North Carolina Money Follows the Person Rebalancing Demonstration Grant

Operational Protocol 2007–2018

North Carolina Department of Health and Human Services

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Contents

Introduction

Purpose of the North Carolina Money Follows the Person Demonstration Project

North Carolina's Money Follows the Person Demonstration Project (NC MFP or the Project) is a time-limited demonstration project administered by the North Carolina Department of Health and Human Services (DHHS) through its Division of Medical Assistance (DMA). The mission of NC MFP is to support qualified Medicaid beneficiaries to transition out of qualified long-term care or inpatient facilities and return to their homes and communities with supports. NC MFP provides time-limited, transition-related supports and resources to participating individuals. These supports and resources are outlined in the Benefits and Services section. This Operational Protocol refers to individuals participating in NC MFP as "person," "people" or "participants." Additionally, NC MFP works to advance the four objectives of the federal Money Follows the Person Demonstration Program:

> (1) Increase the use of home and community-based, rather than institutional, long-term care services.
>
> (2) Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.
>
> (3) Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.
>
> (4) Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community- based long-term care services and to provide for continuous quality improvement in such services.[1]

NC MFP works to develop quality transition practices, and to inform and advance a long-term care system that expands person-centered home and community-based service (HCBS) options for older adults, people with physical disabilities and people with intellectual/developmental disabilities (IDD). North Carolina intends to facilitate 1248 transitions through the life of the NC MFP Project. NC MFP is available statewide.

History

North Carolina has participated in the federal MFP program since May 2007. DHHS, in partnership with advocates and other stakeholders, developed NC MFP's original Operational Protocol in June 2008. NC MFP began supporting people to transition in 2009 and the Project's initial transition coordination structure was established in 2010. Since 2009, NC MFP has worked steadily to expand both covered populations and the transition coordination network that supports MFP participants through the transition process. NC MFP works to incorporate its learning into the design of North Carolina's HCBS programs and the overarching Medicaid program design.

[1] Section 6071 of The Deficit Reduction Act (DRA) of 2005 (P.L. 109-171)

Under the *Affordable Care Act*, the federal MFP program was extended and appropriated funding through 2016, with funding available to participant states through September, 2020. Identified NC MFP transition services and other demonstration services managed by the Project will be integrated into regular Medicaid and DHHS operations between 2018 and 2020.

Systemic Changes That Advanced NC MFP's Mission

North Carolina continues to improve access to HCBS services.
Since NC MFP's inception, DHHS has facilitated the following:

- Establishment of the Transitions to Community Living Initiative (TCLI), which prioritizes supporting individuals with serious mental illness (SMI) and serious and persistent mental illness(SPMI) who currently reside in adult care homes or are at risk of placement, to access home and community-based alternatives;
- Expansion of the Program of All Inclusive Care for the Elderly (PACE) to include 11 agencies with a total of 12 sites throughout the state
- Expansion of waiver slots in the Community Alternatives Program for Disabled Adults (CAP/DA) and in the Innovations waiver;
- Establishment of the statewide Local Contact Agency (LCA) network;
- Development of three different transition coordination structures to more effectively evaluate the transition needs of older adults and people with physical disabilities who want to transition;
- Expansion of the CAP/DA electronic case management platform, e-CAP, fostering consistency in the waiver level of care determination process, expanding data collection functionality and improving information sharing options among transition team members;
- North Carolina General Assembly's authorization to pursue a traumatic brain injury (TBI) waiver.

Systemic Changes that Have Impacted NC MFP's Operations Since the Project's Inception

NC MFP operates within a larger service delivery context. Over the course of the Project, NC MFP has navigated this changing landscape and attempted to leverage opportunities that NC MFP does not initiate, but by which NC MFP is affected. Milestones in North Carolina's service delivery landscape that have influenced the design and operation of NC MFP include the events outlined below:

August 2012: DHHS reached a settlement agreement with U.S. Department of Justice to develop targeted in-reach and transition program for identified individuals with SPMI. Activities under the TCLI settlement are managed by the DHHS Office of the Secretary.

2009-2013: Medicaid managed care for behavioral health and Intellectual and Developmental Disability (IDD) services expands from pilot region to statewide coverage. Through this conversion, identified regional management entities, known as local management entities (LMEs), begin operationalizing Medicaid-funded behavioral health services under a capitated structure. While these organizations operate under the federal designation of Prepaid Inpatient Health Plan (PIHPs), they are known in North Carolina as Local Management Entity-Managed Care Organizations (LME-MCOs).

July 2013: DHHS converts to new Medicaid Management Information System (MMIS) called NCTracks.

2014 (throughout): DHHS converts to a new Medicaid eligibility information system called NC FAST.

September 2015: The North Carolina General Assembly passes legislation instructing DHHS to develop and submit a Section 1115 Medicaid demonstration waiver application to the federal Centers for Medicare and Medicaid Services (CMS) and to operationalize a statewide Medicaid managed care program no later than 18 months after receiving CMS approval of the waiver.

Description of NC MFP Participants

To be eligible for NC MFP, an individual must meet federal MFP eligibility requirements. To transition under NC MFP, an individual also must meet criteria for the HCBS program into which a participant will enroll upon transition. Please see the Recruitment and Enrollment section for more information.

An individual is considered a NC MFP "participant" upon application approval.

A participant may *transition* under NC MFP if he or she:

1. Meets the criteria for enrollment into the CAP/DA or its self-directed option, CAP/CAP/Choice; the Innovations waiver; or PACE and is approved for enrollment prior to transition;
2. Transitions into a qualified residence as defined in the federal MFP criteria; and
3. Continues to meet the agreements set forth in the NC MFP Informed Consent form, transition plan or risk mitigation agreements.

Evolution of NC MFP Transition Process Since the inception of NC MFP, the NC MFP transition process has become more refined and tailored to meet the needs of the specific transitioning population.

In North Carolina, the transition supports available to a person often depend on the person's specific disability and support needs. This has resulted in a diverse network of organizations that provide transition supports to various populations. Despite the numerous providers, a set of principles is beginning to emerge that is shaping how "quality" is defined in the long-term care transition process. These emerging principles (see Attachment C) now guide NC MFP's transition efforts and provide the aspirational framework for the Project's transition design. Transition-related protocols are outlined in applicable transition coordination contracts, but a general diagram of the NC MFP Transition Process is included in Attachment B.

NC MFP Transition Coordination Function

The transition coordination function plays a pivotal role in facilitating NC MFP transitions. While core expectations of the transition coordination function are aligned across NC MFP's target populations, the transition coordination function is

operationalized within the applicable service delivery model of the identified target population.

NC MFP Transition Coordination Function for Participants with IDD
Since 2013, the transition activities for individuals with IDD have been managed by identified staff within each Behavioral Health LME-MCO. To facilitate the transition of an eligible MFP participant with IDD, transition coordinators within the LME-MCO must satisfy NC MFP training requirements.

NC MFP Transition Coordination Function for Older Adult Participants and Participants with Physical Disabilities
The development of a robust, statewide transition coordination network for older adults and people with physical disabilities has remained among NC MFP's biggest opportunity for growth.

Since the its inception, NC MFP has worked to build a statewide transition coordination network that partners with entities instrumental in earlier transition efforts, while also maximizing opportunities to expand and deepen capacities among case management entities and other organizations closely affiliated with the transition process.

Currently, NC MFP's aging and disability populations are served by a network of transition coordination organizations. This network is reflected in the transition coordination map (see Attachment D). See the Benefits and Services section for more information. The current network for supporting older adults and people with physical disabilities to transition under MFP include the following organizations:

1. **Division of Vocational Rehabilitation-Independent Living Program (DVR-IL):** DVR-IL, the state-sponsored entity located within the DHHS Division of Vocational Rehabilitation, provides eligible individuals with an alternative to living in a nursing home or other facility. Services, such as home modifications, adaptive equipment or self-directed personal assistance services, are person-centered and may be provided directly, purchased or coordinated through other community resources as outlined in the individual's person-centered service plan. DVR-IL services are state funded. Service availability depends on available state funding. Since 2010, DVR-IL has been an operational partner in the NC MFP transition coordination network for older adults and people with physical disabilities, appropriating state funding toward NC MFP's transition coordination demonstration service and directly managing the jointly funded transition coordinators.

2. **CAP/DA Transition Coordination Partnership**: To test a streamlined, integrated transition coordination and case management model, NC MFP partners with two CAP/DA case management agencies (known as "lead agencies") to provide transition coordination functions for MFP participants assigned in designated catchment areas. Through this partnership, NC MFP works to streamline waiver assessment and enrollment practices along with establishing clear transition coordination requirements for the partnering CAP/DA lead agencies. The two partner agencies serve as the only transition coordination entity in their respective region.

3. **Identified Area Agencies on Aging (AAA):** To test how to best streamline options counseling and transition coordination, NC MFP partners with two AAAs that AAAs also hold contracts for the LCA function in their respective regions.

4. **Interested CAP/DA Case Managers:** In some areas, there is additional need for transition coordination. CAP/DA agencies not under contract can provide transition coordination on a fee-for-service basis. These CAP/DA lead agencies must the same requirement as all other agencies under contract.

To better ensure cohesion within its transition network, the NC MFP team coordinates Project application approval and transition coordination entity assignment.

Sustaining NC MFP Activities after Demonstration Project End

As a demonstration project, NC MFP will move its grant-sponsored transition activity into DHHS operations between 2018 and 2020. NC MFP has elected to continue grant-sponsored transitions through December 2018 with follow-along services available through December 2019. To accommodate the timelines North Carolina's Section 1115 demonstration waiver application and the anticipated changes to the Medicaid program, NC MFP will also explore the supported transition activity between the federal MFP program's end date and the activation of North Carolina Medicaid managed care.
NC MFP.

For additional information, please see NC MFP's Sustainability Plan, Attachment N.

Benchmarks

NC MFP monitors and measures five benchmarks, two of which are required by CMS and three developed by NC MFP. NC MFP's benchmarks have been revised throughout the Project based on transition experience and stakeholder feedback.

1. Transition Benchmarks

As of May 31, 2017, NC MFP has facilitated 816 transitions since the beginning of the Project. North Carolina has committed to the following transition benchmarks for CY2009-CY2018.

NC MFP TRANSITION BENCHMARKS				
Transition Year	**IDD**		**Aging & Physical Disability**	
	Benchmark	Actual	Benchmark	Actual
CY 2009	20	20	9	9
CY 2010	30	27	10	12
CY 2011	30	31	60	58
CY 2012	30	26	75	78
CY 2013	30	39	105	79
CY 2014	30	37	105	80
CY 2015	30	71	125	63
CY 2016	68	57	125	87
CY 2017	68	68 (projected)	100	100 (projected)
CY 2018	68	68 (projected)	100	100 (projected)
Population TOTAL	404	308 to CYE 2016 444 with projections though CYE 2018	844	466 to CYE 2016 666 with projections through CYE 2018
TOTAL	1,248 projected, 774 transitioned through CYE 2016, 1,110 to transition with projections by CYE 2018			

2. Projected Expenditures for North Carolina Home and Community-based Services

As noted earlier, DHHS continues to expand access to HCBS. NC MFP tracks and reports *maintenance of effort* annually. Projections are based on actual financial performance of the prior year and include the following HCBS services: CAP/DA (including CAP/Choice), home health, personal care services, Innovations waiver, CAP/C, private duty nursing and PACE. Additionally, NC MFP's qualified and demonstration services expenses from the "AB" portion of the quarterly MFP ABCD financial reports are included.

Year	Estimated Amount	Actual Amount	Percent change
2007	$630,880,654.00	$1,310,099,347.00	0.00%
2009	$631,165,217.00	$1,508,612,243.00	102.09%

2010	$631,405,849.00	$1,358,232,363.00	90.03%
2011	$1,363,116,342.00	$1,304,306,871.00	96.03%
2012	$1,304,306,871.00	$1,361,348,437.00	104.37%
2013	$1,361,348,437.00	$1,509,284,533.00	110.87%
2014	$1,509,284,533.00	$1,582,507,210.00	104.85%
2015	$1,582,507,210.00	$1,721,039,554.00	108.75%
2016	$1,721,039,554.00	$1,705,666,968.00	99%
2017	$1,721,039,554.00	$1,721,039,554.00	100% (projected)
2018	$1,721,039,554.00	$1,721,039,554.00	100% (projected)

3. Continued, increased outreach to qualified facilities.

In partnership with DHHS' 's LCA network and the LME/MCOs, NC MFP conducts targeted, in-person outreach and in-reach to the following number of qualified facilities.

YEAR	**In-Reach and Outreach Events within Nursing Facilities**		**ICF-IID/State DD Centers**	
	Benchmark	Actual	Benchmark	Actual
CY 2013	60	195	10	7
CY 2014	300	330	10	4
CY 2015	400	838	40	4
CY 2016	450	881	50	156
CY 2017	500	500 (projected)	60	60 (projected)
CY 2018	550	550 (projected)	70	70 (projected)
Facility Event Totals	2610	2244 total through CY 2016 3294 total with projections though CY 2018	270	171 total through CY 2016 301 total with projections though CY 2018
Grand Total	2880 In-Reach/Outreach Events benchmark, 2415 total through CY 2016, 3595 total with projections though CY 2018			

4. Ninety percent of active, transitioned MFP participants will remain in their communities for at least one year following their transition date

NC MFP is committed to ensuring participants have the supports needed to remain in their community upon transitioning. NC MFP tracks its recidivism rate to assess its effectiveness, measured by identifying the cumulative number of individuals who returned to a long-term care facility during their MFP participation year that resulted in a discharge from the program, and dividing that number by the total number of transitions to date.

Active MFP Participants Remain in Community		
90% of active, transitioned NC MFP participants will remain in their communities for at least one year following their transition date.		
Year	**Benchmark Goal**	**Actual**

CY 2009	85%	79
CY 2010	87%	97.1
CY 2011	89%	90.5
CY 2012	89%	93.5
CY 2013	90%	90.75
CY 2014	90%	87.89
CY 2015	90%	83.25
CY 2016	90%	88.57
CY 2017	90%	90 (projected)
CY 2018	90%	90 (projected)
CY 2019	90%	90 (projected)

5. Expedite access to housing through a streamlined waiver assessment process. NC MFP has a desire to support individuals, regardless of age or disability, to live in their own homes (either owned or rented) if they choose to do so. NC MFP will continue to collaborate with its service delivery and state housing partners to better ensure streamlined, timely access to quality supports and affordable, accessible housing.

[Revised Benchmark]:] 85% of waiver assessments under the responsibility of the NC MFP-CAP/DA Transition Coordination Partnership vendor[2] shall occur within no more than 15 business days of a participant's housing being secured. Housing is considered "secured" if one of three events occur:

1. Person/family confirms housing is available at the first face-to-face transition meeting;
2. A location is identified (through targeted/key program or other venue) and secured sufficiently to conduct a home assessment; or
3. If home modifications are required to meet the health and safety criteria of the waiver, the assessment timeline may start after essential home modifications necessary to meet waiver's health and safety requirements are complete.

This rate is measured by identifying the cumulative number of individuals who transitioned under the MFP/CAP DA Transition Coordination Partnership and dividing that number by the number of assessments that occurred no more than 15 business days after a participant's housing was secured.

Assessment Housing		
85% of assessment under the responsibility of the NC MFP-CAP/DA Transition Coordination Partnership vendor will occur no more than 15 business days of housing being secured.		
Year	**Benchmark Goal**	**Actual Number**
CY 2016	85%	90%
CY 2017	85%	85% (projected)
CY 2018	85%	85% (projected)

[2] Cape Fear Valley Health System; Senior Services

Participant Recruitment and Enrollment

Federal MFP Enrollment Requirements

Federal requirements governing the NC MFP program require that individuals applying for MFP meet the following criteria to transition under the MFP program:

1. Applicant must currently reside in a qualified inpatient facility[3]
2. Applicant has resided in the qualified facility for at least 90 consecutive days, excluding days reimbursed under Medicare Part A;
3. Applicant receives Medicaid benefits from this facility for at least one day prior to transition; and
4. Participant continues to meet federal and state program level of care requirements.

Upon application approval, a person is considered an MFP participant. Upon transition, an MFP participant maintains participant status for 365 days after the transition occurs. During this time, MFP participants may access available MFP demonstration services. See the Benefits and Services section for more information.

NC MFP's Target Populations Based on Waiver Eligibility

For an eligible individual to transition through NC MFP and remain a participant, he or she must enroll in one of three identified North Carolina HCBS programs: CAP/DA; Innovations waiver program or PACE.PACE. The participant must be deemed eligible for enrollment by the time the participant discharges from the qualified facility. An MFP participant enrolls into the selected HCBS program immediately upon transition, with identified services in place to ensure continuity of care.

Participant Recruitment

NC MFP aligns its outreach with its target populations. For tracking purposes, NC MFP classifies its participants using three population categories:

1) Older adults (65 or older and not otherwise identified as being an individual with IDD);
2) People with physical disabilities (individuals under 65 who are not otherwise identified as being an individual with IDD); or
3) Individuals with IDD

See the Outreach, Marketing, and Education section for more information.

MFP Application Submission and Review Process

North Carolina Medicaid-eligible individuals who want to participate in NC MFP or, if appropriate, the individual's legal guardian or representative, are required to sign an informed consent form indicating that they have freely chosen to participate; are aware

[3] "Inpatient facility" is defined in Section 6071 of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) and includes acute care facilities; nursing facilities; Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities. Psychiatric Residential Treatment Facilities (PRTF) are also authorized. In limited circumstances, a person currently residing in a state psychiatric hospital may also be able to transition under MFP. Allowable circumstances for a person in a state psychiatric hospital are outlined in Appendix NOTE HERE. Adult care homes are not considered an "inpatient facility" for the purpose of NC MFP eligibility.

of and understand the transition process; and have full knowledge of the supports and services to be provided. Please see the Informed Consent and Guardianship section for more information.

Participant Enrollment

NC MFP will review and either approve or deny each application to the Project. Staff approve an application if the applicant meets the Project's following threshold criteria:

1. The applicant has resided in a federally-defined qualified facility for at least 90 consecutive days;
2. The applicant is a Medicaid beneficiary;
3. The applicant desires to transition to a federally-defined *qualified residence;*[4]
4. The applicant has completed an Informed Consent, which indicates the applicant's understanding MFP's required alignment with North Carolina waivers or the PACE program.

Participant Enrollment: Determining a Qualified Facility

An applicant is residing in a qualified facility if the applicant has resided in a qualified facility or a continual series of qualified facilities for at least 90 consecutive days. As part of the application review process, NC MFP state staff verify facility type and duration of the stay with the facility business office and cross-verify through North Carolina's Medicaid Management Information System, NCTracks and North Carolina's Medicaid eligibility system, NC FAST if needed.

Special Considerations for Applicants in Nursing Facilities or Acute Care Settings

In addition to confirming the applicant has resided in a qualified facility or an uninterrupted series of qualified facilities for 90 days, the NC MFP team analyzes the funding source of an applicant's 90 day stay. Following federal MFP requirements, NC MFP excludes those days covered by Medicare Part A funding. Further, the NC MFP team confirms nursing facility's NC FAST living code status and licensure status with nursing facility to verify it is not an adult care home.

Special Considerations for Applicants in ICF-IID, Psychiatric Residential Treatment Facilities (PRTFs) or for State Psychiatric Hospitals

If an applicant resides in an ICF-IID, PRTF, NC MFP's criteria as outlined in the Participant Enrollment section applies as written. If an applicant resides in a state psychiatric hospital, the NC MFP team confirms the following additional federal requirements are met before approving the application:

1. The applicant is under the age of 22 or over the age of 65;
2. The applicant is eligible or anticipated to be eligible for the Innovations or CAP/DA waiver.

[4] Qualified residence is defined in Section 6071 of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) and includes: *(A) a home owned or leased by the individual or the individual's family member;*
(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and
(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.
In North Carolina, MFP participants may select from those residence options available under the applicable HCBS program under which the participant is enrolled.

Process for Ensuring Medicaid Eligibility

As part of the NC MFP application review process, NC MFP staff verify an applicant's Medicaid eligibility through North Carolina's Medicaid eligibility information system, NC FAST. If an applicant is anticipated to be Medicaid-eligible under a Medically Needy eligibility category and is anticipated to have a Medicaid cost-sharing requirement ("Medicaid deductible"), the NC MFP team flags this in the applicant's file and informs the transition team.

Enrollment into Appropriate Waiver/HCBS Program Upon Transition

To transition under NC MFP, a person must also qualify for one of the NC MFP-identified HCBS programs and transition to a qualified residence. NC MFP participants transition into the CAP/DA or Innovations waiver program or PACE services on the first day in the community. Slots have been reserved or are otherwise available in each applicable waiver program for Money Follows the Person participants.

An MFP participant is not considered enrolled in a NC MFP- identified HCBS program until the assessment and care plan have been completed by the HCBS program assessment entity, the waiver slot (if applicable) has been assigned and the participant has transitioned into a qualified residence.

Coordination between Transition Planning and HCBS Program Enrollment

During the transition planning process and prior to the transition, each participant is assessed to ensure that s/he meets the proper Level of Care for the NC MFP- identified HCBS program under which s/he will be transitioning. As part of the transition planning process, NC MFP transition coordinators coordinate with the waiver case manager or service coordinator who initiate appropriate assessments, confirm waiver eligibility and develop the plan-of-care/Individualized Support Plan (ISP) (collectively, referred to as the "Care Plan"). The person-centered care plan, which integrates recommendations identified in the transition plan is required to be completed for all NC MFP participants who intend to transition. Factors to be considered in the transition planning process include:

- Participant's history and community-based interests, preferences and goals;
- Housing support needs;
- Direct support staff training needs;
- Medical support needs and resources to meet the identified needs;
- Durable medical equipment needs and assistive technology needs;
- Mental health and substance use disorder considerations;
- Benefits transfer;
- Transportation needs;
- Education and employment interests;
- Behavioral challenges and resources to address the needs including development of a behavior support plan with ongoing oversight and training by a licensed psychologist;
- Risk mitigation and crisis planning.

An interdisciplinary team assists the NC MFP participant to manage his or her transition to the community. The participant's team is comprised of, at minimum: the participant,

the participant's family or friends (as requested and appropriate); the facility discharge planning staff and applicable facility staff; the HCBS program representative (case manager, service coordinator) and the NC MFP transition coordinator.

NC MFP participants are also informed of their rights and responsibilities through the NC MFP informed consent process and the HCBS program enrollment process. Additionally, participants and/or their family/guardian are informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents.

Re-enrollment Policy

An NC MFP participant who has withdrawn from the program or has transitioned and is re-institutionalized for a period greater than 30 consecutive days is categorized as dis-enrolled from the program. However, a dis-enrolled individual may re-enroll in the program without re-establishing the 90 consecutive non-Medicare Part A residency requirements. If the former transitioned participant remains in the qualified facility beyond six months, the participant is defined as a "new" Money Follows the Person participant.

A former participant may re-enroll in the program after being re-evaluated by the transition coordinator and local representative of the HCBS program in which the participant will be enrolling. The circumstances surrounding earlier dis-enrollment shall also be considered as part of the re-evaluation process. Once the participant is determined to be eligible for the identified HCBS program, the HCBS program representative will develop a Plan of Care, addressing any change in the status of the Money Follows the Person participant and/or any lack of necessary supports in the community.

After three occurrences of re-institutionalization of 30 consecutive days or longer, the re-institutionalized Money Follows the Person participant will not be considered for reentry into the Money Follows the Person Project.

Continuity of Care

NC MFP participants will continue to receive waiver or PACE services at the end of the transition period (365 days) if they remain eligible for one of the applicable HCBS programs. If an individual does not continue to remain eligible for a CAP waiver, Innovations waiver or PACE services, all efforts will be made to assist the individual and/or family/guardian in locating community services offered by various organizations and state programs in their local area. This is explained to all individuals prior to enrollment into the Money Follows the Person Demonstration and prior to transitioning out of the Money Follows the Person program.

Informed Consent and Guardianship

All individuals who wish to participate in NC MFP (or, if appropriate, those individuals' legal guardians) are required to sign an Informed Consent form indicating that they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights, responsibilities, options and risks. Additionally, participants and/or their family members and/or guardians are informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents. An applicant acknowledges by signing the informed consent that he or she must meet the criteria for an applicable waiver program or PACE in order to transition under NC MFP. If an individual does not continue to remain eligible for one of the applicable HCBS programs upon transition, the NC MFP team and transition coordinators assist the person and/or family in identifying alternative services and programs in their local area.

Individuals Authorized to Provide Informed Consent

Informed consent for permission to participate in NC MFP can be given by the adult participant, emancipated minors, the parents of minors, or the legal representative or surrogate decision makers who have responsibility for the individual's living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent named in a health care power of attorney.

Guardianship

Guardians are considered surrogate decision makers for individuals who have been adjudicated to be incapable of making and communicating decisions about themselves and/or their assets. The guardian's duty is to advocate for and assist the ward in exercising his or her rights.

A guardian may be an individual, such as a family member or friend; a corporation chartered to serve as guardian; or a disinterested public agent guardian. A disinterested public agent guardian may be the director or assistant director of a local human services agency (county Department of Social Services, Local Management Entity, local health department, or county department on aging) or an adult officer or agent of a state human services agency.

While North Carolina General Statute 35A does not specify the level of interaction between a ward and an individual or corporation serving as guardian, it does speak to the rights of the individual and the guardian/ward. Specifically, North Carolina General Statute 35A-1201(5) reads, "Guardianship should seek to preserve for the incompetent person the opportunity to exercise those rights that are within his comprehension and judgment, allowing for the possibility of error to the same degree as is allowed to persons who are not incompetent. To the maximum extent of his capabilities, an incompetent person should be permitted to participate as fully as possible in all decisions that will affect him."

Training and Information

Individuals Residing in a Nursing Facility

Local Contact Agencies provide information about community-based options to interested facility residents. MFP Transition Coordinators, along with the CAP/DA lead agency staff or the PACE enrollment staff inform interested residents about the MFP transition process, including those considerations outlined in the informed consent process and the requirements of the applicable waiver or HCBS Program to be utilized upon transition.

Each participant identified for transition to the community is provided with information regarding protection from abuse, neglect, and exploitation and the process for notifying the appropriate authorities if the participant is subject to abuse, neglect, or exploitation. This information is given by the applicable HCBS program representative to the individual, as well as to other identified family members, legal guardians, etc., during the person-centered planning process. these the Quality Management section for more information.

Individuals Residing in Private ICF-IID or State-operated ICF-IID (Developmental Centers)

An individual who resides in an ICF-IID and his or her guardian/ legal representative, are provided with information regarding transition options available under the Innovations waiver. As part of the waiver enrollment process, LME-MCO service coordinators provide information about protection from abuse, neglect, and exploitation in the community and how to notify the appropriate authorities if the participant is subjected to abuse, neglect, or exploitation. The information is reviewed with the individual and his or her guardian and/or legal representative by the individual's planning team during the person-centered planning process and at any time a transition meeting is taking place (should the desire to transition occurs prior to the annual person-centered planning process).

Outreach, Marketing, and Education

Throughout the Project's tenure, NC MFP has refined its Outreach, Marketing and Education strategy to be responsive to both the changing service-delivery landscape and the emerging needs of the MFP population.

Throughout the course of the Project, NC MFP has refined its generic outreach materials to clearly answer basic information about the Project's criteria and how the transition process works.
The Project also maintains an MFP-specific toll-free number which is directly connected to MFP staff, and is distributed broadly. NC MFP uses a single toll-free number to field calls from any interested stakeholder. The toll-free number also serves as a backup call option for MFP participants to access information about services or supports.

Outreach to Potential NC MFP Participants

To most effectively leverage the opportunities and circumstances of each NC MFP target population group, NC MFP's outreach to potential participants is largely population-specific.

Targeted Outreach to Older Adults and People with Physical Disabilities

NC MFP partners with the Division of Aging and Adult Services (DAAS) and the Division of Health Services Regulation (DHSR) to support the LCA network, required under the federal Minimum Data Set, 3.0 (MDS 3.0). Under MDS 3.0, LCAs are required to provide counseling about HCBS options to interested people residing in nursing facilities. Under its contract with DHHS, each LCA is also required to facilitate outreach opportunities to people in nursing facilities, their families and facility administrators to learn about MFP and other opportunities to transition.

NC MFP does not have a Data Use Agreement to access MDS data directly from CMS. However, with the support of North Carolina's nursing facility association and the Division of Health Service Regulation, NC MFP is partnering with an identified LCA local partner to pilot targeted in-reach using Medicaid claims and enrollment data already available to the Project.

Targeted Outreach to People with Intellectual and Developmental Disabilities (IDD)

North Carolina's LME-MCOs assume responsibility for coordinating and managing both ICF-IID services and the Innovations waiver program services. Each LME-MCO meets with individuals currently residing at a private ICF-IID or a state developmental center who are served by the particular LME-MCO. If the person/guardian indicates an interest in exploring community-based options, the LME-MCO staff provide information about NC MFP. If the person/guardian expresses an interest in transitioning, the LME-MCO coordinates with the person/guardian to submit an MFP application and begin the transition process.
In addition to outreach efforts driven by the LME-MCO, NC MFP continues to conduct outreach directly to IDD stakeholders through regular conferences and related stakeholder opportunities.

In recognition that family members and guardians often make the final determination about a person's participation in the NC MFP program, NC MFP works with LME-MCOs and state development center staff to engage families in dialogue about the transition process.

Additional Outreach to All Populations

In addition to its population-specific outreach, NC MFP engages stakeholder groups that may represent multiple populations or represent a population that may be reflected in multiple population groups, such as individuals with Traumatic Brain Injury.

Finally, NC MFP has utilized standing education forums that it has created, such has the MFP Lunch and Learns to provide an overview of MFP overview annually. This training is available to all interested stakeholders. Please see the Staff Training section for additional information.

Targeted Outreach to Providers

While NC MFP continues to partner directly with providers of all kinds, its emphasis remains on working most closely with those providers that are responsible for providing information and coordinating HCBS options for potential MFP participants. Providers include:

- Local Contact Agencies (LCAs), managed through the Area Agencies on Aging
- Nursing facilities
- CAP/DA waiver lead agencies
- PACE programs
- Division of Vocational Rehabilitation Independent Living Programs
- Hospital Discharge Planners
- LME-MCO care coordination staff
- Private ICFs/IDD (in partnership with LME-MCOs)
- Division of Social Services
- Corporate Guardianship providers

Outreach and Engagement with State Staff

A wide variety of State staff and DHHS divisions are integrated into NC MFP's activities, including the State agency divisions below:

- DMA
- Division of Aging and Adult Services
- Division of Vocational Rehabilitation Services, specifically the Independent Living Program
- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
- North Carolina Council on Developmental Disabilities

Outreach to Key Stakeholders

Advocacy groups serve as important audiences for Money Follows the Person Demonstration Grant Project information. Throughout the Project's tenure, advocacy

groups serve as key partners in both MFP's outreach activity and in advancing MFP long-range priorities. Examples of organizations engaged throughout the MFP Project:

- disAbility Rights of North Carolina
- Centers for Independent Living
- North Carolina Bar Association
- North Carolina Coalition on Aging
- Friends of Residents in Long-Term Care
- Health Care Facilities Association
- Association for Home and Hospice Care of North Carolina
- Long-Term-Care Regional Ombudsman
- National Alliance on Mental Illness
- Association of Self Advocates
- North Carolina Brain Injury Advisory Council

Types of Media to be Used

Participants

While NC MFP uses multiple forms of media to share information about NC MFP, including written materials, YouTube videos and local newspaper media outlets, the Project has identified "face-to-face" outreach (or "in-reach" when conducted to individuals in a facility) to be the most effective at providing information to potential participants. Media press releases have also been used to announce new partners or to share success stories in local markets.

Providers

Providers receive information about NC MFP using the following channels: North Carolina Medicaid Bulletin (e-postings), NC MFP outreach materials, conference presentations and conference sponsorship; North Carolina Medicaid website; DHHS e-newsletters; mass mailings (post cards) to provider associations; and conference sponsorship.

State Staff

State staff receive information about MFP through personal introductions and orientations, NC MFP Lunch and Learn webinars, the North Carolina Medicaid website.

