be with people, and wants to volunteer her time to help John find someone to support and coach him in a work setting. The transition specialist provides her with information on ISB training scheduled soon in Cedar Rapids. As John's ISB, she becomes part of his IDT.

In the next meeting a few weeks later, the IDT works with John and his friends to choose service providers to address all of the needs identified in their assessments, zero in on employment possibilities, and identify emergency back-up plans. John's sister had already talked to him prior to the meeting about choices he can make under the self direction option, and she and the IDT assist in the development of his budget for services eligible under the CCO. A notification is sent to the Financial Management Services

provider, and they begin the necessary paperwork for John's services. They use the system established for the CCO under the waivers, but John is identified as an MFP participant, so his expenditures will be tracked separately. A plan is made for John, his friends, and their parents to gather on the north side of Waterloo within the month and visit several apartments.

John's emergency backup plan takes into account all of the risks he will face in community living, including the possibility that he may need crisis intervention or behavioral support services. The SCL provider in Waterloo can ensure access to those services, and John also has access to a Personal Emergency Response System (lifeline). (Although staff will be present in the apartment around the clock, John expects to move about the community independently.)

At this point, an issue arises which threatens to derail the planning process. John's friend Joe, who uses a wheelchair, has a rare orthopedic condition that impacts his respiratory system and requires monthly monitoring from a medical specialist. Joe has had access to these specialized services at the ICF/MR, but the only provider in Waterloo is closing his practice. The nearest provider would be in downtown Cedar Rapids, almost an hour from Joe's parents' neighborhood. Joe's parents consider withdrawing from the plan because they do not know this provider and fear that Joe will not have ready access to the services when he needs them. The fact that Joe may not make the move makes his two friends less certain about it themselves.

The transition specialist discusses options with the families, including the possibility of a move to Cedar Rapids instead of Waterloo. It makes no difference to either John's or Mike's parents, as they would have about the same drive to visit their sons. Joe's parents would not have the same convenience but it would be better than what they have now, and Joe has an uncle in Cedar Rapids. The families agree that they would like to pursue this option.

The transition specialist, however, does not serve Cedar Rapids. He explains to the three men and their parents that each specialist works hard to develop relationships with providers and landlords in his or her service area, and that if they want to consider a move to Cedar Rapids, the transition specialist for that area could provide important help. He asks if he can involve the Cedar Rapids specialist in the planning process, and the families agree. He then alerts that specialist, gives her the contents of the ICF/MR's referral packets for the three men, his file notes, and notes from the IDT meetings, and sets up a teleconference for the three friends, their parents, John's sister, the ICF/MR staff, and the two transition specialists. The Cedar Rapids specialist reviews the notes ahead of time, and is able to share a lot of information during the teleconference about available supports in Cedar Rapids. All three men and their families express a willingness to continue.

The IDT meets again with the families several weeks later, in Cedar Rapids. (The ICF/MR staff have driven the three men to the meeting.) The composition of the team has changed slightly, with a new transition specialist and a new SCL provider chosen by

the three families, (who are now working very closely together), but the original transition specialist also attends to make sure that no information or planning elements previously put together are lost in this next round of discussion. During this visit, the three men and their families look at apartments suggested by the SCL provider and also by Joe's uncle, and John meets two prospective employers—a grocery store and a large hospital. The hospital contact resulted from John's sister's efforts; she knows a retired hospital worker who is willing to serve as John's job coach under the Consumer Choices Option. John chooses this job and the self directed support services.

At this point, a new equally serious issue arises, this time in planning for John's supports. The SCL provider does not have the staff capable of providing the behavioral intervention called for in John's transition plan. The ICF/MR social worker acknowledges that this has been a very significant barrier to many transitions. The two transition specialists review with the team the supports provided under Money Follows the Person. The project will cover the costs for ICF/MR staff to share their experience, prior to the transition, with the SCL provider's staff in identifying and responding to John's behavioral/mental health support needs. Under the terms of the provider agreement, ICF/MR staff will stay involved with John and the SCL staff, doing follow-up calls and visits for the first 60 days after transition. The SCL provider agrees to have staff properly trained, which will build the agency's capacity to assist other individuals as well. Many Iowa ICFs/MR also provide HCB services, and the transition of MFP participants to more independent settings will increase demand for their crisis intervention and behavioral support services.

The final planning stages go quickly. Given a choice of retaining either the Waterloo or Cedar Rapids transition specialist, the families decide to use the services of the Cedar Rapids specialist. Service providers sign agreements, the three men interview several direct care workers and choose the one who will live with them in their apartment, and employment services are arranged in cooperation with prospective employers. The men and their families choose a suitable four-bedroom apartment from several that they visit. The direct care worker who will be living with them spends two days at the ICF/MR, getting to know them and learning from ICF/MR staff how to provide what they need. The transition specialist helps the three men apply first to the Local Public Housing Authority, for housing vouchers to provide rental assistance, and then, when notified that no vouchers are currently available, to the Iowa Finance Authority for assistance under the HCBS Waiver Rent Subsidy program. Arrangements are made for local medical, dental and pharmaceutical services. A transition timetable is developed specifying a date certain for transition and the dates for which the necessary community services will begin.

The Transition and Demonstration Year. The three men's individual transition plans are finalized, and the families sign informed consent to the actual transition. A security deposit and utility deposits are placed on the apartment, and MFP grant funds are used to provide necessary modifications. Some grant funds are used to furnish the apartment, but the families enjoy supplying many items themselves. The grant funds can also be used to

purchase additional clothing for John, who will be delivering mail in the hospital, and will be spending more time outside his new residence than he did at the ICF/MR.

The ICF/MR and the SCL services provider arrange for an overnight stay for the men in the Cedar Rapids apartment, with staff from both the ICF/MR and the SCL provider on-site. Mike demonstrates significant anxiety at bedtime, engages in inappropriate behavior, and does not go to sleep until 4:00 AM, but is calm when he wakes up. He states that he still wants to move. However, the plan for modifications to the apartment did not take into account the turn radius from the living room into the kitchen required by Joe's wheelchair, and arrangements are made with the contractor to widen the doorway. The target date for transition is postponed.

The ICF/MR staff and the SCL services provider execute agreements for the transfer of responsibilities for John's services. The transition specialist contacts the DHS Income Maintenance Worker to close out the ICF/MR services and transfer the individuals to grant-funded services. The men are moved without incident, bringing several days worth of medications with them. The transition specialist confirms that all essential services commence as scheduled and then assumes responsibility for monitoring and on-going case management.

John learns the bus route to get to his job at the hospital, and to his exercise program, and greatly enjoys the sense of freedom this gives him. Six weeks after he has started his job, however, he accidentally gets on the wrong bus. When he has ridden the bus for a long time and it has not gotten him to the hospital he becomes increasingly anxious, gets out of his seat and begins yelling. Passengers become alarmed and the bus driver tells him to get off. John has no idea where he is. He is forced off the bus and left on the sidewalk, where he continues to yell. A passerby calls the police on her cell phone. When they arrive and take John to the station, they notice John's PERS, which he has forgotten to use, and they help him to make the call connecting him to a familiar staff person. An SCL staff person arrives, is able to calm him, and is allowed to take him home.

John has a terrible evening. Joe and Mike make jokes about the bus, and John becomes aggressive. The staff tells John that someone will ride with him on the bus the next day, and John says he does not want to go to work because he is afraid his boss will be angry. Attempts to talk through the situation fail, and John's behavior becomes more than the SCL staff know how to deal with. They contact the ICF/MR staff for consultation, and because the ICF staff had not seen this kind of behavior from John in the time they had worked at the facility, they advise the SCL provider to contact the crisis intervention service. The grant funds these services in recognition of the behavioral health needs of many ICF/MR residents who transition. A phone call is placed to the service provider, who suggests strategies to help John get through the night, but agrees to provide on-site support within 24 hours.

The SCL staff notify John's parents and the transition specialists of what has happened. John's mother is extremely upset, because these outbursts and the potential for John to become violent were the main factors originally in his placement at the ICF/MR. She

expresses regret over John's transition. Staff reassure her that community supports are in place to help John stay in the community.

The crisis intervention service provider steps in immediately to de-escalate the situation and determine the need for further assistance. John receives a complete assessment, including a review of his medical history. An adjustment in John's medication is recommended for his co-occurring disorder. A behavioral specialist works on a plan with John and the SCL staff, for him to deal more appropriately with situations that provoke his anxiety. He is encouraged to use the PERS whenever he becomes frightened, and he is given a card to hand to a bus driver if he thinks he is lost, explaining his need for assistance. John is reluctant to use the bus, but staff remind him of how much he enjoyed the freedom public transportation provided him. He is taken to visit the public transit offices, where he learns about routes that take him to places he might want to go. Staff ride the bus with him until his confidence returns and he takes up his original routine.

The transition specialist meets monthly during the next year with John and his parents to assure the adequacy of services under John's plan, to provide quality assurance monitoring under the MFP grant, and to identify implementation issues that need to be considered in grant management. If problems arise the transition specialist assures that the parents are informed and involved in helping John find a solution. During the annual evaluation process the Smiths share how pleasant it has been, watching their son grow more independent and seeing him happier than they had ever anticipated. They also volunteer to talk with other parents that are concerned about their loved one transitioning back to the community from an ICF/MR setting.

Post Transition Period. Sixty and again thirty days prior to the expiration of John's demonstration year, the electronic ISIS system notifies the transition specialist and other personnel tracking case files that he will be transitioning from grant-funded services to the MR waiver, and the ISIS indicates the services to which he will have access under the county system. These services consist of Iowa's MR waiver services (the equivalent of the HCB program services he has been receiving), which have been augmented by legislative action to include crisis intervention, behavioral programming, and mental health outreach. A targeted case manager is assigned, and arranges for annual re-assessment of John's level of care needs. Thirty days prior to this change in John's status, the targeted case manager and transition specialist meet with John and his family to clarify that it will be seamless and that John will see no changes in his Supported Community Living situation, his daily activities, or his self direction option. Together the transition specialist and the family complete the customer satisfaction survey, and John and his family are informed that there will be a follow-up a year later to see if John is still happy with his situation. The transition specialist ensures that all MFP reporting requirements are met, and on day 366 after John's transition her involvement with his case ends.

