



Maine's Money Follows the Person Demonstration Project

OPERATIONAL PROTOCOL

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MAINE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Homeward Bound

Maine’s Money Follows the Person Demonstration

OPERATIONAL PROTOCOL

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Homeward Bound

Maine Money Follows the Person Demonstration

OPERATIONAL PROTOCOL

ADMINISTRATIVE STRUCTURE FOR THE MFP DEMONSTRATION

The Maine Department of Health and Human Services, which serves as Maine’s single state Medicaid agency, is the lead applicant for the MFP Demonstration. Within DHHS, a number of organizational units administer various parts of the Medicaid program and play an active role in overseeing the MFP Demonstration. [FIGURE 2](#) on page 6 provides an organizational chart for select organizational units within DHHS having a role in the administration of the MFP Demonstration. For a complete organizational chart for DHHS, see [APPENDIX A](#).

THE OFFICE OF MAINECARE SERVICES

The Office of MaineCare Services (OMS) develops Medicaid policy and serves as the primary point of contact with CMS for all Medicaid-related matters. The Maine Integrated Health Management Solutions (MIHMS), Maine’s Medicaid claims system, is also housed within MaineCare. The OMS Director plays an active role in overseeing the MFP Demonstration.

THE OFFICE OF AGING AND DISABILITY SERVICES

The Office of Aging and Disability Services is the Lead Agency for the MFP Demonstration. OADS administers the HCBS waivers and state plan services that will be accessed by the majority of demonstration participants. The Demonstration is directed by the MFP Program Director, who is housed within the OADS, under the direct supervision of the Director of Long Term Care Services. The Director of Long Term Care Services will have authority to act in the absence of the Demonstration Director.

The Office of Aging and Disability Services administers the waiver programs for adults with intellectual disabilities or autism, brain injury services and consumer directed personal assistance programs for adults with physical disabilities. Some participants in the Older Adult and the Adults with Physical Disability Group may access the consumer directed services. Some participants in the Complex Needs group will access the Other Related Conditions Waiver and others may access brain injury services. OADS participates on the Adult Services Consortium and the DHHS Complex Case Team and may be involved in facilitating access to services for this latter group.

THE OFFICE OF SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

The Office of Substance Abuse and Mental Health Services (SAMHS) is an active partner in the Demonstration. SAMHS administers many of community mental health treatment and long term supports for persons with mental illness that may be accessed by demonstration participants. AMHS’ field nurses participate in the MFP Demonstration activities on an as needed basis.

THE OFFICE FOR FAMILY INDEPENDENCE

The Office for Family Independence is responsible for determining financial eligibility for MaineCare services.

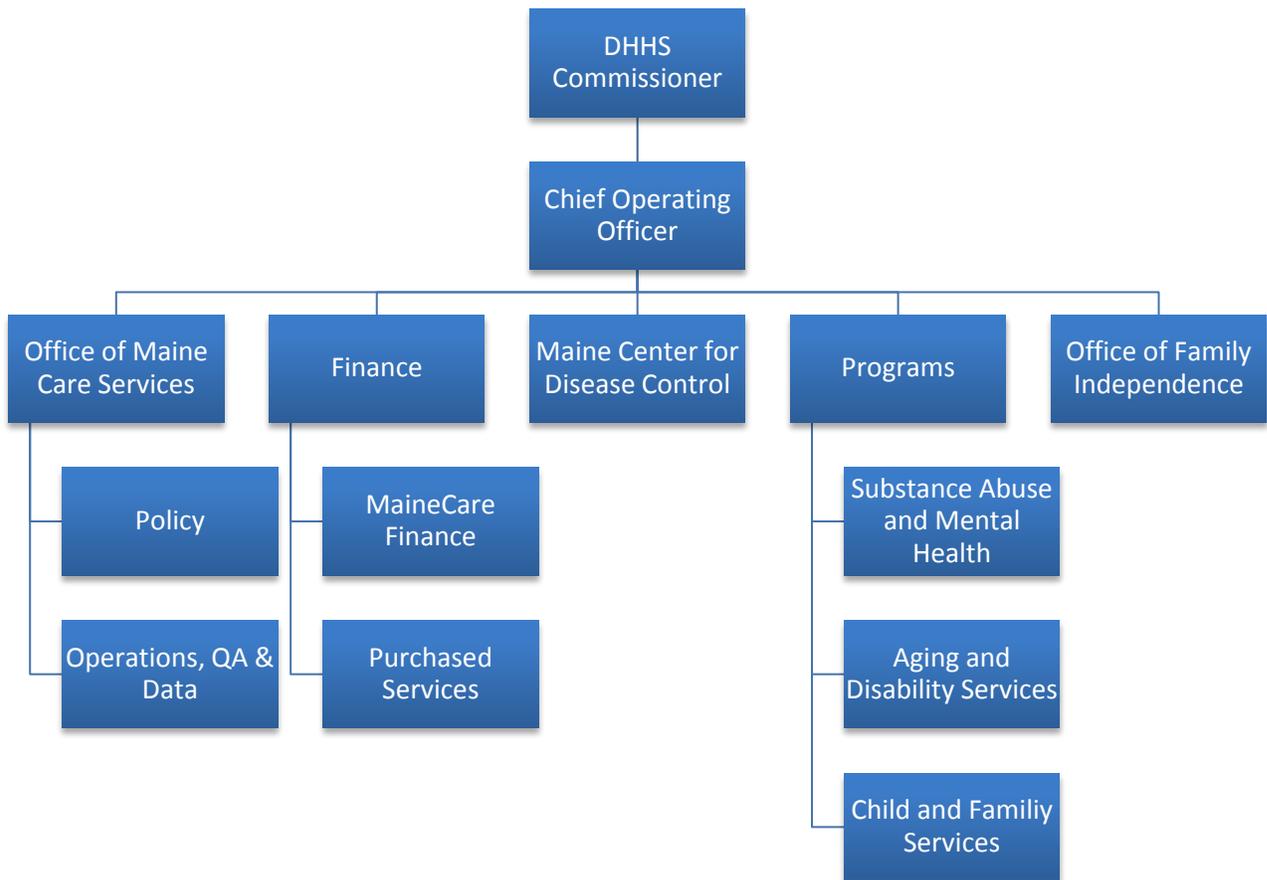
FINANCIAL MANAGEMENT SERVICES

Financial management, accounting and reporting for the MFP Demonstration will be completed through MaineCare Finance, which is under the direction of the Deputy Commissioner for Finance.

FORMAL LINKAGES

Because all of the administrative functions for the MFP Demonstration are housed within DHHS, Maine's single state Medicaid agency, there is no need for a memorandum of understanding documenting these relationships.

FIGURE 1: PRIMARY ROLES IN MFP DEMONSTRATION ADMINISTRATIVE STRUCTURE



BENCHMARKS

Each year of the demonstration, the Department will report on its progress in transitioning people from institutions and rebalancing Maine’s long term services and supports system according to the following benchmarks.

Benchmark #1 NUMBER OF PERSONS TRANSITIONED

Maine projects the following number of transitions during the demonstration period of 2012 to 2016. We hope to find that these projections are conservative and that we can transition a greater number of people than we have identified here. Our estimates are based on the current configuration of Medicaid-covered services and nursing facility admission policy and have been updated to incorporate implementation of the Other Related Conditions Waiver in May, 2013. It’s possible that our estimates will change depending on the outcome of certain budget proposals currently before Maine’s Legislature and on-going discussions relating to potential changes in Maine’s long term care delivery system.

Number of Transitions by CMS-Defined Target Group						
Calendar Year	Older Adults	Physically Disabled	Intellectual Disability (MR-DD)	Serious Mental Illness	Dual Diagnosis or “Other”	Yearly and Grant Total
2011	0	0	0	0	0	0
2012 Actual	0	1	0	0	0	1
2013 Actual	4	7	0	0	4	15
2014	4	13	0	0	10	27
2015	4	12	0	0	10	26
2016	4	12	0	0	10	26
TOTAL	16	45	0	0	34	95

Benchmark #2 MEDICAID EXPENDITURES FOR HCBS

Increase in Qualified HCBS expenditures for each year of the demonstration

Maine assumes flat funding for waiver services through the grant period, with the exception of increases related to implementation of the ORC waiver. All other increases in expenditures will be due to transition of MFP participants to waiver services after one year on the MFP program. The 1915c waiver expenditure increase is based on qualified HCBS costs being added for MFP participants moving to the Elder and Adults with Disabilities and ORC Waivers each year.

