

North Carolina Money Follows
the Person Rebalancing
Demonstration
Project

Funding Opportunity Number
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Submitted by:

North Carolina Department of Health and Human Services
Division of Medical Assistance
October 2006



North Carolina Department of Health and Human Services
Division of Medical Assistance

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October 31, 2006

Ms. Judith Norris
Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Norris:

I am very pleased the North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA) has the opportunity to submit an application for "*Money Follows the Person Rebalancing Demonstration Project*." This application has been prepared based on the collection of informative discussions from five public meetings held in three locations in the state to solicit input and critical comment from interested consumers and other stakeholders. In addition to these public meetings, we established an Internet communications link through the North Carolina Disability Action Network to make sure public comments continued to be a part of the application development process.

As the Division responsible for the administration of the Medicaid program, DMA will take the lead responsibility for implementing this important initiative. Our Assistant Director for Clinical Policy and Programs, Ms. Tara Larson, will serve as the primary contact person for the Demonstration Project. Ms. Larson will be collaborating with Mr. Mike Maseley, Director of the Division of Mental Health/Developmental Disabilities and Substance Abuse Services, Mr. Dennis Streets, Director of the Division of Aging and Adult Services, Ms. Linda Harrington, Director of the Division of Vocational Rehabilitation, and Ms. Holly Riddle, Director of the NC Council for Developmental Disabilities.

The Demonstration will allow DMA to receive over eighty one million dollars in enhanced federal medical assistance percentage (FMAP) during the four year operational period. The first year is a pre-implementation planning year and we are looking forward to getting the pre-implementation process underway. We have created a solid foundation for strong and meaningful participation by consumers and providers of services throughout the process to ensure that the new long-term care system that rebalances services and supports for persons with disabilities is truly person centric.

Sincerely,

for L. Allen Dobson, Jr., M.D.



Location: 1985 Unstead Drive • Dorothea Dix Hospital Campus • Raleigh, N.C. 27601
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NORTH CAROLINA APPLICATION FOR MONEY
FOLLOWS THE PERSON REBALANCING
DEMONSTRATION PROJECT FUNDS

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PROJECT ABSTRACT AND PROFILE

North Carolina Money Follows the Person Rebalancing Demonstration Project

Project Abstract

Background: Since receiving the Money Follows the Person Rebalancing Demonstration Announcement, the North Carolina Division of Medical Assistance (DMA), along with a comprehensive array of stakeholder agencies, organizations, and individuals, have worked to develop a roadmap for rebalancing its Medicaid long-term care (LTC) delivery system.

The Demonstration Narrative documents over twenty years of efforts by the state to develop community alternatives to institutional care. This Application builds upon these past efforts and achievements to move forward with a LTC system that provides an even greater array of home and community-based services and supports. Services and supports designed to promote choice and independence for individuals who are elderly, or have physical, mental, or developmental disabilities.

Target Populations: The NC Demonstration, if funded, will develop a process for transitioning individuals out of nursing facilities, state psychiatric institutions, and state centers and intermediate care facilities for the developmentally disabled. This will be accomplished by: (1) developing an array of services and supports that enhance existing HCBS waiver programs, (2) developing additional waiver programs and state plan optional services, (3) developing regional case management teams that will identify and effectively utilize a broad range of services and supports provided by both public and private agencies and organizations.

Project Goals: The goals of the Demonstration, broadly stated include:

- Maximizing consumer, advocate, and other stakeholder involvement in the Demonstration planning process;
- Identifying and removing institutional biases that favor institution over community care;
- Providing a more comprehensive array of services and supports that will allow individuals to remain in their home and community as long as possible;
- Establishing mechanisms to better manage and coordinate transition services provided by a variety of state and local public and private agencies and organizations;
- Providing a more comprehensive, efficient, and effective case management service for transitioned individuals; and
- Developing a plan to develop and implement a flexible funding arrangement for LTC that enables available funds to move with the individual to the most appropriate and preferred settings as his/her needs and preferences change.

The total proposed budget calls for an expenditure of \$1,889,359 in administrative expenses and \$37,884,394 home and community-based services eligible for the enhanced FMAP match in CYs 2008 through 2011, as summarized below.

Project Profile

Name of State: North Carolina

Primary Contact: Tara Larson, Assistant Director for Clinical Policies and Programs

Population Groups and Settings	
Geographic areas covered	Statewide
Qualified Institutional Settings	Nursing facilities (NFs)
	Intermediate Care Facilities for the Mental Retarded (ICFsMR)
	Level III Group Homes for Children
Populations to be Transitioned	Individuals who are elderly and disabled who have been in nursing homes for at least six months
	Individuals who are developmentally disabled and who have been in ICFsMR for at least six months
	Children with mental illness who have been Level III group homes for at least six months
Qualified Community Settings	Family residences and traditional housing where four or fewer unrelated individuals reside

Projected Number of Individuals to be Transitioned					
	Year 1	Year 2	Year 3	Year 4	TOTAL
From Nursing Facilities	50	65	85	100	300
From ICFsMR	40	50	60	75	225
From Level III Homes	130	130	130	130	520
Total Transitions	220	245	275	305	1045

Cost Summary for HCBS					
NF Transitions	Year 1	Year 2	Year 3	Year 4	TOTAL
Waiver and other HCBS	\$712,712	\$1,019,385	\$1,391,021	\$1,627,478	\$4,750,596.00
Additional Qualified and Demonstration HCBS under	\$296,010	\$420,390	\$574,897	\$673,942	\$1,965,239.00

MFP					
Supplemental Demonstration Services	0	0	0	0	0
Total	\$1,008,722.00	\$1,439,775.00	\$1,965,918.00	\$2,301,420.00	\$6,715,835.00

Cost Summary for HCBS (continued)					
ICFMR Transitions	Year 1	Year 2	Year 3	Year 4	TOTAL
Waiver and other HCBS	\$923,753	\$1,225,350	\$1,540,110	\$1,899,792	\$5,589,005.00
Additional Qualified and Demonstration HCBS under MFP	\$954,842	\$1,255,905	\$1,576,380	\$1,942,452	\$5,729,579.00
Supplemental Demonstration Services	0	0	0	0	0
Total	\$1,878,595.00	\$2,481,255.00	\$3,116,490.00	\$3,842,244.00	\$11,318,584.00
Level III Transitions	Year 1	Year 2	Year 3	Year 4	TOTAL
Waiver and other HCBS	0	0	0	0	0
Additional Qualified and Demonstration HCBS under MFP	\$4,817,340	\$4,911,984	\$5,010,223	\$5,110,428	\$19,849,975.00
Supplemental Demonstration Services	0	0	0	0	0
Total	\$4,817,340.00	\$4,911,984.00	\$5,010,223.00	\$5,110,428.00	\$19,849,975.00
GRAND TOTALS	\$7,704,657	\$8,833,014	\$10,092,631	\$11,254,092	\$37,884,394.00

PART 1: SYSTEMS ANALYSIS AND GAP ANALYSIS

1. A description of the current LTC support systems that provide institutional and home and community-based services, including any major legislative initiatives that have affected the system

In the 1980's, the NC General Assembly began supporting systems change within long-term services and supports through the establishment of the Division of Vocational Rehabilitation's Independent Living (DVRIL) Rehabilitation Program. There are now sixteen IL regional offices throughout the state.

North Carolina conducted a formal nursing facility transitions program from September of 2002 to March of 2006 under a Real Choice Systems Change Grant. Nursing facility transitions have continued through the efforts of the NC Division of Vocational Rehabilitation's Independent Living Rehabilitation Program (ILRP) and Centers for Independent Livings (CILs). A significant discrepancy continues to exist between the number of individuals receiving nursing facility services (43,051 and a budget of \$1.08 billion) and the number of individuals receiving home and community-based services (13,620 and a budget of \$226 million). The Medicaid HCBS Waiver "CAP/DA" program provides a package of services designed to allow adults who qualify for nursing facility care to remain in their home and community. The principal purpose of this program is to control the growth of nursing facility expenditures, despite a rapidly growing population of retirees who are moving to the state, while addressing quality of life issues for frail elderly and adults with disabilities.

The NC General Assembly passed Session Law 2001-437 to implement reform of the mental health, developmental disabilities, and substance abuse (MH/DD/SA) system at the state and local levels, reconfiguring area mental health authorities into 30 Local Management Entities (LMEs) to oversee private provider agencies. The system for individuals with developmental

disabilities includes three State developmental (ICF-MR) centers, one State center that is converting to a neuron-medical center, four State-operated short-term specialty programs located within the developmental centers, 328 private ICF-MR facilities, a Medicaid waiver referred to as Community Alternatives Program for MR/DD (CAP-MR/DD), and state funded residential, day, and periodic services. Individuals who have serious and persistent mental illness are served through the Medicaid Rehabilitation option, and state-funded residential, day, and periodic services, and four State psychiatric hospitals. One LME, Piedmont Behavioral Health, is operating under a Medicaid 1915(b) (c) combination waiver and serves four counties.

The number of beds in the State psychiatric hospitals funded by Medicaid (serving individuals age below age 21 and age 65 and above) is approximately 169 child and adolescent beds and 105 geriatric beds. By contrast, 64,349 children/youth with MH diagnoses and 6,512 with DD diagnoses receive community-based (including community residential) services. In addition to the child/adolescent beds in State Psychiatric Hospitals, Medicaid funds several residential levels of treatment for children with mental health disorders. There are six private psychiatric residential treatment facilities with a capacity of 78 children; five Level IV group homes with a capacity of 91; 632 Level III group homes with a capacity of 2,567; and 139 Level II group homes with a capacity of 566. The State has 2,240 ICF-MR beds in four public facilities and 328 private ICF-MR facilities with a total of 2,677 ICF-MR beds. The combined total of ICF-MR beds is 4,917.

2. An assessment of what is in place and working to rebalance the State's resources, i.e. to increase the use of home and community based rather than institutional, long term care services

The DVRS Independent Living Rehabilitation Program (ILRP) began serving individuals with severe disabilities (who did not have a work objective) in 1983 through a demonstration

project with the Center for Independent Living (CIL) in Charlotte. By 1996, 16 regional ILRP offices were providing community-based services to individuals transitioning to the community from nursing facilities across the state. There are now five Centers for Independent Living, and one satellite Center operated under Title VII of the Rehabilitation Act. These CILs provide information and referral, systems and individual advocacy, IL skills training, and peer counseling and support.

In state fiscal year 2002-2003, each State psychiatric hospital catchment region established a regional structure to identify and develop expansion plans for community-based services. As a result, 381 nursing beds were closed and \$21.9 million was provided for community-based services. The NC Department of Health and Human Services (DHHS) is constructing a new, 432 bed regional psychiatric hospital that will provide inpatient psychiatric services to the north and south central regions of the state. Two of the current hospitals will continue to downsize until remaining patients and admissions are provided by the new facility. During fiscal year 2004-2005, a formula was developed for reductions in the state operated ICF-MR facilities' budgets based on net census reductions. As of July 1, 2006, a total of \$4,622,611 has been reduced from the centers' budgets. Medicaid savings from the reductions will be transferred by the Division of Medical Assistance (DMA) to the CAP-MR/DD waiver for services to individuals residing in the community.