B. Benchmarks

The benchmarks for Iowa's progress in transitioning individuals and rebalancing its long term care system are as follows:

1. The projected number of eligible residents of ICFs/MR to receive assistance in transitioning to a qualified residence during each year of the demonstration:

	Individuals with MR/DD	"Other" (E.g., People with brain injury)	Total individuals to be transitioned
2008			9
2009			50
2010			75
2011			75
2012			75

2. IME proposes to look beyond the number of transitions to assess the effectiveness of the transition model that has been outlined in this Operational Protocol, including outreach to, and education of families, the quality of transition planning in developing meaningful options for individuals, and the sustainability of transitions. IME's web-based Individualized Services Information System (ISIS), which tracks the case history of all Medicaid members, will be used to develop reports on the effectiveness of marketing to all 2079 ICF/MR residents and their families/guardians/legal representatives; the confidence these individuals have in the program; the ability to sustain people in the community successfully over time; and their satisfaction with community living. Numerical targets will be as follows:

a) Percentage of individuals/family members/guardians notified about their options under MFP who consent to begin transition planning

2008	2009	2010	2011
5% (103)	7% (146)	9% (187)	11% (228)

b) Percentage of individuals who began transition planning that ultimately make the decision to transition

2008	2009	2010	2011
73% (75)	78% (113)	81%	82%

IME will track the reasons why individuals and families choose not to transition. As confidence in the program increases, as awareness of success stories rises, and as adjustments are made to the program in response to issues and concerns, there should be a steady increase in the percentages reflected in (a) and (b) above.

d) Percentage of individuals transitioning who are living successfully in the community at the end of the grant period

2008	2009	2010	2011
95%	96%	97%	98%

In this instance, IME will on both ISIS data to confirm the individuals' service setting, but also on annual customer satisfaction surveys to determine that individuals are receiving the services that they need and that they are satisfied with their living situation. IME will also track, for those individuals who re-enter institutions post-transition, the factors responsible and a determination whether modifications to the transition model are warranted.

e) Percentage of individuals transitioning who report a preference for community living over institutionally based services

2008	2009	2010	2011
100%	100%	100%	100%

2. The qualified HCBS expenditures during each year of the demonstration program (2008 through 2011), with increases over 2006 spending currently projected at:

Year	Projected HCBS Expenditure	Iowa MFP Expenditures	Total Qualified HCBS Expenditures
2006	$323,947,388	0	$323,947,388
2007	$350,878,716	0	$350,878,716
2008	$367,779,304	$8,790,000	$376,569,304
2009	$381,852,080	$13,243,713	$395,095,793
2010	$402,578,105	$17,697,351	$420,275,456
2011	$425,043,037	$22,150,800	$447,193,837

3. Increases in available and accessible supportive services for consumers beyond those used for MFP transition participants.

Iowa proposes that at a minimum the following services be added to the MR Waiver:

- Mental health outreach
- Behavioral programming
- Crisis intervention services

Although the principal purpose of these additions would be to ensure sustainability of MFP participants in the community, they would be available to non-MFP participants as well. The addition of these services beginning in 2009 will eliminate barriers to community living for many people besides MFP participants, and make permanent contributions to a rebalanced system. DHS has global budgeting authority over

appropriations to Medicaid; this flexibility and the savings from the enhanced FMAP under MFP will allow IME to use resources to support people's choices.

Anticipated Utilization of Additional Mental Health Services

	2009	2010	2011
Mental health outreach	500	600	1000
Behavioral programming	500	600	1000
Crisis intervention	500	600	1000

4. Systemic improvements in the State's ability to identify and respond to the needs of people with MR requiring an ICF/MR level of care (LOC).

The assessment tools used to establish level of care for individuals seeking ICF/MR or waiver services have not been standardized throughout Iowa. IME plans to develop a standardized functional assessment tool to establish service needs, first, for all individuals residing in ICFs/MR, and then for all individuals receiving MR waiver services and for those applying for ICF/MR or HCBS services. Implementation of a uniform functional assessment would assist IME in identifying community service gaps which would constitute barriers to transition of individuals residing in ICFs/MR, leading to development of strategies to improve access to those services through such initiatives as workforce development, provider incentives, etc. Implementation of the standardized assessment will also allow Iowa to continue to make progress in individualizing service and support plans.

Process-based indicators of success are as follows:

- 2008: The appropriate assessment tool is identified and as necessary, refined (e.g., to identify individuals with issues related to co-occurring mental illness);
- 2009: The tool is implemented for ICF/MR residents at the time of their annual re-assessment;
- 2010: Functional assessments for all 2100 ICF/MR residents are completed, and is begun for individuals currently receiving MR waiver services; an analysis of unmet service needs statewide is completed;
- 2011: Functional assessments are completed for all individuals receiving MR waiver services (currently 10,113).

5. Measurable improvements in quality of life for Iowans requiring an ICF/MR level of care (LOC), and their families.

a. IME anticipates that the State of Iowa will have an enhanced capacity to address the needs of its citizens with significant LOC needs, and that this will be demonstrated by the number of people returning to Iowa from institutionally based care out of State, and by all families and their loved ones opting for in-State services;

b. IME will strive for the goal of 100% of transitioning Iowans reporting increased satisfaction with their quality of life, including satisfaction with the elements of community participation, reduced social isolation and strengthened family relationships. The Iowa QoL survey will develop data on the extent to which participation in MFP has reduced the geographic separation of individuals from their families, especially those from rural areas.

6. Interagency and public/private collaboration.

The *Partnership for Community Integration* provides a fresh opportunity to promote greater coherence in Iowa's public policies on disability and to improve coordination among a variety of programs supporting independence, choice and community inclusion.

DHS, Iowa Finance Authority (IFA), and local landlords. The availability of affordable, accessible housing for MFP participants is a key concern. IFA has committed to partner with DHS in implementation of MFP, by working to ensure sufficient legislative appropriations to support the State-funded HCBS Waiver Rent Subsidy program, which will serve as the affordability safety net for MFP participants, and by assisting transition specialists in understanding housing assistance programs and securing the participation of local landlords. Utilization of the HCBS Waiver Rent Subsidy program by MFP participants, over the period of the grant, is anticipated at the following rate:

Number of MFP Participants Accessing HCBS Waiver Rent Subsidy Program

2008	2009	2010	2011
20	48	66	113

The above figures assume an overlap from one year to the next due to an average twelve month waiting list for housing vouchers.

With funding from Iowa's 2005 Real Choice Systems Transformation grant, IFA is also developing a statewide, web-based Housing Registry providing information on affordable housing. A major component of this initiative will be the marketing of the Registry with landlords to build a database of sufficient size to be helpful to consumers, families and transition specialists in developing a choice of qualified residences.

II. Demonstration Policies and Procedures

a) Participant Recruitment and Enrollment

The target population for the *Partnership for Community Integration* is individuals with mental retardation and related conditions who are residing in intermediate care facilities

for people with MR. Both adults and children will be eligible for participation, and demonstration policies and procedures described in this Protocol will essentially be the same for adults and children. Qualified residences are expected to include the family home for some participants. Children may also receive residentially based supported community living services if determined appropriate by their transition planning team.

i. Participant Selection. Systematic identification/targeting of ICF/MR residents is not anticipated at this time. Participants will generally self select as the MFP demonstration commences. All ICF/MR residents are considered eligible for participation in MFP if they meet the two basic requirements: six months' residency in the ICF, and eligibility for Medicaid. Residency and Medicaid eligibility can be confirmed through IME's electronic consumer case file system. Medicaid eligibility is routinely handled by DHS Income Maintenance workers. Ensuring staff competence in determining MFP eligibility is therefore not an issue.

Three parallel strategies in participant recruitment will be employed. The first strategy is to integrate MFP seamlessly with the transition work that has been underway since 2004 under the State's consent decree with the Department of Justice. The State-run Glenwood and Woodward Resource Centers (Iowa's largest ICFs/MR) have identified several dozen candidates for transition, using current Center procedures which have served as a model in development of the MFP transition process. The candidates have expressed interest in transitioning, and their service needs and the barriers to community living have been identified. Not all guardians involved with these individuals have given their consent, and some may not. However, initiating the MFP transition process for these candidates will allow the demonstration to get underway promptly, and generate information very quickly about any improvements that need to be made in the Operational Protocol.

The second strategy is similar to the first, but focuses on large community ICFs/MR which have expressed interest in active involvement in MFP, and which have in many cases also identified residents in their facilities that seem to be good candidates for transition. The assessment and transition processes used by community ICFs/MR, if they have in fact already helped residents get access to the waiver in the community, may or may not be well-developed, but some have succeeded in closing down residential buildings on their campuses as they have transitioned residents to HCBS. A work group of interested ICF/MR administrators has been convened to look at their business concerns relative to MFP, and as strategies to address those concerns are developed in consultation with IME, individuals that the administrators have identified as candidates for transition will be targeted in the first year.

The third strategy is to launch, in February 2008, the Outreach/Marketing/Education program described in detail in Section II.C (assuming Iowa's Operational Protocol has been approved), and to send written communications to all ICF/MR residents and their families/guardians/legal representatives inviting them to notify their ICF/MR staff or the regional transition specialist of their interest in transitioning, and/or to attend an informational meeting in their area to meet their specialist. Informational community

meetings will be held throughout the State, and will include meetings early in the implementation period at large and medium sized ICFs/MR. The transition specialists will follow up promptly to any request for assistance.

The third strategy relies entirely on self-identification, to be encouraged through social marketing efforts. The limitations of this approach are obvious—individuals and families may resist consideration of the transition option due to ill-founded concerns, for example, and ICF/MR staff and communities may not be proactive in marketing MFP for the same reason. It is likely, however, that the conditions for recruitment and enrollment will evolve over time, due to emerging transition success stories, heightened demand for HCBS services and the availability of technical assistance to ICF/MR operators to develop them, and improved data from assessment of all ICF/MR residents on level of care needs. IME is also contracting with a private firm to assist in outreach and marketing to families.

Data generated from the functional assessment of ICF/MR residents can possibly also identify residents who might be candidates to explore transition options. Although self-identification will be the principal way in which candidates will emerge, and all ICF/MR residents are eligible and potential candidates for MFP participation, the functional assessment can generate data allowing for a certain amount of targeting. It is clear that many ICF/MR residents have a level of care on a par with individuals who are living successfully in the community. This is likely to be true of many residents who have lived at the ICF/MR for years, dating back to a time when few HCBS options existed. People need to know that their service needs can be met in the community—and on the other hand, if those services are not available, the gaps need to be addressed by building network capacity.

ii. Qualified institutional settings. The institutional settings from which individuals will be transitioning are Iowa's 140 intermediate care facilities for people with mental retardation licensed by the Iowa Department of Inspections and Appeals and cited specifically by Section 6071(b)(3) of the Deficit Reduction Act as an qualifying "inpatient facility." Included in this group are Iowa's two Resource Centers at Glenwood and Woodward.