Information Dissemination

The following organizations use NC MFP's information dissemination process:

- Various non-profit health care organizations, including
  - National Multiple Sclerosis Society
  - ARC of North Carolina
  - Easter Seals/UCP of North Carolina
  - National Alliance on Mental Illness
  - Mental Health Association
  - Provider associations
- Behavioral Health Local Management Entities/Managed Care Organizations (LME-MCOs)
- North Carolina Family Health Resource Line

- Area Agencies on Aging and local Councils on Aging
- Centers for Independent Living
- Rehabilitation centers
- Inpatient facilities
- North Carolina Division of Vocational Rehabilitation Independent Living program offices
- Senior Health Insurance Information Program/North Carolina Senior Medicare Patrol
- Long-Term-Care Ombudsmen offices
- North Carolina Council on Developmental Disabilities
- Providers of Programs for All-inclusive Care for the Elderly (PACE)
- Lead agencies for the CAP/DA
- disAbility Rights North Carolina
- Local libraries
- Community spaces (example: Parks and Recreation centers)
- In 2016, North Carolina re-initiated long-standing efforts to develop a "No Wrong Door" information portal in partnership with United Way's 211. Prior to its activation, MFP will orient operators on MFP.

Sharing Stories

NC MFP recognizes the value of people who have transitioned and their families telling their own stories about the transition experience and community life. NC MFP facilitates opportunities to support people in sharing their own stories through:

- The collection of written stories;
- Supporting opportunities for people to speak at conferences and other public forums as they arise;
- The anticipated development of a documentary;
- Using other media (radio, YouTube, etc.) as appropriate.

The Project follows the relevant ethical guidelines related to testimonials and informed consent when supporting people in telling their stories.

Transition-Related Staff Training and Professional Development Opportunities

Since its inception, NC MFP has matured significantly in its staff training and professional development activity.

Through its efforts to improve and coordinate state-level professional development opportunities related to quality transition practice in long-term care, NC MFP has become a central professional development resource for both transition-related functions and on topics relevant to supporting individuals in community-based settings.

Targeted Training to MFP Transition Coordinators

All new NC MFP transition coordinators are required to participate in an orientation about MFP and the key components of quality transition planning. Further, all NC MFP transition coordinators under direct contract with the Project receive targeted shadowing and modeling with NC MFP's lead state staff or with an experienced regional transition coordinator for a minimum of one week. Contracted transition coordinators are also

required to attend the North Carolina DHHS Community Transitions Institute, described later in the section.

All NC MFP transition coordinators also participate in population-specific monthly briefing calls with applicable MFP staff for the Project to provide guidance and for the networks to collectively troubleshoot transition-related challenges.

Quarterly Regional Transition Professional Staff Development
The NC MFP team hosts, either directly or through contract quarterly Regional Transition Professional Development and Networking sessions. Recognizing the collaborative approach required by quality transition planning, these regional Transition Community Collaboration bring transition coordinators from all applicable populations and other professionals in transition-related functions (case managers, options counselors, discharge planners) together for collective networking and learning.

Annual North Carolina DHHS Community Transitions Institute
In 2015, NC MFP launched the DHHS Community Transitions Institute. This summer-long institute accepts approximately 75 members each year, all aligned with various transition-related functions across all transitioning populations. All content for the Institute is developed in partnership with subject matter experts throughout the DHHS and within arena of motivational interviewing and person-centered thinking. The goals of the Institute are to:

- Provide quality content that is immediately relevant to the practice of supporting a transitioning individual;
- Strengthen Institute members' knowledge of, and utilization of, person-centered practices and motivational interviewing techniques in a transition context;
- Foster professional collaboration among Institute members;
- Deliver a learning opportunity that enhances organizational capability to support person-centered transition practices;
- Collect clear data on the efficacy of the Institute;
- Generate clear recommendations for improvements to DHHS-sponsored transition activity.

Continuing Education Units (CEUs) are provided to those Institute members who complete the full Institute. NC MFP

MFP Training to CAP/DA Lead Agencies
The NC MFP team partners with the CAP/DA state management team to develop training materials available to CAP/DA lead agencies at any time through its online information portal, e-CAP. Additionally, NC MFP conducts an annual webinar-based "MFP refresher" course to all CAP/DA lead agencies.

NC MFP *Lunch and Learn* Webinar Series
Since 2012, NC MFP has conducted monthly continuing education opportunities for the public, targeting those individuals who are signed up for the NC MFP Roundtable listserv. These monthly sessions focus on resources critical to quality transition planning including: accessing housing; accessing assistive technology; community-based

transportation options; understanding Traumatic Brain Injury and others. All Lunch and Learn webinars are then posted on NC MFP's website.

Development of Topic-Specific Training Materials Relevant to MFP's Core Mission, including:

Through its experience and in collaboration with other entities responsible for ensuring the quality of transition-related functions, NC MFP funds and/or coordinates the development of other training materials that are relevant to quality transitions. Examples include:

- *North Carolina Medicaid LTSS Guidebook: Community-Based Long-Term Services and Supports Program Eligibility and Reference Guide (Revised April 2017)*
- *Medicaid 101: Medicaid Foundations – What You Need to Know*
- *Medicaid LTSS 101: Medicaid for Long-Term Services and Supports (LTSS)*
- Guidance papers that provide clear simple guidance on accessing identified resources.

Bilingual Materials/Interpretation Services

Materials are available in English, Spanish, Braille, and large print. Electronic materials are accessible to those who use screen readers.

Informing Eligible Individuals of Cost-Sharing Responsibilities

MFP participants are provided information about potential cost-sharing through the MFP application's informed consent form and also counseled during the first transition team meeting. Transition coordinators are trained to link MFP participants and their families with a Medicaid case worker at the appropriate county Department of Social Services to receive complete information and guidance about the likelihood of a deductible and its potential impact on a participant's monthly income.

Stakeholder Involvement

Since the beginning of the Project, NC MFP works to ensure an inclusive, state-wide stakeholder engagement strategy.

The NC MFP Roundtable
Each year, NC MFP coordinates four Roundtable meetings. These meetings rotate to locations around the state. These forums are open to the public and efforts are made to invite a wide range of stakeholders including participants; their families, friends, and guardians; providers; State staff; and other important community stakeholders.

The MFP Roundtable provides guidance and insight on every aspect of the Project's program design including:

- Transition process and transition coordination design;
- Rebalancing Fund priorities;
- Examining and addressing identified challenges and barriers experienced by NC MFP participants;
- Feedback and input on Project's data collection priorities;
- Operational Protocol revisions.

The Project retains a professional facilitator to facilitate its quarterly Roundtable meetings and other workgroups and forums as needed.

The MFP Roundtable event invitations are distributed to all stakeholders enrolled in the NC MFP Roundtable list serve, which is open to any interested person.

Additional Stakeholder Engagement Opportunities
NC MFP engages stakeholders in the following standing committees:

- NC MFP Outreach Committee
- NC MFP Rebalancing Fund Steering Committee
- DHHS & North Carolina Housing Finance Agency Housing & Services Group

As noted elsewhere in the Operational Protocol, NC MFP directly engages front line transition and case management staff in ongoing dialogue about improving transition-related practices. Engagement opportunities include:

- monthly calls with LME-MCO transition coordination network
- monthly calls with aging and disability transition coordination network
- quarterly regional meetings of transition-related professionals
- quarterly LCA Steering Committee meeting
- annually through DHHS Community Transitions Institute member feedback session.

Stakeholder involvement continues to ensure successful implementation of the NC MFP demonstration grant. Stakeholder meetings are instrumental in advancing the Project's goals and developing a long-term care system that provides an array of home and community-based services and supports designed to promote choice and independence.

Informing NC MFP Priorities

In addition to continuous stakeholder engagement through the channels outlined, NC MFP releases an online survey every three years to all MFP stakeholders to assist the Project in establishing its priorities, these priorities inform both MFP staff activity, workgroup design and the use of MFP Rebalancing Funds. An example of this survey is found in NC MFP's Sustainability Plan, Attachment N.

Benefits and Services

Service Delivery Systems

NC MFP participants transition into existing, identified HCBS programs. DHHS did not create a separate demonstration 1915(c) waiver for the ongoing services provided through the NC MFP Demonstration Grant Project.

A person enrolled in NC MFP must qualify and be enrolled in one of three identified HCBS programs at the time of discharge from an institution to be eligible to transition under NC MFP:

1. the CAP/DA waiver or its self-directed option, CAP/Choice:
2. the Innovations waiver; or
3. the PACE program.

After 365 post-transition days of participation in the NC MFP program, individuals continue to be enrolled in the same identified HCBS program so long as they continue to meet the eligibility requirements of the program.

CAP/DA and CAP/Choice Waiver Summary Overview

The CAP/DA waiver and its self-directed option, CAP/Choice serve older adults and people with physical disabilities who meet HCBS nursing facility level of care criteria. Waiver services are managed at the county level through county-specific organizations known collectively as CAP/DA and CAP/Choice lead agencies. As noted in CAP/DA clinical coverage policy referenced below, “these agencies may include county Departments of Social Services, county health departments, county agencies on aging, hospitals or qualified case management agencies.” Lead agencies perform the case management functions for potential and eligible CAP/DA or CAP/Choice beneficiaries.

Upon referral to the lead agency, a Service Request Form and Physician Attestation must be completed and validated to confirm the MFP participant meets the waiver’s level of care criteria. Once Level of Care is established, the lead agency conducts a comprehensive clinical assessment to determine appropriateness for waiver enrollment. Once the NC MFP participant is determined appropriate for waiver enrollment, the lead agency develops the plan of care. Along with other identified priority groups, NC MFP participants who also meet the CAP/DA enrollment criteria receive priority access to waiver services. A full description of the CAP/DA/ Program is found at https://dma.ncdhhs.gov/providers/programs-services/long-term-care/community-alternatives-program-for-disabled-adults.

The Innovations Waiver Summary Overview

North Carolina also operates the Innovations waiver that targets individuals with intellectual or developmental disabilities who meet the ICF-IID level of care. This waiver is part of a larger 1915 (b)(c) behavioral health waiver, managed within the managed care responsibilities of the LME-MCO. The LME-MCO manages level of care determination, assessment and enrollment into the Innovations waiver. DHHS allocates an identified number of waiver slots for MFP participants to each LME-MCO each year. Slots are distributed according to pre-set waiver slot allocation formulas, LME-MCO slot utilization management is assessed quarterly. If an LME-MCO is not fully utilizing its

allocation, DMA redistributes a portion of unassigned slots for MFP participants to other LME-MCOs capable of utilizing them within the current waiver year.

The chart below describes the services currently covered under existing CAP/DA/CHOICE and Innovations waiver programs.

Service Package

Service	Currently Covered Services		
	INNOVATIONS	**CAP/DA**	**CAP/Choice**
Adult Day Health Care	YES [Day Support]	YES [Adult Day Health]	YES [Adult Day Health]
Augmentative Communications	YES [Assistive Technology Equipment and Supplies]	YES [See Assistive Technology]	YES [See Assistive Technology]
Case Management	Case management functions performed by LME-MCO as care coordination and through Community Guide service	YES [Case Management]	NO [See Care Advisor below]
Consumer-directed Goods and Services (equipment and services not covered through State Plan that are needed to increase ability to complete activities of daily living and instrumental activities of daily living and to decrease dependence on aide services)	NO	YES [Participant Goods and Services]	YES
Crisis Services	YES	NO	NO
Day Supports	YES [Community Navigator, Community Networking, Day Supports]	NO	NO
Employment Support	YES [Supported Employment Services]	NO	NO
Enhanced Respite Care	YES [Respite]	NO	NO

Service	Currently Covered Services		
	INNOVATIONS	**CAP/DA**	**CAP/Choice**
Financial Management	YES [Financial Support Services, Employer Supplies]	NO	YES [Financial Management Services]
Home and Community Supports	YES [In Home Skill Building; In Home Intensive Supports; Community Living and Support]	NO	NO
Home Modifications/Home Mobility Aids	YES [Home Modifications]	YES [Home Accessibility and Adaptation]	YES [Home Accessibility and Adaptation]
Individual/Caregiver Orientation/Training/Education	YES [Natural Supports Education]	YES [Training/Education and Consultative Services]	YES [Training/Education and Consultative Services]
Institutional Respite Care	YES [Respite]	YES [Institutional Respite Services]	YES [Institutional Respite Services]
Non-institutional Respite Care	YES [Respite]	YES [Non-institutional Respite]	YES [Non-Institutional Respite]
Personal Care Services/In-home Aide Services	YES [Personal Care Services, Supported Living]	YES [CAP In-Home Aide Service]	YES [Personal Assistance Services]
Personal Emergency Response Services/Telephone Alert	YES [See Assistive Technology Equipment and Supplies]	YES [Personal Emergency Response Services]	YES [Personal Emergency Response Services]
Preparation and delivery of meals (Meals on Wheels)	NO	YES [Meal Preparation and Delivery]	YES [Meal Preparation and Delivery]
Residential Supports (Group Homes)	YES [Residential Supports]	NO	NO

Service	Currently Covered Services		
	INNOVATIONS	**CAP/DA**	**CAP/Choice**
Respite Care (In Home)	YES	YES [See Non-Institutional Respite]	YES [See Non-Institutional Respite]
Specialized Consultative Services (psych counseling, therapy counseling, nutrition counseling, etc.)	YES [Specialized Consultation Services]	NO	NO
Specialized Equipment	YES [See Assistive Technology Equipment and Supplies]	YES [See Specialized Medical Equipment and Supplies]	YES [See Specialized Medical Equipment and Supplies]
Transportation - Non-medical	[embedded in other services]	NO	NO
Vehicle modifications	YES [Vehicle Modifications]	NO	NO
Waiver Supplies	NO	YES [Specialized Medical Equipment and Supplies]	YES [Specialized Medical Equipment and Supplies]
Community Transition	YES	YES	YES
Individual Goods and Services	YES [Individual Goods and Services]	YES [Participant Goods and Services]	YES [Participant Goods and Services]
Consumer-directed Care Advisor	NO	NO	YES [Care Advisor]
Assistive Technology	YES [see other service definitions]	YES	YES

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a managed care program that enables older adults who are certified to need inpatient facility care to live as independently as possible. The PACE provider receives monthly Medicare and/or Medicaid capitation payments for each eligible enrollee. The PACE provider assumes full financial risk for participants' care without limits on amount, duration, or scope of services.

For Enrollment into this program, an individual must be Medicaid eligible and;

- Be 55 years of age or older
- Certified by the State to require inpatient facility level of care
- Able to live safely in the community at the time of enrollment, and

- Reside in the service area of the PACE organization.

Services provided by the PACE program include, but are not limited to:

- All Medicaid-covered services, as specified in the State's approved Medicaid plan
- Multidisciplinary assessment and treatment planning
- Social work services
- Skilled nursing care
- Primary care physician services
- Medical specialty services
- Specialized therapies
- Recreational therapy
- Personal care services
- Nutrition counseling
- Meals
- Medical Supplies
- Home Mobility Aides
- Transportation
- Prescriptions
- Laboratory tests, X-rays, and other diagnostic procedures
- Prosthetics, orthotics, durable medical equipment and corrective vision devices

State Plan Services

In addition to the waiver program services, all Money Follows the Person participants are eligible for Medicaid State Plan Services.

Home and Community Based MFP Demonstration Services

Under the MFP demonstration grant, states are authorized to develop time-limited, demonstration services that are available to MFP participants. Demonstration services enable states to test transition-related services that are not currently covered in the state's Medicaid State Plan. NC MFP's demonstration services are outlined below.

NC MFP Demonstration Service	Applicable Waivers/Programs
Transition Year Stability Resources/Staff and Clinical Capacity Building	Innovations
Transition Coordination	CAP/DA; CAP/Choice
Pre-Transition Case Management	CAP/DA; CAP/Choice
Supplemental Environmental Support Service	Available to eligible MFP participants through Division of Vocational Rehabilitation—Independent Living Program

Home and Community Based Supplemental Services

NC MFP does not provide any supplemental services.

Transition Year Stability Resources Demonstration Service

Ensuring that a person has a stable and well-planned transition is a priority for the Project. If an MFP participant cannot safely and adequately meet his/her transition-

related expenses within the individual service definitions and/or budget cap under the current waiver, the person will have access to “Transition Year Stability Resources (TYSR).” This funding is only available during a person’s transition year and must not be needed as part of a person’s ongoing support plan.

Both CAP/DA/CHOICE and Innovations include a waiver service definition, Community Transitions Services. However, the NC MFP TYSR covers one-time start -up costs that are not covered under the scope of the current definition or cannot be met within the waiver’s existing cost limit.

This demonstration service provides up to $3,000.00 for one-time start-up costs such as:

- utility and rent deposits
- appliances
- essential furnishings
- one-time home preparation: pest eradication, cleaning, allergen control;
- for waiver items, supports and services that cannot be adequately covered in a person’s transition year waiver budget because of the waiver's individual service cap;
- for items, supports and services that are allowed by CMS but not currently available through the waiver chosen by the MFP participant.

Pre-Transition Staffing and Consultation

NC MFP recognizes that strong staff training and clinical consultation are often the most critical “startup” needs a person may have. NC MFP encourages individuals and their transition teams to utilize TYSR funds to cover the staffing costs required for community-based direct support staff or community-based clinicians to visit with the person transitioning and learn the person’s specific preferences and support needs ***prior*** to the person leaving the facility.

LME-MCOs utilizing this service have the authority to determine the staff and travel reimbursement rate based on the specific circumstances of that transition. If an LME-MCO elects to reimburse a provider for travel, travel reimbursement rates must not exceed established North Carolina travel rates. In absence of a LME-MCO specific rate, NC MFP shall reimburse for direct support staff training at a rate of $21.40 per hour and clinical consultation at the applicable billing rate.

This funding is intended to be flexible to adequately meet a person’s specific living needs. If a participant has a specific transition need that is not clearly outlined above, the participant is encouraged to ask for clarification.

This funding may not be used to cover:

- ongoing living expenses upon move-in (such as rent, bill payment)
- entertainment items such as televisions, stereos, etc.

Additionally, since TYSR funds are not available after the first year, there must be clear evidence that the participant's ongoing support needs will be met within the individual service cap and existing scope of approved waiver services after the first year of living

in the community.

All tangible items (furnishings, etc.) acquired using this funding become the personal property of the MFP participant.

All requests for use of TYSR funds must be approved by the Project Director, Associate Director, or Budget and Contract Administrator.

The TYSR funds may be accessed up to 60 days prior to the transition or up to 365 days after the transition.

CAP/DA Pre-Transition Case Management for NC MFP Participants
The CAP/DA case management services that occur prior to a person transitioning are called “pre-transition case management.” To mitigate design issues related to North Carolina’s claims payment system for pre-transition case management, CAP/DA lead agencies may invoice the NC MFP t for up to 14 hours of pre-transition assessment conducted for MFP participants. This process follows NC MFP’s current Pre-Transition Case Management Demonstration Service process, but temporarily expands the hours available, from 8 to 14.

Transition Coordination Services
The Project funds transition coordination services that are separate and distinct from case management services. The Transition Coordination service is a demonstration service and is only provided by professionals who have completed transition coordination training sponsored by NC MFP. The role of the transition coordinator is to support the MFP participant through the transition process.

Transition coordinators follow transition protocols, which include but are not limited to:

- having ongoing, respectful communication with the MFP participant, his/her supports, facility and community provider staff throughout the transition process;
- coordinating and conducting at least two face-to-face planning meetings with the participant and transition planning team members;
- working with the participant and the participant’s family and natural supports to develop a thoughtful, organized transition plan that addresses his/her community-based support needs;
- coordinating with the participant, his/her family and natural supports to identify and secure the community resources necessary to transition. This includes but is not limited to: housing, medical care, financial management (setting up a bank account, etc.), and other community supports that are needed for community living and to meet the health and safety requirements of the applicable waiver;
- coordinating TYSR requests;
- maintaining regular follow up with the MFP participant according to the NC MFP Follow Along Schedule, included in Attachment A, *Supporting People to Thrive: MFP Follow Along Practices*;
- collaborating with the participant’s case manager to ensure coordinated support after transition;

- notifying the Project of any critical incidents impacting the NC MFP participant throughout the participant's participation year.

Fee-for-Service Transition Coordination Services Reimbursed to Participating CAP/DA Case Managers

Except in regions covered by the NC MFP's CAP/DA Transition Partnership outlined in the *Transition Coordination Partnership with Identified CAP/DA Agencies* section, CAP/DA case managers, affiliated with a local CAP/DA lead agency may provide transition coordination to NC MFP participants under NC MFP's fee-for-service Transition Coordination demonstration service.

Transition coordination services provided by CAP/DA case managers are reimbursed at a flat rate of $2000.00 per successful transition. Reimbursement for transition coordination services that do not result in a participant transitioning is reimbursed on a pro-rated basis, up to $1000.00.

Transition coordination services are performed by a case manager but are separate and distinct services from case management. These transition coordination services are distinct from other one-time services allowed under TYSR and must be billed separately. Examples of other one-time services allowed under TYSR include but are not limited to: behavior support consultation and individualized staff training.

Transition Coordination through the Division of Vocational Rehabilitation's Independent Living Program (DVR-IL)

NC MFP/DVR-IL: Transition Coordination Services

NC MFP and the Division of Vocational Rehabilitation's Independent Living Program have partnered together to provide transition coordination for MFP participants who are older adults or have physical disabilities. Under this partnership, DVR-IL shall provide transition coordination services, following NC MFP's established transition coordination practices as outlined in the Interagency Memorandum of Agreement and in this Operational Protocol.

NC MFP/DVR-IL: Supplemental Environmental Support Service

Because individuals with significant physical disabilities often have start up needs that exceed the existing MFP TYSR allocation, DVR-IL has committed additional resources to meet one-time, time-limited start up transition needs. Up to an additional $5,000.00 per MFP/DVR-IL participant may be authorized for transition needs related to home preparation, assistive technology, accessibility modifications, adaptive equipment or tele-support needs not otherwise available under current Medicaid services.

This Supplemental Environmental Accessibility Service is only available to NC MFP participants who are under the auspices of DVR-IL, either directly or through contract. The DVR-IL Housing and Transition Specialist shall review and authorize all requests to access Supplemental Environmental Support services. Supplemental Environmental Support MFP funds are only used pay for goods and services recommended through DVR's assistive technology assessment or the DVR IL home assessment process.

Transition Coordination Partnership with identified CAP/DA Agencies
NC MFP partners with two contracted CAP/DA lead agencies to support older adults and individuals with physical disabilities participating in NC MFP to transition. Under this partnership, these local lead agencies provide transition coordination services, following NC MFP's established transition coordination practices. This partnership intends to promote more cohesive transition practices by:

1. Streamlining transition coordination and case management functions and
2. Incenting partnership with other entities to fully address the support needs of transitioning individuals.

These agencies also pilot transition concepts that are intended to expedite and streamline the transition of individuals from qualified long-term care facilities into their homes and communities with appropriate support.

Transition Coordination Services by Area Agencies on Aging (AAA)
NC MFP partners with two contracted AAA agencies to provide transition coordination for NC MFP participants who are older adults or have physical disabilities. Under this partnership, the AAA provides transition coordination services, following NC MFP's established transition coordination practices. This partnership provides a more cohesive transition structure in underserved areas of the State and tests streamlined referral practices between the LCA and NC MFP transition coordinator functions.

Transition Coordination within North Carolina LME-MCOs
LME-MCOs are responsible for providing transition supports to NC MFP participants with IID and play a key role in ensuring NC MFP participants mental health needs are effectively addressed. NC MFP does not fund a transition coordination demonstration service for participants coordinated by the LME-MCO. However, NC MFP requires that transition coordinators within the LME-MCO network complete NC MFP Transition Coordinator training and follow established NC MFP transition protocols prior to accessing MFP-reserved waiver slots. For specific guidance on how the MFP Demonstration Projects interface with LME-MCO functions, please review *North Carolina Money Follows the Person (MFP) in an LME-MCO Landscape Attachment M*.

Transition Services to High Engagement NC MFP Participants
NC MFP is committed to supporting individuals who demonstrate a higher level of complexity or require more intensive engagement due to their individual circumstances to safely transition and remain in their communities. These populations are referred to as *high engagement* populations and include:

1. Individuals transitioning out of Developmental Center Specialty Units; Psychiatric Residential Treatment Facilities, State Psychiatric Facilities
2. Other specific transitions that the transition coordinator determines is eligible.

NC MFP requires additional activity or oversight of individuals deemed to require high engagement as outlined in Attachment A, and as outlined in transition coordinator training protocols.

Wait List

As noted throughout this Protocol, transitioning MFP participants transition into a CAP/DA/Choice waiver slot, an Innovations waiver slot or into the PACE program on the first day in the community. Slots are available for NC MFP participants in each waiver

program (CAP/DA, Innovations, and CAP/Choice) and PACE for Money Follows the Person participants. Currently, North Carolina gives priority to individuals transitioning out of inpatient facilities, skilled nursing facilities and ICF-IID (state and private). Individuals who enroll in NC MFP are not required to be registered on the waiver program's wait list before accessing a slot. The number of slots sufficient to meet North Carolina's stated transition benchmarks is available every waiver year. *Innovations* waiver slots for MFP participants are managed by the DHHS LME-MCO network and are allocated at the beginning of each waiver year.

Disenrollment/Re-enrollment

A Money Follows the Person participant who is re-institutionalized for a period *greater than 30 days* is categorized as **dis-enrolled** from the program. However, a dis-enrolled individual can re-enroll in the program without re-establishing the three-month institutional residency requirements. As long as a former participant meets Medicaid waiver eligibility criteria, the participant is still eligible for Money Follows the Person services at the enhanced Federal Medicaid Assistance Percentage match. However, if the former participant remains in the qualified institution beyond six months, the participant is defined as a "new" Money Follows the Person participant in terms of the Money Follows the Person services and the Federal Medicaid Assistance Percentage.

A former participant can re-enroll in the program after being re-evaluated and after having an updated plan-of-care/person-centered plan. Once the individual is assessed to be appropriate for home and community based services, a referral is made to the case manager for development of the individualized plan-of-care/person-centered plan that addresses any change(s) in the status of the Money Follows the Person participant and/or any lack of necessary supports in the community. After three incidences of re-institutionalization of 30 consecutive days or longer, the re-institutionalized Money Follows the Person participant cannot be considered for reentry into the Money Follows the Person Project.

Follow Along Practices

To effectively support an individual after the transition occurs, NC MFP requires that transition coordination, care management or case management service entities who assist with the transition, comply with the Project's Follow Along requirements. These requirements are outlined in Attachment A, *Supporting People to Thrive: MFP Follow Along Practices*.

Denial or Termination from the Project

An eligible Medicaid beneficiary is considered an NC MFP participant once an NC MFP application has been approved. If an NC MFP participant transitions into an eligible home and community-based setting, the beneficiary is continuously enrolled in NC MFP for 365 days after the transition date, unless the beneficiary's participation is terminated for one of the reasons described in this section.

If a Medicaid beneficiary is denied or terminated from the NC MFP Demonstration Project, the beneficiary will not have continued access to the NC MFP demonstration service package outlined in the Benefits and Services section. If an MFP participant is dis-enrolled from the CAP/DA Choice or Innovations waiver or is dis-enrolled from the PACE program, the participant is also dis-enrolled from NC MFP.

The NC MFP Project may deny an MFP application or withdraw a current MFP participant for reasons outlined in this section. DHHS provides appeal rights to NC MFP applicants who have been denied enrollment and to NC MFP participants who have had their participation terminated. participant is denied enrollment into an HCBS waiver program, the participant also has appeal rights for that specific program.

Denial or termination from the NC MFP Project does not necessarily restrict the individual's ability to transition from the facility using other supports and resources. Further, a transitioned beneficiary's disenrollment in MFP does not necessarily impact the beneficiary's access to existing Medicaid services.

Denial of the MFP Application

An NC MFP applicant is denied enrollment into NC MFP if the NC MFP team determines the applicant does not meet the Project's federal criteria. NC MFP's eligibility requirements are outlined in federal law and further clarified by the NC MFP Project. To be eligible for NC MFP, an applicant must meet the criteria outlined in the Participant Recruitment and Enrollment section, specifically:

1. Currently resides in a *qualified facility*;
2. Has resided in the qualified facility for at least 90 consecutive days, excluding days reimbursed under Medicare Part A;
3. Receives Medicaid benefits from this facility for at least one day prior to transition; and
4. Continues to meet federal and state program level-of-care requirements.

Discontinuing MFP Participation: Pre-Transition

The NC MFP team may disenroll an MFP participant prior to transitioning because the individual:

1. Does not meet HCBS waiver criteria. Appeal rights for Innovations, CAP/DA, CAP/Choice and PACE are managed according to specific program guidelines;
2. Is unable or unwilling to move into a "qualified residence" that is authorized under federal law and supported by the North Carolina waiver program in which the person wants to enroll;
3. Does not honor transition-related commitments in the NC MFP Informed Consent document, transition planning or risk mitigation tools
4. The individual's housing supports or health and safety needs cannot be adequately addressed with resources available.
5. Voluntarily withdraws from NC MFP.

Discontinuing Participation: Post-Transition

An NC MFP participant remains enrolled for one year after the individual's transition date, referred to as the "NC MFP participation year." After 365 days, the participant is automatically dis-enrolled from NC MFP. During MFP participation year, an NC MFP participant can be terminated because the individual:

1. No longer has circumstances that meet HCBS program criteria;
2. Is re-institutionalized for more than 30 days;
3. transitions to a residence that does not meet MFP federal criteria or does not meet HCBS program criteria;

4. Is no longer is eligible to receive Medicaid;
5. Does not comply with agreements in the informed consent, plan of care or risk mitigation agreements;
6. No longer meets level-of-care criteria for the HCBS program in which the participant is enrolled;
7. The individual's housing supports or health and safety needs cannot be adequately addressed with resources available.

Transition at Termination

For MFP participants who complete their MFP participation year, the 1915(c) waivers and Medicaid State Plan continue to provide services without interruption if the participant continues to meet the criteria for the identified waiver or PACE. Participants are assisted to access other community-based services for which they may qualify. At the end of demonstration services, the waiver services and benefits for which an individual qualifies will support continued community and home-based living.

Consumer Supports

Educational Materials

The DMA has developed informational materials that outline the services provided through NC MFP. The NC MFP team distributes materials about the Project throughout North Carolina's LTSS community. Additionally, NC MFP's application and informed consent form provide additional details to about the Project.

Once an applicant is approved for NC MFP, the transition planning begins. The MFP transition planning tools and relevant waiver plan of care outline the intended services and backup strategies that will be utilized.

Personal Emergency Response System

The Personal Emergency Response System (PERS) is an electronic device that enables people to secure help in an emergency. The individual may also wear a portable "help button" to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a help button is activated. PERS services are provided to individuals who live alone; who are alone for significant parts of the day; who are alone for any period and have a written plan for increasing the duration of time spent alone as a means of gaining a greater level of independence; or who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.

PERS helps when:

- A fall has occurred and the individual cannot get up without assistance. The attendant on the other end of the response system will obtain information regarding the emergency and respond accordingly.
- A personal care attendant does not arrive. The individual makes a call using the PERS and appropriate action will be taken to address attendant care.

Back-up Systems

Because NC MFP participants transition directly into a 1915(c) waiver program or PACE, participants are covered under the back-up requirements of the HCBS program to which they transition. To effectively sustain and improve ongoing supports, NC MFP has improved those back-up systems that will remain after the participation year ends.

Each program's back-up requirement is outlined below. Additional NC MFP back-up protocols immediately follow.

PACE

Each PACE participant (including NC MFP participants enrolled in PACE) have a service plan that includes a backup plan for needed care coverage, including formal and informal supports. As a support to the participant's backup plan, each PACE center is required to have a 24/7 on-call staff person who is able to assist any PACE participant who is in a crisis or emergency and needs to obtain access to critical medical supports. The PACE participant, legal guardian (as applicable) and family members are informed of how to access the 24/7 on-call system during the intake and assessment process,

and in the service plan. This information is reviewed annually and as needed with each participant. PACE on-call staff will document calls received during the center's non-operational hours and the action taken to address the participant's issue or problem. The call and resulting action are also documented in the participant's record. It is the responsibility of the state PACE team to monitor the PACE Center to ensure the 24/7 system is working and that 24/7 coverage needs are identified and addressed adequately and in a timely manner. The PACE team reviews reports of calls to the center's 24/7 system and provides feedback to improve handling calls. Reviews of on-call logs are made during audits, reviews or if concerns arise.