Changes in the provider enrollment process and residential provider rates resulted in additional community-based children's mental health residential providers being established in North Carolina during SFY 01 through SFY 03. In August 2001, there were 148 child residential care providers that housed 1,072 beds. Effective August 2003, the number of licensed residential facilities for children was 848 with total of 3,589 beds. This rapid increase in residential care

providers, along with a desire to support implementation of more evidence-based services and supports, has caused the Division of MH/DD/SAS to re-examine the provision of child mental health services and has provided the impetus for the Child Mental Health Plan. It is intended that implementation of this plan will decrease reliance on residential care and assist in our rebalancing efforts in this area, currently underway. The child plan, in conjunction with the state MHDDSAS plan, requires development of services and supports to help families keep children in their homes and in their home communities.

Efforts are underway to build capacity for the delivery of Medicaid community-based services. Medicaid service definitions have been put in effect to support evidenced-based and emerging best practices. During this period of service transition, MHDDSAS has offered training and mechanisms to develop service capacity in the communities. A Governor's Executive Order, effective June 2006, implemented a revised service definition, improving quality and monitoring of care. The state has developed a therapeutic care service definition that will be submitted to CMS for approval as a Medicaid-funded service, providing smaller community residences for children who need mental health treatment. Also, several new home and community, evidence-based treatment options are included in the new service package implemented in March 2006.

In SFY 2004, North Carolina spent 59% of Medicaid funds on Nursing Facility Care compared to a national average of 75%, placing NC in the top ten states with the lowest proportion of Medicaid spending for nursing facility care. Home and community-based services (HCBS) have grown steadily over the last five years, from 35.5% to 41.4%. In 2002, the NC General Assembly authorized \$28 million to expand the CAP/DA program, resulting in a 12% increase in HCBS spending. From Sept 2002 to March 2006, NC transitioned 125 individuals

from nursing facilities to community living through a Real Choice Systems Change Grant. NC DMA is working with two community organizations to develop two PACE (Program for the All-inclusive Care of the Elderly) sites in North Carolina.

3. A description of current funding mechanisms, including those that restrict the flexible use of Medicaid funds to support individuals living in the community

The DVR's ILRP receives recurring state funds to provide unduplicated, consumer-directed services needed to prevent nursing facility placements or to transition people from nursing facilities to the community. These services are administered by the DVR in collaboration with the Division of Services for the Blind. The Division of Services for the Blind provides comprehensive, independent living services that help people who are blind or visually impaired meet their daily living needs in their homes/communities.

In 2006, the state lifted the individual spending limit on services in the CAP-MRDD waiver program, providing opportunities for individuals with higher needs, such as those in the State developmental centers, to receive services in community settings; however, this has made it difficult to contain the costs for those individuals needing fewer services. In response, NC has drafted a supports waiver that is limited to individuals who want consumer-directed options. This waiver, once implemented, will be utilized for those individuals with fewer support needs, freeing the comprehensive waiver for those with higher levels of need. The current, comprehensive CAP-MR/DD waiver has some limitations on individual services, and needs some additional services (such as intensive behavioral consultation and supports and crisis response services) to more adequately serve individuals with higher levels of need. Some individuals in the State developmental centers receive SSDI rather than SSI, making it difficult for them to receive HCBS services in the community without a spend-down. While the spend-down provisions for Medicaid help individuals with higher incomes and substantial out-of-

pocket expenses to become eligible for Medicaid, it has drawbacks for individuals needing long-term supports. While a person is meeting a deductible, Medicaid will not pay for services. Other options might offer a more stable platform for long term supports, while also offering a means to the State of collecting “excess income.” The State continues to examine options that offer a stable platform for long term supports while offering a means of collecting “excess income.” Under Medicare, some services (such as psychology) have different requirements for provider qualifications, often making those services more difficult to obtain.

The following issues restrict the flexible use of Medicaid funds to support individuals living in the community: 1) Federal provisions reimburse Medicare Part D prescription drug co-pays for nursing facility residents, but not HCBS waiver participants; 2) Medically needy requirements that leave little money for persons to pay for living expenses in the community, while institutions provide room and board; 3) differences in spousal impoverishment rules can create hardships for families if a spouse prefers home or community-based services over institutional care; 4) application of the federal waiver cost neutrality requirement that results in caps in service below what is required to maintain someone in the community when applied on an individual basis; 5) enrollment caps for the waivers that limit number of people who can access care in the community; 6) no consistent differentiation of need among individuals on the CAP waiting lists; 7) inconsistent access to waiver slots due to allocation of those slots to individual counties – thus, individuals in one county may have to wait for waiver services while other counties have unused waiver slots; 8) prior approval process delays appropriate care in the community; and 9) the nature of the bundled funding for ICF-MR services and the fact that many of the facilities were built using HUD money and have six or more beds creates some cost-efficiencies.

4. A description of the various systems of care, waivers, and state plan amendments that are utilized by the State to provide home and community-based supports and services

North Carolina has six waiver programs that provide HCBS. They are CAP/DA, CAP/Choice, CAP/Children, CAP/MRDD, CAP/AIDS, and the Piedmont combination (b)(c) waiver. Optional Services, through SPAs include home health care, home-specialized therapies (occupational, physical, speech, etc.), in-home personal care services, Program of All-inclusive Care for the Elderly (PACE is pending CMS approval), mental health, rehabilitation option services, private duty nursing, home infusion therapy, case management, and hospice services.

In 2004, a NC Medicaid Infrastructure Grant (MIG) Project (1/04 – 12/07) was awarded to DVRS to develop Medicaid infrastructure to support individuals with disabilities who choose to work. Goals include: 1) address barriers and develop a strong voice to increase employment for people with disabilities; 2) design and implement a Medicaid Buy-In (MBI) program to improve employment opportunities for people with disabilities; 3) develop and implement a plan for enhanced personal assistance services (PAS) to support people with disabilities who go back to work, work more hours, or get a better job; and 4) increase employment among Supplemental Security Income (SSI) enrollees through increased use of existing SSI work incentives. The MIG Advisory Council is addressing these goals and was instrumental in getting a Health Coverage for Workers with Disabilities appropriation bill passed in 2005. The Health Coverage for Workers with Disabilities will be implemented in July of 2007.

In 2005, a new CAP-MR/DD waiver was implemented with the goals of promoting the ability of individuals to live in communities of their choice; promoting community transitions for individuals living in State developmental centers by lifting the individual fiscal limit; and enhancing ease of service delivery through service definitions that are flexible and support the natural flow of the person's day. As noted above, the DMH/DD/SAS has developed, and will be

submitting, a “New Focus” Medicaid waiver that will include self-directed supports options. In March 2006, the State implemented a new service package of Medicaid-funded mental health, developmental disabilities and substance abuse services, focusing on best and evidence-based practices.

5. Current expenditures on long-term and community-based care as well as other measures such as the number of institutional beds versus community placements

For state fiscal year 2005/2006, DVR’s ILRP expended \$10,269,092 for community-based services statewide, enabling 5,104 people to live more independently, and 411 people to transition from nursing facilities. The ILRP does not support any institutional beds. The ILRP provides some individuals with severe disabilities an alternative to institutionalization where possible and provides services/support to improve functioning in one’s family, home and community and/or develop the skills necessary for work.

In the State psychiatric hospitals funded by Medicaid (for individuals below age 21 or 65 and above), there are 126 beds for children and adolescents at a cost of \$11,224,929 in SFY 2005-6. Private psychiatric hospitals provided services to 955 children/youth with MH diagnoses and two with DD diagnoses at a cost of \$5,476,833. By contrast, 64,349 children/youth with MH diagnoses and 6,512 with DD diagnoses received community-based (including community residential) services at a cost of \$533,655,221, in addition to those receiving CAP-MRDD waiver services. In SFY 2006, NC spent \$146,884,509 on 3,962 children, an average of \$37,073 per child in Level III group homes. In addition to the four State psychiatric hospitals, the NC Special Care Center served 248 individuals at the skilled or intermediate nursing level of care who also have mental illness. Medicaid funding for those individuals in SFY 2005-6 was \$13,948,852. One hundred forty-four individuals with mental health diagnoses ages 65+ received services in the State psychiatric hospitals, while three

received services in private psychiatric hospitals. By contrast, 12,927 individuals with MH diagnoses in this same age range received community-based services, and 238 with DD in this age range received community-based services at a cost of \$13,429,580, in addition to those receiving waiver services.

As of June 2006, 1,605 individuals were living in the State developmental centers, including the respite services and specialty programs. The authorized budget as of August 31, 2006 was \$255,250,840. Long-term care (LTC) services included institutional care (nursing facility and hospital long-term care and home- and community-based) home health, durable medical equipment, community alternative programs, home infusion therapy, hospice, and personal care services. Total LTC expenditures in SFY 2005 were \$2.7 billion, approximately 33% of the Medicaid budget. In SFY 2005, a total of 43,051 received care in nursing facilities at a cost of approximately \$1.08 billion.

In SFY 2005, the State recorded the following HCBS enrollments and expenditures: home health – total served was 38,825 recipients, annual cost of \$110 million; hospice - 4,804 recipients, \$42 million; home infusion therapy - 2,271 recipients, \$7 million; private duty nursing - 371 recipients, \$44 million; personal care services - total served was 50,087 recipients, \$277 million; and HIV case management - 2,614 recipients, \$8 million. Community Alternative Programs MR/DD recorded the following: monthly average of 5,989 recipients, annual cost of \$266 million (the enrollees will go to over 9,000 in 2006 through budgetary amendments as a part of the current state rebalancing efforts); CAP/Children - 762 recipients, annual cost of \$26 million; CAP/DA and Cap Choice- total recipients 13,620, annual cost \$226 million and ACH Basic Personal Care, in SFY 2005 is \$136.7 million spent on 28,000 recipients and ACH - Enhanced Personal Care in SFY 2005 is \$9.4 million spent on 5,000 recipients.

6. A description of any current efforts to provide individuals with opportunities to self-direct their services and supports

The “New Focus Waiver,” currently under review prior to submission to CMS, will provide opportunities statewide for up to 600 individuals with developmental disabilities to direct their own services over a three-year period. Piedmont LME implemented a combination (b) (c) waiver with self-directed components in 2005. This waiver is available to residents of four counties in the state. NC received both a CPASS and a Real Choice Systems Change grant in recent years to assist with developing consumer-directed options for individuals and four projects were developed to pilot consumer direction. Two of the projects used the CAP-Choice waiver as the foundation, and one of those projects also piloted the use of consumer-directed options under the NC Home and Community-Based Block Grant, a combination of federal and state funding. Another project was used to create a fiscal intermediary and the final one developed a peer support program to assist individuals in transitions from state psychiatric hospitals.