(*iii*) *Minimum residency period.* Eligible participants must have resided in the ICF/MR for at least six months. Compliance with this requirement will be confirmed by data recorded on the DHS Individualized Services Information System (ISIS). Among the information on Medicaid member services which is tracked by ISIS is the date at which service commenced and the provider.

(*iv*) *Eligibility for Medicaid.* Eligibility for Medicaid for the month prior to transition will be determined by the local DHS Income Maintenance worker, contacted by the transition specialist at the onset of transition planning.

(*v*) *Policy regarding re-enrollment into the demonstration after re-admittance to an institution.* Participants who are hospitalized or re-admitted to an ICF/MR during their

demonstration year will be immediately disenrolled from MFP, but will be eligible for re-enrollment for an additional period which, combined with the number of days in which they previously received demonstration services, does not exceed a total of 365 days. Re-enrollment will be authorized only if the following conditions are met (participants would still have access to expanded waiver services assuming the Legislature approves the expansion.

a. The individual was hospitalized for a condition(s) unrelated to his or her diagnosed disability or disabilities, for a period of sufficient duration that he or she lost access to the original qualified residence, and/or the services of the original community provider(s) is no longer available, and an updated assessment indicates that the individual can successfully return to the community only with demonstration and supplemental services available under MFP; ***or***

b. The individual was re-admitted to an ICF/MR or hospitalized for a condition related to a diagnosed disability or disabilities for a period long enough to lose access to the qualified residence and/or the services of the community provider, and an updated assessment indicates that the demonstration and supplemental services currently available under MFP, are both necessary and sufficient to enable a successful return to the community when coupled with other Medicaid and non-Medicaid services for which the individual is eligible. The individual's revised transition plan may call for a higher intensity of MFP services, but not for the creation of new MFP services.

A determination will be made by the IDT prior to discharge as to whether and/or how the conditions that led to hospitalization or re-admission to an ICF/MR were related to an individual's primary disability and whether more intensive services are required.

(*vi*) *Procedures to ensure informed choice, including safeguards against abuse and neglect.* Information dissemination to consumers, families, guardians and legal representatives about MFP in general will occur through (1) media publicity and State web postings about the transition option MFP offers to ICF/MR residents; (2) community meetings geared to concerned families/guardians/legal representatives, providing general information and an opportunity to get specific questions answered; and (3) one-on-one discussions between interested consumers and families/guardians/legal representatives and transition specialists, where the information becomes very specific to a consumer's situation and sequential decisions are made to continue the transition process. Consumers and family members will have access to written information in each of these three situations and in increasing levels of detail. This is described at greater length in the following section, and copies of written information materials are attached in Appendix A.

The health and safety of their loved ones is likely to be the single greatest concern for most families, and the program cannot succeed unless it provides satisfactory assurances in this regard. Emergency back-up plans are one component of transition plans addressing these concerns. Safeguards against abuse, neglect and exploitation are

another. MFP participants will be provided with essentially the same information and tools for preventing abuse and neglect as are now available to consumers participating in Iowa's HCBS Waivers in Iowa. Safeguards exist at three levels. First, case managers provide consumers and family members/guardians/legal representatives with written information on abuse and neglect, which is included in the individual's safety plan. (This responsibility will be assigned to the transition specialist under the MFP demonstration.) The materials are contained in Appendix A - 4. The ISIS system will record the date on which the information was provided. The information is also provided in the Consumer Manual (Appendix C - 7). Every time an individual's service plan is revised/updated, this information will be provided again. The number to call to report abuse and neglect will be posted on a refrigerator magnet in the individual's residence.

Providers are obliged to report incidents. The case manager (or, under MFP, the transition specialist) is the local contact for such reports and complaints. Second, there are system-wide protections through the DHS Adult Abuse and Child Abuse and Neglect programs, through which reports of abuse and neglect can be made either to Protective Service Units in DHS county offices or by calling a toll-free 24-hour hotline number (1 800 362 2178). Third, the quality assurance system for HCBS Waivers, which will apply to the MFP initiative as well, includes methods for identification of abuse in participant experience surveys. IME's Quality Management Team meets weekly to review complaint/incident reports and look for trends among individual providers as well as systemic patterns among providers. There is appropriate follow-up, such as additional training.

The transition specialists will have primary responsibility for ensuring consumers and families are informed about their rights and responsibilities under MFP, including a thorough discussion of the risks of transition and safeguards that can be put into place. This will occur at the point leading to the consent to begin the transition planning process, again where the consent to transition is signed, and any time the service plan is altered. As the consumer moves to the HCBS Waiver system at the end of the demonstration year, it will be the targeted case manager's responsibility to review the safeguards against abuse and neglect with the consumer, and annually thereafter.

b) Informed Consent and Guardianship

(*i*) *Description of procedures used to obtain informed consent from participants.*

The transition process, including steps to ensure that consumers and family members/guardians and legal representatives are fully informed about the process, the services and supports to be provided during and after the demonstration year, and their rights and responsibilities as MFP participants, is defined as follows, picking up from the point that either an ICF/MR resident or family member/legal rep first expresses an interest in or desire for transition:

1. Initial referral: (a.) With the signed consent (Appendix A – 1: Consent to release case information) of the resident, family member or guardian, the ICF/MR staff person

contacts a transition specialist from the region to which the resident has expressed an interest in moving. If the resident has expressed no community preference, the staff person will contact the local transition specialist. (b.) The ICF/MR staff person provides the resident/family member/guardian with a standardized information packet (Appendix A – 4: Basic information packet) explaining the MFP transition program and process, including consumer rights and responsibilities and notification that MFP program participants will be participating in a national evaluation, and will be expected to participate in related data collection activities. They also receive copies of consent forms that will be required: (Appendix A – 2: Consent to initiate transition planning, A – 3: Guardian consent to participate in transition process, and A - 7: Consent to transition) (c) The staff person assembles the referral packet for the transition specialist containing the following items: (i) the current discharge plan; (ii) the signed consent form to explore the transition process; (iii) documentation of the resident's legal status as it pertains to transition (guardianship, court commitment, etc.); (iv) current diagnostics, medical and mental records, current program plan, and social history.

Note: If interest in transitioning is first expressed to the transition specialist (at community meetings or through personal contact), the transition specialist can secure the signed consent to initiate transition planning, and will then provide the interested party with the standardized information packet, contact the ICF/MR in which the consumer resides, and request the preparation of the referral packet described in (c), above.

2. <u>Intake process:</u> (a) Within three business days of the ICF/MR notification that a resident or family member/rep has expressed interest, (or within three days of receipt of the referral packet requested from the ICF/MR), the transition specialist calls to make an appointment with the consumer/family member/guardian to begin the exploration process. The specialist reviews the transition process and consumer/family/guardian rights and responsibilities with them. If the consumer has tentatively identified the community to which he/she wants to move, the transition specialist either provides preliminary information about services/support options, or prepares to refer the consumer to a more appropriate transition specialist. (The consumer will, in any event, will be informed that he or she has a choice of transition specialists once participation in the program begins.) The specialist notifies the appropriate CPC and the local DHS Income Maintenance worker to begin the process of enrolling the consumer in MFP (entering consumer data on the ISIS).

3. <u>Review of guardianship status:</u> In those instances where the expression of interest has been made by the consumer, or by a family member who is not the individual's guardian or legal representative, the transition specialist reviews documentation in the referral packet pertaining to the individual's legal status and takes steps to ensure adequate guardian involvement with the individual and the individual's transition. The transition specialist calls or meets with the consumer's legal representative, explains the MFP demonstration and the consumer's interest in participating, and determines the nature of guardianship, individual guardianship or other legal issues.

The specialist then determines whether guardian involvement with the consumer is sufficient to comply with the Operational Protocol. If the level of involvement has been minimal to date, the transition specialist informs the guardian of Iowa's requirement that in order for transition to proceed he or she must provide a signed agreement (1) to support the individual's choice to begin transition planning; (2) to receive and as necessary respond to monthly communications from the transition specialist throughout planning and the individual's demonstration year, including responding to requests for informed consent to key decisions in the transition process. (Appendix A – 3: Guardian consent) The specialist also secures signed releases to contact providers and other IDT members (Appendix A – 2) to begin the transition planning process.

4. Establishment of the Interdisciplinary Team (IDT): The transition specialist consults with the consumer about the membership of the IDT, which will plan and provide support for the consumer's transition decisions. Besides the consumer, the IDT will generally include the transition specialist, the legal representative, family or friends to be involved in transition, ICF/MR staff familiar with the consumer and supportive or his/her choices, a court advocate if a commitment is in place, and as the planning process proceeds and the consumer has expressed a choice of community, a representative of the county such as a services coordinator, and service providers from that community. The consumer can reject any proposed IDT member. The IDT reviews the most recent diagnostics and discharge plan.

5. The Transition Planning Process:

Phase 1: The IDT discusses with the consumer: (a) where he/she would like to live; (b) with whom he/she would like to live; (c) preferences with regard to work, leisure, volunteerism, transportation, church, etc; (d) preferences about services, including whether or not the individual wishes to participate in the Consumer Choices Option; (e) choices among available service providers; and (f) provisions for 24/7 backup plans as appropriate, e.g., for direct care services, transportation, etc. The IDT discusses with the consumer how the services available under the MFP grant (and from other funding sources as appropriate) can be used to support the individual's choices. If the guardian/legal representative does not participate in person, he or she is regularly provided with updates on progress.

The transition specialist will take care to ensure that consumers, family members and legal representatives are aware of the service options after the individual's demonstration year ends. MFP participants in the first demonstration year are guaranteed access to an MR waiver slot at that point because IME has routinely earmarked 100 slots every year for individuals transitioning out of ICFs/MR. IME does not expect a problem with ensuring that participants in ensuing years to have such access, but if a shortfall is anticipated, IME has confidence that the Legislature's historically strong support for the waivers will be maintained, and that the number of slots will be appropriately increased of the grant. MFP participants will have access to the proposed waiver enhancements (described in (e), below) in the event that the Legislature authorizes DHS to seek approval of the necessary waiver amendments, and CMS issues that approval. If the

Legislature chooses not add the services to the waiver, they can be provided to individuals who need them as a service option under Supported Community Living or as an exception to policy.

Phase 2: When the basic decisions have been made, the second intensive planning phase begins. By this time the transition specialist is identifying local resources and assisting potential providers in building their capacity to support the transition, as necessary. The consumer and family member or legal representative visit the community of choice, and contact is made with potential providers, including employment service providers or volunteer work settings. The assessment is updated as appropriate for discharge planning.