CAP/ DA and CAP/Choice

Each CAP/DA or CAP/Choice participant's service plan includes an emergency 24-hour back-up plan for needed care coverage. This back-up plan includes formal and informal supports. For participants with diagnoses that require rapid access to Emergency Medical Services, CAP/DA provides for the use of telephone response systems. The CAP/DA case manager checks this system as part of home visits and reviews any reports from the Emergency Response System Provider. This case management activity is documented in the client's case notes.

For other non-emergency but critical support needs, the CAP/DA Case Manager is available to assist the participant during the agency's normal business hours. Information regarding these interactions is available to DMA staff during participant record reviews during lead agency site audits. In addition, the case manager is required to perform a monthly review of the provision of services with the client and the agency providing services. Deviation in the waiver service provision is documented in the case manager's notes, and a detailed description of how the client's needs were met are included. The DMA team provides feedback on deficiencies noted during the review, including inadequate actions and issues not handled on time.

The CAP/DA participant, legal guardian (as applicable) and family members are informed of how to access all aspects of 24-hour backup, by the case manager during the intake and assessment process, and in the service plan. This information is reviewed monthly by the case manager as a part of monthly monitoring requirements, assessed annually during the continued need review and as needed with each participant.

* CAP/Choice is administered by the CAP/DA lead agencies; therefore, when CAP/DA is referenced in this document it is understood that CAP/Choice also applies.

Innovations

The Innovations waiver guidelines require that each Innovations participant have a backup staffing plan included in the Individual Service Plan. The backup staffing plan must identify who serves as a backup and the appropriate contact numbers. At least two levels of backup staffing are required for each waiver service identified.

Providers are required to track requests for backup staff support and submit reports to LME-MCOs every two weeks.

Additionally, each LME-MCO staffs a 24-hour call-line that individuals or families can use any time to identify backup support.

MFP solicits reporting directly from LME-MCOs on its monthly reconciliation reports to identify backup staffing issues experienced directly by MFP participants during the reporting period.

MFP provides technical assistance to LME-MCO transition planning teams on effective interventions for ensuring comprehension of the backup staffing plan.

The North Carolina Innovations waiver also requires providers to have a process for ensuring 24-hour backup that is available seven days a week, 365 days a year (24/7/365) to ensure a person is accessible when needed. All participants of Innovations waiver services are informed of and provided with information related to backup staff when the provider is identified and during the person-centered plan/plan-of-care planning process.

Providers of 24-hour services act as the first responders if the participant or a member of the participant's support system initiates contact for assistance in an emergency. The provider is required to notify the participant and support members of the process for accessing emergency services 24/7/365 orally and in writing at the initial contact. The notification includes contact information for an alternate source of assistance if the provider is not available.

The person-centered plan/plan-of-care addresses how the provider will ensure backup staff are available if the staff members are regularly assigned to provide services are unavailable. The backup staff must be trained to meet the specific needs of the participant, as detailed in the person-centered plan/plan-of-care, including health, mobility, communication, risks behavioral issues and skill training.

Durable Medical Equipment

North Carolina Medicaid Clinical Coverage Policy requires durable medical equipment vendors to maintain an emergency call line to address after-hours equipment failures.

Additional NC MFP-specific Backup Supports

Because of the time-limited nature of NC MFP's involvement, NC MFP has prioritized developing supports and systems that empower the participant to use community-based supports and to also improve the data collection of existing methods. North Carolina also manages participant-specific inquiries through its toll-free call line.

Specific interventions include:

1. Supporting the NC MFP participant to identify and engage individuals who can serve as part of the participant's backup support network;
2. Assisting the transitioning participant to identify community-based primary care provider and specialists as needed, including scheduling first appointments;
3. Assisting the transitioning participant to identify and arrange nonemergency medical transport and community-based transportation options;
4. Development and distribution of the NC MFP "Who Ya Gonna Call?" worksheet. This worksheet is completed by the participant with the assistance of the transition coordinator at the time of discharge:

5. Calling the NC MFP state level toll free call line staffed by the NC MFP team. Participant-specific inquiries of all types, including emergency backup, are fielded and managed by the MFP Project Coordinator.
6. Data collection of PERS use for aging and disability participants. NC MFP is partnering with the CAP/DA information platform vendor to access MFP participant-specific reports on PERS device use.
7. Data collection of provider emergency backup data for IDD participants through the LME-MCOs.

Critical Incident Management

People who transition under the NC MFP program enroll directly into established HCBS programs. NC MFP relies on established HCBS program critical incident reporting systems to identify and evaluate incidents experienced by MFP participants during their participation year. NC MFP also pilots additional transition-related incident reporting through its transition coordination demonstration service.

Reporting Abuse, Neglect and Exploitation

Older adults and individuals with disabilities are protected from abuse, neglect and exploitation under North Carolina General Statute 108A, Article 6. Each North Carolina county Department of Social Services operationalizes this protected support from abuse, neglect and exploitation through its Adult Protective Services unit. This unit receives, screens and evaluates reports of individuals in need of protective services, and makes referrals to law enforcement, the district attorney, and other enforcement and regulatory agencies.

The statute requires that any person having reasonable cause to believe that an older adult or individual with disability needs protective services will report such information. For NC MFP participants, this includes, but is not limited to NC MFP staff or contracted designees, NC MFP transition coordinators or CAP case managers. Reports alleging abuse, neglect or exploitation of an adult with disabilities should be reported to the county Department of Social Services where the adult resides. The report may be made orally or in writing, and should include the adult with disabilities':

- Name, address and age;
- Caregiver's, name and address (if known);
- Nature and extent of the injury or condition resulting from abuse, neglect or exploitation.

Critical Incident Reporting

Incident Reporting Under CAP/DA and CAP/Choice

CAP/DA case managers in local lead agencies are responsible for submitting critical incident reports through e-CAP.

In addition to those reports provided to the NC MFP Project directly, NC MFP pulls critical incident data for MFP participants directly from e-CAP, the CAP/DA informational platform and supplements these data with claims-based data queries.

NC MFP and CAP/DA management team meet at least quarterly to discuss trends in NC MFP-CAPCAP/DA transition dynamics, including critical incidents experienced by MFP participants.

For a complete overview of the CAP/DA Incident Reporting policy, please see Attachment E

Incident Reporting under Innovations
Critical incidents for NC MFP participants are submitted through the Innovations Waiver Incident Reporting protocol, included in Attachment F. Additionally, transition coordinators using MFP-funded Innovations waiver slots report incidents directly to MFP through monthly reporting.

In addition to reports directly provided to NC MFP, NC MFP queries critical incident data for MFP participants from the DHHS Incident Reporting Information System (IRIS), which captures incident data for individuals with IDD.

MFP further supplements these incident data by pulling and reconciling incident-related claims data (e.g., hospitalization, emergency department utilization).

Incident Reporting under PACE
DHHS continually identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation. Incident reports are provided to the PACE team for review, including critical incident reporting. Reports are reviewed to ensure that appropriate action was taken at the time of the incident, whether further investigation is needed, or if further action or training may be required to ameliorate or prevent any recurrence of the incident. This is determined by CMS. Each PACE organization is required by CMS to report critical incidents to CMS and DMA.

Additional Critical Incident Reporting under MFP
NC MFP intends for any incident reporting conducted by its transition coordinators to supplement the existing reporting requirements under the participant's enrolled waiver or HCBS program. Further, as NC MFP evolves, additional population-specific incident tracking has become necessary to fully analyze those incidents that may impact the viability of a participant's community support. These additional incident types may be reflected in applicable contractual expectations or additional policy guidance provided by NC MFP.
To supplement incident data provided through the identified HCBS program, NC MFP transition coordinators report incidents directly to NC MFP Project staff through monthly workbooks.

Upon learning of the incident, the NC MFP team reserves the authority to require a state-staffed debriefing and analysis of the incident with the transition coordination team.

Risk Management

The NC MFP risk management approach is built on person-centered planning principles, and applies various interventions to identify what is important *to* an individual and what is important *for* an individual.

To supplement and inform the risk management strategies of the HCBS program used by an MFP participant, NC MFP has mechanisms to help identify and mitigate potential risk related to the transition process or sustained community supports.

As part of its application review process, NC MFP examines the preadmission screening and resident review (PASRR) data and criminal history for every applicant currently residing in a nursing facility.

Contracted transition coordination entities are required to engage in a risk mitigation planning process for each MFP participant. Minimally, these planning elements must ensure a person has clear backup supports and access to *24 hour* resources as clinically indicated and are sustainable after the person's MFP participation year.

Backup planning will address, at minimum, the following scenarios:

1. Urgent medical questions that do not necessitate 911 /emergency
2. A behavioral health crisis
3. Personal support service staff fails to show as scheduled
4. Equipment essential to the individual's health and safety breaks down

The risk mitigation planning process must also ensure other dynamics that impact the participant's ability to remain in his or her home are also identified and addressed prior to discharge. Topics include, but are not limited to:

1. Caregiver fatigue
2. Effective communication and management of personal care assistants
3. Effective household management (e.g., paying bills, household budgeting, lease compliance)
4. Other dynamics as identified by transition coordinator, individual or IDT team members.

Transition coordinators identify potential risk through targeted and ongoing dialogue with the participant, the participant's representatives and facility-based staff, and through review of appropriate records, including the facility medical record, PASRR and criminal background history.

In addition to these minimum requirements, NC MFP has developed the following tools to assist transition coordinators in the risk mitigation discussion and process. NC MFP has begun integrating these tools as required interventions for individuals whose circumstances indicate a need for more intensive risk mitigation planning.

1. *Quality through Conversation: Ideas for Transition Coordinators*
2. *Let's Talk about It So We Can Address It: A Protocol for Identifying High-risk Behaviors or Circumstances*
3. *The NC MFP Supports and Risk Mitigation Planning Tool*

Additional MFP Risk Management Elements for High Engagement Participants
Recognizing that transitioning MFP participants have multi-faceted support needs and may have a history of failed community placement, NC MFP has established a *high engagement* designation that augments NC MFP's basic risk mitigation requirements in three key ways:

1. When a participant's circumstances indicate additional transition support may be warranted, the participant's transition is designated, *high engagement*. Transition coordinators facilitating a high engagement transition are required to participate in a state-staffed pretransition briefing, in which a transition can be stopped or delayed if key transition components are not in place.
2. NC MFP requires the transition coordination entity to follow a more rigorous post-transition follow along schedule when a person's transition is identified as high engagement.
3. NC MFP requires an LME-MCO to implement pretransition staff training and clinical consultation services when supporting an MFP participant with IDD whose transition has been identified as high engagement.

Please see the *Transition Services to High Engagement MFP Participants* in the Benefits and Services section and Attachment A for more information.

Risk Management: CAP/DA and CAP/Choice
For a summary of CAP/DA Risk Management Strategy, see Attachment G.
Since the Project's launch, NC MFP has supported the CAP/DA program's work to develop risk mitigation strategies that assist CAP/DA beneficiaries and the CAP/DA program to address risk, and to balance potential risk with a beneficiary's rights and preferences.

Risk Management: Innovations

The risk management structure for NC MFP participants enrolling/enrolled in the Innovations waiver is built on the risk management strategies for Innovations waiver participants, including the development of a Risk/Support Needs Assessment that informs service planning and a Crisis Prevention Plan that is integrated into the ongoing service plan. Please see Attachment H for North Carolina Innovations Risk Assessment and Mitigation process.

Risk Management: PACE
Diagnoses and symptoms that pose a significant risk to health, safety and well-being of each PACE participant are identified during a very thorough and comprehensive ongoing interdisciplinary assessment process. Each risk identified by the assessment process must be addressed in the individual's service plan. For example, an individual identified with a fall risk may need to have assistance while ambulating using a gait belt; or an individual with a history of bowel obstructions may require a more thorough monitoring of bowel movements and a specialized diet to help prevent hospitalizations.

Since PACE organizations serve a significant number of individuals with cognitive impairments or dementia, wandering and elopement is often an issue. The PACE team monitors service plans with special consideration given to diagnoses and symptoms where risk is more inherent, and evaluate if these risks are addressed adequately. Any

service plan that is deficient in this regard must be amended before approval. Additionally, interventions designed to minimize risk will be assessed during site reviews to ensure they are functioning, and are being implemented as designed and intended.

For additional detail about North Carolina HCBS risk management, critical incident reporting, and 24-hour back-up requirements, refer to the Quality section and to Attachment E.

Consumer Complaints

NC MFP participants have several channels through which to file a complaint. The NC MFP Informed Consent form outlines the various methods available to MFP applicants and participants. These channels are also outlined below. These complaint channels do not reflect due process rights available to MFP participants. See *Denial and Termination from the Project* in the Benefits and Services section for more information. The due process rights for North Carolina Medicaid beneficiaries are outlined at dma.ncdhhs.gov/providers/programs-services/prior-approval-and-due-process.

CAP DACAP/DA

CAP/DA and CAP/Choice participants may direct complaints to their identified lead agency. Complaints are tracked and reported as part of the CAP/DA quality assessment and quality improvement activities.

Innovations Waiver

In addition to formal appeals, Innovations waiver participants are covered through the Innovations Complaint policy reflected in Attachment I.

NC MFP Call Line

NC MFP directly manages a toll-free call line, available to MFP participants, interested stakeholders and the public. Since its development, NC MFP has invested in customer service structures to better meet the needs of MFP applicants and MFP participants.

The NC MFP Applications Coordinator manages the NC MFP call line and fields questions to the appropriate NC MFP staffer. If the question or concern is about a specific transition, the call is directed to the MFP Project Coordinator who follows up on each concern or complaint with the appropriate manager or transition coordinator. The Project Coordinator documents each complaint received, and follows it to resolution.

DHHS Customer Service Line

DHHS manages a Customer Service Line that directs individuals to the appropriate section and team member to address additional concerns.

Consumer-related Complaints Received by the DHHS Secretary's Office, North Carolina General Assembly or Others

Complaints received by the DHHS Office of the Secretary, the General Assembly or the Governor's office are managed by the DMA Policy and Legislative Affairs team, who work with NC MFP program staff to resolve.

Complaints about CCNC-enrolled Primary Care Physician
Beneficiaries who are enrolled in Community Care of North Carolina upon transition may register complaints about a primary care provider through the CCNC regional complaint channel.

Facility-based Complaints
For complaints about the person's experience with his/her facility, MFP participants may also access the DHHS Ombudsman Program or contact the Division of Health Service Regulation (DHSR) Facility Complaint Intake Line.

Self-direction

Self-directed options exist under the aging and disability waiver (CAP/Choice) and under the Innovations waiver for individuals with IDD. Throughout the life of the Project, the options for self-directed options have expanded in North Carolina. Approximately 5 percent of NC MFP participants elect to self-direct their waiver services. A complete description of the self-direction programs within each waiver are in Section E of the respective waiver application.

Self-direction under CAP/DA: CAP/Choice
CAP/Choice is a self-directed for people who qualify for the CAP/DA program want to have increased control over their services and supports. CAP/Choice reflects North Carolina's health reform policy objectives of promoting consumer choice and decision-making, reducing health-care costs, and identifying key stakeholders (especially consumers) in its approach to reform the delivery of services. The CAP/Choice program is available statewide.

NC MFP participants selecting CAP/Choice are covered by the CAP/Choice freedom of choice requirement. Under the" Freedom of choice" requirement, the participant or their authorized representative can meet, interview and select any willing and qualified personal assistant. CAP/Choice participants may hire a personal assistant who is a family member, friend or neighbor. Any individual hired by the CAP/Choice participant is not required to be an employee of a provider agency.

MFP participants are informed about CAP/Choice option during the transition planning and service planning process.

The CAP/DA 2013 waiver application, under CAP/Choice states recipients can:
- Choose (hire) the personal assistant who will provide their care support
- Train, supervise and evaluate the worker
- Negotiate the rate of pay and other benefits
- Terminate the worker should this become necessary
- Select individual providers and direct reimbursement for specified waiver services
- Engage in a cooperative working arrangement with a financial manager who will pay the participant's worker, handle federal/state taxes and other payroll/benefit functions related to the employment of the worker, and reimburse service providers under the direction of the participant.

Under CAP/Choice, a care advisor guides and supports the Choice participant through the service planning process.

MFP participants selecting CAP/Choice may return to the traditional CAP/DA program at any time. Care advisors are responsible for facilitating the transition back to traditional services.

Self-direction under the Innovations waiver: Individual and Family-directed Supports

The North Carolina Innovations waiver provides people with IDD a clear choice about how they receive services. Participant direction is a meaningful option for participants and their families. In the North Carolina, participant-directed services under the NC Innovations waiver are called “individual and family-directed supports.” Participants can choose to self-direct identified services within the Innovations waiver:

1. Community networking services
2. Supported employment
3. Day supports
4. Community living and supports
5. Respite

Individuals are informed about the self-direction option during the Innovations service planning process.

An NC MFP participant enrolled in individual and family-directed supports may withdraw and return to provider-directed services by notifying the participant’s service coordinator. The service coordinator is responsible for revising the individual service plan and for ensuring no lapse in services.

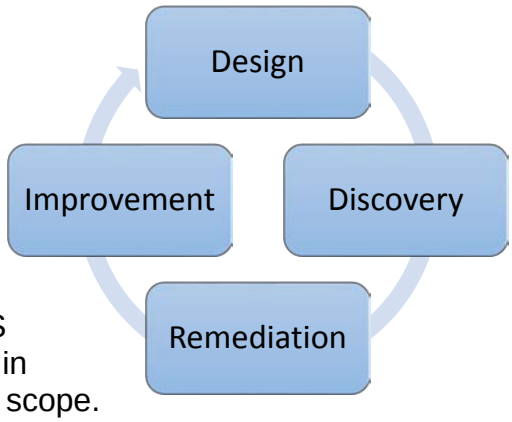
Quality

The NC MFP Quality Management Strategy and Plan ensures that discovery processes and systems for remediation and quality improvement consider the specific and unique needs of MFP participants transitioning from an institutional setting. The NC MFP quality management plan includes oversight of the success of the transition process, successes and barriers to experiences in community living, effectiveness of back-up systems, and risks that might lead to re-institutionalization.

NC-MFP occurs within DHHS' overarching quality management strategy for home and community-based waiver services. NC MFP works with those HCBS programs into which MFP participants enroll to mutually inform the direction and design of the applicable program. Further, NC MFP leverages information gathered through its quality management process to inform the future design of the North Carolina Medicaid program.

DHHS' NC MFP Quality Management Strategy and Plan for NC MFP participants is predicated on the quality strategies and waiver assurances in place under each waiver or HCBS program used by MFP participants. These assurances include but are not limited to:

- Level of care determination
- Service plan description
- Identification of qualified HCBS providers
- Health and welfare considerations
- Administrative authority
- Financial accountability



The complete waiver application package for each program used by NC MFP participants is available on the DMA website. The quality improvement strategy for CAP/DA is included in Attachment J; the quality improvement strategy for Innovations is included in Attachment K.

In addition to the structures outlined in the applicable HCBS program's quality improvement strategy, NC MFP engages in continuous quality improvement (CQI) related to its specific scope. The NC MFP CQI process informs improvements in its own practices and broader DHHS transition-related practice, policy and direction.
The NC MFP CQI activity follows a well-established quality improvement framework:

- Design
- Discovery
- Remediation
- Improvement

Recognizing the iterative process of quality improvement and program design under a demonstration Project, NC MFP has worked to develop a CQI culture that integrates formal and informal mechanisms that advise all stages of the CQI process.

Activities performed by NC MFP must advance one of the four overarching goals of the national MFP program or otherwise strengthen DHHS' ability to operationalize the emerging elements of quality transition planning.

NC MFP's Quality Improvement Framework

What Informs Our Design and Activity (Design)

- **Our values:** Does this design promote quality transition planning and improved access to HCBS services?
- **Our history:** Historic gaps in supports as identified by stakeholders, prior reports or earlier initiatives.
- **The current identified need:** Needs identified directly by transition coordinators, participants and their families, state colleagues and providers, or in the aggregate through data and survey collection.
- **Our current landscape:** What is possible given our current landscape? What can we afford?
- **Our state's long-range priorities:** How can we best inform and support DHHS' long-range direction to effectively integrate quality transition planning and improved access to home and community-based services?

How We Learn What Needs to Be Addressed (Discovery)

- **Direct Feedback from Identified Stakeholders, including**
  - NC MFP Roundtable;
  - Transition coordinator networks, including through monthly calls, quarterly contract calls;
  - Direct visits to current and previous MFP participants;
  - Calls to NC MFP call line;
  - Ad hoc committees or workgroups; and
  - Other informal stakeholder feedback gathered through meetings, presentations and other methods.
- **Formal =Reporting from Contractors**
  - Person-specific challenges
  - Process-specific challenges
- **Data Mining, Reporting and Analysis**
  - Transition data tracked within NC MFP;
  - Post-transition satisfaction surveys to MFP participants;
  - Data gathered for various reporting requirements as outlined in the NC MFP Operational Protocol;
  - Person-specific reporting as required in identified transition coordination contracts;
  - Ad hoc data requests to further analysis on identified quality;
  - Surveys to identified stakeholders; and
  - Operational data related to financial reporting, contract management or administration.
- **Internal Communication**
  - Regularly scheduled meetings with state waiver program colleagues
  - Weekly internal meetings of NC MFP state team

How We Address It (Remediation)
While the mechanism used to address the identified quality improvement opportunity depends on the opportunity itself, NC MFP generally follows the structure outlined below:

- **Address Immediate Need:**
    - What can be done now to address this identified need for this specific person or circumstance?
- **Be Clear on What We Are Addressing:**
    - Is this an administrative/operational challenge or is this a programmatic challenge that directly impacts NC MFP participants?
- **Engage in Collective Examination.** Examination questions Include:
    - How does this experience inform or refute what we already know?
    - Who else needs to help NC MFP in analyzing this experience?
    - What other data are needed to help us understand this dynamic?
    - Is this an isolated circumstance or does it reflect a larger trend?
    - How is this experience best addressed?
    - Does an identified need/challenge reflect a lack of training?
    - Does an identified need/ challenge reflect a confusion in protocol?
    - Does an identified need/challenge have systemic implications that cannot be effectively mitigated by NC MFP alone? If so, how do we best engage others to address it?
- **Practice Adjustment**
    - Adjust internal practices and procedures to address the identified need/ challenge
    - Identify opportunities for additional training or policy clarification
    - Revise Project contracts as needed
    - Examine whether a proposed change will require a change in NC MFP operational practice, demonstration service design or funding

How Lessons Inform Design and Systemic Improvement (Improvement)

- Identified needs and proposed interventions guide the design of NC MFP's rebalancing fund projects;
- Identified needs and compiled data that inform NC MFP's recommendations on DHHS systems design initiatives;
- Where applicable, NC MFP can adjust contract requirements to more effectively address the need;
- Identified needs inform quality improvement projects and performance improvement projects;
    - Through NC MFP team development goals
    - Within contracts (operational requirements and identified *improvement projects*)
- Monitoring and Evaluation;
    - Questions guiding monitoring practices
        - Are improvements and interventions fully implemented?
        - Are improvements and interventions having intended impact?
    - Mechanisms for monitoring:
        - Direct feedback with identified stakeholders, including:

        - NC MFP Roundtable, which meets quarterly;
        - Transition coordinator networks, including through monthly calls, quarterly contract calls;
        - Direct visits to current and previous MFP participants;
        - Calls to the NC MFP call line;
        - Ad hoc committees or workgroups; and
        - Other informal stakeholder feedback gathered through meetings, presentations and other channels.
    - Formal reporting from contractors
        - Person-specific challenges
        - Process-specific challenges
    - Data mining and reporting:
        - Transition data tracked within NC MFP, updated daily;
        - Post-transition satisfaction surveys to MFP participants, which occur quarterly on an NC MFP participant sample;
        - Data gathered for various reporting requirements as outlined in the NC MFP Operational Protocol;
        - Person-specific reporting as required in identified transition coordination contracts;
        - Ad hoc data collection to further analysis on identified quality
        - Surveys to identified stakeholders, including the NC MFP Rebalancing Fund Survey
        - Operational data related to financial reporting, contract management or administration
    - Internal communication
        - Regularly scheduled meetings with state waiver program colleagues, which meet quarterly or more often as needed
        - Monthly contractor meetings with sister agency partners
        - Weekly internal meetings of NC MFP state team

Housing

The lack of affordable and accessible housing in North Carolina remains a significant barrier to meeting the needs of extremely low-income households[5], including MFP participants transitioning into their communities. Through continued stakeholder engagement, NC MFP has identified housing-related barriers to transitioning as a key issue. Accordingly, NC MFP has identified opportunities for direct support and funding to support North Carolina's ongoing efforts to expand affordable, accessible housing for low-income individuals.

Ensuring Sufficient Qualified Residences

DHHS and the North Carolina Housing Finance Agency (NCHFA) have long partnered in a mutual effort to expand and improve the nationally recognized project-based rental assistance model, the Targeting/Key Housing program. This statewide, state-funded program expands the amount of affordable accessible housing to low-income individuals with disabilities in need of affordable housing. For more information about the Targeting/Key Program, visit: http://www.nchfa.com/community-living-programsnchfa.com/community-living-programs.

In partnership with its sister transition initiative, Transitions to Community Living, NC MFP has established priority access to available units within the Targeting/Key Housing program.

To improve housing-related competencies, NC MFP transition coordinators are trained on:

1) The Targeting/Key referral process;
2) How to access www.nchousingsearch.orgnchousingsearch.org;
3) How to write reasonable accommodation requests;
4) Accessing support and technical assistance through DHHS housing coordinator network

Strengthening the DHHS Housing Coordinator Network

The Targeting/Key Program is managed through a regional network of 10 DHHS staffers known collectively as the DHHS Housing Coordinator network. Housing coordinators serve as intermediaries between landlords participating in the Targeting/Key program and the referring agencies supporting DHHS-affiliated clients, including MFP participants. Housing coordinators play a key role in expanding housing stock available through the Targeting/Key program and supporting individuals to maintain housing once secured.

To strengthen this network, NC MFP commits administrative resources to fund one FTE housing coordinator.

[5] To financially qualify for Key Rental assistance, a household must have gross income below 50% of the area median income (AMI); Income includes SSI/SSDI/VA; Households must have a minimum income of $300 per month.

Additional Efforts Specific to MFP Participants Using North Carolina Innovations Waiver

As part of its commitment to expand community living options for transitioning individuals with IDD, NC MFP partners with its colleagues in DMA, DMH, DSOHF and the North Carolina Council on Developmental Disabilities to sponsor and manage multi-year collaborative learning opportunities related to the North Carolina Innovations' supported living service definition. The supported living service enables individuals with significant support needs to live in homes of their own. The supported living service provides a person-centered, individualized alternative to the traditional residential services available under the North Carolina Innovations waiver.

More information about the supported living service and related learning initiatives can be found at: https://www.nccdd.org/supported-living-making-the-difference.htmlnccdd.org/supported-living-making-the-difference.html

Knowing What is Available: Supporting Improved Understanding of Housing Resources

In collaboration with its DHHS and NCHFA colleagues, NC MFP has spearheaded the design of various housing training modules and learning opportunities to expand collective understanding of community-based care managers and transition coordinators about available various housing resources.

To foster collaboration between DHHS housing coordinators and NC MFP transition coordinators, NC MFP hosts quarterly meet-and-greets for transition-related professionals and requires, by contract, that housing coordinators attend the NC MFP roundtable, its quarterly stakeholder meeting.

Post Demonstration - Continuity of Care

The State's efforts to rebalance long-term care support programs and meet federal MFP objectives include ensuring post demonstration continuity of care which allows NC MFP participants continued access to existing 1915(c) waivers (CAP/DA, Innovations, CAP/Choice) and PACE. Participants can continue to be served through these identified HCBS programs in the post-demonstration period if they continue to meet the eligibility criteria for the applicable program. Therefore, there is not a lapse in services for NC MFP participants and a transition plan is not required.

For those participants who do not meet applicable HCBS program qualifications after 365 days of demonstration services, a transition service plan is developed and assistance with referrals to supportive programs is provided. Referrals include connecting participants to local Councils on Aging and/or Departments on Aging, which coordinates aging services that provide transportation, personal care, chore services, adult day care, information and referral, outreach, and case management. For people with physical disabilities, a referral can be made to the regional Center for Independent Living for assistance with services as well as a referral to the county Department of Social Services for assessment of continuing services. Other Medicaid services, such as Personal Care Services (PCS) may also be available, depending on the person's support needs and circumstance.

Organization and Administration

Organizational Structure

The North Carolina Money Follows the Person demonstration grant is managed by DHHS. This structure provides great coordination of services across programs as well as high-level support within the DHHS. DMA has oversight responsibilities for the grant.

NC MFP Staffing Plan

In 2016, to better leverage the demonstration capacities of the NC MFP Demonstration project, NC MFP was transferred into a new team within DMA, the Special Initiatives Team. The NC MFP team reports to the Associate Director for Special Initiatives, who reports to the Deputy Secretary for Medical Assistance.

Project staff[6] for the North Carolina Money Follows the Person demonstration grant include:

a. Project Director

The Project Director oversees the project management, policy development, outreach development, budget management, supervision of project staff, and training and program analysis.

b. Assistant Director

The Associate Director's core responsibilities include

- Oversight of the transition process for aging and physical disability MFP participants;
- Identification and addressing challenges and issues related to the transition practices;
- Assistance with outreach efforts about the Project.

c. Data Coordinator

The Data Coordinator develops, implements and maintains data collection processes and systems to ensure the efficiency and integrity of MFP data reporting. The Data Coordinator is responsible for managing accurate data related to:

- transition benchmarks;
- reporting requirements such as quarterly "data files" reports and bi-annual reports;
- In collaboration with other MFP staff, organize information for the Project's financial reporting requirements.
- Other project information as needed.

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d. Budget and Contracts Manager

The Budget and Contracts Manager coordinates with the Project Director to manage the Project's budget and financial management functions and to assist in the development and monitoring of the Project's expanding number of contracts and formal partnerships with sister agencies and private, community contractors.

[6] All positions except the Professional Development Coordinator are funded with MFP Administrative Funding. The Professional Development Coordinator position is funded with NC MFP Rebalancing Fund dollars.

e. Transitions Program Coordinator

The Transitions Program Coordinator provides programmatic staff support to NC MFP's transition activities and reports directly to the NC MFP Assistant Director. The Transitions Program Coordinator's responsibilities include fielding calls from NC MFP participants, transition coordinators and other program-related stakeholders; scheduling and participating in pre-transition briefing calls; supporting the Assistant Director in troubleshooting related to transition activity and coordinating various transition reporting activities; leading the Project's post-transition satisfaction survey information collection; maintaining the Project's outreach materials and providing staff support to stakeholder events.

f. MFP Applications Coordinator

The Applications Coordinator reviews and processes NC MFP applications and manages the administrative activity related to NC MFP's due process requirements.

g. Special Initiatives Professional Development Coordinator

The Professional Development Coordinator manages training initiatives sponsored by NC MFP/MFP Rebalancing Fund, specifically the North Carolina Community Transitions Institute; the MFP Lunch and Learning Series and the Medicaid Orientation for Options Counselors.

Please see the Special Initiatives Team Organizational Chart in Attachment L

Billing and Reimbursement Procedures

The NC Medicaid Program's fiscal agent, CSRA is responsible for ensuring that CAP/DA, CAP/Choice, PACE and Innovations claims or monthly payments are paid correctly. CSRA has established edits and audits in the claims payment system to ensure that payment is made in accordance with the approved methodology. DMA provides oversight to the contract work performed by CSRA.

The Program Integrity section in the DMA conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid, identifies and collects provider and recipient overpayments, educates providers and recipients when errors or abuse is detected, ensures that recipients' rights are protected, and identifies needs for policy and procedure definitions or clarifications.

Post-payment reviews by the DMA look at the complete audit trail: the approval of the person-centered plan, the case manager's authorization to the provider to render approved services, service provision, service documentation, and the case manager's authorization for claims submission and actual claims data.

CAP/Choice participant files are monitored as submitted and/or changed by the DMA quality assurance contractor, Viebridge. Quality assurance reviews determine that participants are classified correctly at either the intermediate-care or skilled-nursing level of inpatient facility care. Results of monthly monitoring are reviewed by DMA staff and shared with the agencies that have been reviewed. The findings enable the

agencies to improve the way CAP/Choice is operated. The quality assurance review process is not a negative process, but one that leads to the strengthening of program. Additionally, The Carolinas Center for Medical Excellence looks at claims data for possible inappropriate payment of services and monthly budget monitoring.

