

New Jersey Department of Human Services
Division of Developmental Disabilities
Division of Disability Services

New Jersey Department of Health and Senior Services
Division of Aging and Community Services



Money Follows the Person Demonstration Project
Operational Protocol

Version 4: August 3, 2012
CMS Approval: August 9, 2012

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Project Introduction

Increase the Use of Home and Community Based Services

New Jersey over the past 25 years has created long-term care (LTC) systems to enable people of all ages with disabilities and long-term illnesses to live outside of institutions. These systems are managed by the Division of Aging and Community Services (DACS) in the Department of Health and Senior Services (DHSS) and by the Divisions of Disability Services (DDS) and Developmental Disabilities (DDD) in the Department of Human Services (DHS). Administrative and fiscal oversight is delegated by DHS, the single State Medicaid Authority, to its Division of Medical Assistance and Health Services (DMAHS). Together these state agencies operate 5 waivers, state plan services and other state-funded services that make up New Jersey's Home and Community-Based Services System. The system serves the elderly and people of all ages with a physical and/or developmental disability. The LTC system is in the midst of rebalancing, i.e., moving toward a community-based system of care. Since July 1999, DDD has increased the number of people served in the community by 74% from 23,174 to 40,382; HCBS waiver recipients have increased by 52% from 6635 to 9454. Since 1990, DDD has decreased the number of people served in its seven (ICF-MR) Developmental Centers by 98% (2523 people) from 5110 to 2587 people. DACS more than tripled the number of people served by the waiver programs and currently supports 11,138 people under the Global Options waiver. State Plan Adult Day Health services increased from less than 6000 in 1997 to 12,677 in FY 2012. The number of people served in nursing facilities decreased by approximately 4300 people from almost 32,000 in 1997 to 27,700 in FY 2012. At the same time DACS reduced the percentage of funding spent on nursing homes from 92.7% in 1997 to 72% in 2009. (Source: 2010 Independence Dignity and Choice in Long-Term Care Act Annual Governors Report). The rebalancing percentage in each case supported community services.

Over the past ten years, New Jersey has used legislation, executive orders and budget initiatives to further its rebalancing effort. In 1996, a Governor's Executive Reorganization Plan consolidated all senior services within the newly created Department of Health and Senior Services, giving services for the elderly a single focus, allowing expansion and improving the quality of HCBS. In 2004-2005, building upon this expansion of long-term HCBS options, a successful nursing facility transition program and the creation of a single entry system for senior services, a series of Governor's Executive Orders called for the implementation of a global budgeting process and a fast-track eligibility system for LTC support services. Supported by the AARP, the State's FY 2006 budget contained a provision to draw funds from its nursing home line for HCBS. Also in 2006, New Jersey enacted the "Independence, Dignity and Choice in Long-Term Care Act." The Act directs LTC budget rebalancing to support consumer choice and to offer more options for older adults and persons of all ages with disabilities (including developmental disabilities) to live in their homes and communities.

The DDD began a systems change effort with the release of the **Strategic Plan, "New and Expanded Options for Individual's with Developmental Disabilities and their Families."** While adopting a philosophy of person-centered planning, DDD provided more

options for self-direction through a series of budget initiatives that increased state resources for HCBS. These efforts included ensuring that recipients of DDD LTC services receive and maintain Medicaid HCBS Waiver eligibility (as well as Social Security and SSI eligibility). These administrative practice changes were accompanied by the creation of a more efficient, automated infrastructure for claiming federal match for state funded services. The Governor and Legislature supported these efforts allowing the reinvestment of new revenues and further expansion of HCBS.

As described in the Benchmarks section, the enhanced match funding will be utilized by NJ to invest in workforce development efforts targeted to Direct Support Professionals in long term care community settings. MFP enhanced match funding will be utilized for improvements in quality management systems through oversight activities and the investment in the Social Assistance Management System. It should be noted, DACS purchased SAMS through the State Transformation Grant funds and has not utilized enhanced match funding. Going forward, as SAMS is deployed state-wide, enhanced match funds may be considered for this use. DDD is currently investigating the applicability of SAMS. Should DDD decide that SAMS is viable, enhanced match funding will be utilized to include DDD in the implementation. MFP enhanced match funding will be utilized for the development and distribution of materials for public information on home and community based service options.

While no specific plan exists for the use of enhanced match funding for improvements in interagency collaboration, with respect to the issue of housing, NJ will seek to develop and/or enhance relationships with local Public Housing Authorities through visits and a housing forum to provide education about transition programs in NJ (including MFP) and the need for housing partnerships to accommodate needs. Should a use for enhanced match funding become apparent for the support of this initiative, NJ will submit a request for CMS approval.

Eliminate Barriers or Mechanisms, whether in state law, State Medicaid Plan, the State Budget, or otherwise, that prevent or restrict the flexible use of Medicaid Funds

MFP will assist NJ in solidifying a process for moving long term institutional residents into the community. MFP will allow NJ the opportunity to evaluate Demonstration Category services for inclusion in future waiver amendments and renewals. DDD has added Community Transition Services to the 1915 (c) HCBS Community Care Waiver amendment submitted 12/27/08. Utilization of the Demonstration authority allows NJ to provide effective transition services to individuals who would otherwise be unable to leave an institutional setting. New Jersey proposes to expand affordable and cost-effective options for receiving HCBS through the MFP initiative by: increasing awareness of available services in the community through the MFP transition process. MFP will expand community direct care staff knowledge base via MFP funding of the College of Direct Support in support of the statewide implementation of a career path for Direct Support Professionals. MFP will expand transition services to aid in finding housing and services to improve quality of life. In addition, the state hopes to include greater opportunities for self-advocacy and participation of consumers at all levels of decision-making related to the long-term care (LTC) system, design, implementation, monitoring, and evaluation.

New Jersey is witnessing a fundamental change in its long-term care policy for older adults and persons with disabilities across all incomes. It is a transformation that is directed at giving more people more control over their care and providing more support for community living. The plan for New Jersey is a “Money Follows the Person” long-term care system: a person-centered approach of providing service delivery promoting dignity, choice and independence in the most integrated community setting.

It was also Governor Jon S. Corzine’s vision for New Jersey, which was reaffirmed when the Governor signed the Independence, Dignity and Choice in Long-Term Care Act into law on June 21, 2006. As a result of this historic bill signing, the State’s long-term care funding structure was adjusted to provide more options for older adults through budgetary rebalancing.

Thomson Healthcare recently released findings on the long-term care expenditures for all states in Federal Fiscal year (FFY) 2006. In comparison to FFY2005, New Jersey’s data shows a decrease of 7.3 percent spent on nursing home services in FFY2006 with an increase of 37.8 percent on home care.¹

New Jersey’s Roadmap to Long-Term Care Reform: The roadmap to Medicaid long-term care reform in New Jersey began well before the February 2006 passage of the Deficit Reduction Act (DRA). The DRA gave New Jersey additional tools to help rebalance its long-term care system. With the federal awarding of the Real Choice Systems Change Grant for Community Living, other DRA opportunities for change also resulted such as the Money Follows the Person (MFP) Rebalancing Demonstration initiative and the Nursing Home Diversion Modernization Grant.

A number of elements are in place in New Jersey to provide a strong foundation for the successful implementation of the Money Follows the Person Program Demonstration. The first of these is the strong partnership formed by the DHS (DMAHS, DDD and DDS) and the DHSS (DACS). This partnership is based on a common vision for the rebalancing of LTC in New Jersey specifically: 1) consumer-friendly access to information and assistance, especially for those from culturally diverse backgrounds; 2) streamlined eligibility processes for state and federal programs; 3) person-centered planning/self-directed control over service plans; 4) rebalancing state and federal funds from institutional care to HCBS; 5) continued expansion of affordable and cost-effective options for receiving HCBS; and, 6) continuous quality improvement through self-correcting feedback loops with consumers and family caregivers in decision-making roles.

While adopting a philosophy of person-centered planning, DDD provided more options for self-direction through a series of budget initiatives that increased state resources for HCBS.

¹ CMS 64 report shows that for New Jersey in FFY 2005, a total of \$3,394,840,186 was spent on long-term care expenditures: 73 percent (\$2,483,896,701) spent on institutional long-term care services and 27 percent (\$910,943,485) on community-based services. In FFY2006, a total of \$3,677,078,087 was spent: 66 percent (\$2,421,727,657) spent on institutional long-term care and 34 percent (\$1,255,350,430) on community-based services.

These efforts included ensuring that recipients of DDD LTC services receive and maintain Medicaid HCBS Waiver eligibility (as well as Social Security and SSI eligibility). These administrative practice changes were accompanied by the creation of a more efficient, automated infrastructure for claiming federal match for state funded services. The Governor and Legislature supported these efforts allowing the reinvestment of new revenues and further expansion of HCBS.

Increase the ability of the State Medicaid program to assure continued provision of HCB LTC services to eligible individuals who choose to transition from an institution to a community setting.

New Jersey qualified to receive federal grants funded by CMS and the US Administration on Aging because of its strong leadership commitment and progress in enhancing and expanding long-term care support services. CMS has identified many of the initiatives undertaken by New Jersey as best practices precursors needed for major reform. Over the past several years through Real Choice Systems Change grants, New Jersey has developed and implemented strategies to change the service delivery system for its residents based upon CMS' four key building blocks of access, services, financing and quality improvement.

Between 2004 and 2005, two former governors with the support of AARP signed executive orders directing the DHSS to develop and implement a global budgeting process and fast track eligibility process for Medicaid long-term support services. For the first time in State Fiscal Year 2006, \$30 million in state and federal funds were allocated to rebalance the nursing home budget from an institutional bias to expand home and community-based services. NJ has committed its financial resources to ensure that all waiver and Medicaid State Plan Services will be available to eligible MFP individuals after the demonstration period.

The FY 2006 budget, beginning July 2005, funded the Global Options for Long-Term Care (GO for LTC) initiative, a "Money Follows the Person" approach to LTC services. It includes an effort to "fast-track" or streamline clinical and financial eligibility processes for 400 individuals in the Aging and Disability Resource Center (ADRC) pilot counties so that those who appear to meet Medicaid criteria can receive Medicaid state plan services for up to 90 days while the full Medicaid eligibility determination is completed. In 2004 DDD also instituted a "fast-track" process to facilitate the HCBS eligibility process and facilitated the transition from the institution to the community.

DACS, DDS and DDD all have built capacity for self-direction and person-centered planning. DDD serves over 1900 people in Self-Directed Services. DACS serves an average of 300 unduplicated consumers per month in its Participant Employed Provider service option. DDS currently serves 1339 people in its Cash and Counseling Program.

Building service capacity, particularly in challenging areas such as mental health and housing, has been a priority activity. Within the DDD system, statewide expansion of mental health treatment tailored to meet the needs of individuals with developmental disabilities will help to reduce the number of referrals to developmental centers and will aid in supporting individuals who are moving from centers into the community. Examples of these mental health

services include consultation to mental health emergency and psychiatric hospital screening services to assure effective intervention with this population in the community; a DD inpatient unit in a community hospital; Integrated Service Delivery Teams, and Mobile Mental Health - Behavioral Crises Teams and Clinical Resource Teams.

An Emergency Capacity program has been implemented which provides an alternative to developmental center placements by contracting with community providers to immediately support people who are in an emergency situation. The primary aim of the Emergency Capacity System (ECS) is to provide safety, stabilization, and assessment for individuals receiving such services. While providing a safe environment for individuals in crisis, it is the purpose of this system to stabilize the individual and provide assessment of future placement and/or programming needs within thirty (30) days. The first choice is for the individual to return to their home or previous placement whenever possible. Entry to the ECS is made solely through the DDD Community Services regional Office screening process. Upon referral by the screener, the agency providing these services will accept all individuals deemed in need of these services. At this time MFP enhanced match funding will not be used for this effort. NJ will submit a request to CMS for approval to utilize MFP enhanced match funds if it is decided in the future that NJ desires to do so.

The individual situation is stabilized and the person is returned to their previous home, a more suitable home or supported by the agency providing the emergency support services. DDD provides each regional operational unit with flex funds for short-term support needs for individuals residing at home. This provides the support required to assist with stabilization in the person's own home and prevent additional developmental center placements or re-institutionalization.

Through its self-direction options, DDD has also created a process to qualify providers/programs and as a result has widely expanded the number (974) and types of providers/programs (71% are non-traditional providers/programs, e.g. YMCA's.).

The establishment of the **\$200 million Special Needs Housing Trust Fund** in August 2005 gave New Jersey's aging and disability community a new opportunity to develop alternative housing options. Additionally, the NJ Housing and Mortgage Finance Agency's Housing Resource Center (NJHRC), funded under NJ's 2001 Real Choice Systems Change Grant, provides consumers with disabilities a centralized registry of affordable and accessible rental housing by county. The website also contains links to other supportive housing services.

Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid HCBS LTC and to provide for continuous quality improvement in such services.

The success of NJ's MFP depends on the full and trusted participation of all participants and stakeholders including consumers, their caregivers, and advocates; providers; vendors (e.g. IT systems); state agency staff and their career and political leadership. Through the Systems Transformation Grant evaluation process a web-enabled environment will be created in which stakeholders can share information, gain advice, and provide feedback. The Quality Assurance process will also include continuous consultation with the State Management Team. The state

will continue its Quality Management strategy developed under current waivers and grants. Committees within each division will continue to meet to provide a venue for input.

NJ's partner agencies will: (1) For each HCBS program, existing CMS requirements on quality in addition to those included in MFP, MFP will allow NJ to evaluate the utilization of HCBS in the transition of individuals out of long term care institutional settings. The additional fiscal and satisfaction oversight requirements of MFP will allow the state to evaluate the effectiveness of quality systems in the HCBS system in relationship to the underserved populations. NJ will also: (a) Use consumer/family feedback and QM data to continuously improve quality in HCB services. Outcomes will include (b) number of individuals who remain in the community (c) service utilization by the populations, (d) satisfaction with service planning models, transition services and access (e) develop IT applications to collect and aggregate data for CQI efforts for the MFP demonstration and the HCBS waivers and (f) Global Budgeting methodology that will allow movement of funds to support HCBS.

Case Studies

Case Study #1: Mary's Transition from an ICF-MR Facility

The transition process from an ICF-MR is the same regardless of population category.

Mary is a 49 year old woman who resides at New Lisbon Developmental Center. Mary has a history of severe seizures and is diagnosed with mild mental retardation, cerebral palsy, and partial paralysis on her left side of her body. She has lived at New Lisbon for the past 10 years. Prior to living at New Lisbon Developmental Center she resided in her family's home. She was placed at New Lisbon directly after her father's death which was also the time period that her seizures became "uncontrollable". It was originally planned that she would eventually return back home when her seizures were able to be "controlled." Mary has been seizure free with the appropriate medications for the past 5 years. In these past 5 years Mary's mother, who is Mary's legal guardian, has had some significant health issues of her own making it unlikely that Mary would return to her family's home due to the fact that her mother would not be able to provide the needed supports to keep her healthy and safe.

The following case study represents Mary's experience as she transitioned from the New Lisbon Developmental Center.

Phase 1

Identification, Assessment, Pre-transition Orientation & Training

Mary had already been assessed using the Developmental Disabilities Resource Tool, a statistically reliable assessment instrument developed for DDD by the Developmental Disabilities Planning Institute (DDPI) at New Jersey Institute of Technology (NJIT). Modules included Social Work, Psychology, Physical Therapy, Occupational Therapy, Habilitation, Nursing, Nutrition, and Speech programmatic areas. As part of the required annual Individual Habilitation Planning meeting, Mary's IDT identified her as a candidate to transition from the

Developmental Center to the community. The letter she and her mother received prior to the IDT meeting advising Mary of the opportunity to participate in MFP was also discussed. Mary's mother was reluctant to see Mary move, expressing concern about her lack of knowledge about community living arrangements. She also had concerns due to her past experience with Mary's day programs that had been reluctant to keep Mary once her seizures became problematic.

Mary and her Mother received written material and participated in a family forum provided by the Family Education Project at the UMDNJ- School of Public Health through a contract with DDD. The forum provided an orientation where Mary and her mother learned about the process of moving out. How it could begin, what might happen. They met Robert, a peer mentor who lives on his own with the support of staff and friends. He was able to answer some of their questions about what it is like living in the community. Mary's mother also met Ann, a family mentor and the mother of someone who needed a lot of the same supports as Mary. They learned about Support Coordinators and got the opportunity to ask questions about how the process worked.

Mary and her mother also met a number of community providers at the Provider Market Fair held at the Developmental Center to connect consumers and families with community providers

After these events, Mary and her mother agreed to take the next step in moving to the community. Mary's mother still had some questions for DDD about Mary's budget so she talked to some DDD staff in the Central Office to ask more questions and they discussed her budget and planning concerns. DDD reassured her of how much DDD, support coordinators, family mentors, and peer mentors work together as a team.

Once Mary was identified to move from a developmental center as part of Olmstead, she was offered the opportunity to participate in MFP. (Over the course of 8 years, up to 1850 individuals are expected to move from the state's seven developmental centers.) Danielle, DDD's Transition Case Manager, provided information on the MFP program and ensured that Mary and her mother were informed of their rights and responsibilities under MFP. The Transition Case Manager obtained consent from Mary's mother for Mary to participate in MFP.

Phase 2: Transition Planning, the Essential Lifestyle Planning Process

The transitional case manager, Danielle, visited with Mary and talked with her and her support staff at the Developmental Center about the people who were important in her life. Danielle then shared this information with Trace, the support coordinator assigned to assist Mary with this process.

Trace called the people who were closest to Mary and learned about some of the things that were important to her and important for her, including her general likes, dislikes, and needs. Trace also found out from Danielle, the Transitional Case Manager when Brenda, Mary's favorite staff person and Mary could go out together to learn more about Mary.

Trace picked Brenda and Mary up in an accessible mini van and went out to Mary's favorite pizza place where Trace began to get to know a bit more about Mary and the things she

likes to do. At the end of the lunch, a time was set up when they could meet with Bob, a peer mentor, and Ann a family mentor who are all a part of Mary's team helping her move.

The next meeting of the Team was held at a community library. Mary's mother joined them. Trace, the support coordinator showed Mary the information he had recorded on his computer from the last time they met. He asked Mary, her mother and Brenda if he got it right. Together they clarified some of the information.

Mary and her mother still could not answer some questions about where she wanted to live and things that she wanted to do once she moved. So Trace arranged a series of visits (and included Mary's mother and/or Brenda) to check out some local neighborhoods. Mary viewed apartments and houses and got an idea of where and how she might like to live. She also visited some places in town where she could do some of her favorite things (like the local pet shelter because Mary likes animals) so she could see what jobs might be available for her in the future.

After exploring a bit, and a couple of other meetings with her team, an essential lifestyle plan was developed with Mary. She would live in Somerset (near her mother) in a two-bedroom fully accessible place. Mary would live with a friend of Brenda's, Jane, who shares some of Mary's interests and was looking for a place to live. She would be Mary's staff person at night and would get to live in the house for free. Mary would hire staff for other times of the day when she was home. Trace and the support agency staff would help Mary find the housing, get a job working with animals, meet new people in Somerset and find other fun things that she could do to establish a life in her new home.

Support coordination and peer and family mentors, are all HCB Demonstration services. Prior to MFP these services were used by individuals participating in self-directed services and they were paid exclusively through state funds.

Phase 3 Implementing the Plan

A Consumer Profile was created based on the ELP and an e-blast was sent to all qualified providers. In addition to asking providers about the services they have to offer, the e-blast asks why the consumer should choose an agency. Mary needed help finding housing and work and day activities. She also needed staff support for times that Brenda's friend, Jane, was unable to be there. Trace, the Support Coordinator and the Core Team reviewed the provider responses and invited three support providers to meet Mary.

Over the next 30 days, the three providers met with Mary, reviewed the ELP, reviewed records and submitted a proposal. Mary and her Team visited the providers and spoke with consumers and their families who have been served by the providers. The provider would help Mary find an apartment in Somerset. Staff would help Mary meet people and get involved in activities. Staff would also need to help Mary arrange for day activities and at some point in time, to help her find a job. Mary's team conducted an interview with each provider and selected an agency, XYZ Supports, to provide services.

XYZ Supports will provide Mary with 40 hours of staff a week, plus all necessary back up coverage. That way, if Mary has an emergency, or if someone calls out unexpectedly, the agency will send someone right over.

Mary soon started working with Dave, from XYZ Supports, a member of the Supportive Housing Association with a lot of knowledge about accessible housing to help find an apartment. Dave took Mary out to look at places, helped her qualify for a housing voucher, and when she found the right place, he helped her get accessibility modifications. Modifications included changing door handles to lever type handles, installing a ramp, changing the vanity in the bathroom to a pedestal sink and building a roll-in shower, moving the mailbox to an accessible point and adjusting the kitchen counter heights to facilitate access to the microwave and sink. Modifications were paid for through the state's Home and Community Based Waiver.

Jenny, another staffer at XYZ Supports helped Mary start a circle of friends and start visiting places and getting to know people in Somerset. They've spent some time at the local Starbucks where everyone is very friendly; so by the time Mary moves she will already know people in town.

Now that Mary has an apartment in Somerset, staff support, and has started to get to know people, she is buying furniture and getting ready to move. She and her team researched accessible public transportation in the area before an apartment was selected. The apartment they found is on the bus line and Mary is eligible for Access Link so she can call and schedule a ride.

Mary is also working on her employment goals with XYZ Supports. They take her out to interview for jobs working with pets in Somerset. Once she moves she will be volunteering at the animal shelter twice a week and working towards getting a position at the local pet store. XYZ helped her develop a resume, find potential positions, and go out to interviews. They will also help prospective employers figure out what kind of accommodations Mary might need (e.g. and provide ongoing employment support.

Phase 4 Making the Transition- Moving In- Year One

With everything all set, Brenda's friend, Jane and Mary moved into the new apartment over the weekend, about seven months after the Team developed the ELP. One of the folks Mary met at Starbucks has joined Mary's circle of friends and helped with the move. Mary started her volunteer job on the Monday after the move. The Team and Mary's circle of friends had a big house warming party Saturday night.

Brenda, the Developmental Center staff person who knew Mary the best and another DDD staff person have visited often over the last six months. They talk with her to ensure that she is happy with the Plan and the support she is receiving. They will visit Mary in her apartment at 30, 60, 90, and 180 days intervals. Participant-specific information will be gathered to guide decisions about needed modifications to plans of care, to mitigate/ameliorate issues, and inform infrastructure decisions. Mary will also receive the NCI survey and the MFP Quality of Life Survey.

Risk assessments will be completed for 100% of MFP Participants by DDD's Office of Quality Management and Planning.

A telephone listing of the 21 county-based Adult Protective Services (APS) provider agencies, including after-hours and emergency numbers, will be given to all MFP enrollees. As part of the Participant Recruitment and Enrollment process, participants and involved family members and other unpaid caregivers will be informed of APS.

For participants from developmental centers, including their families and/or guardians, information regarding their rights, including protections from abuse, neglect, and exploitation will be reviewed annually.

At the end of the year's time in MFP (Day 366) Mary's financial and function eligibility for the NJ Medicaid program was re-evaluated. As a result of continued Medicaid eligibility, Mary continued receiving home and community based services through the DDD Community Care Waiver. Mary participated in the MFP quality of life survey, where she was asked about the quality of her life one year after her transition out of the institution. It was found that the services offered through MFP allowed her to successfully make the transition.

Phase 5 Ongoing Contacts and Monitoring

Mary will continue to be visited by Developmental Center and DDD Regional Office staff every year for three years to make sure the planned services are effective for Mary.

Case Study #2: - Ronald's Transition from a Nursing Facility – Physically Disabled

The transition process from a nursing facility process is the same regardless of population category.

Phase 1 – Background and Identification

Ronald is a 55 year old man who, prior to his stroke, lived independently and worked as a Medical Assistant for a nursing facility. He worked full time and had an active social life that consisted of close friends in a small community. He lived in an apartment that was a house that consisted of multiple units. The close proximity of the rental units encouraged the tenants to become each other's extended family. He has one adult child (a daughter) who lives in Florida with whom he enjoyed visiting twice per year. The daughter in turn visited him twice per year.

In March of 2003, Ronald was admitted to Morristown Memorial Hospital with right-sided weakness. He later found out he had suffered from a stroke. While he was in the hospital a Social Worker filled out an application for Social Security and Medicaid for him since he would not be able to return to work in the near future due to his mobility obstacles. After receiving rehabilitation he then entered Morris Hills Center nursing facility in May of 2003, because he was unable to live independently at that time.

Ronald immediately expressed interest to the facility Social Worker in transitioning back into the community. From his past experience in working at a nursing facility he knew that he would prefer living independently. The Social Worker qualified Ronald for eligibility for transition services under a Money Follows the Person demonstration. The Social Worker contacted the Community Choice Counselor (CCC) to meet with Ronald about his options. The CCC then contacted the Independent Living Specialist (ILS) from the Center for Independent Living (CIL) in order to partner together to assist Ronald in planning his transition.

Pre-Transition Planning

The CCC and the ILS talked to Ronald about his interest in returning to the community. The Community Choice Counselor provided background regarding his disability and the expected limitations during the transition process. She also explained the transition from the nursing facility and the “round table” process. She explained to Ronald that the round table is an opportunity to identify his specific goals relating to and resulting in the transition back to the community. Ronald was told that he needed to take ownership of the meetings and that this should begin at the very first meeting with an understanding that he directs the process. It was further explained that it was important for him to be involved in the process of transitioning and that would mean his participation in all aspects of the planning process. This empowered Ronald to know that he was directly involved and working with people that wanted to ensure his success in long-term community based living. The ILS left Ronald some literature that explained the transition process in more detail. She said that she would be back in a few weeks to begin moving forward with the process if Ronald was definitely interested.

A few weeks later the Independent Living Specialist visited Ronald again and he told her that he had come to the decision that he would like to begin the transition process. The Independent Living Specialist completed an assessment of Ronald’s needs for returning to the community. This assessment, or Independent Living Plan, was done to consider his goals and what would be needed to meet them and eventually lead to success in community based living. Ronald was made aware that this process of transitioning could take from six months to a year to complete.

During this time period, Ronald had to give up his apartment because he could not maintain it financially and it he knew that it would not be an appropriate living situation due to his decreased mobility. For some time after Ronald had his stroke his daughter stayed in his apartment in order to be closer to him and participate in his transition process. After he gave up the apartment she stayed with various friends and family.

During one of the meetings with the ILS and the CCC Ronald mentioned that during his stay at the nursing facility all of his daily needs were met by staff, so all of these needs would have to be met outside the nursing facility. Ronald knew that he would need assistance with dressing, bathing, shopping, transportation, cooking and budgeting. He expressed his concern that he would need gradual training and assistance to help him to become more independent. Ronald received information about the Money Follows the Person Demonstration, in which he would be able to access services that would allow him to overcome some of the barriers to moving into the community, such as a housing specialist or a peer mentor. Ronald was told that as a participant

in this demonstration, he would be followed (through interviews about his quality of life) for two years after he was discharged into the community. Ronald was told that he could enter the demonstration and at the same time would be enrolled in a Medicaid Waiver Program to ensure that his needs would continue to be met after the demonstration ended. Ronald was enthusiastic about the opportunity to be able to have a voice in potentially guiding policy on future development or improvements to home and community based services. Over the next few months the Community Choice Counselor and the Independent Living Specialist helped Ronald to complete applications for the Medicaid Waiver Program and began to discuss new apartment choices.

Eventually a date was set for the Round table meeting. This meeting included people from a list that Ronald had identified to attend including his daughter. In addition, there were other representatives from various agencies, the Independent Living Specialist, and the Community Choice Counselor that he had been working with. It was explained to all participants that the purpose of the Round table was to provide Ronald with an ongoing opportunity to meet with the individuals assisting in his transition.

At subsequent round tables more support people who assisted Ronald to make a safe transition were added to the meeting. This included the nursing facility Occupational Therapist, Physical Therapist, Nutritionist, other disciplines that relate to Ronald's disability. The individuals invited to the Round Table were modified as the process moved forward. People were added when it was determined that their input is relevant to the particular process. Not all support people needed to attend all of his round table meetings. Only the Consumer, the CCC, ILS and those specifically identified with a task to be accomplished for each successive meeting.

The Round Table is focused around the question, "What life do you want in the community?" It helped Ronald to define his expectations to bring a realistic step-by-step approach to his goals.

This broad question is the basis for increasing specificity until it is clear how Ronald sees himself living in the community. It includes possibilities of education, employment, community involvement, advocacy, socialization and increased independence. Within the framework of the first round table visit, one or more goals and strategies for attaining the goals are established and agreed to by the Consumer. A facilitator was appointed to ensure that the meetings moved along in a timely manner and that all objectives of the meeting were covered. At the first meeting the Community Choice Counselor introduced everyone who was present, reviewed what has occurred at previous meetings with the Consumer and articulated what the Counselor believes the Consumer was interested in regarding housing. Time was then provided for the CIL spokesperson to talk about the CIL and its advocacy for people with disabilities, its advocacy for the Consumer and desire to work with the Consumer to achieve his goals.

The CIL staff talked about how the Consumer has control, how a plan can be developed with a time line that will state who will do what, and how action taken at the round table will assist in developing a support system within the community when the transition occurs.

Family and friends needed to be supportive but could not take over the meeting. (When a relative or friend stated what he/she wanted, the facilitator had to refocus the discussion to elicit

what Ronald wanted.) At some point in the process, discussion and identification of a mentor was a part of the round table agenda.

Ronald was encouraged to articulate his goals. It was written on the Independent Living Plan who would be responsible for each task involved. The timeframes were listed and a follow up meeting date was set. The discussion at the round table meeting was to assure that all possible issues were raised, discussed and that reasonable resolutions were agreed to as a team. Ronald was given a folder to keep various papers that would be a part of his transitioning process. The round table support team continued to meet periodically to discuss progress. During these meetings there was discussion of asking a community mentor to visit the nursing facility to make a peer connection with Ronald. Ronald's lifestyle and how he would spend his days was discussed. Discussions included housing choices, financial level and medical insurance available to Ronald in the community and what constraints this could have on housing choices. There was also discussion of community resources that would be available such as places of worship, pharmacies, grocery stores and available transportation. At the conclusion of each meeting the date was set for a follow-up meeting.

During the round table dynamics within the group started to change. People who were cooperative became more assertive, various roadblocks were raised by different people in the group. The facilitator was prepared to handle all the situations that the group dynamics presented.

Ronald made a decision to look at apartments in his old neighborhood as opposed to larger apartment complexes. The CCC and the ILS took Ronald to look at a few apartments that had been researched by the ILS. Ronald needed an apartment that was on the first floor as opposed to his previous apartment that was on the second floor. Ronald was persistent that he did not want to depend on different accessibility devices (grab bars, a wheelchair, or a fully wheelchair accessible apartment) because he didn't want to lose the mobility that he had gained. The Independent Living Specialist and the Community Choice Counselor from the State assisted Ronald with his apartment search. Ronald qualified for a Medicaid Community Resources for Persons with Disabilities (CRPD) Waiver and his date for discharge would be determined based upon the projected availability of the apartments. The team and Ronald discussed the benefits and finally decided on a home based apartment. The apartment had a few steps getting into it but Ronald viewed it as part of his rehabilitation. He had been practicing his mobility skills in his rehabilitation sessions and the Rehabilitation Therapist at the nursing facility felt as though Ronald could master a few steps and agreed that it would be good for him to continue to use steps within moderation.

Ronald qualified for a Section 8 voucher since he was using the Medicaid CRPD Waiver. It paid for the deposits that he would need to move into the apartment. During this time the Community Choice Counselor, the Independent Living Specialist and the Nursing Facility Social Worker began to review his specific needs in the community and any obstacles that may arise during his round table meetings. Ronald's new apartment was about 20 houses down from his old apartment, so he was familiar with the neighborhood and he had close friends right down the street. An application for food stamps was completed as well as finding a pharmacy which accepted Medicaid and delivered as Ronald did not have a vehicle. He was advised of the

various options for transportation to include MAPS and Access Link. It was agreed that Ronald needed a home health aid and he was approved for 30 hours. Ronald interviewed many aids before he actually choose a person that fit his needs and personality. This took some time and delayed his transition for several weeks. His aid would need to assist him with his personal care needs, shopping, laundry, assistance with meal preparation, and balancing his checkbook. His transition team made sure that he would have all the supports in place before he moved into the community. At this time Ronald was ready to move forward with his transition plan.

At a final round table meeting, everyone present at the meeting gave a report of all the items that were worked on. It was clear that Ronald would be provided with the necessary assistance to succeed in the community. Ronald was also set up with a home alert monitoring system since he would be living alone. He was encouraged to express any concerns or ask any questions. He met with his permanent Case Manager at the meeting and found that he would be there the day of the transition to make sure that everything went well. The Case Manager explained what his role was and what Ronald could expect from him. The State Community Choice Counselor also informed Ronald that he would be visited during his first year in the community and that as part of the Money Follows the Person Demonstration he would be asked to fill out surveys which asked him about his transition process and his life in the community post transition. The Independent Living Specialist informed him of the services available at the Center for Independent Living for additional support. Ronald's move date was finalized after the Apartment Manager and the Community Choice Counselor had met to review the final details of his move in. Various necessities were purchased for Ronald through the MFP demonstration including: furniture, curtains, linens, pots, pans, dishes and other basic necessities.

Post-Transition

Ronald moved into his apartment, and was very excited to be living an independent life again. The Community Choice Counselor, Independent Living Specialist and Case Manager were all there to see that he was settled in. They reviewed who all his services were with and had made a chart for him to know who he should call regarding each service. His Case Manager set a date to let him know when he would be back and that he would be seeing him regularly. In addition, the Independent Living Specialist came back and helped him to set up his entire bill paying system and made sure that Ronald and his home health aid were getting along well. The home health aid took Ronald shopping to purchase all new clothes that were more conducive to his needs. Prior to his injury Ronald always wore button up shirts and slacks but pants with an elastic waist band and shirts without buttons proved to be easier for Ronald. After the wardrobe change Ronald no longer needed assistance in dressing. During the first year they became very close and she was very instrumental to his success in the community, as were all the people on his transition team.

Ronald is now two years post transition and he is still happy and independent in the community. Ronald says that he believes that his transition was successful and that he would recommend it to anyone who was in a nursing facility who wanted to go home. His surveys stated that he would tell other Consumers to be patient and if they have any questions they should ask them. He felt as though there were some speed bumps but that he got through them all with his transition team. His home health aide was reduced from 30 hours to 20 hours as Ronald has become more independent. He spends his time traveling to New York (by train), visiting

friends and family, shopping, participating in community events and attending various sporting events. Ronald has not expressed any interest in learning a new trade for employment and has not explored that option since his discharge. He remains to have right sided weakness as he did when he transitioned. There were some improvements with the rehabilitation he received post transition but he still uses some braces and a walker/cane.

Case Study #3 – Paula’s Nursing Facility Transition - Elderly

Demographics

Client Paula Bucca
3008 Hinck Drive
Belmar, NJ 07719
732-681-7259

Community Choice Counselor

Joyce Dean RN
Central Regional Office
Edison, NJ
732-777-4650

Client is a 68 year old married female. Her name is Paula. She was a resident at Meridian at Wall Nursing Facility following two recent hospitalizations due to exacerbation of congestive heart failure. Prior to admission to the Facility she was residing in the community with her spouse, who worked full time, and she was not managing well secondary to her medical conditions of severe rheumatoid arthritis with contracture and diabetes. Paula is takes 16 medications daily. She needs maximum assistance for locomotion outside of the home, extensive assistance with locomotion in the home, dressing her lower body, personal hygiene, and bathing, and limited assistance with bed mobility, transfer, dressing her upper body, eating, and toilet use. She can eat independently after set up. She is usually continent of bladder, continent of bowel. She was receiving rehabilitation services with transfer and balance training. She uses [02@2L](#) (oxygen at 2 Liters) via nasal cannula continuously. She is dependent for all IADLs. She has a very supportive daughter who lived out of state. Client requires extensive care and was anxious to go back home.

The Community Choice Counselor (CCC), a Registered Nurse from the State’s Regional Office of Community Choice Options, first received a referral for a community visit for the Community Care Program for the Elderly and Disabled Medicaid Waiver, but the client was hospitalized, The CCC did meet up with the client at the nursing facility and opened the case for discharge to the community on a Medicaid Waiver best suited to the individual’s needs. Paula is alert and oriented and able to make her needs known.