NC has developed a pilot consumer self-directed CAP/DA program called CAP/Choice. This program will be implemented statewide over the next two years. NC contracted for an Institutional Bias Study conducted by independent third party. This study identified a number of biases that favor institutional over community services. The Department of Health and Human Services is establishing a committee to develop recommendations to eliminate these biases. NC DMA recently received a Systems Transformation Grant and that will provide additional funds to restructure HCBS, including Internet-based assessment and plan of care tools, chronic disease self-management programs, and interactive case management systems.

DVRS policy requires that all vocational rehabilitation and independent living services be developed and carried out in a manner consistent with respect for individual dignity, personal

responsibility, self-determination, and be based on the inclusion, integration, and informed choice and full participation of the individual with a disability or the individual's representative. Informed choice is an ongoing process and partnership which provides the individual the opportunity to make decisions and selections regarding their options and methods to secure DVRS services. DVRS provides information or assists with getting information necessary for the individual to make informed decisions and to self-direct throughout the rehabilitation process. ILRP personal assistance services are self-directed and consumer-controlled in that the participant is the employer of the assistant and carries out all employer duties.

7. An overall description of any institutional diversion and/or transitions programs or processes that are currently in operation

North Carolina, like many states, historically had a continuum of care approach. Resources were largely allocated according to where one lived, linking housing and supports. In recent years, through multiple efforts, we have increasingly rebalanced our system, seeking to minimize the use of facilities and to move toward a self-directed system model. We are committed to long term, sustainable change.

DHHS is implementing a CMS *Rebalancing Initiative Grant* to prevent inappropriate or undesired placement of adults with significant physical disabilities in nursing facilities. The initiative focuses on working-age and older, Medicaid-eligible adults with significant physical disabilities who are at risk of inappropriate placement in a nursing facility. The Draft Plan covers: 1) access to community-based, long-term supports; 2) financing of programs and services; 3) services that are self-directed, including supports for transition from institutional to community-based supports; and 4) quality management mechanisms. In year two, the project will pilot recommendations of the Draft Plan in Forsyth and Surry counties, in collaboration with the Aging and Disability Resource Centers (ADRCs). Plan refinements will be based on

evidence from the pilot and data gathered from people with disabilities and other stakeholders. During year three, the Plan will be modified and finalized and a plan for statewide implementation produced.

The Division of MH/DD/SAS completes Olmstead assessments of individuals who have been hospitalized in State psychiatric hospitals for 60 days or more. Each assessment consists of a standardized level of care assessment and individualized service plan developed by the individual, hospital treatment team, Local Management Entity staff and, if applicable, the guardian. The outcome of each assessment is a projection of the services and supports the individual will need to transition to community care and serves as a tool for discharge planning. In aggregate, these Olmstead reports help educate the local management entity staff about the planning process required to affect the individual's reintegration into the community.

An important strategy for diverting individuals from the State psychiatric hospitals is the use of Geriatric Mental Health Specialty teams to provide consultation in nursing facilities and adult care homes. Funded through State dollars, there are 20 teams providing consultation and technical assistance throughout the state. Total allocations in SFY 05-06 for these teams were \$3,035,521. This will be increased by \$735,000 in SFY 06-07 to fund an additional position for six months and the increase will be annualized to \$1,470,000 in 07-08. Senate Bill 859, also known as the Diversion Law, prohibits the admission of an individual who has mental retardation, or where there is a reasonable suspicion of such, to any of the NC State psychiatric hospitals unless the individual meets specific criteria that includes: 1) Not Guilty By Reason of Insanity; 2) has committed a violent offense and been deemed by the court as incapable of proceeding to trial; 3) extremely dangerous to others; and 4) has multiple disorders and is either

medically fragile or deaf. Specific processes are in place for exceptions to be made if necessary in crisis situations.

Admissions committees at the State developmental centers determine the appropriateness of the placement and determine whether all community options have been exhausted before admission. LMEs are required to attend annual plan meetings for individuals residing in the centers and the centers send quarterly lists to the LMEs of individuals and their guardians who are interested in moving to the community. Individuals in the State developmental centers and their guardians are specifically provided an opportunity to state their desire to move to community settings at each annual individual planning meeting. To date, guardians of 182 residents have indicated they are in favor of, or are not opposed to, exploring community options.

Nursing facility transitions are being done by the DVR's Independent Living Rehabilitation regional offices and the regional Centers for Independent Living. There is a need to coordinate these programs and to develop more Medicaid-funded services and supports. Currently there are no diversion programs, but the NC Medicaid Uniform Screening Program will be designed to identify options for each recipient requiring nursing facility level of care, including HCBS. Further, the process will identify individuals who only require short, nursing facility stays (90 days or fewer) and make follow-up contact with them before discharge to plan for HCBS placement.

8. An analysis of what shortcomings – “gaps” in the system the State intends to address in the demonstration program

System gaps related to transitioning the target population from nursing facilities to community care include the need for: 1) better coordination at the state level; 2) more effective collaboration and coordination at the local level; 3) more safe, affordable, and accessible

housing; 3) easier access to CAP/DA; 4) an expansion of the availability of consumer self-directed programs statewide (CAP/Choice); 5) more effective methods to identify individuals in nursing facilities who desire to transition to community care; 6) additional community support services, including payment for one-time transition expenses, case management, independent living training, peer counseling, and transportation services; 7) shared, consistent reporting mechanisms for nursing facility transitions and mechanisms for quality monitoring and evaluation; and 8) ongoing education and information sessions for hospital discharge planners, nursing facility staff, local health and human service agency staff, and health care providers.

Within the DMH/DD/SAS, the following are identified as gaps: 1) Although funding has been allocated to LMEs to facilitate the community capacity expansion process for crisis-related services, the timeline for closure of adult admissions beds in State psychiatric facilities has been delayed; 2) increased admissions and census on the Adult Admissions Units are requiring the DMHDDSAS to revisit the current downsizing model; 3) there have been 43 regular admissions to the State developmental centers, many of which were from licensed community residential settings, including private ICF-MR group homes; 4) most admissions were due to behavioral and/or medical needs not adequately addressed in the individual's community setting; 5) The capacity, and quantity of providers to meet the behavioral and/or medical needs of persons living at the developmental centers has not been sufficiently demonstrated or documented in many parts of the state, causing concerns for guardians who would otherwise be in favor of community placement; 6) the CAP-MRDD waiver has some limitations on services that make it difficult to create a service package that can adequately support individuals leaving the centers; 7) many LMEs assert that there are insufficient dollars in the budget to support both people in the community and people coming out of the developmental centers; 8) individuals in the

developmental centers who are receiving appropriate, high quality services are often deemed a lower priority for limited, community funding than people in the community who have significant needs that have not been fully addressed; 9) large case manager caseloads, turnover, and confusion have resulted from changes associated with the shift from LME-operated case management to private provider case management; and 10) due to federal regulations there is not an effective working relationship because between the LME system and the private ICF-MR system.

Another major gap in the system are limitations in community services for children with significant mental health needs, including the need for sufficient crisis services, respite, and small therapeutic homes. This results in the relocation of children with mental health needs to Child and Adolescent Group Homes, typically far away from their home communities and families.

Within the DVR system, the following gaps have been identified: 1) the current CAP-DA waiver focuses on the medical needs of elderly people largely to the exclusion of younger adults with significant physical disabilities, suggesting the need for a “non-elderly disability” waiver; 2) there is a need for Medicaid-funded rehabilitation engineers who can to assess and recommend home and work modifications and for recreational therapists to orient the individual to their community resources; 3) the need by all disability groups for accessible, safe, and affordable transportation and housing; and 4) a well-trained and supervised community workforce.

9. An analysis of what collaboration among the various programs in the State is necessary to ensure the success of the demonstration program

The Department of Health and Humans Services, and its relevant Divisions will collaborate in this process. These agencies include the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services,

Division of Aging and Adult Services, Services for the Blind, Office of Citizen Services, Services for Deaf and Hard of Hearing, Council on Developmental Disabilities, Facility Services, Information Resource Management, Office of Policy and Planning, Rural Health, Social Services, and Vocational Rehabilitation. The Divisions also will work with formally constituted consumer advocate groups, including the Senior Tar Heel Legislature, the Governor’s Advisory Council on Aging, State Consumer and Family Advisory Committee (CFAC), the Statewide Independent Living Council (SILC,) DHHS – Housing, North Carolina Housing Finance Agency (NCHFA), and ad hoc groups such as “Connect the Dots” (CTD). Collaborations with faith-based organizations, and other governmental organizations, including the Displacement Prevention Program (DPP), Citizens Together Advocacy Group (CTA), the NC Department of Transportation and its Elderly, and Disabled Transportation Assistance Program will be continued and expanded during the pre-implementation phase. Further, Regional AAAs, Lead Regional Organizations (administer CAP/DA), and local agencies involved in housing, transportation, social services, and the like will be included in this collaboration, in addition to individual ICF/MR providers and formally constituted provider organizations such as The Provider Association, The NC Providers Council, and the Developmental Disabilities Facilities Association, the NC Alliance for the Mentally Ill, NC TASH, Mental Health Consumers Organization, Association of Self-Advocates of NC, NC Disability Action Network, NC Health Care Facilities Association, Home Care and Hospice Association, and others. All DHHS agencies will partner with the consumer groups and individuals involved with the Demonstration, both formally and informally.

10. What systems, procedures and policies are in place to monitor and address, (i.e., track, identify, and correct) deficiencies related to QA for eligible individuals receiving Medicaid HCBS and provide for continuous quality improvement in such services

The Division of MH/DD/SAS has implemented a number of initiatives over the past several years to create a foundation for quality management to ensure the effective statewide delivery of quality services. These efforts include: 1) expansion of the Division's primary data information systems and the creation of a Web-based query capacity; 2) the creation of a Quality Management Team that is responsible for developing systems and mechanisms to track, evaluate, and improve the quality of the service system; 3) the design and implementation of a comprehensive approach to quality management based on the Quality Framework for Home and Community-Based Services promoted by the federal Centers for Medicare and Medicaid Services (CMS); 4) the implementation of a performance-based contract with local management entities (LMEs) that includes thirty standardized measures of performance that are tracked and published quarterly; 5) implementation of a comprehensive strategy for local monitoring of service providers in coordination with the Division of Facility Services (DFS); 6) implementation of a statewide incident and complaint reporting and response systems that links to state and local quality assurance and improvement activities; 7) expansion of the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS), to collect information on each consumer's mental health and substance abuse service needs, services received, service outcomes and perceptions of care in keeping with the National Outcomes Measures (NOMS) being developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA); 8) Incorporation of the quality management system within the HCBS waiver; and 9) monitoring individuals discharged from the State psychiatric hospitals through the downsizing/ Olmstead process.