Carolinas Center for Medical Excellence (CCME) leads the External Quality Review process for North Carolina's LME-MCO network. CCME conducts an annual validation of encounter data submitted by each of the PIHPs/MCOs utilizing the CMS Protocol for validating Medicaid MCO/PIHP encounter data. The CMS Protocol outlines the process that EQROs should follow for determining that the encounter data is accurate and complete. CCME analyzes electronic encounter data which includes performing a series of checks that assesses whether the encounter data can be used for analysis (e.g. trends, quality monitoring). The review includes encounter and enrollment data. The analysis focuses on finding missing and erroneous data, then comparing the findings to state standards and/or comparison error rates. CCME also analyzes completeness of the encounter data over time and calculate utilization rates.

DMA gathers and monitors encounter data from each PIHP to assess over- and under-utilization using formats consistent with the formats and coding conventions of CMS 1500, UB04 or other formats required under HIPAA. DMA ensures compliance with reporting requirements and can withhold capitation payments until encounter data requirements are met. Should the State determine that encounter data errors are not decreasing as expected, the State can require the PIHP to bear the cost of processing all encounters that consistently exceed the error rate.

NC MFP only draws enhanced federal match on applicable HCBS services and NC MFP demonstration services.

In 2013, North Carolina converted its MMIS vendor and platform to NCTracks. Due to competing priorities for implementation, DHHS elected not to initially integrate NC MFP's claims processing requirements into NCTracks. NC MFP obtained approval from CMS to work around this issue by processing NC MFP demonstration services payments as administrative payments directly to the vendor. These demonstration payments are not able to be billed through the claims process. Qualified service waiver claims for eligible NC MFP participants are verified by the MFP Staff and the Business Intelligence Operations office. Claims are processed through NCTracks under the applicable HCBS program and then reclassified to NC MFP. Applicable data are then incorporated into North Carolina's TMSIS submission.

Evaluation

NC MFP will retain an evaluation entity to assist the Project in its post-Demonstration design. This evaluation is anticipated to be completed in 2018 and will provide recommendations to address the following evaluation goals:

Goal 1: To secure a clear description of North Carolina's current transition activity landscape ("Landscape Analysis").

Goal 2: To clarify roles related to the transition-related functions and processes, as reflected in applicable contracts, job descriptions and service definitions ("Role Clarification").

Goal 3: To receive recommendations for improving transition-related processes for target populations ("Recommendations for Improvement").

Goal 4: To receive recommendations for developing an interim approach to transitions that ensures effective coordination of transitioning individuals ("Recommendations for an Interim Transition Program").

Goal 5: To identify potential future LTSS population growth, with an emphasis on individuals under 65 with physical disabilities, including children to assist DHHS in effectively preparing it community-based LTSS service delivery landscape ("Preparing for the Future").

Project Budget

Budget Presentation and Narrative History

North Carolina's budget projections for this grant are based on the number of people NC MFP anticipates will transition each for each Calendar Year. The current budget is based on the annual goals for transitions in the table on page 8 of this Operational Protocol. The State bases its cost allocations on the amount of Medicaid dollars spent by participants in the prior year. This includes Qualified HCBS programs, as well as NC MFP Demonstration Services. The projected budget for the remainder of the Project listed by year is on page 139 in Attachment N.

Medicaid Administrative Costs

NC MFP employs a full-time Project Director who is responsible for the Project's operations. The State also employees a Project Assistant Director, a Transitions Program Coordinator and a Budget and Contracts Coordinator. The salaries for these positions include related fringe benefits of 33% for each position. Contract positions such as the LCA Coordinator, Housing Specialist, DVR Contract Manager and DVR-IL Administrative Assistant are also included. In addition, the State projects ancillary expenditures including travel, equipment, supplies, brochures, and postage. Please see the Sustainability Plan Attachment N for more details.

Attachment A
Supporting People to Thrive: MFP Follow Along Practices

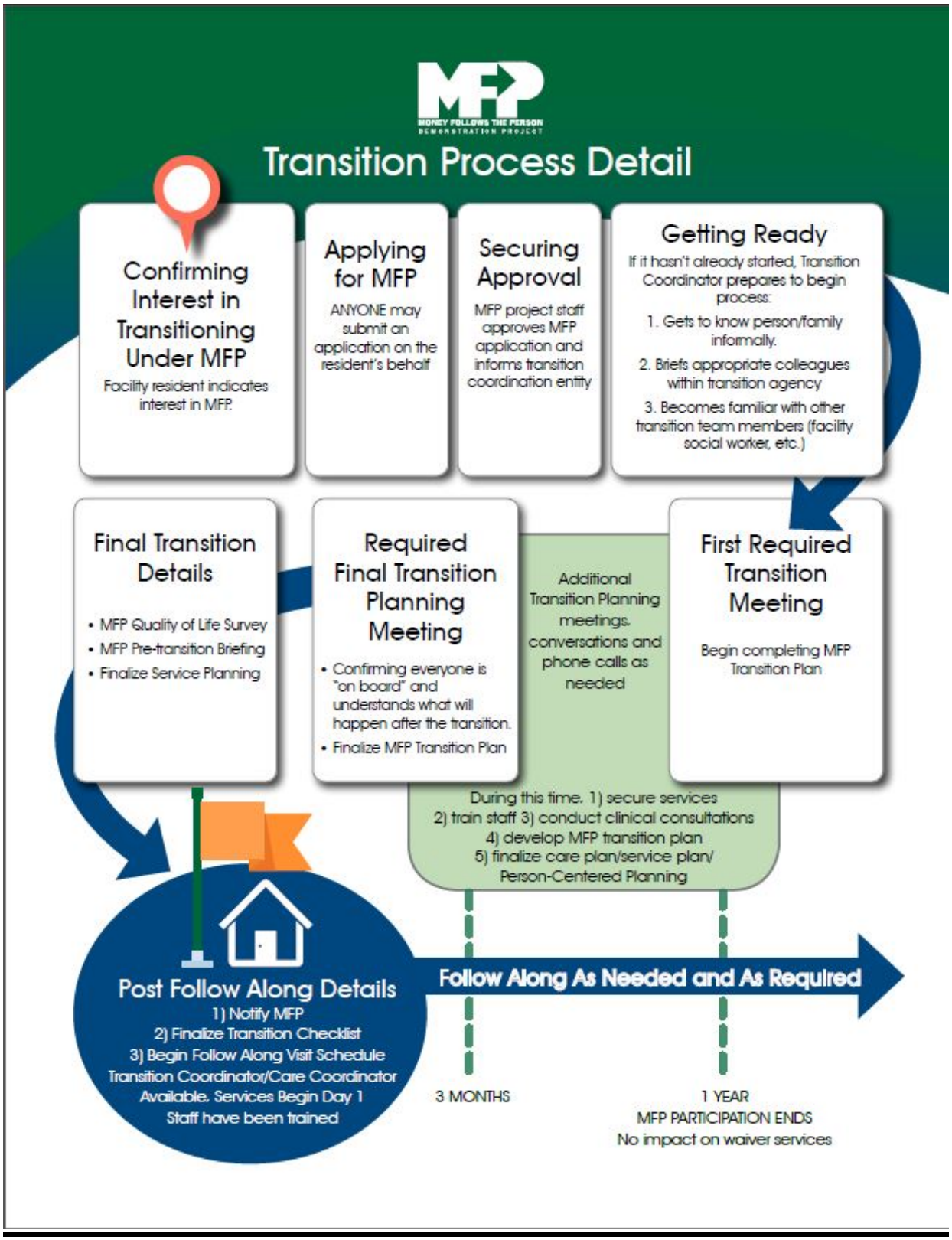
Minimum Follow Along Contact Schedule		
Month	**Minimum Required Activities for Regular Transitions**	**Minimum Required Activities for High Engagement Transitions**
Day of Transition	• Confirming services/key supports (medications, adaptive equipment, housing needs) are in place. • Present in-person on moving day. • Notify MFP of transition	
Month 1 (Within 30 days of Transition)	Two visits, in person: • 1st within one week of transition (within 48 hours recommended) • 2nd within first month (if TC and care coordination same entity, may substitute care coordination/case management visit) Weekly phone call to participant, family and/or residential provider.	Same as Regular Transition Follow Along Requirements plus one team meeting • May be by phone or in person • Meeting also satisfies requirements outlined in DD Center Discharge Protocol; • CAP IDT team meeting also satisfies this requirement. • POC/ISP revision team meeting also satisfies this requirement.
Month 2	• Minimum one in-person visits • Weekly phone call.	• Minimum two in-person visits • Weekly phone call
Month 3 Within 90 days of Transition	• Minimum one in-person visit • Phone calls as needed. • If transition coordinator is "phasing out" at this point, visit must include coordinated handoff to ongoing case manager.	• Minimum one in-person visit • All other weeks--phone call to participant/family/residential provider • Team Meeting (See Team Meeting requirements outlined in "Month 1, Within 30 Days of Transition")
Month 4-11	• Ongoing care management entity continues to provide incident reports to MFP program.	• Monthly in-person visit, • All other weeks, by phone call. • Team meeting must occur at least once each quarter post transition until MFP participation ends. (See Team Meeting requirements outlined in "Within 30 Days of Transition").

Twelfth Month	• Ongoing care management entity continues to provide incident reports to MFP program.

How NC MFP will monitor Follow Along Activity:

1. NC MFP reserves the right to request documentation of all visits.
2. In an effort to monitor *desired outcomes* over mere documentation, NC MFP evaluates the quality of the transition process, including the follow up by sampling NC MFP participants or as appropriate, the participant's representatives. NC MFP will survey a sampling of transitioned NC MFP participants on a quarterly basis. NC MFP's goal is that 90% of all surveyed individuals:
    a. Will have had a clear point of contact on the day of transition;
    b. Thinks the transition coordinator understood his/her needs and was responsive;
    c. If transition coordinator is no longer a part of the team, participant or the participant's representative is clear on who to contact if s/he have issues with:
        i. Residential/Personal Support Services
        ii. Housing
        iii. Medical care
        iv. Behavioral support
    d. Feels team gets together as often as is necessary.
3. MFP will also evaluate transition, recidivism and quality of life trends by population and transition entity to further identify areas of strengths and challenges in the transition process and practices.

Attachment B



MFP Overview

Person in Inpatient Facility

- Hospital
- Skilled nursing facility
- Intermediate care facility

For at Least Three Months

- Medicare considerations

Medicaid Eligible

- Mindful of deductible status

Transition Process

- Community Alternatives Program slot or All-Inclusive Care for the Elderly
- Transition year stability resources
- Enhanced case management
- Transition coordination

Moves Back into Own Home and Community

- Own house or apartment
- Family's home
- Group home of four people or fewer*

* For people with I/DD only in NC

Objectives:

- Increase the use of home and community-based, rather than institutional, long-term care services
- Eliminate barriers or mechanisms, whether in state law, the state Medicaid plan, the state budget, or other obstacles which prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice
- Increase the ability of the state Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting
- Ensure strategies and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement for such services

Website: www.mfp.ncdhhs.gov

State of North Carolina | Department of Health and Human Services | Division of Medical Assistance
www.ncdhhs.gov • http://www.ncdhhs.gov/dma/medicaid/MFP.htm
N.C. DHHS is an equal opportunity employer and provider. 05/2015

Attachment C

Quality Transitions in Long-Term Services and Supports

EMERGING PRINCIPLES

Transitions within the long-term care community are defined by various populations, occur in various settings, and are facilitated by various people serving differing roles. And like any social-professional evolution, the core competencies essential for quality transition planning become more refined over time. Despite North Carolina's diverse transition landscape, an emerging set of principles are helping shape how "quality" is defined in the transition process.

People who facilitate quality transition planning....

- Understand that at the center of every transition, is a person, whose interests, needs, personality and circumstances uniquely inform and shape the transition dynamic;
- Support the person exploring a potential transition in making an informed decision about how, when and where to transition-- facilitating opportunities to see and experience options if needed to feel truly comfortable in her ultimate decision, including not transitioning at all;
- Enjoy the transition process and supporting a person's access to community life—the hard work, the collaboration, the long to-do lists;
- Serve as a knowledgeable guide to the person transitioning and as appropriate, to her family, understanding that the person will soon be making a significant life change and may be anxious about the process;
- Model a respectful, positive, "can do" attitude throughout the process to both the person and all others helping with the transition;

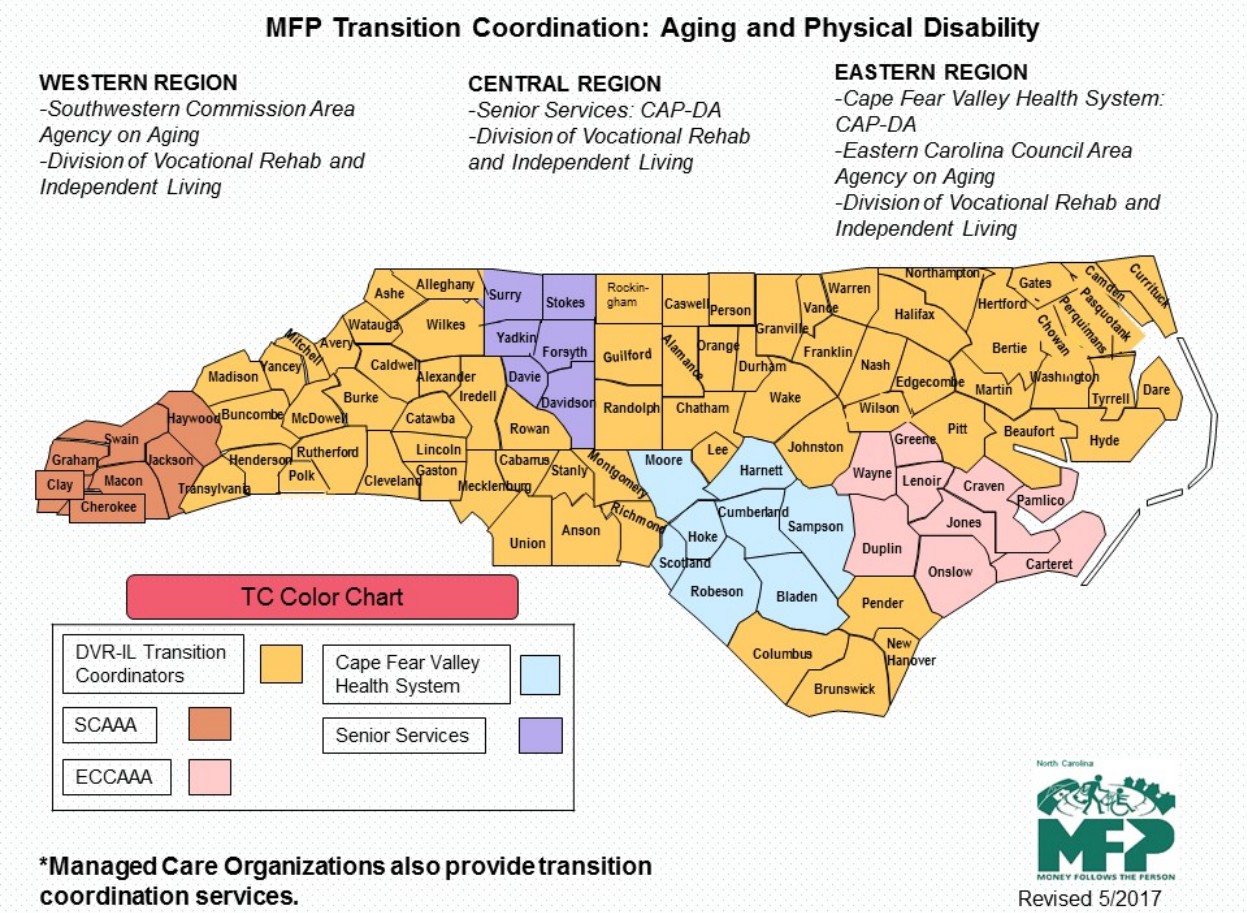
- Understand that an "assessment" of a person's transition needs is deeper than simply reviewing records, but requires building a relationship with the person and others as appropriate to fully appreciate what capacities are present and what supports are needed.
- Are "optimistically honest" about challenges the person transitioning may face, but sincerely works to overcome those challenges even if they may ultimately prove to be insurmountable;
- See the person and, as appropriate, his/her family as central participants in the transition process, deserving regular communication and support and taking on responsibilities in the transition work and guiding the process where possible;
- Understand, through conversation and research, why a person came to the facility and why they are motivated to transition home, using these reasons to guide and shape the transition planning;
- Understand effective transition planning does not hinge on becoming the expert on all areas relevant to a transition but rather partnering with the experts to ensure a person's needs are effectively supported;
- Understand that transition planning requires creative thinking and the curiosity to seek out solutions that are right for the person transitioning;
- Are willing to be flexible to meet the specific transition needs of the person involved;
- Assume responsibility for ensuring all of the necessary partners do their part and that identified services and supports are in place upon transition and begin as intended.
- Are highly organized and responsive to the person and to the team members assisting in the transition.

Quality Transition Planning…

- Is neither chaotic nor sluggish.
  People who facilitate transitions recognize that chaotic planning results in mistakes and potential gaps in care, while sluggish planning results in a loss of momentum and potentially diminished resources and opportunities.
- Is holistic.
  People who facilitate transitions look beyond the essential components related to housing, support services and physical and mental health, but also consider the person's specific needs related to family, community, and sense of contribution.
- Is transparent and collaborative.
  People who facilitate transitions ensure key partners are working together, communicating regularly and sharing information to best ensure a quality transition.
- Ensures continuity in critical services and supports.
  People who facilitate transitions ensure the person has access to the critical services and supports, however defined by and for that person, are in place on the day of the transition.
- Recognizes that the transition day is not the endpoint, but the midpoint.
  People who facilitate transitions provide the post-transition follow up necessary to ensure the transition plan is implemented as intended and facilitates solutions to issues that may have emerged.
- Recognizes that transition roles are often temporary and ensures "warm handoffs" between partners.
  People who facilitate transitions recognize that a person who has recently transitioned deserves to meet and build a relationship with others who may be guiding him/her through the community experience.

Attachment D

Transition Coordination Map



Attachment E

CAP/DA Critical Incident Reporting

[excerpt from CAP/DA waiver application]

State Critical Event or Incident Reporting Requirements

To safeguard the health and welfare of each approved waiver participant, DMA, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation. In assuring the health, safety and well-being of each CAP/DA participant, the lead agency shall address remediation efforts that mitigate the participant's health and welfare when a critical incident occurs. A critical incident report shall be completed each time a CAP/DA participant has been involved in a critical incident that jeopardizes his or her health, safety and well-being. Upon knowledge of the critical incident, a report must be completed within 5 days. Each lead agency is provided a copy of the critical incident report developed by the state Medicaid agency. The form has automatic fill-in responses through drop-down box options. The form is accessible through the e-CAP system. The CWE will track receipt of all critical incident reports to assure timeline is adhered. The CWE will also follow-up to assure the identified waiver participant is receiving the necessary services as identified through the recommendation of the incident report.

The types of critical incidences that must be reported include: death, missing person, use of restraints or seclusions, thefts, injury, abuse, neglect and exploitation, hospital admission, ER visits, concerns of health, safety and well-being, and medication error. Incidences of abuse, neglect and exploitation must be carefully followed to assure services are adequately met to keep the waiver participant safe in the community.

Level of reporting is managed by two incident levels: Level I and Level II. Level I incidences must be reported within 5 days in the e-CAP system. These incidences include, hospitalizations, ER visits, falls, death by natural causes, failure to take medication as ordered. Level II incidences must be reported within 5 days to DMA. These incidences include, APS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, falls requiring hospitalization or results in death, traumatic injury, medication administration that results in injury or hospitalization, wandering away from home, homicide/suicide and media related events.

Participant Education

On an annual basis, each waiver participant is provided information about abuse, neglect and exploitation and how to make a report when concerns arise. The service request form generally addresses potential abuse to assure comprehensive assessment of the waiver participant. The interdisciplinary assessment captures information about informal support systems and their burden of care giving that identifies potential risk factors for abuse, neglect and exploitation. Additional information is provided when requested or when the case manager and care advisor suspect abuse, neglect and exploitation.

After waiver approval, each beneficiary is provided a Welcome Letter. Some of the contents within the letter address ANE: "As a condition for participating in this waiver,

your case manager must plan for your health, safety and well-being. He or she must ensure that you are safe at all times and that you are not abused, neglected or exploited. The case manager or care advisor will talk with your monthly and make a home visit with you every 90 days to monitor your care needs, to ensure services are provided as planned, and to ensure that your health, safety and well-being is intact. If you think that you are not safe or have any concerns about abuse, neglect or exploitation you can call your county Department of Social Services for assistance with Adult Protective Services. You can also call your case manager or care advisor."

Each case manager or care advisor is required to have annual mandatory training that includes discussion about abuse, neglect and exploitation and how to complete, assess, report and mitigate critical incidences of waiver participants.

The state makes available and provides services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation.

In addition, waiver providers are required to give on-going training to direct service staff in how to recognize abuse, neglect and exploitation, and where to go for help. During the review of participant rights and responsibilities, the CWE, case manager and care advisors educate and provide information to participants, families and legal representatives. Participants sign a form indicating that they have received information about incident reporting. A criminal background check is performed on all personal care assistants under participant-direction as an addition safety precaution.

Responsibility for Review
Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each CAP/DA participant are identified as part of the intake and assessment process.

These items are entered into the e-CAP assessment tool along with the service plan which is completed using the e-CAP plan-of-care tool. The e-CAP system has the capacity to compare identified risk factors with elements of the plan to ensure these for all CAP/DA participants. Each risk identified by the assessment process must be addressed in the waiver participant's service plan or through an individual risk agreement.

A critical event is any incident that puts or has put a participant at-risk of harm which jeopardizes their health, safety and well-being to live safely in their home community. When a beneficiary experience any one of the following, each lead agency must complete a critical incident report:
• death• thefts
• injuries
• abuse, neglect or exploitation
• admission to a facility
• health, safety and well-being
• medication errors
• unplanned hospitalizations
• Missing person

• Restraints or seclusions
• other

The Administrative Authority [Division of Medical Assistance] and the CWE actively seek to ensure a participant's safeguards while she/he is participating in the waiver. During enrollment and during continuous participation in the CAP/DA waiver, a beneficiary may be denied based upon the inability of the program to ensure the health, safety, and well-being. Based on assessments of the beneficiary's medical, mental, psychosocial and physical condition and functional capabilities, conditions may warrant inability to participate in the waiver if the following areas cannot be mitigated:

a. The beneficiary is considered to be at risk of health, safety and well-being when they cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a personal emergency response system;
b. The beneficiary lacks the emotional, physical and protective support of a willing and capable caregiver who must provide adequate care to oversee 24-hour hands-on support or supervision to ensure the health, safety, and wellbeing of the individual with debilitating medical and functional needs;
c. The beneficiary's needs cannot be risk stratified and maintained by the system of services that is currently available to ensure the health, safety, and well-being of the individual;
d. The beneficiary's primary private residence is not reasonably considered safe to meet the health, safety and wellbeing in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the beneficiary's safety, and these issues cannot be resolved;
e. The beneficiary's primary private residence presents a physical or health threat due to the proven evidence of unlawful activity conducted; threatening or physically or verbally abusive behavior by the beneficiary or family member exhibited on more than two incidences; physically and verbally abusive behavior or threatening language; or a health hazard is present due to pest infestation. These conditions would reasonably be expected to endanger the health and safety of the individual, paid providers or the case manager or care advisor;
f. The beneficiary's continuous intrusive behavior impedes the safety of self and others by attempts of suicide, injury to self or others, verbal abuse, destruction of physical environment, or repeated noncompliance of POC [Plan of Care]and written or verbal directives;
g. The beneficiary's primary caregiver or responsible party continuously impedes the health, safety and well-being of the beneficiary by refusing to comply with the terms of the plan-of-care, refusal to sign a plan and other required documents when designated responsible party (Power of Attorney, Health Care Power of Attorney, or Legal)
h. The beneficiary's primary caregiver or responsible party refuse to keep the care manager or care advisor informed of changes in the status of the beneficiary; or
i. h. The beneficiary chooses to remain in a living situation where there is a high risk or an existing condition of abuse, neglect, or exploitation as evidenced by an APS assessment or care plan.

When health, safety and well-being issues are identified, a participant has the discretion to enter into an Individual Risk Agreement (IRA). This agreement outlines the risks and benefits to the beneficiary of a particular course of action that might involve risk to the beneficiary, the conditions under which the beneficiary assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement permits individuals to assume responsibility for their choices personally, through surrogate decision makers, or through planning team consensus. Each participant is required to have an emergency back-up plan. The emergency back-up plan is created by the CAP/DA beneficiary with the assistance of the case manager or care advisor. This plan specifies who provides care when key direct care staff cannot provide services or tasks as indicated in the current plan-of-care. Because both personal and home maintenance tasks are essential to the well-being of the participant, the case manager or care advisor is responsible for ensuring that an adequate emergency back-up plan is in place. In the event of an emergency or an unplanned occurrence, the plan includes family, friends, neighbors, community volunteers and licensed home care agencies to assist with care needs. An emergency back-up plan is necessary for times when the Personal Care Aide or Personal Care Assistant is unavailable during regularly scheduled work hours and when the unpaid informal support is unavailable for the balance of the remaining 24-hour coverage period.

Additionally, the CWE in conjunction with the case managers and care advisors monitor service plans with special consideration given to diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately on at least a monthly basis.

Assessments are completed at intake, during continued need reviews, or as needed, when the health of the participant changes. Every time the assessment (initial, CNR, or a change in status) is completed, a plan-of-care is completed or amended based upon the most current assessment.

The e-CAP system generates reports of service plans to address risk factors identified in the assessment. These reports are provided to the lead agency for continuous care planning as well as to make revisions to the care plan, when needed. The interventions, as set forth in the individual's service plan, are designed to minimize risk and are assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

When an event/issue is observed by or reported to a waiver provider, the provider has the responsibility to notify the local lead agency, and if applicable, other agencies (CPS, APS, DMA or law enforcement). When an event/issue is identified by, or reported to the local lead agency, an event/issue (report) form is completed. The report is designed to document: who the report is from; the type of event or issue; the date and time of the event/issue, if applicable; the location of the incident (participant's home, etc.); details of the event; involved parties; the source of the information; individuals who have first-hand knowledge of the event; whether the attending physician was notified; and the name, address and phone number of the physician and any other agencies or individuals that were also notified. The specific nature of an event or issue will determine if notification to others is warranted, e.g., CPS, APS, DMA, law enforcement, etc.

Any contact made with other agencies or individuals is kept confidential. The local lead agency develops a plan of resolution. All plans developed to resolve identified problems are thoroughly evaluated by local lead agency managers to ensure that they are appropriate, result in a resolution, which is amenable to the participant and/or his/her legal guardian. Reports of neglect, abuse and exploitation are reported to the county Department of Social Services to the Adult Protective Services Department.

Reports pertaining to inappropriate care by the In-Home Aide Agency, the assigned CNA or personal care aide are reported to the Division of Health Services Regulations, Home Care compliant section and Health Care Personnel registry. Reports that pertain to skilled nursing care are reported to the Board of Nursing. Reports pertaining to mismanagement of services or misappropriation of Medicaid dollars are reported to Medicaid Program Integrity Section.

Reports pertaining to violations against the law are reported to law enforcement. The county Department of Social Services, Adult Protective Services (APS) is responsible for evaluating all cases of abuse, neglect and exploitation. The APSAPS unit has a prescribed timeframe of 24, 48 and 72 hours to investigate a case. The beneficiary is provided a disposition of the case within 30- days of the initial home visit. APS has specific guidelines for evaluating a case to determine if a beneficiary is at risk and needs protection. The assigned APSAPS Worker evaluates the beneficiary's cognitive skills to determine capacity to make decisions and the need for supportive care. If a beneficiary is deemed not to be able to make an appropriate cognitive decision, APS provide an order of protection.

The lead agency is responsible for investigating all other reports except for reports of criminal involvement, to ensure the health, safety and well-being of waiver participants. An evaluation of the report is made against the clinical coverage policy to assure appropriateness of the waiver performances. The lead agency is at liberty to seek guidance from the CWE and state Medicaid agency. The waiver participant must be notified of the recommendation of the investigations within 30-days of the incident.

Responsibility for Oversight of Critical Incidents and Events.

Critical Incident Reports are filed through the case management IT system, e-CAP. The CWE aggregates the data on the critical incident report and sends alerts regarding needs and recommendations to the lead agency and the waiver authority. The local lead agencies are responsible for completing a critical incident report within 5 days of the occurrence. The lead agency identifies aa remediation plan for the beneficiary to mitigate the situation. The CWE reviews the remediation plan to ensure it addressed mitigation of the situation and facilitation of the outcome. The provider and local lead agency act immediately on any report of incidents placing the waiver participant in immediate or imminent danger; including contacting local law enforcement when the event/issue consist of abuse, neglect, and/or exploitation.

The state has an agreement with the state aging and adult agency (Division of Aging and Adults Services-DAAS) to provide quarterly data query of waiver participants

reported to be abused, neglected or exploited. The data query provides the date of the report, the alleged perpetrator, and the disposition of the case, confirmed or substantiated.

The report is compiled by county, the waiver program, type of report, disposition decision, and the number of reports received on a given waiver participant. The local DSS trains the APS workers on how to captured and complete the needed information on the report. A planning meeting is scheduled quarterly with DMA staff and the DAAS staff to review and analyze the data query to identify trends and implement strategies to mitigate future occurrences.

The state has trained each lead agency on how to detect and accept critical incident reports (CIR). Upon the knowledge of an incident, each lead agency is required to submit a CIR via e-CAP within 5-days. The e-CAP system compiles all critical incident reports to ensure accuracy of policy compliance and that the incident was clearly followed-up. Each incident is placed in a data query to track the frequency of each incident to identify trends.

The data query generated by the e-CAP is reviewed by DMA on a quarterly basis and compared against the data query generated by DAAS. These two reports are used to identify trends and strategies to mitigate future occurrences.

If the CWE disapproves the lead agency's remediation plan, the CWE seeks guidance from the state Medicaid agency. The state Medicaid agency makes the final remediation plan recommendation based on the nature of the incident and in combination of the policy guidelines.

The waiver participant must be notified of the recommendation of the investigations within 30- days of the incident.

An incident/death committee meets quarterly to track and trend level II incidences. The committee reviews summary of care history, age and gender of the participant, date of enrollment in the program, the significant diagnosis, participant's extent on formal and informal supports, summary of events, contributing factors, participants enrollment/action surrounding the event, immediate action taken, participant status, identification of risk points and their potential contribution to the event. An analysis of the following will be assessed to trend occurrences for quality improvement:

- Human factor (staffing levels, knowledge, training and competency)
- Prior addressed risk factors
- Equipment-related factors (maintenance)
- Environmental factors (lighting, noise clutter)
- communication factors (training and adequate tools)

Attachment F

Innovations Waiver Critical Incident Reporting

[excerpt from Innovations waiver]

"The DHHS Incident and Death Response System Guidelines describes who must report the documentation required, what/when/where reports must be filed and the levels of incidents, including responses to each level of incidents. Critical incident reporting requirements are outlined in North Carolina Administrative Code at 10A NCAC 27 G.0600. Providers of publicly funded services licensed under North Carolina General Statute 122C, with the exception of hospitals, and providers of publicly funded non-licensed periodic or community based mental health, developmental disability or substance abuse services are required to report critical events or incidents involving consumers receiving mental health, developmental disability or substance abuse services.

Critical incidents are defined as any happenings which are not consistent with routine operation of a facility, or service, in the routine care of consumers and that is likely to lead to adverse effects upon the consumer. Any incidents containing allegations or substantiations of abuse, neglect or exploitation must be immediately reported to the county Department of Social Services responsible for investigation of abuse, neglect or exploitation allegations. Other reports may be required by law, such as reports to law enforcement. Facts regarding the incident should be reported objectively, in writing, without unsubstantiated conclusions, opinions or accusations.