This table is completed using an estimated annual projection according to the budget. It does not show cumulative representation of total expenditures. There is some fluctuation from year to year related to a change in the number of people projected to transition each year. Additionally, the amount of MFP expenditures decreases in the final year CY2016 due to the funding year ending 3/31/16.

Calendar Year	1915c Waivers	State Plan HCBS (Personal Care & Home Health)	MFP (Qualified, Demo & Supplemental)	Total	Annual Percentage Increase
HCY 2009 (Baseline)	\$337,950,303	\$52,692,783	\$0	\$390,643,086	0%
2011	\$312,800,016	\$72,078,088	\$0	\$384,878,104	0%
2012	\$356,673,271	\$75,897,326	\$1,716,300	\$434,286,897	12.84%
2013	\$365,077,660	\$90,201,748	\$1,199,411	\$456,478,819	5.11%
2014	\$375,252,409	\$85,541,023	\$3,271,189	\$464,064,621	1.66%
2015	\$387,893,435	\$88,107,254	\$3,166,422	\$479,167,111	3.25%
2016	\$400,801,248	\$90,750,471	\$1,231,818	\$492,783,537	2.84%

Benchmark # 3 Self Direction

An increasing percentage of MFP participants self-direct their personal support services

Measure: (1) Number of MFP participants each calendar year that self-direct their personal support services divided by (2) number of MFP participants each calendar year

	CY2013	CY2014	CY2015	CY2016
MFP Participants	15	27	26	26
Benchmark Target	10%	25%	30%	35%
Calculated MFP Participant Target	2	7	8	9

Benchmark # 4 Referrals

Referrals are received at a rate which supports achievement of annual transition benchmarks

Measure: Realize a transition to referral efficiency of 59.5%

	CY2013	CY2014	CY2015	CY2016
# of outreach contacts with potential MFP participants (MDS Q or other sources)	n/a	75	75	75
# of referrals to MFP	37	46	44	44
# of Transitions (Benchmark)	15 (Actual)	27	26	26

Transition to referral efficiency in baseline year (2013) is 59.5%

Benchmark # 5 Quality of Life

At least 75% of MFP participants indicated that those who receive help are treated by their helpers the way they want them to during the 11 month MFP Quality of Life (QoL) Survey

Measure: (1) Number of MFP participants who indicated Yes on QoL Question during the 11 month survey divided by (2) the number of individuals that answered Yes plus the number of individuals that answered No.

MFP Participants	Transition Year CY13 (CY14 QoL)	Transition Year CY14 (CY15 QoL)	Transition Year CY15 (CY16 QoL)	Transition Year CY16 (CY17 QoL)
MFP QoL 11-month	15	27	26	26
Benchmark Target	75%	75%	75%	75%
Calculated MFP Participant Target	11	20	20	20

REBALANCING AND BUILDING HOME AND COMMUNITY-BASED CAPACITY

With one full year of experience with program implementation, we have re-evaluated our initial proposed use of rebalancing funds and are currently engaged in a process with stakeholders to identify *priority uses* of the rebalancing fund, targeting the areas of Housing, Assistive Technology and Home Care, with our initial use being to expand our Housing Specialist Contract as detailed below:

EXPANDED HOUSING SPECIALIST CONTRACT

With Housing being a primary need, we will use rebalancing funds is to support expansion of the MFP Housing Specialist from a .5 FTE to a 1 FTE, with MFP administrative funds supporting \$50,000 of the contract and rebalancing dollars supporting \$30,000, for a total annual cost of \$80,000

Maine has very similar experience as other states who are participating in the MFP Demonstration with the most significant challenge in returning people back to the community being a lack of accessible/affordable housing. Thus far in Maine we have had less than a full time person working on this very challenging issue and if we are to achieve long term, sustainable solutions, it has become increasingly clear that we must devote more time to our efforts.

Increasing capacity of the Housing Specialist will allow for us to address several key issues. It will increase the availability of individual assistance, to include the ability to serve persons that may not qualify for Homeward Bound/MFP services and most importantly, will support an ability to fully examine our current housing system and develop long term strategies to address the shortage of accessible and affordable housing.

Maine will expand its reach on housing by partnering with the Maine Statewide Independent Living Council (SILC). State Independent Living Councils were established by Title VII of The Rehabilitation Act of 1973, As Amended. Each state has a SILC that is appointed by the Governor of its respective state. The Council is comprised of a majority of people with a disability and includes representatives from state agencies, service providers and advocates. The SILC in collaboration with the Designated State Unit establishes a State Plan for Independent Living (SPIL) every three years. The Maine SPIL for 2014-2016 includes goals related to Transportation, Housing, Emergency planning and preparedness, Economic Self- Sufficiency and Assistive Technology.

The goals of housing, community-based living and assistive technology directly address the overall purpose of Money Follows the Person (Homeward Bound) program. Maine SILC has established a work group focused on the goal of housing that includes Maine SILC members, Maine State Housing, Maine HUD, an architect employed by the CIL, consumers, and others. Maine SILC is also in the process of establishing work groups for Community-based Living and Assistive Technology.

Together Maine's Homeward Bound Housing Specialist and the Maine SILC will extend their mutual reach through collaboration and cooperation. They will be able to promote the availability of affordable, barrier-free housing statewide by raising the issue to higher visibility with public policy makers, advocates and the general public. In addition they will explore best practices already in use in other states and work to implement these practices in Maine.

Monitoring

Goal: Expanded access to affordable, physically accessible housing.

Tracking and Reporting: Progress will be tracked by the Housing Specialist and monitored through quarterly reports submitted to Homeward Bound Program Director, as per contract requirements and through Maine's Statewide Independent Living Council as per their federal reporting requirements.

Sustainability

This partnership with the Maine SILC offers a sound way for sustaining this work. The Maine SILC is a 501 (C)(3), non-profit organization that will continue its mission focus on the independent living goals and aspirations of Maine citizens with a disability after MFP has ended. As such, Maine MFP/Homeward Bound and Maine SILC will benefit from this collaboration. More importantly, Maine people with disabilities will have greater housing options available to them as a result.

PARTICIPANT RECRUITMENT AND ENROLLMENT

TARGET POPULATIONS

Maine will target three population groups:

- Persons age 65 and older whose primary needs are medical or functional.
- Persons over age 18 and under age 65 whose primary needs are medical or functional.
- Persons age 18 and older who have significant physical disabilities or a complex combination of behavioral, cognitive, medical and functional needs

Qualified Individuals:

- At the time of transition, have resided in a nursing facility or hospital (in-state or out-of-state) for a minimum of 90 days, excluding any short-term rehabilitative stay.
- At the time of transition, have received Medicaid benefits for inpatient institutional services for at least one day.
- At the time of transition, are eligible for MaineCare-funded services necessary to meet identified needs.
- Would require institutional or nursing facility level of care, but for the provision of home and community-based services.

TRANSITION STAFF

Maine's Transition Staff includes a Transition Manager, Referral Managers and Transition Coordinators who are qualified Medicaid providers. The Referral Manager has primary responsibility for the preliminary stages of recruiting and enrolling demonstration participants. The Transition Manager has responsibility for overseeing the implementation of the transition process, including the activities of the Transition Coordinators. Referral and Transition Management is arranged for through contract with Maine's Long Term Care Ombudsman's Program. The Transition Coordinators will provide Transition Assistance, including the development and implementation of the Individualized Transition Plan, and may also be qualified to provide community coordination for the post-transition period, when appropriate.