An Interdisciplinary Team (IDT) meeting was scheduled and held in the nursing home. In attendance at the IDT meeting was Joyce Deane RN CCC, Paula, Paula’s daughter, Nursing Facility Social worker, County Care Manager, and Paula’s spouse. Paula’s goals were to: return to the community and reside with her spouse, receive sufficient services to provide for her safety, prevent falls or other adverse occurrences, and to receive appropriate durable medical equipment

(side railing for toilet). The desired outcomes were the safe and uneventful transition to her home and increased privacy and choice of placement. Through the team effort, family has accepted responsibility for providing 24 hour care and the Enhanced Community Options Medicaid waiver will provide access to Home Health Services, PERS (Personal Emergency Response System), care management, and durable medical equipment. Client is not interested in Adult Day Health Services at this time, but will consider it for the future. Family agreed to provide for any gaps in Waiver services. Daughter was going to seek neighbor and aunt to assist

The service plan was discussed and all agreed upon the services to be provided. The Money Follows the Person Demonstration was explained to Paula as a way to obtain services that would allow her to overcome some obstacles to community placement. After careful consideration and consultation with her family and other professionals, Paula decided not to participate in the demonstration project. Paula's family felt that her care needs were being sufficiently addressed without the added responsibility of participating in the demonstration project.

Paula was successfully discharged home on 05/19/2008 with services in place. Daughter had initially agreed to assist mother on Thursdays but is finding it to be difficult to care for her. Care manager is now increasing service plan to include 2 more hours on Thursday to assist with care. Client would not be able to remain in the community without the services of the Enhanced Community Options Medical Waiver.

All present at the IDT signed the transition plan, which confirms that Paula had been advised that she could remain in the nursing facility or return home with home and community-based services, voluntarily chose to return to the community with services, voluntarily agreed to participate in the waiver, accepted the potential risk factors if she left the nursing facility to return home, helped develop the transition plan and the Plan of Care, had the freedom to choose the providers of her services, based upon available providers; agreed with the transition Plan and Plan of Care, and advised that the amount, frequency, and continuation of services depend upon the availability of state and federal funds.

Benchmarks

New Jersey will measure five benchmarks, two of which are required by CMS and three that New Jersey chose. New Jersey recognizes that as Money Follows the Person is implemented, there may be the need to change benchmarks based on information obtained as a result of implementation. Any changes to benchmarks will be included in subsequent reports. Ongoing participant assessment and community reviews of services provided will direct rebalancing expenditures. Results of any decisions made will be communicated in state reporting to CMS.

Benchmark #1:

Projected number of individuals in each target group to be assisted in transitioning to the community:

New Jersey has committed to increase MFP transitions from 305 over the next five (5) years to 2176 over the next five (5) years (2011 – 2016). The numbers are reflected in the chart below.

PROJECTION FOR CY CYCLES

	Elderly	ID/DD	Physically Disabled	Total of Populations	functional time	Operational Grant Period
CY 2007	0	0	0	0		
CY 2008*	3	10	5	18	6 months	Period 1 7/1/08 - 12/31/08
CY 2009	51	97	32	180	12 months	Period 2 1/1/09 - 12/31/09
CY 2010	25	31	6	62	12 months	Period 3 1/1/10 - 12/31/10
CY 2011	50	44	30	124	12 months	Period 4 1/1/11 - 12/31/11
CY 2012	150	172	75	397	12 months	Period 5 1/1/12 - 12/31/12
CY 2013	160	229	80	469	12 months	Period 6 1/1/13 - 12/31/13
CY 2014	169	144	83	396	12 months	Period 7 1/1/14 - 12/31/14
CY 2015	179	198	88	465	12 months	Period 8 1/1/15 - 12/31/15
CY 2016	191	40	94	325	12 months	Period 9 1/1/16 - 12/31/16
Total Count	978	965	493	2436		

Benchmark #2:

Reporting Period	HCBS Expenditures	MFP Expenditures based on 12 month projection	MFP % Change Variation	MFP Actual based MFP budget form	HCBS + MFP= TOTAL HCBS	Percent Change Year to Year
CY2006*	\$960,057,912	\$0	0		\$960,057,912	0
CY 2007 (baseline)*	\$991,256,400	\$0	0	0	\$991,256,400	3%
CY 2008	\$1,029,197,753	\$20,074	9.95%	\$1998	\$1,029,199,751	4%
CY 2009	\$1,086,049,633	\$900,574	98.7%	\$889,217	\$1,086,938,850	6%
CY 2010	\$1,157,202,045	\$7,018,168	5.10%	\$3,580,818	\$1,160,782,863	7%
CY 2011	\$1,142,007,254	\$13,581,930	41.5%	\$5,632,116	\$1,147,639,370	-1%

* Source: Home Health and Personal Care Services are from the CMS-64 report and exclude costs for the 1915B and 1115 Personal Preference Waivers. Home and Community Based Services for AIDS, CRPD, GO and TBI are also from the CMS-64 report (1915C waiver pages). The DDD/CCW amounts are from a Shared Data Warehouse (SDW) query based on claims by date of service instead of the CMS-64 which is based on date of payment. Due to the retrospective reimbursement process for this waiver, the CMS-64, DDD waiver amount may spike when claims are adjusted for the final rates for prior periods. This query is based on claims with category of service = 90 and matchable federal financial participation (FFP) indicators of 0, 2, 3, 4, 5, and 6 for claims paid through 6/22/08.

MFP expenditures were calculated by totaling service dollars only as indicated on the MFP Budget worksheet provided by CMS contained in the budget section of this document.

2012 – 2016: Increase in Qualified HCBS Expenditures:

CY	HCBS Spending Categories				Projected Total Medicaid HCBS Spending	Percent change from previous year
	1915c Waivers	State Plan HCBS	HCBS share of managed LTC plan spending (PACE)	MFP (Qualified, Demo & Supplemental)		
2012	\$835,678,723	\$318,044,069	\$20,836,810	\$28,991,666	\$1,203,551,268	4%
2013	\$860,749,084	\$327,585,391	\$21,461,914	\$28,471,839	\$1,238,268,228	3%
2014	\$886,571,556	\$337,412,952	\$22,105,771	\$28,480,647	\$1,274,570,926	3%
2015	\$913,168,702	\$347,535,340	\$22,768,944	\$25,651,533	\$1,309,124,519	3%
2016	\$940,563,763	\$357,961,400	\$23,452,012	\$14,962,668	\$1,336,939,843	2%

Source: Home Health and Personal Care Services are from the CMS-64 report and exclude costs for the 1915B and 1115 Personal Preference Waivers. Home and Community Based Services for AIDS, CRPD, ECO, TBI and DDD/CCW are also from the CMS-64 report (1915C waiver pages).

MFP expenditures were calculated by totaling service dollars only as indicated on the MFP Worksheet for Proposed Budget for 2012-2016. The forecasting for the increase in HCBS expenditures is based on the percent change between CY 2006 and CY 2007 HCBS expenditures in which the increase was 3%.

Benchmark #3:

Increases in an available and trained community workforce (i.e., direct interventions, undertaken by the State, to increase the quality, the quantity and the empowerment of direct care workers).

There is an effort to provide Direct Support Professionals (DSP) with continuing education and training opportunities that will foster an increase in the quality of services delivered, reduce turnover and improve the professionalism of DSPs by the utilization of the College of Direct Support. The College of Direct Support is an advanced internet-based educational program for professionals providing direct care to people receiving HCBS through DDD. This online learning system combines a cutting edge curriculum with testing and suggestions for on-the-job competency development. It allows for the ability of anyone connected to a service recipient to take the courses. Its use expands knowledge and skills on all levels of the service delivery system.

As part of the College of Direct Support, DSPs are given the opportunity to participate in a Career Path. The Career Path is presented as a systematic way to provide incentives for DSPs to remain in direct support while also increasing skills and competencies necessary to providing person-centered supports, strengthening relationships and ensuring the health and welfare of people with disabilities. The Career Path structure is consistent statewide and is competency-based, accessible, portable, and leads to recognition and professionalism. The NJ Career Path aligns with the credentialing requirements of the National Alliance for Direct Support Professionals (NADSP) giving NJ DSPs the opportunity to pursue a nationally recognized credential.

The competency-based Career Path is a process whereby DSPs complete up to three levels of coursework combined with mentoring and participation in on-the-job activities. Upon documented completion of each level a certificate is attained. The intention is that agencies will offer the Career Path as an option to its employees, but will also utilize a selection of the courses offered through the College of Direct Support to expand upon the required training of its entire staff. Outcomes of these training opportunities include an increase in the skills of DSPs taking courses through the College of Direct Support and recognition of DSPs through certificates earned through completing the Career Path.

The Career Path was designed through a multi-year, statewide, collaborative process and was further enhanced through a CMS technical assistance grant on workforce development and a grant from the NJ Council on Developmental Disabilities.

In January 2008, the College of Direct Support was used to implement a pilot that tested the design of the Career Path. The pilot ended in July 2010 and a maximum of 10 agencies participated in this pilot.

In July 2010, utilizing state funding, New Jersey purchased the College of Direct Support for statewide implementation under the Division of Developmental Disabilities (DDD). New Jersey made a commitment to statewide implementation and completed the statewide

implementation of the College of Direct Support in June 2011. DDD service providers across the state now are able to provide cutting edge, easily accessible, competency based online training to their staff. This availability of enhanced training opportunities is aimed at improvements in the quality of services provided and the professionalism of today's direct support workforce. Continued funding for the College of Direct Support will be funded through New Jersey's MFP rebalancing fund.

Success of this benchmark will be measured through surveys conducted by The Elizabeth M. Boggs Center with Direct Support Professionals who have received the training.

It is anticipated that the number of agencies offering continuing education through use of the College of Direct Support will increase across the years.

Currently the College of Direct Support is only available for DSP's in the field of ID/DD. A component for DSP's working with the elderly is currently being developed. Once it has been developed, NJ will be requesting to utilize rebalancing fund monies to purchase that curriculum as well.

The number of agencies offering continuing education through use of the College of Direct Support will increase by at least 10 agencies per year from 2012 through 2016.			
	First 6-month target	Second 6-month target	Full year target
2012	30	30	60
2013	35	35	70
2014	40	40	80
2015	45	45	90
2016	50	50	100

Benchmark #4:

Improvements in quality management systems (i.e., direct interventions undertaken by the State to ensure the health and welfare of participants is protected while also maintaining consumer choice).

The Division of Aging and Community Services has purchased the Social Assistance Management System (SAMS) through the CMS Systems Transformation Grant with the availability of licensure for the Division of Disability Services.

NJ will investigate the possibility of utilizing rebalancing funds to expand the implementation of SAMS to include DDD. Enhanced match funding may be utilized to offset the cost of implementing SAMS in DACS and DDS. SAMS will enable NJ to realize an improvement in quality management systems through enhanced ability to track shared consumers across service delivery systems.

The software will allow participating agencies to better monitor cross system usage and patterns of treatment. Currently agencies are limited to reporting on only their own data. This restricts their ability to control individual consumer treatment for consumers who utilize services provided in other agencies. This compromises the analysis of service patterns, dollars or utilization to individual outcome.

By monitoring utilization cross system the system will enable participating agencies to prospectively forecast service needs of targeted services rather than relying on retrospective composite reports.

Once SAMS is implemented, NJ will report on the average service utilization per consumer, per service across service delivery systems.

NJ Division of Developmental Disabilities

Quality assessment of HCBS assurances for those individuals transitioning out of institutions (ICF-MRs) as well as those in the community who are in the HCBS waiver program (CCW) is currently accomplished through the sampling process articulated in the waiver program. Risk assessment is part of the quality review process for all waiver participants. The National Core Indicator review process is also conducted through a random sampling of waiver participants.

For Money Follows the Person, the following will apply:

DDD Measure			
Risk assessments will be completed for 100% of MFP Participants. Risk factors will be documented in the Health and Safety Risk Summary. As part of annual service planning, DDD will complete risk assessments on all projected MFP transitions.			
	Target Measure	Measure: Mid-Year	Measure: Year-End
Base Year *			
2008	18	9	18
2009	97	48	97
2010	31	16	31
2011	31	16	31

Measure 1 - Risk assessments will be completed for 100% of MFP Participants. Risk factors will be documented in the Health and Safety Risk Summary. As part of annual service planning, DDD will complete risk assessments on all projected MFP transitions.			
	First 6-month target	Second 6-month target	Full year target
2012	86	86	172
2013	115	114	229
2014	72	72	144
2015	99	99	198
2016	20	20	40

The NJ Division of Aging and Community Services:

Prior to January 1, 2009, the Division of Aging and Community Services was the state operating agency for three separate 1915(c) waivers all serving individuals who were over the age of 65 and individuals between the ages of 21-64 who were determined physically disabled. These three programs were ultimately consolidated into one 1915(c) program called the Global Options for Long-Term Care 1915(c) Medicaid Waiver.

The Quality Management Strategy the Division has used over the years in operating these programs has been refined to improve processes and continue to adequately demonstrate that it has effective systems and mechanisms in place to comply with core quality assurance measures.

Since 2005, a team of three to four State representatives from the DACS Quality Assurance Unit has conducted on-site survey visits for each County every 24 months. Multiple care

management agencies cover the same Counties. During this visit, the care management services rendered for Global Options for Long-Term Care (GO) Medicaid Waiver participants is monitored. While on-site, team surveyors obtain pre-selected files to review. Primarily files that have been opened with the past three years are selected for examination. After the on-site review is complete, a Follow-up Letter is sent to the care management agency within 30 business days of the visit to outline the conclusions of the quality assurance survey. If a Remediation and Improvement Plan is warranted, the care management agency has 30 days from the date of the letter to respond to DACS. The New Jersey Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) has established a Quality Management Unit (QMU) in its Office of Provider Relations for the purpose of routine and ongoing oversight and monitoring of the Quality Management Strategies implemented by all State Operating Agencies of Medicaid Waiver programs, including the one operated by the DACS.

Seventy percent of the case records of Global Options participants who were transitioned out of a nursing facility through the Money Follows the Person initiative will be included in the overall on-site reviews of GO cases when QA visits are conducted according to the 24 month review cycle detailed in the Quality Management section of this Operational Procedure.

Benchmark 4: DACS/DDS Measure 2 – Each year a targeted number of on-site reviews of case management files will be assessed for compliance with quality assurance requirements. MFP cases will be included in audit.			
	First 6-month target	Second 6-month target	Full year target
2012	181	181	362
2013	181	182	363
2014	181	183	364
2015	181	184	365
2016	181	185	366

Benchmark #5:

Interagency and public/private collaboration (i.e., direct interventions undertaken by the State to achieve a higher level of collaboration with the private entities, consumer and advocacy organizations, and the institutional providers needed to achieve a rebalanced long-term care system).

As referenced in the housing section of this Operational Protocol, MFP program staff will seek to meet with at least 15 PHAs per year beginning in 2011 to provide them with education and information on MFP. The time period prior to beginning visits to PHAs will be spent establishing relationships with PHAs and other public/private housing organizations.

In order to accomplish the above goal, New Jersey will be seeking to hire a full-time Statewide Housing Coordinator to oversee statewide efforts to develop/expand the availability of affordable and accessible housing for all vulnerable populations but primarily for those that meet the MFP eligibility criteria. The Statewide Housing Coordinator will be hired by the Division of Developmental Disabilities and be responsible to provide leadership in developing a housing strategy in coordination with the NJ Housing and Mortgage Finance Agency (HMFA), The NJ Department of Community Affairs (DCA), Public Housing Authorities and local housing providers and advocates.

Measure 1: MFP Statewide Housing Coordinator will meet with at least 15 PHAs per year.			
	First 6-month target	Second 6-month target	Full year target
2012	7	8	15
2013	7	8	15
2014	7	8	15
2015	7	8	15
2016	7	8	15

Benchmark #6:

Provision of Informational Materials on Community Based Options

The State will devote funding from the rebalancing fund for the development of educational and promotional materials on community based service options. These materials will be available in English, Spanish and other languages and formats, as needed. The state will also devote funding from the rebalancing fund to standardize web sites across the MFP partners to be in compliance with the ADA.

Under the CMS Systems Transformation Grant, the Public Access and Awareness workgroup coordinated focus groups with consumers and providers to identify how people access information, where they obtained information, and the type of information they needed to search for community based options. Based on these findings a report was prepared by Rutgers Center for State Health Policy and based on the recommendations from this report, the State began developing MFP Brochures and informational fact sheets.

In 2011, a new collaborative partnership was formed between the state’s MFP program and the NJ Office of the Ombudsman and Institutional Elderly (OOIE). This office will play a critical role in educating older adults and those with physical disabilities and their families about community living options available to them. This will be accomplished by implementing a comprehensive, multi-layered marketing and outreach plan that features strategies for facility-based marketing and education as well as focused messaging to the larger community.

With CMS approval, New Jersey plans to utilize 100% administrative match funding for start-up production costs for the marketing and outreach program. The maintenance of this program will be funded through the State’s rebalancing fund.

DACS/OOIE Measure 1 –Education and marketing materials will be distributed to key stakeholders and the community at large in all NJ counties via a comprehensive, multi-layered marketing and outreach plan that features strategies for facility-based marketing and education as well as focused messaging to the larger community to inform NJ residents of their community based options. As a result of the education and marketing campaign, it is expected that the number of referrals/request for information will increase by a minimum of 25 % each year.

	First 6-month target referrals/request for information:	Second 6-month target referrals/requests for information:	Full year target referrals/requests for information:
2012	100	100	200
2013	125	125	250
2014	156	156	312
2015	195	195	390
2016	244	244	488

Benchmark #7:

Increases in available and accessible supportive services (i.e. progress directed by the state in achieving the full array of health care services for consumers, including the use of “one time” transition services, purchase and adaptation of medical equipment, housing and transportation services beyond those used for MFP transition participants).

New Jersey would like to add an employment component to its MFP Program. The addition of an employment component coincides with the fact that New Jersey has become the fourteenth (14th) state to adopt an Employment First Initiative. This initiative embraces a philosophy – implemented through policies, programs and services – to proactively promote competitive employment in the general workforce for people with any type of disability.

As a result of New Jersey adopting Employment First, the Department of Labor and Workforce Development (LWD) and the Department of Human Services (DHS) will coordinate to deliver services that advance the goals of this initiative. That means assessing policies to ensure that the infrastructure of education, social services, transportation and workforce expectations support getting individuals with disabilities to work. It will also require all of state government to examine their respective policies and regulations to prevent barriers to employment for individuals with disabilities.

The Governor of New Jersey has committed to creating employment opportunities for New Jerseyans with disabilities by:

- Protecting funding for Vocational Rehabilitation Services at the enhanced level provided in the Fiscal Year 2012 Budget, so that providers will have the resources necessary to offer enhanced work activities for a second year;
- Continuing NJ WorkAbility, a New Jersey Medicaid Buy-In Program which offers full health coverage to people with disabilities who are working, and whose earnings would otherwise make them ineligible for Medicaid. Currently, there are more than 9,200 participants in NJ WorkAbility;
- Contracting with supportive employment agencies through the Division of Mental Health and Addiction Services. Approximately 900 individuals have obtained competitive employment through this process since January 2010;
- Contracting with supportive employment agencies through the partnership of the Division of Mental Health and Addiction Services and the Division of Vocational Rehabilitation Services. Approximately 900 individuals have obtained competitive employment through this process since January 2010;
- Continuing to provide job training and placement and assistive technology through the Commission for the Blind and Visually Impaired’s vocational rehabilitation program to over 2,500 clients since January 2010.

In addition, building upon a public/private initiative called ‘DiscoverAbility’, the Departments of Human Services and Labor and Workforce Development, together with hundreds of businesses statewide, will intensify efforts to collaboratively provide the services and training necessary for individuals with disabilities to prepare for and find and retain employment.

DHS supports numerous education and employment programs within the Divisions of Developmental Disabilities and the Division of Disability Services.

The Division of Disability Services (DDS) has been one of the lead agencies, administering New Jersey’s Medicaid Infrastructure Grant, and thereby supporting the employment of individuals with disabilities in New Jersey and believing that people with disabilities are an integral part of the labor force and are active and valuable participants in the economic growth and vitality of the state. With CMS’ approval, New Jersey will hire an MFP Employment Specialist who will assist transitioning individuals interested in entering the workforce upon discharge from an institutional setting. Specifically, all participants between the ages of 18-64 and any other MFP participant who self identifies an interest in employment/volunteerism will receive an Employment Resource Packet and follow up services upon discharge from the institutional setting. The Employment Specialist will develop the employment resource packet which will contain resource materials for individuals interested in work or volunteering. The Employment Specialist will provide follow up technical assistance and supports both directly to MFP participants and to community agencies who work with participants who are transitioning to the community or who have successfully transitioned and are now seeking to explore employment as a second phase of their integration. Follow up services by the Employment Specialist will be case specific. Some individuals will take the Employment Packet and “run with it”; others may need more assistance with finding resources and making connections; some may need to be driven and accompanied to their local VR office. The follow up and assistance will be driven by whatever barriers are determined. The level of support will be based upon the individual’s own unique needs.

With CMS’ approval, Peer Mentors will be hired from each of the MFP target populations and will serve to provide mentorship to individuals as they transition and seek employment. They will also serve as a guide as New Jersey moves forward with its “Employment First” effort. The Peer Mentors will provide each MFP participant with an informal support mechanism to lessen any anxiety around issues of transition and employment and serve as a facilitator between the participant and the professional staff. Peer Mentors will be individuals who through their own self advocacy, have successfully transitioned from an institution or facility with support or avoided placement in an institution or facility and have become successful in the community and in the workforce.

Measure 1: All MFP participants between the ages of 18-64 and any other MFP participant interested in employment/volunteerism will receive an Employment Resource Packet upon discharge from the nursing facility. The Employment Specialist will meet 1:1 with <u>all</u> individuals expressing a desire for employment/volunteerism to provide technical assistance and supports both directly to MFP participants and to community agencies who work with these participants.			
	First 6-month target	Second 6-month target	Full year target
2012	37	38	75
2013	40	40	80
2014	41	42	83
2015	44	44	88
2016	47	47	94

Implementation Policies and Procedures

Participant Recruitment and Enrollment

In all cases, a person will be considered enrolled when the following have been completed:

1. Signed Informed Consent
2. Completed MFP-75 enrollment form (see Appendix 6). Actual date of move must be recorded on this document.
3. Completed MFP Quality of Life Survey

Elderly/Physically Disabled

Identification and Referral for Money Follows the Person (MFP) Clinical and Financial Eligibility

PURPOSE: To ensure that individuals are appropriately referred for MFP, are clinically and financially eligible to participate and that preliminary discussions are begun with individuals and families to determine their interest in returning to the community.

Impact: If eligible individuals are not referred properly, the enhanced service package provided under MFP will not be available to them.

Participants will be recruited from all state Nursing Facilities. There will be no staging or targeting of specific Nursing Facilities. A listing of all nursing homes is included in this section of the Operational Protocol. A Nursing Facility is defined as a facility that provides care to those who meet the Nursing Facility Level of Care need as determined through the Pre-Admission Screening (PAS) assessment process.

1. Individuals who are clinically and financially eligible for Medicaid and wishing to return to the community must meet the MFP eligibility criteria, which are that the individual:
 - Nursing Facility Level of Care appropriate
 - A resident of a Nursing Facility for a minimum of 90 consecutive days
 - Medicaid eligible for at least 1 day prior to transitioning out of the Nursing Facility
2. Individuals who are not eligible for MFP are those who:
 - Are on SSI and New Jersey Care who need Medicaid State Plan Services only;
 - Are assessed as appropriate for the Medicaid Hospice benefit;
 - Are chronically mentally ill;
 - Are Medically Needy;

Roles and Responsibility for Effective Referral

1. When the NF Social Worker knows that a NF resident is interested in participating in MFP, he or she contacts the Regional Office of Community Choice Options (OCCO) for MFP screening using the CP-2 as a referral form. Referrals from the NF for Section Q should also trigger referrals for MFP.
2. Community Choice Counselors (CCC) from the Regional Office of Community Choice Options are assigned to nursing homes. It is the CCC's responsibility to reassess elderly and/or disabled individuals on a periodic basis to identify the potential for discharge. Individuals are also referred by themselves, family members, nursing home social workers, and former case managers. If someone meets the clinical, financial, and resident time frame criteria for MFP, the program is explained, and wish to participate is confirmed. The CCC sets up an Interdisciplinary Team meeting with the resident, family members, relevant NF staff, NF Social Worker, Care Manager and a transition plan is developed.
3. Social work and other appropriate transition staff will be encouraged to make referrals to MFP through ongoing informational meetings with the MFP Project Director. The MFP Project Director will highlight the benefits of MFP to consumers in their effort to identify means to overcome service barriers to community placement.

The Initial MFP-Nursing Facility Transition Screening Process

1. The goal for the CCC is to complete the PAS within 14 calendar days of receiving a MFP referral.
2. The CCC will review the individual's NF chart, the current PAS, and visit the resident to:
 - Determine his or her desire to return to the community;
 - Verify that all eligibility criteria for MFP are met; and
 - Establish the extent to which the resident wishes to participate in the Interdisciplinary Team (IDT) meeting.
3. If resident is a candidate for MFP, the CCC will:
 - Discuss the full range of services offered under MFP and determines if the resident wants to re-locate. If the resident is interested in an Adult Family Care (AFC) home, then the resident must be informed that there is a potential cost share responsibility and Room and Board fee;
 - Update clinical information in the MDS-HC database;
 - Obtain the resident's signature on the Release of Information form;
 - Identify the appropriate IDT participants/agencies including the potential care management agency, family, nursing social worker/discharge planner, Centers for Independent Living (CIL), Occupational or Physical Therapist, AFC provider, or the

- Office of the Public Guardian;
 - Contact the IDT participants to coordinate and arrange the meeting date(s), providing at least seven working days notice of the meeting; and
 - Forward the current PAS to the NF SW/DC Planner and prospective CM.
4. If the resident does not meet MFP eligibility criteria, the CCC will:
- Counsel the person on other LTC options including State funded programs, Medicare services, Older American Act programs, and private pay options.
 - Notify the individual who made the referral that the resident is not eligible for MFP and the reasons for the ineligibility.

The Interdisciplinary Team (IDT)

PURPOSE: Convening the IDT is critical to the MFP process. It assumes that the participant will take ownership of the IDT meeting, and will direct the process of creating a person-centered Transition Plan. Team members will work together to counsel and assist the participant/designee to identify appropriate and available support services that meet their individual care needs; establish an estimated individualized budget; develop a Transition Plan that identifies the services that will allow the participant to return to the community; and coordinate and schedule services prior to discharge.

Potential MFP participants are identified prior to the IDT. The CCC completes or updates an existing assessment for a resident referred to him or her by the resident, family, NF Social Worker, or as part of the CCC's follow-up to NF admissions. If the person seems a likely candidate, MFP will be discussed in depth. If it is the resident's choice to return to the community, an IDT would be scheduled.

Roles & Responsibilities of IDT Members

1. Resident/Designee:

- Directs the IDT process to the extent he or she wishes;
- Defines personal goals and preferences;
- Identifies the potential informal and formal support systems;
- Completes tasks assigned at the IDT meeting;
- Signs the required documents:
 - A. Agreement of Understanding
 - B. Transition Plan, the Consumer Choice Section
 - C. Attestation Form
 - D. Release of Information Form if not previously signed.

2. Community Choice Counselor (CCC):

- Facilitates the IDT process;
- Supports the participant/designee to engage in the IDT process;
- When appropriate, advocates and negotiates on behalf of the participant;
- Identifies Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL)

- needs to be met in the community;
 - Arranges for Community Transition Services as necessary;
 - Locates and arranges the housing/facility;
 - Serves as the timekeeper for the IDT meeting and ensures that it does not exceed one and a half hours;
 - Summarizes the results of the IDT meeting with next steps, including additional IDT meetings, and identifies the tentative date for discharge.
3. **Nursing Facility Discharge Planner/Social Worker:**
- Reviews and updates relevant documents in NF Client Record and reconciles information with CCC;
 - Secures meeting area for the IDT;
 - Notifies Social Security of change in address and other participant-related matters;
 - Arranges for prescription drugs;
 - Arranges for and schedules post discharge Medicare services; and
 - Working with the care manager, coordinates and links discharge services.
 - Arranges for Durable Medical Equipment (DME) if the need is identified prior to discharge
4. **Care Manager (CM):**
- Serves as the community resource expert;
 - Assists in locating and gaining access to needed medical, social, educational and other services identified in the Transition Plan;
 - Assists in the writing of the Transition Plan; and
 - Estimates the cost of services identified in the Transition Plan.
 - Arranges DME if the need is identified post discharge.
5. **Other Possible Members of the IDT**
- Occupational Therapist;
 - Physical Therapist;
 - Speech Therapist
 - Representative from Center for Independent Living;
 - Social Worker or other representative from the Assisted Living Provider/Adult Family Care Program;
 - Representative from the Office of Public Guardian;
 - Housing advocate; and
 - Friend or other designee.

The IDT Pre-Meeting

The CCC convenes the meeting one half hour before the participant's arrival to review background, clinical level of care needs, degree of functional limitations, potential difficulties in the transition process, and the participant/designee's wishes and preferences.

The IDT Meeting:

1. To qualify as an IDT meeting, the resident/family or responsible party, community choice counselor, nursing facility social worker/discharge planner, and care manager must be present.
2. Limited circumstances permit IDT participation by conference call:
 - For current AL/AFC Medicaid Waiver participants that will be returning to the same facility as a MFP participant, an AL/AFC designee and care manager may participate in the IDT meeting via a conference call.
 - For new MFP participants, who will be entering AFC for the first time, an AFC designee must meet the resident prior to discharge and contact CCC to confirm the AFC's acceptance of the resident on MFP as of the date of discharge from the nursing facility.
 - If AFC designee is unable to attend IDT, the CCC will forward a copy to him or her of the Transition Plan, which outlines the specific needs of the participant.
3. The IDT reviews:
 - ADLs/IADLs;
 - Cognitive status,
 - Personal goals and preferences;
 - Informal support system; and
 - Environmental safety, including barriers and needed adaptations
 - Evaluation of risk factors.
4. The team discusses the options and choices:
 - Home and Community-Based Services (HCBS); and
 - Available providers.
5. The participant who selects AFC is counseled about his or her cost share.
6. The IDT develops the Transition Plan and estimates the cost of services.

The Transition Plan

1. The Transition Plan serves as the interim Plan of Care for discharge planning purposes and is completed by the CCC in conjunction with the CM.
2. The Transition Plan must include the following:
 - Personal goals, cultural preferences, and strengths and weaknesses;
 - Desired outcomes;
 - State Plan and Waiver Services to meet assessed needs;
 - Community Transition Services (one-time purchases, security deposits) that must be arranged prior to discharge,

- Informal supports;
- Potential agencies to provide services and supports;
- Number of hours approved for each service (State Plan and Waiver); frequency, and cost per unit*;
- Estimated budget based upon approved services, rates, and hours;
- Consumer Risk Factors,
 - Identification of environmental barriers in the participant’s home that might affect the transition;
- Back-up plans to address risk factors;
- Consumer Choices and Responsibilities, and
- Signatures of all IDT members.

Although community agencies initially may not be able to schedule the total number of hours authorized in the Transition Plan, the care manager has the authority to arrange services up to budget amount authorized in the IDT without seeking additional approval.

Individualized Budgets

1. The individualized budget is based upon the level of care needs as determined by the MDS-HC assessment tool.
2. The CCC has the authority to authorize up to \$2,841 per month for waiver services. (The authorized budget does not include the cost of State Plan Services, environmental modifications/adaptations or Community Transition Services.)
3. When care needs exceed \$2,841 per month:
 - The CCC forwards the Transition Plan, which includes justification for the higher level of care needs, to the DACS county liaison for review and approval or denial.
 - DACS county liaison reviews the documentation and the MDS-HC assessment and notifies the CCC that the increased budget request is approved or denied.
 - An individual whose care needs exceed \$2,841 will not be denied admission into MFP. During the IDT, the Community Choice Counselor (CCC) will contact the DACS county liaison to request authorization to exceed the spending cap. The CCC justifies the request by identifying assessed needs, services necessary to meet the needs, and the cost of providing the services. To date, no individual has been denied participation in existing waivers because care needs exceed the spending cap.

Community Transition Services

1. The MFP program will pay for the one-time expenses related to relocation such as moving related costs, furniture, household items, other incidentals, and security deposits for apartments/utilities.
2. The CCC must locate items and submit itemized voucher/Individual Service Agreement

(ISA) with the cost of the items to the Nursing Facility Transition Coordinator (NFT) at OCCO Central Office.

3. The OCCO Regional Managers or GO Specialists will review and approve or deny the proposed purchases on the voucher/ISA that was initially submitted.
4. Once the purchases or expenses have been approved, the CCC will finalize purchases, security deposits, and/or moving arrangements and forward the original receipts to the DACS Fiscal Unit.
5. Upon MFP enrollment the CM must enter Client Profile on HCBS website.
6. The Care Manager will set-up the Individual Service Agreements (ISA) and forward copies of the receipts to PPL for payment.

Arranging for Environmental Accessibility Adaptations (EAA) or Special Medical Equipment (SME) not covered by Medicaid State Plan.

1. If the IDT identifies environmental barriers in the participant's home such as entryways or bathrooms that are not wheelchair accessible that need to be corrected, the CM must obtain at least two bids from approved GO/JACC providers for making the modification.
2. When the resident is discharged and enrolled in MFP, the CM will submit the Special Request Form to the OCP County Liaison for review and determination.

Forms Associated With IDT Process

The Referral Packet is completed at the IDT meeting and distributed to the appropriate IDT members. The packet includes:

1. Nursing Facility Check-off List (IDT professional members). This form is optional.
2. MDS-HC & Interim Plan of Care/Service Authorization - completed by CCC (CM receives a copy).
3. Transition Plan - completed by the CCC & CM (all IDT members receive copies).
4. Transitional Services – Addendum completed by the CCC (all IDT members receive copies).
5. Agreement of Understanding (residents & CM receive copies). The Agreement of Understanding is a signed acknowledgement by the applicant and/or his or her family/representative that he or she: chooses to participate in the appropriate waiver, agrees to share in the implementation of the Plan of Care (POC) and accepts the specific responsibilities outlined in the POC, acknowledges that his or her Care Manager will assist him or her in arranging and coordinating services but will not provide direct care and that there are financial limits on the amount of money that can be expended on his or her care in the community under the waiver program.
6. Proof of Medicaid Financial Eligibility CP-2 or SINQ for SSI residents (CM receives copy).
7. Cost-share introductory letter for AL/AFC, when appropriate (resident/designee receive

copy)

Discharge from the Nursing Facility to MFP

PURPOSE: The discharge process is intended to ensure that services and supports identified in the Transition Plan are arranged and coordinated prior to the individual's departure from the nursing facility.

Roles and Responsibilities for Effective Discharge

1. Nursing Facility Discharge Planner:

- Assures that the discharge is planned, coordinated and executed.
- Assures that tasks assigned to IDT members are completed.
- Notifies the Community Choice Counselor (CCC) and the Care Manager (CM) of the consumer's actual date of discharge, or if changed, the new date of discharge and the reasons for the delay.
- Assures that the Transition Plan is modified to incorporate changes since the IDT.
- Faxes the Transition Plan to OCCO and the care management agency.
- Returns any Personal Needs Allowance (PNA) to the consumer.
- Ensures that the Zero PA-3L is completed so that the resident will have his or her last month's income returned as part of the Month-of-Discharge Exemption.
- Arrange for Medicare services post NF.

2. Community Choice Counselor:

- Contacts the MFP participant within 48 hours to verify that services have been delivered, and that he or she is adjusting to the community.
- Contacts the CM if problems are identified and follow-up is required.
- Notify OCCO Regional Office of date of discharge. A CP-5 Enrollment Form will be completed by OCCO Regional Office and distributed to CWA, CM and provider if applicable.

3. Care Manager:

- Enters the Client Profile on the HCBS website.
- Within 30 days:
 - A. Visits the participant to affirm that the services and supports identified in the Transition Plan are appropriate;
 - B. Incorporates Transition Plan and any changes to the Plan of Care (WPA-2);
 - C. Finalizes the POC and obtains signatures of the participant/designee, CM, and CM's supervisor;
 - D. If the participant selects AFC:
 - Prepares the Cost Share Worksheet and gives a copy to the participant and the facility/program if participant has a cost share.

Transition of the Elderly/Physically Disabled from NFs under the MFP will build upon the collaborative practice of having all relevant parties participate in the Interdisciplinary Team

meetings necessary to transition an individual to the community. The MFP and Waiver Care Manager are the same individual who will become primary Care Managers for the implementation of the Plan of Care for waiver services. In October 2011, all MFP participants who are enrolled in the 1915c Waivers will mandatorily be enrolled in Medicaid Managed Care and receive Care Management services from the HMO for all acute and State Plan Services. The Waiver Care Manager and HMO Care Manager will coordinate services between State Plan and Waiver services.

Performance Standards and Outcome Measures

The following are performance measures that will be evaluated through the use of a survey instrument.

- Services and supports identified in Transition Plan are scheduled prior to discharge.
- The CCC and CM are notified when the participant is discharged or when the discharge is delayed.
- The CCC contacts the MFP participant/designee within 48 hours of discharge and again within 14-30 days.
- The CM is contacted when the CCC identifies problems/issues with participant and/or Transition Plan.
- The CM visits the MFP participant/designee and finalizes the Plan of Care within 30 days of discharge.