An individualized plan is completed (Appendix B: Transition Plan) indicating individual responsibilities, essential supports that must be in place before the actual transition and non-essential supports that must be in place within 60 days after transition, a transition/timetable, and a schedule for addressing training needs for HCBS provider staff.

Final documentation: Memoranda of agreement are signed (Appendix A – 8: Sample provider agreement) between the ICF/MR and community providers, specifying pre/post transition interaction and involvement of ICF/MR and community provider staff.

6. Community transition: Informed consent forms are signed by the individual and his or her legal representative (Appendix A – 7: Consent to transition). The consumer moves to the community. The transition specialist ensures that documentation of grant compliance is entered on the ISIS. The monitoring process for the demonstration period begins

7. Demonstration year monitoring: The transition specialist will notify the CPC in the consumer's county of residence of the consumer's status as an MFP participant and the services he or she is currently receiving. The transition specialist maintains consumer contact as needed to ensure the availability of all essential and non-essential services identified in the individualized transition plan. The specialist will meet with the consumer and his or her IDT a minimum once per month , for the first year after transition. The specialist will visit the consumer in a variety of his/her community settings including home, work and places chosen sites for leisure activities. The specialist will also have monthly telephone or written communication with the consumer's legal representative to provide updates on the consumer's status and satisfaction with community living.

8. Transfer of consumer to permanent waiver services. Sixty and again thirty days prior to the expiration of the consumer's demonstration year, the ISIS will provide notification to the CPC and other concerned parties that the consumer will be transitioning from grant-funded services to the MR or BI Waiver, and will indicate the grant-funded services which will cease on the final day of the transition year, and the services to which the consumer will have access under the county system. The individual's legal representative will also be notified in writing. A targeted case manager will be assigned.

The transition specialist will meet with the consumer and family members or legal representative to complete the consumer satisfaction survey. The transition specialist will also ensure compliance with all reporting requirements under MFP. On day 336 after transition, the transition specialist's involvement with the case comes to an end, and the targeted case manager assumes responsibility for the consumer's case.

c) Outreach/Marketing/Education

1. *Information that will be communicated to enrollees, participating providers, and State staff.* The Department of Human Services is contracting with a vendor to develop an outreach strategy, and marketing and education materials to be used with residents of ICFs/MR and their families/guardians/legal representatives, and with prospective providers. Draft materials targeted to both groups are attached. (Appendix C - 1 through C - 7). The vendor will not itself conduct the marketing but will assist IME in crafting the public message. The materials may be used in training transition specialists and State staff to be involved in MFP, but DHS will assume primary responsibility for that training.

The message to the public about the *Partnership for Community Integration* will be geared to building support for offering more meaningful choices to Iowans with disabilities about where and how they receive the supports they need, for providing ways for families to be engaged with their loved ones in the community while having assurance of their health and safety, and for the aspects of MFP which hold the promise of greater efficiency and cost effectiveness in the service system. This information will be conveyed through media releases and the Department of Human Services web site.

Information to ICF/MR residents and their families/guardians/legal residents will be more specific, including: (a) how they can take advantage of the MFP options; (b) a description of the transition process; (c) the services available during the demonstration year; and (d) how participants will be sustained in the community after the demonstration year ends.

Information to providers will be tailored to address specific concerns they have communicated to date through the Partners Group. For ICF/MR providers, the concern relates to the impact of transitions on the stability of their operations, and the availability of technical assistance to respond to shifts in service demands. For community providers of HCB services, the concerns relate to their capacity: the difficulties in recruiting, training and maintaining sufficient numbers of staff, the services eligible for reimbursement and the adequacy of reimbursement levels, and the assurance of continuity of funding for individuals after their demonstration year.

Staff involved in implementation will be transition specialists and ICF/MR service staff. Targeted case managers and ICF/MR staff will need sufficient information about MFP to respond to questions and concerns of consumers, families, and guardians. ICF/MR staff also need to understand their own role in the transition process and in ensuring compliance with grant requirements.

2. *Types of media to be used.* A variety of media will be used for outreach, marketing and education, including (a) for the general public: media releases and the DHS web site; (b) for consumers, family members, guardians and legal representatives: brochures, letters and written FAQs (Appendix C – 2), public meetings at ICFs/MR and in communities which include presentations by consumers and/or their family members who have participated in successful transitions, as well as a video about success stories; and (c) for providers: written materials such as the Operational Protocol, FAQs (Appendix C – 3), the administrative rules, and one on one marketing, education and technical assistance from transition specialists and as appropriate, IME staff.

As noted in (5), below, a curriculum will be developed for statewide training for transition specialists. The outline of the curriculum for transition specialists is contained in Appendix G - 2. Case managers will receive more general information at appropriate venues such as their quarterly meetings and through the ICN.

3. *Specific geographical areas to be targeted.* Any Iowa Medicaid ICF/MR resident in the State or out of State will be eligible to receive assistance under MFP at any time over the four-year demonstration as long as they meet the MR or BI diagnosis as defined in Iowa's 1915c waivers.

The transition specialists, who are charged with outreach, marketing and education, will each be assigned a regional service area. Their responsibilities will include outreach to ICFs/MR in their region, to family members and guardians whose loved ones/charges may or may not live in ICFs/MR which are located within the region, and to community providers who could develop the enhanced capacity to serve MFP participants.

In the first year of the grant there is likely to be a relatively greater focus of efforts in north central and west central Iowa due to the simple fact that some administrators of large ICFs/MR in those areas have stepped forward to express interest in participating, and have identified candidates for transition. The state-run Glenwood Resource Center in southwest Iowa and Woodward Resource Center in central Iowa have also identified candidates.

4. *Location where information will be disseminated.* Information will be disseminated in the following venues: (1) in the general media, through press releases and posting on the DHS web site; (2) through letters to all Iowans in ICFs/MR and their family members/guardians/legal representatives notifying them of the transition option under MFP; (3) through community meetings offered by transition specialists and, as appropriate, at ICFs/MR within their regions.

5. *Staff training schedules.* Staff training schedules will depend upon the date when transition specialists are hired, the date on which the Operational Protocol is approved, and also the date on which rules for administration of the program are approved. At present the hiring of transition specialists is anticipated to occur in May 2008. Transition specialists will receive 40 hours of training tentatively scheduled for the beginning of June 2008.

Also in June 2008, (again, assuming CMS approval of the Operational Protocol), letters will be sent to ICF/MR residents and family members/guardians/legal representatives notifying them of the transition option and of the opportunity to attend community meetings scheduled by the transition specialist for their region.

6. *The availability of bilingual materials/interpretation services and services for individuals with special needs.* In 2004, only 3.3% of Iowa's population was foreign-born; most requests for interpreter services are expected to be from individuals who are Spanish-speaking. There are small pockets of Serbians and other ethnic minorities. Transition specialists will have access to Tele-Interpreters, a business service providing immediate telephone access to interpreters of 156 languages. Iowa COMPASS, housed at the University of Iowa's Center for Disabilities and Development, provides information and referral services for Iowans with disabilities, and has access to interpreter services. COMPASS staff will be trained to provide information on MFP, including how to refer individuals to the appropriate transition specialist.

The brochure directed to families/guardians/legal representatives will be available in Spanish.

The letter inviting families/guardians/legal representatives to community meetings will encourage those who have need for an ASL interpreter or for materials in alternative formats to notify the transition specialist in advance so that accommodations can be made.

7. *Information about cost-sharing responsibilities.* Participants will not be responsible for any portion of the costs of MFP services funded under the grant. They and their families will receive clear and complete information from the transition specialist and also from the consumer manual (Appendix C-7) about the implications of transitioning from a facility in which room and board are included with services, to a community living situation in which individuals are principally responsible for room and board, and for any supports not eligible for reimbursement under the grant. Individuals opting for self direction under the Consumer Choices Option will have the assistance of an Independent Support Broker in developing a budget for services and supports eligible for self direction, which may include supports from non-traditional providers.

d) Stakeholder Involvement

As noted in Section B (8)(c), above, the principal vehicle for interagency and public/private collaboration in MFP planning and implementation is the 30-member Partners Group and its five Subcommittees. About 70 stakeholders in total are involved in the work of this group, including advocacy organizations, family representatives, ICF/MR administrators and staff, community providers and case managers, direct care worker representation, counties, and key State agencies. A list of Partners Group members and Subcommittees and the constituencies they represent is contained in Appendix D.

The Partners Group and Subcommittees drafted a transition process, the list of demonstration services, a marketing plan, a housing inventory and resources for consumers and transition specialists. These documents became the foundation for the Operational Protocol, with relatively few modifications by IME.

1. *A chart reflecting the stakeholder role in the MFP organizational structure is on the next page*.

2. *Consumer involvement in the demonstration.* Ten people with disabilities or family members of individuals requiring an ICF/MR level of care participated in the Partners Group or Subcommittees, and eleven organizations engaged in disability advocacy, many of them run by people with disabilities, were also represented. Family member and consumer participants in IME-sponsored planning sessions are eligible to receive reimbursement for travel expenses, and for personal attendant services if needed. The family members were particularly helpful in identifying the principal concerns and fears likely to be expressed by family members of ICF/MR residents, and in identifying measures to address those concerns, such as the inclusion of crisis and behavioral intervention services in the list of qualified HCB services. It is expected that their involvement will continue, in a monitoring capacity, as MFP is implemented.

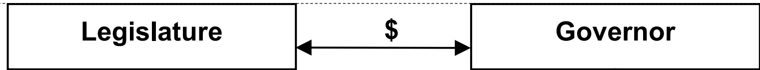
3. *Institutional providers' involvement in the demonstration.* Institutional providers have participated in planning directly as members of the Partners' Group, and through the Iowa Association of Community Providers (IACP), which represents many ICFs/MR. More than a year prior to IME's application several of Iowa's largest ICFs/MR met with IME to discuss steps they might take to respond to changing market demands for long term care services, and how those steps might be supported by IME. When IME embarked on the development of the MFP proposal, IACP provided assistance by arranging a teleconference exchange between IME and interested ICFs/MR about the purpose of the grant, and the extent to which community ICFs/MR would be willing to participate. The preliminary numerical estimates of transition were developed on the basis of the teleconference and follow-up conversations with individual ICF/MR participants.

The University of Iowa Center for Disabilities and Development, which provides staff support to the Partners Group under the grant, also conducted additional outreach, meeting with IACP members in an open session in May to solicit their comments and concerns.