The Division of Medical Assistance provides a wide variety of quality and utilization management activities for nursing facilities and waiver programs. For example, CAP/DA: 1)

conducts regular reviews of the 96 local lead agencies that administer the CAP/DA program including on-site audits; 2) reviews records and documentation randomly selected CAP/DA recipients served through the lead agency via local case managers; and 3) provides a report on all service areas to the lead agency through a contract with the Carolinas Center for Medical Excellence, the federal Quality Improvement Organization. Specific QA services include: 1) collecting and tracking key, recipient outcome measures; 2) utilizing a Web-based quality and utilization improvement reporting system used by local case managers to document CAP/DA assessments and plans of care; 3) having CCME registered nurses conduct clinical reviews of CAP/DA assessments that do not meet nursing facility level of care criteria; 4) quarterly training throughout the state for system users; 5) requiring lead agencies to report on a prescribed form the actions they are taking for individuals found not to meet Nursing Facility Level of Care (LOC) through CCME review activities, and; 6) engaging CAP/DA waiver consultants in discussion of the proposed actions with the local case managers, leading either to approving actions or suggesting alternatives.

DVRS has in place several systems to monitor and address deficiencies related to quality assurance for eligible individuals. These include: 1) providing training through Quality Development Specialists (QDS) on procedures and policies, casework, and conducting casework audits; 2) conducting financial audits using the DVR's accountants to ensure the lawful use of and accounting for case service dollars; 3) upon closure or continuation of post-outcome services, conducting follow-up visits and contacts with consumers; and 4) obtaining feedback and input on services through consumer surveys and the Division's appeal process.

11. What State legislative and other changes are necessary (and accompanying timelines) to implement the MFP demonstration

There are numerous issues that require legislative action or changes in State Rules to be accomplished before January 1, 2008. A study on barriers to consumer self direction conducted by The Human Services Research Institute in 2004 recommended: 1) the inclusion of statutory/regulatory language that specifically permits and encourages self-direction and individual budgeting; 2) modification of the NC Workers' Compensation Act if necessary to accommodate individually hired workers; 3) requiring criminal background checks for people employed in small facilities or individual homes; 4) changing the definition of "facility" to separate issues concerning licensure of a building from program concerns about quality assurance; and; 5) expanding rules to address guardianship issues, especially post-institutionalization, advance directives, fiscal intermediaries, health care proxies, and other similar tools.

Legislative changes are required to address a number of issues relating to the provision of HCBS, including: 1) enrollment caps that limit the number of individuals who can access care in the community; 2) budget caps that limit access to CAP/DA for individuals with the greatest (i.e., most expensive) service needs; and 3) reconfiguring the allocation of county CAP/DA slots that may place an individual on a long waiting list in one county, while other counties have unused slots.

Medicaid policy and administrative changes are required to address prioritization of need for those on CAP/DA wait lists and to improve a prior approval process that often delays appropriate care in the community. There is also a need to convene a state level committee to develop a strategic plan for establishing a "Non-elderly Disability" CAP waiver for adults with significant physical disabilities. If this strategy is employed, funding will be required from the NC General Assembly. In addition, the Institutional Bias study identified issues that are being

studied by DHHS, such as the medically needy requirements for Medicaid allowing little money for persons to pay for living expenses in the community and differences in the spousal impoverishment rule between community care and institutional care. Addressing these issues will require legislative action.

Clearly additional rebalancing is needed to further our goal of implementing a person centered, self-directed system of care and supports. Participation in the Demonstration will assist the state to rebalance its long-term care delivery system in a more comprehensive and timely manner.

PART 2: DEMONSTRATION DESIGN

1. The Pre-Implementation Phase, including the interventions and length of time expected to put in place the infrastructure needed (including legislation) to expand their community-based long-term care capacity and sustain the demonstration participants in community-based care settings

Upon approval from CMS, the State of North Carolina's Department of Health and Human Services (DHHS) and its respective Divisions will implement a one-year, pre-implementation planning phase to begin on January 1 and end on December 31, 2007. During this period, DMA and its collaborators will develop a Rebalancing Blueprint that will provide a detailed plan for restructuring and rebalancing its Medicaid LTC delivery system. While the state has a good foundation, much infrastructure work must be done to assure success. Tara Larson, DMA's Assistant Division Director for Clinical Policy and Programs will direct the project until a permanent director is appointed. The following agencies and organizations will be actively involved in this collaborative project: The NC Divisions of Medical Assistance (DMA, Lead Agency), Vocational Rehabilitation (DVR, Lead partner) and Mental Health Developmental Disabilities and Substance Abuse (DMH/DD/SAS, Lead Partner); thirty Local Mental Health Management Entities; Lead Regional Organizations (that administer CAP/DA); Regional VR Independent Living Offices; DHHS – Housing; Regional Area Aging Offices; NC Council on Developmental Disabilities; NC Housing Finance Agency; and the five Centers for Independent Living (CILs). (Please see Part 1 for complete partners list.)

Consumers will make up 60% of the MFP Executive Committee, which will be the steering committee for subcommittees. Collectively, these committees will address such key issues as establishing policy and procedures for MFP implementation and ensuring consumer involvement. We will actively involve a wide range and variety of stakeholders, including local, grassroots advocacy and faith-based organizations; and local agencies and government units.

Consumer representation, from each of the primary participant groups, appointed to these committees will receive the supports essential to ensuring their full participation.

During the pre-implementation phase, the Project Director will establish appropriate committees and sub-committees, responsive to the CMS Elements. These committees will address the critical issues associated with performance benchmarks necessary to the successful community transition for each individual participant. Committee functions are delineated throughout the later discussion of the applicable CMS elements. To assure success, the committee chairpersons will meet regularly with the Project Director within the MFP Executive Committee to establish the detailed MFP Vision/Values; provide public relations, outreach, and community education; coordinate development and implementation; remove specific and systemic obstacles and barriers; create a climate “that works,” monitor progress; and maintain an on-time schedule for work completion, during both the pre-implementation and implementation phase. The committee shall also be responsible for ensuring the system rebalancing occurs in favor of home and community-based services, eliminating institutional biases, and building sustainable, person-centered supports.

The MFP Executive Committee and content subcommittees will work closely with the DHHS “Connect the Dots” long-term services and supports initiative and the Systems Transformation Grant. These efforts are creating a seamless system of access, developing supports for person-centered planning, self-direction and self-management, and creating necessary IT infrastructures.

We will utilize demonstrated, contemporary, best and emerging practices. We will develop an outcomes-focused approach with performance benchmarks for the project overall, and for each individual participant. A robust, person-centered approach, built on self-determination

principles and practices, will assure choice and the achievement of outcomes valued by consumers. This will include a comprehensive, person-centered planning process for each individual and, when desired by the individual, self-directed options.

All of the above may require revisions, modifications, or additional waiver service definitions, as well as alternative ways of defining “units” of service, or other efforts directed toward minimizing restrictions (space precludes further explanation here).

Using existing research, we will develop and conduct strengths-based, needs assessments and connect these to budgetary allocations. The approach will go far to ensure that participants have their needs, preferences, and desires addressed within appropriate, individualized budgetary allocations. Community transitions must meet all of the individually identified needs, within a quality framework inclusive of health and safety, improved personal satisfaction, and positive personal outcomes. We also will develop contingency funds to support people with acute, emergency, or unplanned needs that are beyond the budgetary allocation system. We hope these approaches will reduce silo funding and programming.

Other barriers and obstacles to community transition for each participating individual will be reduced or eliminated through a variety of means that include extensive retraining for provider agencies, case managers, and all other personnel involved in this new way of “doing business.” North Carolina has successfully used this approach with previous elder transition grants, and thus we intend to replicate that success. We will develop Community Support Teams inclusive of “Community Guides” to facilitate community connections and behavior and crisis support personnel. Likewise, Regional Support Teams will be developed, including existing personnel working with community providers (e.g., dentists, physicians, and other health care professionals), to build the community capacity and skills to support transitioned participants.

As necessary, we will pilot modifications to residential licensure requirements. As it is critical to success that the provider community embraces system transformation, we will consider implementation of a variety of incentives for providers to reduce or eliminate financial and programmatic disincentives and other inefficiencies.

The Project Director shall establish an MFP Policy and Legislative Committee to address the **LEGISLATIVE AND INFRASTRUCTURE CHANGES**. Legislative changes may be required to: 1) authorize changes in the way institutional and HCBS providers are compensated (such as MFP budget transfers); 2) authorize changes in Medicaid financial eligibility requirements for Medicaid and HCBS services, especially to eliminate known institutional biases; 3) alter how CAP services are financed and delivered; 4) secure additional state appropriations for HCBS; and 5) obtain authorization for Medicaid clinical coverage policy changes needed to change the way CAP/DA wait lists are managed and to implement changes in program administration.

The CAP/DA Waiver will need to be amended to implement new transition services, such as new case management services, payment of one-time transition costs, etc. and to implement consumer self-directed services statewide. It is anticipated that the CAP-MRDD Waiver may require similar amendments (see below).

Focus groups held for the Medicaid Rebalancing Grant identified the need for a “Non-Elderly Disability” or similar waiver to better meet the needs of adults with significant physical disabilities than the current CAP-DA waiver. There is also a need to implement CAP-Choice statewide. There is also a need to simplify and increase efficiency regarding eligibility determinations, needs assessments, documentation, billing, etc. A review of financial eligibility for Medicaid and “work exclusions” must be conducted as well. The State Medicaid Plan will

require modification to amend the Community Supports definition for consumers who have been in the State Psychiatric Hospitals for one or more years.

The 2008 CAP-MR/DD waiver renewal application will include a richer array of services for individuals with higher levels of need. These services include: 1) new service definitions for Behavioral Consultation and Supports; 2) an enhanced residential definition and rate for individuals with the highest behavioral and/or medical needs; 3) payment for one-time transition costs (for moving, transportation, utility and rent deposits, housing modifications, etc.); 4) an enhanced service definition for Crisis Supports (consistent with best practice crisis models); 5) an amended Home and Community Supports service definition to include assistance to the individual to access health care; 6) a decrease to the limits on the hours for Specialized Consultation services, and; 7) implementation of self-directed waivers by 2008. In addition, an individual resource allocation process will be in early stages of utilization in the supports and the “New Focus” self-direction waiver. That process will be assessed over time for the possibility for broader use.

A State Plan Amendment for Therapeutic Foster Care (to be renamed) for children with mental health needs will be required. Other State Medicaid options for stabilizing the Medicaid platform for individuals not eligible for SSI, certain disregards to income as allowed, and the TEFRA 134 and Katie Beckett options for children whose family incomes would otherwise be too high will be explored.

There may be additional legislative recommendations that are made during this phase to both specifically permit and encourage self-directed options, in response to a grass-roots advocacy efforts associated with the MFP fund release and statutory/regulatory analyses already conducted.

We are addressing the following eleven elements for the pre-implementation phase through an Executive Committee and nine, content-specific committees, detailed below.

Element 1: Trusted, Visible, and Reliable System for Accessing Information and Services

The true measure of a responsive service system is not measured by how well it looks on paper, but rather the extent to which people with disabilities and their families are able to access the system in a user-friendly, flexible, and real time manner. Therefore, it is critical that the service system provide functional, responsive, and customer-friendly ways to access the supports required. In North Carolina, the MHDDSAS system has a “no wrong door” access policy that enables individuals to contact the LME Access Unit or through direct contact with a provider agency. The person receives a standardized screening and the person is registered in the system.