Forms Associated with Discharge

1. **Transition Plan:** The CCC and CM complete the Transition Plan, which is signed by all members of the IDT prior to discharge.
2. **CP-2: Long-Term Care Referral:** The NF SW/DP requests from the CWA for the CCC.
3. **SINQ: -Social Security Inquiry:** CCC requests as proof of SSI eligibility from OCCO.
4. **CP-5 – Notice of Program Enrollment:** The CM completes the form and forwards it to OCCO and MIS/Data Unit, and to CWA if the participant is not on SSI. The CWA will enter SPC 75 into the client eligibility file.

Administrative Responsibilities

1. The NF discharge planners notify the Social Security Administration of any change in the individual's address.
2. The NF discharge planners ensures that the PNA and month of discharge income is returned to participant.
3. The NF discharge planners notify OCCO and the CM of the actual date the participant is discharged or that there is a delay in discharge.

The CCC notifies the OCCO Regional office of date of discharge for entry into Molina and enrollment in the program.

* It should be noted that: Assisted Living, which is an Assisted Living Residence or Comprehensive Personal Care Home, is not a qualified residence for MFP and will not be used as a discharge location for an individual using MFP to return to the community. There are two additional programs which have been deemed appropriate as qualified residences namely, Assisted Living Program (ALP) and Alternate Family Care (AFC). Please refer to the Housing section for further detail on ALP and AFC as it relates to MFP.

MR/DD Recruitment and Enrollment

Individuals participating in the MFP program will be transitioning from the seven ICF/MR publicly operated developmental centers funded and administered by the NJ Division of Developmental Disabilities (DDD). All individuals identified to move from a developmental center as part of Olmstead will be offered the opportunity to participate in MFP. Individuals are expected to move from each of the seven developmental centers each year. The Transition Case Manager will ensure that individuals will be informed of their rights and responsibilities under MFP. The Transition Case Manager will obtain consent from the guardian for a person's participation in MFP.

All seven of New Jersey's publicly operated Developmental Centers maintain certification under the federal ICF/MR program. The centers are located throughout the state.

North Jersey Developmental Center – Passaic County
Hunterdon Developmental Center – Hunterdon County
Woodbridge Developmental Center – Middlesex County
Green Brook Regional Center – Somerset County
New Lisbon Developmental Center – Burlington County
Vineland Developmental Center – Cumberland County
Woodbine Developmental Center – Cape May County

Process to identify eligible individuals each year.

At least annually the Interdisciplinary Team (IDT) shall review recommendations for community placement and identify supports the individual will need to facilitate a successful transition and support him/her to live as independently as possible in a community setting.

Social work and other appropriate transition staff will be encouraged to make referrals to MFP through ongoing informational meetings with the MFP Project Director. The MFP Project Director will highlight the benefits of MFP to consumers in their effort to identify means to overcome service barriers to community placement.

Criteria for Community Placement from the Developmental Center

In New Jersey, the primary criteria presently used to identify individuals who can move from developmental centers to a community setting are:

- The person expresses a desire or does not oppose living in the community.
- The Interdisciplinary Team (IDT) recommends a move to a community setting. Criteria used by the IDT include
 - There is no court order prohibiting such a move.
 - The IDT recommends an individual be placed in a community setting due to the absence of behavior that poses a significant risk to self/others and the level of

intervention the persons requires does not exceed what can be provided in a community setting at the time of the recommendation.

Because a large number of individuals living in the Developmental Centers meet these criteria it is necessary to prioritize the groups in the following manner:

- The family/guardian does not oppose the plan to transition the person to the community.

The Division is providing extensive educational opportunities for families/guardians who oppose their relative moving to a community setting in order to promote informed decisions about community placement.

Additional Criteria for MFP Participants

- The institution the person is coming from must be an ICF/MR facility.
- The person must live 90 consecutive days or more in a DC.
- Medicaid eligibility must be obtained 1 day before the person moves.
- The individual must move into a qualified residential program
 - Own home or family home.
 - Apartment where the lease is in the person's name and they have control of life domains and who enters and exits the home.
 - Setting with no more than 4 (including the person in MFP) unrelated individuals.
- Person is HCBS Waiver eligible on the day he/she moves.
- Person/Guardian must sign consent agreeing to MFP participation, including follow-up interviews as part of evaluation.

Information Used

Informants who knew each person well in eight programmatic areas of expertise at each Developmental Center (DC) were trained in the use of a statistically reliable assessment instrument developed for DDD by the Developmental Disabilities Planning Institute (DDPI) at New Jersey Institute of Technology (NJIT). Staff completed that module that was specific to their programmatic area. The programmatic areas were Social Work, Psychology, Physical Therapy, Occupational Therapy, Habilitation, Nursing, Nutrition, and Speech.

The assessment provides the Division with:

- a. A standardized tool for use by all developmental center staff members to describe the unique abilities and needs of each resident;
- b. A statewide database which includes information regarding the abilities, preferences and support needs of each resident of the developmental centers; and;
- c. The information necessary to identify specific obstacles which may influence the decision-making of staff members who determine, in the Individual Habilitation Plan (IHP), the potential for an individual's community placement.

Information provided to individuals to explain the Transition process and options and how disseminated

- Fact Sheet for MFP. (1 page sheet – Contained in Outreach/Marketing/Education)

- Instructional Training for Professional Staff about MFP. (power point presentation – contained in Outreach/Marketing/Education Section)
- Letter sent to families about 6 weeks prior to the IDT meeting.(letter)
- Overview at the IDT meeting.(script)
- Calendar of Educational and Training Opportunities (paper) Updated 2 times per year.
- Booklet describing the transition process (Support coordination: Using person centered thinking and planning to build on your loved one’s Current Life by Neighbours, Inc.).
- Instructions about how to access the page on the DDD website focusing on Olmstead.
- Family Forums (UMDNJ – School of Public Health – Family Education Project) – 4 per year
- Mailed Newsletters (New Beginnings in Community Living)
- Pamphlets (New Beginnings in Community Living: Exploring the Possibilities) (UMDNJ – School of Public Health – Family Education Project)
- Fact Sheets (Path to Progress – Community transition from a Developmental Center – Fast Facts) (UMDNJ – School of Public Health – Family Education Project)
- Training Modules for Families (UMDNJ – School of Public Health – Family Education Project)
 1. Getting Started- Learning about self-direction and new opportunities for community living;
 2. Putting it Together-Developing a Plan for Successful community Living;
 3. Choosing a Path: Options in community housing and supports;
 4. Making it work: Moving to the community and monitoring for success;
 5. Community Providers – in development
- Provider Market Fairs (annually) – Connecting Consumers and Families with Community Providers
- DDD Today (Email newsletter) – formerly “Olmstead Newsletter” – sample contained in this section

For those individuals with cognitive impairments, program rules, responsibilities and risks will be explained to guardians, parents, interested/involved relatives to ensure proper informed consent to participate in MFP.

For those individuals with resistant guardians, family members or other interested parties, ongoing information/educational meetings and visits to community services will be offered. As stated previously, the benefits of MFP will be explained as a way to enhance the ability of a person to overcome barriers to community placement.

Individuals participating in MFP must live in the developmental center 90 consecutive days or longer before they move from the center. The Transition Case Manager at each DC will verify the admission date of each individual to a developmental center at least 30 days before the individual moves.

The Supervisor of Patient Accounts at each DC will verify with the NJ Division of Medical Assistance and Health Services (DMAHS) (i.e., the state Medicaid agency) that each MFP participant has been eligible for Medicaid for at least 1 day prior to the move date from the developmental center.

In coordination with the Transition Case Manager, a referral will be made from the developmental center to the community on the participant's behalf for enrollment in DDD's HCBS 1915(c) waiver program, the Community Care Waiver (CCW). This referral will be made to the regional CCW coordinator with indication that the participant will be enrolled into the waiver and MFP simultaneously. The regional CCW coordinator will forward all enrollment information to the Institutional Services Section (ISS) of DMAHS. ISS staff will enter the enrollment information into the Medicaid system which will identify the participant as enrolled in the CCW and MFP. Notice of all enrollments into the MFP will be sent to the MFP Project Director.

Training for participants on protection from abuse, neglect, exploitation

A telephone listing of the 21 county-based Adult Protective Services (APS) provider agencies, including after-hours and emergency numbers, will be given to all MFP enrollees. As part of the Participant Recruitment and Enrollment process, participants and involved family members and other unpaid caregivers will be informed of APS.

For participants from developmental centers, including their families and/or guardians, information regarding their rights, including protections from abuse, neglect, and exploitation will be reviewed annually. This is current practice for all individuals within DDD's system and it is documented within each consumer's Individual Habilitation Plan (IHP). Participants will be able to contact any Interdisciplinary Team (IDT) members (the D.C. IDT consists of a Case Manager, Transition Case Manager, Social Worker, Support Coordinator, Psychologist or other professionals) in order to report concerns of abuse, neglect, and exploitation.

Upon the consumer's transition to the community, the licensed provider agency shall issue and explain the DDD's rights document. In addition, the consumer, family member and/or guardian will be given a contact list of advocacy agencies for further assistance with understanding and enforcing these rights if need be. (N.J.A.C. 10:44A requires; Every community provider agency must have a procedure to ensure the safety and well being of any individual under its care.

MFP Policy for Reenrollment

In all cases:

- If a person's initial community placement as part of MFP is unsuccessful and the individual returns to an institution reenrollment in MFP will be allowed.
- If an individual moves back into an institution for less than 30 days, then returns to their community placement, they will still be considered part of MFP.
 - For those individuals re-admitted to a NF for less than 30 days, and for whom Medicaid reimbursement is required for any or part of the stay, the individual's MFP enrollment will be temporarily suspended to enable payment to the NF.
- If an individual moves back into an institution for 30 consecutive days or more, they will no longer be considered part of MFP and are eligible for reenrollment. Termination from MFP will be effective back to the first day of placement in an institution upon reaching 31 days of placement in an institution.

To re-enroll in MFP

In all cases:

- All the criteria for enrolling in MFP must be met.
- In addition, the circumstances relating to the person's readmission must be addressed by the IDT.
- There must be evidence that the cause of re-institutionalization was examined, via review and revision of the Plan of Care to ensure appropriate supports are in place, to assist the individual with increasing success of community transition.

Informed Consent

The following describes the procedures that NJ will utilize to ensure that informed consent is obtained for individuals participating in the Money Follows the Person Demonstration Project:

NJ recognizes an individual's ability to make his or her own decisions when capable and utilizes the following hierarchy of authorized decision-making. If a person is unable to make his or her own decisions regarding the Demonstration Project, New Jersey recognizes the least restrictive form of decision-making possible given each individual circumstance.

1. The individual has capacity to make his or her own decisions.
2. The individual has appointed a Power of Attorney or a Health Care Surrogate through the NJ Advance Directives Act. The appointed person has the authority to make decisions as specified in the document when the individual is unable to make those decisions.
3. A legally appointed guardian makes decisions on the individual's behalf based on the specifications in the court order.
4. If no guardian or surrogate decision maker exists and there is question as to the individual's capacity for decision making as determined by professionals, then involved family or the person who knows the individual best is involved in the process of the decision making.

For non-verbal and cognitively impaired individuals, the risks, benefits and rules of MFP will be explained to guardians, family members and other interested involved parties. Information will be communicated to him or her in a language or form of communication that he or she understands. Also, an explanation will be given to those people closest to the individual so they can further reinforce and explain the program.

Informed consent will be obtained through consultation with interested parties, such as family members, friends, and/or if assigned, a court appointed guardian of the person. Informed consent for participation in MFP must be given by a guardian of the person (if so appointed).

In NJ, if an individual has been adjudicated incapacitated through the courts, that person is appointed a guardian. If the person receives services through the NJ Division of Developmental Disabilities and there is no family to act as guardian, the Bureau of Guardianship Services can be appointed guardian of the person pursuant to N.J.S.A. 30:4-165.12.

If the individual is 60 years old or older, and in need of a guardian, the Office of the Public Guardian can be appointed guardian of person and property if there is no family to serve.

For individuals receiving services through the NJ Division of Developmental Disabilities, Division Circular #41, "Informed Consent", shall apply.

For individuals who have been appointed a guardian through the Office of the Public Guardian:

Plenary guardians pursuant to R. 4:86 orders are authorized to give consent based on a number of factors including but not limited to:

- Whether the ward has the ability to express their opinion;
- Information about the ward's preferences either in writing such as an advance health care directive or reliable information from family or friends
- Best interest of the ward based on medical information and recommendations of medical personnel

For example an incapacitated person who has directly expressed to family or friends over the years that she wanted to die naturally without being kept alive by machines would indicate the ward's wishes.

Based on this information a judgment could be made and informed consent given to the medical personnel.

The process of obtaining informed consent will be the review of program information with prospective participants. See the Outreach, marketing and education section of this manual for specific information that will be presented to participants.

Participants or their guardians (including BGS court appointed guardians) must agree to participate in the Money Follows the Person Demonstration Project. Their consent will be documented through the **“INFORMED CONSENT FOR PARTICIPATION - STATE OF NEW JERSEY MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION PROJECT”**

Guardians may withhold consent if the individual with the disability did not want to participate or if the guardian determined it was not in the best interest of the individual. BGS guardians by regulation always seeks the wishes of the individual (if the individual is capable of expressing an opinion) before giving consent.

New Jersey's statutory criteria for informed consent for guardians are contained in N.J.S.A. 3B:12.

“A guardian of the person of a ward shall exercise authority over matters relating to the rights and best interest of the ward's personal needs, only to the extent adjudicated by the court of competent jurisdiction. In taking or forbearing from any action affecting the personal needs of a ward, a guardian shall give due regard to the preferences of the ward, if known to the guardian or otherwise ascertainable upon reasonable inquiry.”

Authority for decision making for guardians is also contained in N.J.S.A. 3B:12.

“Subject to the provisions of subsection c. of N.J.S.A.3B:12-56, **[the guardian shall]** give or withhold any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service”.

The policy and corollary documentation which demonstrates guardians have a known relationship with their wards exists in N.J.S.A. 3B:12,

“Powers and Duties of a Guardian of the Person of a Ward”

“... Personally visit the ward or if a public agency which is authorized to act pursuant to P.L. 1965, c.59 (C.30:4-165.1 et seq.) and P.L. 1970, c.289 (C.30:4-165.7 et seq.) or the Office of the Public Guardian pursuant to P.L. 1985, c.298 (C.52:27G-20 et seq.) or their representatives which may include a private or public agency, visits the ward not less than once every three months, or as deemed appropriate by the court, and otherwise maintain sufficient contact with the ward to know his capacities, limitations, needs, opportunities and physical mental health...”

For individuals receiving services through the NJ Division of Developmental Disabilities, N.J.A.C. 10:45 “Guardianship Services” shall apply. This document contains eligibility criteria for persons to receive guardianship services through the Bureau of Guardianship Services (BGS). The contact requirement is not less than annually, more frequently as necessary. N.J.A.C. 10:45 also states that the BGS staff may give or withhold approval for major changes of program or transfers.

BGS documents contacts/visits with individuals through progress notes and the BGS Annual Report. The BGS guardian shall demonstrate through case records active involvement in the transition process. The guardian will review the Plan of Care/Service Plan to ensure appropriate identification of services to support transition to the community.

The Office of the Public Guardian documents contacts/visits with individuals through progress notes and annual reports.

A telephone listing of the 21 county-based Adult Protective Services (APS) provider agencies, including after-hours and emergency numbers, will be given to all MFP enrollees. As part of the Participant Recruitment and Enrollment process, participants and involved family members and other unpaid caregivers will be informed of APS.

For participants from developmental centers, including their families and/or guardians, information regarding their rights, including protections from abuse, neglect, and exploitation will be reviewed annually. This is current practice for all individuals within DDD’s system and it is documented within each consumer’s Individual Habilitation Plan (IHP). Participants will be able to contact any Interdisciplinary Team (IDT) members (the D.C. IDT consists of a Case Manager, Transition Case Manager, Social Worker, Support Coordinator, Psychologist or other professionals) in order to report concerns of abuse, neglect, and exploitation.

Upon the consumer’s transition to the community, the licensed provider agency shall issue and explain the DDD’s rights document. In addition, the consumer, family member and/or guardian will be given a contact list of advocacy agencies for further assistance with understanding and enforcing these rights if need be. As required at N.J.A.C. 10:44A every

community provider agency must have a procedure to ensure the safety and well being of any individual under its care.

In addition, Complaints by BGS staff on behalf of a consumer are made up the chain of command in DDD or in a hospital etc.

As indicated on the following consent form, participants in MFP who wish to register a complaint or concern may contact the MFP Project Director who will record the complaint and direct the person accordingly.

DIVISION CIRCULAR #7 – GUARDIANSHIP SERVICES

(N.J.A.C. 10:45)

EFFECTIVE DATE: March 19, 2001

DATE ISSUED: August 31, 2001 (Rescinds DC#7 issued on February 1, 1997)

I. TITLE: Guardianship Services

II. PURPOSE: To establish procedures whereby persons receiving services from the Division of Developmental Disabilities (DDD) are provided state guardianship services.

III. SCOPE: This circular applies to all functional service units of the DDD with respect to persons who need a state guardian.

IV. POLICIES:

- The Department of Human Services is directed to provide comprehensive services, specifically including guardianship services, to persons who are eligible for services, in order that they may be provided with adequate training, care and protection. N.J.S.A. 30:4-165.1
- DDD is directed to perform such services for adults who are incapacitated, for whom no guardian has been appointed, as would otherwise be rendered by a guardian of the person. N.J.S.A. 30:4-165.5
- DDD is responsible for providing guardianship services to minors receiving functional or other services who have no available parent or guardian. N.J.A.C. 10:45-2.2
- BGS is designated by the Division Director to provide guardianship services where appropriate. BGS staff shall function distinctly and independently from functional service unit staff in terms of their relationship with individuals receiving services from DDD.
- DDD will provide guardianship only when no other suitable private party is available.

V. GENERAL STANDARDS:

NOTE: The remainder of this circular is the guardianship services rule which appears at N.J.A.C. 10:45.

Deborah Trub Wehrlen
Director

SUBCHAPTER 1. GENERAL PROVISIONS

10:45-1.1 Authority

(a) The Department of Human Services is directed to provide comprehensive services, specifically including guardianship services, to eligible developmentally disabled persons, in order that they may be provided with adequate training, care and protection (see N.J.S.A. 30:4-165.1).

(b) The Division of Developmental Disabilities is directed to perform such services for adults who are incapacitated, for whom no guardian has been appointed, as would otherwise be rendered by a guardian of the person (see N.J.S.A. 30:4-165.5).

(c) The Commissioner of the Department of Human Services is mandated to make all reasonable and necessary provisions to insure the health, safety, welfare and earliest appropriate release of persons admitted to residential services for the developmentally disabled (see N.J.S.A. 30:4-25.7).

(d) The Bureau of Guardianship Services within the Division of Developmental Disabilities has been assigned the responsibility of providing guardianship services by the Division Director. Guardianship services are limited to guardianship of the person only and not property.

10:45-1.2 Definitions

The following words and terms as used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

“Bureau of Guardianship Services (BGS)” means the unit within the Division of Developmental Disabilities, which has the responsibility and authority to provide guardianship of the person services to individuals in need of such services.

“Commissioner” means the Commissioner of the Department of Human Services.

“Developmental disability” means a severe, chronic disability of a person which: (1) is attributable to a mental or physical impairment or combination of mental or physical impairments; (2) is manifest before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity, that is self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economic self-sufficiency; and (5) reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and are individually planned and coordinated. Developmental disability includes, but is not limited to, severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina bifida, and other neurological impairments where the above criteria are met. (See P.L. 1985, c. 145).

“Director” means the Director of the Division of Developmental Disabilities.

“Division” means the Division of Developmental Disabilities.

“Functional or other services” means those services and programs in the Division which are available to provide the persons with developmental disabilities with education, training, rehabilitation, adjustment, treatment, care and protection. Functional or other services shall include residential care, case management, social supervision, and day programming.

“Functional service unit” means any of the following components of the Division: a Developmental Center, a Regional Office of Community Services.

“Guardian” means a person or agency appointed by a court of competent jurisdiction or otherwise legally authorized and responsible to act on behalf of a minor or incapacitated adult to assure provision for the health, safety, and welfare of the individual and to protect his or her rights.

“Guardian ad litem” means a person appointed by a court to perform an extremely limited type of guardianship, namely to protect a child’s or incapacitated adult’s interest during a single instance of some form of court proceedings or litigation.

“Guardianship services” means those services and programs provided by the Division for the purpose of implementing its responsibility toward the individual with developmental disabilities, for whom it is performing the services of guardian of the person.

“Individual Habilitation Plan (IHP)” means a document that provides an evaluation of the capabilities and needs of an individual with developmental disabilities and sets forth clearly defined and measurable goals and behaviorally stated objectives describing an individualized program of care, training, treatment, and therapies designed to attain and/or maintain the physical, social, emotional, educational and vocational functioning of which the individual is presently or potentially capable. Specific contents of an IHP are elaborated in N.J.S.A. 30:6D-11.

“Limited guardian” means a person or agency appointed by a court of competent jurisdiction to make only those decisions for which an incapacitated person has been adjudicated to lack capacity.

“Mental retardation” means a state of significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

SUBCHAPTER 2. ELIGIBILITY REQUIREMENTS FOR GUARDIANSHIP SERVICES

10:45-2.1 Eligibility requirements for adults

(a) An individual 18 years or older is eligible for guardianship services if he or she is receiving or has been formally determined by the Division to be eligible for functional or other services from the Division and has been:

1. Administratively determined to be in need of guardianship by the administrative head of the functional service unit, based upon an assessment and recommendation of a team of professional staff, and referred to BGS before April 12, 1985;
2. Adjudicated as an incapacitated person by a court of competent jurisdiction and have had BGS appointed by the court as guardian of the person; or
3. Adjudicated as an incapacitated person by a court of competent jurisdiction and has had BGS granted power of attorney by the appointed guardian of the person.

(b) Notwithstanding the provisions of (a) above, every person receiving guardianship services from BGS without prior judicial review will be reevaluated pursuant to N.J.S.A. 30:4-165.13 to determine whether the need for such services continues and, if so, application shall be made to a court of competent jurisdiction for appointment of a guardian of the person for that person.

10:45-2.2 Eligibility requirements for children

(a) An individual under the age of 18 years is eligible for guardianship services if he or she is receiving functional or other services from the Division, and:

1. Is without parent or guardian after the requirements of (b)2 below have been satisfied; or
2. Has a legal guardian of the person, who has granted a power of attorney to BGS to make personal decisions on behalf of the child.

(b) In the instance of a child determined eligible for guardianship services where no parent or guardian is deemed available, staff of the functional service unit shall verify such status by:

1. Documentation that the child’s legal guardian(s) is (are) deceased and that there are no other relations or close family friends available to serve as guardian; or
2. Documentation that the following efforts to locate the child’s guardian(s) have been unsuccessful:

- i. Notice in the primary language of the guardian, if known, by regular mail and follow-up by certified mail, return receipt requested, to the guardian’s last known address, with no response received within 45 days of forwarding the certified letter;
- ii. Documented inquiry among any known relatives, friends and current or former employers of the guardian(s); and
- iii. Documented inquiries, unless restricted by law, using the guardian’s last known or suspected address, to the local post office, the Division of Motor Vehicles, and any social service and law enforcement agencies known to have had contact with the guardian(s) both in New Jersey and in

other states. Failure to receive response to the inquiries within 45 days shall constitute a negative response.

3. The New Jersey Protection and Advocacy, Inc. shall be notified in writing by the BGS within 10 days of initiation, termination or change of guardianship services for a child whose parents are deemed unavailable.

SUBCHAPTER 3. CONTINUATION OF ELIGIBILITY FOR GUARDIANSHIP SERVICES

10:45-3.1 Continuation of eligibility for adults

(a) Eligibility for guardianship services continues for an adult individual as long as:

1. He or she remains a recipient of functional or other services from the Division; and
2. None of the following has occurred:
 - i. A court order reversing a previous adjudication of incapacity and appointment of BGS as guardian;
 - ii. In the instance of an individual receiving guardianship services on the basis of determination of need for guardianship prior to April 12, 1985, a change of this status resulting from a review and re-evaluation of the IHP pursuant to N.J.A.C. 10:43; or
 - iii. A revocation of a power of attorney by the guardian, or a lapse of the time specified therein.

10:45-3.2 Continuation of eligibility for children

(a) Eligibility for guardianship services continues for a child as long as he or she:

1. Remains a recipient of functional or other services from the Division;
2. Remains under the age of 18 years. Prior to reaching the age of majority, an assessment shall be made as to the continuing need for a guardian as an adult, in accordance with the provisions of N.J.S.A. 30:4-165.4 et seq. and N.J.A.C. 10:43; and
3. Remains without a guardian, or there is a power of attorney still in force designating BGS to act on the child's behalf.
 - i. In the instance of a child previously without a parent or guardian available, when a parent or appointed guardian who had been inaccessible again becomes available to exercise his or her role:
 - (1) If interim guardianship services are provided, guardianship services shall immediately and automatically cease with written notification to the parent or appointed guardian.
 - (2) If BGS has been appointed by a court as guardian, a termination or change of guardianship is required by the court.
 - (3) In the instance of the return of a parent or a guardian who is deemed by BGS to be unsuitable, BGS shall petition the court of competent jurisdiction for termination of the parent guardianship rights.
 - (4) If a power of attorney lapses or is revoked, BGS shall discontinue services as of the applicable date.
 - (b) A referral to the courts for appointment of a guardian shall be made within one year of the initiation of BGS guardianship services.

SUBCHAPTER 4. ROLE AND RESPONSIBILITIES OF BUREAU OF GUARDIANSHIP SERVICES

10:45-4.1 Distinct role of BGS staff

- (a) BGS staff shall function distinctly and independently from functional service units in terms of their interrelation with individuals receiving services from the Division.
- (b) BGS staff shall focus exclusively on the following:

1. Protective services;
2. Safeguarding individual rights;
3. Substitute decision-making;
4. Advocacy on behalf of the individual; and
5. Maximizing the individual's self-determination.

10:45-4.2 Functions and duties of BGS staff

(a) In order to exercise their role and responsibilities, for all individuals receiving guardianship services, BGS staff shall be knowledgeable and informed about individual status, program and progress by means of the following:

1. Direct contact: Individuals served should be visited at least annually, more often as necessary;
2. Interviews with staff, service providers, relatives and other involved parties;
3. Participation at case conferences, individual habilitation plan sessions and other meetings when feasible;
4. Review of records; or
5. Utilization of any other appropriate source of information.

(b) BGS staff shall be responsible to advocate for individuals served in areas including, but not limited to:

1. Placement in the least restrictive environment;
2. Programs and services appropriate to individual needs;
3. The exercise of individual rights; and
4. Self-advocacy.

(c) BGS staff may give or withhold consent for proposed medical or dental procedures and behavior modification involving the use of Level III techniques as defined in "Levels of aversiveness" at N.J.A.C. 10:41-4.3

Such consent shall be premised upon:

1. Adequate information regarding the procedure, the risks involved, anticipated benefits, the possible alternatives and any experimental or irreversible aspects of the proposed procedure. (A second opinion may be requested.); and
2. Freedom from coercion by other parties.

(d) BGS staff may give or withhold consent for access to client records, release of confidential information and/or photographing individuals served consistent with the requirements of N.J.S.A. 30:4-23.4 governing confidentiality of client records.

(e) BGS staff may give or withhold approval for major changes of program or transfers.

(f) BGS staff may give or withhold approval of the IHP.

(g) Consent or approval as provided for in (c) through (f) above may be withheld if there is basis for an informed judgment by BGS staff that what has been proposed would not be in the individual's best interest or that the potential risks involved would outweigh any anticipated benefit.

(h) BGS staff shall make surrogate decisions on behalf of individuals receiving guardianship services, as delineated above under (c) through (f), only within the following parameters:

1. If the individual is receiving guardianship services on the basis of an administrative determination and referral to BGS prior to April 12, 1985, and no court review has yet transpired, the Individual Habilitation Plan developed in accordance with the provisions of N.J.S.A. 30:6D-10 shall include content addressing the individual's capacity to make decisions. BGS staff, in the course of providing guardianship services, shall give due consideration to the

conclusions delineated in the most recent Individual Habilitation Plan relative to the individual's decision-making abilities.

2. If the individual has been adjudicated as an incapacitated person by a court of competent jurisdiction, BGS staff shall make decisions on the person's behalf in accordance with the provisions of the court order appointing BGS as guardian of the person.

(i) With respect to the decisions described under (c) through (f) above, BGS staff shall ascertain and consider those characteristics which define personal uniqueness and individuality, including, but not limited to, likes, dislikes, hopes, aspirations and fears. Moreover, BGS shall encourage the individual to express preferences and to participate in decision-making to the extent of his or her capability. Special care should be taken to ascertain the feelings of the individual whenever possible before making a decision.

10:45-4.3 Duty to inform

Functional service unit staff shall inform BGS staff promptly and comprehensively regarding any significant life events, proposed program changes, or incidents involving individuals being served by BGS.

SUBCHAPTER 5. LIMITATIONS OF AUTHORITY BUREAU OF GUARDIANSHIP SERVICES

10:45-5.1 Guardianship of person

The responsibility and authority of BGS shall be restricted to guardianship of the person only, and not of property, pursuant to N.J.S.A. 30:4-165.12. BGS' role as provider of guardianship of the person services shall be exercised according to the guidelines and within the parameters described above under N.J.A.C. 10:45-4.2 (h) and (i).

10:45-5.2 Procedures requiring court approval

(a) In accord with N.J.S.A. 30:6D-5(a), BGS staff shall not consent to the following procedures but may, with the approval of the Chief of the Bureau, refer the matter to a court of competent jurisdiction for appointment of a guardian ad litem:

1. Shock treatment;
2. Psychosurgery;
3. Sterilization; or
4. Medical, behavioral or pharmacological research as experimentation.

10:45-5.3 Guardianship services for a child whose parent or guardian is deemed unavailable

(a) Guardianship services initiated on the basis of the procedures delineated in N.J.A.C. 10:45-2.2(b) may be provided on an interim basis for a maximum of one year without judicial appointment.

(b) No later than 10 months after the commencement of guardianship services, petition shall be made to a court of competent jurisdiction pursuant to N.J.S.A. 30:4-165.1 et seq. for the appointment of a guardian, unless the parent(s) or appointed guardian shall have reassumed their role under the provision of N.J.A.C. 10:45-3.2(a)3i.

(c) During the course of providing interim guardianship services, BGS shall render consent in certain critical areas of decision-making only after an administrative review procedure shall have been conducted.

1. Critical areas of decision-making requiring administrative review shall include the following:
 - i. A transfer which involves a change of the individual's place of residence;

- ii. A medical procedure which entails major, irrevocable consequences including, but not limited to, amputation of a limb, abortion, removal or transplant of a vital organ; and
 - iii. A major change in the individual's IHP, including but not limited to implementation of a behavior modification program involving the use of Level III techniques as defined in "Levels of aversiveness" at N.J.A.C. 10:41-4.3.
2. When the need for consent in a critical area of decision-making arises, BGS staff shall renew attempts to locate the child's parent(s), unless the child is orphaned. The extent and time-frame for these efforts shall be proportionate to the emergent nature of the situation, but shall be documented. Within one working day of reaching conclusion that the parent(s) is/are unavailable, the matter shall be referred to the Chief of BGS at which time notice shall be given to the New Jersey Protection and Advocacy, Inc.
 3. Within one working day of receipt of the referral, the Chief, BGS, shall request assignment of an Administrative Review Officer by the Director. The Administrative Review Officer shall not have any role of responsibility in a functional service unit of the Division.
 4. The Administrative Review Officer shall arrange and schedule an administrative review as soon as possible, but no later than eight working days after his/her designation.
 - i. Participants shall be a representative of the New Jersey Protection and Advocacy, Inc., a representative of BGS and, at their option, witnesses for either party.
 - ii. The representatives of BGS shall present evidence relating to the unavailability of the parent(s) and the appropriateness of the proposed decision in the best interests of the child.
 - iii. The representatives of the New Jersey Protection and Advocacy, Inc., shall define that office's position, either of concurrence or disagreement with the proposed action of BGS. In either case, the basis for the New Jersey Protection and Advocacy, Inc.'s position regarding the issue shall also be defined and supported by evidence where appropriate.
 - iv. After hearing the evidence presented by both parties, the Administrative Review Officer shall render a final decision either to uphold or to reverse the proposed decision of BGS. The final decision shall be based upon clear and convincing evidence. The final decision shall be communicated to the New Jersey Protection and Advocacy, Inc. and BGS, in writing, no later than five working days after the hearing. The final decision shall clearly articulate the positions of the parties, what evidence was presented and considered, and how the determination was reached.
 - v. A tape recording of the Administrative Review shall be maintained by the Administrative Review Officer for a minimum period of one year.
 5. In any situation of extreme medical emergency, where any delay of decision-making on behalf of the child would pose a serious threat to the child's life or health, BGS shall render a decision without an administrative review. The existence of an extreme medical emergency must be certified in writing by a licensed physician. The physician's certification shall be maintained in the child's client record.
 6. The New Jersey Protection and Advocacy, Inc. shall be informed of the decision of BGS to (c)5 above as soon as possible.

APPENDIX

A. Referral Package

When a referral to BGS is appropriate, the functional service unit shall forward the following referral material to the appropriate BGS Regional Office:

1. A completed referral form: BGS #10;
2. As applicable, the completed power of attorney document or the documentation as to the unavailability of a guardian;
3. The most recent psychological evaluation, as well as any other clinical evaluations;
4. Available social data and/or social history; and
5. The current IHP.

B. BGS offices assigned to receive referrals for guardianship services

1. As indicated in Division Circular #6, an individual assessed for the first time to be mentally incompetent and in need of a guardian should be referred to the Chief, BGS.
2. An adult or minor for whom guardianship services are requested on the basis of a power of attorney or documentation that a minor has no available guardian should be referred to the BGS Regional Office indicated in the following chart:

**BGS REGIONAL OFFICE COMMUNITY SERVICES DEVELOPMENTAL CENTERS
NORTHERN BERGEN, ESSEX, HUDSON, NORTH JERSEY, WOODBRIDGE
PASSAIC, MORRIS, SUSSEX, GREENBROOK
UNION, WARREN
CENTRAL BURLINGTON, OCEAN HUNTERDON, NEW LISBON,
HUNTERDON, MERCER
MIDDLESEX, MONMOUTH
SOMERSET
SOUTHERN ATLANTIC, CAMDEN, CAPE VINELAND, WOODBINE
MAY, CUMBERLAND,
GLOUCESTER, SALEM**

3. An adult or minor in a private residential facility under Purchase of Care, for whom guardianship services are requested should be referred to the BGS Regional Office assigned responsibility for the private residential facility where there is a power of attorney document or documentation that a minor has no available guardian.

C. BGS Staff shall the responsibility and authority to:

1. Review the adequacy of services provided;
2. Communicate with interested parties especially parents, regarding the status, needs and wishes of the individuals.
3. Provide or withhold consent for elective medical or dental procedures which require specific authorization, as well as the general consent sufficient for routine medical or dental care;
4. Provide or withhold consent for the use of Level III aversives in a behavior modification program;
5. Provide or withhold consent for the release of records or other confidential information and for the publication or photographs, newspaper articles, books, etc., which identify the individual;
6. Provide or withhold consent for the use of psychotropic medication as part of an ongoing treatment plan to address maladaptive behavior;

7. Approve or withhold approval for trips and other absences which involve at least one overnight. General permissions may be granted for recurring overnight absences with parents or other approved individuals;

8. Approve, disapprove or restrict visits and vacations;

9. Agree or disagree with the content of the IHP as well as substantive changes to the IHP.

D. Functional Services

1. Staff of functional service components shall be responsible for:

a. Advising BGS within one working day of the following developments regarding an individual:

i. Conclusion reached as a result of a clinical evaluation that an individual no longer needs a guardian;

ii. Request of an individual to see his/her BGS worker;

iii. Missing status or failure to return from vacation;

iv. Alleged or suspected abuse, neglect, exploitation or denial of rights;

v. Serious illness or injury; vi. Death, including circumstances, cause, results of investigation, if any.

b. Processing referrals in a timely manner to the appropriate offices of the BGS;

c. Facilitating access of BGS staff to all client records and other sources of information;

d. Providing adequate advance notice, and seeking approval from BGS in respect to proposed changes in program, transfers, or discharges from services;

e. Notifying BGS staff sufficiently in advance of scheduled IHP meetings and providing a copy of the most current IHP;

f. Giving due consideration to BGS' recommendations on behalf of individuals.