A number of community ICFs/MR, as well as the State Resource Centers, have been transitioning their residents out of their facilities to HCBS services. Those who have broadened the scope of their services to HCBS are in a position to share their expertise with ICFs/MR which have not. IACP has collaborated with IME in the establishment of a work group to facilitate this exchange, and to provide some strategic insights into how the industry can adapt to multiple demands for more expanded choice without jeopardizing existing services.

4. *Consumers/family members' and institutional providers' roles and responsibilities throughout the demonstration.* Both consumers and institutional providers participate in

MFP Stakeholder Participation – Organizational Chart



Dept. of Public Health

Dept. of Inspections & Appeals

Iowa Board of Nursing

Dept. of Education

Dept. of Human Services

Iowa Finance Authority

$

Federal Housing Agencies
- USDA
- HUD

Bureau of Disability & Violence Prevention
↓
Brain Injury Program

Iowa Vocational Rehabilitation Services

Governor's Developmental Disabilities Council

Iowa Medicaid Enterprise
MFP Project Co-Directors

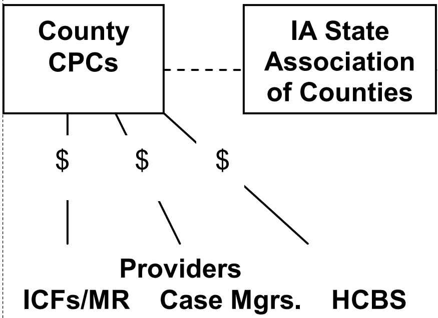
Mental Health & Disability Services Division

MH/MR/DD/BI Commission

UI-CDD

State Resource Centers

$ - IME
↓ - MHDS & MH/MR/DD/BI Comm.



Consumers, Family Members, Disability Advocates
- Arc
- Brain Injury Assn.
- ASK Resource Center
- Statewide Independent Living Council
- Iowa State Assn for Independent Living

KEY
↓ policy authority
↔ other legal relationship
$ funding relationship
- - - communication/participation
→ staff support
~ administrative relationship

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the Partners Group in order to communicate what, from their perspective, has to happen in order for MFP to work. This is essentially the role of all stakeholders, including community providers, state agencies, advocacy organizations, direct care worker representatives, county representatives and case managers. Most of the members of the Partners Group have some degree of experience with the transition process, and all have a direct interest at stake in MFP. Since MFP's success depends upon the establishment of many effective partnerships (most of them voluntary), the worries, fears and in fact the dreams of all constituents have been set out before the group and dealt with respectfully. The contractor assisting IME in outreach and marketing will be working with individuals and families to communicate stories of successful transitions to community living.

Once implementation begins, the Partners Group is expected to meet at least twice a year. Meetings will continue to be held at a central location in Des Moines, with travel and expense stipends of participants covered as appropriate.

Stakeholders participated in the drafting of major components of the Operational Protocol, which involved highly detailed work at the Subcommittee level. Following approval by CMS and the launch of MFP in June 2008, the role of the Partners Group will shift from planning and program development to monitoring, with at least twice-yearly meetings to review progress, troubleshoot, and recommend changes in the Protocol as appropriate.

5. *Operational activities in which the consumers and institutional providers are involved.* As noted earlier, consumers and family members have played and will continue to play an important role raising public awareness of the possibilities for and advantages of community living. The current social marketing plan calls for the development of video and slide presentations as well as written narratives about compelling success stories of transitions from ICFs/MR. In addition, the Parent Advisory Group meetings at the Resource Centers will continue to be a vehicle for communicating with consumers and family members about MFP. Consumers/family members will also continue to participate in the Partners Group as it assumes its monitoring role.

As noted in (3), above, an institutional provider work group will be involved in technical assistance to peers as implementation proceeds. Interested ICFs/MR will continue to participate in the Partners Group. Most important, IME hopes for collaboration from all ICFs/MR in identifying consumers who are good candidates for transition, encouraging them to learn more about their options, testing the transition process as defined in this protocol, and bringing to IME's and the Partners Group's attention any changes or refinements that would strengthen the process.

e) Benefits and Services

1. *Description of the service delivery system.* Iowa's disability service delivery system is county-based, and partially funded by local property taxes. Counties are required by statute to serve adults with mental illness and mental retardation; over the years many counties have chosen to serve people with developmental disabilities who do not have an MR diagnosis, as well as people with brain injury. DHS has an office in each county, which is supposed to be co-located with other state and local service offices for the convenience of the public. The eight

DHS regions in Iowa each have service area advisory boards which work to maintain communication between the State and the counties. The DHS field staff make income eligibility determinations for Medicaid and the waivers, and once people secure their disability determinations the field staff refer individuals for targeted case management. Level of care determinations are made by the Iowa Foundation for Medical Care, under contract with IME.

Although counties have no specific administrative or fiscal responsibilities under the grant, they will be working with transition specialists in building local service capacity and in ensuring continuity of service after an individual's demonstration year ends, and he or she moves off the grant and onto the MR or BI waiver (for which counties provide the non-federal match). Counties provide targeted case management for people with MR, either by hiring staff directly or by contracting for services from DHS. Transfer of responsibilities from the transition specialist to the targeted case manager on day 366 will help to ensure continuity of services after the MFP demonstration ends.

Iowa's provider network includes traditional Medicaid providers, both waiver and facility based service providers, and most recently, self-direction of services not requiring licensed providers, under the Consumer Choices Option (CCO) available in six of the seven waivers. Individuals choosing to self-direct receive assistance from a trained Independent Support Broker (ISB) of their choosing. The ISB helps the individual to develop a budget for eligible services which may include provision for services by non-traditional providers.

Iowa's MR Waiver is generally considered to be flexible and consumer-responsive in its array of services, particularly under Supported Community Living. The Partners Group has identified some significant gaps, however, which are discussed in the following section.

The Legislature has appropriated funds for the non-federal match for the first demonstration year, and will be asked to ensure adequate funding for county disability services to sustain the target population. People with brain injury who transition will have access to the enhanced services they need during the demonstration year, and then will access the Brain Injury Waiver on day 366.

2. *Services available to MFP participants.* A chart showing the service package that will be available to MFP participants is on the following page. The Qualified HCB Services listed are the equivalent of the services available under Iowa's MR Waiver. For reasons described below, the Partners Group recommended inclusion of the following additional services, and DHS will recommend to the Iowa Legislature that they become permanent under the MR Waiver:

- Mental Health Outreach
- Behavioral Programming
- Crisis Intervention Services

The Partners Group includes both family representatives and providers with experience in transitioning individuals, particularly from the Woodward and Glenwood Resource Centers. Behavioral issues resulting both from mental retardation and from mental illness co-occurring with mental retardation have proven to be a significant barrier to transitioning Resource Center

PROPOSED SERVICES FOR IOWA'S MFP PROJECT

State Plan Services for Long Term Support (80.9 match)	Qualified HCB Program Services (80.9% match)	HCB Demonstration Services (80.9% match)	Supplemental Se (62% matc
• Skilled Nursing • Home Health • Occupational Therapy • Physical Therapy • Speech Therapy • EPSDT • Hospice • Targeted Case Management	• Adult Day Care • CDAC* • Day Habilitation • Consumer Choices Option** • Home Health Aide • Home/Vehicle Modifications • Interim Medical Monitoring† • Nursing • Personal Emergency Response • Prevocational Services • Respite • Supported Community Living‡ • Supported Employment • Transportation **Permanent Services to be added:** • Mental Health Outreach • Behavioral Programming • Crisis Intervention Services	• Transition Services Coordination • ICF/MR staff participation in trial overnights • Community provider participation in transition planning and preparation *** • Assistive Technology not covered in MR Waiver (e. g. computers, med. dispensing equipment) • Environmental modifications (e.g. for safety) • Nurse Delegation	• Initial household costs • DME° • Clothing

* Under this option consumers are responsible for finding, hiring, training, directing and firing individuals who enable consumers to do are unable to do without assistance because of disability.

** Provides consumers with a flexible monthly budget based on functional and service needs, allows consumers to direct and manage th support services.

*** Includes cost of provider participation in IDT, staff training and support, and HCBS provider staff time during community visit overnight stay in community.

† Monitoring and treatment of a medical nature beyond what is normally available in a day care setting for persons age 20 and under. M medical assessment, monitoring, and intervention as needed. Used when regular caregiver is unavailable due to employment, academic vocational training, illness or death. May not be duplicative of any regular Medicaid or waiver services provided under the state plan.

‡ Assistance with daily living needs. Services may include, but are not limited to: personal and home skills, community skills, personal transportation and treatment services. Services provided vary according to the needs of the individual receiving services but can include residential services.

° Durable Medical Equipment in excess of coverage provided by waivers, state plan, or otherwise provided by this demonstration proj bathroom safety equipment, wheelchair upgrades, back-up supplies).

residents. Some research indicates a high percentage of individuals residing in institutional settings who have undiagnosed mental illness, and while no data are available on the prevalence of mental illness in Iowa's community ICFs/MR, this is expected to be a factor in transitioning residents from those settings as well. (The functional assessment to be undertaken in 2009 will provide more definitive information on this issue.) Resource Center staff have addressed the challenge posed by behavioral issues in several ways that have been found to greatly enhance the probability of a successful transition. First, Resource Center staff work closely with community provider staff prior to transition, offering opportunities for the latter to get to know the consumer and to receive training in how to respond to the individual's needs. Second, the Resource Center routinely executes agreements with providers to respond to their needs for additional support and training after transition. This can include intensive work with the consumer and provider staff in development and implementation of strategies to increase the individual's appropriate behaviors. Third, the Resource Centers provide crisis intervention services as necessary, including out-of-home crisis stabilization.

In light of the highly beneficial effect of these services on transition outcomes to date—seen clearly by the case managers participating in the MFP Partners Group, the inclusion of these services in the list of HCB Qualified Services, and indeed their permanent addition to the MR and other waivers was strongly recommended. In addition, all demonstration services listed will be evaluated for possible addition to the waiver at a future date.

The transition process and the services available for children under MFP do not differ significantly from those available for adult participants. Children and their families have the option of either residentially based supported community living (RBSCLL) or of moving from the ICF/MR back to the family home. The service package for children includes EPSDT under the State Plan.

In order to be available to participants completing their demonstration year in mid-2009, the Legislature will need to take action during its session beginning in January. This is anticipated by DHS as it prepares its budget recommendations for the Executive Office. The Governor's budget recommendations are released in January. Following legislative action, waiver amendments will be submitted to CMS for approval. Until such time as the Legislature acts, continuity of services can be sustained for MFP participants after their demonstration year ends through the crisis intervention and behavioral programming allowable (though with a capped dollar amount) under Supported Community Living, and also through inclusion in an individualized budget under the Consumer Choices Option.