North Carolina’s Family Support Network presently holds a grant from the US ADD, “Strengthening Families with Children Who Have Developmental Disabilities: One Stop for Family Support.” The project goals include “the establishment of a model of service coordination that involves parents as service coordinators for other families to pilot an information referral system to serve as a single point of entry for families and to facilitate state-wide replication of the model.” Further, NC CareLink is a web-based information and referral system that includes information about all services and supports statewide and is currently in use.

In 2004 the Division of Aging and Adult Services (DAAS) received a grant from the US Administration on Aging to develop trusted, visible one-stop service centers. DAAS has implemented two Aging and Disability Resource Centers (ADRC's) and will increase the number of ADRCs to at least six over the next five years (with support from the Systems Transformation Grant). The goal of ADRC’s is to empower individuals to make informed choices and to

streamline access to long-term supports including in-home, community-based, and other programs that are designed to support individuals with disabilities.

The information regarding our system transition will be disseminated by the MFP Project Director, other state agencies, and stakeholders. A committee identified under Element 2 will also address information needs and dissemination.

Element 2: Screening, Identifying, and Assessing Persons Who Are Candidates for Transitioning to the Community

An MFP Information, Referral, and Selection Committee will be appointed by the Project Director to oversee this critical selection process and to establish policies and procedures that are “user friendly” and use methods that are culturally and disability sensitive. The Committee will develop mechanisms, across all disability groups, to inform consumers and their representatives and families of the MFP program; assist them in decision-making; and ensure a fair and equitable selection process for all individuals wishing to participate. Work with stakeholders as we designed the MFP response pinpointed significant problems that several groups currently have accessing community care options. These include veterans with non-service related needs and their spouses, those who have multiple diagnoses, and people who have traumatic brain injuries. We will make significant effort to reach these populations. Our broad approach will ensure interested individuals and their families have fair access for involvement in this project. This approach will include: 1) inquiries by residents, family members, guardians, and advocates; 2) referrals by hospital discharge planners, facility staff, case managers, and transition coordinators of facilities and programs; 3) nursing facility visits by regional nursing facility ombudsmen and CIL staff; 4) use of Minimum Data Set (MDS) data; 5) referrals made by community organizations, provider organizations and related stakeholders, and 6) access via the NC Care Link and NC Self Care web systems which help families and individuals make

decisions about transitioning and managing their own illness/care at home.

DMHDDSAS will work with DMA to target individuals transitioning from nursing facilities who have a diagnosis of mental illness, developmental disabilities, or traumatic brain injury, and to secure CAP-DA waiver slots to those individuals. DMHDDSAS will also work with DMA to dedicate some CAP-DA waiver slots to individuals planning to leave the NC Special Care Center and the geriatric units of the State psychiatric hospitals. A total of 182 individuals (with their guardians) at the State developmental centers are currently identified as not opposed to or desiring movement to the community. Strategies and procedures for targeting individuals in ICFs/MR and children in Medicaid-funded Level 3 mental health group homes will be determined during the pre-implementation stage of the grant.

We will utilize state-of-the-art assessment instruments, such as the Supports Intensity Scale (SIS) developed by the American Association on Intellectual and Developmental Disabilities (AAIDD, formerly, AAMR). We propose to explore adapting the SIS for use within the MFP project, and if possible, for all disability groups and individuals who are elderly. The SIS provides a direct measure of support needs that can be aggregated across comparable groups and agencies, such that it has important implications as a "piece of the puzzle" for individualized resource allocation. We will utilize the SIS for assessing needs, in the context of the consumer-directed component, both in relation to person-centered planning and individualized resource allocation relative to personal budgets. We will also utilize relevant experts, such as Dr. Marc Tasse', one of the primary developers of the SIS, and HSRI's Gary Smith, as appropriate.

Element 3: Mechanisms for Flexible Financing

It is our intention to develop an individual budgeting approach, based on the needs assessment conducted with the SIS and/or other applicable instruments. It is our intention to

assign budgetary allocations based on intensity of need so that participants are given resource allocations in a fair and equitable manner. We will utilize work from other states that have successfully adopted a reliable, valid needs assessment/individual budgeting system within one or more applicable, HCBS waivers. We also intend to incorporate variances for the differences in costs between different geographic areas of North Carolina. Finally, our intent is that the system be explored under both a provider-directed service and participant-directed system, allowing variances for fiscal intermediaries and support brokers under the later system.

Thus, the Project Director shall also establish a committee on the Development and Implementation of a Cross-Disability Needs Assessment/Individual Budgeting System. It is our intention to have the initial system operational by December 31, 2007. Until we are confident of this process, global budget strategies will continue to be employed based on the approximate current level of funding for each participant within the institutional setting in accordance with a formula established by DMA on a pro rata basis.

Element 4: Available and Accessible Supportive Services

The project director will appoint members to the MFP Specialized Service and Support Development Committee to address the availability, accessibility, and, when necessary, the development of supportive services across North Carolina for this project including housing, transition services, and transportation; self-directed services; guardianship and legal services; provider capacity and community building; and HCBS waiver services and additional services and supports needed. We plan to transform our system so that the type of residence in which a person lives does not determine the types, nor level, of support offered. We will begin with the premise that we need to find every adult MFP participant a home where they have the option to lease, purchase, or control the housing. Our transformed system will offer flexible, wraparound

supports, available for individuals regardless of disability or community setting. We envision a unified effort across systems and divisions and desire to make this plan, first, affordable and, second, as flexible as possible.

We believe that the MFP grant will propel this effort forward. Our stakeholders have consistently told us that this is the system that they envision and the future that they want. It is our job to build the system where flexible, personalized, wraparound supports make this possible.

We must reiterate that we are committed to creating a template for broad, system transformation through our rebalancing efforts. For the minimum of 1045 people that will be part of our efforts, it is our intention that once a bed is vacated, it will not be utilized again for a person with a disability. We will close the 520 beds for the individuals leaving Level 3 Children's group homes and the 225 people leaving ICF/MR beds. For the 300 people leaving nursing facilities, we will ensure that we do not backfill these beds with another person with a disability.

Element 5: Community Workforce

Quality of services and at a broader level, a well-balanced system, requires an available and well-trained workforce, including direct support workers and informal caregivers. Because of significant shortages of new personnel, the NC human services system must establish a plan of action to create community workforce incentives that ensure both provider agencies and direct support professionals are available to meet the needs of transition participants.

We will use the work of Amy Hewitt, Ph.D., of the University of Minnesota's Institute on Community Integration in a NC Developmental Disabilities Council study, entitled “Quality Support: A Prospectus to Strengthen the Direct Support,” as guidance for our efforts, in concert

with the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services' current workforce planning efforts. The Project Director shall establish an MFP Community Workforce Development Committee to address the human resource needs within this MFP grant during the pre-implementation phase and to develop a plan of action for implementation that will address: provider agency and personnel needs; incentives to attract and retain competent personnel; transitional staffing from institutional facilities; provider training needs; the impact (e.g., need for training) of participant-directed services on family and paid care givers; variances between rural, urban, and limited English proficiency direct support professionals and their needs; human resource contingency plans; utilizing unpaid support personnel; and needed legislative actions to ensure that human service resource needs can be met in these community transitions.

Element 6: Self-Directed Services

We firmly believe that the true measure of quality in a system is the extent to which an individual, if he or she so desires, is able to self-direct the portions of his/her life that are important to him/her so that they can achieve the outcomes that matter to them. We are committed to implement principles and practices of self-determination and self-direction in this grant. We believe that person-centered planning is a necessary, but not sufficient, condition for true self-direction. It is our intent to make self-direction a reality, to the greatest extent possible, for the individuals targeted in our application. This includes establishing a true person-centered planning process coupled with an individual budget. We will also seek to develop independent support brokerage and fiscal intermediaries to further enhance the process. Our commitment is evident in our support for the NC Piedmont 1915(b) (c) waiver, which we see as a way to inform the state on implementation of self-directed supports. The Systems Transformation grant, just

received by NC from CMS, will be employed to assess and modify person-centered planning processes for persons who are aging, and to provide training in person-centered thinking and person-centered planning.

We have further demonstrated our commitment in several recent efforts. DMA piloted a program called “CAP/Choice” in two locations to incorporate consumer self-direction and consumer supports into the CAP/DA program. This program will be expanded statewide over the next 3-5 years. The “New Focus” waiver, with self-directed options, for individuals with MR/DD will also be submitted to CMS for approval. Training, technical assistance, and other supports will be provided for individuals and providers regarding self-directed services. The MFP Service and Support Development Committee will address development and implementation of self-directed services within this MFP grant.

Element 7: Transition Coordinators

The Project Director will establish an MFP Cross-Disability Transition Coordination Committee to make this MFP grant work successfully for at least 1,045 individuals who are elderly or have disabilities. The committee will address the following key transition coordination activities: identification of participants; principles/practices of self-determination and person-centered planning; provider and self-directed services; cross-disability technical assistance; community integration resources and informal/generic supports; unified cross disability support systems; conducting needs assessments; understanding services/support needs, including specialized services; applicable Medicaid HCBS waivers and the Medicaid State Plan; budgetary allocations connected to needs; development and implementation of services/supports; accessing effective service providers and broker services; placement and transition requirements; ongoing monitoring based on quality assurance and enhancement standards; adjusting person-

centered plans based on needs; monitoring for unusual and major unusual incidents and taking immediate steps for their remediation; coordinator staffing needs; case management issues including effective caseloads; and training needs, including planning and associated costs. We will build on the success of NC First in Families' Lifetime Connections, and national efforts such as ARC's "Roommates," as well as tap other advocacy and community organizations to support each individual's move to community.

Element 8: Quality Management

The most effective quality management system design is one that prevents problems before they occur. As we rebalance our system to include self-direction and a flexible supports, some of the problems with access, assessment, infrastructure, funding, and inefficiencies that are built into the current system will diminish. At the same time, we are aware that we need a strong system in place to assure quality every step of the way and to respond immediately when issues or problems present themselves.

It is then our intent to implement a system that is both preventative and responsive in nature as these issues arise. Health and safety issues will be addressed under the demonstration QA Program by building on current mechanisms and including new strategies designed to monitor, evaluate, and continuously improve participant access, participant-centered service planning and delivery, provider capacities and capabilities, participant safeguards, and participant outcomes at the individual and system levels. Additionally, DMHDDSAS received a grant from CMS to develop a system based on the HCBS quality framework and to use independent assessors for people transitioning. We will use this experience, as well as our recent work with HSRI's Val Bradley and the TAC's Steve Day, in developing the broader QM system. We want whenever possible to capitalize on the myriad, related projects, statewide, in our

rebalancing effort.

DMA hereby assures the following: 1) North Carolina conducts level of care need determinations consistent with the need for institutionalization; 2) Plans of Care are responsive to waiver participant needs; 3) qualified and competent providers serve Waiver participants; 4) Maintain the Health and Welfare of Waiver Participants; 5) State Medicaid Agency retains administrative authority over the waiver program; and 6) state provides financial accountability for the waiver. DMA will be responsible for quality management strategies related to the demonstration and for ensuring cooperation with national entities providing QA services and evaluations under CMS contract. An MFP Quality Management Committee will be appointed by the Project Director to address the delineation of a uniform and consistent Quality Management strategy across all participating agencies and systems.