DIVISION CIRCULAR #41 – INFORMED CONSENT

DEPARTMENT OF HUMAN SERVICES DIVISION OF DEVELOPMENTAL DISABILITIES

EFFECTIVE DATE: December 12, 2003

DATE ISSUED: December 12, 2003 (Rescinds Division Circular 41, “Informed Consent”, issued September 30, 1996)

I. TITLE: Informed Consent

II. PURPOSE: To establish policies to obtain informed consent.

III. SCOPE: This circular applies to all components of the Division as well as providers under contract with or regulated by the Division.

IV. POLICIES:

A. Instances where informed consent is required shall be specified in the appropriate Division Circular.

B. For minors (individuals under the age of 18), the legal guardians are the natural or adoptive parents unless another guardian has been legally appointed.

C. Informed consent shall be required for certain medical, surgical, psychiatric or dental treatments or behavioral interventions and restrictions of individual rights, including the right to privacy.

D. Informed consent shall not be coerced.

E. A competent individual or the legal guardian of an individual has the right to refuse medical, surgical, psychiatric or dental treatment or behavioral intervention.

F. A Chief Executive Officer (CEO) and Regional Administrator has the authority to grant informed consent in certain limited instances as set forth in N.J.S.A. 30:4-7.2 and N.J.S.A. 30:4-7.3.

G. Informed consent may only be obtained from a competent adult (an individual over the age of 18) or from the guardian of a minor or incapacitated adult.

H. When the Bureau of Guardianship Services (BGS) has administrative guardianship of an individual, BGS is considered the legal guardian until the court makes other disposition.

I. When there is the need for medical, surgical, psychiatric or dental treatment and no legal guardian exists, a special medical guardian may be appointed in accordance with Division Circular #32, “Authorization for Emergency Medical, Surgical, Psychiatric or Dental Treatment”.

J. When medical, surgical, psychiatric or dental treatment is to be performed by a facility outside the Division (e.g. hospital, surgical center), that facility shall be responsible to obtain informed consent.

K. A guardian ad litem shall be required for a minor or adult adjudicated incapacitated if the use of electro shock, psychosurgery, sterilization or medical, behavioral or pharmacological research is proposed. (N.J.S.A. 30:6D-4).

L. When the court has established limited guardianship for an individual, informed consent by the individual or guardian shall be in accordance with the judgment of guardianship.

V. GENERAL STANDARDS:

A. Definitions - For the purpose of this circular, the following terms shall have the meaning defined herein:

1. "Bureau of Guardianship Services (BGS) means the unit within the Division of Developmental Disabilities, which has the responsibility and authority to provide guardianship of the person services to individuals in need of such services.
 2. "Chief Executive Officer (CEO)" means the person having administrative authority over a developmental center.
 3. "Guardian ad litem" means a person appointed by a court to perform an extremely limited type of guardianship, namely to protect a child's or incapacitated adult's interest during a single instance of some form of court proceedings or litigation.
 4. "Informed Consent" means a formal expression, oral or written, of agreement with a proposed course of action by someone who has the capacity, the information and the ability to render voluntary agreement or by someone with fiduciary authority to act for another's benefit.
 5. "Limited guardianship," means a legal disposition whereby a guardian is granted authority by a court of competent jurisdiction to act only in specifically prescribed areas of decision-making where an individual lacks capacity as defined in the court order.
 6. "Power of Attorney" means an instrument in writing whereby one competent individual, as principal, appoints another competent individual as his or her agent and confers authority to perform certain specified acts or kinds of acts on behalf of the principal. Such power may be either general (full) or special (limited).
 7. "Regional Administrator" means an employee of the Division with administrative authority over community operations within several counties.
 8. "Regional Assistant Director (RAD)" means an employee of the Division with administrative authority over community programs and institutions within a specific geographic region of the state.
- B. In securing informed consent, the individual or legal guardian must be apprised of:
1. Reasons for the request for consent;
 2. Potential benefit or intended outcome of the proposed action;
 3. Potential risk to the individual or others if the action is or is not implemented;
 4. Alternatives to the action that might be used and the reasons for choosing the planned action; and
 5. The right to disapprove this action or to withdraw approval at any time.
- C. When informed consent is either denied or subsequently withdrawn by the competent adult or legal guardian and the CEO or Regional Administrator determines that such refusal is not in the individual's best interest:
1. The matter shall be referred to the RAD for further consideration.
 2. If the RAD believes that further consideration or possible judicial action is warranted, he or she shall refer the matter to the Director, Division of Developmental Disabilities or his/her designee.
- D. Under certain limited circumstances, the CEO or Regional Administrator may grant informed consent in accordance with Division Circular #32, "Authorization for Emergency Medical, Surgical, Psychiatric or Dental Treatment."
- E. When it is known that a legal guardian will not be available:
1. Staff shall encourage the legal guardian to delegate decision making authority for informed consent by power of attorney to a competent family member, friend, BGS or other interested party in order to assure the availability of a guardian.

2. Delegation of decision-making authority shall terminate upon revocation of the power of attorney by the legal guardian or death of the legal guardian.
3. A copy of the power of attorney shall be included in the client record.
- F. Except for BGS, power of attorney may not be delegated to Division staff, providers under contract with or regulated by the Division, or staff hired by providers or the agency they work for, if they are providing direct services to that individual.
- G. Generally, informed consent must be obtained annually. There may be standing consents that are valid until withdrawn by the competent adult or legal guardian.
- H. Privacy includes the use of photographs or videotapes.

VI. PROCEDURES:

- A. Informed consent shall be obtained by appropriate professional staff, as identified in the applicable Division Circular.
- B. When informed consent is required for medical, surgical, psychiatric or dental treatment or behavioral intervention, the individual obtaining the informed consent shall be qualified to explain the proposed action and to answer questions regarding the proposed action.
- C. Informed consent shall be in writing except in urgent situations (e.g. emergency surgery, behavioral crisis).
- D. In urgent situations, informed consent may be obtained orally but shall later be confirmed in writing by the individual granting consent.
 1. When informed consent is obtained orally, a second staff member shall witness the consent.
 2. Such witness shall be documented in the client record.
- E. All attempts to obtain informed consent, as well as the results of attempts to obtain written consent, shall be documented in the client record.
- F. In order to establish lack of response to a request for informed consent, two mailings, one via certified mail and one by regular mail, shall occur.

These attempts may be made simultaneously.
- G. The request for informed consent shall include a date, by which a response is required no later than 10 calendar days.
- H. When informed consent for medical, surgical, psychiatric, or dental treatment or behavioral intervention is refused by an individual or the legal guardian:
 1. The efforts of staff to obtain the informed consent shall be documented in the client record.
 2. The individual or legal guardian shall be requested to sign a refusal of the recommended treatment or intervention.

James W. Smith, Jr.
Director



STATE OF NEW JERSEY
 DEPARTMENT OF HUMAN SERVICES
 DIVISION OF DEVELOPMENTAL DISABILITIES
 PO BOX 726
 TRENTON, NJ 08625-0726

CHRIS CHRISTIE
 GOVERNOR

KIM GUADAGNO
 LT. GOVERNOR

Jennifer Velez
 COMMISSIONER

DAWN APGAR
 Deputy Commissioner

TEL. (609) 631-2200



**INFORMED CONSENT FOR PARTICIPATION
 STATE OF NEW JERSEY MONEY FOLLOWS THE PERSON (MFP)
 DEMONSTRATION PROJECT**

*Completion of this form is voluntary; however, this form is required in order to participate in the MFP Demonstration Project.

Name of Participant – Please Print	Social Security Number:
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I have been informed that:

- The MFP Demonstration Project is sponsored by the Federal Centers for Medicaid and Medicare Services (CMS).
- The demonstration project helps states rebalance their Medicaid long term care system so that more focus is on living in the community by moving individuals from institutional settings into community settings.
- The New Jersey Department of Human Services was granted an award to participate in this demonstration project by CMS.
- New Jersey’s MFP demonstration project contains a package of services based on the current home and community based waivers. I will enter the waiver program that best meets my needs on the day I leave an institution to live in the community. Specific services available to me have been explained by my transition coordinator.

- The MFP package of services will end after one year; however I will continue to receive services from the waiver program I enrolled in when I moved out of the institution.
- CMS has contracted with Mathematica Policy Research, New Editions and Thomson Healthcare to provide technical assistance and research evaluation on the demonstration project nationwide. Certain information about me and others in the demonstration will be shared to meet federal rules that require an evaluation for the MFP demonstration.
- I have chosen to participate in the MFP demonstration.
- If I don't want to participate in the MFP demonstration project, I can still access any other Medicaid programs or any other home and community based services that I am eligible for.

BENEFITS OF THE MFP DEMONSTRATION

Potential benefits of my participation in the MFP demonstration include:

- I will receive a package of services that will help me to successfully transition from the institution I live in to a community based residence (a house with family, an apartment or a residence in which four or fewer unrelated people live) for one year as long as I meet the MFP eligibility requirements. I understand that this year in time does not need to be consecutive days, weeks or months.
 - For example, if, after living in the community for 100 days, I need to return to an institution for any reason, I may transition back to the community under MFP with 265 days of MFP eligibility remaining.
- At the end of one year, I will continue to receive the services of the Medicaid home and community based waiver program as long as I continue to meet the eligibility requirements for services in that program.

POTENTIAL RISKS

I have been informed that there is a slight chance that I may not be able to return to the institution I came from should I decide to voluntarily end participation in MFP and want to return to the institution.

- For individuals transitioning out of NJ's developmental centers, the NJ Division of Developmental Disabilities will allow the person to return to the specific institution they transitioned out of.

I have been informed that I may lose Medicaid eligibility if I no longer meet Medicaid eligibility requirements. I understand that I have a right to appeal the termination of my benefits

RESEARCH PARTICIPATION

- I will be responding to three Quality of Life surveys, developed by Mathematica Policy Research. These surveys are intended to provide information that will help evaluate the success of MFP.

CONFIDENTIALITY

I have been informed that the information provided by New Jersey to CMS and its contracted organizations is confidential and is released only for the purposes of evaluating and administering the MFP demonstration or as otherwise required by law.

VOLUNTARY WITHDRAWAL FROM THE PROJECT

I have been informed that my participation in the MFP demonstration is voluntary. I may withdraw from the MFP demonstration at anytime after I enroll.

COMPLAINTS

If I have any concerns or complaints about my participation in the MFP demonstration, I can contact the MFP Project Director by mail at: PO Box 726, Trenton, NJ 08625, by telephone at (609) 689-0564, or by email, Terre.Lewis@dhs.state.nj.us.

I have been informed that as a Medicaid participant, I have certain rights to file a grievance or appeal. My transition coordinator has provided me with information regarding my rights as a Medicaid waiver participant and has provided me with information regarding the process for fair hearing.

CONSENT

My transition coordinator explained my rights and responsibilities under the MFP demonstration. I understand that I will be given a signed copy of this consent form.

If I have questions that cannot be answered by my transition coordinator, I can contact the MFP Project Director at (609) 689-0564.

By signing this Informed Consent, I am agreeing to participate in the MFP Demonstration Project and accept all of the terms and conditions for participation.

SIGNATURE - Participant	Date Signed
Address (Street, City, State, Zip Code)	Telephone Number () -

In accordance with the Terms and Conditions set forth by CMS, as guardian I certify that I have a legal relationship with the above named individual and that I have regular personal visits with the participant. I certify that I have had contact within the past six months specifically on the issue of transitioning out of an institution and participation in MFP. My continued contact with and participation in the transition process is expected.

By signing below, as guardian I agree that participation in the MFP demonstration project is appropriate for the above named individual.

SIGNATURE – Guardian (if applicable)

Date Signed

Address (Street, City, State, Zip Code)

Telephone Number

() -

MFP Transition Coordinator Acknowledgement

I ensure that the applicant has read or has had all informed consent materials read to him/her, and I believe that he/she (or the guardian if signed) understands the information.

SIGNATURE – MFP Transition Coordinator	Date Signed
Name of Agency	Telephone Number
	() -

Outreach, Marketing and Education

The State's procedures and processes to ensure that participants will have the requisite information to make choices about their care.

How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation, including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.

** Appendices 1 and 2 contain the PowerPoint presentations on Money Follows the Person and the Guide to Information and Training Sessions respectively.*

A telephone listing of the 21 county-based Adult Protective Services (APS) provider agencies, including after-hours and emergency numbers, will be given to all MFP enrollees. As part of the Participant Recruitment and Enrollment process, participants and involved family members and other unpaid caregivers will be informed of APS.

For participants from developmental centers, including their families and/or guardians, information regarding their rights, including protections from abuse, neglect, and exploitation will be reviewed annually. This is current practice for all individuals within DDD's system and it is documented within each consumer's Individual Habilitation Plan (IHP). Participants will be able to contact any Interdisciplinary Team (IDT) members (the D.C. IDT consists of a Case Manager, Transition Case Manager, Social Worker, Support Coordinator, Psychologist or other professionals) in order to report concerns of abuse, neglect, and exploitation.

Upon the consumer's transition to the community, the licensed provider agency shall issue and explain the DDD's rights document. In addition, the consumer, family member and/or guardian will be given a contact list of advocacy agencies for further assistance with understanding and enforcing these rights if need be. As required at N.J.A.C. 10:44A every community provider agency must have a procedure to ensure the safety and well being of any individual under its care.

In the event of an emergency, consumers, their families, guardians and other interested parties will be reminded that in the event of a serious medical emergency, Daniel's Law requires 911 to be notified without delay for those persons residing in state funded community residences. In addition, DDD operates a 24 hour on-call system. Consumers will be given information on how to access the 24 hour on-call along with instructions on reporting incidents of abuse, neglect or exploitation. This information is contained in a tri-fold pamphlet that is given at the time of transition and annually thereafter at the annual Plan of Care review.

For persons with severe disabilities, who may not be able to use a phone or those who are non-verbal, the person who is providing care, relative, neighbor etc. should make calls on SR's behalf. DDS (609-292-1210) DACS have TTY services. The Department of Human Services TTY is [1-877-294-4356](tel:1-877-294-4356).

Each partner entity also can be contacted through their respective websites by clicking on the contact us button. The links are:

<http://www.state.nj.us/humanservices/ddd/index.html>

<http://www.state.nj.us/humanservices/dds/index.html>

www.state.nj.us/health/senior/contact.shtml

Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished.

In the Division of Aging and Community Services, training responsibilities are housed in the DACS Training Academy. The academy is a known and trusted resource within the aging network, providing information and referral, care management and numerous continuing education trainings each year. The information and schedule of MFP trainings is below.

Information related to MFP will be embedded in the training sessions contained in the Information and Training Guide as well as in the process of transition discussion with consumers, families and other interested parties. The sessions contained in the guide are intended for families, consumers and others interested in learning about community transition. Further, MFP will be included in the aforementioned forums contained in the Participant Recruitment and Enrollment section.

With individuals in developmental centers, it is the responsibility of the IDT to keep the participants informed and educated. As individuals participating in MFP transition to the community the IDT, consisting of the community provider, Case Manager and other support staff/professionals will continue to take the lead in educating and training the consumers. If there is a need for additional staff training or re-training the IDT will make those arrangements.

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

The state has developed a concise, primary source document on New Jersey's MFP initiative for all subsequent educational and training activities. This document, *Key Points for Education and Training*, will ensure that a consistent message is promoted to, and by, all interested parties throughout the life of the grant.

The housing task force will also develop plans to ensure that individuals who transition are aware of transportation options available in the locality in which they will be living. Transition coordinators and case managers will receive training on how to support people in using available transportation options as a part of each transition.

Types of media to be used.

From *Key Points for Education and Training*, the state will create a single-page summary of the document as a flyer for insertion into existing materials used to train staff and counsel individuals on their community-based care and support options. These current materials include, but are not limited to, the Department of Health and Senior Services' *A Guide to Community-Based Long Term Care in New Jersey* and the Department of Human Services, Division of Developmental Disabilities' *Support Coordination booklet*. The partners have also developed an informational PowerPoint presentation for use. All MFP materials will be posted on the Division of Aging and Community Services', Division of Developmental Disabilities, and other partners' websites.

Specific geographical areas to be targeted.

All 21 New Jersey counties.

Locations where such information will be disseminated.

Informational materials will be disseminated to staff at main and district offices and facilities. Staff will take these items with them to nursing homes, hospitals and developmental centers when they counsel individuals and their families and caregivers.

Staff training schedules, schedules for State forums or seminars to educate the public.

MFP is included in the agenda for senior management meetings at the Division of Aging and Community Services. An update is provided to the OCCO Regional Managers on a monthly basis. MFP is a standing agenda item for the regional OCCO staff meetings where information and updates on the initiative are consistently disseminated.

The Division of Developmental Disabilities has contracted with a number of provider agencies which implement the support coordination process for individuals transitioning from institutions. These agencies are involved in various facets of the training of individuals from the DCs and are responsible for production of a document entitled the Guide to Information and Education Training Sessions on a bi-annual basis. (Jan.-Jun. 2008 document included in Appendix 2). The trainings are designed for participation from individuals, families, community staff or DDD staff.

Regional trainings will also be offered for aging and disability network care managers, nursing facility and developmental center social workers, discharge planners and other interested parties.

The availability of bilingual materials/interpretation services and services for individuals with special needs.

Language Line Services is used to translate any materials needed for non-English speaking participants and over the phone interpretive services are available as well.

A description of how eligible individuals will be informed of cost sharing responsibilities.

Individuals will be told of their cost sharing responsibilities as part of the recruitment and enrollment process, and will be given a cost-share introductory letter for Alternate Family Care, when appropriate.

Institutional Providers

DACS provides in-service trainings for NF administrators and NF management staff regarding the philosophy of helping a person return to the community, has developed a training video describing nursing transitions to return individuals to the community, and provides technical assistance to facilities to further their knowledge of the program.

DDD, as part of the Olmstead Process has regular meetings with officials from the Developmental Centers, where MFP is a regular item for discussion. Information related to CMS policies, state procedures, program risks, rules and benefits are communicated. In addition, DC social workers have met with and will continue to meet with Olmstead managers and the MFP Project Director to ensure ongoing flow of information related to MFP.



FACT SHEET

What is MFP?

Money Follows the Person (MFP) is a federal demonstration project that helps eligible individuals who have been residing in nursing homes and developmental centers for a minimum of 90 consecutive days move into a community-setting. The setting will offer transitional services and long-term supports that prevent or delay the need to return to institutionalization care. The same public funds that pay for services in the institution will pay for services in the community, only the service providers may change. Participants are monitored to ensure the program meets their needs and interviewed periodically as part of the grant's evaluation process. Participants receive a special package of services through MFP for one year after they move from an institution.

What services are provided?

An interdisciplinary team that includes participants and/or their guardians, social workers, discharge planners, and other care professionals decide what services are needed on a case-by-case basis and include those services in individualized and flexible plans of care. All MFP participants receive care (case) management services. All MFP participants will enter the Medicaid Waiver program that most appropriately meets their needs on day one of transition to the community. In addition, the plan of care specifies other services to be delivered, which may include:

- Homemaker Services – (For Individuals transitioning out of Nursing Homes)
- Peer/Family Mentors – (For Individuals transitioning out of Nursing Homes)
- Chore Services – (For Individuals transitioning out of Nursing Homes)
- Attendant Care – (For Individuals transitioning out of Nursing Homes)
- Medication Administration – (For Individuals transitioning out of Nursing Homes)
- On-going Assessment

- Health Monitoring
- Transportation
- One Time Clothing Purchase
- One Time Food Purchase
- One Time Environmental Assessment
- Community Transition Services (Security Deposits, moving expenses, furnishings, 1x cleaning)
- Assistive Technology Devices

Are there limits to MFP services?

Enrollment in MFP is for one year after someone moves from an institution. The time does not have to be consecutive. A person may only receive a total of 365 days of MFP eligibility in their lifetime.

For example, if you are living in the community for 100 days and need to return to an institution for any reason, you may transition back to the community under MFP, but with only 265 days of MFP eligibility remaining.

Since MFP is a demonstration project and not a permanent stand-alone program, MFP participants will be enrolled in one of the existing Medicaid Waiver programs so they will continue to receive services after MFP ends in 2016. The availability of funding under these various waiver programs may affect an individual’s ability to enroll in MFP.

Who provides these services?

Care management services are provided by a registered nurse or social worker employed by a state or county office or a licensed agency in your community. Additional services are provided by these same agencies or by contracted vendors.

Who is eligible for MFP services?

An MFP eligible individual is a New Jersey resident who:

- Has spent a minimum of 90 consecutive days in a nursing facility or developmental center;
- Is both clinically and financially approved for Medicaid. (Note: The individual must be receiving Medicaid assistance for 1 day prior to discharge.)

Who is NOT eligible for MFP services?

Individuals who are NOT eligible for MFP services are those who:

- Are on SSI and New Jersey Care who need Medicaid State Plan Services only;
- Are assessed as appropriate for the Medicaid Hospice Benefit;
- Are chronically mentally ill;
- Are Medically Needy; and

- Are receiving Medicaid HMO benefits.

Is there a co-pay in MFP?

There are no co-pays in MFP.

How do I apply for MFP?

Developmental Center residents and/or their guardians interested in receiving community-based supportive services should speak with the DC social worker.

Nursing facility residents interested in receiving community-based supportive services should ask their nursing facility Social Worker to contact the appropriate Regional Office of Community Choice Options to arrange for a Community Choice Counselor visit. Regional office contact information is as follows:

Northern Regional Office
Bergen, Essex, Hudson, Morris, Passaic, Sussex, & Warren Counties
973-648-4691

Central Regional Office
Hunterdon, Middlesex, Monmouth, Ocean, Somerset, & Union Counties
732-777-4650

Southern Regional Office
Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, & Salem Counties
609-704-6050

For additional information contact:

Developmental Center residents call: Div. of Disability Services (DDS),
Office of Information & Assistive Services (OIAS) at 1-888-285-3036.

Nursing Home residents call: Community Choice at 1-877-856-0877.



- ▶ Meet the Director
- ▶ Contact Us
- ▶ Publications
- ▶ Email



Money Follows the Person - MFP

Transitioning Individuals from Institutions to Community Settings

- [NJ Awarded Enhanced CMS Funding to Transition Residents from Institutions](#)
- [NJ *Money Follows the Person* Rebalancing Demonstration - Application Proposal Summary](#)
- [MFP Fact Sheet](#)

New link to MFP Fact Sheet.

Stakeholder Involvement

Consumer Dialogue

During the development of NJ's application, the partner Divisions sought input on the types of services that should be included as Demonstration Services and as Supplemental Demonstration services. At stakeholder meetings participants were encouraged to follow up with written suggestions and indicate if they wished to participate in Pre-Implementation Planning. During the Pre-Implementation Phase a series of meetings, conference calls and written communications provided multiple pathways for individuals with a disability, their family members, advocates, providers and other stakeholders to participate in creating the final Demonstration Design and Operational Protocol including the target populations, participant selection mechanisms, a detailed service delivery plan, and a quality management system.

The consumer dialogue for the development of MFP highlighted the importance of bringing service recipients to the table. Consumers and other stakeholders identified several gaps and barriers that may impede successful transition from institutions to communities. A critical barrier is the belief of some families, staff and even some consumers that institutionalized individuals can not live safely in the community. There is a need to refine the transition process to enable the transitioning individual, their family and involved service providers to identify the possibilities and to formally recognize and accept the risks he/she is assuming in returning to a more independent living situation. Institutional staff from ICF-MRs and Nursing facilities were part of the team that developed the Participant Recruitment and Enrollment as well as the Outreach, Marketing and Education sections of this Operational Protocol

There is also a need to provide emotional support for the transitioned individual and for families caring for such individuals once the person returns to the community. Although consumers are involved in a number of LTC advisory committees, this experience has highlighted the fact that there should be greater opportunities for self-advocacy and for consumers to participate at all levels of decision making related to the LTC system design, implementation, monitoring and evaluation. As a result of this consumer dialogue, the Demonstration and Supplemental Demonstration categories of services for MFP were created. These are specified in the Benefits and Services section.

NJ initiated a Community Choice program in 1996 to assist individuals in returning to the community. There is a track record of success that can be used to demonstrate that individuals can live in the community with proper supports. Also, as previously mentioned, for those individuals with hesitant or resistant family members, guardians or other interested parties, ongoing opportunities for education around available community supports, the advantage of MFP to provide access to services that will allow someone to overcome transition barriers will be made available.

Consumers/Providers/Stakeholders:

Kate Blissard, NJ Adapt
Anita Claverling consumer from the Developmental Disabilities Council
Scott Elliot PCIL Center for Independent Living
Lisa Smith, Resources for Independent Living
Eileen Johnson, DAWN Center for Independent Living
Peter Fresulone
Louise Gardner
Brian Leahy
Nate Smith and Bonnie Schuller, Seeking Ways Out Together, a self-advocacy group in the Developmental Centers.
Kalpanah Shah – Woodbridge Developmental Center (ICF-MR)
Jessica Anastasi – New Lisbon Developmental Center (ICF-MR)
Kathleen Silvagni – Senior Citizens United Community Services
Anna M. Auerbach – NJ Housing and Mortgage Finance Agency
NJ Association of Area Agencies on Aging
NJ Association of County Offices for the Disabled
Health Care Association of NJ
NJ Association of Non-Profit Homes for the Aging
NJ Hospital Association
NJ Elder Rights Coalition
County Welfare Directors Association of NJ
NJ Adult Day Services Association
The Home Care Association of NJ
Home Health Services and Staffing Association
Epilepsy Foundation of NJ
ABCD-Alliance for Betterment of Citizens with Disabilities
NJ Protection and Advocacy,
Center for Outreach & Services for the Autistic Community (COSAC)
ARC of NJ,
NJ Association of Community Providers
Boggs Center – UMDNJ-UAP, UCE
Cerebral Palsy of North Jersey
NJ Developmental Disabilities Council
Developmental Disabilities Health Alliance, Inc.
Executive Management Consultant
Family Link
ARC of Burlington County
Parents of Consumers
Community Health Law Project
Mentor – NJ
NJ Conferences of Executives of the ARC
Family Alliance
ARC, Morris County Chapter, William Testa
NJ ADAPT
Burlington County Social Services

Consumer Involvement

Each Division has an advisory committee(s) which includes representation from key stakeholders (consumers/providers/state staff/advocacy organizations) who provided input into the design of their respective quality management system and will continue to have input into the discovery, remediation and improvement. As a recent recipient of a Systems Transformation Grant NJ has partnered with one provider organization that will begin to facilitate linkages between each of the consumer advisory committees and ensure that consumers have a contributing voice in designing the supports needed to access both waiver and non-waiver services and rebalancing the system. Additionally, consumers will have a voice in how to best provide supports that ensure their health and safety as well as quality of care and quality of life services (e.g.: medical, dental, family respite, community activities, employment and/or volunteer activities as well as informal and formal supports). This information will be shared with the inter-departmental State Management Team. Through participation in the MFP Quality of Life Survey, each division will report back to continue the dialogue on how to best improve the service delivery system.

Ongoing consumer involvement in the implementation of MFP will be achieved through the use of consumers to provide the service of Peer and Family Mentor, becoming a part of the “MFP Road Show” as the MFP Project Director travels NJ delivering training and information on MFP and through continued participation in the State Management Team. State Management Team is further detailed in the Organization section. There are currently 4 consumers on the State Management Team.

Benefits and Services

Service Delivery System

The MFP program will be operated through the coordinated efforts of the NJ Department of Human Services (DHS), Divisions of Developmental Disabilities (DDD), Disability Services (DDS) and Medical Assistance and Health Services (DMAHS) and the NJ Department of Health and Senior Services (DHSS), Division of Aging and Community Services (DACS).

NJ DHS is the single State Medicaid Agency. DMAHS is the designated entity within DHS responsible for oversight of the Medicaid program. The divisions noted above are responsible for the day to day operation and implementation of 1915(c) Medicaid Waiver programs.

Participants in MFP will enter into a 1915(c) HCBS Medicaid Waiver program that most appropriately meets their needs as identified in the transition planning. Entrance into a waiver program must occur on day one of transition into the community.

Target Populations

The MFP demonstration will serve individuals who reside in institutions for 90 consecutive days or longer and are Medicaid eligible at least 1 day prior to transition to the community.

- MR/DD: 18+ with developmental disabilities living in a State Developmental Center
- Elderly: 65+ living in a Nursing Facility
- Physically Disabled: 18 – 64 with a physical disability living in a Nursing Facility

MR/DD participants will access services through the Community Care Waiver (CCW) program through DDD. These participants will be recruited from the seven state run developmental centers throughout the state. Elderly and physically disabled participants will be recruited from nursing facilities throughout the state. Elderly and physically disabled participants will access services through the waivers operated by DDS and DACS, that most appropriately meet their needs based on assessment. MFP services are available through DDS' Community Resources for Persons with Disabilities (CRPD) and the Traumatic Brain Injury (TBI) waiver. MFP services are available through DACS' Global Options (GO) waiver program.

MFP Service Package

The MFP services will vary based on the individual needs for services identified through the transition planning process. All MFP participants will be eligible for services contained within the MFP services package. Medicaid State Plan services will be available to MFP participants, per the limitations, authorized by CMS, of the waiver program providing services. Medicaid state plan services are not being claimed for enhanced match under MFP. Transition Case Managers, Support Coordinators and/or Community Choice counselors will work with

participants, support networks and service providers to develop transition plans that meet the needs of the participant.

Support Coordination will offer individuals who self direct additional assistance in creating/devising more non traditional types of service delivery systems. For example the waiver includes a standard in the habilitation section of the waiver that allows for services from adult education, YMCAs, etc. The Support Coordinator would assist the individual in identifying the services and procuring them. The Division case management system would function as the approving QMRP for the level of care, authorization of the plan and the quality oversight of the service delivery system.

Adult Family Care (AFC) is a waiver service under Global Options and is available in MFP and is also eligible as a qualified residence for MFP.

For DACS, the MFP Demonstration services detailed on the services chart are for evaluation at this time. They were not included in the GO waiver consolidation. If at the conclusion of MFP in 2016 it has been found that these services would be beneficial to the DACS waiver program, they will be added in an amendment to the waiver at that time.

Medicaid State Plan Services will be available to all MFP participants subject to the requirements of the waiver program providing services for transition.

As stated earlier in this section, the continuation of services post participation in MFP will be achieved through entrance into the waiver program that most appropriately meets the service recipient's needs on day one of transition to the community. At the end of 365 days of MFP eligibility the service recipient will remain enrolled in the same waiver program so long as they continue to meet eligibility requirements. NJ's waiver programs have sufficient slot capacity to accommodate MFP participants. Should this change, an amendment to the affected waiver program will be sought. Further details are provided in the Continuity of Care Post the Demonstration section of this Operational Protocol. Continuation of services will be explained during the informed consent process.

The billable unit of service for Demonstration and Supplemental Demonstration services is per occurrence. There are no medical necessity criteria to receive Supplemental Demonstration category services. The tables below indicate proposed payment rates and units of service for Demonstration and Supplemental Demonstration categories of service.

DEMONSTRATION SERVICES (DDD)					
Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Individual Goods and Services **				\$239.43	

* Information is taken from the DDD waiver amendment submitted to CMS 12/27/07.

Demonstration (DACs)**	Units	Cost
Vehicle modification	1	\$11,000
Peer & Family Mentor	Per hour	\$10.00
Job Development	Per hour	\$25.00

** Taken from DACS: based upon cost of services provided under non-traditional provider services.

Supplemental Demonstration (DACs)***	Units	Maximum Cost
1 x Groceries	1 week supply	\$150.00
1 x Clothing	1 Month supply	\$500.00
EAA Occupational	Per eval	\$75.00

*** Taken from DACS: Costs were based upon cost of services provided under non-traditional provider services.

Supplemental Demonstration (DDD)####	Units	Cost
1x Groceries	1 Month Supply	\$500.00
1x Clothing	1 Month Supply	\$1000

Taken from DDD: Please see Appendix 7 for cost assumptions and methodologies.

The specific services available to the target populations of MFP are detailed in the table below:

**Services
Money Follows the Person**

Department/ Division	Health and Senior Services (DACS)	Human Services (DDD)	Human Services (DDS)	
POPULATION	Elderly/Physically Disabled	MR/DD	Elderly/Physically Disabled	
Waiver	Global Options 0032	- Community Care Waiver (CCW) Control #NJ.0031.R01.00	- Community Resources for Persons With Disabilities (CRPD) Control # 4133.90.R3 -Traumatic Brain Injury (TBI) Control # 4174.90.R2	
Qualified HCB Services Existing WAIVER Services	<ul style="list-style-type: none"> • Care Management • Respite • Env. accessibility adaptations • Special medical equip. and supplies • Chore services • PERS • Attendant care • Home delivered meals • Caregiver/recipient training • Social Adult Day Care • Home Based Supportive Care • Transportation • Transitional care mgnt • Community Transition Services • Assisted Living Program • Adult Family Care 	<ul style="list-style-type: none"> • Case Management • Support Coordination (Self-Directed Services) • Day Habilitation services • Supported Employment • Individual supports (PCA) • Environmental./Vehicle accessibility adaptation • Assistive Technology Services • PERS • Respite care • Transportation (non-medical) • Community Transition Services <ul style="list-style-type: none"> ○ Security deposits ○ Utility set-up/installation ○ Furnishings ○ Moving expenses ○ 1x food ○ 1x clothing 	<ul style="list-style-type: none"> • Care Management • Private duty nursing • Envir/Vehicle Modification • PERS • Community transitional services 	<ul style="list-style-type: none"> • Case Management • Counseling (behavior/drugs) • Community Residential Svcs • Therapies through a CRS or Day Program: <ul style="list-style-type: none"> ○ Occupational ○ Physical ○ Speech ○ Cognitive Rehab • Behavior Programs • Envir/Vehicle Modifications • Structured day program • Supported day program • Respite care • Adult Companion service

Department/ Division	Health and Senior Services (DACS)	Human Services (DDD)	Human Services (DDS)
POPULATION	Elderly/Physically Disabled	MR/DD	Elderly/Physically Disabled
HCB Demonstration Services	<ul style="list-style-type: none"> • Peer & Family Mentor • Job Development Specialist 	<ul style="list-style-type: none"> • Individual Goods and Services 	
Supplemental Demonstration Services	<ul style="list-style-type: none"> • 1x Groceries • 1x Clothing • EAA Occupational 	<ul style="list-style-type: none"> • 1x Groceries • 1x Clothing 	<ul style="list-style-type: none"> • Environ Assessment (occupational) for Individuals with Disabilities • 1x Clothing

-Environmental Assessment (occupational) for Individuals with Disabilities was removed from the DDD and DACS lists as they are already part of Assistive Technology Services for DDD and Environmental Accessibility Adaptations for DACS waiver programs.

In January 2009, DACS received approval of its consolidated HCBS waiver, Global Options. All services contained in Global Options are considered MFP Qualified HCBS services. The Global Options waiver combined the services contained in Enhanced Community Options and Community Care for the Elderly and Disabled.

Consumer Supports

The housing task force will develop plans to ensure that individuals who transition are aware of transportation options available in the locality in which they will be living. Transition coordinators and case managers will receive training on how to support people in using available transportation options as a part of each transition.

Complaint Resolution

A telephone listing of the 21 county-based Adult Protective Services (APS) provider agencies, including after-hours and emergency numbers, will be given to all MFP enrollees. As part of the Participant Recruitment and Enrollment process, participants and involved family members and other unpaid caregivers will be informed of APS.

For participants from developmental centers, including their families and/or guardians, information regarding their rights, including protections from abuse, neglect, and exploitation will be reviewed annually. This is current practice for all individuals within DDD's system and it is documented within each consumer's Individual Habilitation Plan (IHP). Participants will be able to contact any Interdisciplinary Team (IDT) members (the D.C. IDT consists of a Case Manager, Transition Case Manager, Social Worker, Support Coordinator, Psychologist or other professionals) in order to report concerns of abuse, neglect, and exploitation.

Upon the consumer's transition to the community, the licensed provider agency shall issue and explain the DDD's rights document. In addition, the consumer, family member and/or guardian will be given a contact list of advocacy agencies for further assistance with understanding and enforcing these rights if need be. As required at N.J.A.C. 10:44A every community provider agency must have a procedure to ensure the safety and well being of any individual under its care.

In the event of an emergency, consumers, their families, guardians and other interested parties will be reminded that in the event of a serious medical emergency, Daniel's Law requires 911 to be notified without delay for those persons residing in state funded community residences. In addition, DDD operates a 24 hour on-call system. Consumers will be given information on how to access the 24 hour on-call along with instructions on reporting incidents of abuse, neglect or exploitation. This information is contained in a tri-fold pamphlet that is given at the time of transition and annually thereafter at the annual Plan of Care review.

For persons with severe disabilities, who may not be able to use a phone or those who are non-verbal, the person who is providing care, relative, neighbor etc. should make calls on SR's behalf. DDS (609-292-1210) DACS have TTY services. The Department of Human Services TTY is 1-877-294-4356.