Incident reports are maintained in administrative files; however, incidents that have an effect on the participant must be recorded in the progress note of the participant record, as would any other consumer care information. Incident reports, including follow-up action requirements, are defined as one of three levels.

- Level I incidents are defined as any incident that does not meet the requirements to be classified as a Level II or Level III incident. Examples of Level I incidents include, but are not limited to: consumer injury that does not require treatment by a licensed health care professional, and HIPAA/confidentiality violations. Level I incident reports are reviewed by the employee's supervisor, managing employer or employer of record and are submitted to a designated person, per agency policy, and maintained in the administrative files of the employer of record. Level 1 reports are maintained by the provider agency and reviewed by the PIHP during routine monitoring which occurs annually for Alternative Family Living providers and every two years for other providers.
- Level II Incidents include any incident that involves a threat to a consumer's health or safety or a threat to the health and safety of others due to consumer behavior. Level II incidents are reported immediately to the employee's supervisor, employer of record, or managing employer. The managing employer immediately notifies the agency with choice. A written report is prepared that is submitted to and reviewed by the employee's supervisor, employer of record, or managing employer. The managing employer forwards the report to the agency with choice. A written report is prepared that is submitted to and reviewed by the

employee's supervisor, employer of record, or managing employer. The written report is forwarded to the PIHP within 72 hours of the incident's occurrence.

- Level III Incidents include any incident that results in a death or permanent physical or psychological impairment to a consumer, a death or permanent physical or psychological impairment caused by a consumer or a threat to public safety caused by a consumer. Level III incidents are reported immediately to the employee's supervisor, employer of record or managing employer. The managing employer immediately notifies the agency with choice. The supervisor (including the financial support service provider in the Agency with Choice model) or Employer of Record immediately notifies the PIHP, who notifies DMH/DD/SAS. The PIHP coordinates all activities required by state standards related to Level III incidents within 24 hours of being informed of the Level III incident. A written report is prepared that is submitted to and reviewed by the employee's supervisor (including the Agency with Choice) or Employer of Record. The written report is forwarded to the PIHP within 72 hours of the incident's occurrence. All providers (including the Agency with Choice) and Employers of Record are required to conduct a peer review of Level III incidents, beginning within 24 hours of the incident.

Providers must follow IRIS reporting requirements. Where a provider's individual policies are more restrictive (i.e. timelines), then the provider must also be compliant with their own policies."

The following language outlines the Waiver's oversight requirements for critical incident management:

"Incident reporting requirements and responses are based on state laws and regulations for each of the three levels of incidents.

- Level 1 Incidents are maintained by the provider agency (including the Agency with Choice) and Employer of Record. Each provider agency (including the Agency with Choice) or Employer of Record is required to maintain copies of these reports for review by the PIHP during routine monitoring.

- Written reports of Level II incidents are forwarded to the PIHP within 72 hours of the incident's occurrence. The provider agency (including the Agency with Choice) and Employer of Record are responsible for attending to the health and safety of involved parties as well as analyzing causes, correcting problems and review in quality improvement process to prevent similar incidents. Level II incidents may signal a need for the PIHP to review the provider's clinical care and practices and the PIHP's management processes, including service coordination, service oversight and technical assistance for providers. These incidents require communication between the provider and the PIHP, documentation of the incident and report to the PIHP and other authorities as required by law. The PIHP is responsible for reviewing provider handling of the incident and ensuring consumer safety.

- Level III Incidents are immediately reported to the PIHP who notifies DMH/DD/SAS. The PIHP coordinates all activities required by state standards related to Level III incidents within 24 hours of being informed of the Level III incident. A written report is prepared and reviewed by the agency or employer submitting the incident. The written report is forwarded to the PIHP within 72 hours of the incident's occurrence. Providers (including the Agency with Choice) and Employers of Record attend to the health and safety needs of involved parties, and conduct a peer review of Level III incidents beginning within 24 hours of the incident. The internal review:
  (1) Ensures the safety of all concerned
  (2) Takes action to prevent a reoccurrence of the incident
  (3) Creates and secures a certified copy of the consumer record
  (4) Ensures that necessary authorities and persons are notified within allowed timeframes
  (5) Conducts a root cause analysis once all needed information is received.

  Level III incidents signal a need for DHHS, including DMH/DD/SAS and the PIHP, to review the local and state service provision and management system, including coordination, technical assistance and oversight. These incidents require communication among the provider, the PIHP and DHHS, documentation of the incident, and report to the PIHP, DHHS and other authorities as required by law. The PIHP reviews provider handling of the Level III incident:
  (1) To ensure that consumers are safe
  (2) A certified copy of the beneficiary record is secured
  (3) A review committee meeting is convened
  (4) Appropriate agencies are informed

DMH/DD/SAS reviews the PIHP oversight of providers and follows up, as warranted, to ensure problems are corrected. The PIHP also analyzes and responds to patterns of incidents as part of quality improvement and monitoring processes. DMH/DD/SAS analyzes and responds to statewide patterns of incidents as part of quality improvement and monitoring. DMH/DD/SAS includes information about deaths in their annual Legislative Report.

Other agency responsibilities for follow-up of incidents are:

(1) Local law enforcement agencies investigate legal infractions and take appropriate actions
(2) County Department of Social Services investigates abuse, neglect or exploitation allegations and takes appropriate actions
(3) The Health Service Regulation Division of DHHS investigates licensure infractions and take appropriate actions
(4) The Health Care Personnel Registry section of the Health Services Regulation Division investigates personnel infractions and takes appropriate actions
(5) The Disability Rights, formerly the Governor's Advocacy Council for Persons with Disabilities analyzes trends and advocates as warranted

A summary of incident reporting and follow-up actions is included in the PIHP'S reporting to DMA. Providers are required to develop and implement written policies governing their response to incidents, including conducting investigations. The policies must also include attending to the health and safety needs of individuals involved in the incident, determining the cause of the incident, and developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days. Polices must also include notification of the participant of the results of any investigation. The timeframe for informing the beneficiary, including all relevant parties, of the investigation results is within three (3) months of the date of the incident. The PIHP submits a summary of incident reports as well as related performance measures to DMA on a quarterly basis.

A provider internal review team must meet within 24 hours of any incident that results in, or creates a significant risk of resulting in death, sexual assault or permanent physical or psychological impairment to a consumer or by a consumer. In North Carolina, these are referred to as Level III Incidents. The internal review team consists of individuals who were not involved in the incident and who were not responsible for the consumer's direct care or with the direct professional oversight of the consumer's services at the time of the incident.

Preliminary findings of fact are sent to the host PIHP and the PIHP where the consumer resides (if different) within five (5) working days of the incident. A final written report signed by the owner of the provider organization is submitted to the PIHP within three (3) months of the incident. The final written report must address the issues identified by the internal review team; include all public documents related to the incident, and make recommendations for minimizing the occurrence of future incidents. The provider must also immediately report incidents of this level to the host PIHP, the PIHP where the consumer resides (if different), DHHS through the online Incident Response Improvement System (IRIS), the provider agency with responsibility for maintaining and updating the consumer's treatment plan if different from the reporting provider, the consumer's legal guardian if applicable, and any other authorities required by law.

The PIHP must report Level III Incidents to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Licensed providers must also send a copy of all Level III Incidents involving a death to the North Carolina Division of Health Service Regulation within 72 hours of becoming aware of the incident when the death was an accident, suicide or homicide. All cases of client death must be reported immediately to the PIHP.

Each PIHP develops and implements written policies governing local monitoring based on provider incident reporting. Minimally, these policies include review of how providers respond to incidents and ensure consumer safety, monitor and provide technical assistance as warranted to ensure that problems are corrected, analyze and respond to patterns of incidents as part of QI monitoring and processes, determine if public scrutiny is an issue, and ensure that Level III Incidents are reported to the DMH/DD/SAS.

The DMH/DD/SAS is responsible for analyzing and responding to statewide patterns of incidents as part of QI and monitoring PIHP oversight of response processes, produce

statewide quarterly incident trend reports, review PIHP oversight of providers and follow up as warranted to ensure problems are corrected, and analyze and respond to statewide patterns of incidents as part of QI and monitoring processes.

The DHHS is the North Carolina agency that oversees DMA and DMH/DD/SAS. DMA tracks performance measures and receives all incident reports quarterly. DMH/DD/SAS also assists in the oversight of critical incidents and events.

Aggregate data for all incidents is collected by the provider and submitted to the PIHP quarterly.

Additionally, all Level II and Level III incidents are recorded in the North Carolina online Incident Response Information System. DMA and the DMH/DD/SAS reviews all data and monitors the PIHPs oversight of providers and follows up as warranted to ensure that problems are corrected. The DMH/DD/SAS also analyzes and responds to statewide patterns of incidents as part of Quality Improvement and monitoring processes.

Level I incidents are maintained on site by the provider agency and are reviewed by the PIHP during routine monitoring. Level II and Level III incidents are reported by the provider within 72 hours of the incident occurring. The PIHP and the DMH/DD/SAS

Critical incidents for MFP participants are submitted through the Innovations Waiver Incident Reporting protocol. Additionally, transition coordinators utilizing MFP-funded Innovations waiver slots are expected to report any known incident to MFP directly through monthly reporting.

MFP staff also draw IRIS data for MFP participants bi-annually and supplement claims research through NCTracks.

Attachment G
CAP/DA Risk Management

The state has procedures to promote individual and family preferences and selections for care and services. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences and goals of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

An Individual Risk Agreement (IRA) outlines the risks and benefits to the beneficiary of a particular course of action that might involve risk to the beneficiary, the conditions under which the beneficiary assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement permits individuals to assume responsibility for their choices personally, through surrogate decision makers, or through planning team consensus.

The state has procedures to promote individual and family preferences and selections for care and services. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences and goals of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts). To ensure that family or individual decisions are honored an individual risk assessment tool is used to help provide a framework for supporting individuals to remain in their homes despite identified risk of health, safety and well-being. This tool helps the case manager, care advisor or the participant to think through risks and identify ways to minimize them. Risk and outcomes are identified to develop a risk plan and service plan to monitor and control the probability and/or effects of unfortunate events or to maximize the realization of opportunities for ongoing community living.

The individual risk assessment tool ensures full understanding through:

- Written and Signed Statement to Negotiate Risks
- Process Balances of Autonomy & Safety
- Degree of Specialization of Service Plan

The tool identifies real or potential risks by:

- Fostering communication, discussing and setting expectations
- Describing service delivery plan
- Acknowledging participant’s right to make choices involving risks
- Assigning responsibilities

This tool on an ongoing basis:

- Addresses changing risks over time;
- Evaluates how things are going;
- Adjusts the outcomes; and
- Provides Remediation.

The primary consideration underlying the provision of services and assistance for disabled and elderly adults is their desire to reside in a community setting. Enrollment and continuous participation in CAP/DA waiver may be denied based upon the inability of the program to ensure the health, safety, and well-being of the beneficiary despite the

implementation of an individual risk agreement. Based on the evaluation of the risk agreement and the assessment of the beneficiary's medical, mental, psychosocial and physical condition and functional capabilities, conditions may
warrant inability to participate in the waiver when the following considerations cannot be mitigated:

a. The beneficiary is considered to be at risk of health, safety and well-being when they cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a Personal Emergency Response System;
b. The beneficiary lacks the emotional, physical and protective support of a willing and capable caregiver who must provide adequate care to oversee required 24-hour hands-on support or supervision to ensure the health, safety, and well-being of the individual with debilitating medical and functional needs; or
c. The beneficiary's needs cannot be risk stratified and maintained by the system of services that is currently available to ensure the health, safety, and well-being.
d. The beneficiary's primary private residence is not reasonably considered safe to meet the health, safety and wellbeing in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the beneficiary's safety, and these issues cannot be resolved;
e. The beneficiary's residential environment would reasonably be expected to endanger the health and safety of the individual, paid providers or the case manager or care advisor; presents a physical or health threat due to the proven evidence of unlawful activity conducted in the primary private residence; threatening or physically or verbally abusive behavior by the beneficiary or family member exhibited on more than two incidences; physically and verbally abusive behavior or threatening language; or present of a health hazard due to pest infestation.
f. The beneficiary's continuous intrusive behavior impedes the safety of self and others by attempts of suicide, injurious to self or others, verbally abusive, destructive of physical environment, or repeated noncompliance of POC and written or verbal directives; or
g. The beneficiary's primary caregiver or responsible party continuously impedes the health, safety and well-being of the beneficiary by refusing to comply with the terms of the plan-of-care, refusal to sign a plan and other required documents of when designated responsible party (Power of Attorney, Health Care Power of Attorney, or Legal) and refusal to keep the care manager or care advisor informed of changes in the status of the beneficiary.
h. The beneficiary chooses to remain in a living situation where there is a high risk or an existing condition of abuse, neglect, or exploitation as evidenced by an Adult Protective Services assessment or care plan.

The case manager or care advisor will review all critical incident reports to identify and address risk and to assist in preventing future instances of abuse, neglect and exploitation. Case managers will be required to report monthly on

substantiations of abuse and neglect of all waiver participants to assure health, safety and well-being is maintained.

As another safety precaution and risk mitigation, each waiver beneficiary must have an emergency back-up plan with adequate formal and informal supports to meet the basic needs outlined in the CAP/DA assessment and plan-of-care (POC) to maintain their health, safety and well-being. The plan may include family, friends, neighbors, community volunteers and licensed home care agencies when possible in the event of an emergency or an unplanned occurrence.

An emergency back-up plan is necessary for times when the personal care aid or personal assistant is unavailable during regularly scheduled work hours and when the unpaid informal support is unavailable for the balance of the remaining planned services of the POC coverage period. The emergency back-up plan must also address emergency preparedness.

The emergency back-up plan is created by the beneficiary with the assistance of the case manager or care advisor. This plan specifies who shall provide care when key direct care staff cannot provide services or tasks as indicated in the current POC.

Attachment H
North Carolina Innovations Risk Management

The Risk Management Structure for MFP participants enrolling/enrolled in the Innovations waiver is built upon the risk management strategies in place for all Innovations waiver participants, including the development of a Risk/Support Needs Assessment that informs service planning and a Crisis Prevention Plan that is integrated into the ongoing service plan.

North Carolina Innovations Risk Assessment and Risk Mitigation
"The NC Innovations Risk/Support Needs Assessment assists the beneficiary and the ISP team in identifying significant risks to the beneficiary's health, safety, financial security and the safety of others around them. In addition, this assessment identifies needed professional and material supports to ensure the beneficiary's health and safety. Risks identified in this assessment could bring great harm, result in hospitalization or result in incarceration if needed supports are not in place."

"The NC Innovations Risk/ Support Needs Assessment is completed prior to the development of the ISP and updated as significant changes occur with the beneficiary at least annually. The care coordinator works with the participant, family and other team members to complete the assessment.

1. The NC Innovations Risk/Support needs assessment includes: health and wellness screening to include the primary care physician to act as the locus of coordination for all health care issues, medication management, nutrition, preventive screenings, as
   appropriate, and any relevant information obtained from other supports needs assessments.
2. Risk screening to include behavioral supports, potential mental health issues, personal safety and environmental community risk issues.

Support needs and potential risks that are identified during the assessment process are addressed in the ISP, which includes a crisis plan as applicable. Strategies to mitigate the risk reflect beneficiary needs and include consideration of the beneficiary preferences. Strategies to mitigate risk may include the use of risk agreements.

The ISP states how risks will be monitored and by whom, including the paid providers, natural and community supports, participants and their family and the care coordinator.

A backup staffing plan is included in the ISP and designed to meet the needs of beneficiaries to make sure that their health and safety is ensured. It outlines who (whether natural or paid) is available, contact numbers, at least two levels of backup staffing are identified for each waiver service provided."

The North Carolina Innovations Crisis Prevention Plan
"The ISP will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and type of provider who will furnish each service or support. A Crisis Prevention Plan is incorporated within the ISP. The Crisis

Prevention Plan includes supports/interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive). A proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to address them. A reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond. The planning team are to consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably.

The Crisis Prevention Plan should include what positive skills the participant has which can be elicited and increased at times of crisis; how to implement redirection of energies towards exercising these skills that can prevent crisis escalation; how to implement positive behavioral supports that may be relied upon as a crisis response.

The Crisis Prevention Plan is an active and living document that is to be used in the event of a crisis. After crisis, the participant and staff should meet to discuss how well the plan worked and make changes as indicated."

Additional NC MFP Risk Management Elements for High Engagement Participants
Recognizing that a number of MFP participants transitioning onto the Innovations waiver have behavioral complexities, MFP has established a high engagement designation that augments the Innovations risk mitigation requirements in three key ways:

1. High engagement transitions are required to participate in a state-staffed pre-transition briefing, in which a transition can be stopped or delayed if key transition components are not in place.
2. High engagement transitions require more rigorous follow along schedules.
3. High engagement transitions are required to implement pre-transition staff training and clinical consultation services and may use Pre-Transition Staffing and Consultation demonstration service to reimburse community-based providers.

Attachment I
North Carolina Innovations Complaint policy

Formal Complaint Process: Innovations Waiver
The North Carolina Administrative Code (NCAC) at 10A NCAC 27G.0609 requires local management entities (operating as PIHPs for waiver purposes) to report to the DHHS Division of MH/DD/SAS all complaints (grievances under 42 CFR 438 Subpart F) made to the PIHP not less than quarterly. The submission of the PIHP complaint report is included in the contract between the PIHP and the Division of MH/DD/SAS. Four documents provide procedures and instructions relative to the complaint process:

1. Guidelines for the complaint reporting system
2. Customer service collection forms
3. Quarterly complaint report
4. Complaint reporting instructions

A copy of the quarterly complaint report is shared with the PIHP Client Rights Committee and the PIHP Consumer and Family Advisory Committee in order to develop strategies for system improvement.

Guidelines require the documentation of any concern, complaint, compliment, investigation and request for information involving any person requesting or receiving publicly-funded mental health, developmental disabilities and/or substance abuse services, local management entity or MH/DD/SAS service provider.

Complaint Reporting Categories include:

(1) Abuse, neglect and exploitation
(2) Access to services
(3) Administrative issues
(4) Authorization/payment/billing
(5) Basic needs
(6) Client rights
(7) Confidentiality/HIPAA
(8) PIHP services
(9) Medication
(10) Provider choice
(11) Quality of care
(12) Service coordination between providers
(13) Other to include any complaint that does not fit the previous areas.

Information is recorded on the customer service form and recorded in the PIHP complaint database for analysis. Action taken by the PIHP is recorded to include a summary of all issues, investigations and actions taken and the final disposition resolution. Guidelines define the resolution for types of complaints that may be made. The total number of calendar and working days from receipt to completion are also recorded.
If the complainant is not satisfied with the initial resolution, the individual may request to appeal the decision.

The quarterly complaint reporting form includes the aggregate information on complaints to include:

(1) The total number of complaints received by the customer service office
(2) The total number of persons (by category) who are reporting complaints
(3) The total number of consumers by age group
(4) The total number of consumers by disability group (if applicable) involved in the complaint
(5) The primary nature of the complaints/concerns (by category)
(6) A summary of data analyses to identify patterns, strategies developed to address problems and actions taken
(7) An evaluation of results of actions taken and recommendations for next steps.

Grievances (complaints) are also reported to the state Medicaid agency on a quarterly basis as required by the risk contract between the DHHS DMA and the PIHP. The DMA and the DMH/DD/SAS have developed a joint reporting form to increase consistency of processes to the extent possible.

The grievance process is conducted by the PIHP and is an expression of dissatisfaction by the enrollee about things that are not “actions.” Actions refers to denial of a service request; limited authorization of a service request; reduction, suspension, or termination of a previously authorized service; denial of payment for a service; failure to authorize or deny a service request in a timely manner; or failure to resolve a grievance (i.e., within 90 calendar days). The grievance process is separate from the reconsideration/state fair hearing process. Enrollees do not have to file a grievance before requesting reconsideration of an action.

The appeal process (called “reconsideration” in North Carolina) is conducted by the PIHP. Appeal refers to a request for review of an action (please refer to the definition in the previous section of what constitutes “actions”). Appeals can be filed in writing or orally by the enrollee or provider (with written consent). The enrollee has 30 days to request an appeal of the PIHP action. If the request is made orally, the enrollee must submit a written request within 30 days of the date of the adverse notice. Individuals making decisions on appeals cannot have been involved in any previous level of review or decision-making. The enrollee must be allowed a reasonable opportunity to present evidence and allegations of fact or law and must be allowed to examine his/her medical records and the documents considered during the appeal.

For standard resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 45 days from the day the PIHP receives the appeal. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the PIHP receives the appeal. Timeframes to decide both grievances and appeals (both standard and expedited) may be extended up to fourteen (14) calendar days if additional information is required.

In North Carolina, enrollees must exhaust the PIHP Appeal Process (“Reconsideration”) before accessing the State Fair Hearing (referred to as an “Appeal”). Medicaid State Fair Hearings are governed by 42 Code of Federal Regulation (CFR) Part 431 and

utilize the Administrative Hearings procedure. These hearings apply to an appeal (“reconsideration”) not decided wholly in favor of the enrollee. The PIHP is a party to the State Fair Hearing and the process is controlled by state law and rules. The enrollee has 30 days to request a State Fair Hearing from the date of the appeal (“reconsideration”) decision. After 30 days, the PIHP appeal(“reconsideration”) decision becomes final.

Attachment J
CAP/DA QUALITY IMPROVEMENT STRATEGY
[excerpt from CAP/DA waiver]

System Improvements: Trending, Prioritizing and Implementation

DMA has developed a quality management plan that integrates, analyzes and responds to information from multiple sources across functions within the state system. The plan also involves partners and stakeholders including participants/families, Contracted Waiver Entity, CAP/DA lead agencies, provider agencies, as well as representatives from various state agencies.

The overall purpose of the Quality Improvement Strategy (QIS) for CAP/DA is to design, develop, implement, and manage a Quality Assessment and Quality Improvement Program for CAP/DA waiver that:

1. Ensures that the DMA meets the Centers for Medicare and Medicaid Services' (CMS) through monitoring of the 6 waiver assurances;
2. Designs and implements the Quality Framework that will discover, remediate and improve assurances for waiver services;
3. Establishes a systematic approach to monitor, evaluate, and continuously improve the quality of CAP/DA services;
4. Identifies and sets appropriate performance and outcome measures to evaluate CAP/DA services; and
5. Implements a Quality Management (QM) Program for CAP/DA that focuses on participant-centered outcomes related to:
    a. Participant access;
    b. Participant-centered services planning and delivery;
    c. Provider capacities and capabilities;
    d. Participant safeguards;
    e. Participant rights and responsibilities;
    f. Participant outcomes and satisfaction; and
    g. System performance.

The process for trending and prioritizing will be achieved through a quality management plan and the assembly of a QA/QI committee

The quality management plan includes:

- Provide training and technical assistance to the waiver community as needed;
- Analyze trended data and take action to remediate findings;
- Review and prioritize recommendations from all stakeholders and make changes as deemed appropriate;
- Disseminate information compiled from analysis of QA/QI data to appropriate stakeholders, including participants, family members and system advocates.

A QI/QA committee will be assembled that is comprised of participants/families, VieBridge, Inc., CAP/DA lead agencies, provider agencies, and representatives from various agencies of the State system. This committee convenes quarterly. This committee works to support and encourage systematic quality management activities and improvements. The responsibilities of this committee consist of:

- Reviewing QA/QI system data;

- Analyzing data to determine patterns, trends, problems, and issues relative to all assurances;
- Making recommendations to DMA for changes in policies and procedures based on analysis of compiled QA/QI data;
- Making recommendations to DMA regarding the provision of training, technical assistance and other activities, based on analysis of QA/QI data and conducting follow-up monitoring of the activity to assure remediation and statewideness;
- Continuing to develop and refine the QA/QI quality indicators to be monitored;
- Reviewing the QA/QI plan at least annually and making changes as needed to assure that the data gathered is generating useful information to improve quality of service delivery;
- Reviewing the QA/QI policies and procedures at least annually and modifying as needed; and Disseminating information compiled from analysis of QA/QI data to appropriate stakeholders, including participants, family members and system advocates.

In addition to the activities described above, each QM performance indicator written into the waiver includes the type and frequency of activity in gathering data specific to the indicator, the sampling methods for each indicator, how data will be collected, and who will collect the data.

System improvement will be achieved through the following:

Data gathered during the first waiver year will be used to establish baseline performance levels and will be the basis for setting acceptable thresholds for each indicator for the following waiver years. Through the analysis and review process, indicators that reflect changes from expected trends will be identified for further analysis and study. If applicable, special studies will be undertaken on prioritized measures to understand changes in trends.

Method that will be utilized:

The Participants and their families will:

- Contact their case managers or care advisors if they have concerns about their services or supports;
- Access grievance and complaint processes, with assistance from their case managers or care advisors, if needed, based on materials provided by the CWE/DMA;
- Provide feedback on state and local plans and budgets; and
- Participate in the monitoring of service development and delivery through participation in surveys and stakeholders' meetings.

The CAP/DA lead agency and CWE will:

- Help identify under-served populations and gaps in the service array; Review reports generated by DMA;
- Advise on the development of additional services and new models of service delivery;
- Participate in quality improvement projects at the provider;

- Facilitate the Person-Centered Planning (PCP) process and ensure that the PCP includes all needed services and supports as well as all state and waiver requirements (including a Crisis Plan based on a risk assessment);
- Re-asses each participant's needs at least annually and develop a revised PCP based on that reassessment (Continued Need Review);
- Act on and remediate any issues related to the participant's health, safety, and welfare or service delivery. Unresolved issues will be brought to the attention of DMA/CWE. Revise the PCP as the participant's needs change;
- Conduct quarterly face-to-face visits with the participant to oversee PCP implementation; monitor health safety and welfare; identify risk factors determine if the back-up plan remains effective and is implemented as written.

Other waiver service provider agencies are responsible for:

- Maintaining licensure, certification and accreditation as required, including ensuring that staff are qualified to deliver services, criminal background/Healthcare Registry checks and staff receive required supervision;
- Monitoring the provision of services; contacting the case manager or care advisor if there are any concerns regarding the participant;
- Participate in the development of the PCP;
- Implementing the PCP including risk mitigation strategies and the back-up plan;
- Submitting Incident Reports and Quarterly Incident Reports as required by DHHS rules;
- Responding appropriately to all participant incidents; maintaining documentation of critical incidents;
- Reporting and remediating critical incidents to the CWE/DMA;
- Developing and implementing an internal quality improvement plan;
- Developing and convening an internal client rights committee;
- Participating in stakeholders' meetings.

The CWE is responsible for:

- Reviewing and assuring plans completions monthly;
- contacting the case manager or care advisor to address any deficiencies prior to approval;
- following up to ensure that case managers or care advisors have corrected any deficiencies prior to approval.

The CWE is a non-governmental contracted entity that is responsible for the day-to-day operation of CAP/DA waiver.
The functions of the CWE include:

- Operating a uniform local access system;
- Monitoring, evaluating and conducting continuous quality improvement;
- Managing secure information systems with data on participants,

- Monitoring and overseeing services, including provider compliance with standards for state and waiver requirements, provider qualifications, and utilization;
- Providing technical assistance to providers; Providing information to waiver participants including their responsibilities, protections and rights, as well as grievance and complaint resolution processes;
- Resolving issues related to any participant's health, safety, welfare or service delivery that are unresolved by the case manager or care advisor;
- Ensuring that CAP/DA providers participate in the DHHS incident reporting system;
- Receiving, reviewing and following up on incident reports from CAP/DA lead agencies and other providers as required by DMA/DHHS rules;
- Ensuring that reporting is made to the county Department of Social Services if the circumstances surrounding an incident, complaint or local monitoring reveal that a participant may be abused, neglected or exploited;
- Submitting Quarterly Incident Report and Quarterly Complaint Report to DMA;
- Submitting a Quarterly Provider Monitoring Report of monthly local monitoring activities to DMA that identifies provider monitoring issues requiring correction and an explanation of uncorrected issues.

The CWE will also perform:

- Yearly audits of paid claims to CAPDA providers, as well as record reviews and PCP reviews;
- Investigating incidents and complaints that are unresolved at the local level or that have the appearance of conflict of interest with the CAP/DA lead agency;
- Tracking, reviewing, analyzing and reporting on aggregated data reported on all waiver assurances;
- Tracking and reviewing incident reports and investigating as needed;
- Collecting, aggregating, analyzing and reporting quarterly and annually on statewide and sub-state incident and complaint data; Routinely monitoring the performance of CAP/DA lead agency;
- Conducting yearly accountability audits;
- Conducting surveys of individual and family outcomes;
- Meeting with DMA on at least a quarterly basis to review trends and issues and to communicate information on any needed changes to the waiver.

DMA will:

- Conduct quarterly audits of Level of Care and PCPs for waiver participants;
- Conduct fiscal audits of the waiver programs;
- Review waiver data/evidence from CWE/CAPDA;
- Ensure remediation by DMA for any identified issues and conduct ad hoc reviews of the waiver program;
- Meet with CWE/CAPDA lead agencies on at least a quarterly basis to review trends and issues and to communicate information on any new CMS policies and procedures;
- Enroll qualified providers; and

- Oversee the performance of the Utilization Review vendor.

Remediation

Remediation is the action taken to remedy specific problems or concerns that arise. When an issue of weak performance is discovered, the CWE will notify the lead agency to make that entity aware of the issue, inform of the policy and assist with implementing an action plan to bring the weak performance to a level consistent with waiver compliance. Subsequently, a root cause analysis will be performed to identify the problem to improve future performances and to prevent other problems in the future.

Continuous monitoring will be implemented to improve system design flaws that allowed for weak performance, but more importantly map out how both existing and improved data and quality information can lead to continuous improvement in the waiver program.

Systems Design Changes

DMA is the state Medicaid agency responsible for the administration of the CAP/DA Program. Case management services and business processes are delivered through a network of county agencies called CAP/DA lead agencies (lead agencies). Several agencies play key roles in the CAP/DA service delivery system, as summarized below:

- The Medicaid CAP/DA Unit – The CAP/DA unit is one of ten long-term care programs in DMA's Home and Community Care Section. The primary responsibilities of the CAP/DA Unit include providing overall management oversight of the program, developing and implementing program policies and procedures, conducting the CAP/DA quality management program, setting the county slot allocations, and providing training, consultation, providing oversight and monitoring of the Operating Waiver Agency, and technical assistance to the lead agencies and CAP/DA providers.