The definitions of the Qualified HCB, Demonstration and Supplemental Services are provided in Appendix E, along with the billable units of service, and their rates. The Iowa Legislature has provided the funding for the non-federal share of these services—counties are not expected to provide the match out of county funds. These services will be uniformly available throughout Iowa, and will be tracked separately on the ISIS system from other Medicaid services funded by the counties or the State. In order to facilitate delivery of non-traditional demonstration and supplemental supports, (those which are not offered by certified Medicaid providers), the transition specialist will serve and be recorded as the fiscal agent (financial management service) and will coordinate payments for the services.

MFP participants are also eligible for all appropriate State Plan services they need.

f) Consumer Supports

As described in case study and Section II (b) on the informed consent process, the principal vehicle for consumer support in the MFP demonstration will be the transition specialists. Depending upon approval of the Operational Protocol by CMS, recruitment will begin in April 2008. These individuals are expected to have case management experience, and are in fact likely to be drawn from the State's pool of targeted case managers, but IME has opted not to rely upon the current case management system for two reasons: first, the position description for transition specialists includes important social marketing and community development functions for which many targeted case managers would be unprepared, and second, it was the consensus of the Partners Group that most (though certainly not all) targeted case managers lack sufficient background in transitions and would have difficulty managing the significant workload. Consumers will, however, be able to seek approval from DHS to secure their transition services coordination from an entity other than a transition specialist, such as targeted case managers and/or ICF/MR discharge planning staff.

IME has opted to recruit and train a small cadre of transition specialists who will maintain primary responsibility for ensuring effective transitions. At the outset, approximately six transition specialists will be recruited and trained. Each transition specialist would have a caseload of approximately 15 in the first year, which would achieve the first year goal of 75 transitions, and in later years the caseload would range from 15 to 30. Additional specialists would be recruited if necessary. Final decisions on the service areas for individual specialists have not been made, but there are six areas within the state that contain high concentrations of ICF/MR facilities:

- Northwest Iowa (Woodbury, Buena Vista, Calhoun, Carroll and Crawford Counties)
- Southwest Iowa (Mills, Pottowatamie, and Adams Counties)
- Central Iowa (Boone County)
- Central Iowa (Polk, Story, Marion and Jasper Counties)
- Northeast Iowa (Blackhawk, Dubuque, Cerra Gordo and Clayton Counties)

While the first two concentrations coincide reasonably well with DHS regions, the rest do not. Central Iowa's ICF/MR beds are twice as concentrated as other areas because of the Woodward Resource Center in Boone County and the number of ICFs/MR in Des Moines (Polk County). Northeast Iowa concentrations, roughly proportional to the other areas above, overlap two DHS regions, as do the relatively smaller concentrations in Cedar Rapids/Linn County and the Quad Cities area in Eastern Iowa, which might constitute a sixth service area.

Transition specialists need to ensure the availability of community supports throughout the State, not just in the counties identified above. However, they must also cultivate working relationships with ICF/MR administrators and staff, as well as the residents and family members/guardians/legal representatives. Marketing efforts will include meetings at ICFs/MR.

Consequently, the distribution of the facilities will be fundamental to how transition specialists are deployed.

Job descriptions and required qualifications for transition specialists are contained in Appendix G.

The proposed schedule for recruitment, hiring and training of transition specialists in 2008 is as follows:

April:	Positions advertised
May:	Positions filled
Early June:	Intensive training

1. Educational materials to convey procedures by which consumers secure needed supports. The draft consumer/family manual providing this information is attached in Appendix C - 7.

2. Description of 24 hour backup systems. All MFP participants (and all participants in Iowa waivers) are required to have backup systems based upon the risk assessment undertaken by their planning teams. During the evaluation/reevaluation of level of care, risks are assessed using the Mental Retardation Functional Assessment Tool. A summary of the assessment becomes part of the service plan, and the transition specialist, the consumer and the interdisciplinary team incorporate strategies into the plan to mitigate risk. This includes appropriate service providers available to reduce risk, subject to the consumer's preferences.

All service plans must include a plan for emergencies and identification of supports available to the consumer in an emergency. Emergencies are those situations for which no approved individual program exists and which, if not addressed, may result in injury or harm to the consumer or other persons or significant amounts of property damage. Emergency plans shall be developed on the following basis:

- Providers must provide for emergency back-up staff in applicable services.
- Interdisciplinary teams must identify in the service plan, as appropriate for the individual consumer, health and safety issues based on information gathered prior to the team meeting, including a risk assessment. This information shall be incorporated into the service plan.
- The team will identify an emergency back-up supports and crisis response system to address problems or issues arising when support services are interrupted or delayed or the individual's needs change.

Personal Emergency Response is an available service under the waiver and it is encouraged that this service be used when a scheduled support worker does not appear, as part of emergency back up plan. Other providers may be listed on the service plan as source of back up as well, and their contact numbers can be available through the PERS. Many times, the list of numbers includes a neighbor or relative. The transition specialist will be the contact of last resort. The PERS can also be used as described in the case study presented earlier, for those situations in which MFP participants are away from their residence and service workers.

Most MFP participants in Iowa are likely to receive services from an SCL provider in settings where support staff will be present around the clock. The SCL providers will be responsible for ensuring essential services, including backup services, for personal assistance, transportation, equipment repair, etc. MFP participants who opt for self direction will need to work out a backup plan for nontraditional services, which can include reliance upon friends or relatives, or other arrangements, as currently required under the Consumer Choices Option

3. Complaint and resolution process; remediation. Procedures for receiving and resolving complaints are incorporated into IME's incident management process, discussed in detail in Appendix I. Consumers, family members and legal representatives receive information prior to transition about how to file a complaint, as described in Section a (vi). Complaints are reviewed weekly by the HCBS quality management team, which also reviews incident reports to determine if patterns exist among individual providers, or by service, geographic location, etc. Remediation steps are tailored accordingly.

g) Self-Direction

The State of Iowa has an approved self direction option under six of its seven waivers, known as the Consumer Choices Option (CCO). The CCO is available statewide, and will be available to all MFP participants. Under this option, a consumer may use the value of certain services in their individual service plan to develop an individual budget plan. Instead of receiving services from enrolled Medicaid providers, consumers may use funds in their individual budget to hire people to provide self directed personal care services, or self directed community support and employment and/or to purchase services, equipment or supplies that are not otherwise provided through the Medicaid program.

Consumers choosing this option must work with an independent support broker who will help plan for their individual budget and provide guidance, as needed, with self directing their services. The consumer can choose from Independent Support Brokers that have already been trained, or they can identify a family member or friend to complete the independent support broker training and perform that role for them. The consumer will also work with a financial management service provider. The funds allocated to the individual budget are transferred to the financial management service which is responsible for paying for the goods and services the consumer purchases and receives. The consumer does not actually have direct access to the Medicaid funds.

The consumer must develop an individual budget with his or her support broker. The consumer can choose to purchase goods and services from the list of individual goods and services approved for individual budgets (Appendix J-2). If the consumer has a need for a good or service not on the approved list, it must be approved by IME. The Financial Management Services does not pay for any good or service that is not identified on the individual budget, or for which a signed invoice or receipt is not provided. The financial management service is also responsible for accounting and for employer-related duties such as withholding taxes and issuing paychecks. The independent support broker, the financial management service and, for MFP participants, the transition specialist, are all responsible for monitoring and assuring funds are spent according to

the program guidelines and not misused. These basic components will be adapted to the MFP initiative to provide a fully comparable self direction option. Further information is contained in Appendix A of the Operational Protocol guidelines, which is incorporated as Appendix J-1) of the Operational Protocol.

h) Quality

IME contracts with Iowa State University to provide Quality Assurance functions for the seven HCBS waivers, and this unit of QA specialists will serve this function for the MFP demonstration as well. The unit supervisor has participated in CMS technical assistance conference for MFP grantees, and the unit is prepared to comply with grant requirements.

IME's Quality Management team includes both QA specialists and IME program specialists (including MFP grant management staff) who meet weekly to review critical incident reports and complaints, identify trends, determine remedial action, and develop a plan to address needs in the Department's continuous quality improvement process.

Iowa Medicaid Enterprise will integrate the MFP demonstration into existing 1915(c) waivers, and provides 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 its Section 1915(c) waiver applications (attached as Appendix I) during the transition of MFP participants and during the 12 month demonstration period. The HCBS quality management system will be modified to incorporate the quality assurance requirements emerging from discussions among CMS grant management staff, Mathematica Policy Research, and grantees, including the proposed requirement for pre- and post-transition interviews with each MFP participant. IME will ensure the incorporation of additional questions in participant surveys pertaining to the transition process itself, as well as consumer satisfaction with community living and demonstration services. IME intends to contract with Iowa State University to assist with QA functions under the grant, including the conduct of QoL/customer satisfaction surveys. The surveys will be administered to 100% of all MFP participants, rather than to the sampling undertaken in Iowa's HCBS Quality Management program. In every other respect, however, the QA functions under the grant will be identical to the processes defined in Appendix I, and will be applied to Qualified HCB, Demonstration and Supplemental Services.

The MFP Quality Management System will address QA requirements as follow:

1. Level of care determinations. LOC determinations for individuals with MR are made by the Iowa Foundation for Medical Care (IFMC), and consumers have rights to notification, appeal and requests for reconsideration. Patterns of inappropriate LOC determinations are addressed through action plans developed by the IFMC, the Bureau Chief of Long Term Care and the QA unit manager. Implementation of the standardized functional assessment of ICF/MR residents in 2008 will incorporate this policy.

2. Service plan. The service plan for MFP participants planning to transition will be developed by the Interdisciplinary Team (IDT) using processes and procedures found to be successful in the transition of individuals with extremely complex needs who have moved to the community from

the State Resource Centers. Stipulation of the services which must be in place at the time of transition and within 60 days following is contained in the Provider Agreement (Appendix A – 8). Once the transition has taken place, the transition specialist has responsibility for monitoring the service plan to assure that services are delivered in the type, scope, amount, duration and frequency in accordance with the plan. The QA interview process, which incorporates sampling of HCBS participants under Iowa's current waiver system, will be modified to ensure 100% sampling of MFP participants, to assure that services are adequate and appropriate and that the plan is updated as needed. If systemic inadequacies in service plan development are found, transition specialists and providers will receive additional training. Consumer choice of providers is documented. Consumer rights and responsibilities are outlined in the consumer manual.