ROLES AND RESPONSIBILITIES OF THE REFERRAL MANAGER

- Receive referrals of potential demonstration participants from a variety of referral sources.
- Provide information and educational resources to potential demonstration participants, family members, and other interested parties.
- Ensure the informed choice and consent of all potential and enrolled demonstration participants.
- Conduct the Preliminary Assessment Process according to the MFP Operational Protocol. Refer the participant to the appropriate type of Transition Coordinator given the participant's needs.

ROLES AND RESPONSIBILITIES OF THE TRANSITION MANAGER

- The Transition Manager will: Determine and document program eligibility based on application and supporting documentation.
- Monitor the Transition Planning Process according to the MFP Operational Protocol; hold the Transition Coordinator and the Transition Team accountable for development and implementation of the Individualized Transition Plan.
- Arrange for the *Quality of Life* (QoL) survey to be completed 30 days to two weeks prior to discharge and arrange for the surveyor to conduct the QoL Survey at 11 and 24 months post community placement.
- Conduct post-transition activities to monitor the success of each transition
- Oversee quality management functions related to reviewing and monitoring transition process reports, transition plans, health and welfare reports and areas of unmet need.
- Oversee individual remediation of unmet needs that arise and ensure appropriate response to complaints about back-up services

ROLES AND RESPONSIBILITIES OF THE TRANSITION COORDINATOR

The Transition Coordinator may be:

- A registered nurse licensed to practice nursing in the State of Maine.
- An occupational therapist who is licensed to practice occupational therapy in the State of Maine.
- A licensed social worker who is licensed to practice social work in the State of Maine.
- A person certified by DHHS as a Mental Health Rehabilitation Technician/ Community (MHRT/C).

In addition to the training already required of Community Coordinators for professional licensing and certification or employment and as qualified MaineCare providers, Transition Coordinators will receive supplemental training prior to providing Transition Assistance to participants. The supplemental training program will focus on the policy and procedures and roles and responsibilities that are unique to the Homeward Bound program including:

- Overview of Homeward Bound program
- Roles and responsibilities of the participant, the participant's guardian, agent or surrogate, the MFP Demonstration Director/the MFP Transition Manager, Referral/Advocacy, the multi-disciplinary team, the Transition Coordinator, the Housing Consultant, and the Community Coordinator.
- Rights and responsibilities of participants.
- Homeward Bound eligibility criteria.
- Homeward Bound services
- MFP enrollment, assessment, transition planning and transition procedures
- MFP informed consent procedures.
- The elements of the Individualized Transition Plan and guidance on how to meet participant's needs identified in the plan.

The Transition Coordinator will:

- Assemble a multi-disciplinary team to provide transition planning consultation services.
- Develop and implement the Individualized Transition Plan, with the guidance of the participant and in collaboration with the Transition Team.
- Ensure a seamless transition from institutional to community services.
- Ensure a seamless transition from MFP funded services to non-MFP funded services at day 366.
- Reinforce the role of the guardian, agent or surrogate in Transition Planning and the Transition Processes.
- Attend mandatory MFP training for transition coordinators
- Conduct risk assessment and risk mitigation for demonstration participants.
- Aggressively address issues that may lead to hospitalization/re-institutionalization to prevent recurrence.

- Maintain records on all MFP participants.
- Report changes in the participant’s status to the Transition Manager.
- Submit reports and completed documentation as requested by MFP project staff.
- Facilitate on-going communication with Community Coordinators.

PARTICIPANT IDENTIFICATION

Potential demonstration participants will be identified through a variety of mechanisms:

OUTREACH, REFERRALS AND SELF-REFERRALS

Maine’s Long Term Care Ombudsman, contracted to serve as Outreach Provider and Referral Manager will be responsible for conducting outreach, initial eligibility screening and completion of the HOMEWARD BOUND APPLICATION FORM. Referrals are expected from institutional and community providers. Family members and residents may also self-refer. Potential participants may also be identified by AMHS Field Nurses and the OADS Long Term Care Behavioral Management Consultant, who works with nursing facility and hospital staff to address the needs of persons with behavioral health needs. The Transition Manager will maintain contact with the DHHS Complex Case Team to identify persons in hospitals and in out-of-state placements who may be eligible to participate in the MFP Demonstration.

MEDICAL ELIGIBILITY DETERMINATION ASSESSMENT UPON ADMISSION

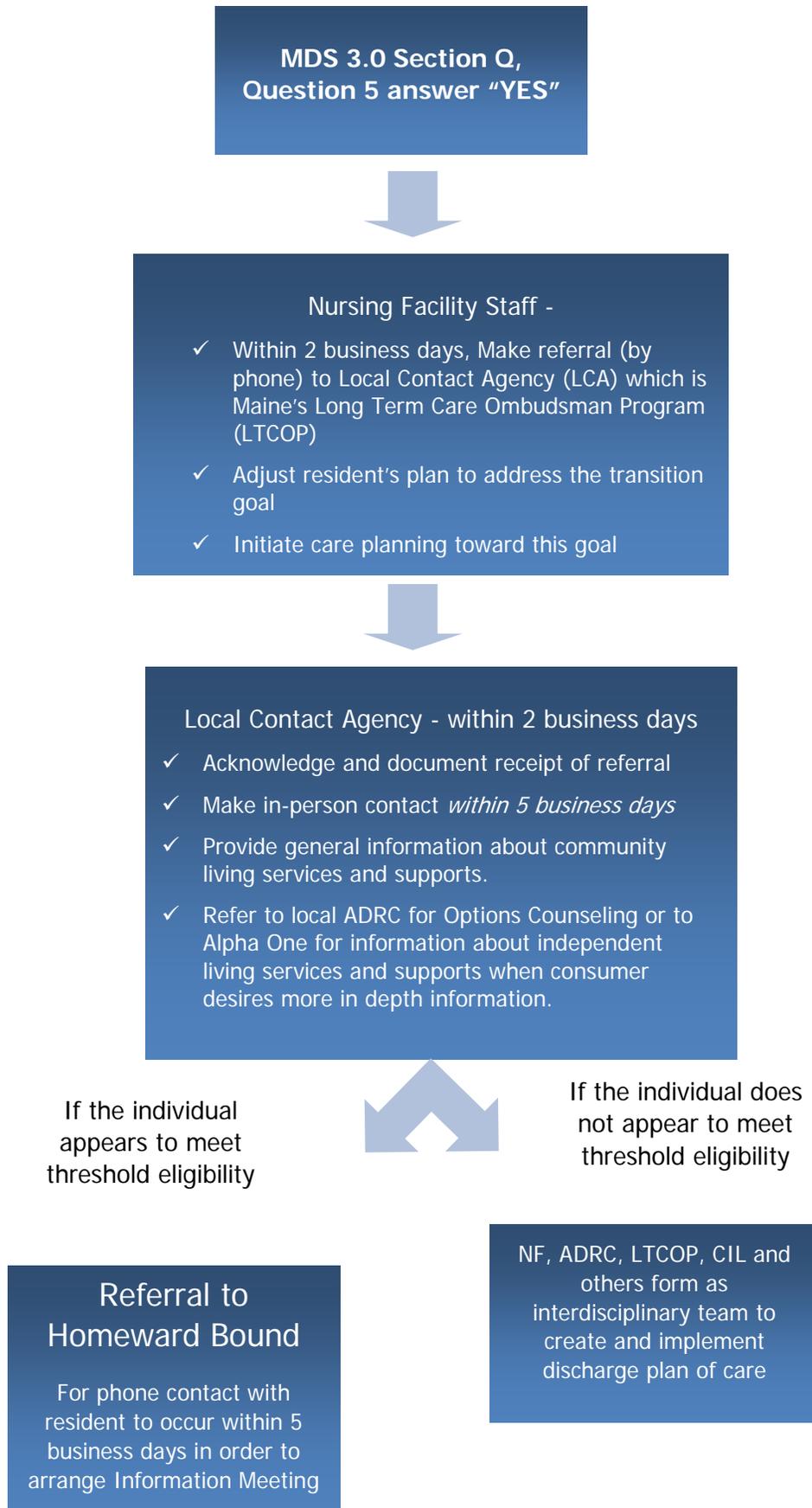
Maine law requires that all persons are assessed for medical eligibility for the nursing facility level of care prior to admission to a nursing facility. The Department will work with the assessing service agency who conducts this assessment to develop a referral protocol and a factsheet that may be shared with the individual and family at the time of this assessment. For persons identified as likely to return to the community after 90 days of non-skilled nursing facility care, the Transition Manager will initiate contact to provide information and resources about home and community options and strategies for maintaining a person’s home while in the nursing facility.