We will also employ a cross-disability quality assessment, conducted not less than annually. It will measure, for all participants, the extent to which the following happen: Individuals believe they have choices; make major life decisions; make decisions about everyday matters, and identify their needs, wants, likes, and dislikes; have the best possible health and access to customary medical and dental services; know what to do in the event of threats to health and wellness; are comfortable where they live; have stable living arrangements; are safe and free from abuse, neglect, or exploitation; are part of the mainstream of community life and live, work and play in inclusive environments; individuals' experiences extend beyond the local community; individuals' lifestyles reflect their cultural preferences; express satisfaction with services and supports; make progress and/ or achieve stated life goals; have opportunities to establish relationships with friends, family and community members; exercise their rights and responsibilities; have access to advocates; are treated with dignity and respect; have their

confidentiality maintained and have services and supports that change as consumer wants, needs, and preferences change. These assessments shall be conducted by the participant's chosen service and support coordinator, and randomly by independent assessors. Feedback shall also be actively and routinely sought from the participant, participant selected representatives, and providers of services and supports. These assessments shall be a major evaluation mechanism for the MFP project and to determine if a successful transition has been made by each participant.

Element 9: Health Information Technology (HIT)

DMA will use its Medicaid Management Information System to capture the financial information on all MFP participants, the services and supports that they are receiving, applicable financial information, evaluation information including quality management assessments, and any other required information for successful reporting to CMS and for State of North Carolina purposes to advance this project during the project implementation phase and thereafter. DMA plans to have the new screening and assessment systems operational by September 2007.

During the pre-implementation phase, the Project Director will appoint an MFP Health Information Technology Committee to analyze system needs and make recommendations to DMA, especially as it relates to current HIT grants and transformation efforts. They will address the following issues: providing the HIT infrastructure to support single point of entry functions; identification, assessment and tracking of persons who have transitioned across service providers (while meeting Federal privacy and confidentiality requirements); supporting the flexible financing structure required to support the MFP principles; designing, developing, or modifying HIT applications to support person-centered processes; enabling consumer control over services and budgets; measuring of participant satisfaction and outcomes; building, or significantly

enhancing, existing data warehouses and/or data marts used to collect, store, analyze and report trends and comparisons on the quality and outcomes of services in non-institutionalized, long term care settings; and building systems that accommodate the business needs of organizations that provide services to the same target populations. These changes are essential for the success of the MFP grant.

Element 10: Cultural Competence

In addition to a relatively large American Indian and African-American populations, North Carolina has one of the fastest growing Hispanic populations in the country. We believe it critical to provide information and services in ways that are culturally sensitive and translated to a consumer's native language. Thus, DHHS will continue to offer and provide translated materials, signage, and other language assistance services, including bilingual staff and interpreter services, at no cost to each consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation. Friends and family will not be used to provide interpretation services (except on request of the consumer). DHHS will also make information and services available in culturally competent ways to individuals with disabilities such as visual impairment, intellectual and physical disabilities, and those who are deaf and hard of hearing.

Element 11: Interagency and Public/Private Collaboration

The response to this question was incorporated within the pre-implementation phase narrative.

2) The Implementation Phase

North Carolina is submitting this Money Follows the Person Rebalancing Demonstration Project (MFP) to assist 1) a minimum of three hundred (300) individuals from nursing facilities,

including those age 65 and older and individuals with physical disabilities such as orthopedic, spinal, and brain injury to community services under the CAP/DA waiver program, 2) a minimum of two hundred and twenty five (225) individuals from ICFs/MR to community services under waivers, and 3) a minimum of five hundred twenty (520) children currently living in congregate care facilities for mental diseases (Level 3 group homes) to home and community based services under applicable therapeutic home environments. We see the numbers as minimums and will strive to offer these transition opportunities to others in these facilities, based upon the success of our initiative and available resources. **We are committed to system transformation through our MFP rebalancing efforts. For the 1,045 people to be part of our efforts, we intend that once a bed is vacated, it will not be utilized again for a person with a disability. We will close the beds for the 520 individuals leaving Level III Children's group homes and the 225 people leaving ICF/MR beds. For the people leaving nursing facilities, we will ensure that we do not backfill these beds with another person with a disability. Because of our rapidly growing elderly population seeking services, we may, depending on need, utilize these beds for individuals who are non-disabled and elderly.**

A. Fundamentals of the Demonstration

a. Objectives

PROJECT PARTICIPANTS: There are over 43,000 individuals who are elderly or have physical disabilities residing in North Carolina nursing facilities. We plan to transition 300 of these individuals over the four-year, operational period of the Demonstration. There are a total of 4297 individuals residing in ICFs/MR. The recommended transition number of 225 is approximately 5% of the individuals residing in those facilities. Target numbers for individuals with traumatic brain injury and mental illness who will transition from the NC Special Care

Center and from the geriatric units in the State psychiatric hospitals are covered under Nursing Facility Transition numbers. The State also wants to focus on moving children from Level 3 mental health group homes into home and community services and/or therapeutic (foster) care homes. During SFY 05-06, 3,962 children were served in these settings and 1,584 of these children had a stay six months or longer. The State will target approximately 1/3 of the children who have been in these settings for six months or longer, with a total of not less than 520 to be transitioned over the four year grant implementation period.

The **SERVICES AND SUPPORTS UNDER WAIVERS AND OTHER HOME AND COMMUNITY BASED SERVICES** for all transitioning participants including elderly, individuals with developmental or physical disabilities and children with mental illness are identified in the answer under Question 7. The **DEMONSTRATION SITE** for this project will be the entire state of North Carolina. Individuals will be transitioned to **QUALIFIED RESIDENCES** including houses and apartments in the community located by the case management/transition staff assigned to assist these individuals, or to family homes or therapeutic (foster) homes for children. Individuals will also be transitioned into licensed group settings in which there are four or fewer unrelated individuals. Houses constructed under HUD programs and the QAP Program (provides tax incentives to builders who construct homes that are accessible to individuals with physical disabilities), and housing programs developed by local hospitals, rehabilitation centers, and other community programs will be utilized where available. Residences will be located as close to the individual's home community and family as possible, taking into account the needs for specialty mental health, developmental disability, or medical services. Apartment and utility deposits can be paid with one-time transition funds. Housing

provided to transitioned individuals will comply with the definition of “qualified residence” contained in Section 6071(b)(6) of the Deficit Reduction Act of 2005.

3) Anticipated requests for the waivers necessary to operate its program, including modifications to existing waivers and State plan amendments

This question is addressed under the section on legislative and infrastructure changes in the pre-implementation and implementation phases.

4) A description of methods that will be used by the state for each fiscal year to increase the dollar amount and percentage of expenditures for HCBS

NC has consistently been rebalancing its system by growing its home and community services in comparison to nursing facility expenditures. This demonstration will help continue that trend. Growth in services and expenditures for home and community services has been coupled with efforts to assure minimal growth and a reduction in the growth trend in the nursing home program.

Medicaid savings from the reductions will be transferred by the Division of Medical Assistance from the ICF/MR line in Medicaid to CAP-MR/DD for the provision of waiver services to individuals residing in the community. Closure of beds in the State Psychiatric hospitals and NC Special Care Center will generate funding to be re-directed to the community as additional recurring funds. Funding from Level 3 mental health group homes for children will be re-directed to existing Medicaid Rehabilitation Option home and community services.

Notably, NC Council on Developmental Disabilities contracted with Robin Cooper of the National Association of State Directors of Developmental Disabilities (NASDDDS) to produce a white paper for NC on successful deinstitutionalization strategies in other, similarly situated states. In that report, Ms. Cooper makes a number of recommendations regarding potential financing strategies that the state may elect to explore. Ms. Cooper is available to the state

during the pre-implementation phase of the grant to provide technical assistance on ICF/MR and HCBS financing strategies.

5) A list of proposed benchmarks to establish empirical measures to assess the States progress in rebalancing its long-term care system

Routinely using applicable data collection methods and systems, the Project Director shall establish the at least the following levels of benchmark information: 1) number of individuals leaving the State Developmental Centers; 2) number of individuals leaving the State Psychiatric Hospital Geriatric Units and the NC Special Care Center; 3) number of individuals leaving ICFs/MR; 4) number of individuals with mental illness, developmental disabilities, physical disabilities, traumatic brain injury, or who are elderly leaving nursing facilities; and 5) number of children leaving Medicaid-funded Level 3 Mental Health Group Homes. The data shall also establish other details concerning services and supports, location of the qualified residences, and an assessment of the success of the transition and the reasons for success or failure. Financial information shall include the cost of services and supports before and after transition for each individual for the last year of institutional care, versus the first year of transition services, documenting the continued funding of transition services after year one of community services, and documenting increases in State Medicaid support for home and community-based, long-term care services.

6) Processes for how the State intends to target and recruit individuals to transition from institutional settings to the community, including specific strategies and procedures.

This question was answered in Element 2. We see this process as opening a dialogue with families and individuals that began with our Olmstead efforts and intend to continue this under the grant. We envision community “coffees” where members from diverse advocacy groups (e.g., Association of Self-Advocates of NC, NC Council on DD, NC Disability Action Network,

NC TASH, Arc, Mental Retardation Association) meet with interested families and individuals to share transition success stories via informal conversations with policymakers and providers and others. The NC Council on Developmental Disabilities (NCCDD) has expressed interest in supporting these efforts and other MRP-related efforts with their *People Can't Wait* project (Dennis Harkins). The NC Nursing Facility Transition Program found that CEU training programs were an effective way to reach hospital discharge planners and nursing facility staff, and providers.

7) A description of the cross agency and cross service delivery system collaboration that will need to occur to ensure success of the State's transition program.

We are establishing, within the pre-implementation phase, nine committees to work on the pre-implementation and implementation activities. Committee membership will be collaborative, with members chosen from the applicable, participating state and local agencies, participant and participant representatives, and community organizations, including providers, advocates and related stakeholders. These collaborative committees, fully inclusive of primary stakeholders, are essential to the successful implementation of all aspects of the MFP grant for North Carolina.

NC has been developing a plan for long-term services and supports through a "Connect the Dots" process initiated by the DHHS Office of Long Term Care. This drafted plan includes strategies from numerous other grants, including the most recently acquired Systems Transformation Grant, as well as ideas being generated through the Money Follows the Person stakeholder meetings. The DHHS will continue to synchronize initiatives throughout the long-term services and supports system, including coordination of the MFP Executive Committee and nine subcommittees with the "Connect the Dots" and all related efforts.

As an example of the type of support received for MFP, NC Council on DD has offered to

tie several of their programs to the goals of MFP. The NC Housing Coalition (grant award in progress) has been asked to specifically address enhancement of efforts around the target populations for MFP. NCCDD has extended the grant to be contiguous with the five-year period of MFP. NCCDD is also supporting MFP with their *People Can't Wait* and *Workforce Development* projects (see above), Access to Primary Health Care and NC DAN projects. NCCDD supports the cross disability efforts whenever possible.