- The local CAP/DA lead agency – Local CAP/DA lead agencies are appointed in each county by the CAP/DA unit and may be a county Department of Social Services, local health department, area agency for the aged, a hospital or an organization with proven substantial history in providing community long-term care. CAP/DA lead agencies perform the following duties:
    - Develop referral procedures according to DMA standards and local policy and share these procedures with the appropriate providers and organizations;
    - Educate the aging and disabled community about CAP/DA;
    - Determine case management capacity, case mix and caseloads;
    - Provide assistance in obtaining and verifying documentation from medical staff and other health care professional to determine support for level of care and other medical and functional needs;
    - Complete comprehensive assessments to ascertain medical, psychosocial and functional needs for waiver participation;
    - Coordinate and collaborate in an interdisciplinary team approach for the provision of waiver services that prevent institutionalization;

    - Develop a person-centered service plans that identifies the amount, duration and frequency of each service and the responsible party to render the service;
    - Assure cost neutrality of the CAP/DA waiver by budgeting the approved waiver resources allotted by DMA; Review all initial and revised service plans to provide written authorization for approval and participation in the waiver;
    - Provide each beneficiary or primary caregiver freedom of choice between institutional care or waiver participation choice among waiver services and providers;
    - Provide monthly monitoring of the service plan with beneficiary and all approved services providers;
    - Provide direct observation of hands-on personal care services performed with the beneficiary to include personal care and participation in adult day health quarterly;
    - Initiate Due Process tasks when an adverse decision is made and coordinate with beneficiary, providers and due process management vendor;
    - Provide assistance, when requested, in verifying whether medical documentation supports nursing facility level of care;
    - Monitor and assess the CAP/DA beneficiary monthly to assure safe community living (health, safety and well-being criteria); concerns must be mitigated through referral to Adult Protective Services (APS) or a revision to the service plan; and provide monthly and quarterly Case Management/Care Advisement to the CAP/DA beneficiary.
- The Medicaid Fiscal Agent – Computer Science Corporation (CSC)/NCTracks, provides the prior approval review for CAP/DA participants, processes and pays provider claims, allows provider enrollment in the Medicaid program, and provides training related to these activities to provider organizations.
- CAP/DA Provider Organizations – Provider organizations are enrolled with Medicaid to provide certain defined services, as specified in their enrollment contracts. Provider qualifications are specified in the CAP/DA Clinical Coverage Policy and the Medicaid Provider Enrollment Agreement Packet/Handbook.
- Contracted Waiver Entity – The CWE is a non-governmental contracted entity designated as the quality improvement organization. The CWE, under contract to DMA, conducts a comprehensive internet-based quality management program for the CAP/DA Program called e-CAP. This automated quality management system is described below under the heading of e-CAP. The Contracted Waiver Entity (CWE) is the day-to-day administrator of the CAP/DA waiver to manage administrative tasks. The CWE shall:
    - Assure participant waiver enrollment;
    - Assure waiver enrollment against approved limits;
    - Assure waiver expenditures managed against approved limits;
    - Assure level of care evaluation;
    - Review participant service plans;
    - Perform prior authorization of waiver services;
    - Perform utilization management;

- Perform quality assurance and quality improvement strategy (QIS Framework);
- Perform continuous quality improvement;
- Monitor randomly selected beneficiaries case files from the local lead agency to ensure compliance with the six waiver assurances according to all applicable state and federal laws, state and federal rules and regulations, and agency policy;
- Maintain access to a web-based automation tool for case management and quality improvement activities;
- Monitor and review approved CAP/DA assessments and POCs for all waiver participants to assure compliance to Waiver Assurances;
- Track mediation and appeal for Due Process;
- Monitor the CAP/DA program through various audits and reports including on-site visits and desk reviews of selected lead agency and beneficiary record to ensure compliance with the intent of the waiver and with state policies and procedures;
- Establish ongoing communication mechanisms with CAP/DA providers to include:
    - Posting Frequently Asked Questions(FAQs) to the DMA website (http://www.dhhs.state.nc.us/dma);
    - Providing instructional memos to CAP/DA providers when changes occur to the program;
    - Provide training and technical assistance to lead agency

The e-CAP system is a Web-based software application developed by VieBridge, Inc. to support the operation of HCBS waiver programs operated under the provisions of 1915(c)HCBS. The e-CAP system provides the means by which the waiver case management services can be organized, tracked and made more effective.

The e-CAP system refines the 1915 (c) HCBS waiver assessment process in order to consistently and accurately assess beneficiary's needs, determine beneficiary's eligibility, authorize service provision, make provider referrals, ensure beneficiary's due process and support HCBS level of care prior approval for waiver participation.

The e-CAP system, refines the provider-based services planning process for the 1915(c) HCBS Waiver to ensure that:

1) HCBS waiver assessments are the basis for services planning;
2) service plans can be reviewed by the waiver Administrative Authority entity quickly and effectively;
3) service plans are reflective of CMS guidelines for person-centered planning and the beneficiary's assessment; and
4) service plan data can be used for DMA utilization management reviews.

The e-CAP system, improves beneficiary monitoring to include outcomes definition and tracking. The e-CAP system, refines the quality assurance reporting process, as described in the CMS QIS for the 1915 (c) HCBS Waiver, to ensure all core quality measure reporting is consistent and timely and that the quality assurance data will support DMA quality oversight of Medicaid waiver long term care services.

The e-CAP system implements a continuous quality improvement process that encompasses direct service providers, case managers and DMA in concert with the beneficiaries and/or their informal caregivers or representatives.

The e-CAP system, retools the day-to-day waiver administration and oversight as one integrated process for the 1915(c) waivers to include:

- participant waiver enrollment;
- waiver enrollment managed against approved limits;
- waiver expenditures managed against approved limits;
- level of care evaluation; review of participant service plans;
- prior authorization of waiver services;
- utilization management; and
- quality assurance and quality improvement activities.

The e-CAP system arranges the following:

- On-line processes for service requests and level of care determination processes for both waiver programs and other HCBS services, as appropriate;
- Prior approval functionality;
- An e-CAP consumer interface for use by waiver beneficiaries or their informal caregivers;
- Quality assurance reporting system that meets CMS reporting guidelines;
- Web-based continuing education;
- Case management video conferencing capability with consumers/beneficiaries;
- Telehealth functionality to support case management and risk management;
- On-line mediation and appeals tracking for waiver programs.

The e-CAP system will:

- perform on-line workflow management processes and tools for the various administrative authority responsibilities related to waiver enrollment, monitoring waiver limits, level of care evaluations, review of service plans, prior authorization of waiver services, utilization management, and quality assurance/quality improvement;
- process on-line request for service/level of care determination that is standardized and computerized for both waiver programs and other HCBS services, as appropriate;
- generate module for electronically-generated prior approvals for the waiver program, including an interface to MMIS to transmit prior approvals for use in MMIS claims processing;
- generate quality assurance reporting system for the waiver programs that meets CMS reporting guidelines that can be implemented using e-CAP service provider interface, case management interface and administrative authority interface;
- refine reporting model for a continuous quality improvement program that allows DMA to analyze quality data state-wide and directly target, time-limited quality improvement initiatives state-wide in response to identified quality problems or best practices;
- implement Web based model for continuing education designed to support DMA

implementation of a continuous quality improvement program.

The quality improvement system captures and assesses data in three areas to assure each individual beneficiary receives quality health care that is delivered cost effectively and in the appropriate setting:

1. Level of Care: Are enrollees categorized properly, and can this be compared across lead agencies?
2. Cost: Are we staying within the cost limits, both at the individual level and at the county and state levels?
3. Quality: Are there opportunities for systems improvement? Are there variations between counties that can help us identify ways to more effectively provide services? Are there individuals who need immediate attention? Are the six waiver assurances being adequately monitored and met?

The e-CAP system provides an automated assessment and plan-of-care tool that captures data on all CAP/DA beneficiaries. In addition to providing the automated assessment and plan-of-care tool, CWE provides the following services:

1. Customer service
2. Clinical staff support;
3. Web-based, HIPAA compliant, searchable database that contains data on all CAPDA beneficiaries;
4. 24/7 on-line secure access and data entry support;
5. Automated system that accepts claims data from DMA and matches it to beneficiary data;
6. Links claims to the beneficiary by preparing cost summary reports for use by DMA in monitoring expenditures per beneficiary;
7. Assist DMA in implementing a quality measurement and improvement system which can identify both individual and systematic quality issues;
8. Provide training sessions on a quarterly basis for new users;
9. Establish, maintain, and monitor a standardized Waiting List;
10. Development of training videos

The Process to periodically evaluate, as appropriate, North Carolina CAP/DA's Quality Improvement Strategy.

Quality Assurance is monitored by the Home and Community Care Section's Quality Management Committee. Home and Community Care Section QM, the CWE and CAP/DA Program staff monitor quality on an ongoing basis. Each year the QM Committee will conduct an annual evaluation of the QM Program and Develop an Annual QM Work Plan.

Attachment K

North Carolina Innovations Quality Improvement Strategy 2017

The North Carolina quality management strategy for the 1915(c) Innovations waiver and the accompanying 1915(b) waiver is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes. The strategy focuses on methods for coordinating, assessing and continually improving the delivery of behavioral healthcare and intellectual and developmental disabilities (IDD) services provided through prepaid inpatient health plans (PIHPs). The strategy encompasses an interdisciplinary collaborative approach through partnerships with enrollees and their families, stakeholders, governmental departments and divisions, contractors, the PIHPs, and community groups.

Discovery Activities
System improvements are made based on findings from a number of discovery activities, including: performance measures outlined in both waivers and the DMA-PIHP contracts; ongoing performance improvement projects; onsite reviews by intradepartmental monitoring teams (IMT); external quality reviews; grievances and appeals tracking and trending; network adequacy studies; and, and consumer and provider surveys. (A brief description of each key activity and how they are used for system improvement is provided at the end of this narrative.)

Findings from these activities are reviewed and addressed at three levels.

First, each PIHP operating under the (b)/(c) waivers has a contract manager/consultant from DMA's Behavioral Health/IDD section who monitors the PIHP on a day-to-day basis, provides technical assistance, and collects and analyzes data from the discovery activities. Any issues needing immediate remediation are handled at this level.

The second level is an intradepartmental monitoring team (IMT) assigned to each PIHP. Each IMT is led by DMA and consists of DMA contract manager and other staff from the State Medicaid Agency, the Division of MH/DD/SAS, other divisions within the DHHS as needed and the PIHP. Collectively, the individuals staffing the IMT have expertise in all areas of waiver operations, including clinical, finance, health information systems, program integrity, quality management and state and federal rules and regulations relevant to the waiver program. The IMTs meet monthly initially, then quarterly once the waiver program is fully implemented by the PIHP. The role of the IMTs is to monitor the operations of their respective PIHPs, provide technical assistance, review findings from discovery activities, identify challenges and successes, make recommendations for system improvements and monitor progress of any corrective action plans.

A third level of review and feedback is conducted by the DHHS Waiver Advisory Committee. As the (b)/(c) waiver program moved from the demonstration phase to statewide implementation, the DHHS Waiver Advisory Committee (DWAC) was

developed to provide input and consultation on the expansion and ongoing operations of the waiver program. The DWAC is comprised of staff from DHHS, DMA, DMHDDSAS, the PIHPs, and representatives from provider and consumer groups, including local community and family advisory committees (CFAC), provider associations and local provider network councils. The individual intradepartmental monitoring teams assigned to each PIHP report community accomplishments, concerns and recommendations to the DWAC. The DWAC reviews quarterly and annual report summaries of PIHP performance. The DWAC provides consultation around local and statewide system goals; reviews outcome measures and trend data; highlights and recommends areas of best practice; and assists with problem identification and resolution. DWAC members serve on the committee for a two year term and are expected to communicate issues, concerns, and feedback from their constituent groups.

Through this multi-level process which provides for evaluation and feedback from consumers, providers, state staff and program experts, both challenges and successes in operating the waivers are identified. Potential solutions to concerns are thoroughly vetted by all stakeholders through the IMT and DWAC, and recommendations are made to DMA for system improvements.

Performance Measures and Performance Improvement Projects:
DMA, in conjunction with the PIHPs and system stakeholders, identified the performance measures outlined in the Innovations waiver document and in DMA-PIHP contract. The performance measure results are reviewed annually and benchmarked with established performance standards/goals. DMA has also identified performance improvement projects that address a range of priority issues for the Medicaid population. Each PIHP is required to implement performance improvement projects in both clinical and non-clinical areas and report findings to DMA.

On-Site Reviews:
DMA and DMH conduct onsite monitoring reviews of each PIHP annually to evaluate compliance with the terms of the contract between DMA and the PIHP and State and federal Medicaid requirements, including Innovations waiver requirements. The review of administrative operations (financial management, information technology, claims) and clinical operations (care management, utilization management, network management, quality management) consists of a documentation review and onsite interviews. A review of MH/DD/SAS care management records may be included in the review. Any compliance issues found during the review will require the submission of a corrective action plan to the IMT for approval and ongoing monitoring.

External Quality Review:
The federal and State regulatory requirements and performance standards as they apply to PIHPs are evaluated annually for the State in accordance with 42 CFR 438.310 by an independent External Quality Review Organization (EQRO), including a review of the services covered under each PIHP contract for a) timeliness, b) outcomes and c) accessibility. The EQRO produces, at least, the following information:
•A detailed technical report describing data aggregation and analysis and the conclusions (including an assessment of strengths and weaknesses) that were drawn as to the quality, timeliness and access to care furnished by the PIHP.

•Validation of performance measures and performance improvement projects
•Recommendations for improving the quality of healthcare services furnished by the PIHP
•An assessment of the degree to which the PIHP effectively addressed previous EQRO review recommendations EQR results and technical reports are reviewed by the IMT for feedback. Ongoing EQR status reports, and final technical and project reports, are communicated through the IMT. Report results, including data and recommendations, are analyzed and used to identify opportunities for process and system improvements, performance measures or performance improvement projects. Report results are also used to determine levels of compliance with requirements and assist in identifying next steps.

Grievance and Appeal Reports:
DMA review of grievance and appeal information is used to assess quality and utilization of care and services. The PIHP reports address type of grievance, source of grievance, type of provider (MH, IDD, SA) and grievance resolution. The number, types and disposition of appeals are also reported. Results from ongoing analysis are applied to evaluation of grievances with quality expectations. Reports are submitted to DMA quarterly.

Network Adequacy:
The PIHPs are required to establish and maintain provider networks that meet the service needs of the waiver participants and to establish policies and procedures to monitor the adequacy, accessibility and availability of their provider networks. The PIHPs are required to conduct an analysis of their networks to demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access of its members to practitioners and facilities. The analysis and findings are submitted to DMA annually.

Provider and Consumer Surveys:
Each PIHP administers a consumer survey annually designed to measure adult and child consumer experience and
satisfaction with the PIHP. The survey contains questions designed to measure at least the following dimensions of client satisfaction with PIHP providers, services, delivery and quality:
•Overall satisfaction with PIHP services, delivery, access to care and quality
•Consumer knowledge of managed care from a patient's perspective
•Consumer knowledge of rights and responsibilities, including knowledge of grievance procedures and transfer process
•Cultural sensitivity
•Consumer perception of accessibility to services, including access to providers
•Additional factors that may be requested by the State
Each PIHP also administers a provider survey annually. The purpose of the provider satisfaction survey is to solicit input from providers regarding levels of satisfaction with program areas, such as claims submission and payment, assistance from the PIHP and communication.

System Improvement Activities

System Design Changes

The need for system design changes is identified through the intradepartmental monitoring teams (IMT) and DHHS waiver advisory committee (DWAC) which make recommendations to DMA. DMA prioritizes and implements the needed changes. Contract managers, the IMTs and the DWAC use the discovery activities described above on an ongoing basis to determine whether the desired improvements have been achieved. Additional discovery activities or changes to those already in place may be made to more effectively track the result of system changes.

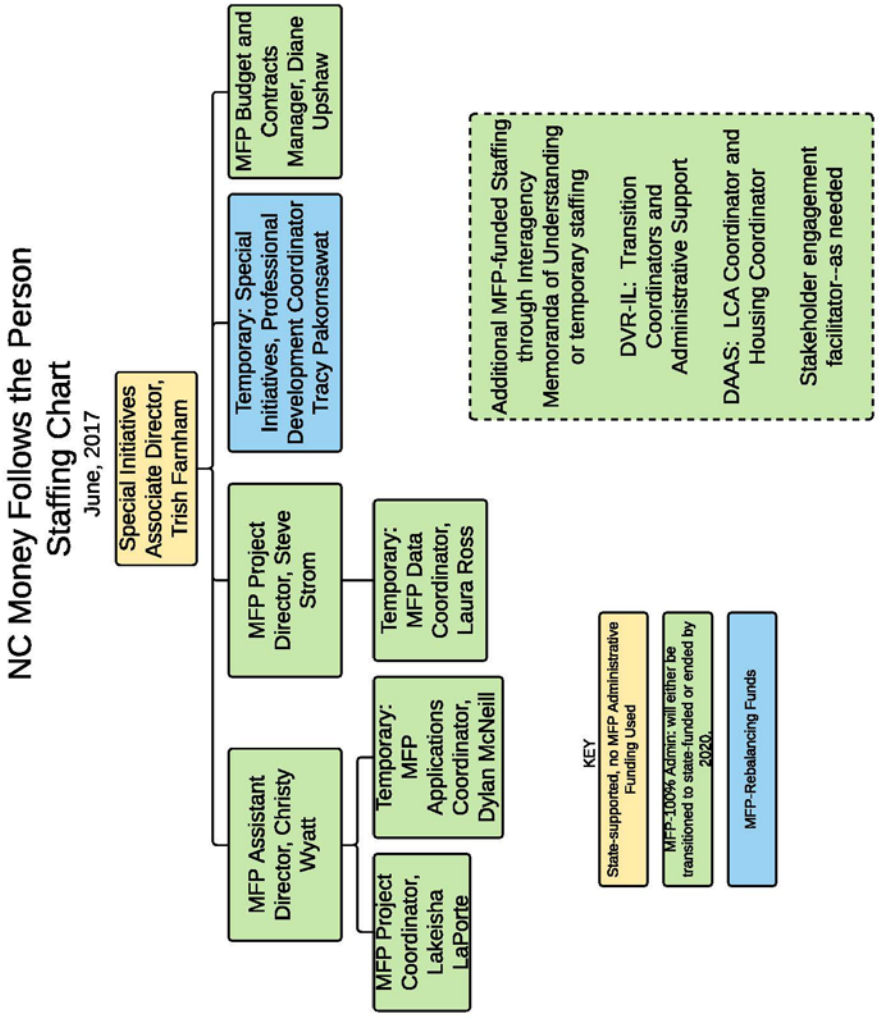
Process for Evaluating the Quality Improvement Strategy.

The quality strategy is reviewed by the quality staff of DMA through an ongoing process that incorporates input from a multitude of sources. The effectiveness of the quality strategy is reviewed on an annual basis and revised based upon analysis of results by the quality management staff in DMA and the IMT. The quality strategy may be reviewed more frequently if significant changes occur that impact quality activities or threaten the potential effectiveness of the strategy. As a result of the annual analysis process, a quality plan for the upcoming year is developed that is congruent with the overall quality strategy. If changes need to be made to the quality strategy, DMA seeks public input.

The revised quality management strategy is placed on the DMA website for public input over a 30-day period. In addition, each PIHP will present the quality strategy update for comments at CQI and CFAC meetings. Once public input has been received, the final strategy document is prepared and approved by the quality management staff in DMA. Following approval by DMA, any amendments to the quality strategy are shared with CMS. The final quality strategy is also published on the DMA website.

Attachment L

Special Initiatives Team Organizational Chart



Attachment M

North Carolina *Money Follows the Person* (MFP) in the LME-MCO Landscape

A Description of MFP The North Carolina *Money Follows the Person* Demonstration project (NC MFP) is a state and federal Medicaid initiative that supports individuals to transition out of qualified facilities and back into their own homes and communities.

Conceptualized under the 2005 *Deficit Reduction Act* and extended through 2020 under the *Affordable Care Act*, the Money Follows the Person Demonstration Project provides enhanced funding and technical assistance to support states in transitioning qualified individuals and to address the barriers the impede a person's ability to effectively live in his community.

Interested states apply to CMS to participate in the MFP Demonstration Project. Housed with the DMA, North Carolina's MFP Demonstration Project began supporting people to transition in 2009.

Currently, NC MFP works closely with established Medicaid waiver programs to support three primary populations to transition: individuals with physical disabilities; older adults and individuals with intellectual and developmental disabilities (IDD). While individuals within these three populations sometimes also experience mental illness, NC MFP does not currently target individuals whose mental illness is their primary disability.

Requirements for a Beneficiary to Enroll in NC MFP
Individuals interested in transitioning under the NC MFP Demonstration Project must apply and be approved for enrollment into the Project

Applications are available on the Division of Medicaid Assistance NC MFP website, under *How to Apply*.

To be approved for NC MFP, the applicant must:

1. Be *currently* residing in a *qualified facility*. Qualified facilities include:
    a. state developmental centers,
    b. private ICFs-IDD;
    c. skilled nursing facilities,
    d. acute care hospitals;
    e. psychiatric residential treatment facilities; or
    f. under very limited circumstances, state psychiatric hospitals[7].
2. Have resided in a qualified facility for at least three months immediately prior to discharge;
3. Receives Medicaid;
4. Is eligible for home and community-based waiver services.

[7] If an individual in a state psychiatric hospital is under the age of 22 or over the age of 65, MFP may be able to support the transition, *so long as* the individual *also* qualifies for NC Innovations services.

5. Must be able to transition into a *qualified residence* which includes:
    a. own or family's home (regardless of rental/ownership status);
    b. A group facility of four beds or less.
    c. An adult foster living placement[8]

For additional information about MFP's eligibility requirements, please review the Money Follows the Person *Operational Protoc*ol's (Operational Protocol) Eligibility Section, found on the NC MFP website, under *MFP Tools and Resources* or contact the Project's staff at 1-855-761-9030.

Important Note about Adult Care Homes and Assisted Living Facilities: Under current federal policy, assisted living facilities/adult care homes do *not* constitute a *qualified facility*. As a result, individuals residing in these facilities are not eligible to transition through the NC MFP Program.

Applying to the NC MFP Project

In order for an individual to enrolled in the NC MFP Project and receive the Project's waiver and enhanced services, the individual must have an approved application and informed consent on file.

Applications are available on the NC MFP website, under *How to Apply*. Both the application and the informed consent form are included under the application link.

Currently, anyone may submit an application on a person's behalf, so long as the application is complete. LME-MCOs are encouraged to submit MFP applications on behalf of individuals who are seeking access to an MFP Innovations slot. Applications are submitted to the MFP Project staff, following the instructions on the Application itself.

Important Considerations Regarding NC MFP Application Process

1. Only MFP Project staff may approve applications.
2. An individual must have an approved application on file PRIOR transitioning.
3. An approved application does not automatically guarantee an MFP-funded waiver slot. LME-MCOs are still responsible for determining the individual's eligibility for Innovations services. The MFP Project defers to the LME-MCO and waiver managers within the DHHS' determination of an individual's waiver eligibility.
4. MFP applications do not expire, however if the application is over a year old, MFP will need an updated informed consent form.

Duration of NC MFP Participant's Enrollment Status

A person is considered an NC MFP participant upon enrollment into the NC MFP Project. A person maintains this designation for *one year* after transition. During this year, NC MFP's Project-specific resources outlined in this guidance are available to this participant.

[8] In North Carolina, this option is only available to individuals receiving an *NC Innovations* waiver.

If an NC MFP participant returns to a facility setting during the year of participation, the Project has specific criteria regarding *dis*enrollment and *re*enrollment into the Project.

For additional information about these disenrollment and reenrollment practices, please refer to the *Operational Protocol*, found on the NC MFP website, under *MFP Tools and Resources* or contact the Project's staff at 1-855-761-9030.

How NC MFP Relates to LME-MCOS

LME-MCOs are directly involved in NC MFP through two key populations:

1. MFP eligible individuals who have Intellectual/Developmental Disabilities (IDD).
2. MFP eligible individuals who have physical disabilities, are transitioning under other Medicaid long-term care services (i.e. CAP/DA) and also demonstrate a support need related to a traumatic brain injury, mental illness or an addiction disorder.

NC MFP Participants and Special Care Needs Care Coordination Designation

MFP participants often represent the most complex individuals. As a result, MFP participants should be designated individuals with Special Care Needs.

- NC MFP participants with IDD using the North Carolina Innovations waiver will have access to the care coordination as will all Innovations recipients.
- NC MFP participants with physical disabilities or older adults *may* also have Traumatic Brain Injury, mental health or substance addiction support needs. While the LME-MCO may not be responsible for coordinating the transition process, care coordinators may be asked to participate in the transition planning process to ensure that individuals are effectively linked with necessary mental health supports.

Supports to NC MFP Participants with Intellectual/Developmental Disabilities Utilizing MFP- North Carolina Innovations Slots

North Carolina Innovations Slot Distribution/Assignment and Utilization

•DMA allocates each LME-MCO, MFP-specific North Carolina Innovations waiver slots each waiver year.
•LME-MCOs assign MFP/Innovations slots based on slot availability and only if the MFP participant also meets North Carolina Innovations waiver criteria.
•MFP slots are intended to be assigned on a first come, first-able-to-transition basis. However, transition teams must have confidence in the availability of a waiver slot to effectively plan for the transition. To balance these two priorities, DMA will consider an MFP slot "assigned" when:
•An MFP participant has been identified for the slot;
•Residential or primary support provider is identified OR Level of Care has been completed.;
•The slot is assigned prior to the transition occurring. A person may not enroll in MFP after the transition has occurred.
•An LME-MCO must assign 25% of its annual MFP slot allocation each quarter of the current waiver year.

Reassignment of MFP Innovations Waiver Slots

If an LME-MCO does not meet its 25% assignment threshold each quarter, DMA will evaluate reassigning identified unused slots. Slot assignment is assessed through the monthly slot reporting. NC MFP reserve slot usage reported is reconciled with NC MFP enrollment and transition data.

Steps for Reconciling and Reassigning Open Slots

1. LME-MCOs are encouraged to access technical assistance from NC MFP or the DMA Behavioral Health Unit if the LME-MCO is having difficulty filling NC MFP waiver slots.
2. NC MFP staff establish quarterly reconciliation session with DMA IDD staff for reconciliation months outlined in table below.
3. Reconcile MCO waiver report with NC MFP transition data.
    a. Confirm if participant has not yet transitioned, assigned participant is enrolled in NC MFP.
4. Based quarter reviewed and number of slots allocated, identify 25% of remaining unused slots.
    a. For example:
        i. LME-MCO has 12 slots, by February, 2017 reporting, the LME-MCO has correctly assigned 5 of the 12 allocated slots (41% of the required 50%). The LME-MCO has 7 slots remaining. 25% of 7 = 1.75.
        ii. In cases where calculation produces a fraction, DMA will follow standard rounding practices—rounding up if .5 or higher, rounding down if .4 or lower. In the example provided above, that would mean that 2 slots would be reassigned.
5. The LME-MCO will be notified of pending re-assignment by phone and updated allocation letter via email. The revised allocation letter reflects revised annual allocation, which would be the original allocation less the re-allocated slots.
6. LME-MCO slot allocation reverts back to its original allocation at the beginning of the next waiver year.
7. Slots identified for reassignment shall be offered to other LME-MCOs in order of highest slot utilization to date and/or those who have utilized all their allocated slots. LME-MCOs identified to receive re-assigned slots will be notified via email and will have 5 business days to confirm in writing whether the slot can be utilized before the end of the waiver year. Any additional slots an LME-MCO receives through this re-allocation process must be will not carry over until next waiver year. At the beginning of the next waiver year, a turnover slot will need to be utilized.
    a. If an LME-MCO identified to receive a reassigned slot does not expect to be able to use the slot, it will be reassigned to the next MCO with next highest utilization rate.
    b. If more than 1 slot is available for reassignment, DMA will reassign it by dividing the slots by the number of LME-MCOs.
    For example:
        i. Three LME-MCOs have not met the threshold (utilizing at least 25% of slots per quarter) with a total of 3 slots to be reassigned. All other MCOs have met their threshold. The slots will be reassigned 1 each to the 3 MCOs who have utilized all their slots and/or with the highest utilization to date.

ii. One LME-MCO has not met the threshold with a total of 2 slots to be reassigned. All other LME-MCOs are determined to meet the threshold for the quarter. The two LME- MCOs with the highest utilization to date and/or who have used all their slots to date will receive 1 slot each.

iii. One LME-MCO has not met the threshold with a total of 1 slot to be reassigned. All other LME-MCOs are determined to meet the threshold for the quarter. The LME-MCO with the highest utilization to date and who has utilized all their slots to date will receive the 1 slot.

c. If there are multiple LME-MCOs that are equally positioned for slot assignment, the slot will be awarded to the LME-MCOs with the earliest identified transition dates.

Using NC MFP *North Carolina Innovations* Slot

The individual intended to use the MFP/Innovations slot must be an **approved** NC MFP participant **prior** to transitioning.

Important Considerations about Individuals with Dual Diagnoses (IDD and MI) and NC MFP

In addition to participants residing in State Developmental Centers, private ICF-IID, nursing facilities or acute care hospitals, NC MFP is also an available resource to individuals with co-occurring diagnoses under the following circumstances:

1. IDD individuals who are in a state psychiatric hospital *and* are not excluded under the federal IMD exclusion.
2. IDD individuals who are residing psychiatric residential treatment facilities
3. IDD individuals in short-term specialty unit programs at state developmental centers.

To be included in MFP, individuals must *also* be eligible and receive an North Carolina Innovations waiver slot and must also meet MFP's eligibility criteria (three months in facility, etc.).

MFP Transition Protocols and Expectations

To be authorized to use MFP/Innovations slots, LME-MCOs will follow the NC MFP application and transition protocols as outlined in the MFP Transition Coordination Training and the Transition Roles and Responsibilities out of State DD Centers, available on NC MFP's website under *MFP Tools and Resources.*

These identified staff must receive NC MFP training to be designated MFP Transition Coordinators *before* the transition occurs.

MFP does not assume responsibility for training on care coordination functions or other functions within the LME-MCO's scope.

Trainings will be held periodically and can also be organized on request. To request an MFP Transition Coordination training session, please contact the NC MFP Project staff at 1-855-761-9030.

Accessing Administrative Payments for Staff and Clinical Capacity Building Funding ("MFP TYSR funds" or "Start Up Funds") for Innovations-NC MFP Participants with Intellectual or Developmental Disabilities (IDD)

- NC MFP recognizes that strong staff training and clinical consultation are often the most critical "startup" needs a transitioning individual with IDD may have. MFP encourages individuals and their transition teams to consider utilizing MFP "startup funds" for this purpose as appropriate. LME-MCOs will be authorized to access up to $3,000.00 per NC MFP IDD participant to support person-specific community-based staff and clinical capacity building. Accordingly, NC MFP has re-categorized its Transition Year Stability Resource Funds to meet training needs not allowed under the Innovations' Transition Services waiver service.
- These funds shall be available to cover authorized, transition-related expenses incurred 60 days prior to the transition date and up to 356 days after the transition occurs.
- These resources are not included in the LME-MCO's capitated rate payment but are *additional* resources available to LME-MCOs to support MFP participants.
- *Staff and Clinical Capacity Building Funding* ("SCCB Funds") Guidelines:
  - LME-MCOs utilizing this service have the authority to determine the staff and travel reimbursement rate based on the specific circumstances of that transition. If an LME-MCO elects to reimburse a provider for travel, travel reimbursement rates must not exceed established North Carolina travel rates.
  - In absence of a LME-MCO specific rate, MFP shall reimburse for direct support staff training at a rate of $21.40 per hour and clinical consultation at the applicable billing rate.
  - These resources are for training and consultations specific to the MFP participant (i.e. person specific training, participation in planning meetings)
  - These resources cover the time of direct support staff training, not administrative staff time for participating in planning sessions.
- For the most current SCCB procedures and invoice, please visit the NC MFP website at https://dma.ncdhhs.gov/mfp-resources-providers.
- NC MFP *may* authorize additional expenditures for other items or services not covered under the Innovations Transitions Services or by Medicaid.
- To access these funds, the MCO will submit on its letterhead an itemized request to the MFP staff, using the attached template. The LME-MCO will attach relevant invoices and receipts when submitting the request.
- If NC MFP authorizes the request, NC MFP staff will initiate an administrative payment to the requesting LME-MCO.
- The LME-MCO is then responsible for ensuring that appropriate vendors and provider are paid for the services invoiced.
- SCCB funds are reimbursement-based. NC MFP does not advance funding for SCCB expenses.
- NC MFP will reimburse the LME-MCO authorized SCCB-related expenses for NC MFP participants who do not transition, but will require additional information from the LME-MCO regarding to the reasons why the transition did not occur.
- NC MFP participants who are older adults or individuals with physical disabilities also have access to MFP "startup funds." These funds are not managed by the

LME-MCO, but rather the participant's transition coordination entity. Please See MFP's Transition Year Stability Resource policy for these individuals.

See *MFP Tools and Resources* on the NC MFP website at dma.ncdhhs.gov/providers/programs-services/long-term-care/money-follows-theperson.

Additional Reporting Requirements

Wherever possible, NC MFP will draw from established datasets (i.e. IRIS for incident reports) to address federal reporting needs.

However, DMA staff may request ad hoc reports as needed from LME-MCOs to satisfy federal reporting requirements or to examine trends in transition activity and quality that cannot be met through current reported data sets.

Learning and Training Opportunities

Transition Coordination Trainings (Required prior to providing transition support to MFP participant).

- MFP Transition Coordinator trainings are offered quarterly or on an as needed basis.
- Over time, NC MFP's training requirements will be incorporated into the DHHS' larger transition coordination capacity building initiatives.

NC MFP Roundtable (Voluntary)

- NC MFP Stakeholders' listserv that announces MFP-specific opportunities, including the NC MFP *Learning Series* outlined below.
- Quarterly Stakeholders' meeting.
- To participate in the NC MFP Roundtable's activities, please email mfpinfo@dhhs.nc.gov

MFP/LME-MCO Discussion Group (Voluntary)

- Along with its partners within DMA, DMH and DSOHF, MFP hosts a discussion group on the 3rd Thursday of every month from 1:00-2:00.