MINIMUM DATA SET ASSESSMENT

Maine has designated the Long Term Care Ombudsman Program (LTCOP) as the Local Contact Agency (LCA). When a resident indicates a preference for living in the community, the Nursing Facility will follow the Section Q Protocol detailed in FIGURE 3, page 28. The role of LTCOP as the LCA is to make in person contact and provide general information about community living services and supports upon receipt of the referral. LTCOP will in turn make referrals to the Center for Independent Living (Alpha One) and or the local ADRC as per individual needs. For individuals who appear to meet threshold eligibility (the individual is currently or likely to become eligible for Medicaid, and the individual is currently or likely to meet the 90-day residency requirement), a referral will be initiated for HOMEWARD BOUND.

Supported by ADRC supplemental funds, Maine’s Long Term Care Ombudsman Program will work in partnership with the Office of Aging and Disability Services, the ADRCs and Alpha One to support full implementation of the MDS Section Q protocol to include development of a tracking system in order to monitor compliance and address challenges.

FIGURE 3: MDS 3.0 SECTION Q PROTOCOL



ACCESS TO RESIDENTS AND PATIENTS IN NURSING FACILITIES AND HOSPITALS

The Department will conduct an education and outreach campaign targeting nursing facilities, working with their provider association and the Maine Long Term Care Ombudsman to deliver the message. This training will provide information about the MFP Demonstration and its processes as well as introduce the revisions to the Section Q referral protocols incorporating referrals to Homeward Bound.

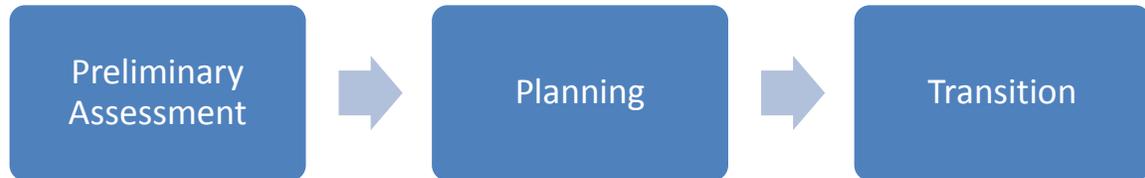
Persons whose activities involve contacting participants or potential participants in nursing facilities will, if needed, have access to a PROVIDER LETTER describing the MFP Demonstration, their roles and responsibilities, the fact that they are agents of the Department, and have the authority to meet with residents to determine their interest in MFP.

THE ENROLLMENT AND TRANSITION PROCESS

The enrollment process will take place in three stages:

- Participation in the Preliminary Assessment Process
- Enrollment into the Transition Planning Process
- Enrollment into the Transition Process

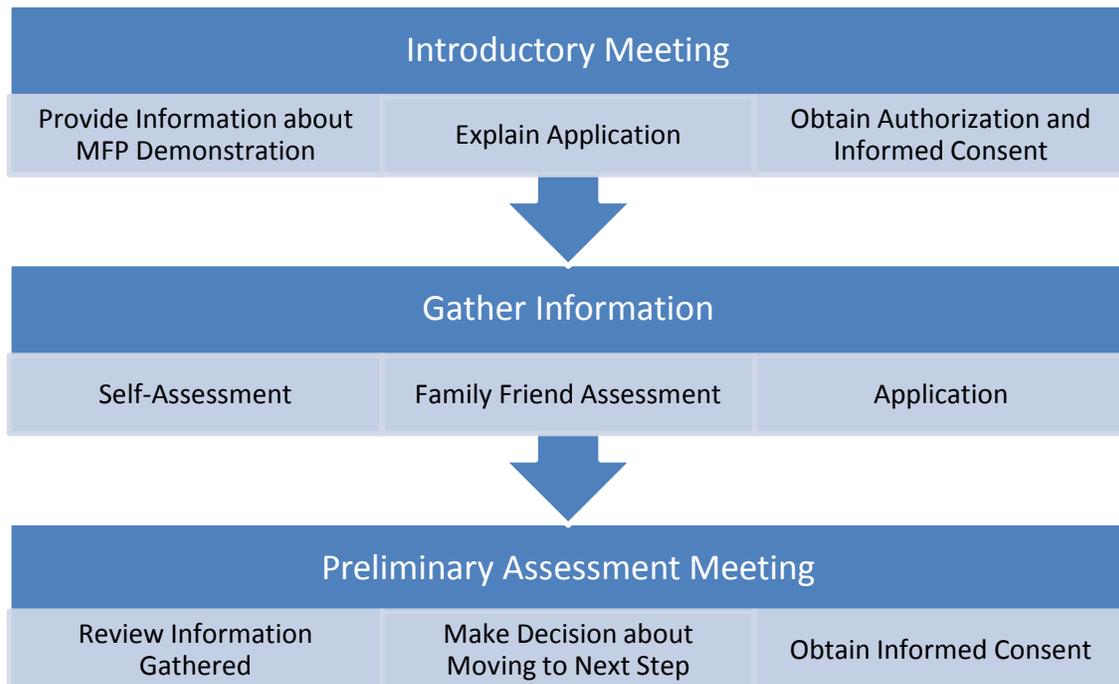
FIGURE 2: THE THREE PHASES OF ENROLLMENT AND TRANSITION



THE PRELIMINARY ASSESSMENT PROCESS

Upon referral the Referral Manager initiates the Preliminary Assessment Process. The purpose of the Preliminary Assessment process is to capture information about the potential Homeward Bound participant. The information collected will help determine if the individual is a likely candidate for Homeward Bound and, if so, what type of Transition Coordinator is needed. This information will also help the Transition Coordinator build an Individualized Transition Plan.

FIGURE 3: THE PRELIMINARY ASSESSMENT PROCESS



The Preliminary Assessment Process will follow the following protocol.

INTRODUCTORY MEETING

The Referral Manager initiates enrollment in the Preliminary Assessment Process by conducting an introductory meeting with the potential MFP participant, the individual's guardian, agent, or surrogate if applicable, and any support person selected by the individual. During this meeting the Referral Manager will:

- Provide information and answer questions about the MFP Demonstration, home and community-based services, transition services and residential options available through the demonstration.
- Explain the MFP eligibility criteria.
- Explain the three stages of the transition process and the decision points for moving through the three stages.
- Explain the Preliminary Assessment Process, including the elements of the APPLICATION, the Self-Assessment tool, and the criteria and process for planning a successful transition.
- If the resident is choosing to participate in the PRELIMINARY ASSESSMENT phase, provide a copy of the Participant Manual with related forms and tools.
- Work with the potential participant to complete the Homeward Bound APPLICATION WHICH includes submission of supporting documentation from the Nursing Home to Transition Manager for eligibility determination.
- Use the SELF-ASSESSMENT tool as a guide to begin gathering preliminary information about the individual, including preferences and needs, anticipated barriers to transition, and the presence of a guardian.
- Develop a plan for completing the Self-Assessment, where assistance is required.
- Develop a plan for completing the FAMILY/FRIEND SELF-ASSESSMENT as applicable.
- Obtain the resident's authorization to access information about the resident in order to complete the APPLICATION.
- Plan for the next meeting, identifying people the resident would like to participate in that meeting.

The Referral Manager will obtain the resident's acknowledgement of the information provided and document the resident's decision to participate in the Preliminary Assessment Process, whether yes or no. If yes, the Referral Manager will obtain the resident's signature (and that of the resident's Legally Authorized Representative, if applicable) on INFORMED CONSENT #1: ENROLLMENT IN THE PRELIMINARY ASSESSMENT PROCESS. The consent form explains that this phase is exploratory and focused on gathering information before determining whether moving to the next stage is appropriate.