8) A description of the “qualified home and community-based program” which will be available to individuals following the year they receive services through the demonstration program.

The CAP/DA waiver will provide the basic services for transitioned individuals who are elderly or have physical disabilities on a priority basis to live in the community in qualified residences. Other services offered will include: assistance with housing, home and vehicle modifications, medical equipment, adaptive aids and technology, prosthetics, and orthotics; consumer-managed personal care services; assistance with employment, and; emergency response systems, independent living training, case management, counseling, transportation, home delivered meals, caregiver supports, and assistance with other one-time transition costs.

The CAP-MRDD waiver program will continue to be available to individuals being transitioned. This program already includes the following services: Adult Day Health, Augmentative Communication, Crisis Services, Day Supports, Home and Community Supports, Home Modifications, Individual/Caregiver Training and Education, Personal Care, Enhanced Personal Care, Personal Emergency Response, Residential Supports, Respite, Enhanced Respite, Institutional Respite, Non-institutional Nursing Respite, Specialized Consultative Services, Specialized Equipment and Supplies, Supported Employment, Transportation, and Vehicle

Adaptations. The state also funds Targeted Case Management services as NC awaits formal approval from CMS for the pending TCM State Plan Amendment.

Adults with mental health needs transitioning from Nursing Facilities, the State Psychiatric Hospitals and NC Special Care Center will receive services through the CAP/DA waiver, or through the array of services available through the State Medicaid Rehabilitation Option. Children will also be able to access a new therapeutic (foster) care service as well as an array of Medicaid wrap-around services.

9) A description of the State’s preliminary design of a proposed Quality Management Strategy

This preliminary design was answered in Element 8.

10) HCBS Preparedness, i.e., capacity and capability to provide HCB services before and after individuals are transitioned

Through a variety of Medicaid waivers that have been mentioned throughout Part 2, we have the core structure for delivery of services. We are addressing additional service, human resource and financial needs through a variety of committees such as the Individualized Needs Assessment Budgetary Allocations, Community Workforce, Quality Management and Service and Support Services, and Transition Coordination committees, as well as the oversight Executive Committee, which will have the responsibility for building HCBS capacity and capability of the system to meet the needs of a minimum of 1,045 individuals who are aged or who have disabilities. With money following the person, we will ensure that budgetary resources are available to meet the needs of each individual transitioning from institutional care to community life.

11) Delivery of necessary quality of care and quality of life services to individuals who are transitioned, such as medical, dental, family respite, social and community activities, work or volunteer activities, transportation, DME services, and other informal and formal supports

Please see the response under Element 8 and Question 9 and the Current Efforts Appendix.

12) An overall description of the State’s current quality management system, where the gaps are and what will be developed and implemented in order to ensure the health and safety of consumers who are transitioned and the continuous improvement of HCBS and institutional care

See Element 8 and Question 9. While we believe we have a comprehensive quality management system, there is always room for improvement and we will work for the continuous improvement of our quality management system, especially as it relates to this project. Further, NC is committed to relating the MFP quality framework to the overall quality framework for MH/DD/SAS reform and our overall efforts to rebalance our system.

13) A brief description of barriers that prevent the flexible use of Medicaid funds so that money follows the person and a summary of strategies the state will employ under the demonstration to eliminate those barriers

Identified barriers to flexible use of Medicaid funds include: 1) federal provision to reimburse Medicare Part D prescription drug co-pays for nursing facility residents, but not for HCBS waiver participants; 2) medically needy financial eligibility requirements leave little money for individuals to pay for living expenses if they prefer to remain in the community, while institutions provide room and board; 3) differences in spousal impoverishment rules can create hardships for families if a spouse prefers HCBS over institutional care; 4) enrollment and benefit dollar caps limit the number of individuals who can access care in the community; 5) no differentiation of need on CAP/DA wait lists; and 6) individuals may wait for waiver services in one county while other counties have unused waiver slots.

Our primary strategies have been discussed elsewhere within this proposal. These strategies will be fully developed during the Pre-implementation Phase.

14) An analysis of how the State will use or enhance existing IT systems to address identification of MFP participants including: Demographic information identifying Medicaid and MFP participation eligibility prior to transition

This question was answered within Element 9. There will be a committee on HIT that will address these important issues and to enable identification of MFP participants.

15) Financial information to be reported for services eligible for enhanced FMAP according to the MFP demonstration.

DMA will use its Medicaid Managed Information System to capture the financial information on all MFP participants, their services and supports, providers of these services, and other applicable financial information to complete all required reports

16) Assessment data to monitor quality of services post transition.

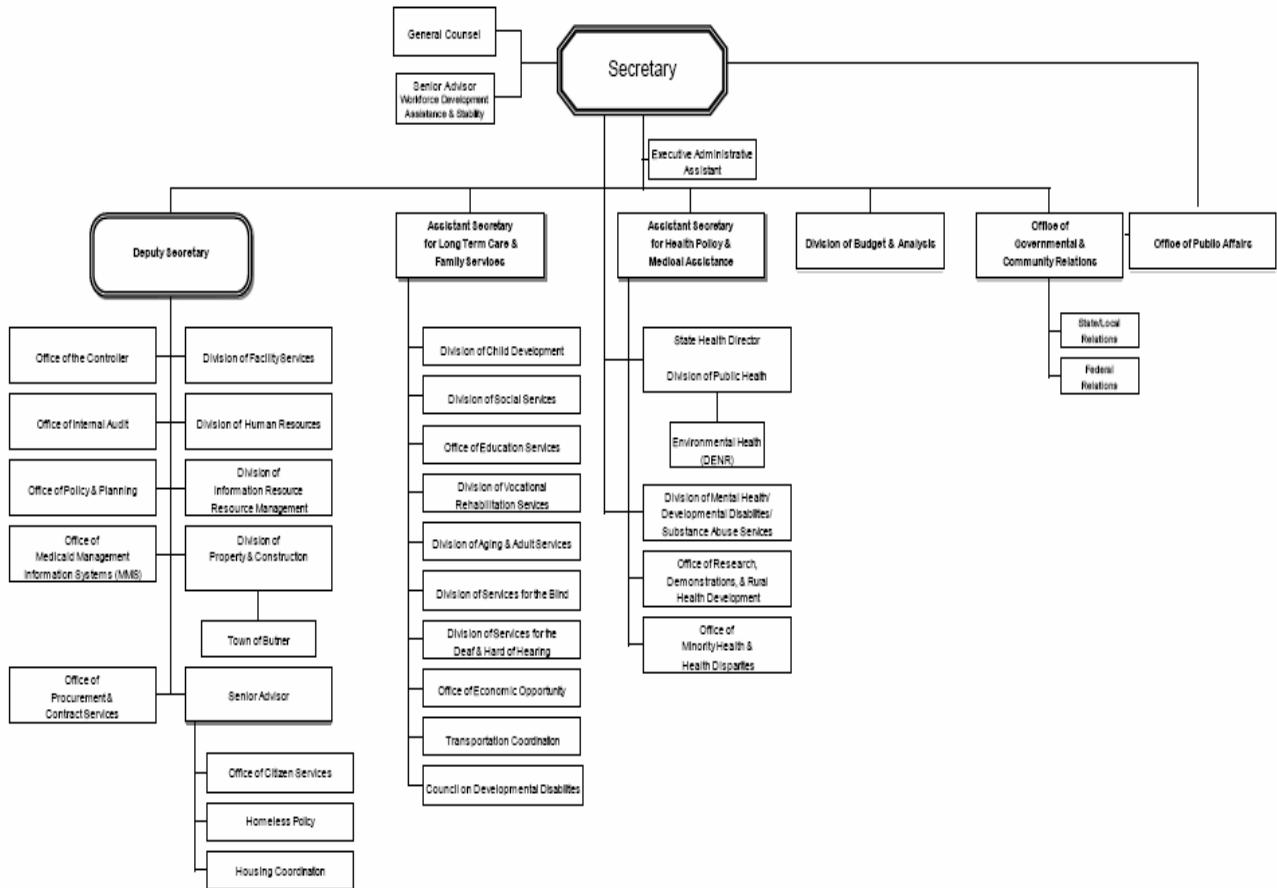
MIS reporting on CAP/DA quality of care and quality of service will be assessed through an Internet-based assessment and reporting system. Additional systems are under development.

PART 3: ORGANIZATIONAL STRUCTURE STAFFING PLAN AND PRELIMINARY BUDGET

Organizational Structure

The Division of Medical Assistance is the Single State Medicaid Agency for the State of North Carolina. The Division of Medical Assistance is part of the North Carolina Department of Health and Human Services, as depicted below.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
October 1, 2006



Staffing

The State will hire a staff of three individuals to manage the planning process for Funding Year 1, including a Project Director, a Mental Health Project Director, and an

Administrative Assistance. The Preliminary Budget includes personnel costs for the five-year Demonstration period. Other individuals with relevant experience will assist the project staff. Stakeholders will participate, as described in the Project Narrative.

Budget Narrative

The Preliminary Budget focuses on the number of individuals that can realistically be transitioned from institutions, including nursing facilities, ICFsMR, and Level III homes for children with mental illness. In each case, the number selected is converted to member months and the average cost of providing care and services in the home and community calculated by taking the average waiver costs plus the cost of the other HCBS provided. In addition, the cost of new services to be added as part of the Demonstration are calculated and added to the total to provide a total cost of HCBS. This cost is then compared to current costs for institutional care to ensure cost neutrality. Service costs are inflated over the four-year operational period based on typical inflation rates for the specified service(s).

A number of new services were selected to enhance the HCBS waiver packages and provide additional services under the State Plan. These services include: enhanced case management services during the transition period, one-time transition costs, peer mentoring, rehabilitation engineering, crisis management, and respite care.

This budget identifies those services that will be addressed during the Planning Year, the goal being to continue them after the Demonstration funding as part of a Qualified HCBS or State Plan service. The expenditures for the planning year will consist of project staff to coordinate the planning (50/50 federal match) and funds to pay the state's fiscal agent to configure the MMIS (75/25 federal match) to administer MFP flexible financing arrangements and enhanced match for qualified and demonstration HCBS.