Each partner entity also can be contacted through their respective websites by clicking on the contact us button. The links are:

<http://www.state.nj.us/humanservices/ddd/index.html>

<http://www.state.nj.us/humanservices/dds/index.html>

www.state.nj.us/health/senior/contact.shtml

As indicated on the Informed Consent Form, participants in MFP who wish to register a complaint or concern may contact the MFP Project Director who will record the complaint and direct the person accordingly.

As detailed in Outreach, Marketing and Education section materials and information about the benefits of MFP will be provided to consumers as a normal function of the transition process. Special emphasis will be placed on the fact that MFP allows for the access to services that are not normally available that would assist an individual in overcoming barriers to transition. Consumers will also be informed that they will have the opportunity, through participation in Quality of Life Surveys, to provide input to the state on possible improvements in HCB services. A schedule of training events is contained in the Appendix entitled Guide to Information and Training Sessions.

24-Hour Back Up System

The DDD has an existing emergency back up system /after hour on-call system. On-call is a system of responding to emergency issues that begin after the office is closed. Issues that begin while the office is open are not considered issues for on-call. On-call will transition any unresolved issues to the appropriate worker once the office re-opens. The on-call answering service is in operation from 5pm to 9am during the workweek and 24 hours a day on weekends, holidays and for those periods when offices are closed due to inclement weather or other events. The main number in each regional office is the emergency number. The answering service monitors all incoming calls to the main office after hours. Should a caller identify an emergency situation, the service is to contact the on-call worker immediately.

Each DDD region assigns staff to be “On-Call” to cover the non business hours and accept all service recipients’ emergency calls.” The On-Call employee must have at least one year case management experience. If the matter cannot be resolved, or if the situation merits supervisory or administrative attention, the On-Call employee must contact supervisory/administrative personnel. The on-call worker is then responsible to respond to the situation taking any actions advised by supervisory/administrative personnel. The DDD on-call worker is then responsible to write a report regarding the matter and actions taken in response. Division contracted provider agencies also have their own 24 hour on-call procedures.

The Division will develop a process to track the number and type of participant requests for emergency assistance, timeliness of responses to consumer calls, the number of transitioned individuals who re-enter institutions or nursing homes, and the reasons for returning to the institution by January 2009. The aggregated information will aid policy decisions, resource allocation and quality improvement activities.

DDD has established an Emergency Capacity System. The primary aim of the Emergency Capacity System (ECS) is to provide safety, stabilization, and assessment for individuals receiving such services. While providing a safe environment for individuals in crisis, it is the purpose of this system to stabilize the individual and provide assessment of future placement and/or programming needs within thirty (30) days. The first choice is for the individual to return to their home or previous placement whenever possible. Entry to the ECS is made solely through the DDD Community Services regional Office screening process. Upon referral by the screener, the agency providing these services will accept all individuals deemed in need of these services

For DACS

No one is discharged from a Nursing Facility to a Waiver operated by DACS without an Interdisciplinary Team/Round Table Meeting. The applicant/NF resident conducts the meeting as much as he or she is capable of doing or wishes to do. All relevant parties including the Community Choice Counselor from the Regional OCCO, NF Social Worker, Applicant's representative, Waiver Care Manager, and Rehab. Staff, doctors, nurses as necessary participate. Risk factors, those that pertain to health and welfare, should a service not be delivered as planned, are identified and back-up plans are created. Each IDT participant understands their own responsibilities and signs off on the Transition Plan as confirmation that he or she has participated in the Transition Plan and agree with its contents. The applicant has an additional 13 check off boxes that confirm choices were given including the statement: "I understand and accept the potential risk factors if I leave the nursing facility to return to a community setting."

For DDS

BACK UP PLANS:

As stated, in the process of developing the POC, the Case Manager and Waiver participant/ representative identify those risk factors that would trigger the need for back-up plans, should services not be delivered. Back-up plans are needed if the provider identified as responsible for furnishing the services fails or is unable to deliver them and it would have a critical impact on the participant's immediate well being. Alternative arrangements for the delivery of services would therefore be imperative. This information is included in narrative form on the Long-Term Care Re-evaluation form (CP-CM-1) and addresses the interventions to respond to safety concerns including contact information for the person responsible. In addition to the back-up plan strategies identified below, the availability of informal supports is discussed and identified in the POC, if viable. The Case Manager verifies that informal supports identified in the POC are valid. The current HCBS waivers for the physically disabled already include some requirements to ensure the health and safety for individuals requiring PDN services. In order to be eligible to receive PDN services, the participant must have a live-in primary caregiver that accepts responsibility for the participant 24-hours/day and must provide at a minimum 8-hours of direct care. The purpose for this criterion is so that an individual is not without care should a provider fail to deliver services. For those participants reliant on electrical DME i.e. ventilator, a generator is purchased in the event that there is electrical failure.

Medicare certified home health agencies are required by regulation to have a 24-hour on-call system in place. New Jersey requires those agencies that are not Medicare certified must

be accredited by one of four Accreditation Agencies, (i.e. JCAHO). A 24-hour on-call system is also a requirement for accreditation. MFP participants will be instructed to access this on-call system for those instances when critical health and safety personal care assistant (PCA) or private duty nursing (PDN) are not being provided as scheduled.

For individuals participating in MFP, an additional page will be included with the POC that will outline the individualized back-up plan for the services that are critical for the health and safety of the participant. The participant will be instructed to notify the case manager of those instances when he/she had to implement the back-up plan and the outcome. The case manager will be required to submit a report to the DDS outlining the participant's need to implement a back-up plan, including the reason, who contacted, when the incident occurred, and the outcome. This information will be reviewed by DDS staff and any remediation recommendations will be discussed with the case manager. The information contained in this report will be tracked in a database maintained by DDS staff including any remediation recommendations and related outcomes.

Listed below are some standard methods for addressing routine back-up plans:

- CM contacts the participant monthly; unmet needs are identified at those times and detailed in the POC with reasons for unmet needs. Future service planning addresses how the unmet needs are to be met.
- Each Case Management Agency has plans to identify back-up CM for the waiver participant. Home and Community Services' providers develop their own internal system to provide back up services. At times, one home health agency will be identified as a back-up for another home health agency for critical PCA or PDN services.
- The participant or his/her representatives receive information to call the CM if services are not delivered. The CM investigates and resolves the problem with the existing agency or changes the agency. If needed, the CM arranges for emergency services.

Transportation

The NJ Division of Medical Assistance and Health Services (DMAHS) entered into a contract with LogistiCare, LLC to be the primary single source vendor for non emergency medical transportation services to be provided statewide for all eligible Medicaid Managed Care (MMC) and Fee for Service (FFS) beneficiaries. These services include livery, Mobility Assistance Vehicle (MAV) transportation, non emergent Air Transportation Services, Basic Life Support (BLS) and Advance Life Support (ALS) Ground Ambulance Services.

Logisticare is responsible for maintaining a provider network; determining the appropriate mode of transport; and dispatching an appropriate vehicle to transport beneficiaries; and developing a quality assurance program to ensure access to the appropriate mode of transport based on medical necessity.

Logisticare has engaged current transportation providers, experienced in providing these services to the counties. The contractor will be responsible for paying the network provider.

Logisticare is responsible for:

- A toll-free Call Center with sufficient dedicated “800” telephone lines to respond to provider, prescriber and beneficiary inquiries concerning the transportation program, in accordance with performance and service standards listed in the contract
- The Call Center is accessible to eligible Medicaid beneficiaries twenty-four (24) hours per day/seven (7) days per week. The contractor’s personnel are available for calls during regular business hours, Monday through Friday, from 8AM to 4PM. Logisticare hired bilingual staff, uses a language interpreter service and have adequate TTY/TTD capability to ensure that non-English speaking and hearing impaired beneficiaries can access transportation services
- Logisticare is responsible for the following: receiving and responding to all inquiries complaints, oral or written with regard to the delivery of transportation services under the contract, from beneficiaries, providers, DMAHS or other sources. The contractor should encourage everyone to submit their concerns in writing. A complaint can be filed by a beneficiary or a network provider orally or in writing within sixty (60) days of the incident that resulted in the complaint. Complaints shall be resolved within ten (10) days of their filing. The contractor and the beneficiary/network provider should attempt to resolve any complaint.

Logisticare provides beneficiaries and network providers an independent unit of the customer service center to monitor and address complaints. This unit is adequately staffed to receive the phone calls and respond to beneficiary/network provider concerns. Logisticare identifies and documents any inquiry patterns and/or trends to the State Contract Manager. Logisticare submits accurate and complete management reports to DMAHS no later than thirty (30) days after the close of the month so that fully reconciled data can be provided to the State.

Self Direction

For those individuals entering into services through the auspices of DACS or DDS, self direction is described below.

*Demonstration and Supplemental Demonstration Categories of service are outside of self direction. MFP participants will not self direct these services. They will self direct only those services available in the DACS waiver program entered into upon discharge from the Nursing Facility.

Participants may elect to engage in participant-directed services, acting as the employer of their care providers. The participants must be willing and able to direct their care and perform essential employer functions, such as interviewing, checking references, hiring, supervising, and firing. The ability to direct one's care shall be confirmed prior to the approval to hire one's employee. An individual's ability may be reevaluated at any time, as determined by the Care Manager, in response to objective evidence indicating changes in capability. An individual may opt to use an authorized representative approved by the Department to act in his or her behalf, except in attendant care.

The Participant-Employed Provider may provide Chore, Home-Based Supportive Care (Assistance with Activities of Daily Living and Instrumental Activities of Daily Living), Transportation, and Attendant Care services and must have demonstrated the experience, training, education or skills necessary to meet the participant's needs, consistent with program standards for the task. Demonstration is accomplished through: documentation of formal training or education; previous experience; written documentation from previous employers; ability to clearly and effectively explain, verbally or in writing, specifically how the task is to be accomplished; and through actual observation of task performance. The Care Manager verifies that the Participant-Employed Provider meets the qualifications identified for the particular service.

A contracted Fiscal Intermediary, Public Partnerships, LLC (PPL), acts as agent for the participant/employer in performing fiscal responsibilities associated with processing payroll and withholding obligations. This is an administrative function and not a separate waiver service.

The Care Manager notifies (PPL) to send the employee/employer packets to the participant. The employer packets are pre-populated with the participant information and have tabs to indicate where the participant needs to sign. The participant completes the forms and returns them to PPL with proof of Workman's Compensation coverage. PPL reviews the Workman's Compensation verification and sends the forms to the appropriate federal and state agencies. PPL sends the employee packet to the participant. (The packet can also be downloaded from PPL's web site.) The PEP completes the forms and sends them to PPL. PPL reviews the PEP tax form for completion and processes the forms. PPL notifies designated staff in the Division of Aging and Community Services, who updates the PEP database and notifies the Care Coordinator/Care Management Site Supervisor of the approved start date for the PEP to begin

work. Once the packets are returned to PPL and the fingerprints are completed, a start date is given. The whole process takes from two to three weeks.

The Participant supervises and directs the employee in the provision of services as specified in his or her Plan of Care. The Plan of Care is developed by the participant, Care Manager, and other pertinent individuals requested by the participant, and is based on careful assessment of needs, personal preferences, current supports, and abilities, and risk factors. The Plan of Care drives service linkage and monitoring.

The Care Manager formally monitors implementation of the Plan of Care, which identifies minimum monitoring frequency, methodology to verify serviced provision and service outcomes. The Care Manager is also available to the participant to provide support in PEP service delivery as needed to ensure the health, safety, welfare and rights of the individuals receiving services.

A service agreement is mandatory for each PEP, which delineates the specific care, as identified in the Plan of Care, to be provided in terms of type, amount, duration, and frequency. Care Managers complete an Individual Service Agreement (ISA) on the HCBS (Home and Community-Based Services) website to document the above. PPL matches the timesheet signed by the participant/employer, against the ISA authorization to ensure that the approved hours of Participant-directed services are the same.

Individuals who will be self directing services received through the auspices of DDD, self-direction is described below.

* There is no difference between self-directed opportunities within the CCW and the Demonstration and Supplemental Demonstration Categories of service.

Self-Direction began in 1997 with the Self Determination program. Through a succession of Quality Improvement efforts, the system has evolved.

Budget Authority/Fiscal Management

Participants in Self-Direction have budget authority over the resources allocated to them as well as the ability to hire/fire staff. They can choose to hire qualified individuals to support them (using a Fiscal Intermediary), authorize changes in qualified providers or they can purchase supports from the traditional provider agencies. A contracted Fiscal Intermediary supports participants in managing their budget authority. This Fiscal Intermediary acts as the employer of record for individuals whom the participant chooses to hire and pays individuals and/or agencies for services rendered to the participant.

Method of Budget Determination

New Jersey is utilizing a methodology based on level of support. Individuals are grouped by the level of support needed and given a maximum budget amount based on their grouping. Costs for the typical service set for each group were established using reasonable and customary rates for these services. The budget amount for each group was determined by an analysis of services required to satisfy the individual need for supports and establishing a maximum budget amount.

Additional dollars are infused to the base amount for specific needs that may require additional and/or enhanced services (e.g. behavioral issues, medical issues).

New Jersey is utilizing the DDD Individualized Resource Tool. Nationally recognized experts for reliability and validity have evaluated the tool. It assesses individual competencies and determines relative need for services and supports by assessing the individual in the following areas: cognition, communication, self-care and mobility and determines the grouping that would meet the individual's needs. There are seven (7) groups of individuals with similar levels of need determined by the tool. Each grouping is allocated a corresponding budget amount over which the individual has authority.

Level I

Individual needs assistance in community integration skills (e.g., independent use of public transportation).

Level II

Individual needs assistance in shopping, money management and activities of daily living.

Level III

Individual needs assistance in the following areas of daily living; dressing, choosing clothing, meal preparation, and understanding money concepts.

Level VI

Individual needs assistance in getting out of bed, ambulating and in the following daily living activities; dressing, eating, managing money.

Transition Level Descriptions

Individuals whom have aged out of their educational entitlement will be assessed to determine the level of support needed to replace the service(s) previously provided through educational entitlement that will prevent institutional placement. In these cases levels of budgeting are established in accordance with the specific need of day activities.

Level I Description:

Individual needs assistance in community integration skills, shopping, money management and activities of daily living.

Level II Description:

Individual needs assistance in the following areas of daily living; dressing, choosing clothing, meal preparation, understanding money concepts.

Level III Description

Individual needs assistance in getting out of bed, ambulating and in the following daily living activities; dressing, eating, managing money.

Individuals applying for waiver services and their families are invited to an orientation conducted by staff known as Regional Monitors who are QMRPs. The Orientation Meeting presents information on the person-centered planning process known as Essential Lifestyle Planning (ELP). Individuals are given forms to list information about themselves that will help them, their families and other people who care about them describe the “things that are important for the individual” and put into words both the outcomes they want to achieve and the things about the individual that a person providing support will need to know. The ELP tools and process, together with a Health and Safety checklist, assist the individual and the person who know him/her best work with the Support Coordinator and others to develop a Service Plan that identifies the necessary waiver services and supports. The plan will identify state plan, natural community supports (e.g. community resources, friends), and generic community supports (e.g. Division of Vocational Rehabilitation (DVR) or another agency not funded by the Division) that will help the individual attain his/her desired outcomes. The budget is used to purchase waiver services that complete the necessary services comprising the total service package to address the individual’s needs and desired outcomes.

The Orientation provides the individual and family with an understanding of the planning process, the responsibilities they will assume in self-direction and the assistance they can expect from the Support Coordinator, Regional Monitor and the Fiscal Intermediary. They are advised regarding how to use the website and other services of the Family Support Center to identify qualified and/or licensed providers in their area.

At the Orientation, individuals who want to request a reassessment of their level of need and corresponding budget amount are given information on how to request the reassessment. They are also given information on the circumstances under which a fair hearing can be requested and how to request one. An orientation packet given to them provides reference material and contact information regarding the Regional Monitor, Support Coordinator, Family Support Center and other resources.

Please see the Self Direction Appendix (Appendix 5) for further detail on self direction for MFP in NJ.

Quality Management Strategy for Money Follows the Person (MFP)

New Jersey Department of Human Services *Division of Developmental Disabilities (DDD)*

DDD will apply the same quality management practices currently undertaken in the Community Care Waiver program to the Demonstration and Supplemental Demonstration categories of service.

New Jersey's Division of Developmental Disabilities (Division) is committed to, complying with waiver assurances, ensuring the health and safety of people receiving services, implementing promising practices, and offering the highest quality services that promote choice and control in people's everyday lives. DDD continuously strives to improve the quality of services and supports through:

- Guidance from people who receive services and supports and their families and
- Collaboration with all partners – advocates, providers, administrative entities, and the community.

The Division will integrate the MFP demonstration into its existing 1915(c) HCBS waiver. The MFP program will incorporate, at a minimum, the same level of quality assurance and improvement activities required in Appendix H of the existing 1915(c) HCBS waiver. This document provides a brief overview of The Division of Developmental Disabilities Quality Management Strategy.

Current System Overview and Activities

The Divisions current system includes the critical processes, structures and operational features necessary to meet the CMS Assurances related to, Monitoring and Responsibilities, Data Management Reports and Report Frequency. Each activity is chosen to provide evidence that compliance with each assurance is demonstrated. Evidence is developed from qualitative and quantitative data from record reviews, participant feedback surveys, participant or provider interviews, NJ's Unusual Incident Reporting Management System (UIRMS), Complaint/Grievance database, paid claims and other sources.

In 2006 the Division formed the **Office of Quality Management and Planning OQMP** by joining the Offices of Planning and Quality Improvement. Additionally the Office of Risk Management (ORM) was formed. The OQM&P is responsible for analyzing patterns and trends to discover problems or deficiencies. Data on remediation and quality improvement efforts will be collected and analyzed by the OQM&P and provided to Division leadership and management for the purpose of setting goals, assigning resources and guiding policy. Audit processes for oversight by the Single State Agency (Medicaid) are planned as part of the Quality Strategy.

DDD's existing Waiver Monitoring activities collect data both on paper and electronically, Quality, IT, Waiver, and Regional Staffs are working in collaboration to develop and implement IT applications to track timeliness and approval of Level of Care Determinations,

Annual Plan development and annual re-determinations. Data and information from the following: DHS' Office of Program Integrity and Accountability units; Unusual Incident Report Management System (UIRMS), Office of Licensing (OOL), Budget Office and Special Response Unit (SRU), information from complaints and grievances, and participant/family satisfaction will be used to monitor provider compliance with standards and to assess participant Health, Safety and Freedom from Exploitation.

DDD employs a full time CCW Monitor who audits a random sample of records monthly for level of care determination, timeliness/appropriateness of service plan implementation and other compliance standards. Case Managers currently monitor services for compliance with the annual service plan. OQM&P monitors Employment and Day Services for compliance with existing standards.

National Core Indicators (NCI)

In July of 2007, The Division joined the National Core Indicators Project (NCI) a collaboration of 28 participating states and the NASDDDS member state agencies and the Humans Service Research Institute (HSRI) with the goal of developing a systematic approach to performance outcome measurements. Through this project participating states pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, work out comparable data collection strategies and share results. The OQM&P is responsible for the NCI Project and is responsible for the following:

- Conducting face to face consumer interviews per the NCI cycle
- Complete mailer surveys to families and guardians of individuals receiving services per the NCI cycle
- Complete provider surveys per the NCI cycle

Day Program Quality Reviews

In January 2008 The Division of Developmental Disabilities implemented a Day Program Supported Employment Review process to monitor compliance with the Day Program and Supported Employment Standards. Annually Regional and OQM&P staffs will review 20% of all day program and supported employment service contracted agency sites. Review findings and information will be shared with Provider Agency. Information will be aggregated and analyzed for trends to promote systems improvement with reports made available through the Divisions Website for all stakeholders.

Olmstead

New Jersey's Olmstead plan "Path to Progress" (Plan) outlines the process of transitioning individuals from developmental centers to the community. Supporting the transition to the community requires a quality management system that ensures a continued focus on quality of services and supports that result in chosen outcomes for people receiving services. OQM&P has specific oversight of the Quality Review Process for all individuals transitioned to the community. Toward this end, DDD organized an Implementation and Planning Advisory Council (Council) to work closely with the Division's leadership. The Council includes service recipients and their families, service providers, Division leadership and members of the broader community. The primary responsibility of the Council is to assure the benchmarks set forth in the

plan are met and continue to meet the needs of individuals with developmental disabilities through ongoing review and feedback. The quality management strategies designed to assess whether or not the system is meeting the needs of its customers relies on data that is generated by multiple sources including individuals, families, advocates, providers and other stakeholders. These multiple sources feed the work of the Council.

Self Directed Services

Persons who self-direct their services in MFP are included in the same processes and practices of all persons who self direct services in the CCW. The current Self-Directed Services record makes information accessible electronically to a Fiscal Intermediary and to a contracted Support Coordination entity. Staff in the Regional Offices and the Office of Quality Management and Planning can also access the record. This application allows the individual/family to create a service plan online for their Individual Budget allocation. The electronic record stores data on plan content, review and approval. Additionally it permits for the documentation of other required data to be tracked and aggregated.

Case Management and Regional Operations Redesign

DDD continually seeks to redesign the Regional System, as a component of building and strengthening community infrastructure which includes case management services. Redesign seeks to improve the quality and the responsiveness of services through restructuring caseloads, case management advanced training and implementing IT improvements and developments.

A significant effort within Redesign is the development of four Regional Quality Improvement Units. These Units are proposed to sustain the delivery of quality service and supports through the provision of technical assistance and training to service providers (which include the community care providers). Additionally it is planned these units will review and monitor day activities and programming in the community, develop/review continuous quality improvement systems, and implement all aspects of quality improvement services and supports.

Assurances

The Division continues to improve its processes of discovery, remediation and improvement to assure the health and welfare of participants by monitoring: a) level of care determinations; b) individual plans and services delivery; c) provider qualifications; d) participant health and welfare; e) financial oversight and; f) administrative oversight of the waiver. All problems identified through these discovery processes will be addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. The State's single state Medicaid Agency, Department of Human Services, will conduct reviews of waiver operations, in accordance with interagency agreements.

Satisfaction Surveys

Individuals participating in the MFP Demonstration have the added benefit of an enhanced monitoring during their transition period. As part of NJ's Olmstead Quality Process during the first 12 months following an individual's transition to the community, regional and

developmental center staff visit the individual at 30, 60, 90, and 180 days intervals. Participant-specific information is gathered to guide decisions about needed modifications to plans of care, to mitigate/ameliorate issues and inform infrastructure decisions. In addition, MFP individuals will participate in the Quality of Life Surveys (MFP required surveys).

Roles and Responsibilities

DDD Central Office Responsibilities:

- *Ensure individuals access to services*
- *Monitor health and safety*
- *System oversight*
- *Financial auditing*
- *Quality improvement initiatives*
- *Incident report trend analysis*
- *Mortality review*
- *Data management*
- *Rules and regulation implementation*
- *Constituent input*
- *Waiver and Medicaid compliance*
- *Training standards*
- *Correcting oversight*
- *Collaborations with other system partners (OOL,SRU,CIMU, Auditing)*

Regional Responsibilities:

- *Health and Safety monitoring*
- *Reviews regional performance outcomes and trends*
- *Review data to determine waiver assurances*
- *Monitor progress on remediation plans*
- *Contracted provider management*
- *Incident report collection and review*
- *Corrective action monitoring*
- *Approves remediation plans*
- *Incident management and reviews*
- *Mortality reviews*
- *Case management*
- *Fiscal management*
- *Collaboration with central office*

DDD Office of Quality Management and Planning

- *Study and analyze DDD data and information to recommend improvement to DDD Leadership*
- *Establish performance indicators that need to be assessed in the system*
- *Review statewide performance outcomes, trends and patterns.*
- *Recommend quality improvement actions based on the review of information*

- *Evaluate the effectiveness DDD quality improvement activities*

Olmstead Implementation and Advisory Council

- *Review reports on benchmarks*
- *Make recommendations for improvements based on data*
- *Conduct consumer focus groups*
- *Conduct public meetings*
- *Recommend policy actions*
- *Monthly/quarterly meetings to review the implementation plan.*
- *Ongoing work groups to based on the response*

Three additional requirements: 24 Hour Back Up System, Incident Management and Risk Mitigation

24-Hour Back Up System

The Division has an existing emergency back up system /after hour on-call system. On-call is a system of responding to emergency issues that begin after the office is closed. Issues that begin while the office is open are not considered issues for on-call. On-call will transition any unresolved issues to the appropriate worker once the office re-opens. The on-call answering service is in operation from 5pm to 9am during the workweek and 24 hours a day on weekends, holidays and for those periods when offices are closed due to inclement weather or other events. The main number in each regional office is the emergency number. The answering service monitors all incoming call to the main office after hours. Should a caller identify an emergency situation, the service is to contact the on-call worker immediately.

Each DDD region assigns staff to be “On-Call” to cover the non business hours and accept all service recipients’ emergency calls.” The On-Call employee must have at least one year case management experience. If the matter cannot be resolved, or if the situation merits supervisory or administrative attention, the On-Call employee must contact supervisory/administrative personnel. The on-call worker is then responsible to respond to the situation taking any actions advised by supervisory/administrative personnel. The DDD on-call worker is then responsible to write a report regarding the matter and actions taken in response. Division contracted provider agencies also have their own 24 hour on-call procedures.

For MFP, the Project Director will forward a roster of MFP participants to each of the DDD regions. The on-call worker will forward any on-call information related to a MFP participant to the MFP Project Director for inclusion in the MFP database which will track required information for reporting to CMS.

Incident Management

Office of Risk Management (ORM)

The Office of Risk Management is responsible for the routine review and analysis of incidents of abuse, neglect and exploitation, follow up on investigations and promotion of best

practices and continual improvement. DDD's incident management system, relies on functions that exist within both the ORM and the Department's Office of Program Integrity and Accountability, respectively; Critical Incident Management Unit (CIMU), the Special Response Unit (SRU) and the Office of Licensing (OOL). Currently incident management key functions are:

- Review data, analyze, and provide summaries of problem remediation,
- Identify areas of weakness and improvement,
- Produces ad hoc reports and recommendations moving towards a more proactive system approach,
- Implement system improvements related to data aggregation,, analysis, problem remediation, and the development of processes related to individual risk.

Office of Program Integrity and Accountability (OPIA)

OPIA has direct responsibility for incident investigations, licensing of human services programs and facilities and ensuring fiscal and program accountability of community programs and departmental units. The units within OPIA are; Unusual Incident Report Management System (UIRMS), Office of Licensing (OOL), Budget Office and Special Response Unit (SRU) OPIA has a unique role in DHS in that it verifies and validates, independently, activities and operations required and carried out by various departmental units. The OPIA is the entity that certifies DHS compliance with various state and federal regulations and independently investigates or conducts reviews of abuse, neglect and fatalities, as well as financial and program audits. The Office of Licensing is the licensing and regulatory authority that regulates programs serving persons with mental illness, developmental disabilities and traumatic brain injuries. Through its licensing and regulatory process, the Office of Licensing supports the provision of a safe environment in which DHS consumers receive services. Reviews are conducted annually, with unannounced visits to agencies as necessary. Agencies are required to submit a plan of correction to the licensing office regarding deficiencies identified through the licensing review. The Department partners with the Division to take appropriate action in situations where a plan of correction is found to be unacceptable.

Risk Assessment

The risk assessment will identify the participant's individual health care needs and all supports needed in order for them to safely transition to and remain in the community. Risk assessments will be completed for 100% of MFP Participants. Risk factors will be documented in the Health and Safety Risk Summary (HSRS). The process is as follows:

1. The IDT discusses the risk and the supports needed to mitigate the risk.
2. Potential risks, the supports needed to mitigate them, who will provide the supports and services, and how, will be indicated on the HSRS.
3. Information from the HSRS will be included in the Service Plan.
4. The Service Plan will be monitored for the effectiveness of the services provided in mitigating risk and for any changes that may potentially place the individual at greater risk.
5. When changes occur, the cycle will begin again.

The Quality Management Strategies Outlined by DACS will apply to all categories of service included in Money Follows the Person (Qualified HCBS, Demonstration and Supplemental Demonstration categories of service).

**The Quality Management Strategy for the
Global Options for Long-Term Care (GO) Medicaid Waiver**

The following provides evidence as to the implementation of the quality management and improvement strategy for the Global Options for Long-Term Care Medicaid Waiver program. The State demonstrated through its approved Interim Procedural Guidance that adequate and effective mechanisms for finding and resolving compliance issues on an ongoing basis are in place and where appropriate, remediation efforts and timelines for each assurance are indicated as well. The GO Waiver Renewal Application was submitted to and approved by CMS in February 2012 with the effective October 1, 2011.

Quality Management Strategy Overview

The Quality Management Program combines Quality Assurance and Quality Improvement strategies to assure there is a system in place that continuously measures performance, identifies opportunities for improvement and monitors outcomes. Through robust system Discovery, information is gathered and analyzed to determine when there are problems and where the locus of the problem lies. Once appropriate action is taken to remedy the problem, the system of Discovery is used continuously to assure the proposed solution has been successful. Embracing the “participant-centered approach” to service provision, the New Jersey Department of Health and Senior Services and the New Jersey Department of Human Services, along with many public and private associations and service provider agencies work collaboratively with Waiver participants with a focus on his or her satisfaction and choice.

The Quality Management Program uses a five-level approach. Each level has a responsibility and an opportunity for identifying problems (Discovery), creating solutions at the provider level (Remediation) and assisting in changes in program policy (Improvement).

Level One is the Waiver participant and informal supports/caregivers. Waiver participants must have the tools needed to self-direct their services to the best of their capabilities. Waiver participants work with Waiver service providers to develop a Plan of Care that reflects personal goals and strategies to assure successful outcomes. The Quality Management Program assures that Waiver participants receive ongoing support and monitoring of their health and welfare throughout their participation in the Waiver program through: Waiver participant education and Options Counseling, Interdisciplinary Team Meetings, annual Participant Satisfaction Surveys, Critical Incident Reporting, Care Management service coordination and monitoring, on-site Quality Assurance reviews conducted by the Department of Health and Senior Services, and audits conducted by the Department of Human Services. Waiver participants play an active role in the Discovery process through communicating problems or issues to Waiver service providers. Working with Waiver service providers, Waiver participants are part of the remediation process and provide input into solutions to assure successful outcomes.

Level Two is the Waiver Care Manager and other Waiver service providers. Providers must employ self-monitoring strategies that assure that the agency's Quality Assurance and Quality Improvement policies and procedures regarding service provision to Waiver participant meet the standards of the Waiver program (Discovery). When problems are identified, Waiver providers must evaluate whether the difficulty is staff-specific and/or related to provider-specific or programmatic policy and procedure. If the provider's own policy and procedures are the source of the problem, then the provider must assure that changes in policy and procedure are made that continue to support the Waiver participants and maintain compliance with the standards of the Waiver program. Each provider will have the tools needed to understand and measure the quality of services provision through a number of various means such as recently issued Program Instructions, Policy Memorandums, and Information Memorandums in addition to referencing past program manuals and attending regular meetings and trainings as offered by the Department of Health and Senior Services and state fiscal intermediaries.

Level Three is the Community Choice Counselor and other Office of Community Choice Options Staff. The Department of Health and Senior Services' Division of Aging and Community Services employs Community Choice Counselors who function out of three Regional Offices of Community Choice Options, directed by Field Office Managers. There is also a Global Options/Interdisciplinary Team professional in each Regional Office who serves as a specialist in assessing complex cases and developing responsive Plans of Care to assure health and welfare needs of the Waiver participants are met in a cost-effective manner and who serves as a resource and expert to Office of Community Choice Options Staff in Global Options Medicaid Waiver program operations. The State Office of Community Choice Options also employs a Regional Quality Manager who serves as a liaison to all three Regional Offices of Community Choice Options. The Office of Community Choice Options serves as a gatekeeper for the Global Options Medicaid Waiver. The Community Choice Counselor is responsible for outreach, options counseling, resource identification and referral, networking, and ultimately assuring Level of Care. The Community Choice Counselor conducts Interdisciplinary Team Meetings. Each of the three Field Office Managers, three Assistant Field Office Managers and the Regional Quality Manager compile and review data collected from the functions of the Community Choice Counselors regarding referrals and evaluations of Waiver participant in his or her region for Quality Assurance. Through these activities, the Office of Community Choice Options Staff plays an essential role in the Discovery, Remediation and Improvement processes. The Office of Community Choice Options Staff maintains regular contact with the Department of Health and Senior Services' Division of Aging and Community Services' County Liaison/Quality Assurance Specialists regarding quality management issues.

Level Four is the County Liaison/Quality Assurance Specialists (Quality Assurance Unit) and other Office of Long-Term Care Programs staff, within the Department of Health and Senior Services Staff. The Department of Health and Senior Services presently employs six County Liaison/Quality Assurance Specialists who function out of the Division of Aging and Community Services (DACS). The County Liaison/Quality Assurance Specialists act as liaisons between care management and other Waiver service providers and Department of Health and Senior Services Waiver Management Staff. In the DACS' Office of Long-Term Care Programs, Quality Assurance Unit, the County Liaison/Quality Assurance Specialists' primary

responsibilities are: to ensure compliance with Federal 1915(c) Global Options for Long-Term Care Medicaid Waiver; to facilitate program effectiveness in assigned counties through quality activities such as conducting participant satisfaction surveys and completing on-site Quality Assurance surveys at care management agencies; to supply technical assistance, training and consultation necessary to promote proper program implementation and to respond to customer needs; to contribute to the development and maintenance of Quality Assurance systems that promote effective operation of the Office of Long-Term Care Programs/Division of Aging and Community Services; and to provide technical assistance at the county level on issues related to Global Options and the implementation of the Aging and Disability Resource Connection processes.

The County Liaison/Quality Assurance Specialists are a vital component to the effectiveness of the Division of Aging and Community Services' Quality Management Strategy and the Office of Long-Term Care Programs' Quality Assurance Unit. For example, since May 2005, the Quality Assurance Unit has implemented Quality Assurance Visits for all care management agencies statewide. A team of 3 to 4 DACS County Liaison/Quality Assurance Specialists conducts survey reviews for each county every 24 months. Every care management agency that operates within the county is monitored during this visit, at which time the local administration of Medicaid Waiver program and care management practices are reviewed. In-depth reviews of the case records/participant files, as maintained by the Care Manager, are completed to verify a number of assurances are upheld. A standardized and electronic Participant File Review Tool is used by all surveyors and findings are exported into a database for future reporting purposes.

Sampling

During these on-site surveys, DACS County Liaisons review a sample of case records/participant files, using a stratified sampling method. When an On-site Quality Assurance Visit Notification Letter is sent, each care management site is asked to return a list of active participants enrolled within the past three years. The sampling design calls for selecting a sample of 1 in 10 of the participants on the list. By having the lists arranged by care management site, it ensures that exactly 1/10 of the participants serviced by each care management site is selected. If a simple random sample were selected from the list, or a systematic sample from an alphabetical list, the proportion of the sample for each care management site would be subject to normal sampling variability and could be slightly higher or lower than was the case for the population being served.

In the approved Waiver, DACS used a CMS referred 'Sample Size Calculator' to compute the following parameters:

Confidence Interval (margin of error accepted): 5

Confidence Level Needed: 95%

Population Size: 9,000 Enrolled Medicaid Waiver participants

Response Distribution: 50%

Sample Size: 369

After completing the on-site quality assurance visits since October 2006, DACS utilized this calculator again to verify DACS reviewed enough participant files in order to get results that reflect the target population as precisely as expected. DACS continues to be successful in its

existing sample size determination. For example, when finding the level of precision DACS has in our existing sample, it was concluded that during Round III (QA visits occurring between October 2008- October 2009), using the confidence level of 95%, with a population of 10,082 and an actual survey of 401 participant files, the DACS confidence interval is 3.18

A number of audit tools are used by the Quality Assurance Unit to collect information and measure quality outcomes.

Survey Tools

Care Manager Questionnaire: solicits comments about care management practices, policy implementation, and suggestions for ways to make the Care Manager's role more effective.

Participant File Review: evaluates the completeness of consumer files, such as the inclusion of all core documents, Plan of Care and Level of Care comprehensiveness, thorough documentation, and regular service verification.

Participant Satisfaction Survey: asks consumers about program access, participant choice and satisfaction with services, as well as suggestions for improvement.

System Design Changes

The State utilizes several methods to determine the effectiveness of the solution or resolution. The most immediate measure is the ongoing review of care management agencies and participant records which is done on an on-going basis by the DACS County Liaison/Quality Assurance Specialists, who monitor the response of the sites to corrective actions to ensure that the resolution is addressing the identified problems and that it is effective on an ongoing basis. Data and reports that aggregate information gathered during these monitoring reviews is analyzed and allows for the initial stage of trend identification with follow-up occurring based on the prevalence and scope of the concern. Follow-up could consist of immediate corrective action requests, state-wide trainings being provided or policy and procedure memorandums being developed or updated and distributed to all applicable entities.