THE RESIDENT'S SELF-ASSESSMENT

Beginning with the Self-Assessment process, the participant will be an active participant in shaping his or her life in the community. During the initial meeting, the Referral Manager will provide the resident with a tool for assessing his or her own readiness to return to the community. This self-assessment process will be designed to optimize the resident's control over the transition process and help the resident to identify his or her preferred outcome. The self-assessment will prompt the individual to consider the kinds of community services and supports he or she needs, housing needs and preferences, financial resources, transportation needs, educational and vocational goals, community interests including social, religious, and recreational interests. The self-assessment will also invite the resident to identify hopes and fears relating to the transition

FAMILY/FRIEND SELF-ASSESSMENT

If the potential participant believes that a particular family member, friend or other natural support person is available to help once he or she is out in the community, it will be important to gather some information about that person. The FAMILY/FRIEND SELF-ASSESSMENT asks the potential caregiver about the type and level of support he or she is willing and able to provide in order to assess the strength of this person's available supports.

Application/Eligibility Determination

The Application and Eligibility Determination comprises a review of the individual's:

- Strengths, assets, resources, and natural supports
- Clinical and support needs, including those identified in the most recent MDS, MED, and PASRR, as relevant and the individuals' current service plan
- Other needs including housing and financial needs
- Likely financial eligibility for home and community-based Medicaid services.

The Referral Manager will arrange for submission of the Application and supporting documents to be provided to the Transition Manager for the eligibility determination.

When indicated, the Transition Manager will arrange for an AMHS Field Nurse to conduct an Adult Needs and Strengths Assessment (ANSA) to gauge the complexity and level of need. The Transition Manager will also consult internal DHHS clinical expertise and a qualified Transition Coordination provider as necessary during this process. Preliminary Assessment "Round-Up" meeting. Upon completion of the Application, Self-Assessment and Family/Friend Self-Assessment, the Referral Manager meets with the resident (and the resident's Legally Authorized Representative, when relevant) and any natural or peer support person selected by the resident, to review and discuss the information that has been gathered. The Referral Manager may also include the selected Transition Coordinator in this meeting.

The meeting focuses on whether or not moving to the Transition Planning Process is an appropriate option and the resident's choice. During the Preliminary Assessment Meeting, the Referral Manager will also discuss the range of services and housing options and which are most likely to be available to him or her.

Together the group will determine whether or not the individual is appropriate to move to the Transition Planning phase. Factors to be considered include whether the individual:

- Is or is likely to be eligible for the MFP Demonstration (*i.e.*, is or is likely to be a Qualified Individual, moving from a Qualified Institution with plans to move to a Qualified Residence).
- Has service needs that can be met through the MFP Demonstration.
- Wishes to enroll in the demonstration.

Depending on the Referral and Transition Manager's assessments and the resident's preference, three possible outcomes are anticipated:

THE RESIDENT CHOOSES NOT TO ENROLL IN MFP TRANSITION PLANNING

If the resident chooses not to enroll in the MFP Transition Planning phase, the Referral Manager documents the resident's choice. The resident signs an acknowledgement that he or she had the opportunity to consider his or her options and has chosen to remain in the institutional setting or transition to something other than a Qualified Residence. The Referral Manager provides the individual with appropriate referrals, in the event the individual would like to transition but not through the MFP Demonstration. A copy of the acknowledgement form is given to the resident and the nursing facility.

THE RESIDENT ENROLLS IN THE MFP TRANSITION PLANNING PROCESS

If the Referral Manager and the resident both agree that transition to the community is an appropriate and realistic option for the individual, and the individual meets the eligibility criteria for moving to the Transition Planning phase, the Referral Manager provides the resident with the Participant Handbook and explains the Transition Planning Process. Part of this explanation includes a disclosure that enrollment in the Transition

Planning Process is not a guarantee that the individual will transition under the MFP Demonstration and the conditions under which the transition may or may not occur.

Following this exchange of information, the Transition Manager will request the resident's acknowledgement (or that of a Legally Authorized Representative) of the information received and the individual's consent to participate in the Transition Planning Process. The resident's signed consent constitutes enrollment into the Homeward Bound Transition Planning.

THE TRANSITION MANAGER DETERMINES RESIDENT DOES NOT MEET CRITERIA

If it is determined that the resident does not meet the criteria for moving forward with the Homeward Bound program (e.g., the resident is unlikely to be financially eligible for Medicaid-funded home and community-based services or the member would like to transition to a residence other than a Qualified Residence), the Referral Manager explains the reason for this determination and informs the resident of other options and makes appropriate referrals. The Referral Manager provides a letter from the Transition Manager explaining the reason for his or her determination, with an explanation of the resident's right to request reconsideration of that decision.

If the resident requests reconsideration the Transition Manager will assemble the DHHS Complex Case Team to review the information that's been gathered through the Preliminary Assessment process. The Complex Case Team will confirm or overrule the Transition Manager's decision.

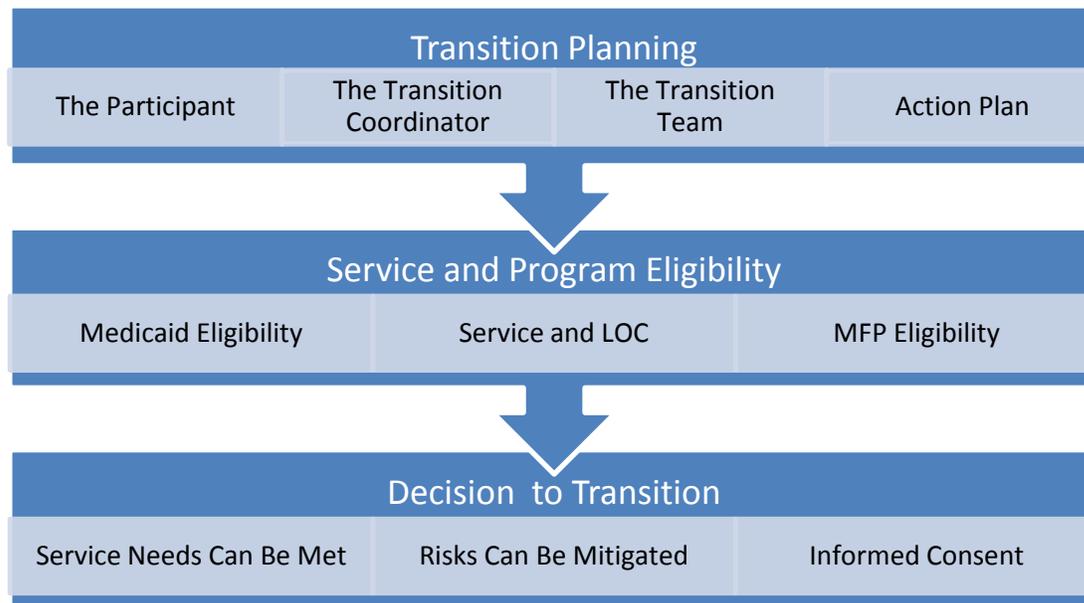
If the DHHS Complex Case Team confirms the Transition Manager's decision, the Transition Manager will provide the resident with an explanation of rights, including the right to appeal this decision.¹

If the DHHS Complex Case Team overrules the Transition Manager's decision, the Transition Manager will enroll the resident into the Transition Planning phase, as described below.

¹ Appeals under this demonstration will be governed by applicable appeal mechanisms for the MaineCare program, with the ultimate authority for final decisions resting with the DHHS Commissioner.

THE TRANSITION PLANNING PROCESS

The Transition Planning Process will build on the information gathered in the Preliminary Assessment phase.



Transition Planning will involve the following elements.