**North Carolina MFP Rebalancing Demonstration
Preliminary Budget**

Demonstration Personnel

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	TOTAL
Project Director	\$57,979	\$59,428	\$60,914	\$62,437	\$63,998	\$304,756
MH Services Director	\$57,979	\$59,428	\$60,914	\$62,437	\$63,998	\$304,756
Admin Assistant	\$26,825	\$27,496	\$28,183	\$28,888	\$29,610	\$141,002
Total Salary	\$142,783	\$146,352	\$150,011	\$153,762	\$157,606	\$750,514
FICA	\$10,923	\$11,196	\$11,476	\$11,763	\$12,057	\$57,414
Retirement	\$10,195	\$10,450	\$10,711	\$10,979	\$11,253	\$53,587
Health Insurance	\$11,562	\$11,562	\$11,562	\$11,562	\$11,562	\$57,810
Total Benefits	\$32,680	\$33,207	\$33,749	\$34,303	\$34,872	\$168,811
Total Personnel	\$175,463	\$179,559	\$183,760	\$188,065	\$192,478	\$919,325

Other Administrative

MMIS Configuration	\$1,000,000					\$1,000,000
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Total Administrative

\$1,919,325

Service Costs/NF Transitions

Projected Nursing Facility Transitions

Individuals to be Transitioned	50	65	85	100	300
Total Member Months	286	405	547	634	1,872
Average PMPM	5.72	6.23	6.44	6.34	6.24

**Average Costs for Waiver Services and
Other HCBS (enhanced Match)**

Ave PMPM Waiver Costs plus Other HCBS Additional HCBS Qualified and/or Demo Services (enhanced match)	\$2,492	\$2,517	\$2,543	\$2,567	
PMPM One-Time Transition Costs	\$400	\$403	\$405	\$410	
PMPM Enhanced Case Management	\$210	\$210	\$212	\$215	
PMPM Rehabilitation Engineering	\$25	\$25	\$27	\$28	
PMPM Peer Mentoring	\$50	\$50	\$52	\$55	
PMPM Computer with Internet Access	\$350	\$350	\$355	\$355	
Total HCBS PMPM	\$3,527	\$3,555	\$3,594	\$3,630	
Total HCBS Costs	\$1,008,722	\$1,439,775	\$1,965,918	\$2,301,420	\$6,715,835
Nursing Facility Costs Versus HCBS					
Ave Nursing Facility PMPM	\$3,818	\$3,952	\$4,090	\$4,234	
Total Nursing Facility Costs	\$1,091,948	\$1,600,560	\$2,237,230	\$2,684,356	
Total HCBS Savings	\$83,226	\$160,785	\$271,312	\$382,936	\$898,259

Service Costs/DD Transitions

Projected MR/DD Transitions	40	50	60	75	225
Total Member Months	241	315	390	474	1,420
Average PMPM	6.03	6.30	6.50	6.32	6.31
Average Costs for Waiver Services and Other HCBS (enhanced Match)					
Ave PMPM Waiver Costs plus Other HCBS Additional HCBS Qualified and/or Demo Services (enhanced match)	\$3,833	\$3,890	\$3,949	\$4,008	
PMPM One-Time Transition Costs	\$498	\$498	\$498	\$498	
PMPM Enhanced Case Management	\$1,481	\$1,503	\$1,526	\$1,549	
Best Practices Crisis Model	\$78	\$79	\$80	\$82	
Health Care Access Model	\$99	\$100	\$102	\$104	
Coordinator Training	\$8	\$8	\$8	\$8	
QM Assessments	\$311	\$311	\$311	\$311	
Ongoing Case Management	\$1,487	\$1,487	\$1,517	\$1,547	
Total HCBS PMPM	\$7,795	\$7,877	\$7,991	\$8,106	
Total HCBS Costs	\$1,878,595				

ICFsMR Costs Versus HCBS

Ave ICFMR PMPM	\$9,600	\$9,840	\$10,086	\$10,338	
Total ICFMRCosts	\$2,313,600	\$3,099,600	\$3,933,540	\$4,900,212	\$14,246,952
Total HCBS Savings	\$435,005	\$3,099,600	\$3,933,540	\$4,900,212	\$12,368,357


Service Costs Level III Home Transitions

Projected Level III Home Transitions	130	130	130	130	520
Total Member Months	811	811	811	811	3,244
Average PMPM	6.24	6.24	6.24	6.24	6.24
Average Costs for Waiver Services and Other HCBS (enhanced Match)	\$0	\$0	\$0	\$0	
Ave PMPM Waiver Costs plus Other HCBS					
Additional HCBS Qualified and/or Demo Services (enhanced match)	\$2,450	\$2,499	\$2,549	\$2,600	
PMPM One-Time Transition Costs	\$481	\$491	\$500	\$510	
PMPM Enhanced Case Management	\$1,050	\$1,071	\$1,092	\$1,114	
Crisis Respite Services	\$804	\$820	\$836	\$853	
Mentoring Program	\$105	\$105	\$105	\$105	
Ongoing Case Management	\$1,050	\$1,071	\$1,092	\$1,114	
Total HCBS PMPM	\$5,940	\$6,057	\$6,178	\$6,301	
Total HCBS Costs	\$4,817,340	\$4,911,984	\$5,010,223	\$5,110,428	\$19,849,975
Level III Costs Versus HCBS					
Ave Level III PMPM	\$5,943	\$6,240	\$6,552	\$6,880	
Total Level III Facility Costs	\$4,819,773	\$5,060,762	\$5,313,800	\$5,579,490	\$20,773,824
Total HCBS Savings	\$2,433	\$148,778	\$303,576	\$469,062	\$923,849

PART 4: ASSURANCES

The state must include a discussion of the procedures that will be used to ensure informed consent for participants or their authorized representative in the demonstration project. The state must discuss the ways in which it will assure that participants have choice in selecting their community-based residence

The State of North Carolina, Department of Health and Human Services, Division of Medical Assistance (DMA) and its three partnering divisions, Aging and Adult Services, Vocational Rehabilitation, and Mental Health, Developmental Disabilities and Substance Abuse Services will utilize the informed consent process used for all other Medicaid home and community-based services waivers. We will offer each individual, and the individual's legally responsible person, the option of transitioning to the qualified home and community-based services as an option to remaining in their current institutional setting. We will describe this option to them in ways they can understand and will make it clear that they have the free option to stay where they are, or they can make the transition to the community with the full array of services and supports available. Each individual shall sign the same form as is used for the Medicaid Home and Community-based services waivers, as is required by Medicaid.

 The Division of Medical Assistance, and collaborating Divisions, will establish uniform and consistent policies to ensure that each participant in this Money Follows the Person Rebalancing Demonstration Project are given choice in where they will live and the type of qualified residence. The residences offered shall be in accordance with MFP regulations regarding a qualified residence, and we shall seek such residences near the participant's family, friends, and representatives when desired by the participants. To the maximum extent possible, a range of at least three residential options shall be provided to each participant so that true choices can be made. Documentation of these efforts will be completed and maintained to demonstrate the range of options provided to each participant and their selection.

States must engage in a public process for the design, development and evaluation of the MFP demonstration project. Provide a description of the public development process that was used to develop the application as well as ongoing processes to allow for input from eligible individuals, their families, authorized representatives and other key stakeholders parties

North Carolina hosted a total of five public meetings concerning the Money Follows the Person (MFP) Rebalancing Demonstration and kept the public involved via the postings on the NC Disability Action Network (NC DAN) website. On September 5, 2006, DMA convened the first meeting of its MFP Stakeholder Work Group, of which 60% were primary stakeholders and their families. The group was comprised of individuals and families representing adults with diverse developmental, physical, and acquired disabilities, inclusive of veterans, individuals in the HCBS waivers; families of children with disabilities; families of individuals living in ICFs/MR; individuals from the MH consumer advocacy communities; and aging individuals and their families. Also at the table was a broad mix of advocacy and provider groups. The approximately 25 appointed, consumer stakeholders were joined at the open meeting by other members of the public, for a total of approximately 82 participants.

Dennis Harkins, A Simpler Way, Wisconsin, facilitated a discussion that focused on the parameters of the MFP Application process, application requirements, and target populations

In addition to the consumer representatives, the following organizations were part of the stakeholders group: Carolina Center for Hospice and End of Life, Area Office on Aging, Centers for Independent Living, DHHS, Division of Social Services, Governor's Advocacy Council for Persons with Disabilities, Division of Aging and Adult Services, Easter Seals/UCP NC, NC Council of Community Programs, DHHS – Transportation Program, Division of MH/DD/SA, NC Health Care Facilities Association, AARP, Friends of Residents in LTC, Division of Medical Assistance, First in Families, Association of Self Advocates NC, Governor's

Advocacy Council on Persons with Disabilities, Center for Development and Learning, Division of Vocational Rehabilitation, NC Coalition on Aging, ARC NC, Association of Home and Hospice Care of NC, NC Council on Developmental Disabilities, Division of Vocational Rehabilitation, and the State Independent Living Council.

NC DAN, a grassroots group of over 800 people with disabilities, offered its website for posting Q&A and feedback on the grant development process. Subsequent to this meeting, DHHS hosted two follow-up “Listening Sessions” for some 50 members of the public in the western and eastern parts of the state, respectively, Sylva (9/11/06) and Wilmington (9/27/06).

On September 18 and on November 18, 2006, DMA again convened the Stakeholder Work Group, with Human Services Research Institute Director, Val Bradley, facilitating the meeting. DMA announced that Michael Mayer of Community Resource Alliance would be assisting the DHHS in drafting the application. At these meetings, the group reviewed the CMS elements and brainstormed ways to incorporate best-practice strategies for addressing them. The NC DAN website (www.NCDAN.com) continued to be used throughout for Q&A, posting of notes/minutes and posting of the draft application.

The state must include a plan to demonstrate maintenance of effort. The plan must include total expenditures under the State Medicaid program for home and community-based long-term care services for fiscal year 2005 or any succeeding fiscal year before the first year of the demonstration project

Expenditures by the State for Home and Community-Based long- term care services is provided in Table 1 below.

**Table 1: State of North Carolina
Money Follows the Person Rebalancing Grant
Maintenance of Effort
HCBS Expenditures for SFY 2005**

Program	Unduplicated Recipients	Total FY 2005 Expenditures
Home Health	38,825	\$110,000,000
Hospice	4,804	\$42,000,000
Home Infusion Therapy	2,271	\$7,000,000
Private Duty Nursing	371	\$44,000,000
Personal Care Services	50,087	\$277,000,000
HIV Case Management	2,614	\$8,000,000
CAP:MR/DD	5,989	\$266,000,000
CAP:Children	762	\$26,000,000
CAP:Choice and DA	13,620	\$226,000,000
ACH:Personal Care	28,000	\$136,700,000
ACH:Enhance Personal Care	5,000	\$9,400,000
Total	152,343	\$1,152,100,000

The State will maintain this effort after Demonstration funding through: (1) increased state appropriations for HCBS, (2) the development of HCBS through waiver amendments and new waiver programs, and (3) the elimination of institutional biases and the development of flexible financing for LTC. In addition, transition services will be continued through the state-funded ILRP program and through non-profit organizations such as the Centers for Independent Living.

The state must assure reports specified by CMS that will permit reliable comparisons of MFP projects across states and an effective evaluation of the MFP demonstration will be submitted timely and according to specifications established by CMS

As the single state Medicaid agency (SMA), The North Carolina, Department of Health and Human Services, Division of Medical Assistance (DMA) hereby provides assurances to the Centers for Medicare and Medicaid Services (CMS) that it will complete all require reports for the MFP Rebalancing grant in a manner that permits reliable comparisons across states and an effective evaluation of the MFP Demonstration. The reports shall be submitted in a timely manner and according to CMS specifications.

Attachment 1

Letters of Support