A second measure of the process for monitoring and assessing system design changes is the ongoing oversight and audits conducted by the Administering Agency.

Level Five of the Quality Management and Improvement System is the Quality Management Unit (QMU) in the Department of Human Services' Division of Medical Assistance and Health Services, which has the ultimate authority for administering oversight and monitoring the GO Waiver program. The Quality Management Unit is responsible for ensuring Administrative Authority Oversight and maintaining a Monitoring Work Plan. As the State Administering Agency, the New Jersey Department of Human Services' Division of Medical Assistance and Health Services has established a Quality Management Unit in its Office of Provider Relations for the purpose of routine and ongoing oversight and monitoring of the Quality Management Strategies implemented by all State Operating Agencies of Medicaid Waiver programs, including those operated by the Division of Aging and Community Services' Office of Long-Term Care Programs. The Quality Management Unit consists of skilled professionals who have a wealth of knowledge regarding diverting and transitioning individuals from nursing facilities and maintaining them in the community. This Unit works collaboratively with other State agencies for information sharing. As the Department of Health and Senior Services Waiver Management

Staff conduct ongoing reviews of Discovery information received through Critical Incidence Reporting, quarterly and regional meetings with providers, reports submitted by the Office of Community Choice Options, on-site Quality Assurance visits, financial audits, and surveys conducted, data is analyzed and shared with the Quality Management Unit for use in implementing remediation at the provider and/or regional level and developing strategies for implementation on a State or system-wide level. The Waiver Management Staff may initiate remediation actions including additional provider trainings, restriction of the provider opportunity level for providing services to participants, or termination of a provider agreement. In turn, the Quality Management Unit meets regularly with the Waiver Management Staff to identify concerns and examine remedial actions. As warranted, the Quality Management Unit will schedule interim targeted desk audits to be conducted for care management agencies. All interim targeted desk audits will include random selection of Medicaid Waiver participant records and supporting documents which assess those components targeted for remediation in the Corrective Action Plan. The purpose of the interim targeted desk audit is to track continued compliance to the Corrective Action Plan. Unresolved findings, if noted on interim targeted desk audit, will require a joint on-site visit (i.e., interim targeted on-site audit) by the Department of Human Services' Quality Management Unit and the Department of Health and Senior Services' County Liaison/Quality Assurance Specialists to reach resolution. The Quality Management Unit continuously monitors the outcomes of all Quality Improvement efforts through ongoing Discovery measures to assure the standards of the Waiver program are maintained through all levels of the Quality Management and Improvement Strategy.

The Quality Management and Improvement Strategy is an ongoing process whose strategies change over time in response to the changing needs of the Global Options Medicaid Waiver program and the agencies that administer and operate it Statewide. The success of the Quality Management and Improvement Strategy design and operation are reviewed minimally every twenty four months between the Department of Health and Senior Services Division of Aging and Community Services and the Department of Human Services Division of Medical Assistance and Health Services.

DACS Quality Assurance Unit On-Site Quality Assurance Protocols

A team of three to four State representatives from the Division of Aging and Community Services' Quality Assurance Unit conducts a two-day on-site survey visit for each county. During this two-day visit both the Global Options for Long-Term Care Medicaid Waiver program and the state-funded, Jersey Assistance for Community Caregiving program, are reviewed.

Prior to Survey Visit

Agencies are given five weeks notice of their scheduled on-site review.

- A Care Manager Survey is to be completed by any new Care Managers who have been hired since the last on-site review. The submission of this survey is not required by all Care Managers, but it should be made available to any Care Manager who is interested in completing the survey.
- A list of all participants and their Medicaid number by Care Manager, by program, and by enrollment date is to be submitted electronically to the County Liaison.

The DACS QA team leader will conduct a brief Entrance Interview with appropriate agency staff to explain the general format of the monitoring visit.

- The survey team reviewers will examine a random stratified sample of participant files opened within the past three years.
- The Liaison will review the Participant File Review tool with the Care Management Supervisor to assist the CM agency's internal Quality Assurance oversight.
- Upon completion of the file review and the Care Manager interview, the team will meet privately to discuss the visit, identifying its concerns or areas to be addressed. A formal Exit Interview will then be held for the supervisory staff, including the participation of the Executive Director, to summarize the findings of the visit.

At the completion of the visit, the team meets privately to discuss the visit, identifying its concerns or areas to be addressed. A formal Exit Interview is then held for the agency's administrative staff to summarize the overall findings. This Exit Interview is always used to provide technical assistance and guidance if the agency has questions about any program policies or procedures. It also gives the state a chance to get feedback from the county-based agencies on how they operate their programs. Sample forms or illustrated procedures may result in a best practices model to be shared with other agencies.

After the Survey Visit

- A Summary Report / Follow-up letter is sent to the agency within 30 business days of the on-site visit to outline the findings of the quality assurance survey. If a Remediation and Improvement Plan is warranted, the agency has 30 days from the date of the letter to respond.
- Once the Remediation and Improvement Plan is received, both the County Liaison and his or her supervisor review it.
 - If the Corrective Action Plan is complete, an acceptance letter is drafted for the signature of Quality Assurance Unit Supervisor advising the CM agency that the Plan is approved.
 - If the Plan is insufficient, a response is generated, or a contact is made, by the County Liaison requesting additional information from the agency.
 - When warranted, an additional on-site visit will be made by at least one County Liaison to assess the progress that has been made in the cited areas of deficiency.

Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses Back Up Plans and the arrangements that are used for backup

No one is discharged from a Nursing Facility via Money Follows the Person onto the Global Options for Long-Term Care Medicaid Waiver without an Interdisciplinary Team/Round Table Meeting. The applicant/NF resident conducts the meeting as much as he or she is capable of doing or wishes to do. All relevant parties including the Community Choice Counselor from the Regional OCCO, NF Social Worker, Applicant's representative, Waiver Care Manager, and Rehab. staff, doctors, nurses as necessary participate. Risk Factors, those that pertain to Health and Welfare, should a service not be delivered as planned, are identified and Back-up Plans are

created. Each IDT participant understands the responsibilities and signs off on the Transition Plan as confirmation that he or she has participated in the Transition Plan and agree with its contents. The applicant has an additional 13 check off boxes that confirm choices were given including the statement: "I understand and accept the potential risk factors if I leave the nursing facility to return to a community setting."

Plan of Care Development Process

A Plan of Care policy was originally distributed in September 2007 and then revised and updated in 2011. This Policy and Procedure fully addresses the standards established for all participant-centered service plans.

a) The Plan of Care is developed by the participant (to the degree desired), his or her representative/legal representative (as requested by the participant) and the Care Manager. A fully developed Plan of Care must be finalized and signed by the participant, his or her representative/legal representative, Care Manager, and Care Manager's Supervisor within 30 days of the Care Manager's having received the case file. It is permissible to use the Service Authorization/Interim Plan of Care, which is developed as part of the Comprehensive Evaluation/Pre-Admission Screen, as the interim plan to initiate services before the development of a full Plan of Care (WPA-2). For those individuals who are discharged from a nursing facility to Global Options for Long-Term Care, an Interdisciplinary Team, directed by the applicant (as much as he or she desires or is capable of) and including his or her representative/legal representative, Community Choice Counselor, Nursing Facility Social Worker, and other relevant professionals, may develop a transition plan based on an updated evaluation and input of the team, which can also serve as an interim Plan of Care to initiate services before the development of a full Plan of Care (WPA-2).

b) The Comprehensive Evaluation, on a Department approved evaluation tool, is completed by professional staff designated by the Department of Health and Senior Services to determine whether the applicant meets the clinical criteria of nursing facility level of care. The evaluation tool measures cognitive patterns; communication/hearing patterns; vision patterns; physical functioning (Self Performance of activities of daily living and instrumental activities of daily living); continence; disease diagnosis and disabilities; health conditions and preventive health measures; nutritional/hydration status; dental status (oral health); skin condition; service utilization of formal care and special treatments, or therapies; medications; environmental assessment; mood and behavior patterns; social functioning; informal supports; and an assessment summary.

Before developing the Plan of Care, the Care Manager reviews the initial Comprehensive Evaluation completed by the Office of Community Choice Options Staff or Professional Staff designated by the Department. The individual's Comprehensive Evaluation used to determine nursing facility level of care is also used in developing the Plan of Care.

Services are authorized by the Care Manager. All authorized services, which are identified in the participants Plan of Care, are based on an individual's assessed needs. Waiver services are arranged to complement and/or supplement (not replace) the services that are already available to participants through the Medicaid State Plan and other federal, state and local public programs as

well as the supports that families and communities provide. The GO program is not intended to off-set the cost of agencies paid for privately by other parties. Upon enrollment, a comprehensive Plan of Care is developed by the GO participant and his or her Care Manager. A need based care allocation tool was developed and is utilized as a consistent and objective means of assisting Care Managers (CM) in determining the hours of home and community based services a GO participant requires. The need based care allocation tool is used to assist Care Managers in determining a GO participant's care needs when developing the initial Plan of Care, the annual Plan of Care or when there has been a significant change in the participant's functional abilities or a significant change in caregiver status requiring a revision to the Plan of Care. GO participants are provided services based on the information recorded on the comprehensive evaluation and the need based care allocation tool while also considering the professional judgment of the Care Manager in determining hours of service. The need based care allocation tool is used in conjunction with the following documents, as applicable: Comprehensive Evaluation and the Re-evaluation of Nursing Facility Level of Care (WPA-1).

The state must provide for the consistent, uniform administration and operation of the Waiver across all geographic areas where the Waiver is in operation, which for the GO Waiver is statewide. For example, when the care management agencies (which are located in local/regional non-state agencies) perform waiver operational functions such as Plan of Care development, the state must ensure that consistent decisions are made about the authorization of waiver services wherever a GO participant may reside. While there may be local variations in how waiver operational functions are conducted, the results should be consistent jurisdiction-to-jurisdiction. Absent a waiver of 'Statewideness', it is expected that the GO waiver will be administered and operated in a consistent fashion in all parts of the state of NJ and, thereby, ensure that waiver services are provided on a comparable basis to the entire target group of GO waiver participants in compliance with 42 CFR §440.240(b) (comparability of services for groups).

The needs based care allocation tool assists the state in demonstrating that services available are equal in amount, duration, and scope for all GO participants based on their individual assessed needs. The GO Waiver is managed in a manner to promote the cost-effective delivery of home and community-based services, and the use of the need based care allocation tool assists in linking the delivery of waiver services to other state and local programs and their associated service delivery systems. If the Waiver Participant or his/her Authorized Representative does not agree to the hours determined by the need based care allocation tool and the professional judgment of the Care Manager, after discussing areas of concern directly with the care management site, he/she can request an administrative review by the DACS Quality Assurance Unit staff as warranted.

Upon receiving a referral for a newly enrolled GO participant, the Care Manager schedules a face-to-face meeting in the participant's residence to interview the participant and family/caregiver. During the face-to-face meeting, the Care Manager continues the evaluation process started by the assessor and observes the participant's interactions with those present; participant's ambulation/navigation ability; physical environment; cognitive status and appropriateness of participant's appearance. The Care Manager asks about changes in participant's support system(s), health conditions, hospitalizations/rehabilitations, ability to

perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), goals or preferences, new needs and preferences, and overall functioning and independence level since the Comprehensive Evaluation. The Care Manager also identifies and discusses any assessed risk factors and the need for a backup plan.

c) The GO Participant Handbook and a web-based Fact Sheet list all the services that are available in the Global Options for Long-Term Care program. In addition, a thorough Policy on GO Medicaid Waiver Service Definitions and Special Considerations, was distributed to all care management agencies, which describes each service, its standards, requirements and limitations. At the time of the initial inquiry into service availability and potential program enrollment, designated Staff provides Options Counseling to applicants about the services available through the GO Waiver and other home and community service programs. For those individuals in an institutional setting who are seeking relocation to the community, the Community Choice Counselor will discuss the Global Options for Long-Term Care program with eligible candidates.

d) The Plan of Care (WPA-2) has fields to ensure all dimensions of the service plan process are addressed. The fields indicate date, Problem Statement regarding the reason for the assessed needs, risk factors and personal goals, need codes, services warranted, desired outcomes, service delivery pattern (units and frequency), unit cost, payment source, provider type, provider name, monitoring method, monitoring frequency, back up plan (if applicable), and unmet needs (if applicable). The Plan of Care has a narrative section for special instructions/comments to incorporate participant preferences or concerns, expound on unmet needs, and describe back-up plans, explaining any situations considered to be at-risk concerns for the safety and/or well-being of the participant and listing the interventions to respond to such safety concerns including who is responsible with emergency contact information.

e) The Plan of Care Policy and Procedures, POC Form and Instructions, comprehensive evaluation tool, and need based care allocation tool are available to CMS upon request. The Plan of Care identifies the participant's services and the payment source for that service. If the service indicates Medicaid as the payment source, the Care Manager is responsible to coordinate. Other possible payment sources are Medicare, other third party liability, community, informal support or other formal support. The Care Manager helps the participant secure services from these other payment sources.

f) The Care Manager oversees the implementation and the monitoring of the service plan. There are fields in the Plan of Care that indicate the monitoring method to identify how service provision will be verified: participant record/chart in an Assisted Living facility, client report, face to face visit with participant while service is occurring, observing participant and environment, receipts (review proof of payment, vouchers, or invoices of services delivered), documentation (review of assignment sheets, service delivery logs, medication or treatment administration records, telephone contact (telephone conversations with participant, caregiver, service provider, wellness nurse, or billing agent.) and the monitoring frequency (daily, weekly, biweekly, monthly, quarterly, annually, random, and other).

g) The Plan of Care is updated at least once a year or more often if participant's needs or circumstances change.

h) There is a participant signature line on the Plan of Care for the participant and/or his or her representative/legal representative to acknowledge his or her agreement with the Plan of Care process. In September 2007, another field was added to the Plan of Care (WPA-2) for the participant to sign to acknowledge he/she had choice in services and providers.

i) Assisted Living:

In NJ, when an individual moves into a licensed Assisted Living facility the Certified Assisted Living Administrator or Registered Nurse initiates a Plan of Care/General Service Plan within 72 hours of move-in. The Certified Assisted Living Administrator or Registered Nurse coordinates all services, including State plan services and services furnished through other State and Federal programs. The participant's strengths, capacities, needs, preferences, desired outcomes, health status and risk factors are considered. The responsible party (family member, Power of Attorney, etc.), participant, and Staff of the AL facility are included in all discussions about the care to be rendered to the individual, and agree to, and sign the Plan of Care/General Service Plan. The Plan of Care/General Service Plan includes an Evaluation of the needs of the individual, a Plan to meet those needs, the steps taken to Implement the Plans, identification of the person to implement the plan, and an Evaluation of the effectiveness of the steps taken. This Plan of Care/General Service Plan is reviewed at least monthly, monitoring notes are written as needed, but at least quarterly, and revised annually by the Certified Assisted Living Administrator or Registered Nurse.

The Care Manager reviews these plans and, if approved by the participant and/or his or her representative/legal representative, Care Manager and Care Management Site Supervisor as meeting the participant's needs, the assisted living facility's plan serves as the Plan of Care under this Waiver. The participant and/or his or her representative/legal representative, Care Manager, Care Management Site Supervisor, and facility designee sign a specially designed "Approval Form," which confirms agreement that the facility plan meets the individual's needs. If the Care Manager determines that the participant has additional needs not specified in the assisted living facility's plan(s), then a Plan of Care (WPA-2) is developed and given to the facility/program for implementation. The assisted living facility's/program's plan(s) is incorporated by reference into the WPA-2.

j) Adult Family Care:

When a client has been deemed eligible for the Adult Family Care Program, an initial interview is arranged between the participant, caregiver, responsible party (Power of Attorney, family member, etc.), and Care Manager. The participant's strengths, capacities, preferences, needs, desired outcomes, health status and risk factors are discussed, and all parties agree on what services are to be rendered and what services are available to the participant, and verify their agreement with the Plan of Care. This meeting is to be held within 30 days of move-in. The caregiver is made fully aware of the services to be rendered, and agrees to render those services to the participant. All rights and responsibilities are discussed, and the participant is afforded choice in services. The Plan of Care is based on an evaluation of the needs of the individual, a Plan to meet those needs, back up plans, the steps taken to Implement the Plans, coordination and oversight of all services by the Care Manager, including State Plan services and those

furnished through other State and federal programs (Medicare), and an Evaluation of the effectiveness of the steps taken.

The Care Manager or Registered Nurse makes a home visit to the newly admitted client on the day of move-in and weekly for the first 4 weeks after move-in, and makes any necessary changes to the Plan of Care. The Care Manager and/or Registered Nurse continually assess compatibility of the client with the caregiver. The Plan of Care is reviewed again in 30 days and every 30 days thereafter. The Care Manager makes a face-to-face evaluation at least monthly, and the Plan of Care is revised or updated at that time or earlier if necessary. If the Care Manager is not a Registered Nurse, the Sponsor Agency's Registered Nurse visits the participant quarterly and makes any necessary revisions to the Plan of Care.

Risk Assessment and Mitigation

- In the past, the Division's training unit offered Core Care Management training to all Care Managers. The Division also offered a one-day Continuing Education training on various topics to all Care Managers throughout the year. The trainings included risk evaluations of the home environment, health, behavior and personal safety. Care Managers have used this information from the trainings to assess potential risks of their participants. At this time, the Division's Quality Assurance Unit provides program training to new GO care management sites minimally on an annual basis. Specialized raining sessions and continuing education opportunities are developed and provided periodically, as DACS staff prioritizes topics in demand.
- Care Managers are trained to continually assess the participant with each contact (telephone, in-home visits). The Care Manager annually reevaluates the participant for level of care and to develop the Plan of Care updates. For those residing in an assisted living setting, GO participants receive regular monthly monitoring by the AL staff (i.e. Certified Assisted Living Administrator or Registered Nurse).
- Any assessed risk is identified in the Plan of Care in the need code field in the Plan of Care. The risk factors are those that address personal safety (supervision needed for personal safety; participant is self-neglecting, abusive of alcohol or other substance); health conditions (needs medical attention, visual impairments, obese, sedentary lifestyle, chronic illness, poor nutrition, sleep disturbance, poor health/hygiene, lack of oral/dental care, skin condition/bed sores, improper foot care, at risk of falls, at imminent risk of long-term institutional placement in nursing facility); behavioral conditions (risky or inappropriate behaviors or lifestyle habits); environmental conditions (home environment, living conditions are insecure or hazardous, neighborhood is unsafe; or medication risk (unable to appropriately manage medications, multiple medications and/or prescribing physicians) or any other factors. A corresponding field identifies the service needed to meet the risk and a separate field to State the desired outcome of the service. If the assessed risk cannot be mitigated by Plan of Care services then it will be listed as an unmet need on the Plan of Care. The possible repercussions of the lack of service will be discussed with the participant and/or his or her representative/legal representative and the participant/representative/legal representative acknowledges on the Plan of Care statements that affirm that 1) I have been advised of the potential risk factors outlined in this Plan of Care and 2) I understand and accept these potential risk factors.

A Plan of Care policy was originally distributed in September 2007 and then revised and updated in 2011. This Policy and Procedure fully addresses the standards established for all participant-centered service plans. The Plan of Care (WPA-2) has fields to ensure all dimensions of the service plan process are addressed. The fields indicate date, Problem Statement regarding the reason for the assessed needs, risk factors and personal goals, need codes, services warranted, desired outcomes, service delivery pattern (units and frequency), unit cost, payment source, provider type, provider name, monitoring method, monitoring frequency, back up plan (if applicable), and unmet needs (if applicable). The Plan of Care has a narrative section for special instructions/comments to incorporate participant preferences or concerns, expound on unmet needs, and describe back-up plans, explaining any situations considered to be at-risk concerns for the safety and/or well-being of the participant and listing the interventions to respond to such safety concerns including who is responsible with emergency contact information.

As stated, in the process of developing the Plan of Care, the Care Manager and GO Waiver participant/representative/legal representative identify any risk factors that would trigger the need for back-up plans, should services not be delivered. Back-up plans are needed if the provider identified as responsible for furnishing the services fails or is unable to deliver them and it would have a critical impact on the participant's immediate well being. Alternative arrangements for the delivery of services would therefore be imperative. This information is included in narrative form on the Plan of Care and addresses the interventions to respond to safety concerns including contact information for the person responsible. In addition to the back up plan strategies identified below, the availability of informal supports is discussed and identified in the Plan of Care, if viable. The Care Manager verifies that informal supports identified in the Plan of Care are valid. Listed below are some of the standard methods for addressing back-up plans:

- o Care Managers contact the participant monthly (in Assisted Living Facilities, it may be quarterly after the first three months of placement) and visit quarterly as part of their responsibility in monitoring the participant's needs. Unmet needs are identified at those times and detailed in the Plan of Care with reasons for unmet needs. Future service planning addresses how the unmet needs are to be met.
- o Participants in Assisted Living facilities/programs and Adult Family Care are in sheltered settings where risk factors are addressed through managed risk agreements and plans implemented to address them.
- o Each Care Management Agency has systems in place to plan to identify back-up Care Managers for the Waiver participants as needed. Home and community-based services' providers develop their own internal system to provide back-up services.
- o Respite is a Waiver service that can be identified in the Plan of Care and used in emergencies for participants who need crisis back-up services.
- o The participant/representative/legal representative receives information to call the Care Manager if services are not delivered. The Care Manager investigates and resolves the problem with the existing agency or changes the agency. If needed, the Care Manager arranges for emergency services.

Quality Management Strategy for Money follows the Person (MFP) - physically disabled

New Jersey's Division of Disability Services (DDS) is committed to complying with waiver assurances to ensure the health and safety of waiver participants. With the Centers for Medicare and Medicaid Services' (CMS) introduction of the Quality Assurance Framework, which embodied the essential elements for assuring and improving the quality of waiver services, DDS began to focus its efforts on developing databases, designing audit tools to collect and track information that reflected the assurances, and developing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework. The DDS will integrate the MFP demonstration into its existing 1915(c) HCBS waiver. **The MFP program will incorporate, at a minimum, the same level of quality assurance and improvement activities required in the approved Appendix H of the existing Traumatic Brain Injury (TBI) Waiver and the proposed plan for the Community Resources for People with Disabilities (CRPD) Waiver submitted to CMS with the State's Evidentiary Report and subsequent requests for additional information. This will apply to all categories of service in the MFP program (Qualified HCBS, Demonstration and Supplemental Demonstration categories of service).** The State is waiting for the final report from CMS. The information contained in Appendix 4 outlines the process for monitoring evidence of compliance with assurances for Level of Care, Service Plan, Qualified Providers, Health and Welfare, Administrative Authority and Financial Accountability.

The Division of Disability Services (DDS), Office of Home and Community Services (OHCS) is responsible for the operation and quality assurance of the CRPD and TBI Waiver programs. In addition to the audits conducted by OHCS staff, the DDS/OHCS has developed a quality management team. The Total Quality Management Team (TQMT) is comprised of representatives from DDS/OHCS, the Division of Medical Assistance and Health Services (Administrative Authority), and the Department of Health and Senior Services (Quality Oversight for the initial level of care determinations). The purpose of the TQMT is to further develop, implement, and oversee the waiver quality management operation; meetings are held on a quarterly basis.

Once the OHCS staff receives confirmation that all other eligibility requirements established in the waiver document have been met (i.e. medical appropriateness and financial eligibility), contact is made with the Department of Health and Senior Services (DHSS) Regional Offices of Community Choice Options (OCCO). In accordance with the 1997 inter-departmental memorandum, DHSS is the only state entity responsible for performing the level of care (LOC) assessment. The LOC assessment is completed by either a registered nurse or a licensed/certified social worker. DHSS supervisory staff reviews the LOC assessment, known as Home Services Delivery Plan (HSDP) to ensure that:

1. The process and instruments described in the approved waiver are applied in determining LOC.
2. If the LOC recommendation is deemed inappropriate, DHSS/OCCO supervisors will ensure that:
 - a. Reasons for disputing the original LOC determination are documented and tracked to assist in identifying trends such as inappropriate waiver referrals by DDS.

- b. Waiver candidates are informed in writing of their right to administrative relief (Fair Hearing) options, once they have been formally notified that they did not meet the LOC criteria necessary for waiver enrollment.

DDS utilizes an Oracle base system to capture waiver enrollment data to track waiver enrollment trends and compliance with timeframes. Data obtained from the Oracle Platform database is aggregated, presented and discussed at the quarterly Total Quality Management Team (TQMT) meetings. The DHSS Quality Assurance Coordinator directs the review of initial LOC approvals and the correct use of the assessment tool. The data results are now reported by specific waivers and are discussed at the quarterly TQMT meetings.

Case Managers (CM) are responsible to reevaluate a participant's continued eligibility by assessing the participant's needs and certifying they continue to meet LOC criteria. The reevaluation is completed at least every six-months for participants receiving private duty nursing (PDN), annually for participants not receiving PDN services, or more frequently if there is a change in the participant's condition or informal supports. If the participant does not appear to meet LOC criteria, the CM consults with the CM Supervisor. If the CM, CM Supervisor and DDS Representative agree with the LOC reevaluation, the CM asks the participant to voluntarily withdraw from the Waiver and offers other appropriate non-waiver services or resources. If the participant does not agree to voluntarily withdraw from the waiver program, DDS requests that the DHSS' Offices of Community Choice Options (OCCO) reassess the participant. If the OCCO concurs that the participant does not meet LOC, a written LOC denial is issued to the participant. The individual is notified of his or her right to a Fair Hearing and services continue until the appeal verdict is rendered.

The LOC reevaluations are performed by the Case Managers using the Long-Term Care Assessment for (CP-CM-1). The Case Management Supervisor is required to review and sign the CP-CM-1. As each waiver participant is due for reassessment, DDS Representative is notified and records are made available to verify the participant's continued LOC eligibility, timeliness, unmet needs, appropriateness of services, personal goals, and any corrective action. DDS Representatives visiting case management sites on a continuous basis throughout the year and the results of the client record review are reported on the quarterly Case Management Deficiency Report (CMDR). This information is entered on the CMDR and submitted for data-entering, aggregation and review by the TQMT.

Case Managers prepare an initial Plan of Care (POC) based on the original assessment completed by professional staff from the DHSS/OCCO, which has components to evaluate the health and safety risk factors of the participant. In addition, the Case Manager completes his/her own evaluation during the initial home visit with the participant. The POC (Form CP-11) development includes consideration of participant and caregiver preferences and goals; physician recommendations; consultation with any informal supporters; the participant's medical and social needs. The POC is reviewed and signed by the participant or his/her representative, the Case Manager, Case Management Supervisor and the DDS Representative. The Long-Term Care Assessment Form (CP-CM-1; LOC re-evaluation) is completed simultaneously and includes a description of the participant's social support network and physical environment. Within the physical environment section of this form, the CM addresses the participant's safety

and general welfare issues, including safety risk factors; and describes the Emergency Back-up Plan.

The Case Managers are required to perform a reassessment of the participant's POC and CP-CM-1 every six-months for participants receiving private duty nursing services and annually for all other waiver participants. Reassessments should be conducted more frequently should the participant's condition or informal supports change.

The compliance with this requirement is monitored by the DDS Representative and reported on the Case Management Deficiency Report form. The DDS Representative reviews the files for comprehensiveness of the POC, the timeliness of the development of the initial POC, the timeliness of consecutive POC, and that the POC includes all formal and informal assess needs, as well as unmet needs. The frequency, duration, and scope of the services provided to waiver participants are monitored by the case manager and entered on the POC along with any changes during the approved POC timeframe. Changes in the delivery of services are entered on the POC along with the use of code indicators labeled "outcome codes." This information is entered on the CMDR and submitted for data-entering, aggregation and review by the TQMT.

Waiver applicant's institutional vs. community based services options are fully explained by the DDS Representative during the initial screening visit and again by the DHSS representative during the initial LOC evaluation. The waiver candidate signs a "Choice of Care" form (CP-6) indicating that they have been fully advised of the care options available to them. The DDS Representative will also review the services available and limitations under the selected waiver program. The waiver participant signs a document confirming their understanding of the waiver program and the related limitations. Copies of these documents are provided to the participant and the originals are maintained in the participant's file.

Case Managers are provided with a list of available waiver and state plan service providers. This information is shared with the waiver participant during the POC development. The CP-11 form (POC) includes a statement signed by the waiver client or his/her representative that he/she has participated in the selection of the providers and in the development of the POC. On the second page of the POC, the participant completes a section indicating his/her opportunity to select providers. Compliance with this requirement is monitored by the DDS Representative and reported on the Case Management Deficiency Report form. The forms are submitted for data-entering, aggregation and review by the Total Quality Management Team.

DDS has taken numerous steps to monitor providers to ensure quality services are delivered to HCBS waiver participants. There are two types of providers:

- Traditional Provider: an individual or entity provider/worker who provides authorized services to a participant and who is enrolled as an approved Medicaid provider able to bill Molina, the New Jersey Medicaid Program's fiscal agent, directly for the authorized service.
- Non-Traditional Provider: an individual or entity that is not enrolled to bill Molina directly for services but who demonstrates competence to qualify as a provider of services pursuant to the approved Medicaid waiver criteria and provides authorized services to a participant.

Molina has a provider unit that reviews all new traditional provider applications or requests from existing traditional providers to add provider sites or add/delete services. Requirements that need to be met have been developed by the Division of Medical Assistance and Health Services (DMAHS) Provider Enrollment Unit. Molina verifies that all requirements (licensure, certification) have been met before the provider is approved and assigned a provider number so they can directly bill the Medicaid Program. DDS staff is available to provide agency training concerning waiver program requirements during the enrollment process. Molina enrolls Traditional Waiver Service Providers, such as Case Managers and Private Duty Nursing providers. In 2006, DMAHS and Molina completed a three year re-enrollment process of all qualified traditional providers. All waiver service providers in this category are licensed, certified, or accredited to provide services. In the event of an erroneous provider eligibility or service error is identified, DDS would submit a report of the incident to both DMAHS' Bureau of Provider Enrollment and Bureau of Program Integrity, requesting correction of the error and, if applicable, recoupment of funds.

Additionally, any applications for requests to become a provider of HCBS waiver services are also screened by DDS after Molina has confirmed that all standard provider criteria have been met. Screening consists of validating that the provider applicant and its staff meet state licensing requirements by reviewing the provider's licensure and credentials and the understanding that all waiver services are authorized by the waiver case manager.

Providers of private duty nursing services must be accredited by one of four accrediting bodies. A memorandum of understanding between DMAHS and these four bodies, approved in October 2005 mandates that all members who are Medicaid providers receive an annual on-site visit from the accrediting body to review 100% of the PDN cases and employee personnel files. Results are forwarded to DMAHS for review and possible follow-up. A comprehensive audit is conducted every three years and includes a waiver participant satisfaction survey. The accreditation bodies report directly to DMAHS any suspected fraud or abuse for any PDN case and DDS for any PCA case that is discovered during the course of the audit. DDS reports this information to DMAHS' Bureau of Program Integrity for investigation and necessary action.

Providers of environmental/vehicular modifications and personal emergency response system (PERS) are non-traditional providers. They do not bill Medicaid directly for services rendered but are reimbursed by DDS' fiscal intermediary, Community Access Unlimited (CAU). The providers of these services are closely monitored by the case managers as per established DDS written protocols and final approval for the modification is obtained by the DDS Regional Representative.

For environmental/vehicular modifications, it is customary to request that the participant obtain three estimates and attach to the request. A licensed contractor must be used for any environmental modification and the participant must obtain appropriate permits for the work. The case manager must complete an authorization for payment form once verification of modification completion in accordance with approved specifications. The fiscal intermediary, Community Access Unlimited (CAU) is then authorized by DDS to make payment to the provider of the modification service.

The provider of the PERS is an electronic communication equipment vendor and monitoring agency. A roster of approved vendors is maintained and verified by DDS prior to the approval of service.

The Plan of Care (POC) developed by the participant and Case Manager indicates the participant's health and welfare needs. The POC is then reviewed and if appropriate approved by the DDS Representative. The CMs continually monitor the participant's health and welfare with monthly contacts and take prompt remediation actions when needed. The CM documents any changes to the participant's health and/or welfare on the Monitoring Record and will revise the POC and level of care (LOC) reassessment accordingly. When problems with POC and LOC re-assessment are identified during the DDS on-site or file monitoring of case management agencies, the Case Manager Supervisor is alerted to the deficiencies immediately during the Exit Interview. A summary report is sent as a follow-up to the review, and the agency if necessary the case management is instructed to submit to DDS a formal Corrective Action Plan. This information is reported and discussed during the quarterly TQMT meetings. Any TQMT recommended remediation is implemented.

DDS has implemented a policy outlining the CM's responsibility and role for reporting any alleged instances of abuse, neglect, or exploitation. Three new forms were developed and distributed to the CM provider agencies. On an annual basis, the participant and case manager are to complete a form confirming that the participant received information as to whom they can report allegations of abuse, neglect, or exploitation along with a copy of New Jersey's Resources Guide. If the CM witnesses or receives a complaint of participant abuse, neglect, or exploitation, they are to verbally notify the DDS within 24-hours and follow-up within 72-hours in writing outlining the nature of the complaint on the CM Report of Participant Abuse, Neglect or Exploitation Form. The third document, Incident Investigation and Resolution Monitoring Record, is used by the CM and DDS to document pertinent facts pertaining to the incident, individuals notified, and the action taken to assure that appropriate intervention is initiated and resolution occurs.

Waiver Case Managers are informed as to their responsibility, to report all incidents of suspected neglect, abuse, and/or exploitation of participants to the proper authorities, i.e. Adult Protective Services, Division of Youth and Family Services, etc. Individuals on the TBI Waiver residing in Community Residential Service programs are required to report incidents to the Unusual Incident Report Management System (UIRMS) managed by the Division of Developmental Disabilities. The Total Quality Management Team (TQMT), on a semi-annual basis, reviews all complaint reports to ensure that the incidents were thoroughly investigated and that all necessary recommendations were implemented.

The approved waiver delineates Molina as the contracted fiscal intermediary responsible for Medicaid claim coding review, processing, and payments. Molina has mechanisms in place for overseeing correct coding and subsequent payment to providers. All New Jersey Waivers are assigned a unique special program code (spc) indicator. In addition, each waiver service is assigned a procedure code for reimbursement. Reimbursement for HCBS waiver case management, private duty nursing, and other traditional provider waiver services are issued on a fee-for-service basis. Each waiver provider must have a billing specialty code in their Molina provider profile that allows them to bill for these services under the appropriate procedure codes.

Within Molina, there are various units that are responsible for mutually exclusive areas of claim processing. The reason they are mutually exclusive is to maintain a secure “check and balance” as well as a tracking system and audit trail. Claims are submitted directly to Molina by the service provider, which is assigned a unique internal control number (ICN) for claim identification purposes. If the claims are not coded correctly, they will either pend or be denied. On a weekly basis, Molina sends a Remittance Advice for to all providers of Medicaid services. All paid, denied, and pended activities, by ICN, are contained in the RA. If there is a pended or denied claim, the RA also reports the reason for the error so that the provider can make any adjustments and resubmit the claim. These procedures are necessary to ensure that claims are coded properly and tracked as they go through the payment and subsequent reporting process. If necessary, DDS has the ability to view the RA online for any HCBS provider in the Molina system.

The New Jersey Medicaid Management Information System (NJMMIS) Recipient Subsystem provides and maintains a single source of eligibility information for HCBS Waiver participants. The recipient subsystem has been developed to maintain identification of all participants enrolled in the HCBS waiver and provide timely updating of the Recipient History Master File of new recipients and all changes to existing participant records. The claims processing system verifies the eligibility status of a HCBS waiver participant prior to the reimbursement for a waiver service. Traditional providers of waiver services are instructed to submit a claim using their usual and customary charge for the service rendered, however, Molina will reimburse the provider for the rate Medicaid has established for the service.

All services that are provided by both the Traditional and Non-Traditional Medicaid provider through the waiver are authorized by a DDS-contracted case manager and included in the participant’s plan of care and individual cost service record. The CM is provided with a monthly cost limit that is used as a guide to ensure that waiver services are cost neutral, as documented on the financial CMS-372 reports. DDS representatives visit case management sites on a regular basis to review and approve services plans, LOC reassessments and cost-services records. This information is included in the narrative section of the CMS-372 reports.

DDS currently receives monthly reports, Medicaid Automated Reporting System (MARS), from Molina to document the cost of waiver and State Plan services for waiver participants. The reports contain participant’s name, Medicaid number with line item summaries of waiver expenditures. However, the reports do not contain the service provider numbers. DDS can access detailed provider reports through the Decision Support System (DSS) using the Molina claims payment history.