FIGURE 4: THE TRANSITION PLANNING PROCESS

THE PARTICIPANT

A successful transition plan cannot be developed without putting the participant at the center of the planning process, ensuring that the plan is designed around the individual's needs and preferences. The Transition Coordinator will be responsible for finding the best strategy for giving the participant as strong a role as possible in mapping out the goals he or she wants to address in the Individualized Transition Plan (ITP) and their thoughts on how these goals can best be met. When there are choices to be made, the Transition Coordinator (or the Housing Consultant, in the case of selecting a Qualified Residence) will be responsible for making sure the participant has an opportunity to express a preference and has enough information to make an informed choice. When the participant has a Legally Authorized Representative or other surrogate, this person should also be actively engaged in the planning process. At a minimum, the Transition Coordinator will keep in close communication with the Legally Authorized Representative to make sure they know what the decision points are and what decisions are being made.

ADVOCACY

Maine's Long Term Care Ombudsman program will offer Advocacy services to all Homeward Bound participants, and will be present transition team and other planning meetings as desired and determined by the participant.

THE TRANSITION COORDINATOR

The Transition Coordinator will be responsible for the overall quality of the transition plan, making sure that the right people come together on the participant's team, documenting the plan and planning process, making sure team members fulfill their responsibilities and making sure that all is done consistent with the guidance and

direction of the participant. The Transition Coordinator will ensure that the Plan includes key elements to prevent re-hospitalization or return to a nursing home and a continuity plan for when Homeward Bound services end.

THE TRANSITION TEAM

The Transition Coordinator will convene and facilitate a Transition Team. The transition team will comprise the demonstration participant, support persons of the individual's choosing, the Housing Consultant as necessary, the individual's guardian, agent, or surrogate, as applicable, a multi-disciplinary team (MDT) of professionals with the expertise required to develop and implement a successful transition plan; and the Transition Coordinator. When the individual is a person with complex needs, members of the DHHS Complex Case Team will serve on the team if needed.

THE TRANSITION MANAGER

The Transition Manager holds the Transition Coordinator and team members accountable and makes sure the Team keeps to timelines. The Transition Manager will approve the Individualized Transition Plan and authorize services under the plan.

THE INDIVIDUALIZED TRANSITION PLAN

Based on preliminary assessments, the Transition Team will begin to develop an Individualized Transition Plan (ITP) that will:

- Identify the participant's goals and desired outcomes
- Identify the type and frequency of services and support necessary to meet the participant's goals, through a combination of MFP services, MaineCare services, and state-funded and community resources, and informal supports
- Identify risks and describe the plan for managing risks
- Describe the emergency back-up plan
- Describe the monitoring process for plan implementation and the post-transition period
- Describe the justification or rationale for the recommended services and document the participant's acceptance of these recommendations.
- Document the transition plan assignment, follow-up plans and required transition team signatures
- Address and anticipate the termination of MFP funding at the 365-day mark to ensure the individual has sufficient services and resources to remain in the community.
- Include timeframes for each objective in the plan, and identify those individuals who are responsible for implementation and follow-up.

Based on the individual's goals, preferences, needs and barriers to transition, the Team will identify service needs, and related action items. The Transition Coordinator will ensure that responsibility for each action item is assigned and the Team will develop a timeline for completing assigned action items.

DEVELOPING THE ITP

The action items for developing the Individualized Transition Plan are likely to cover these items to be addressed in the ITP, according to individual need and preferences and within available resources:

Educational and Vocational Goals. When the individual has identified educational or vocational goals, the ITP will identify available resources and supports to achieve those goals.

Social and Community Engagement. In response to the individual's preferences, the ITP will identify resources and supports needed to promote the individual's engagement in social and community activities, and other strategies for preventing isolation, etc.

Health and Nutrition. The ITP will address the individual's health maintenance needs, including exercise and access to preventive care. As appropriate, the ITP will address nutritional planning.

Transportation. The ITP will include a plan for accessing transportation, building on informal and public transportation resources whenever possible.

Expenses. The ITP will include a plan for how the individual will meet expenses associated with the transition to a community setting, but not limited to rent, utilities, food, transportation, medicine, and recreation. When necessary, the plan will address financial management.

Housing. The ITP will identify a Qualified Residence, and include a plan for making sure the residence addresses the individual's needs and preferences, is ready at the time of transition, the participant has a role in its selection. In the Self-Assessment, the participant will be asked where he or she would like to live and the Individualized Transition Plan will be shaped around collaboratively meeting and addressing the participant's goals. The Housing Specialist will be responsible for working directly with each demonstration participant to identify housing preferences and select among available housing options.

Equipment, Supplies and Modifications. The ITP will identify any special equipment or supplies necessary for the transition, including assistive technology or home modifications as necessary.

Services and Supports. The ITP will identify skilled, specialized, and direct support services needed to support the individual in the community setting. The Transition Coordinator will fully explore the possibility of self-direction with program participants and provide the appropriate support for those interested in pursuing this option. For those who choose to receive services under the more traditional agency model, discussion regarding staffing preferences will be a part of the transition process.

Risk Assessment and Mitigation. The RISK IDENTIFICATION TOOL will be used during the planning process to identify potential risk. Based on the risks identified, a RISK MITIGATION PLAN will be developed as part of the ITP.

Continuity of Care. The ITP will also include a viable plan for the continuity of care following completion of the 365-day Homeward Bound demonstration period. Although circumstances may change following transition, the Transition Team will ensure that a viable plan for continuity of care is in place prior to transition.

DETERMINE PROGRAM AND SERVICE ELIGIBILITY

Part of the Transition Planning Process will include applying for services. The Transition Coordinator and the Housing Consultant, as appropriate, will help the participant prepare applications for services or make appropriate referrals. The Transition Coordinator ensures that the individual meets financial and functional or clinical eligibility for services and arranges for the Level of Care Determination for persons transitioning to the waiver.

DETERMINE MONEY FOLLOWS THE PERSON ELIGIBILITY

Prior to transition, the Transition Manager will confirm the individual's eligibility for the MFP Demonstration. In particular, the Transition Manager confirms that:

- Based on nursing facility records, the individual has resided in the nursing facility or hospital for at least 90 days, excluding any short-term rehabilitative Medicare stay.
- Based on nursing facility records, the participant has been eligible for MaineCare at least one day prior to transition.
- Based on a determination by the Housing Consultant, the individual will be moving into a Qualified Residence.
- Based on a determination by DHHS, the individual meets financial and medical eligibility for home and community-based waiver or state plan services.

If the individual is not eligible for Homeward Bound, the Transition Manager informs the resident of other options and makes appropriate referrals. The Transition Manager issues a letter explaining the reason for the determination, with an explanation of the resident's right to appeal the eligibility determination.

DECIDE TO MOVE FORWARD WITH THE TRANSITION

For persons determined eligible to participate in the MFP Demonstration, the final decision to move forward with the transition will be made by the Transition Team, consistent with the Department's obligation to prevent occurrences of abuse, neglect and exploitation. This determination will consider whether or not:

Service Needs Can Be Met. The individual is eligible for needed services, the needed services and supports are available under the MFP Demonstration to meet identified needs, and qualified providers are available to meet the participant's service needs. The Transition Coordinator will document when no community providers are available or able to provide services to meet the participant's service needs.

Risks Can Be Effectively Mitigated. The identified risks associated with the transition to the community can be effectively mitigated according to the Risk Mitigation Plan.

The ITP is Approved. The Transition Manager has approved the ITP. The Transition Manager will access appropriate expertise within DHHS as necessary to ensure that the plan is sound (e.g., the Transition Manager may choose to consult with OADS' long term care nurse manager to ensure a plan to provide skilled nursing services is adequate), that the services are appropriate and necessary for the success of the transition to the community, and that the plan for risk mitigation is adequate. When the Transition Manager does not approve the ITP, she will document the reasons for disapproval and identify the necessary conditions for her approval, consistent with the Department's obligation to prevent abuse, neglect and exploitation.

The Participant Accepts Transition Plan/Wishes to Enroll. The individual, or the individual's guardian, agent or surrogate, agrees to the terms of the Transition Plan, understands the risks associated with the transition, and wishes to move forward with the Transition.

The Team may choose to defer a final decision until all of these conditions can be met. When the Team concludes these conditions cannot be met, the Transition Manager issues a written explanation documenting the reason for this decision, with an explanation of the individual's right to appeal the Team's decision.