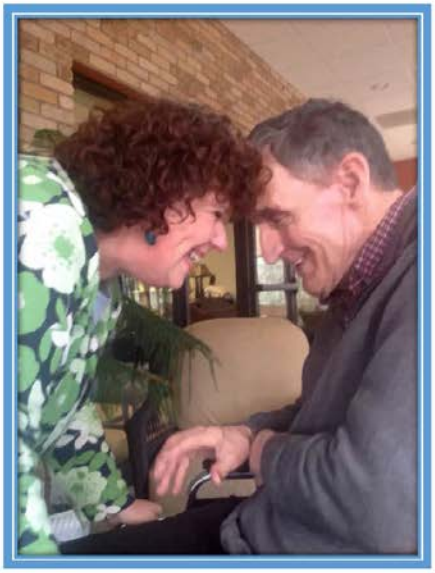
NC MFP Learning Series (Voluntary)

A monthly 2 hour webinar and conference calls that focuses on different elements of quality transition planning. Open to everyone, but targets the topics and needs most relevant to transition coordinators.

Topics have included:

- Understanding the ADA and the *Olmstead* Decision
- Accessing Housing
- Understanding Guardianship
- Support Supported Employment
- Understanding Telesupport Options
- Understanding Peer Supports

Attachment N



A public initiative and a community effort:

The *North Carolina Money Follows the Person Demonstration Project's*

Sustainability Plan

nc department of health and human services

SECTION 1: Executive Summary

Where We Are

Since beginning transitions in 2009, the North Carolina Money Follows the Person Demonstration Project ("NC MFP" or "the Project") has grown into a valued and respected initiative that is recognized within North Carolina ("NC") as a vehicle for supporting and shaping the State's direction related to long-term care. NC MFP has functioned as a catalyst bringing together stakeholders across disciplines and the life stand of human services.

A Commitment to Transitions

This sustainability plan outlines NC's intention to maintain the intent and the core functions of the MFP program for both the remainder of the grant period and after the grant ends in 2020. Primarily, this commitment encompasses three key decisions:

1. MFP will assist individuals to transition through 2018.
2. NC DHHS will integrate a number of MFP's current demonstration services into its home and community-based waiver programs.
3. NC DHHS recognizes the importance of both the transition coordination and Local Contact Agency function, however, have concluded the specific funding and operational structures related to these two functions may need to be revised in light of NC's pending direction under Medicaid Reform.

The functions of MFP staff have been recognized as important in the state's effort related to transition practices and managing "quick start" projects related to LTSS.

Strengthening Our Capacities

NC MFP has always viewed itself as a "public project and a community effort" with stakeholder engagement playing a critical role in determining its design and direction. NC MFP and its stakeholders have identified the following priorities which will guide the work and resources deployed for the next five years. These prioritize the needs of *all* transitioning individuals, not just MFP participants and will guide the direction of MFP Rebalancing Funds:

1. Elevate Transition Related Competencies;
2. Support and Facilitate Access to Quality Housing;
3. Support Family Caregivers;
4. Support Individual in Community Life;
5. Facilitate Collaboration Among Agencies;
6. Support Coordinated, Integrated Access to Behavioral and Medical Supports;
7. Growth of Provider Capacity to Provide Community-Based Options.

Expanding Our Initiatives:

Related to Transition Activities: NC MFP will continue transitioning individuals in 2018 and have updated NC's transition benchmarks to reflect this decision.

Related to Rebalancing Funds: NC MFP anticipates most of its expansion activities will center on launching a number of Rebalancing Fund activities.

Related to Other Systems Change Initiatives: With the onset of Medicaid Reform, the NC Medicaid program anticipates changes to its payment and service delivery models. To support the State's efforts to ensure adequate preparation for changes within the Long Term Services and Supports ("LTSS") community, NC MFP proposes using a portion of future MFP administrative dollars to fund technical assistance opportunities for Department staff; LTSS providers and other relevant stakeholders consistent with MFP's objectives and Olmstead principles. The funding specifics of this request will be refined prior to 2019 budget submission and will not exceed amounts summarized in this Sustainability Plan.

SECTION 2: Stakeholder Involvement

a. **Process:**
   i. The MFP Roundtable has long served as the Project's stakeholder group and resource. Over 700 individuals representing a cross section of the disability and stakeholder community receive invitations to participate in every MFP event, including our year-end Roundtable meeting in November, 2014 and our February, 2015 Roundtable meeting that focused exclusively on sustainability planning. Despite the priorities being driven by the identified needs of MFP participants, ensuring in-person participation of former and current MFP participants at Roundtable events remains challenging. MFP has recently revised its transition coordination contracts to create more flexibility in its stakeholder reimbursement process to better meet the needs of these stakeholders.
   ii. Stakeholders' Role(s):
      - The MFP Roundtable has always helped shape NC MFP's direction and priorities, both generating priorities directly and refining proposed priorities identified by other committees or by the DMA leadership team. Specifically,
        - NC MFP held two Roundtable meetings that highlighted or focused exclusively sustainability planning:
          - November 14, 2014 (as part of our November Year End Meeting),
          - February 13, 2015 (MFP Sustainability Planning was exclusive focus).
        - February, 2015 Roundtable Attendees have had the opportunity to review and provide input on this Plan.
        - NC MFP issued its second MFP Rebalancing Fund Survey in summer, 2015 to the entire MFP Roundtable network. This survey is used to prioritize Rebalancing Funds and asked two questions. The top five responses to each question are listed below. The full survey results are included in Appendix A.
          - "What are the top five factors that keep people out of facilities and able to live in the community?"
            1. Safe, Affordable, Accessible Home;
            2. Support to Family Caregivers;
            3. Community Network of Friends and Family;
            4. Reliable, Accessible Community-Based Transportation;
            5. Strong Behavioral Health Supports.
          - "What are the top five factors that help someone leave a facility and live in the community?"
            1. Safe, Affordable, Accessible home;
            2. Community Network of Friends of Family;
            3. Strong Behavioral Health Supports;
            4. Support to Family Caregivers;
            5. Access to Quality Health Care.
          - NC MFP has integrated these priority responses into its Rebalancing Fund allocation.
        - The Roundtable and Individual stakeholder committees help shape many of the specific activities outlined in this Plan. Appendix B identifies which workgroup either directly identified or assisted in the shaping of current and future proposed Rebalancing Fund priorities. Additionally, the February, 2015 Roundtable provided observations about many of the specific tasks the Project should prioritize over the next several years (See Appendix C for these recommendations).
        - There is no known dissent to the identified priorities, however stakeholders often have various perspectives about *how* to best accomplish and address priorities. NC MFP appreciates the different

perspectives and works to integrate ideas to achieve better outcomes for each initiative. However, because the ultimate responsibility for the Project management rests with DMA, DMA staff synthesize differing approaches and make the final decision, informed by these differing perspectives.

b. Summary of Recent Stakeholder Contribution Opportunities

a. Rebalancing Fund Survey Responses: 103

b. Summary of MFP Roundtable Attendance for November, 2014 and February, 2015 Meetings

Stakeholder Group	Year End Roundtable November, 2014 (Raleigh)	Roundtable February, 2015 (Greenville)	Unduplicated Counts	Additional Notes
People with Disabilities	While several attendees represented in other categories also identify as having a disability, no MFP participants were present.			MFP has recently revised transition coordination contracts to better address the reimbursement challenges that chronically limit MFP participant's ability to attend Roundtable meetings.
Family Members	4	2	5	
Transition Partners	21	15	29	This group includes Transition Coordinators; Care Coordinators; Local Contact Agencies Counselors; Area Agencies on Aging and Centers for Independent Living. Transition Coordinators within transitioning populations also meet monthly to identify and address issues and opportunities.
Medical Community	1	0	1	
Facility Community	1	1	2	
HCBS Provider Community	3	0	3	
State Partner Staff and Department Executive Team	16	2	17	Sustainability Planning is a standing agenda item during monthly contract maintenance discussions MFP holds with both its DAAS and DVR-IL partners. Further, MFP convenes quarterly meetings with both its aging and disability Medicaid waiver colleagues and its colleagues who manage the Medicaid waiver for people with Intellectual and Developmental Disabilities ("I/DD").
Rebalancing Fund Grantees	5	0	5	
MFP admin staff	6	5	6	
Other	3	2	4	
TOTALS	60	27	72	

SECTION 3:

State's Plan for Continuing to Support People Transitioning Out of Institutions

a. The State **will** continue to actively support persons moving out of institutions after MFP concludes.

b. **Overview of continued activities:** NC has already taken steps to sustain transition activities and priorities within its HCBS waivers and is also examining how to best operationalize critical functions of transition coordination and options counseling. In addition to NC's ongoing commitments related to transitioning non MFP participants related to the Transitions to Community Living Initiative and under the DVR-IL transition priority, NC DMA commits to pursuing the following waiver/Medicaid program revisions.

CURRENT MFP POPULATION	TARGETED INSTITUTIONS	ONGOING SERVICE SUPPORT
Older Adults	Nursing Facilities	CAP DA waiver transition priority
People with Physical Disabilities	Nursing Facilities	CAP DA waiver; DVR IL supplemental support transition priority
People with Intellectual/Developmental Disabilities (I/DD)	State Developmental Centers; Intermediate Care Facilities for I/DD; Psychiatric Residential Treatment Facilities (dual diagnosis); State Psychiatric Hospitals (age appropriate and dual diagnosis)	The Innovations waiver (NC's waiver for people with I/DD) has reserved de-institutionalization ("D/I") slots.

c. *Section not applicable for NC.*

d. **Sustaining MFP Activity,** Please see Sections 4, 5, and 6

e. **Estimate of funding needed.** The full estimated budget for our Program is outlined in Section 8. Below are the anticipated costs specific to managing the financial and data reporting elements of our program.

	(1) CY 2016	(2) CY 2017	(3) CY 2018	(4) CY 2019	(5) CY 2020	(6) Total
Total MFP Staff	$326,463	$331,588	$336,725	$341,873	$347,032	$1,403,614
CSC/Data IT maintenance	139,057.76	139,057.76	139,057.76	139,057.76	139,057.76	$695,289
QOL	$40,700	$40,700	$40,700	$40,700	$40,700	$203,500
Total	$506,220	$511,346	$516,483	$521,631	$526,790	$2,302,402

Section 4:

Demonstration Services and Service Funded by MFP Administrative Fund

Demonstration Service	Description	Applicable Population/Waiver	Will Retain?	Approach for Retaining	Anticipated Timelines
Transition Year Stability Resources	Startup funds for rent deposits and household items	Aging and Disability waiver (CAP DA); Innovations waiver	Yes	-CAP DA budget limit for Transition Services will be increased to $3,000.00. -Innovations: no change.	To be integrated with CAP DA waiver renewal, slated to be in effect in 2020.
Pre-Transition Staffing and Clinical Capacity Building (SCCB)	Funds pre-transition community staff training and clinical evaluations not otherwise funded prior to waiver enrollment.	Individuals with Intellectual/Developmental Disabilities Innovations Waiver	Yes	The state intends on incorporating this demonstration service either into its Community Transitions service definition under its 1915c Innovations waiver or will develop an (b) (3) option to enable MCOs to develop and fund this service as needed.	Timelines to be finalized with confirmation of direction from CMS. Anticipated timeline for 1915 (c) waiver: by January, 2016; 1915 (b) (3) option by Spring, 2016.
Transition Coordination	Coordinates transition activities including housing access, service access, etc.	Aging and Disability populations	Yes, but likely with modifications based on Evaluation	Transition Coordination functions have been recognized as important and in many ways distinct from case management. However, to more fully assess how transition coordination function should be sustained, NC will contract for an evaluation of both the transition coordination and LCA functions before concluding sustainability.	

Demonstration Service	Description	Applicable Population/Waiver	Will Retain?	Approach for Retaining	Anticipated Timelines
Pre-Transition Case Management	Provides additional case management hours to accommodate additional time required to perform assessment of institutionalized individual.	Older Adult/Physical Disability	Yes	Aging and Disability waiver allowable assessment hours will be increased in future waiver to accommodate additional time needed.	August, 2015
Over and Above" Home Modification/Adaptive Equipment funds.	DVR/MFP Funded funding pool to support exceptional home modification needs.	Physical Disability	To be determined based on level of utilization during duration of Project. Decision to be finalized by 2017.	"Over and Above" demonstration service anticipated to be sustained but will be would be contingent on funding availability by DVR.	Final decision to be made by 2017.

SECTION 5: Administrative Staff Positions

To effectuate its mission, MFP formally partners with two sister agencies: 1) The Division of Vocational Rehabilitation's Independent Living Program ("DVR-IL") and 2) The Division of Aging and Adult Services ("DAAS").

	MFP Project Director
Job Description	MFP Project Director's Responsibilities: ▪ Developing and managing transition support structures and practices for MFP participants; ▪ MFP budget management and grant oversight; ▪ Contract management between MFP and affiliated agencies and/or community partners; ▪ Strategic thinking related to Rebalancing Fund initiatives and state partnerships; ▪ Oversight and management of MFP informational systems design in NC's MMIS and eligibility systems; ▪ Outreach and training related to MFP and transition practices; ▪ Ad Hoc: supporting/coordinating identified DHHS initiatives related to Olmstead activities including: temporary project management of DOJ Settlement trainings; LTSS coordinator for Medicaid Reform initiative, DMA staff point of contact for federal 811 Housing Grant and No Wrong Door Planning Grant; temporary project management related to PACE program.
Number of FTE	1
State's Decision to Retain	The functions of this position have demonstrated to be important components of NC's transition practices. The State's intent is to ensure these functions are sustained after the Project ends. Additional funding is contingent on availability of resources.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project unless funding is allocated before Project's end date.

	MFP Assistant Director
Job Description	The primary functions of the MFP Assistant Director include: 1. Coordinating the transitions of MFP participants out of qualified facilities and into their homes and communities, with an emphasis on supporting waiver agencies to develop and expand their transition capacities and competencies; 2. In collaboration with the Project Director, applicable state and community partners, help design transition coordination efforts in a way that can be sustained beyond the grant period; 3. Serve as a "bridge" between case management entities and transition coordinators; This would include a special focus on facilitating the transition of facility and institution residents with the potential and desire to community independent living. This position develops and implements protocols for transition as well as identifies and collaborates with appropriate statewide community partners and programs. This position involves high-visibility activities, including presentations to various professional groups and frequent interactions with health care industry officials.
Number of FTE	1
State's Decision to Retain	The functions of this position have demonstrated to be important components of NC's transition practices. The State's intent is to ensure these functions are sustained after the Project ends. Additional funding is contingent on availability of resources.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project unless funding is allocated before Project's end date.
	MFP Budget and Contracts Coordinator

Job Description	Primary Functions include: 1. Serve as the Project's liaison to the financial and contracting units within DMA and DHHS. 2. Coordinate with relevant financial staff and contractors to complete and submit accurate quarterly financial reports, the Project's annual budget and other Project expenditure data as needed. 3. In conjunction with the MFP Project Director and other relevant partners, coordinate the Project's grant and contract development efforts. 4. Implement tracking mechanisms and manage contract deliverable compliance of MFP contractors and grantees. 5. Coordinate and facilitate the MFP Rebalancing Fund Steering Committee and work to implement the Committee's recommendations. 6. Assist the Project Director in development/revision of MFP administrative and financial policies that govern its resources allocation and administrative structure, including the MFP Operational Protocols.
Number of FTE	1
State's Decision to Retain	The functions of this position have demonstrated to be important components of NC's transition practices. The State's intent is to ensure these functions are sustained after the Project ends. Additional funding is contingent on availability of resources.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project unless funding is allocated before Project's end date.

	MFP Project Assistant
Job Description	The MFP Program Assistant provides programmatic and administrative support to MFP Project Staff, with specific emphasis on assisting the Assistant Director and Project Director in supporting the Project's statewide network of transition coordinators and other activities related to the transition process. In addition to providing support to the Project's transition activities, this position is also responsible for providing administrative support to the Project related to meeting preparation, outreach and other administrative functions.
Number of FTE	1
State's Decision to Retain	The functions of this position have demonstrated to be important components of NC's transition practices. The State's intent is to ensure these functions are sustained after the Project ends. Specific funding is contingent on availability.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project unless funding is allocated before Project's end date.

	MFP Applications Coordinator
Job Description	This position is responsible for the intake, review and processing of every MFP application that the Project receives. The Applications Coordinator must be proficient in MFP eligibility requirements and in effectively navigating the NC Medicaid Eligibility Information Systems (NC FAST). Applications are processed on timelines that ensure the Project remains responsive to applicants.
Number of FTE	1
State's Decision to Retain	This position is staffed by an individual with "temporary staff" designation and is a position specific to MFP. Decision to retain specific staff a future role will be separated from decision to retain position.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project.

	DVR-IL MFP Transitions Coordinator (Funded at EFMAP through Admin Funding)
Job Description	The Transition Coordinator's purpose is to lead a participant and the transition planning team (consisting of IL staff, local CAP/DA agencies, nursing facility staff, the client and their family) through the transition planning process and ensure the participant has the supports in place to live successfully in his or he community once s/he has transitioned. The Transition Coordinator's tasks varies from transition to transition. The Transition Coordinator is not expected to perform all required elements of the transition but rather assign elements to the appropriate member of the transition planning team and ensure all functions are performed in an efficient, person-centered manner. While a number of entities are directly involved in the transition process, the Transition Coordinator is ultimately responsible for the quality of the transition and for the specific tasks related to the MFP Transition Process.
Number of FTE	4
State's Decision to Retain	The functions of this position have demonstrated to be important components of NC's transition practices. The State's intent is to ensure the core functions of this position are incorporated into the existing organizational infrastructure after the Project ends. Additional funding is contingent on resource availability.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project unless funding is allocated before Project's end date.

	DVR-IL Housing & Transitions Specialist
Job Description	Position is housed in sister agency, Division of Vocational Rehabilitation's Independent Living Program. This position supervises MFP's transition coordinator staff and contractors who facilitate the transitions of MFP participants who have physical disabilities. This position also serves as a "bridge" between the Transition Coordinators and the Department's housing staff. Position also identifies opportunities for streamlining and improving DVR-IL policies and practices that impede transition work.
Number of FTE	1
State's Decision to Retain	The functions of this position have demonstrated to be important components of NC's transition practices. The State's intent is to ensure the core functions of this position are incorporated into the existing organizational infrastructure after the Project ends. Additional funding is contingent on availability.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project unless funding is allocated before Project's end date.

	DVR-IL Program Assistant

Job Description	Assist the Housing and Transition Specialist with the day-to-day operations of the Money Follows the Person project and Priority 1 IL Clients such as: 1. Receive applications from DMA and begin a file for each new client; assist the Housing and Transition Specialist in the transition coordination process by requesting medical, disability and financial information from the facility in order for an IL Counselor to determine eligibility. Upon receipt of information, Assistant will fax the referral and supporting documentation to the assigned IL Counselor, MFP transition coordinator, and others as needed. 2. Track each case and its progress in a shared database or white board and ensure that all documentation is on file and federal and state project compliance has been met. Examples include approved applications, purchase authorizations, client transition planning document (2 versions), quality of life surveys, withdrawal from program, MFP funds accessed, etc. 3. Submit the Transition Year Start-Up Funds Request forms (for each purchase for each client) for Program Specialist approval and then submit to the MFP office for final approval. Ensure that all requests for approvals are accompanied by appropriate documentation such as valid receipts, vendor quotes and bill. Follow-up maintenance will be required to make sure all purchase documentation is in place and that the budget is reconciled. 4. Develop a database of all referrals in order to monitor each case as well as for the preparation of reports as requested. Examples include number of referrals per region, active transitions per region/per coordinator, clients by disability, etc. 5. Assist the Program Specialist with the editing, formatting, and development of spreadsheets, forms, and other documents as requested. 6. Record minutes on behalf of the Program Specialist at the monthly Disability Housing Collaborative meetings. Prepare minutes and disseminate to members of the group. Monitor collaborative activity. 7. Provide logistical support to the Program Specialist in the coordination of meetings and events.
Number of FTE	1
State's Decision to Retain	The functions of this position have demonstrated to be important components of NC's transition practices. The State's intent is to ensure the core functions of this position are incorporated into the existing organizational infrastructure after the project ends. Additional funding is contingent on availability.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project unless funding is allocated before Project's end date.

1 FTE in NC's Housing Coordinator Network	
Job Description	**Purpose of Regional Housing Coordinators:** 1. To serve as the "expert in affordable, accessible housing resources" in his/her catchment area and serve as both a resource and a "bridge builder" between the private landlord community and the network of service provider organizations that provide supports to individuals requiring housing. 2. To serve as a resource to local service providers, including transition coordinators, in accessing the housing-related tools and resources needed to successfully support a person to access appropriate housing. This includes providing information about how housing subsidies work; how to access information about housing resources available and how to support individuals in applying for and securing appropriate housing. 3. To streamline access to housing for individuals, with attention to those issues specific to transitioning individuals. DAAS Housing Coordinators shall by manage and synchronize all relevant housing waiting lists and assist transition coordinators in identifying possible housing options for an individual when units become available. 4. To expand the participation of local community landlords in the various housing subsidy programs, so as to increase the overall availability of affordable, accessible housing in an area. 5. To strengthen the knowledge base and sensitivity of local landlords about reasonable accommodations and other disability-related tenancy topics.
Number of FTE	1 (out of 9)
State's Decision to Retain	The functions of this position have demonstrated to be important components of NC's transition practices. The State's intent is to ensure the core functions of this position are incorporated into the existing organizational infrastructure after the project ends. Additional funding is contingent on availability of resources.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project unless funding is allocated before Project's end date.

State LCA Coordinator	
Job Description	Primary Functions Include: • Provide day-to-day planning, coordination, and management of the federal Local Contact Agency initiative. • Support the development and expansion of the Options Counseling required function. • Represent the Division's interests in the Departments long-term services and support reform strategies.
Number of FTE	1
State's Decision to Retain	The State shall be evaluating this function before reaching a conclusion on future design. Additional funding is contingent on availability.
Timeline for Converting	Position will remain funded by MFP administrative costs for the duration of the Project unless funding is allocated before Project's end date.

SECTION 6: State's Plan for Utilizing Rebalancing Funds

a. **Use of Rebalancing Funds Prior to December, 2014:** NC MFP has used its funds to date to support its Family Peer Support Pilot in partnership with the NC Division of Aging and Adult Services' Lifespan Respite Program.

b. **Planned Future Use of Rebalancing Funds:**

i. **Existing Projects:**

a. SUPPORTING FAMILY CAREGIVERS: MFP is currently in the process of developing its second initiative in partnership with the Department's Family Lifespan Respite initiative: Through its collaboration with NC Lifespan Respite Grant staff and stakeholders, MFP will use Rebalancing Funds to initiate a project that will identify and address the needs of family caregivers during and after individual transitions. *"Families in Transition Support Project"* staff will use person-centered planning tools to assess what is "important for" and "important to" family caregivers; offer ongoing certified options counseling; and, assist the family in accessing both formal and informal services, such as support groups, education and respite care. An evaluation will be designed and administered throughout the life of the project so that MFP and its collaborating partners will better understand effective approaches to supporting families in transition with the goal of reducing recidivism that is related to caregiver stress.

i. Timeline: Launched October, 2015; Assessment/Surveying Begins January, 2016; Activities End March 30, 2017.

b. ELEVATING TRANSITION CAPACITY: NC Community Transitions Institute

i. Pilot initiative to test and evaluate a summer-long Institute for professionals engaged in the transition process. Events include:

1. 2 Day Transitions Symposium;
2. 3 Day Person Centered Approaches and Applications Session;
3. Opportunity to evaluate the Department's Learning Management System Modules Related to Transition Activities;
4. Participation with other Institute members in Virtual Learning Community.

ii. Timeline: Pilot is slated to begin May 21, 2015; evaluation completed by April, 2016. Rebalancing Funds Project a second Institute will occur and has reduced Fund contribution to 50% to ensure sustained funding structure.

iii. See attached overview of the *Institute* in Appendix D.

c. SUPPORTING ACCESS TO COMMUNITY LIFE: Housing Crosswalk

i. Evaluate current Medicaid policies and examine how to effectively align Medicaid service definitions to better support housing outcomes.

ii. To be re-initiated July, 2015. Evaluation to be completed by July, 2016.

ii. **New Projects:**

a. EVALUATING TRANSITION CAPACITY: Evaluation of Transition Coordination and Local Contact Agency Functions[1]
    i. Fund an evaluation of transition coordination and LCA functions to ensure appropriate rate methodology and function assignment.
    ii. Timeline: Evaluation completed by December 31, 2015.

b. ELEVATING TRANSITON CAPACITY: Piloting Regional Transition Coordination/Case Management Function
    i. The Need: Currently, MFP funds full time transition coordinators (via contract) and provides only a supplemental payment to waiver case managers who may choose to provide transition services. Efforts to date have revealed the following dynamics:
        1. Case managers are currently unable to perform comprehensive transition activities (i.e. securing housing, etc.) for high need MFP participants.
        2. "De-linking" the transition coordination function and the case management function produces avoidable "coordination lag" which both complicates and prolongs the transition process.
        3. Neither function currently is established in a way to truly meet the needs of hospital-based transitions.
        4. Other MFP activities with the Behavioral Health MCO staffers have indicated that having the case management function and the transition coordination function housed within the same entity better ensures coordinated, responsive transition planning.
    ii. The Activity: NC DMA will be establishing at least two pilot sites with existing CAP DA case management entities who have *also* demonstrated leadership and initiative in MFP transition coordination activities to operationalize the following concepts:
        1. Develop joint case management and transition coordination capacity within the same entity;
        2. Eliminate "assessment lag." Waiver assessments can take up to 90 days to complete, which results in a person's housing and discharge options being compromised;
        3. Assume a regional scope. Currently CAP DA lead agencies are county-based, which creates "boundary lag" when multiple case management agencies must coordinate to accommodate a person's living needs, preferences and county housing availability;
        4. Increase responsiveness for hospital discharge planning process. To evaluate how to best design both the transition coordination and case management functions to better meet the needs of the hospital discharge planning process, we are anticipating housing one test region in a hospital-sponsored waiver team and a second in a community-based waiver team.
    iii. Timeline: Initiated by July, 2015, Pilot launched by July, 2016; pilot ends June 30, 2019.

[1] While NC will be sponsoring an evaluation of the LCA function, it does impact NC's federal obligation to provide this service in some form.

c. IMPROVING ACCESS TO MEDICAL CARE: Pre-Transitions Pilot Initiative with NC's Health Home Network:

i. The Need: Currently, NC's Health Home network is not contractually funded nor expected to participate in pre-transition activities. Additionally, NC's eligibility protocols do not enable a participant to be formally enrolled with the appropriate health home until after discharge. The involvement of the health home care manager during the pre-transition planning phase would better ensure continuity and linkage to community-based medical care.

ii. The Activity: To fund pre-transition engagement of CCNC care manager in pre-transition planning and to better link MFP participants with community-based medical home.

iii. Timeline: Initiative to begin by July, 2015; Activities launched by September 30, 2015; Pilot ends September 30, 2017.

d. SUPPORTING EXPANDED ACCESS TO COMMUNITY LIVING OPTIONS: Supporting the State's Roll Out of the Supported Living Definition under the Innovations Waiver.

i. The Need: MFP's I/DD participants currently do not have access to the one of the most person-centered options available: receiving the supports needed in one's own home. For the past 3 years, MFP has been partnering within DMA and with our sister agencies who manage I/DD services to examine the viability of adding a supported living waiver service definition into the NC Innovations Waiver. With support from MFP technical assistance, the Department has researched and developed a suitable definition that is anticipated to "go live" in January, 2016. The supported living concept is deeply rooted in person-centered philosophy. To fully honor the integrity of the concept, providers, families and regulators must have a clear understanding of how supported living differs from provider-managed "residential service" options like group homes

ii. The Activity: In partnership with our DMA colleagues and our sister agencies[i2]MFP will sponsor a learning initiative around the supported living concepts. While this is not fully conceptualized yet, we anticipate it will include opportunities to learn from other organizations who facilitate supported living and receive guidance from those who first conceptualized the concept, John and Connie O'Brien, Jack Pearpoint and others.

iii. The Timeline: Initiative launched by July, 2015, tentative end date: December 31, 2016.

e. SUPPORTING ACCESS TO BEHAVIORAL HEALTH: Developing a High Engagement Interdisciplinary Team

i. The Need: The need for coordinated, interdisciplinary support at the time of transition is greatest for individuals with behavioral or medical complexities. Through its experience in supporting behaviorally complex adults and children with IDD to transition out of our state developmental centers, MFP has witnessed firsthand the challenges in ensuring *true* continuity and linkage to community-based options, specially related to behavioral health, staff training, educational access and true community engagement. Transition planning also requires a more intensive "hands on" period for clinical and staffing consultation and assistance as the transitioned individual gets settled into his community life.

[2] Division of Mental Health, Developmental Disabilities and Substance Abuse Services; Division of State Operated Healthcare Facilities.

ii. The Proposed Activity: Learning from similar models in other states, MFP seeks to use Rebalancing Funds to pilot a "transition IDT" initiative that will provide intensive, time-limited oversight and technical assistance to community-based support networks. While the pilot is still being conceptualized, we anticipate the team will include clinical/subject matter expertise in the following areas
    1. Physical health: providing technical assistance ("TA") to community-based medical practice
    2. Behavioral health: providing TA to staff and community-based clinicians.
    3. Education (as needed): providing TA to public school the transitioned child is attending
    4. Community Engagement: providing TA to direct support staff and "community guides" to help build community opportunities for individuals with significant behavioral or medical complexities
iii. The timeline: Initiative in July, 2015; pilot to begin no later than January, 2016; Pilot ends by December 31, 2018.

f. SUPPORTING IMPROVED ACCESS TO COMMUNITY LIFE: Transportation Pilot
    i. The Need: Lack of affordable, accessible, reliable transportation remains a chronic challenge to supporting transitioned individuals, particularly in rural areas, to fully engage in their communities.
    ii. The Proposed Activity: Launch a national evaluation of transportation options and innovative practices that could be utilized in NC to better meet this need.
    iii. Timeline: Started and completed in 2018.

g. SUPPORTING IMPROVED ACCESS TO COMMUNITY LIFE: Catalyst Conference for Supporting Facility-Based Providers to Explore Conversion to Home and Community-Based Options
    i. DMA leadership recently suggested that we support efforts related to the voluntary, collaborative business model conversion of facility-based providers. This had been an original priority of the Project in 2011 for I/DD providers but had been dropped because of work volume related to NC's conversion to managed care in behavioral health. MFP is renewing this effort and will be amending this sustainability plan to reflect anticipated scope and costs. We anticipate utilizing currently unallocated Rebalancing Funds to support this initiative.

c. Plans for Continuing Rebalancing Projects

a. Since the Fund's inception, DMA leadership has required MFP Rebalancing Funds to be prioritized to pilot and test initiatives that improve the State's capacity to support transitioning individuals. Rebalancing Fund-sponsored activities are never long-term in nature by themselves, though they are intended to test concepts that the State may choose to sustain.
b. Each initiative includes an evaluative component. Assuming a favorable evaluation, NC may seek funding necessary to scale pilots or implement report findings as appropriate.
c. Because many of our initiatives have not been completed, we cannot conclusively identify which pilot initiatives will be considered for expansion.

d. Rebalancing Fund and Waiver Slots: NA. NC does not utilize Rebalancing Funds to fund waiver slots.