DDS has a designated staff person licensed to use the DSS which provides access to the Molina paid claim history and eligibility files to obtain individualized and/or aggregate financial information. This resource is employed by the DDS representatives and case managers especially when there are concerns about over or under-utilization of services. A formal record is now maintained documenting the number of and type of DSS reports generated for DDS representatives or CMs.

Community Access Unlimited (CAU) acts as the fiscal intermediary for Non-Traditional Providers who are not enrolled through Molina as a Medicaid Provider, submits invoices on their behalf, and pays them for services rendered. The case manager documents the need for the service on the participant's POC, completes the request for either environmental/vehicular modification, personal emergency response system, or the community transitional service, obtains the waiver participant's signature on all documents and submits to the DDS representative for final approval. Once the participant and case manager provide written verification that the service was rendered satisfactorily, DDS provides CAU with written notification authorizing the payment to the Non-Traditional Provider.

Three Additional Areas: Back-up Plans, Incident Reporting and Risk
Appendix H – Quality Management Strategy

Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses **Back Up Plans** and the arrangements that are used for backup.

- Case Managers (CM) are trained on the requirements of performing risk assessments of the home environment, health, behavior and personal safety of the waiver participant and to include this information in the level of care and plan of care documents. CM is further instructed to assess the participant with each contact (telephone, in-home visits) and to address the participant's needs accordingly. Both the Long-Term Care Assessment/Level of Care (LOC) and the Plan of Care (POC) are re-assessed semi-annually for individuals receiving private duty nursing services (PDN) and annually for non-PDN service participants.
- The assessment used in determining Level of Care is also used in developing the Plan of Care. The Case Manager schedules a face-to-face meeting in the participant's residence to interview the participant and family/caregiver. During the face-to-face meeting, the Case Manager continues the evaluation process started by the assessor and observes the participant's interactions with those present; participant's ambulation/navigation ability; physical environment; cognitive status, and appropriateness of participant's appearance. The Case Manager asks about changes in participant's support system(s), health conditions, hospitalizations/rehabilitations, ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), goals or preferences, new needs and preferences, and overall functioning and independence level since the previous assessment. The Case Manager also identifies risk factors and the need for back-up plans. The Case Manager has 30 days from receipt of the case record to finalize a comprehensive POC (CP-11) with signatures from the participant and supervisor who reviewed the POC. The POC is re-evaluated semi-annually for participants receiving PDN services and annually for non-PDN service participants, it may be updated more frequently if the participant's circumstances or needs change.
- The assessed risk is identified in the POC and identified in the problem statement field with a corresponding field identifying the service needed to meet the risk along with the desired

outcome of the service. The risk factors discussed in the POC are those that address personal safety (supervision needed for personal safety; participant is self-neglecting, ambulation risks, etc., abusive of alcohol or other substances); health conditions (needs medical attention or private duty nursing, visual impairments, obese, chronic illness, poor nutrition, poor health/hygiene, skin condition/bed sores, improper foot care, at risk of falls, at risk of long term institutional care in nursing facility); behavioral conditions (risky or inappropriate behaviors or lifestyle habits); environmental conditions (home environment, living conditions are insecure or hazardous, neighborhood is unsafe; or medication risk (unable to appropriately manage medications, multiple medications and/or prescribing physicians) or any other factors

- If the assessed risk cannot be mitigated by POC services then it is listed as an unmet need on the POC. The possible repercussions of the lack of service will be discussed with the participant and/or his or her representative. The POC is being revised to include documentation of the participant/representative's awareness of the potential risk factors outlined in the POC and that he/she understands and accepts these potential risk factors.
- The forms have a narrative section for special instructions/comments to incorporate participant preferences or concerns, expound on unmet needs, and describe back-up plans, explaining any situations considered to be at-risk concerns for the safety and/or well-being of the participant and listing the interventions to respond to such safety concerns including who is responsible with emergency contact information.

BACK UP PLANS:

As stated, in the process of developing the POC, the Case Manager and Waiver participant/representative identify those risk factors that would trigger the need for back-up plans, should services not be delivered. Back-up plans are needed if the provider identified as responsible for furnishing the services fails or is unable to deliver them and it would have a critical impact on the participant's immediate well being. Alternative arrangements for the delivery of services would therefore be imperative. This information is included in narrative form on the Long-Term Care Re-evaluation form (CP-CM-1) and addresses the interventions to respond to safety concerns including contact information for the person responsible. In addition to the back-up plan strategies identified below, the availability of informal supports is discussed and identified in the POC, if viable. The Case Manager verifies that informal supports identified in the POC are valid. The current HCBS waivers for the physically disabled already include some requirements to ensure the health and safety for individuals requiring PDN services. In order to be eligible to receive PDN services, the participant must have a live-in primary caregiver that accepts responsibility for the participant 24-hours/day and must provide at a minimum 8-hours of direct care. The purpose for this criterion is so that an individual is not without care should a provider fail to deliver services. For those participants reliant on electrical DME i.e. ventilator, a generator is purchased in the event that there is electrical failure.

Medicare certified home health agencies are required by regulation to have a 24-hour on-call system in place. New Jersey requires those agencies that are not Medicare certified must be accredited by one of four Accreditation Agencies, (i.e. JCAHO). A 24-hour on-call system is also a requirement for accreditation. MFP participants will be instructed to access this on-call system for those instances when critical health and safety personal care assistant (PCA) or private duty nursing (PDN) are not being provided as scheduled.

For individuals participating in MFP, an additional page will be included with the POC that will outline the individualized back-up plan for the services that are critical for the health and safety of the participant. The participant will be instructed to notify the case manager of those instances when he/she had to implement the back-up plan and the outcome. The case manager will be required to submit a report to the DDS outlining the participant's need to implement a back-up plan, including the reason, who contacted, when the incident occurred, and the outcome. This information will be reviewed by DDS staff and any remediation recommendations will be discussed with the case manager. The information contained in this report will be tracked in a database maintained by DDS staff including any remediation recommendations and related outcomes.

Listed below are some standard methods for addressing routine back-up plans:

○ CM contacts the participant monthly; unmet needs are identified at those times and detailed in the POC with reasons for unmet needs. Future service planning addresses how the unmet needs are to be met.

○ Each Case Management Agency has plans to identify back-up CM for the waiver participant. Home and Community Services' providers develop their own internal system to provide back up services. At times, one home health agency will be identified as a back-up for another home health agency for critical PCA or PDN services.

○ The participant or his/her representatives receive information to call the CM if services are not delivered. The CM investigates and resolves the problem with the existing agency or changes the agency. If needed, the CM arranges for emergency services.

Critical Event or Incident Reporting. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- The DDS has a written Critical Incident Report form and policy mandating the reporting of incidents that could have a negative impact on the waiver participant's health and welfare that must be submitted by CM to DDS within 72 hours of reporting the incident. An electronic database collects the information provided on these reports and tracks the status of case until resolution. This information will be used to establish any trends and potential areas for further provider training.
- Reports of abuse, neglect and exploitation of waiver participants living in the community are reported to an Adult Protective Services (APS) agency or the Division of Youth and Family Services for child waiver participants. There is an APS program in each of the 21 counties. The types of incidents reported to APS are based on the definitions from regulations. "Abuse" means the willful infliction of physical pain, injury or mental anguish, unreasonable confinement, or the willful deprivation of services, which are necessary to maintain a person's physical and mental health. "Neglect" means an act or failure to act by a vulnerable adult or his caretaker those

results in the inadequate provision of care or services necessary to maintain the physical and mental health of the vulnerable adult, and which places the vulnerable adult in a situation which can result in serious injury or which is life-threatening. "Exploitation" means the act or process of illegally or improperly using a person or his resources for another person's profit or advantage. Any professional, including Case Managers, Case Management Supervisors, and Case Coordinators is obligated to report incidents of abuse, neglect and exploitation. N.J.S.A. 52:27-7

- The method of reporting of abuse, neglect, and exploitation to APS is through phone, written form, fax, and a web-based reporting system. Assembly Bill A853 has been pre-filed for introduction in the new legislative session. The Bill requires: (1) A health Care professional, law enforcement officer, firefighter, paramedic or emergency medical technician who has reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation to report the information to the county adult protective services provider. (2) Any other person who has reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation may report the information to the county adult protective services provider.
- The Division of Disability Services (DDS) has initiated discussions with APS and DYFS to establish collaboration on the sharing of information so that incidents involving waiver participants may be tracked as reported and resolved. The data will not contain specific details about the allegation due to the respective protective agencies confidentiality rules. Initial meetings were held in May 2008 with anticipated guidelines developed by 7/1/08.
- The Case Management Supervisor may serve as an alternate critical incident reporter if the Case Manager is unable to report critical incidents. Waiver participants are also provided, on an annual basis, contact information for reporting allegations of abuse/neglect/exploitation. They are also provided with a Resource Directory produced by the Division of Disability Services, annually.
- The APS Provider Agency and Division of Youth and Family Services (DYFS) are responsible for evaluating reports. Reports are evaluated based on the definitions of a vulnerable adult/child, abuse, neglect and exploitation as defined in statute and regulations (NJSA 52:27 D-406 et seq). Reports are substantiated when the preponderance of evidence supports the allegation.
- All information generated by the investigation is confidential. The participant is advised of the results of the investigation within 60 days. Because of confidentiality mandated by the APS statute (NJSA 52:27 D – 406 et. seq), the only investigation results that are shared with agencies are information that is needed for that specific provider/agency to deliver services, e.g., medical information may be given to a VNA that is providing services to the client. A court order is necessary to make the case file public.
- DDS has established a database for the receipt and maintenance of all reports of suspected abuse, neglect and exploitation of waiver participants and outcomes; when available. See Quality Framework for Health and Safety for further monitoring details.

Back up for Transportation

The NJ Division of Medical Assistance and Health Services (DMAHS) entered into a contract with LogistiCare, LLC to be the primary single source vendor for non emergency medical transportation services to be provided statewide for all eligible Medicaid Managed Care (MMC) and Fee for Service (FFS) beneficiaries. These services include livery, Mobility Assistance Vehicle (MAV) transportation, non emergent Air Transportation Services, Basic Life Support (BLS) and Advance Life Support (ALS) Ground Ambulance Services.

Logisticare is responsible for maintaining a provider network; determining the appropriate mode of transport; and dispatching an appropriate vehicle to transport beneficiaries; and developing a quality assurance program to ensure access to the appropriate mode of transport based on medical necessity..

Logisticare has engaged current transportation providers, experienced in providing these services to the counties. The contractor will be responsible for paying the network provider.

Logisticare is responsible for:

- A toll-free Call Center with sufficient dedicated “800” telephone lines to respond to provider, prescriber and beneficiary inquiries concerning the transportation program, in accordance with performance and service standards listed in the contract.
- The Call Center is accessible to eligible Medicaid beneficiaries twenty-four (24) hours per day/seven (7) days per week. The contractor’s personnel are available for calls during regular business hours, Monday through Friday, from 8AM to 4PM. Logisticare hired bilingual staff, uses a language interpreter service and have adequate TTY/TTD capability to ensure that non-English speaking and hearing impaired beneficiaries can access transportation services.
- Logisticare is responsible for the following: receiving and responding to all inquiries complaints, oral or written with regard to the delivery of transportation services under the contract, from beneficiaries, providers, DMAHS or other sources. The contractor should encourage everyone to submit their concerns in writing. A complaint can be filed by a beneficiary or a network provider orally or in writing within sixty (60) days of the incident that resulted in the complaint. Complaints shall be resolved within ten (10) days of their filing. The contractor and the beneficiary/network provider should attempt to resolve any complaint.

Logisticare provides beneficiaries and network providers an independent unit of the customer service center to monitor and address complaints. This unit is adequately staffed to receive the phone calls and respond to beneficiary/network provider concerns. Logisticare identifies and documents any inquiry patterns and/or trends to the State Contract Manager. Logisticare submits accurate and complete management reports to

DMAHS no later than thirty (30) days after the close of the month so that fully reconciled data can be provided to the State.

Housing

Defining and Documenting Qualified Residences

There are three types of qualified residences in which MFP participants can choose to reside. New Jersey will only enroll an individual in the MFP Demonstration to a setting that meets the definition of a “qualified residence” as defined in Section 6071(b) (6) of the Deficit Reduction Act:

- A home owned or leased by the individual or the individual's family member;
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.
- A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

The definitions of the four residential settings that may serve small groups of unrelated individuals:

Alternative Living Unit

"Alternative living unit" means a residence that:

- Provides residential services for individuals who, because of developmental disabilities, require specialized living arrangements;
- Admits not more than 3 individuals; and
- Provides 10 or more hours of supervision per unit per week.
- Regulated by the Division of Developmental Disabilities

Group Home

"Group home" means a residence that:

- Provides residential services for individuals who, because of developmental disability, require specialized living arrangements;
- Provides services to no more than 4 unrelated individuals*.
- Provides 10 or more hours of supervision per home, per week
- Regulated by the Division of Developmental Disabilities

* NOTE: DDD does operate group home settings that house more than 4 unrelated individuals. These settings will not be allowed as a qualified residence for MFP.

Adult Skill Sponsor Care Home (Also known as Community Care Residence)

- "Adult Skill Sponsor Care" means a program that provides a family setting in the community for an aged adult or an adult with disabilities who requires:
 - Protective oversight;
 - Assistance with the activities of daily living; and
 - Room and board
- Regulated by Division of Developmental Disabilities

Assisted Living Services

Assisted Living Program

"Assisted living program" (ALP) are programs (packages of services, not actual living structures) of in-home personal care and health-related services designed especially for residents of subsidized housing buildings. There is a clear difference between an ALP and the other types of Assisted Living. An ALP is a package of assisted living services provided in subsidized apartment buildings. An ALP is not a separate facility, and there are a limited number of buildings in which an ALP is available. Assisted living services are a coordinated array of supportive personal and health services, available 24 hours per day, to residents who have been assessed to need these services, including residents who require formal long-term care. Assisted living services promote resident self direction and participation in decisions that emphasize independence, individuality, privacy, and dignity, in homelike surroundings.

Congregate Housing Services Program (CHSP) generally provides selected supportive services (housekeeping, laundry, or personal assistance) and group meals to tenants in certain subsidized housing facilities. The CHSP provides funds for congregate services for tenants living in subsidized housing buildings which have management agencies that have contracted with the State Department of Health and Senior Services for this purpose. Individuals who live in the buildings operated by the contracting agency may apply to the agency for the provision of services. Fees are charged on a sliding scale, based upon the tenant's income. Presently, this program offers services to tenants in approximately 70 subsidized buildings. (Packages of services NOT places where people live). This only operates in subsidized senior housing.

Residence Types

Adult Family Care (AFC)

Adult Family Care homes offer individuals who are no longer able to live alone the opportunity to move in and share the home of a caretaker who is capable of providing needed assistance and supervision. AFC provides a home-like environment where participation in the family and community are encouraged. These homes are supervised by a "sponsor agency", which has been licensed by the Department of Health and Senior Services. The individual has the right to participate in the planning of their treatment, access shared areas of the house such as the kitchen and living room, and to make choices with respect to services and life-styles. An integral component of adult family care is the emphasis on providing a uniquely individualized approach to care and promotion of an individual's sense of autonomy, privacy, and self-esteem. Typically serves three or less individuals.

Shared Living Residences are homes in which unrelated people live together. The residence may be owned cooperatively, sponsored by a nonprofit organization, or owned or managed by a person who continues to reside there. Each person has a private bedroom, but bathrooms may be either private or shared. All other spaces in the house are shared. A residence generally accommodates residents who furnish and clean their own rooms. A volunteer or paid manager is usually responsible for overall maintenance, housekeeping, shopping, and dinner preparation. Breakfast and lunch may be prepared individually. Most group residences are licensed as Class B

or Class C boarding homes. For more information about shared living residences, contact the Shared Housing Association of New Jersey in Somerset County 908-526-4663 and in Hunterdon County 908-237-0650.

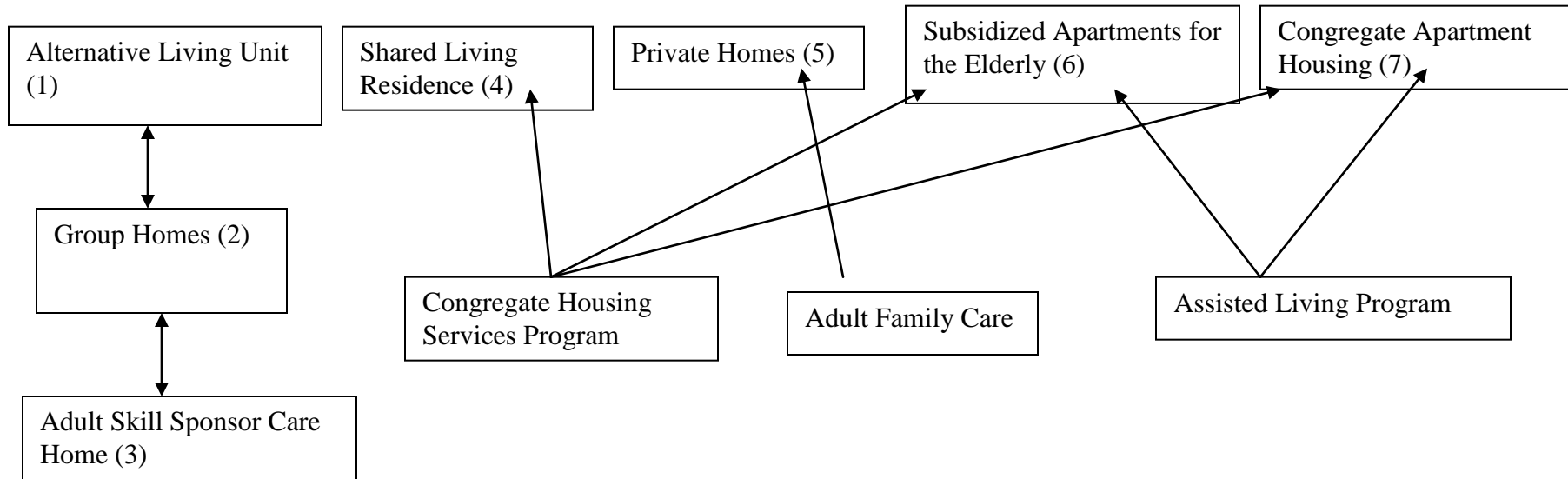
*Shared Living Residences will only be counted as eligible community residences for MFP where 4 or less individuals reside.

Congregate Apartment Housing is specially designed multi-unit housing for independent to semi-independent people, and includes community social and dining facilities. Individual living units include, at minimum, a living room/bedroom, bathroom, and kitchenette. Developments offer at least one hot meal per day and some housekeeping services. Transportation and personal assistance services may also be available. Service fees may be included in the rent or billed separately.

Currently, New Jersey does not license congregate apartment housing. Congregate apartment housing can be part of a multi-level facility or can stand on its own. Both market-rate and subsidized facilities can offer congregate apartment housing.

Subsidized Apartments for the Elderly are rental units, generally in the form of garden apartments or apartments in high-rise or mid-rise buildings. The units have been specially designed for, and are limited to, people who are at least 62 years old or are handicapped. Construction or rental costs are financed by the local, state, or federal government. Sponsors of this housing include nonprofit or limited profit organizations or public housing authorities. There are income limitations for eligibility for this type of housing, and the rents are usually subsidized, with the amount of rent based upon the income of the household. There are usually lengthy waiting lists for this housing. In some buildings, recreational activities and support services such as meals, housekeeping, or transportation are provided. Fees for services may be included in the rent or charged separately.

Relationship Chart



There are actually **seven** residential settings in which an individual qualifying for Money Follows the Person (MFP) can actually be used. The vagueness of the section dealing with the types of residential settings in which the individual could be assisted for comes from the way we think of the programs offered. The chart above shows the seven types of homes that provide waiver programs that will be included in the MFP grant. These homes already provide the types of services that will be needed. MFP will provide the means for paying for additional services and/or the availability to individuals who have the need for and have not had access to the services they need due to lack of funding.

The MFP housing staff and the community placement specialists will document the type of qualified residence where each MFP participant chooses to live. The information will be stored on a secure Money Follows the Person Database developed for this project. Staff will verify that homes or apartments meet the statutory definitions under MFP. Verifications may be based on a visit to the residence, a report of the consumer or representative, information obtained from the property manager or landlord, licensure information, or information from a local housing authority. For community-based settings serving four or fewer individuals, the MFP housing staff will document the type of setting based on the above definitions. For assisted living facilities, this means verifying with the Department of Health and Senior Services that the facility is licensed to serve four or fewer individuals. For Alternative Living Units, the staff need only verify the type of setting, since by definition this residence serves 3 or fewer individuals.

Assurance of Sufficient Supply of Qualified Residences

Historically, individuals transitioning from ICFs/MR have successfully transitioned into the residential model of housing (as defined in the previous section); accordingly, at this time, New Jersey can state that there are not adequate housing opportunities for individuals in these transition situations. Additionally, the state has a sufficient provider base to serve some of the individuals who locate into the community.

With respect to all MFP and community waiting lists initiatives transitions, New Jersey is dependent on adequate additional funding from the Department of Housing and Urban Development (HUD) to meet all current and future demand for safe, affordable, and accessible housing for individuals who desire to participate in the MFP Demonstration. Without this support, New Jersey cannot make such an assurance. It must be noted that New Jersey has successfully transitioned individuals into community residences since 1980. The number of people living in developmental centers in New Jersey has dropped from 7,317 in 1980 to 2587 now (a 64.6% decrease). During this same time interval, the number of people living in licensed programs (e.g., group home, supervised apartment, community care residence and supportive living) has increased from 471 in 1980 to 7,892 in 2011 (a 1,576% increase).

However, New Jersey intends to carry out activities to expand housing opportunities and awareness of housing needs throughout the state. It is a goal of this MFP Demonstration to be able to make the global assurance. New Jersey is developing a three-year plan that focuses on demographics and the needs of individuals that are moving out of institutional settings. Individuals' choices in community locations, housing options as well as support needs are being mapped so that plans can be established with housing developers in creating the type of community residences that individuals are interested in moving to over the next three years. This plan will be shared with the New Jersey Housing and Mortgage Finance Agency (NJHMFA) and Department of Community Affairs (NJCA) who are also responsible for increasing New Jersey's housing capacity. In addition, the Three-Year Housing Plan will be shared with the local communities and Offices on Smart Growth so the Council on Affordable Housing (COAH) obligations can be met in each community with the preferences of individuals moving from developmental centers.

Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions; and Planned Inventories of Accessible and Affordable Housing

The NJ Department of Community Affairs, the New Jersey Council on Developmental Disabilities, the New Jersey Housing and Mortgage Finance Agency Low-Income Housing and the NJ Supportive Housing Association will organize a housing summit with a goal to generate recommendations to increase affordable housing opportunities for New Jersey.

New Jersey is partnering with the Supportive Housing Association (SHA) and the National Association of Housing Redevelopment Offices (NAHRO) to develop workshops to educate participants about Money Follows the Person and the associated housing needs and support services required for individuals moving into the community from institutional settings. The local Newark HUD Office and PHAs will be participating.

Explain how the State will address any identified housing shortages for persons transitioning under the MFP demonstration.

The New Jersey Department of Community Affairs (DCA) and the New Jersey Housing and Mortgage Finance Agency are the New Jersey state housing finance arm and public housing authorities (PHAs). DCA allocates funding of federal housing funds/programs to local Public Housing Authorities (PHA) in non-participating jurisdictions throughout the state. PHAs in larger communities receive funding directly from the U.S. Department of Housing and Urban Development (HUD); there are 109 PHAs in New Jersey. PHAs develop their own programs and priorities through their local Consolidated Housing Plans.

The New Jersey Department of Community Affairs (DCA) is the State agency created to provide administrative guidance, financial support and technical assistance to local governments, community development organizations, businesses and individuals to improve the quality of life in New Jersey. DCA offers a wide range of programs and services that respond to issues of public concern including fire and building safety, housing production, community planning and development, and local government management and finance.

New Jersey Housing and Mortgage Finance Agency (HMFA) is dedicated to increasing the availability and accessibility of affordable housing throughout New Jersey. Its financing programs support traditional affordable rental and for-sale housing developments, first-time and urban homebuyers, citizens in senior and assisted living facilities and residents with special needs. HMFA also administers the New Jersey Housing Resource Center, an online searchable registry of affordable and accessible housing located throughout New Jersey.

Until recently, the New Jersey Department of Human Services Divisions and affiliates and the PHAs have had little interaction on housing issues. With the implementation of a Memorandum of Understanding between the DCA and the DHS in FY 2005, which was part of the New Jersey response to the Olmstead decision, an evaluation was started of the need for additional program resources to assist the development of accessible units in appropriate locations, and for recommendations for the allocation of additional DCA resources for the DHS

disabled clients. Also, it was at this time that DHS and DCA began the process of collaborating on a number of housing issues.

We are in the process of setting up meetings with Administrators from HUD and PHAs to educate and share the goals of MFP. In addition, New Jersey will be visiting 15 local PHAs over the next year in addition to planning the workshops at the annual housing conference to reinforce the message of housing needs for MFP participants.

One result of this collaboration materialized last year when the DHS approached DCA to request an increase in funding for housing assistance during the development of the New Jersey Consolidated Housing Plan. DCA responded favorably by increasing annual funding for State Tenant-Based Rental Assistance (SRAP) vouchers to at least 17% of the allotment. These recent activities of the DHS and DCA have brought attention to the continued need for human service agencies and advocates and housing developers to work closely with the state agencies and local PHAs. The efforts necessary to increase the stock of affordable and assessable housing and rental assistance must come through mutual cooperation, identification of housing need and education by all parties involved. DCA also allocated funds to DHS for major maintenance and life safety improvements to our current shared living residences. The MFP Statewide Housing Coordinator, hired by the Division of Developmental Disabilities, will act as the housing liaison for the Department of Human Services MFP.

Program on all housing related issues; the Program is comprised of the following:

- Department of Human Services
- Division of Developmental Disabilities
- Division of Disability Services
- Division of Medicaid
- Department of Community Affairs
- Housing and Mortgage Finance Agency
- Department of Health and Senior Services
- Department of Labor, Division of Workforce Development and the Division of Assistive and Rehabilitative Services and the Department of Children and Families.

Furthermore, New Jersey will build upon its recent successes to establish more comprehensive working relationships with its state housing finance agency and its PHAs. New Jersey will begin this process with the following activities:

Upgrade of New Jersey's Housing Inventory/Registry - New Jersey Housing Resource Center (NJHRC).

The MFP Program will work with the Department of Community Affairs, the Division of Disability Services, the Division of Developmental Disabilities, and the New Jersey HMFA to upgrade New Jersey's current housing inventory that is linked to each agency's website. Individuals interested in looking for affordable housing will be able to search this website – <http://www.njhousing.gov/> and do the following:

- Find and list affordable housing
- Help people with disabilities find housing

- Obtain housing information and links

The inventory/registry will be upgraded to include an alert e-mail message sent to staff involved in locating housing for individuals with special requirements such as accessibility features, close to transportation, size specifications, etc. The message will provide a notification of new vacancies or plans for future vacancies. As well as provide information on:

- Number of bedrooms
- Number of affordable housing units in their inventory and accessible units.
- Allow pets
- Proximity to stores, etc. and
- Number of housing vouchers currently available and the number dedicated to individuals with disabilities.

Training Activities

The MFP Program, in conjunction with the participating agencies, will:

- Collect and distribute basic information on housing and housing plans. Information collected and shared will include: the most recent Consolidated Housing Plan and Annual Action Plan to identify priorities for State Rental Assistance, HOME, Low Income Housing Tax Credits, Special Needs Housing Trusting fund, Community Development Block Grant and other programs used to develop affordable housing.
- Develop a Computer Based Training (CBT) curriculum for all interested parties in housing programs that are available for accessible and affordable housing and for community-based services. This project will begin in state fiscal year 2009.
- Create a Housing Advocacy E-mail Distribution list to distribute housing related information. As an example, federal Notice of Funds Availability (NOFA) and draft housing/action plans will be distributed in a more expedient manner.
- Provide linkages to the MFP Program website for individuals who want more information about New Jersey's Public Housing Authorities (housing plans, rental application requirements, housing availability, etc.).

The following measurable activities will act as sub-measures for the overall housing benchmark for the MFP Program.

1. MFP Program will go to at least 15 housing authorities per year to provide them with education and information on the current MFP Initiative and the new MFP Demonstration.
2. Review and Comment on PHA Consolidated Housing Plans.
3. The MFP Program will review the DCA draft Consolidated Housing Plans (CHP) in 2008 and provide comments on increasing need for housing opportunities for individuals with disabilities. Each year, the MFP Program will also review at least three other CHP to help prepare advocates for their own review and comments at public hearings of housing authorities.

A housing task force with broad-based membership, including key leaders in the disability, aging, housing, and transportation communities, has been established to focus on expanding affordable and accessible housing opportunities for people with disabilities consistent with the housing action plans in the DCA Strategic Plan. The housing task force's work will include informing and educating task force members and all other stakeholders on the four federally-mandated plans: Low Income Housing Tax Credit Program - Qualified Allocation Plan (QAP); the HUD Consolidated Plan (HUDCP); the Public Housing Agency Plan (PHAP); and the Continuum of Care Plan (COC). The task force will develop a long-range plan for continued efforts that will build on knowledge gained, partnerships and coordination outcomes from the grant. Most resources controlled within these four plans are specifically targeted to low-income households, including people with disabilities and seniors. SSI recipients are financially unable to obtain decent and affordable housing unless they have these resources and other federal housing resources. By developing partnerships, coordinating, collaborating, and thinking creatively across state agencies, people with disabilities and seniors in need of subsidies can be supported in the community.

The Housing Taskforce meets every two months and consists of Inter-Departmental and Inter-Divisional Staff that are responsible for various aspects of housing including financing, development, service provision, rental assistance and future planning. The purpose of this task force as previously mentioned, is to increase all housing types including those for MFP participants.

The housing task force will also:

- Advocate for as part of the MFP Demonstration a community living supplement for individuals who lack sufficient income to otherwise afford housing in the community
- Develop a directory of local public housing agencies (PHAs) and a timetable for review of local plans for use of HOME, Community Development Block Grant, and Housing Choice Voucher funding and disseminate the list to organizations to encourage their participation in needs statements and priorities for allocation of resources in local plans
- Encourage collaboration and coordination of supports with developers and public housing managers, develop a directory of organizations, providers, and service offices to distribute to PHAs and agency providers
- MFP Program will Promote use of the Housing Resource Registry (<http://www.njhousing.gov/>)
- Advocate for continued funding development of the Special Needs Housing Trust Fund
- Establish an annual action plan that commits task force members to collaborate in needed policy development, capacity building, and improved coordination of resources
- Set a priority for housing choice vouchers for people transitioning from an institution.
- Fund an Assistive Technology Loan Fund to make funds available to all individuals with disabilities in need of some type of accessibility modification in their home whether or not tied to an employment objective. Explore funding sources for the fund expansion.
- Identify appropriate agencies to submit grant applications or to take the lead on state budget initiatives.
- Encourage Universal Design features for all new construction.

In addition, DHS will work with the MFP Program to use existing programs and resources to help support the creation of new housing units that are designed to be accessible, affordable and available to persons leaving institutions and entering the community as a result of the proposed grant activities.

New Jersey has made steady progress in increasing interagency collaboration, both within the DHS divisions and between the DHS agencies and other state agency partners. The DHS/DCA MOU has served, and will continue to serve, as an ongoing state agency forum for collaboration and coordination of community integration efforts. The MFA Program Strategic Plan provides guidance to all agencies on cross-cutting initiatives that can be incorporated into each agency's own strategic plan. A successful MFP Demonstration and related strategies are an integral part of this Plan, but the demonstration seeks to address the concerns discussed in previous sections.

The Housing Appendix (Appendix 3) contains a NJ Housing Resource Center Web Page Screen Shot, which provides a picture of what people will see if they are conducting an on-line search for affordable housing in NJ. It also contains detailed information on various programs available in NJ to assist with homeownership. They are:

- **Home Buyer Mortgage Program** – Provides flexible Mortgage terms and conditions to first time home buyers
- **Home Plus Program** - This program is used to purchase a residence and to provide funds for the cost of minor home improvements (up to \$15,000), all included in one loan. Improvements may include retrofitting necessary to make the home handicapped-accessible.
- **Kinship Care Home Loan Program** – seeks to provide affordable housing opportunities for eligible borrowers for eligible grandparents, uncles and aunts, or other close relatives recognized by the Department of Human Services or the Department of Children and Families as qualified “kin”, providing long term care for their displaced grandchildren or nieces and nephews or other minor relatives. To the extent practicable, the Agency will make loans to eligible borrowers through the Agency's Home Buyer Program.
- **Smart Start Program** - The Smart Start Program is available to participants in the Agency's first mortgage homebuyers program who are purchasing homes in Smart Growth areas and who earn over the 80% of HMFA's homebuyer county income limits. The program helps these families by offering a second mortgage for down payment and/or closing costs up to 4% of the first mortgage.
- **Welcome Home Program** – seeks to provide affordable housing opportunities for eligible borrowers formally pursuing adoptions, including providing permanent placement of those children defined as Children with Special Needs. To the extent

practicable, the Agency will make loans to eligible borrowers through the Agency's Home Buyer Program (including the 100% Financing Program).

Continuity of Care Post the Demonstration

Participants will carry eligibility for MFP, and receive the waiver program services that most appropriately meet their need as identified in the Plan of Care. Upon the 366th day of community placement, eligibility in MFP will terminate. The participant will remain eligible for the waiver program that most appropriately meets their needs. Post the Demonstration, so long as the participant is Medicaid eligible, he/she will remain in the waiver program that was providing services under MFP.

Participants in NJ's Money Follows the Person Demonstration Project who meet the MFP eligibility criteria, will access home and community based services through NJ's array of 1915(c) Home and Community Based Medicaid Waiver programs.

They are:

1. **DDD Community Care Waiver (CCW)**: This waiver allows DD persons who meet the ICF/MR level of care to remain in the community. Services offered under this waiver include:
 - Case Management
 - Day Habilitation
 - Individual Supports
 - Respite
 - Supported Employment
 - Community Transition Services
 - Support Coordination
 - Assistive Technology Devices
 - Environmental and Vehicle Adaptations
 - Personal Emergency Response System (PERS)
 - Transportation (Non- Medical)

2. **Traumatic Brain Injury Waiver (TBI)**: This waiver serves people between 21 and 64 who have an acquired brain injury. It allows for persons who are currently in nursing facilities to return to their homes and assists persons who are currently in the community and at risk for institutionalization to remain living at home. Participants in the program receive full Medicaid benefits plus additional services including:
 - Case management
 - Counseling (behavior and drug)
 - Therapies through a CRS or Day Program
 - i. Occupational
 - ii. Physical
 - iii. Speech
 - iv. Cognitive Rehab
 - Behavior Programs
 - Environmental/Vehicle Modifications
 - Structured day program

- Supported day program
- Community residential services
- Adult companion services
- Respite care

3. **Community Resources for Persons with Disabilities Waiver (CRPD)**: This waiver serves individuals with disabilities of any age, as determined by the Social Security Administration or the Disability Review Section of the New Jersey Division of Medical Assistance and Health Services, who meet the nursing facility level of care, and require the services offered under this waiver. Participants in the CRPD Waiver Program receive all Medicaid State Plan services plus additional services including:

- Case Management
- Private Duty Nursing for up to 16 hours per day
- Environmental/Vehicle Modifications
- PERSONAL Community Transition Services

4. **Global Options (GO)** : In January 2009 CMS approved the DACS HCBS Waiver program known as Global Options. Existing slots and waiver allocations will be combined into one Global Budget to be used in the rebalancing of long-term care dollars. It is anticipated that as the number of individuals returned to the community continues to grow and NF populations diminish, dollars will be transferred from the NF budget to GO to accommodate the needs of the MFP population.

This waiver will allow persons who meet the nursing facility level of care to remain living at home and in the community. Services offered under this waiver include:

- Care management
- Homemaker
- Respite
- Environmental accessibility adaptations
- Special medical equipment/supplies
- Chore
- PERS
- Attendant care
- Home delivered meals
- Caregiver/recipient training
- Social adult day care
- Home-based supportive care
- Transportation
- Transitional care management
- Community transition services
- Adult family care
- Assisted living residence
- Assisted living program in subsidized housing

DDD received approval for waiver amendment to the CCW for the addition of Community Transition Services, which will be provided as a Qualified HCBS service for MFP participants who enroll in the DDD Community Care Waiver. Demonstration Category services will be evaluated at the conclusion of MFP in 2016 to determine whether or not it is beneficial to submit waiver amendments requesting the addition of those services.

Organization and Administration

Staffing Plan

New Jersey remains committed to the success of the Money Follows the Person (MFP) Demonstration Project through its partnership between the Division of Medical Assistance and Health Services (DMAHSS), the Division of Developmental Disabilities (DDD), the Division of Aging and Community Services (DACS) and the Division of Disability Services (DDS). This partnership is based upon a common vision for the rebalancing of long-term care spending in the state of New Jersey.