DECIDE TO ENROLL AND OBTAIN INFORMED CONSENT

The individual's decision to move forward, or not move forward with the transition is documented. If the individual chooses to enroll into the Transition phase, the individual acknowledges that he or she understands the terms of the Transition Plan and the risks associated with transition and consents to the Transition by signing INFORMED CONSENT #3: ENROLLMENT IN THE TRANSITION PROCESS. The participant also signs a CHOICE LETTER reflecting the individual's choice of home and community-based services over institutional services.

DOCUMENTATION RESULTING FROM THE TRANSITION PLANNING PROCESS

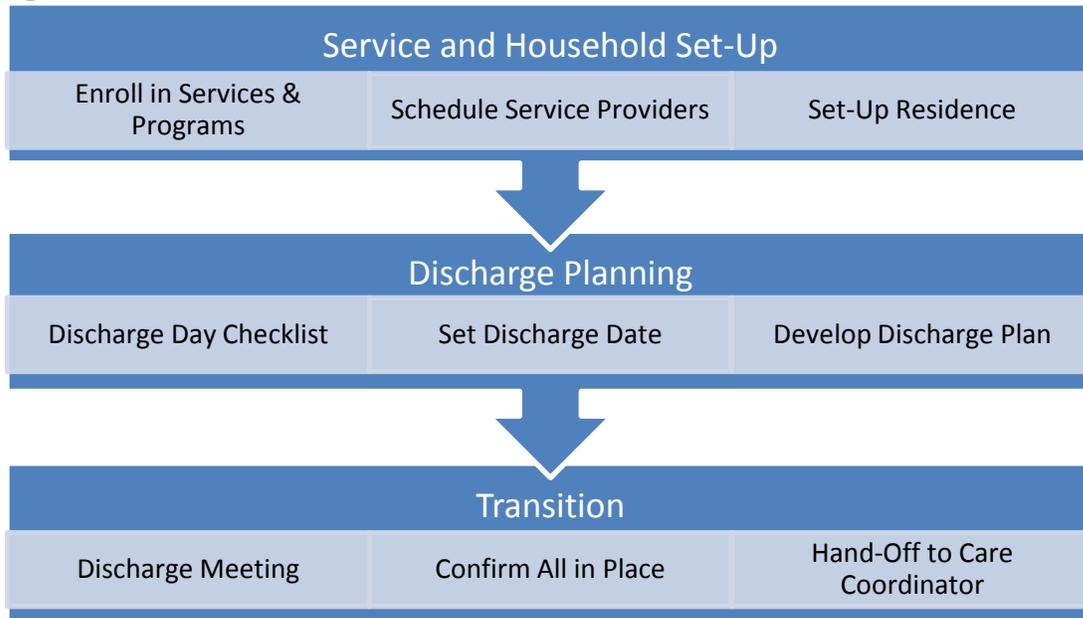
The following documents will be completed and collected during the Transition Planning Process:

- Individualized Transition Plan
- Risk Identification Tool
- Risk Mitigation Plan
- Emergency Back-Up Plan
- Informed Consent #3: Enrollment in the Transition Process
- Informed Choice Letter

THE TRANSITION PROCESS

When the decision to transition has been made, the Transition Coordinator will work with the participant to implement the Individualized Transition Plan. This may involve enrolling in programs, arranging and scheduling services and supports, and setting up the household. The Transition process also involves carefully planning for moving day, and making sure all of the pieces are in place for a successful transition from institutional to community services.

Figure 5: The Transition Process



SERVICE ENROLLMENT/DISENROLLMENT

The Transition Coordinator arranges for or schedules the:

- Enrollment into home and community-based services and other services necessary for implementing the ITP.
- Disenrollment from institutional services.
- Enrollment into the Money Follows the Person Demonstration.

SET-UP OR ARRANGE SERVICES

The Transition Coordinator oversees the arrangement and scheduling of services and supports, including formal and natural supports, and the emergency back-up plan. The process of selecting providers of services will involve the active participation of the participant.

SET-UP THE RESIDENCE

For persons moving into their own home or apartment, the Housing Consultant will work with the participant to identify and secure a Qualified Residence. The Transition Coordinator will oversee setting up the residence, which will include household start-up including getting a lease in place, setting up utilities, purchasing furnishings and household supplies. In addition, the Transition Coordinator will arrange for environmental modifications, vehicle modifications and the purchase of assistive technology when required under the ITP.

DEVELOP A DISCHARGE DAY CHECKLIST/SET DISCHARGE DATE/DEVELOP DISCHARGE PLAN

The Transition Coordinator works with the nursing facility or hospital staff, the Community Coordinator, the demonstration participant, support person, and the participant's guardian, agent or surrogate as applicable, to develop a Discharge Day Checklist and discharge plan and set a discharge date. The Discharge Day Checklist will address the status of services and other items from the ITP, change of address, the schedule for follow-up visits and other details associated with the transfer of residence and services from one setting to another.

CONDUCT QUALITY OF LIFE SURVEY

The Transition Manager will ensure that the Quality of Life Survey is administered just prior to transition.

TRANSITIONING

The Transition Coordinator will work with the Community Coordinator to ensure a seamless handoff of responsibility during the transition process, no later than the day of transition. Transitioning will be individualized based on the discharge plan but will include the following steps:

- Beginning with a Discharge Meeting, scheduled shortly before discharge, the Transition Coordinator, the Community Coordinator, nursing facility or hospital staff, and the demonstration participant, support person, and legal surrogate when applicable, will review and confirm the discharge plan.
- The Transition Coordinator ensures that the elements of the Discharge Day Checklist are in place.
- On Moving Day, the Transition Coordinator ensures that the transition occurs according to the discharge plan.
- The Transition Coordinator ensures that enrollment in institutional services is terminated and enrollment in community services is effectuated.
- The Transition Coordinator ensures that the participant is enrolled in the MFP program for the purposes of tracking the 365-day MFP Demonstration period.
- The Transition Coordinator ensures that documentation of a Qualified Residence is submitted to the Transition Manager.

DOCUMENTATION RESULTING FROM THE TRANSITION

The following documentation will be completed and collected during the Transition phase:

- Quality of Life Survey
- Discharge Day Checklist
- Discharge Plan
- Documentation of a Qualified Residence

POST TRANSITION FOLLOW-UP

Following the Transition, the Community Coordinator is responsible for monitoring the implementation of the Transition Plan, and identifying needed modifications. The number and frequency and nature of contacts will be determined on an individualized basis but must include at a minimum an initial visit within two weeks of transition, monthly phone contacts and quarterly visits. The Community Coordinator will be responsible for:

- Completing at every home visit the appropriate case review form that is used to identify any unmet need and risks.
- Reviewing the ITP at least quarterly, more frequently when necessary and will involve the participant's multi-disciplinary team in that review as appropriate. The Community Coordinator will notify the Transition Manager of any needed modifications to the ITP and make any needed requests for additional services. Upon authorization from the Transition Manager, the Community Coordinator will implement the revised ITP.

- Notifying the Transition Manager of any change in status, including hospitalization and re-institutionalization.
- Submitting the appropriate completed Reportable Event form within 24 hours of a reportable event.
- Arranging for a review of the participant service needs and the availability and anticipated eligibility for needed services following the 365-day Homeward Bound demonstration period.
- Documenting actions taken, events, and changes in status in the Homeward Bound tracking system.

THE TRANSITION MANAGER

The Transition Manager plays an important role in monitoring and facilitating the ongoing success of the transition. The Transition Manager is responsible for:

- Reviewing the case review reports
- Making quarterly contact with participants to confirm the ongoing success of the transition.
- Monitoring changes in status including hospitalizations and re-institutionalization
- Approving modification to ITP and authorizing changes in services
- Approving Homeward Bound re-enrollments following hospitalization and re-institutionalization
- Triaging and investigating reportable events, ensuring that appropriate referrals are made to Adult Protective Services, law enforcement, emergency personnel, Division of Licensing and Regulatory Services or other relevant agency; and that other necessary follow-up activities are performed appropriately.
- Documenting actions and participant events in Homeward Bound tracking system.
- Arranging for the Quality of Life Survey to be administered 11 months after the transition date and again 24 months post-transition.