3. Identification of qualified HCBS providers. Most MFP service providers will be current certified HCBS providers. The safeguards for MFP will be the same as for current waiver service providers, and will include requirements for documentation of compliance with eligibility criteria, random audits, a discovery process to identify deficiencies, and development of a corrective action plan.

4. Health and welfare. All service plans must address the health and welfare of the consumer and include provisions for backup and emergencies as described in Section II (e). Providers are required to report critical incidents, and the Quality Management Team meets weekly to review reports, track trends and develop an action plan.

5. Administrative authority. The Bureau of Long Term Care provides oversight to the waiver program, and contracts with Iowa State University (ISU) to provide QA monitoring. DHS is responsible for monitoring the contractor's performance of all its responsibilities, and to review, approve and monitor corrective actions taken. ISU will provide QA monitoring for MFP consistent with the processes described in Appendix I.

6. Financial accountability. The web-based Individualized Services Information System (ISIS) is the mechanism by which DHS tracks Medicaid case files, including services plans and program expenditures. The ISIS system has been adapted to meet the needs of consumers opting for self direction under the Consumer Choices Option, and will be adapted again to track MFP participants separately prior to transition, during their demonstration year under the grant, and as they transfer into the county based system and waiver services. In addition, the Department of Human Services Bureau of Purchase Services analyzes payments and selects providers for financial and performance audits.

As noted elsewhere in the Operational Protocol, IME will with the assistance of the Partners stakeholder group continue to monitor implementation of the grant to determine the adequacy of procedures and services in assuring effective transitions to community living, and will recommend changes to either as necessary and appropriate. IME will also cooperate fully with Mathematica Policy Research in its national evaluation of MFP.

Iowa's MFP initiative calls for only three supplemental supports: initial household setup (furniture, appliances, cleaning supplies, etc.), clothing (if needed for employment or other

community participation), and DME in excess of what is available under the current waiver, to ensure safety, adequate mobility, etc. The need for these services will be determined by the IDT. The transition specialist will be authorized to make purchases directly on behalf of the consumer.

i) Housing

1. *Process for documenting qualified residences.* The transition specialist has responsibility for reviewing the availability of qualified residences in the community of choice, and in ensuring that the consumer and family member/guardian/legal representative has a meaningful choice of qualified residences. The specialist will provide documentation of compliance through the ISIS system, which will provide a drop-down menu for reporting the type of qualified residence chosen by the consumer.

2. *Assuring a sufficient supply of qualified residences.* The Iowa Finance Authority assembled a stakeholder group, including Department of Housing and Urban Development (HUD) and United States Department of Agriculture (USDA) officials in Iowa, which served as the Housing Subcommittee of the Partners Group. They have defined the issues facing Iowa in assuring a sufficient supply of qualified residences, and suggested strategies to address them.

3. *Existing or planned inventories and/or needs assessments of accessible and affordable community housing.* The "Iowa Affordable Rental Housing Inventory" (Appendix F) lists the total number of affordable rental housing units by major development funding program for each county in Iowa. The following programs are included in the analysis:

- USDA Rural Rental Housing Section 515 Program: Very low-, low-, and moderate-income families; the elderly; and persons with disabilities are eligible for tenancy in Section 515-financed housing. Very low-income is defined as below 50 percent of the area median income (AMI); low-income is between 50 and 80 percent of AMI; moderate-income is capped at $5,500 above the low-income limit. In new Section 515 projects, 95 percent of tenants must have very low-incomes. In existing projects, 75 percent of new tenants must have very low-incomes. Those living in substandard housing are given first priority for tenancy. When rental assistance is used, top priority is given to very low-income households. Section 515 projects must be located in rural areas (communities under 20,000 in population) and do have contracts for project-based rental assistance in place.

- HUD Multifamily Programs: These projects fall under a wide variety of HUD programs all designed to provide multifamily rental housing opportunities. Specific program requirements vary by funding program and project. In order to live in Section 811 housing, the household must be very low-income (at or below 50 percent of the median income for the area) and at least one household member must be 18 years or older and have a disability, such as a physical or developmental disability or chronic mental illness. Occupancy in Section 202 housing is open to any very low-income household comprised of at least one person who is at least 62 years old at the time of initial occupancy. Section 236 units were restricted to households that met the low- and moderate-income limits established for the program, which ended additional construction in 1973. All families

are eligible to occupy existing properties with mortgages insured under the 221(d)(3), 221(d)(4), and 207/223(f) programs, subject to normal tenant selection without income limits, although these projects may also be designed specifically for the elderly or handicapped.

- HUD Public Housing: Public housing was established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. Public housing comes in all sizes and types, from scattered single-family houses to high rise apartments for elderly families. Public housing is limited to low-income families and individuals. A housing authority determines eligibility based on: 1) annual gross income; 2) qualification as elderly, a person with a disability, or as a family; and 3) U.S. citizenship or eligible immigration status. Housing authorities use income limits developed by HUD with the lower income limits at 80% and very low-income limits at 50% of the median income for the applicable county or metropolitan area. Public housing in Iowa is administered by 71 local public housing authorities. They generally have waiting lists, which can range from several months to five years. The average is about a year.

- Low-Income Housing Tax Credit Program through the Iowa Finance Authority: The Tax Reform Act of 1986 created the tax credit as an incentive for Low-Income Housing Tax Credit (LIHTC) project owners to invest in the development of rental housing for individuals and families with fixed or limited incomes. The tax credit, rather than a direct federal subsidy, provides a dollar for dollar reduction (or credit) to offset an owner's federal tax liability on ordinary income. Tenants in LIHTC properties are typically restricted to households at or below either 60 percent or 50 percent of the AMI, as defined by HUD guidelines.

- State HOME Program through the Iowa Department of Economic Development's Housing Fund: Housing Fund assistance is restricted to activities serving low- and very-low income families. All assisted rental units must be occupied by families below 80 percent of the AMI, as established by HUD. At least 20 percent of the units must be occupied by tenants below 50 percent of the AMI. At least 90 percent of Housing Fund assistance for rental housing must be invested in units occupied by families with incomes at or below 60 percent of the AMI.

In total, nearly 43,000 affordable rental housing units are identified as operating under one or more of the major affordable housing development programs in Iowa as of July 2007. As noted above, specific tenant occupancy requirements vary by program and by project. Despite differences among programs, MFP participants will be eligible for many of the units accounted for in this inventory.

Given the role choice of community will play in the *Partnership for Community Integration* process, it was impossible for the Housing Subcommittee to evaluate whether a qualified residence will be available for every MFP participant in his/her area of choice. Where such information was available, overall vacancy rates seem to support an adequate supply of affordable housing options in most areas, with a 9.5 percent vacancy rate reported among USDA

Section 515 units as of June 1, 2007 and an 11 percent vacancy rate among LIHTC units as of July 1, 2007. The *2007 Iowa Housing Study* reports a statewide vacancy rate of more than eight percent.

4 *How the State will address housing shortages for MFP participants.* The availability of safe, decent affordable housing is key to Iowa's *Partnership for Community Integration* Money Follows the Person (MFP) initiative. Those choosing to transition from ICFs/MR to community-based housing options must be provided with an adequate supply of qualified residences. The general lack of affordable, accessible housing in the United States for persons with long-term disabilities has been well documented. According to *Priced Out in 2006*, published by the Technical Assistance Collaborative and the Consortium for Citizens with Disabilities Housing Task Force, in 2006 – for the first time – the national average fair market rent of $633 for a studio/efficiency apartment rose above the entire monthly income of a person who solely relies on Supplemental Security Income (SSI). Although on average housing is more affordable in Iowa, in 2006, 78.1 percent of an Iowan's monthly SSI benefit was needed to rent a modest one-bedroom apartment at HUD's fair market rent, and 68.5 percent of monthly SSI was required to rent an efficiency unit. The Housing Subcommittee recognized these market barriers and has identified the following sources of rent subsidy as keys for the MFP initiative to succeed.

Rent subsidy programs available to MFP participants. With Iowa's SSI benefit totaling only 17.9 percent of the one-person area median income and a statewide housing wage of $9.06 (the hourly wage that a person needs to earn to afford a one-bedroom apartment at HUD's fair market rent), people in Iowa with SSI-level income must have access to rent subsidy programs to make most housing options affordable. The major source of rental assistance for very low-income households is the U.S. Department of Housing and Urban Development's Housing Choice Voucher program (commonly referred to as Section 8), which provides a rent subsidy directly to the landlord on behalf of the participating household. Voucher recipients pay approximately 30 to 40 percent of their adjusted gross monthly household income toward rent/utilities and are free to choose any housing meeting program requirements, including minimum health and safety standards, where the owner agrees to rent under the program.

Housing Choice Vouchers are administered at the local level by 45 of Iowa's 71 public housing authorities (PHA). Due to high demand in relation to supply, long waiting periods for Housing Choice Vouchers are common – with waiting list periods as long as five years reported in some areas, according to the *2007 Iowa Housing Study*. The Iowa Affordable Rental Housing Inventory in Appendix F details the number of Housing Choice Vouchers currently allocated in each Iowa county. In Iowa, the Housing Choice Voucher program is subject to the local control of the area's PHA, which may establish local preferences for selecting applicants from its waiting list. Although "disability" is an allowable preference that can move qualified disabled applicants ahead of others on the waiting list who do not meet the preference criteria, the preference may not be disability-specific and, according to a 2003 report completed for the Iowa Finance Authority (IFA), only seven PHAs in Iowa had an established preference for people with disabilities. Despite the general lack of established preference, 39 percent of Iowa's Housing Choice Vouchers are allocated to disabled households, according to the most recent HUD Resident Characteristics Report. Furthermore, 60 percent of the Housing Choice Vouchers in the state are allocated to extremely low-income households at or below 30 percent of the area

median income, with the average voucher holder's annual household income at $9,906. Of the disabled households holding Housing Choice Vouchers in Iowa, 67 percent of those households are categorized as non-elderly people with disabilities with no children, which is the reporting category most in line with the targeted MFP population.

In addition to the Housing Choice Voucher program, disabled Iowans are afforded another important source of rental assistance – the Home- and Community-Based Services (HCBS) Rent Subsidy Program administered by IFA. This rent subsidy program assists those receiving services under one of Iowa's HCBS Medicaid waiver programs who are at risk of placement in a nursing facility or ICF/MR. Assistance under the program serves as a bridge until such time as the recipient is able to secure a Housing Choice Voucher from the local PHA or another source of rental assistance. HCBS Rent Subsidy Program recipients pay 30 percent of their gross monthly income toward rent, with the maximum monthly rent subsidy amount capped at the applicable HUD fair market rent for a one-bedroom unit or a proportionate share of the rental cost in units containing more than one bedroom.