SECTION 7: Timeline for Planned Activities

Please see timeline in Appendix E

SECTION 8: Estimated Budget Summary

Object Class Categories	(1) CY 2016	(2) CY 2017	(3) CY 2018	(4) CY 2019	(5) CY 2020	(6) Total
a. Personnel	$191,923	$195,923	$199,923	$203,923	$155,267	$946,959
b. Fringe Benefits	$66,732	$67,399	$68,073	$68,754	$52,081	$323,040
c. Travel	$36,537	$36,537	$36,537	$36,537	$27,403	$173,551
d. Equipment	$10,000	$10,000	$10,000	$10,000	$3,750	$43,750
e. Supplies	$9,500	$9,500	$9,500	$9,500	$5,250	$43,250
f. Contractual	$1,470,643	$1,479,101	$1,483,101	$1,487,101	$658,690	$6,578,636
g. Construction						$0
h. Services	$13,933,929	$13,933,929	$13,933,929	$259,935		$42,061,722
i. Total Direct Charges (sum of 6a-6h)	$15,719,264	$15,732,389	$15,741,063	$2,075,750	$902,441	$50,170,908
j. Indirect Charges	$100,000	$100,000	$100,000	$100,000	$75,000	$475,000
k. Total Federal Budget (sum of 6i-6j)	$15,819,264	$15,832,389	$15,841,063	$2,175,750	$977,441	$50,645,908

Budget Notes:

- 2016-2019 Services line reflects all demonstration services. Demonstration services may end prior to 2019. As a safeguard, we are requesting resources to cover all MFP transitions, but as each Demonstration Service becomes sustained through NC waiver programs, MFP will not require these funds.
- 2016-2019 Salaries and Fringe Benefit increases to accommodate potential cost of living adjustments. This also accounts for part of increase in Contracts, as several partnering agencies are also state staffers.
- 2019 Service costs reflect transition work being completed with follow along after transitions occurred in 2018.
- 2019 Contract costs reflect termination of LCA function on June 30, 2019 but also one half of total $360,000 expenditure being requested for Medicaid Reform LTSS technical assistance.

The NC MFP 2020 budget decreases because services will conclude. However, 2020 budget also includes second half of $360,000 for time-limited technical assistance support related to the NC Medicaid Reform initiative.

SECTION 9: Optional Elements

Affordable Housing Strategies:

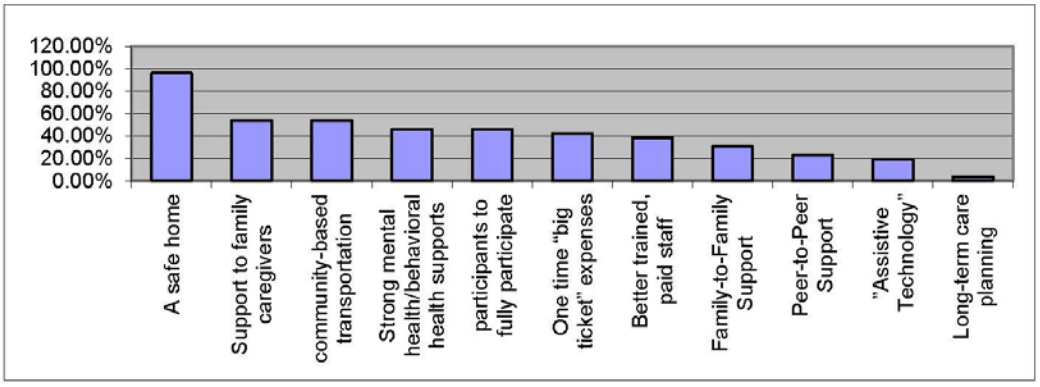
a. NC MFP continues to partner with housing stakeholders, state housing staff and the NC Housing Finance Agency ("NCHFA") to identify and address barriers to affordable, accessible housing. NC MFP recently secured priority status for state-funded housing subsidies. Additionally, based on the "real world experience" of transition coordinators, NC MFP is currently partnering with NCHFA and sister transition initiatives (DOJ Settlement's *Transitions to Community Living* Initiative) to conduct a "line by line" analysis of barriers to securing and maintaining state subsidized housing units. This group re-launched in 2014 and has already revised existing protocols to begin addressing these barriers. NC MFP anticipates its continued involvement with this effort through the Project's conclusion.

Quality Improvement

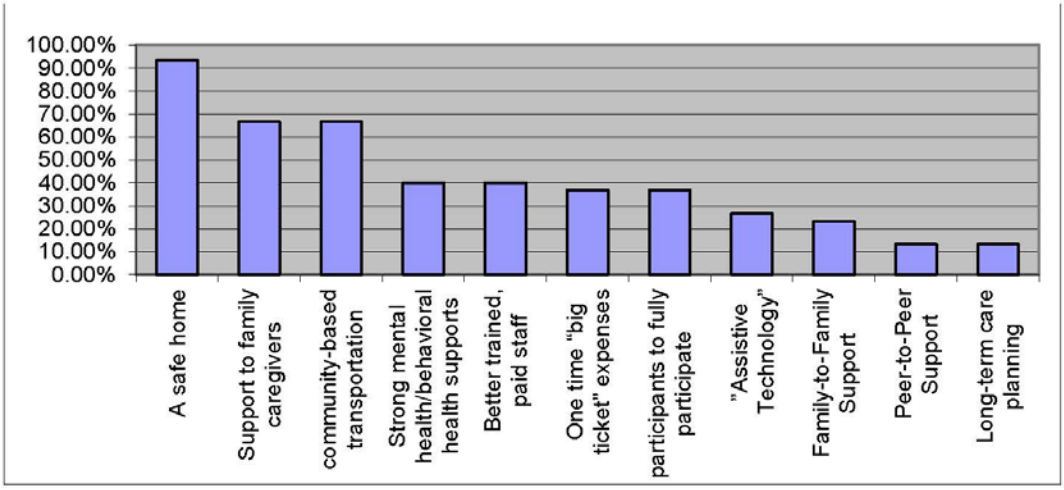
a. NC MFP's contribution to NC's overarching Quality Assurance and Improvement efforts for home and community-based services have centered around 1) analysis and strengthening of transition-specific practices and expectations and 2) supporting learning opportunities to improve statewide capacity related to supporting transitioning individuals. Funding evaluation and capacity building options through Rebalancing Funds.

Appendix A: NC MFP 2014 Rebalancing Fund Survey Results

Stakeholder Survey Feedback on Factors that are Essential for Supporting People to Transition to their Communities



Stakeholder Survey Feedback on Factors that *Keep* People in their Communities.



Appendix B: Stakeholder Contribution to NC MFP Rebalancing Fund Priorities

The Priority Initiative	•Stakeholder and Workgroups that Advised on Need and Design •ALL initives also vetted by MFP Roundtable, MFP Rebalancing Fund Advisory Group and DMA Executive Team.
Families in Transition Project	•NC LifeSpan Respite Advisory Group
NC Community Transitions Institute	•NC Community Transitions Institute Steering Committee •NC MFP MCO (I/DD) Transition Coordination Group •NC MFP Aging and Physical Disability Transition Coordinator Group •NC CAP DA and I/DD Manaagement Teams •Transitions to Community Living (DOJ Settlement) Management Team
Housing Crosswalk	• Housing and Disability Advisory Group •Transition to Community Living (DOJ Settlement) Management Team
Evaluation of Transition Coordination and LCA	•Driven by DMA Executive Team in partnership with lead sister agencies
Regional Waiver-BasedTransition Coordination Pilot	•NC CAP DA Management Team •NC MFP Transition Coordinator Group
Pre-Transitions Pilot with Health Home Network (NC3N)	•NC CAP DA and I/DD Management Teams •DMA Executive Team
Supporting Supported Living Defintion Roll Out	•NC I/DD Innovations Management Team •NC MFP MCO (I/DD) Transition Coordination Group
High Engagement IDT Team for I/DD	• NC I/DD Innovations Management Team •NC MFP MCO (I/DD) Transition Coordination Group
Transportation Evaluation (to be more fully developed)	•Initiated by DMA Executive Team and also supported in NC Roundtable Rebalancing Fund Survey
Conversion Catalyst Iniative (to be more fully developed)	•* Initiated by DMA Executive Team and will be developed in collaboration with stakeholders.

MFP Sustainability Action Planning Summary – February 13, 2015

What key steps need to be taken to sustain:

1. Transition Competencies?
2. Housing Access?
3. Family Caregivers?
4. Community Life?
5. Collaboration?
6. Behavioral/Medical Supports?

What is already known and underway (provided by Trish before group work)

1. Transition-Related Competencies
    a. Keep in mind for Medicaid Reform
    b. Launching Community Transitions Institute – Summer 2015 (2-day conference kick-off in May)
        i. Setting up Curriculum with NC State/UNC Chapel Hill (e.g., dignity of risk, medical supports, employment supports);
        ii. Sharpening/honing skills;
        iii. Forming Learning Communities;
        iv. 3-day person-centered practices;
        v. Pilot – if it works, will sustain.
2. Housing Access
    a. Section 8 housing slots, 811 housing grant – hard to use/access;
    b. Sometimes it's not that housing is unavailable – sometimes barriers are related to awareness, rules, and logistical issues;
    c. MFP has priority access to Targeting/Key housing slots;
    d. Housing taskforce working with NCHFA on these issues.
3. Family Caregivers Supported

a. Initiatives developed through MFP Rebalancing Funds in collaboration with the Lifespan Respite Grant State Advisory Team and staff. Three pilots currently underway (i.e., Family Caregiver-to-Caregiver Peer Support mini-grants) and new project proposal under development.

4. People Participate in Community Life
   a. Need to think through employment;
   b. Need team of folks that work with Transitions Coordinator & Care Coordinator to make sure participant is integrated in community;
   c. Helping person build community with particular support needs...
5. Agencies Collaborate to Support Individuals
   a. Few formal structures for inter-organizational collaboration during and after transition
6. Access to Behavioral/Medical Supports
   a. CCNC potential to be part of transitions process
   b. Encouraging Transition Coordinators to link with MCOs/LMEs for support (e.g., substance abuse)

Sustainability Action Table Created through Group Process on February 13, 2015:

Topic:	2015	2016	2017	2018	2019	2020
Transition-Related Competencies	Establish list of resources currently present for support in each county. Support & utilize CILs. CILs have a federal mandate to do transitions work.	Focus on Transition Coordinator retention – reduce turnover and provide training. Training for staff on disabilities so that aging and disability populations have equal access.	Get Transitions Institute off the ground and have reliable data about its impact	Educate SNF, resident about options, opportunities, encourage, build POSITIVE environment to enable/motivate resident through ongoing PC training. Social worker/ Discharge Planner education –	Continuation of efforts	Competency to Transition exists throughout community

Topic:	2015	2016	2017	2018	2019	2020
		Continuing Education Module Development		mandatory training		
Housing Access	Do whatever is necessary to hit that housing benchmark – Period. Identify & recruit subject matter experts	Improve databases Priority for Section 8/NED, etc.	Address lack of appropriate housing, especially in rural areas Education for housing arena	Continue efforts	Continue efforts	Housing available for 100% of transitions
Family Caregivers Supported	Mode of Communication	Expand/Extending Information	Training	Support Groups	Respite	Individual Caregiver Plan
People Participate in Community Life	Educate each community & collect information from each community	Bridge the gap of resources available in the communities Build a financial base	Develop our brand to raise visibility and awareness Build & share a user friendly database	Continue efforts	Continue efforts	Personalized, self-directed access to services
Agencies Collaborate to Support Individuals	Identify team with tools – assess. org. chart	Cross training - in-person Technology (email, database,	Measurements (# transitioned, length of time, environment of	Participatory re-evaluation	Continue efforts	Consumer – Optimal independence & self-determination

Topic:	2015	2016	2017	2018	2019	2020
		contacts up-to-date)	choice & less restrictive)			Agencies - Efficiency
Access to Behavioral & Medical Supports	Research unmet needs	Assessment for services & results Identify quality providers	Training for TCs & providers Ongoing evaluation	Continue efforts	Continue efforts	Expanded quality provider network

Individual ideas for each priority area, generated by those attending the February 13th MFP Roundtable:

Transition-Related Competencies – all ideas represented on the Sustainability Action Table

Housing Access

- Examine what grants (funds) support infrastructure and the community's voice in regards to development and growth in different areas;
- If a person is on a public housing wait list, they should not be discharged from SNF to another facility. (thinking about Olmstead Decision);
- Legislative buy-in to have housing as part of discharge planning.
- Need to incorporate residential providers; info/database on vacancies matched to individuals; who is willing to work with & throughout MFP/transition process;
- Reaching out to more/all housing options to offer Target housing or incentives to renting to participants;
- Policy change to enable housing application process to accommodate a person who is in a facility;
- Support efforts that facilitate home ownership;
- Strengthen database of accessible housing;
- Develop more housing specialists who can assist the transition team in identifying and overcoming barriers to housing (not just lack of housing);
- Expand housing options for ex-offenders;
- Maintain housing lists by county/city;
- Landlords with Targeted or Key units to learn about SNF residents - talk or have regional Ombudsman/TCs/CILs train on SNF to Community Living (i.e., "How Tos");
- Combine rent and utility costs (like HUD) for Section 8/NED housing.

Family Caregivers Supported

- Career Coaching to allow for employment that allows more flexibility in schedule;
- Educate families about different resources through PSA, meetings, education. Also, conduct assessments to examine the needs of families and individual, whether they are accessible online or a facility;
- Encourage use of Family Caregiving Learning Modules (Lifespan Respite?);
- Bring guardians/family ideas – community connection;
- Respite – relieve caregivers;
- Support Groups;

- Having a Family Advocate to support and educate and link families;
- Hands-on training for caregivers that want to take participant home;
- Professional Personal Care training for non-professionals (ex: moving from bed to chair without personal injury);
- For full-time caregiver, have "Caregiver Day Out" with volunteers staying with client/participant;
- Marketing of Family Caregiver Specialist provider in county;
- Build relationships with AAA Family Caregivers who can provide consults about services;
- Continue work on No Wrong Doors grant to support stronger options counseling and information availability;
- Link resident & their family to caregiver specialists who can link to education, support groups, etc.
- Access to adult day, respite care, PACE;
- Provide specific information on Social Security benefits – SS/SSI/SSDI.

People Participate in Community Life

- Telephone reassurance to call daily for needs;
- Local churches have outreach/senior ministries. Encourage individuals to link with these groups;
- Access to county 1st contacts;
- Develop informal "care teams" to facilitate involvement in community life;
- Hold or create a support group that should meet at least once a month to discuss and familiarize people in the community of the different conditions and much needed supports to provide and lay the groundwork for understanding what is needed;
- Identification of groups around interests/talents of the client for engagement (e.g., LGBT community tapped for volunteerism to a transgender hospice patient abandoned by family);
- Call system (call center) for someone with disabilities – referral specialist will send email to agency regarding information on call;
- Employment;
- Involve faith community with transition work (e.g., transportation);
- Link our 60+ individuals with senior services, transportation to Senior Center to take part in services and programs that are FREE at senior center;
- Connect people with Centers for Independent Living.
- Contact the employment office or relative agency to get data regarding employment available. Also, ask public what jobs would be feasible or of interest;

- Define the role of the entity the Transition Coordinator will hand over the resident to. (e.g., Life Coach, Community Specialist) who will help resident engage in community;
- Pull in police, medical, churches, commissioners – community leaders as part of process of integration into community;
- LCAs, transition coordinators, link with local Ombudsman to have VR representatives go to speak at Resident Council meetings.

Agencies Collaborate to Support Individuals

- Training on physical and mental disabilities;
- Outreach;
- Formal organization structure shared between MCO and aging agencies – meeting with MCO & aging agencies;
- Agency cross training to expand partnerships;
- Encourage widespread access to internet for residents of SNFs (encourages self-motivation & resourcefulness);
- Staff trainings to foster professional development to work towards rapport with other agencies – professionalism – conduct;
- Support for/connection between Transition Coordinators;
- When training Transition Coordinators, connect them with different players (so many different pieces);
- Linkage to college (interns/depts.); linkage to senior centers; have church/organization sponsor a participant; adult daycare; funding for peer support through LME/MCO;
- Websites focused on agency services to support at-home caregivers & participants;
- Develop professional networks like CRC;
- Encourage SNFs to use email. Phone tag is a huge waste of time.

Access to Behavioral/Medical Supports

- Organize data about MFP participants related to behavioral and medical needs;
- Uniform assessment for services;
- List of knowledgeable agencies that can and are willing to support medical and behavioral needs;
- Training in communities;
- Increase availability of technology to support access to physician/nursing information and guidance;
- Collaborate with all of the MCOs and with all Mediation (?)/Psych amenities/facilities to get ideas on how to better support those in need;
- PSAs on TV for accessing support for med/behavioral services;
- More providers that provide specialized consultative services for behavior support plan development;
- Can directly refer to MCO and receive care coordination;
- Facilitate communication between transition coordinator and MCOs;
- Training for agencies on how to support individuals with medical & behavioral (issues) by agencies that currently are (providing these services).

Next Steps (following Roundtable):

1. Written notes – Group table (transcribed from post-it notes on wall) & individual remarks
2. May need MCO and other organizations to test out (i.e., behavioral/med topic)
3. Some things relevant to Medicaid Reform - *group encouraged to follow this
    a. Educate members of the General Assembly.
    b. Need to have unified agenda --"NC Community Living" agenda.

N.C. Department of Health and Human Services

NC Community Transitions Institute: Ensuring Quality Transitions to Community Life

Inviting Applications for Participation

In collaboration with its community partners, the NC Department of Health and Human Services will soon launch a pilot initiative that provides a collective learning opportunity for professionals who assist individuals with long-term care needs to transition from facility settings to their homes and communities.

Summary of Key Application Information

Application Deadline: April 6, 2015

Application: Please see page 3

Questions about Institute or Application Process:
DHHS.NCTransitionsInstitute@dhhs.nc.gov

The NC Community Transitions Institute ("The Institute") will create a learning community among participating transition coordinators, care managers, care coordinators, discharge planners, options counselors and others in order to collectively deepen the skills and approaches necessary to best ensure a quality transition.

If the Institute pilot proves to be an effective, scalable method for supporting the learning of professionals involved in transition work, the Department will develop a strategy for the Institute's long-term sustainability.

The goals of the Institute include:

- Piloting a learning opportunity that:
  - Includes quality content immediately relevant to the practice of supporting a transitioning individual;
  - Strengthens Institute members' knowledge of and utilization of person-centered practices and motivational interviewing techniques;
  - Determines which training methods/approaches are most effective in conveying practical application of information and fostering collaboration among Institute members.
- Collect clear data on the efficacy of the Institute and clear recommendations for improvements, including both content and approach

For additional information about why the Department is piloting the *Institute* concept, please see the "Background on Institute Concept" section within this announcement.

What the Institute Participation Includes

- The Institute will hold various events throughout the summer of 2015, in which Institute members are expected to participate:
  - A virtual, on-going learning community with other Institute members to share insight and information about transition practices and the Institute's content and format.
  - *The NC Transitions Symposium*
    - May 21-22, 2015
    - See preliminary Symposium program at end of this announcement.
  - A two day training on person-centered approaches, with a third day dedicated to Institute member recommendations for systems changes.
    - August 4 and 5, 2015 and September 9, 2015
    - Training provided by the University of North Carolina
    - While this person-centered approaches training builds off existing person-centered planning trainings provided through UNC, there will be increased emphasis on application and implementation of person-centered theories into planning and support processes.
    - Practices discussed will comport with those person-centered practices outlined in CMS' Home and Community-Based Services *Final Rule*. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

Individuals Eligible to Participate in the Institute

- Money Follows the Person Transition Coordinators within CAP DA Lead Agencies, Behavioral Health Managed Care Organizations or Contracted Entities
- Transitions to Community Living Transition Coordinators
- Transitions to Community Living In-Reach Specialists
- Certified options counselors
- CAP DA Case Managers
- PACE Case Managers
- DVR-IL regional staff
- Centers for Independent Living
- Nursing Facility Discharge Planners
- Hospital Discharge Planners
- ICF/IDD Facility Discharge Planners
- Peer Support Specialists
- CCNC Care Managers
- DSS Staffers working with Long Term Care Community
- Long-term Care Ombudsmen
- Other individuals as space allows

The Institute is intended to be as inclusive as possible but space is limited to 75 attendees.

Each applying organization may submit no more than two applications.

Applications will be considered on a *first come, first served* basis, and will be selected to ensure organizational, population and geographic diversity.

The Application Content and Submission Process:

- Please submit an application at: http://ncsu.qualtrics.com//SE/?SID=SV_e5PvUIxvCy8hQ33
- Applicants are encouraged to provide thoughtful but succinct responses to the questions included in the on-line application.
- Applicants will also upload a scanned letter of commitment from a manager or organizational director indicating organizational commitment to the applicant's participation in the Institute and to the Institute's goals. Letters should be signed and written on agency letterhead.
- Applications are due by midnight on April 6, 2015. Members selected to participate in the Institute will be notfied by April 20, 2015.

Important Considerations for Participation

- All Institute attendees will receive certificates of completion. *Contact hours* will also be provided.
- The Institute's two-day symposium and person-centered approaches training will occur in Raleigh. All other activities will occur through conference calls and webinars.
- Lunch will be provided for every in-person event.
- **There is no charge for Institute attendees to participate in any of the sessions. Institute attendees/sponsoring organizations will be responsible for all travel and lodging costs.**
- To assess the efficacy of the Institute's components in achieving its desired goals, the Department has partnered with NC State University's Department of Leadership, Policy and Adult and Higher Education. Members are expected to participate in the feedback gathering process.
- Because this Institute is a pilot, continuing education units (CEUs) are not provided.

NC Community Transitions Institute: Ensuring Quality Transitions to Community Life Two-Day Symposium May 21-May 22, 2015		
	Day 1: Supporting Success: Key Concepts in Quality Transition Planning	Day 2: Supporting the Skills: Tools and Resources for Quality Transition Planning
9:00 am-10:00 am	Key Note: Supporting Dignity of Experience	Supporting the Whole Person: Building community-partnership between long-term services and supports; behavioral health and physical health care
	Closing/Debriefing/Evaluation	*Closing/Debriefing/Evaluation*
10:15 – 11:15 am	Understanding Guardianship and Powers of Attorney	Supporting Independent Living Skills & Innovative and Assistive Technology
	Closing/Debriefing/Evaluation	*Closing/Debriefing/Evaluation*
11:30 – 12:30 pm	Supporting Community Life: Supporting Employment Opportunities and how Employment Impacts Social Security	Understanding NC Housing Resources
	Closing/Debriefing/Evaluation	*Closing/Debriefing/Evaluation*
12:30 – 1:30 pm Lunch		
1:30- 2:30	Supporting Partnerships: Collaborating with hospitals and facilities through the transition planning process.	Supporting Physical Health & Wellness: NC Resources for Assisting Individuals in Accessing Primary Care
	Closing/Debriefing/Evaluation	*Closing/Debriefing/Evaluation*
2:45 – 3:45	Supporting Family Dynamic: supporting and preparing caregivers for transition	Why This Matters Closing Keynote Address
	Closing/Debriefing/Evaluation	

NC Transitions Institute Announcement

March, 2015

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Background on the Institute Concept

Across the country and within our state, an increasing number of long-term care facility residents are choosing to transition into their homes and communities, with the supports they need to do so. Effectively supporting an individual's transition requires strong coordination between the resident, the resident's family, and the professional network that will support him through the transition and once he returns to his community. In addition, as an increasing number of individuals transition— many of whom experience significant clinical and social complexities—the need for strong transition supports becomes increasingly apparent.

Quality transition practices ensure the effective integration of physical, behavioral, and long-term services for transitioning individuals. Strong, coordinated transitions are also more likely to facilitate improved health outcomes and quality of life once a person has transitioned.

To strengthen the state's "transition capacity," three key functions related to the transition experience must be enhanced:

1. Ensuring individuals have the information necessary to make informed decisions about where they receive services ("options counseling").
2. Ensuring a transitioning individual has comprehensive, coordinated transition planning to identify support and resource needs and to facilitate securing community-based resources to meet these needs (i.e. clinical and rehabilitative services, housing, benefits transfers, and crisis services). This transition function is often known as "transition coordination."
3. Ensuring individuals *continue* to receive the services and supports necessary to maximize positive quality of life outcomes and to minimize the risk for recidivism. This concept is often referred to as "follow along" and is typically coordinated between transition coordination (for the short-term) and a care coordinator/case manager (ongoing).

Despite the Department's increased activity related to all three functions, there is currently no consistent, department-wide, competency-based standard or curriculum used to ensure consistency on core transition concepts across the long-term care communities and to train on resources specific to North Carolina. As the need for transition capacity becomes increasingly recognized, we wish to establish a Departmental pilot project, the *NC Community Transitions Institute: Ensuring Quality Transitions to Community Life*. This effort furthers the workforce capacity development priorities outlined as part of the *Partnership for Healthy NC, Medicaid Reform* initiative.

Attachment O
Definitions

Area Agencies on Aging (AAA) - regional network of designated agencies that facilitate and support programs addressing the needs of older adults in a defined geographic region. AAA program was established offices through the federal Older Americans Act.

Carolinas Center for Medical Excellence (CCME) - assist state Medicaid departments, hospitals, accountable care organizations, and providers of all types manage their data and claims to benefit patients, providers, and payers, simultaneously.

Centers for Medicare and Medicaid Services' (CMS) – The federal agency responsible for the management of the Medicare and Medicaid programs. As part of its scope, CMS oversees the operations and activity of the Money Follows the Person Program.

Community Alternatives Program for Disabled Adults (CAP DA) - The North Carolina aging and disability waiver program that provides personal assistance, supplies, home modifications and other services to individuals who meet nursing facility level of care and CAP/DA program requirements. The self-directed option under the CAP/DA waiver is known as “Choice.”

CAP /DA Lead Agency: A lead agency refers to the local entry point and approval authority for CAP/DA. The lead agency is appointed by DMA to be responsible for the day to day case management functions for potential and eligible CAP/DA or CAP/Choice beneficiary. These agencies may include county Departments of Social Services, county health departments, county agencies on aging, or hospitals.

Computer Sciences Corporation (CSC, currently CSRA - IT and business services company that is the Medicaid program's fiscal agent and manages North Carolina’s Medicaid claims processing platform, NCTracks.

Continuous Quality Improvement (CQI) - an approach to quality management that builds upon traditional quality assurance methods by emphasizing the organization and systems: it focuses on "process" rather than the individual; it recognizes both internal and external "customers"; it promotes the need for objective data to analyze and improve processes.

Demonstration Service- A term used to describe the time-limited services available to an MFP participant to assist in the transition. Demonstration services are developed to test services and interventions that are not currently available through the North Carolina Medicaid program. Demonstration Services are only available to MFP participants.

Durable Medical Equipment (DME) - Durable Medical Equipment is primarily and customarily used to serve a medical purpose, is generally not useful to an individual in

the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.

e-CAP - the CAP/DA information platform used for managing assessment, planning and case management activity for people enrolled in the CAP/DA/Choice waiver.

Home and Community-Based Service (HCBS) - refers to assistance with daily activities that generally helps older adults and people with disabilities to remain in their homes.

Identified HCBS Programs – North Carolina HCBS programs in which MFP participants are enrolled: Innovations, CAP/DA, CAP/Choice and PACE

Incident Reporting Information System (IRIS) – DHHS information platform that captures critical incident data for individuals with IDD

Individualized Support Plan (ISP) – the planning document that reflects written details of the supports, activities, and resources that an individual, Personal Agent or Service Coordinator, and other people of the individual's choice agree are important to or for achieving and maintaining personal outcomes.

Intermediate Care Facility for people with Intellectual/Developmental Disabilities (ICF-IID) - an institution that functions primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or with a related condition and provides ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services in a residential setting.

Local Contact Agency (LCA) – The federally required function that provides options counseling to nursing facility residents who, through their assessment process, request additional information about HCBS options. In North Carolina, DHHS contracts with the AAA network to perform this function.

Local Management Entity/Managed Care Organizations (LME-MCOs)
A local management entity that is paid a capitated rate by DHHS to provide mental health, developmental disability, and substance abuse services to Medicaid beneficiaries pursuant to a combination of a Section 1915(b) and a Section 1915(c) waiver. For the Medicaid population, these entities are recognized under CMS Medicaid managed care rules and are known as a Prepaid Inpatient Health Plans (PIHP). LME-MCOs also manage federal block grant, State, local and county funds for other behavioral health services.

Long-Term Services and Supports (LTSS) - Includes institutional care and home and community based long-term services and supports provided to individuals with functional limitations or chronic illnesses who need assistance to perform activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping).

Medicaid Management Information System (MSIS) and Transformed Medicaid Management Information System (T-MSIS) - is a mechanized claims processing and information-retrieval system that State Medicaid programs must have to be eligible for federal funding.

Medicare Part A - is managed by Medicare and provides Medicare benefits and coverage for: Inpatient hospital care stays in most skilled nursing facilities; hospice and home health services.

NC FAST – North Carolina Medicaid's eligibility and enrollment information system and platform.

NCTracks – North Carolina's multi-payer Medicaid Management Information System

North Carolina Department of Health and Human Services (DHHS)—Manages the delivery of health- and human-related services for all North Carolinians, especially our most vulnerable citizens – children, older adults, people with disabilities, and low-income families. DHHS works closely with health care professionals, community leaders and advocacy groups; local, state and federal entities; and many other stakeholders. DHHS is made up of several divisions, which include but are not limited to the following:

- **Division of Health Service Regulation (DHSR)** – Division that provides regulatory oversight to health care and long-term care facilities, emergency medical services, and local jails. DHSR ensures people receiving care in these facilities are safe and receive appropriate care.
- **Division of Medical Assistance (DMA)** – North Carolina state Medicaid operating agency.
- **Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)** – Division that provides support to achieve self-determination for individuals with intellectual and or developmental disabilities and to promote treatment and recovery for individuals with mental illness and substance use disorders
- **Division of State Operated Healthcare Facilities (DSOHF)** – Division within DHHS oversees and manages 14 state operated healthcare facilities that treat adults and children with mental illness, developmental disabilities, substance use disorders and neuro-medical needs.

Division of Vocational Rehabilitation-Independent Living Program (DVR-IL) - Division within DHHS that supports people with disabilities to live a more independent life. DVR-IL provides an alternative to living in a nursing home or other facility for eligible individuals. Services are person-centered and may be provided directly, purchased or coordinated through other community resources.

North Carolina Housing Finance Agency (NCHFA) – state quasi-governmental agency that creates and manages affordable housing opportunities for North Carolinians whose needs are not met by the market. In partnership with DHHS, NCHFA manages the Targeting/Key Housing Program.

North Carolina Money Follows the Person Demonstration Project (NC MFP) - a time-limited demonstration project administered by DHHS to assist qualified individuals in long-term care facilities to transition back into their homes and communities with identified supports.

Personal Care Services (PCS) - provide Personal Care Services in the Medicaid beneficiary's living arrangement by paraprofessional aides employed by licensed home care agencies, licensed adult care homes, or home staff in licensed supervised living homes.

Personal Emergency Response System (PERS) - an electronic device which enables people to contact and secure pre-programmed services and supports in an emergency.

Prepaid Inpatient Health Plan (PIHP) – Federal designation for a North Carolina Local Management Entity/Managed Care Organization. A PIHP is defined in federal regulation as an *entity that provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates. Also provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees.*

Program for All Inclusive Care for the Elderly (PACE) – A program that provides comprehensive medical and social services to certain frail, community-dwelling individuals who are 55 years of age or older, most of whom are dually eligible for Medicare and Medicaid benefits.

Psychiatric Residential Treatment Facility (PRTF) - provides non-acute inpatient facility care for customers with a mental illness or substance abuse/dependency, and who need 24-hour supervision and specialized interventions.

Qualified Facility - a state or private Intermediate Care Facility for people with Intellectual /Developmental disabilities (ICF-IID); a nursing facility or other qualified inpatient facility included under the federal MFP definition.

Qualified Residences - a home owned or leased by the individual or the individual's family member; an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside. In North Carolina, MFP participants may select from those residence options available under the identified HCBS program under which the participant is enrolled.

Serious Mental Illness (SMI) - a condition that affects persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet specific diagnostic criteria.

Services Request Form (SRF) - Screening performed to determine if an induvial meets Level of Care requirement for the CAP/DA waiver program.

Transition Year Stability Resources (TYSR) – An NC MFP demonstration service which can cover time-limited start -up costs that are not covered under the scope of current Medicaid service definition or cannot be met within the definitions existing cost limit. TYSR funds may only be accessed by transition coordination entities and used only to meet the approved start up needs of NC MFP participants.

Transitions to Community Living Initiative (TCLI) - DHHS initiative that provides opportunities for eligible individuals living with serious mental illnesses to choose where they live, work and play in North Carolina. This initiative provides long-term housing stability and promotes reduced reliance on crisis services and hospitalizations.

Traumatic Brain Injury (TBI) - Traumatic brain injury (TBI), a form of acquired brain injury, occurs when a sudden trauma causes damage to the brain. TBI can result when the head suddenly and violently hits an object, or when an object pierces the skull and enters brain tissue.