As stated previously in the Benchmark section, New Jersey has committed to increase MFP transitions from 305 over the next five (5) years to 2176 over the next five (5) years. In order to accomplish this goal, New Jersey has requested to utilize 100% administrative match funding to hire twenty-four (24) new staff.

The staffing plan is as follows:

DDD:

MFP Project Director: The Project Director for New Jersey's Money Follows the Person Demonstration Project, a full-time position, was filled in November 2010 as the previous MFP Project Director was working in an acting capacity.

MFP Financial Coordinator: A full-time position responsible for developing, preparing and executing the MFP projected budget for the operation of the MFP program within the state of New Jersey according to CMS guidelines and time frames. This position will enable New Jersey to prepare clear, sound and accurate financial reports and submission of said reports to CMS in a timely fashion.

Statewide MFP Housing Coordinator: A full-time position responsible for overseeing statewide efforts to develop/expand the availability of affordable and accessible housing for all vulnerable populations but primarily for those who meet MFP eligibility criteria. This will include the formulating and implementing of housing program policies, procedures, goals and objectives for MFP participants and other vulnerable populations. The Coordinator will be responsible to provide leadership in developing a housing strategy in coordination with the NJ Housing and Mortgage Finance Agency (HMFA), the NJ Department of Community Affairs (DCA), Public Housing Authorities and local housing providers and advocates. The Coordinator will be responsible to implement the Housing Plan detailed in New Jersey's Operational Protocol. This position will enable the New Jersey MFP Demonstration Project the opportunity to formulate policy and recommend legislative changes within the State.

MFP Quality Assurance Specialist: A full time position responsible for developing a quality assurance process for those individuals who have transitioned from an institution to a community living arrangement. This individual will assure through this process that individuals are

receiving the services required in order for them to live safely and happily in the community. These reviews will occur at 30 day intervals for 90 days and then at longer intervals thereafter. This individual will coordinate the findings, collect and analyze data and assure corrections are made in a timely fashion.

DACS and DDS:

The Office of Community Choice Options (OCCO) under the Division of Aging and Community Services (DACS) is responsible for transitioning those who are elderly and those with physical disabilities affiliated with both DACS and DDS.

7 Regional MFP Transition Nurses: Full-time positions responsible for identifying and transitioning individuals eligible for MFP by providing Options Counseling, comprehensive needs assessments and all appropriate pre-transition and community transition services necessary to transition individuals safely into community living. These positions will ensure that all individuals who meet the MFP eligibility criteria will be enrolled in the program.

MFP Associate Project Director: A full-time position responsible for supporting the MFP Project Director and leading DACS transition teams to assess, identify and transition elderly and physically disabled nursing home residents that meet MFP eligibility criteria, waiver criteria and any other criteria for which a transition can occur. This individual will work closely with healthcare and service providers to coordinate planning for those who are elderly and those with physical disabilities who desire to transition to a community living setting. This position will ensure all individuals who meet MFP eligibility criteria will be enrolled in the program, as well as provide support to the MFP Project Director to ensure the goals and objectives of the MFP Program are accomplished within the prescribed time frame and funding parameters.

MFP Housing Specialist/Coordinator: A full-time position responsible for providing housing resources and securing appropriate housing for MFP participants who require assistance to relocate from an institutional setting to community living. This position will ensure the available housing resources within the state are communicated to the Regional MFP Transition Nurses and will enhance the utilization of the Non-Elderly Disabled Voucher Program within DACS.

Clerk Typist: A full-time position to assist the MFP Associate Project Director and Transition Nurses by performing and coordinating administrative support services pertaining to nursing home transitions.

MFP Employment Specialist: A full-time position responsible for developing an employment resource packet which will contain resource materials for individuals interested in work or volunteering. The Employment Specialist will provide follow up 1:1 technical assistance and supports both directly to MFP participants and to community agencies who work with participants who are transitioning to the community or who have successfully transitioned and are now seeking to explore employment as a second phase of their integration. This position will ensure that these individuals have the opportunity to fully participate in their communities through employment and/or volunteer connections.

2 MFP Peer Mentors: Peer Mentors will be hired from each of the MFP target populations and will serve to provide mentorship to individuals as they transition and seek employment. They will also serve as a guide as New Jersey moves forward with its “Employment First” effort. The peer mentors will provide each MFP participant with an informal support mechanism to lessen any anxiety around issues of transition and employment and serve as a facilitator between the participant and the professional staff. Peer Mentors will be individuals who through their own self advocacy, have successfully transitioned from an institution or facility or avoided placement in an institution or facility.

In order to further accomplish our transition goals, New Jersey’s MFP Demonstration Project has partnered with the New Jersey Office of the Ombudsman for the Institutional Elderly (OOIE).

The OOIE works to preserve the health, safety, welfare and protect the rights of New Jersey residents 60 years of age and older who reside in long-term care facilities. The program protects older adults’ right to choose the least restrictive environment in which to receive care and treatment and is uniquely positioned to counsel older adults on the increasing number of self-directed, community-based options and services available to them.

As the state of New Jersey endeavors to dramatically increase the number of nursing home residents transitioning to community care, and, as nursing facilities begin to implement the SNF/NF MDS 3.0 Section Q assessment tool, the OOIE can play a critical role in educating older adults and those with physical disabilities and their families about community living options available to them.

In order to accomplish this goal, the OOIE is requesting 100% administrative match funding to hire the following staff:

4 MFP Outreach and Advocacy Coordinators: Full-time positions responsible for a specific catchment area to educate residents, family members and facility staff about the range of community choice options available in that catchment area; distribute MFP marketing materials to residents and family members via personal contact or through family and resident council meetings; follow up with Section Q referrals; make referrals to the Offices of Community Choice Options; inform and educate nursing facility staff and community groups about MFP; visit nursing facilities in their catchment area at least twice per year and during those visits contact each new admission and make a presentation to staff or resident/family members. These positions will ensure that the voice of all individuals residing in nursing homes who wish to move into the community are heard, thus increasing referrals to the local contact agencies.

1 MFP Statewide Outreach and Advocacy Supervisor (bilingual): A full time position responsible for ensuring the MFP Outreach and Advocacy Coordinators accomplish the above tasks in a timely and efficient manner, monitor their performance and ensure they meet their referral goals. This position is critical to the monitoring of the productivity of the MFP Outreach and Advocacy Coordinators. If the duties of the MFP Outreach and Advocacy Coordinators are not fulfilled, the voices of the nursing home residents may not be heard.

1 MFP Project Support Staff: A full time position responsible for providing administrative supports to the MFP Outreach and Advocacy Supervisor and the four MFP Outreach and Advocacy Coordinators.

Chief of Staff: A full-time staff person is in an existing position within OOIE. OOIE requests to receive 100% administrative match funding for 20% of this salary. The current Chief of Staff has extensive experience as a Communications Director in several state government agencies and will directly supervise the OOIE/MFP Statewide Coordinator and oversee the implementation of the MFP outreach plan.

Billing and Reimbursement Procedures

Describes the procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.

A unique value will be assigned to all MFP claims. This value will ensure that claims for MFP will not fall through to the regular federal CMS64 reporting system.

The Claim Processing Assessment System (CPAS) subsystem in the NJMMIS interfaces with the Claims, Reference, Provider, Recipient, LTC, and TPL subsystems to produce comprehensive review information for each claim in the CPAS sample selected. There is a weekly random sample, across all claim types, of claims selected systemically. The claim dumps, as well as supporting documentation from other areas in the NJMMIS in printed and the review packages for each claim are sent to the SMU so that the claims can be reviewed and re-priced manually. Any errors that are detected or suspected are brought to the attention of Molina quality assurance staff and are addressed immediately.

For fraud control, NJMMIS contains a component called J-SURS which is proprietary software that is designed specifically for reporting and is monitored by a team of state employees that run reports and review them for program integrity and fraud. If inconsistencies are found they are referred to a fraud and abuse unit within Medicaid. All MFP claims processed would be available through this system for review.

For DDD as specified in the 1915(c) Appendix I:

Independent audit of provider agencies on an annual basis is a requirement for agencies operating under contract with the Single State Medicaid Agency (DHS). This requirement is delineated in the State Contract Manual in The Department of Human Services' Policy Circular P2.01. Specifically section 3.09 of this policy requires an annual audit that is agency wide in scope. The audit must be conducted in accordance with the Federal Single Audit Act of 1984, generally accepted auditing standards as specified in the Statements of Auditing Standards issued by the American Institute of Certified Public Accountants (AICPA) and Government Auditing Standards issued by the Comptroller General of the United States. In addition the policy stipulates that at any time an agency may be audited by the Department of Human Services (DHS), the Single State Medicaid Agency, or any other appropriate unit of the state or federal government and/or by a private firm approved by the DHS. In addition, agencies providing

Individual Support services in residential settings for Traumatic Brain Injury (TBI) are required by state regulation N.J.A.C. 10:44C to have an agency wide audit conducted annually. DHS does not dictate the auditing corporation selected by a provider agency but rather ensures compliance re: scope and standards for the annual audit. A more detailed explanation of the mandatory audit requirements are documented in DHS Policy Circular P7.06.

Provider billing is done by MOLINA, a corporation under contract with the Division of Medical Assistance and Health Services (DMAHS), the component of the DHS designated with oversight of HCBS waivers. MOLINA is audited annually according to the SAS 70 auditing standard of the AICPA. The audit evaluates systems control design process, key controls that support control objectives, effectiveness of the control design, and any control gaps which would indicate a risk factor. The SAS 70 auditing standard also comports with CMS focus on quality in that in addition to an audit of controls the system also provides for an evaluation of the operating effectiveness of specified controls over a specified time period (generally six (6) months). The audit is bid by RFP. Currently the auditing agency is Ernst & Young, LLP. The specific policies and procedures for the MOLINA audit are available through the State Medicaid agency. DDD Fiscal Department requires the executive director of provider agencies to monitor the accuracy of attendance records and expenditure reports and to certify that they are accurate on a monthly basis.

DDD staff on an ongoing basis review provider and DDD case files records to insure that individuals receiving waiver services are in need of the services, maintains eligibility, and receive the services as documented in their individual service plans. Many of these checks are accomplished monthly and/or quarterly through case management on site visits and again annually at the time of the service plan meeting.

DDD reviews to ensure that federal claim rates have been appropriately calculated by analyzing cost reports submitted by provider agencies. High and low rates that are at a deviance of 50% or 200% of the mean are reviewed and justified during the process of setting cost rates.

On a monthly basis DDD reviews Unusual Incident Reports of deaths to ensure that the service claims ceased on the date of death.

DHS conducts five audits for select agencies that provide services for the Division of Developmental Disabilities as an additional line of oversight beyond the required annual independent audit. The audit findings are reviewed when calculating final Community Care Waiver (CCW) rates.

Required single audit (section P7.06 of the Contract Policy Manual) performed in accordance with federal OMB circular A-133 and Department policy by a licensed accounting firm on an annual basis, ascertain that the financial statements fairly represent the financial position of the organization including a review of the DDD/DHS final Report of Expenditures (ROE) as mandated by section P2.01 of the Contract Policy Manual.

DDD Fiscal Department requires the executive director of provider agencies to monitor the accuracy of attendance records and expenditure reports and to certify that they are accurate on a monthly basis.

DDD staff on an ongoing basis review provider and DDD case files records to insure that individuals receiving waiver services are in need of the services, maintains eligibility, and receive the services as documented in their individual service plans. Many of these checks are accomplished monthly and/or quarterly through case management on site visits and again annually at the time of the service plan meeting.

DDD reviews to ensure that federal claim rates have been appropriately calculated by analyzing cost reports submitted by provider agencies. High and low rates that are at a deviance of 50% or 200% of the mean are reviewed and justified during the process of setting cost rates.

On a monthly basis DDD reviews Unusual Incident Reports of deaths to ensure that the service claims ceased on the date of death.

DHS conducts five audits for select agencies that provide services for the Division of Developmental Disabilities as an additional line of oversight beyond the required annual independent audit. The audit findings are reviewed when calculating final Community Care Waiver (CCW) rates.

Required single audit (section P7.06 of the Contract Policy Manual) performed in accordance with federal OMB circular A-133 and Department policy by a licensed accounting firm on an annual basis, ascertain that the financial statements fairly represent the financial position of the organization including a review of the DDD/DHS final Report of Expenditures (ROE) as mandated by section P2.01 of the Contract Policy Manual.

Posted provider attendance and reports of expenditure (ROE) data in the DDD systems are reviewed by DDD to correct potential errors and omissions.

By matching on an ad hoc basis DDD eligibility files with the DMAHS eligibility files, apparent discrepancies are discovered and resolved.

Review of billing factors is done to ensure eligibility which results in the generation of a pre-claim report to finalize billing.

Billing reports are screened by the fiscal agent for the Medicaid System through exception edits that remove contradictory or unauthorized claims which are then reported to DDD for follow up.

Denied claims are reviewed by DDD to determine errors and make corrections where possible.

By matching on an ad hoc basis DDD eligibility files with the DMAHS eligibility files, apparent discrepancies are discovered and resolved. DDD IT and Fiscal staff then work to correct the issue(s). These issues often mean correcting addresses and/or middle initials.

Billing reports are screened by the fiscal agent for the Medicaid System through exception edits that remove contradictory or unauthorized claims which are then reported to DDD for follow up. DDD then reviews and reconciles the denied claims to determine errors and make corrections where possible.

There are duplicate checks and balances to assure that claims are made only for individuals eligible for Medicaid waiver payment by providers of services that meet the required waiver standard on the date the service was rendered. DDD, the component of DHS charged with the daily administration of the CCW does an initial screening through its Management Information System to ensure eligibility of both the individual and the service prior to submitting the billing to MOLINA. MOLINA also has edits that prevent billing for individuals that are not eligible on the date of service delivery.

With regard to service provision, DDD requires attendance records from the contracted entities prior to billing for services. There are a number of internal checks to ensure that each waiver service was rendered including case management visits, logs maintained at the residence and in the day program, reports submitted to the Division by the service provider etc.

At the time of the annual service plan the interdisciplinary team is required to include all services the individual will require or utilize within the upcoming year in Division Circular #35. A random representative sample audit performed by Division staff on a quarterly basis in each region examines the service plan to ensure that the services for which DDD receives federal reimbursement are included in the service plan.

For the Division of Aging and Community Services as specified in the 1915(c) Appendix I:

In Adult Family Care (AFC) and the Assisted Living Program (ALP), there are fixed all-inclusive per diem rates paid to providers for services delivered to participants. Claims submitted for an amount greater than the per diem rate will be denied. Other waiver services for which individuals enrolled in AFC or ALP are eligible are limited in order to prevent a duplication of services. Participants in both programs may attend Social Adult Day Care, up to three days a week, with prior authorization from DACS Quality Assurance Unit. AFC participants may have a cost share after payments for room and board; a personal needs allowance, and other allowable deductions.

Monitoring of financial accountability is governed by the Fiscal Intermediary contract between MOLINA, the State Fiscal Agent, and the Division of Medical Assistance and Health Services (DMAHS), the State Medicaid Agency, in the Department of Human Service.

Parameters for providers are set such as participant eligibility files, procedure codes for services permitted under the Waiver, and financial records for claims payment data. Provider groups are analyzed to identify problems.

Edits placed in the system monitor payment limits and prevent overpayments. Financial irregularities or billing errors are identified, addressed, and corrected.

The MOLINA Provider Services Department provides comprehensive training services to the provider community. The training sessions are held at MOLINA, provider sites, or other locations throughout the State of New Jersey.

Section XIII of the Interagency Agreement between DHSS and DHS details the specific responsibilities of each Department regarding reports, forms, and procedures that largely deal with fiscal matters. DHS provides DHSS with a number of fiscal reports identified in the Data/Reports column.

DACS maintains a Home and Community-Based Services (HCBS) website, which was designed so the GO Care Manager can set up services with non-traditional providers that have been approved by the Division. The Care Manager enters an Individual Service Agreement (ISA) onto the website to authorize monthly payment amounts to each provider for every service to be delivered to a particular participant. The authorization includes the number of units, frequency, amount and cost. The HCBS System feeds this authorized information to the DHSS fiscal intermediary. If a provider bills for a service that is not authorized or more than the monthly -authorized amount, the fiscal agent does not pay the provider.

The GQ staff is in constant communication with other State staff from Medicaid and other DACS Offices/Units to address any financial irregularities on an as needed basis.

For Waiver Services, billed through Molina by traditional Medicaid enrolled providers, DACS relies on SURS reports that address over-billing. Any questions regarding interpretation of the report are directed to the SURS unit in Medicaid.

For the Division of Disability Services:

Review of HCFA-372 report to identify any trends or service utilization issues, as well as cost-neutrality of the waiver. Maintaining a DDS staff liaison with DMAHS fiscal agent, Molina. Comparison of POC and paid claims. Use of the Decision Support System (DDS) to create unique ad-hoc reports within parameters set by the DDS staff requesting the report. Post-payment surveillance utilization review (SURS) of paid waiver claims. In March 2008, DDS initiated meeting with DMAHS/SURS Unit to re-establish the claims analysis for waiver clients. Discussion was held on the waiver programs and service requirements/limitations. Monthly meetings will be held to review SURS reports and take necessary action.

Organizational Structure

State Management Team

The State Management Team was created to formalize and strengthen the collaborative partnership between the Department of Health and Senior Services and the Department of Human Services. The State Management Team is comprised of high-level management (i.e. Assistant Commissioners, Deputy Directors, and Directors) from DDD, DACS, DDS, and DMAHS. The purpose of the team is to provide leadership, guidance and ensure coordination of effort with respect to all Long Term Care initiatives (grants, policies, etc.) across all partners.

The State Management Team originally developed to oversee the ADRC grant will continue to oversee the System Transformation Grant and the Money Follows the Person Demonstration. Through these complementary efforts, NJ will continue to improve coordination and service delivery for Medicaid waiver programs across DACS, DDS and DDD. Consumer representatives have been added to the State Management Team. Consumers and stakeholders who were part of the development of specific parts of the MFP Operational Protocol provided comment and recommendations for change prior to final submission to CMS..

The Project Director for MFP has been added as a regular participant of the State Management Team. The Project Director provides monthly updates on the status of MFP. The MFP Project Director has also been added to the Interdepartmental Project Staff, which is comprised of management level personnel from all partner divisions. The Interdepartmental Project Staff communicates regularly through email and telephone on the day to day operations of the MFP demonstration.

The Money Follows the Person Organizational structure is detailed in the tables that follow.

Money Follows the Person

New Jersey Organizational Structure

NJ State Management Team Organizational Structure

- Ensure alignment of STG, ADRC, MFP, and State goals
- Facilitate system change at State level

STG Partnership: Dawn Apgar, Deputy Commissioner DHS/DDD; Valerie Harr, Director DHS/DMAHS, Nancy Day, Acting Assistant Commissioner, DHSS/DACS; Joseph Amoroso, Director, DHS/DDS; James McCracken, Ombudsman.

Interdepartmental Project Staff: Terre Lewis – MFP Project Director DHS/DDD, Catherine Dailey, Assistant Project Director DHSS/DACS; Maribeth Robenolt, DHS/DDD

Consumers; William Cramer, Andrew McGeady

**Department of Health & Senior Services,
Division of Aging & Community Services**

Nancy Day, Acting Assistant Commissioner
Mary Malec, Director, LTC Supportive Services
Catherine Dailey, MFP Assist. Director
Nancy Field, ADRC Project Director
Lou Ortiz, ADRC Assistant Project Director
Amy Ancharski, Supervisor, Go Medicaid
Waiver Quality Management
Kevin Murphy, GO Quality Assurance
Michelle Pawelczak, Special Assistant
Luz Maldonado, Administrator, Office of
Community Choice Options

**Department of Human Services
Division of Disability Services**

Joseph Amoroso, Director
Joseph Amoroso, Waiver Services

**Division of Medical Assistance & Health
Services (DMAHS)**
Valerie Harr, Director
Elena Josephick, Policy Administrator
Margaret Springer, Quality Assurance
Meredith Van Pelt, Regulatory Officer,
Carol Grant, Office of Managed Care
Eileen Calabro, Office of Managed Care

**Department of Human Services
Division of Developmental Disability**

**Dawn Apgar, Acting DDD Asst
Commissioner and DHS Deputy
Commissioner**
Terre Lewis, MFP Project Manager
Maribeth Robenolt, Director of Medicaid
Services and Quality Assurance

**Office of the Ombudsman for the
Institutionalized Elderly**

James McCracken, Ombudsman
Laurie Brewer, Chief of Staff

MFP WORKGROUPS
(State staff, consumers, advocates & community agencies)



**DHS – DMAHS
Medicaid Oversight**

Terre Lewis
MFP Project Director

Maribeth Robenolt, Unit Director
DDD Medicaid Waiver Services

Joseph Amoroso, Director
DDS Medicaid Waiver Services

Amy Ancharski, Supervisor
DACS Medicaid Waiver Services

James McCracken, Ombudsman
Laurie Brewer, Chief of Staff
Office of the Ombudsman
for the Institutionalized Elderly

MFP Participants

Community
Providers

MFP Participants

Community
Providers

MFP Participants

Community
Providers

TERRE LEWIS

NJ Department of Human Services, Division of Developmental Disabilities | P.O. Box 726 Trenton, NJ 08625
Phone: (609) 689- 0564 | Terre.Lewis@dhs.state.nj.us

EXPERIENCE:

Supervising Community Program Specialist: Division of Developmental Disabilities (DDD), Hamilton Township, New Jersey, (November 22, 2010 – Present)

- Coordinate, implement and expand the Money Follows the Person (MFP) Demonstration Project in the state of New Jersey
- Establish and maintain working business relationships with partnering Divisions within the state of New Jersey associated with the MFP Project
- Maintain a working business relationship with the Centers for Medicare and Medicaid Services (CMS) and their stakeholders
- Coordinate outreach, marketing and education in relation to the MFP Demonstration Project to promote program participation
- Ensure eligibility of all MFP participants
- Maintain database of all MFP participants and interpret data upon request by CMS and their stakeholders
- Develop and prepare proposed MFP Project budget and associated financial reports
- Provide data file reports as well as semi-annual web based reports to assist CMS in the evaluation of the fiscal effectiveness of the MFP Project
- Hire and supervise MFP professional staff
- Plan and assign MFP job duties as appropriate
- Supervise and maintain MFP Project records and files
- Draft correspondence as appropriate
- Attend and participate in conferences and meetings as appropriate

Quality Assurance Specialist: Division of Developmental Disabilities (DDD), Hamilton Township, New Jersey, (October 2004 – November 19, 2010)

- Develop and coordinate qualification process for Real Life Choices, Olmstead Initiative and various Request For Proposals/Request For Qualifications
- Review, analyze and evaluate provider applications and supportive documentation to determine eligibility for qualified status under Real Life Choices
- Review, analyze, interview and evaluate provider applications and recommend potential applicants for qualified status under Olmstead Initiative
- Prepare statistical reports containing findings and analysis of all qualified providers
- Analyze operational problems through review of Real Life Choices plan summaries to develop a course of action for more effective utilization of resources
- Provide technical assistance to Support Coordination and qualified providers pertaining to services and supports eligible for federal reimbursement under the Community Care Waiver
- Provide technical assistance to Support Coordination and qualified providers pertaining to allowable cost guidelines for each service eligible for reimbursement under the Community Care Waiver
- Plan, organize and conduct training for Support Coordination and qualified providers to improve service delivery
- Prepare and direct coordination of information for families and providers posted on the Family

Support Center web site pertaining to Real Life Choices

- Coordinate the revision of the Memorandum of Understanding (MOU) between the Division of Vocational Rehabilitation Services (DVRS), the Commission for the Blind and Visually Impaired (CBVI) and the Division of Developmental Disabilities (DDD) to enable all three Divisions to operate in an efficient and successful manner to ensure quality service provision and improve employment outcomes for individuals with developmental disabilities
- Participate in the statewide Integrated Employment Coalition in order to facilitate consistent communication, continued cooperation and continuous improvement in the field of Supported Employment
- Participate in the Policy and Procedure Committee charged with reviewing, analyzing and updating all Division policy and procedures in effort to improve service delivery and be in compliance with Department of Human Services and State of New Jersey rules and regulations
- Participate in the Community Capital Committee charged with reviewing and approving DDD contracted agency's major maintenance packages for group home repair, renovations and purchase.
- Draft correspondence as appropriate
- Supervise maintenance of records and files
- Provide assignment and instruction to support staff

Habilitation Plan Coordinator: Division of Developmental Disabilities (DDD), Freehold, New Jersey, (August 2003 - October 2004).

- Compile and issue a master individual habilitation plan for each individual assigned
- Coordinate, monitor, and audit individual progress in following the individual habilitation plan.
- Recommend, approve, and monitor individual habilitation plans through the interdisciplinary team and sees that these changes are carried out
- Perform monitoring and assessment of individual's residential, program, training, behavior, social, and health needs
- Investigate and follow up on any report of abuse, neglect, or incident which may impact on an individual's well-being
- Monitor sponsors engaged in the operation of community residences for compliance with state licensing standards
- Recommend contract modifications including continuation or termination of alternate living contract
- Coordinate the development of crisis prevention and intervention plans
- Review and analyze case histories and other data concerned with intake, placement, program and referral issues

Clinical Coordinator: Mentor NJ, Moorestown, New Jersey, (April 1999 – August 2003).

- Review and analyze case histories and other data to develop appropriate goals and improve quality of care
- Compile and issue an individual rehabilitation plan for each individual assigned
- Coordinate, monitor, and audit individual progress in following the individual rehabilitation plan.
- Recommend, approve, and monitor individual rehabilitation plans through the interdisciplinary team and see that these changes are carried out
- Investigate and follow up on any report of abuse, neglect, or incident which may impact on an individual's well-being
- Monitor Mentors engaged in the operation of a Mentor home for compliance with DDD

licensure standards

- Recommend contract modifications including continuation or termination of Mentor contract
- Complete Risk Management Assessment Form within 30 days of Admission
- Conduct quarterly home safety evaluations on all Mentor homes and provide feedback to the Mentor.
- Provide clinical direction, training and supervision to Mentors
- Complete annual Mentor Home evaluation of services
- Provide supervision of Mentor Information Book and review monthly for maintenance by Mentor Home family
- Audit clinical files

Case Manager: PLUS, Absecon, New Jersey (March 1998 - April 1999).

- Obtain and maintain records/documentation
- Ensure that each individual assigned receives necessary medical, dental, psychiatric and psychological services available through the program as well as in the community.
- Develop quarterly goals and coordinate, monitor and audit the individual's progress in following their plan of care
- Liaison between consumers, families, rehabilitation nurses, professional staff, and insurance carriers
- Ensure quality and efficiency of programs and documentation
- Investigate and follow up on any report of abuse, neglect, or incident which may impact on an individual's well-being
- Coordinate the development of crisis prevention and intervention
- Coordinate discharge and follow up on status following transfer or discharge

Vocational Specialist/Cognitive Retraining Specialist: PLUS, Absecon, New Jersey (January 1997 – March 1998).

- Provide cognitive rehabilitation therapy services through direct services
- Assess cognitive areas, vocational potential, target goals, select tasks and strategies
- Facilitated group sessions designed to enable individuals to participate in various activities such as vocational skills, life skills, personal development and community participation
- Counsel residents in developing appropriate vocational goals
- Evaluate resident's job readiness, assist with developing and improving job seeking skills, prepare resident for job interviews and provide job coaching when job placement occurs
- Facilitate the learning of those skills and functions essential for adaptation and productivity in the work place
- Conduct field visits to provide, evaluate and coordinate necessary services
- Establish and maintain cooperative working relationships with other organizations/agencies whose services may benefit the residents
- Develop, organize and maintain a referral network to inform residents of other appropriate programs, services or resources

Social Worker: HealthSouth Rehabilitation Hospital of NJ, Toms River, New Jersey (March 1996 – October 1996).

- Provide a service plan to restore patient to optimum social and health adjustment
- Arrange for discharge or postoperative care at home
- Assist patient and families through individual or group conferences to understand, accept and

follow medical recommendations

- Interview patient and family to obtain information about home environment, family relationship, health history, mutual and personal resources
- Evaluate data to determine appropriate treatment plan
- Attend case conferences to present case history and collaborate on case records
- Provide follow-up after discharge

Clinical Coordinator: HealthSouth Rehabilitation Hospital of NJ, Toms River, New Jersey (January 1995 - July 1996).

- Clinical management of such issues as implementation and coordination of interdisciplinary functions, therapeutic strategies, establishments of discharge dates and recommendations for follow up care
- Supervise and evaluate clinical staff performance and conduct
- Ensure quality and efficiency of program and documentation

Vocational Counselor: HealthSouth Rehabilitation Hospital of NJ, Toms River, New Jersey (November 1993 – October 1996).

- Develop and implement vocational therapy programs in the Long Term Care unit to facilitate rehabilitation
- Counsel residents in developing appropriate vocational goals
- Review and evaluate diagnostic data to determine resident's limitations based upon disability
- Evaluate resident's job readiness, assist with developing and improving job seeking skills, prepare resident for job interviews and provide job coaching when job placement occurs
- Facilitate the learning of those skills and functions essential for adaptation and productivity in the work place
- Conduct field visits to provide, evaluate and coordinate necessary services
- Establish and maintain cooperative working relationships with other organizations/agencies whose services may benefit the residents
- Develop, organize and maintain a referral network to inform residents of other appropriate programs, services or resources

EDUCATION: Lebanon Valley College, Annville, Pennsylvania (September 1973 – May 1977).
Bachelor of Arts: Sociology/Social Work.

Reference Available Upon Request

NJ Department of Health and Senior Services
Division of Aging and Community Services
PO Box 807
Trenton, NJ 08625
609-943-3357
catherine.dailey@doh.state.nj.us

Catherine Dailey, RN

Experience

July 2011 – Present

State of New Jersey Department of Health and Senior Services Division of Aging and Community Services

Assistant MFP Program Director

- Assists all administrative and training projects for MFP program. This includes all aspects of project planning and implementation, supervision of staff and reporting.
- Conducts ongoing evaluations of programs by identifying and reporting on proximal and distal outcomes and their influential inputs and processes.
- Prepare monthly, quarterly and annual reports on programmatic activities.
- Assists with other MFP projects as needed.
- Conducts outreach to nursing homes in service area in order to identify consumers interested in moving out.
- Establish relationships with local community providers, local access agencies and other organizations.
- Serve as a liaison between the providers, access agencies, community based organization and state transition program.
- Prepare and conduct one-on-one and group training sessions with local access agencies, other organization and state transition teams
- Attend conferences, focus groups and transition related groups.
- Conduct team meetings to identify successful strategies and barriers for improvement and to reach projected goals.

- Continue roles as specialist to assist individuals to transition from Nursing Facility to Community.
- Create a network to identify individuals who are potential candidates for transition into the community.

May 2008 – July 2011

State of New Jersey, Department of Health and Senior Services, Trenton, NJ

Quality Assurance Specialist

- Schedule, plan and conduct quality assurance audits of care management sites to determine compliance with waiver and JACC policies and expectations including cost effectiveness of consumer participation and satisfaction.
- Provide technical assistance, education and outreach necessary to promote growth, effectiveness and awareness of waivers and JACC programs.
- Troubleshoot issues surrounding Assisted Living, GO, JACC assigned counties.
- Support the increase of Medicaid participation by AL/AFC providers and encourage them to apply the Medicaid policies appropriately.
- Assist the state in conducting and reviewing financial accountability efforts by providing follow up activities and record keeping related to quality management and improvement.
- Participate in development systems and initiatives to advance the mission of DACS and GO.
- As Quality Assurance Specialist, contribute to the development and maintenance of the DACS quality management strategy that promotes effective program operations and adequate monitoring for continual quality improvement.
- Assist with the integration and coordination of new state initiatives including, Aging and Disability Resource Center (ADRC), Global Options for LTC, Independence, Dignity and Choice in LTC Act and Money Follows the Person (MFP).
- Point person for Care Giver pilot program.

6/2000-5/2008

State of New Jersey, Department of Health and Senior Services, Edison, NJ

Regional Staff Nurse/Community Choice Counselor

- Clinical assessments performed on clients in community and/or institutionalized settings to determine appropriate level of care for the individual, following state and federal regulations

to assist in making in-depth clinical determination as well as formulating a health service delivery plan (HSDP).

- Working cooperatively with hospital, nursing facility and community personnel to assure delivery of proper services to the client.
- Performs presentations, in-services, and scheduled conferences to clients, health care providers/staff, and community services in order to provide optimal care to meet client needs.
- Acted as Case Manager to various assisted living facilities in Ocean and Monmouth counties assuring clients care needs were met. Also, educated staff to assure proper care as well as instruction to comply with Medicaid regulations and to be of assistance to those who are having difficulties/questions with compliance of the regulations.
- Participated in blitz of adult day health providers several years ago and presently assessing adult day care client to determine continued eligibility. Assisting staff of adult day health providers to understand and comply with new Medicaid regulations.

7/1999-6/2000

Nottingham House Assisted Living, Toms River, NJ

Facility Manager/Director of Nursing

- Responsible for the administration, clinical and marketing requirements of the St. Barnabas Health Care System assisted living facility.

7/1998-7/1999

Helping Hands Healthcare, Toms River, NJ

Director of Nursing

- Directed skilled and para-professional personnel for health care agency.
- Management of over 100 cases.
- Direct supervision of RNs and CHHAs.
- Certified to train personnel for CHHA licensing.

9/1996-7/1998

VNA of Central New Jersey, Red Bank, NJ

Field RN

- Complete Case Management responsibilities in Monmouth and Ocean Counties.
- Worked as a Patient Care Coordinator for home health aides and rehabilitation services.

8/1988-9/1996

Ocean Home Care, Toms River, NJ

Senior Clinical Manager

- Directed the activities of home care nurses, providing clinical coverage to patients throughout the county.
- Responsible for the recruitment process including interviewing, hiring and training.
- Developed procedures to meet changing health care standards.
- Enforced regulations to adhere to infection control standards.
- Updated Quality Assurance programs.
- Performed routine clinical record audits, reviewed nursing team operations and detected areas for improvement.
- Controlled the activity between Ocean Home Care and three area hospitals.
- Supervised Ocean Home Care intake coordinators.
- Played an integral role in the development of programs to gain Joint Commission Accreditation.
- Maintained records and managed operations to pass Medicare audits.
- Worked on the evaluation team to computerize home care field operations, increasing accuracy in reporting and documentation.
- Promoted from staff RN. Initially responsible for patient case management for up to 35 nursing visits per week.
- Utilized clinical skills to provide necessary health care to patients
- Gained valuable experience as a hospital coordinator, where I coordinated the discharge of home care patients.

9/1984-6/1988

St. Peter's Elementary School, Pt. Pleasant, NJ

School Nurse

- Provided students with general health care screenings.
- Maintained necessary records and documentation.
- Developed and instructed curriculum related to health and sex education.

1975-1984

Per Diem Nurse, New Jersey

Medical-Surgical RN

- Served as general medical-surgical nurse at area hospitals including Riverview Medical Center, Red Bank, NJ; Pt. Pleasant Hospital, Pt. Pleasant, NJ; Jersey Shore Medical Center, Neptune, NJ

Education

St. Francis School of Nursing, Jersey City, NJ

- Registered Nurse –State of NJ license # 26NO04117800 Valid through 5/31/2012. Additional training includes: IV Certified, Chemotherapy Certified, Fox Chase Hospice and Certified Home Health Aide Instructor.

References

Available upon Request

Final Project Budget

Budget Narrative/Methodology

NJ will not be conducting an independent state evaluation of MFP.

With CMS approval, NJ plans to utilize 100% Administrative Match Funding for the following MFP expenses:

- Personnel:
 - Project Director;
 - Associate Project Director;
 - Financial Coordinator;
 - Statewide Housing Coordinator;
 - Quality Assurance Specialist;
 - Regional Transition Nurses (7);
 - Housing Specialist/Coordinator;
 - Employment Specialist;
 - Peer Mentors (2);
 - Clerk Typist (2);
 - Outreach and Advocacy Coordinators (4);
 - Statewide Outreach and Advocacy Supervisor (bilingual);
 - OOIE Chief of Staff: 100% administrative match funding for 20% of this salary.
- Travel reimbursement for the MFP staff listed above
- Outreach and Marketing
- Administration of Quality of Life Surveys

All other NJ personnel associated with the function of this demonstration project are already reimbursed through the Medicaid program. In keeping with requirements set forth in OMB Circular A-87 regarding consistency of reimbursement, staff activities related to the Money Follows the Person Demonstration Project will be a part of their normal work activities.

Please see Appendix 7 which provides detail on the methodology used by the partner Divisions for developing the budget for MFP.

Please see attached Appendix 8 for the Worksheet for Proposed Budget.