Since January 2005 through the second quarter 2007, the program had assisted 1,635 Iowa Medicaid waiver recipients, with an average monthly rental subsidy of $152 for an average length of 12 months. Due to its targeted population's alignment with Iowa's intended MFP beneficiaries, the HCBS Rent Subsidy Program has been identified as the primary rental assistance resource for those who will transition to community-based housing options under the Partnership for Community Integration initiative. Although current funding levels for the rent subsidy program are thought adequate to serve the MFP initiative's transition goals in year one, HCBS Rent Subsidy Program resources will be closely monitored by IFA staff to ensure legislative budget requests are sufficient to provide needed rental assistance for the transitioning population long-term.

The *Partnership for Community Integration* MFP initiative will also benefit greatly from the state's other recent efforts to provide housing units for people with disabilities. In February 2003, then Governor Vilsack and Lt. Governor Pederson directed state agencies to address barriers to community living and established a target to "develop or preserve 1,000 independent living units in communities across Iowa to ensure that people with disabilities have access to housing in their communities." In August 2006, then Lt. Governor Sally Pederson announced that the state of Iowa had reached this goal. As the state's leading provider of affordable housing, IFA worked in cooperation with organizations including the Olmstead Real Choices Consumer Task Force, the Iowa Department of Economic Development and many federal, state and local housing organizations to meet the goal in less than three years, one year shy of the original four-year timetable.

During those three years, IFA implemented changes to several of its housing programs to spur the creation or preservation of units for the disabled. Some of those changes include establishing a special set-aside in the LIHTC program for developers of affordable housing, changing the state's first-time homeownership program to accept housing choice vouchers for homeownership, and creating a loan program that provides low-interest money to help people with disabilities modify their homes to meet their individual needs. To date, the Governor's

2003 goal has led to funding commitments for more than 1,572 housing units for people with disabilities across Iowa.

Today, IFA continues to encourage the development and preservation of housing for people with disabilities. The 2008 LIHTC Qualified Allocation Plan includes set-asides for affordable assisted living and for service-enriched housing, in which at least 25 percent of the units must be set-aside and rented to families with a member who has a disability. Scoring criteria in the 2008 Qualified Allocation Plan also encourages expansion of affordable housing opportunities for people with disabilities through incentives to provide items such as supportive service plans, locations near services, and fully handicapped accessible units. IFA will monitor Iowa's need for additional housing units for people with disabilities and incorporate any needed program changes to help meet those needs in the years to come.

Many participants in the Partners' planning process favored program support for simultaneous transition of individuals interested in having roommates, which can not only reduce social isolation but also enhance housing affordability by spreading costs. The vast majority of affordable rental housing units included in the inventory have one or two bedrooms. Of the participating programs, only the LIHTC program reported units including three or four bedrooms in any sizeable number, with 2,230 such units reported as in service across the state.

Therefore, although private housing is an option for all MFP participants, those choosing a community-based housing environment with roommates will particularly need to consider units owned by private landlords, including single-family properties. Nonprofit service and housing providers serving on the Housing Subcommittee have reported encouraging success stories as they have engaged private landlords on a one-on-one basis in previous client transitions from ICFs/MR to community-based housing.

Based upon their wealth of past experience in this area, these providers can continue to serve as a valuable resource in the MFP process and may be especially helpful to the transition specialists going forward. The Housing Subcommittee has also prepared a "Transition Specialist Housing Toolkit" to provide basic reference information that may be useful to the transition specialists in relation to housing in Iowa (Appendix G). Training in how to access Iowa's housing resources, and in the development of constructive relationships with landlords, will be incorporated into the curriculum for transition specialists. In addition, the proposed housing locator/registry website to be completed by IFA under the Real Choices Systems Transformation grant will be an invaluable resource in the MFP transition process, providing information on affordable and accessible units throughout the State.

j) Continuity of Care Post Demonstration

- Continuity of care for participants post-demonstration period will be ensured by (a) the 100 MR Waiver slots reserved annually and currently available for individuals transitioning out of ICFs/MR in calendar year 2008; (b) future earmarking of sufficient waiver slots to accommodate MFP participants, with the understanding that if a shortfall in funding or slots is anticipated, DHS will work with the Legislature to ensure that sufficient waiver slots are available; and (c) the DHS initiative to secure approval, the

necessary funding, and authorization to make application to CMS for proposed waiver amendments incorporating qualified HCB services offered under MFP but which are not currently in the MR or BI Waivers (mental health outreach and crisis intervention), as well as behavioral programming, which is not available in the MR Waiver.

A letter from DHS Director Kevin Concannon affirming his commitment to seek the necessary authority from the Iowa Legislature and from CMS is contained in Appendix H.

Continuity in the mental health outreach, behavioral programming and crisis intervention services can be provided using Supported Community Living, under which these are allowed services, or they may be purchased by a consumer under the Consumer Choices Option.

IME will be reviewing two other issues that have been raised as having an impact on implementation: provider staff training costs which may not be fully accommodated under current reimbursement policies, and the cap on reimbursements for home and vehicle modifications, and will make recommendations as appropriate to ensure that the needs of MFP participants are met.

III. Organization and Administration

A. Organizational structure.

Iowa Medicaid Enterprise (IME) is responsible for management of the grant. The State Medicaid Director is Principal Investigator. For a chart of the organizational structure, see page 31.

B. Staffing plan.

1. Project Director. CMS has approved IME's proposal for the assignment of Eileen Creager, Bureau Chief of Long Term Care, and Debbie Johnson, Program Manager, as Co-Directors of the MFP project. Brooke Lovelace of the Bureau of Long Term Care Project is assigned full time responsibilities as Project Coordinator.

2. Dedicated positions. The grant funds the Project Coordinator position. IME is considering the use of grant funds to establish a Quality Assurance position. The salary for the two Co-Directors is an in-kind contribution. DHS will not charge administrative support services to the grant.

3. Percentages of staff time. The Co-Directors dedicate .20 FTE to the grant. The Project Coordinator is full-time.

4. Roles and responsibilities. The primary responsibilities of the Co-Directors are oversight of the administrative and fiscal functions relative to Medicaid services, approval of contracts and requests for payments associated with the project, and over-all project management.

The Project Coordinator's primary responsibilities are the coordination of departmental and stakeholder activities leading to the development of the Operational Protocol, the drafting of administrative rules for MFP implementation, ensuring adaptation of ISIS and internal reporting systems to the requirements of the grant, and monitoring of contracts.

5. In-kind support. The Co-Director positions are in-kind contributions.

6. Number of contracted individuals supporting the grant. The Project Coordinator position, though housed in IME, is a contractual position. The other contractual positions are three individuals at the University of Iowa – Center for Disabilities and Development (CDD) who provide general staff support: Robert Bacon, Director of the University Center for Excellence in Developmental Disabilities (UCEDD), Ann Riley, Deputy Director of the UCEDD, and Liz O'Hara, Disability Policy Analyst. CDD has assisted in research, project planning, the establishment and staffing of the Partners stakeholder group, development of the Operational Protocol, and assistance in grant compliance.

7/8. Staffing timeline. All staff are currently on-board.

9. Performance evaluation. Project Co-Director Eileen Creager is responsible for supervision and evaluation of the Project Coordinator.

C. Billing and Reimbursement Procedures

All MFP participants will be tracked separately from HCBS waiver consumers in the Individualized Services Information System (ISIS) described below. All qualified HCBS services will follow the same billing procedures as any HCBS waiver payments. For the demonstration and supplemental services, the Transition Services Coordination agency (the vendor employing the transition specialists) will act as a Financial Management Service similar to the process of the Consumer Choices Option program. The Transition Services Coordination agency will be the Medicaid provider and will submit claims for all approved demonstration and supplemental services and will pay for these services on behalf of the consumer. All services must be identified in the MFP participant's service plan and in ISIS and will be subject to the same billing audit procedure as the HCBS waiver providers. This process as been tested with the Consumer Choices Option program and has been shown to work.

The Iowa Department of Human Services has developed a computer program, named the "Individualized Services Information System" or "ISIS," to support the waiver programs. The purpose of ISIS is to assist workers in these programs in processing and tracking requests, starting with an initial entry from the ABC system through approval or denial. Upon approval, participants will use ISIS to provide the Iowa Medicaid Enterprise (formally called the fiscal agent) with information and authority to make payments to or on behalf of a consumer. The consumer is tracked in ISIS until that consumer is no longer accessing a waiver program. The ISIS system provides for edits to make sure that all claims are made only when an individual is eligible for waiver payments and when the services was included in the plan. The Iowa Department of Human Services Bureau of Purchased Services performs financial audits on providers to ensure

the services were provided. The transition specialist and, after the demonstration year ends, the case manager also ensures that the services were provided.

In addition, the Department of Human Services Bureau of Purchased Services performs both financial and performance audits of Medicaid Providers. The billing audit is intended to:

- Ensure HCBS providers appropriately and accurately document the provision of services so that claims paid by the Department are eligible for reimbursement;
- Limit the risk of providers having to refund payments to the Department because they have submitted ineligible claims.
- Limit the risk of the Department losing or having to return matching federal funds because of having paid ineligible claims.

The flow of billing is as follows:

- Providers shall submit claims on a monthly basis for waiver services provided to each individual served by the provider agency.
- Providers may submit manual or electronic claim forms:
  - Manual claims shall be directed to the Iowa Medicaid Enterprise (IME)/Provider Services Unit.
  - Electronic claims shall utilize the HIPAA compliant software, PC-ACE Pro32 and shall be processed by the Iowa Medicaid Enterprise/Provider Services Unit.
- Providers shall submit a claim form that accurately reflects the following:
  - The provider's approved Medicaid waiver provider number
  - The appropriate waiver procedure code(s) that correspond to the waiver services authorized in the service worker or case manager's service plan (case plan).
  - The appropriate waiver service unit(s) and fee that corresponds to the service worker, transition specialist or case manager's service plan (case plan).
- The IME/Provider Services Unit issues provider payments on the second and fourth Mondays of each month.
- The ISIS system edits insure that payment will not be made for services that are not included in an approved service plan (plan of care). Any change to ISIS data generates a new program request. The program request culminates in a final milestone that verifies an approved service plan has been entered into ISIS. ISIS data is updated daily into MMIS.

IV. Evaluation

Iowa has not planned or budgeted for a state administered evaluation of MFP, but will collaborate with the national evaluation.