The following documentation may be used during the Post-Transition Period

- Case Review Report
- MFP Reportable Event Report
- Participant Enrollment Status Change Form
- Request for additional MFP Transition Services

The following documentation will be collected during the Post-Transition Period

- Quality of Life Survey – Month 11
- Quality of Life Survey – Month 24

RE-ENROLLMENT POLICY

If a participant returns to an institution for more than 60 consecutive days prior to completion of the 365-day demonstration period, the person may reenter the demonstration upon return to the community and participate for that participant's unexpended duration of the demonstration period. If a participant must return to an institution for fewer than 60 consecutive days, the individual will continue to be a participant in the MFP Demonstration while in the institution.

If an individual completes the 365-day demonstration period and needs to return to the institution, the individual may reapply to participate in the demonstration but must meet MFP eligibility requirements associated with the subsequent stay in the institution (*e.g.*, 90-day residence in a qualified institution excluding any short-term rehabilitative stay; at least one-day of Medicaid eligibility while in the institution).

The Community Coordinator will notify the Transition Manager when a demonstration participant is re-institutionalized. The Transition Manager will be responsible for evaluating and addressing the reasons for the re-

institutionalization and submitting required reports to the MFP Demonstration Director, if Transition Management responsibilities are fulfilled by someone other than the Demonstration Director.

INFORMED CONSENT AND GUARDIANSHIP

INFORMED CONSENT PROCEDURES

Informed consent is a decision made after all relevant information about an issue has been presented, in a language the individual can understand, the individual understands the consequences of the decision, and makes the decision in the absence of duress. Informed consent is a process not a document and is a necessary element of participant direction over the transition process, by ensuring that the individual's participation in the demonstration is the product of his or her knowing, informed and voluntary choice.

FIGURE 6: THREE PHASES OF INFORMED CONSENT



To reinforce the ongoing need to confirm the participant's informed consent, the transition protocol will incorporate formal informed consent procedures at three points in the process:

- At initiation of the Preliminary Assessment Process
- At enrollment into the Transition Planning Process
- At the decision to Transition into the community

At each point, the Transition Manager will be responsible for ensuring that the participant is provided the information he or she needs, is fully aware of his or her rights and responsibilities, and understands the risks and benefits associated with participating.

INFORMED CONSENT AT ENROLLMENT INTO THE PRELIMINARY ASSESSMENT PROCESS.

At enrollment into the Preliminary Assessment, the participant needs to know at a minimum:

- What the MFP Demonstration offers for services and supports, during the demonstration period and which services and supports are expected to be available after the demonstration period.
- MFP eligibility criteria
- What the Preliminary Assessment Process involves, and the possible outcomes of the Preliminary Assessment phase.
- The risks and benefits of participating in the demonstration; that participation in all phases of the demonstration is voluntary; and the participant can withdraw at any time. For persons who are difficult to place, the risk of relinquishing a current placement will be an identified risk.
- The individual's rights and responsibilities during the Preliminary Assessment phase.
- That participating in the Preliminary Assessment Process does not guarantee enrollment into the planning phase, or guarantee transition to the community.

During this meeting the Transition Manager explains the necessary elements of informed consent and offers the participant the opportunity to ask questions. The Informed Consent Form summarizes the information provided to the individual. The individual signs the Informed Consent, acknowledging receipt of the information and the opportunity to ask questions, and documents his or her choice to participate in the preliminary assessment process.

INFORMED CONSENT AT ENROLLMENT INTO THE TRANSITION PLANNING PHASE

Upon completion of the Preliminary Assessment Phase, if it is determined that transitioning to the community appears to be an appropriate option for the individual, the Referral Manager explains the Transition Planning Process. At this point, the individual needs to know at a minimum:

- What the MFP Demonstration offers for services and supports, during the demonstration period and what services and supports are expected to be available after the demonstration period.
- What the Transition Planning Process involves, and the possible outcomes of this phase.
- The risks and benefits of participating in the demonstration; that participation in all phases of the demonstration is voluntary; and the participant can withdraw at any time.
- That enrollment into the Transition Planning Process is not a guarantee that the participant will be able to transition.
- The individual's rights and responsibilities during the Transition Planning Phase.

Following this exchange of information, and the opportunity to ask questions, the Referral Manager will obtain the individual's acknowledgement of the information received and document the individual's choice to participate in the Transition Planning Process.

INFORMED CONSENT TO TRANSITION TO THE COMMUNITY

During the Transition Planning Phase, if the Transition Team determines that transitioning to the community is an appropriate option for this individual, the Transition Coordinator reviews:

- The terms of the Individualized Transition Plan, including transition services, the post-transition services and supports available during the demonstration period, and the plan for continuity of services following the demonstration period.
- The risks and benefits of participating in the demonstration; that participation in all phases of the demonstration is voluntary; and the participant can withdraw at any time.
- The identified risks associated with the transition and the plans in place to mitigate identified risks.
- The individual's rights and responsibilities associated with the Individualized Transition Plan.

Following this exchange of information, and the opportunity to ask questions, the Transition Coordinator will obtain the individual's acknowledgement of the information received and the individual's choice to transition according to the terms of the Transition Plan.

CRITERIA FOR WHO MAY PROVIDE INFORMED CONSENT

Under Maine law, “A valid consent is one which is given by a person who, under all the surrounding circumstances, is mentally and physically competent to give consent.”² A person is presumed to be competent unless proven otherwise.

The Transition Manager will be responsible for confirming, in consultation with a physician as necessary, that an individual is competent to provide informed consent, and has no guardian or designated Power of Attorney. The Transition Manager will confirm guardianship and the scope of decisions within the guardian’s authority through the Probate Court or obtain documentation of the Power of Attorney. In those cases where the person is competent, the Transition Manager will encourage the individual to designate a Power of Attorney.³

When a person is determined not competent to provide informed consent but has no guardian or other designated agent, the Transition Manager may rely on a surrogate in compliance with Maine law.⁴ A surrogate may make health care decisions on behalf of an individual when the person has been determined to lack capacity by the individual’s primary physician. Maine law identifies classes of persons who may serve as surrogates in order of priority, including a spouse, a person sharing an emotional, physical and financial relationship equivalent to a spouse, an adult child, a parent, or other category as set forth in the law.

If the Transition Manager determines that the member does not have a person suitable to serve as a surrogate, the individual may not participate in the demonstration unless and until the individual obtains a guardian and the guardian’s consent to participate.

In those cases where a guardian, Power or Attorney, or a surrogate is providing informed consent, the Transition Manager will ensure that the participant’s representative participates fully in the informed consent procedures described above.

THE ROLE OF GUARDIANS

In Maine a person may be under full or limited guardianship and guardians may be public or private. Maine law does not specify the amount of contact a guardian, whether public or private, should have; in practice, public guardians are expected to have at least monthly contact.

Through the Informed Consent process, the Transition Manager and Transition Coordinator will confirm and reconfirm the level of guardian involvement in the participant’s life, and the guardian’s role in the transition process, the participant’s life, and implementation of the participant’s service plan following transition. The Informed Consent will document the frequency and nature of contact the guardian has with the participant and the participant’s Care Coordinator, and will require a commitment to monthly contact for the demonstration period. The Informed Consent will also describe the guardian’s commitment to participate in the transition planning process and the periodic review of the transition plan. If the guardian does not agree to the terms outlined in the Informed Consent, the Transition Manager when appropriate will refer the participant to the Long Term Care Ombudsman or another appropriate advocacy organization.

When a guardian opposes transition, against the wishes of the participant or potential participant, the Transition Manager, or the Transition Coordinator, as the case may be, will be responsible for working closely with a guardian to better understand any reasons for opposition, to attempt to address those concerns.

² 24 M.R.S.A. §2905.

³ In accordance with 18-A M.R.S.A. §5-801 et seq.

⁴ 18-A M.R.S.A. §5-804.

OUTREACH, MARKETING AND EDUCATION

TARGET AUDIENCES

Maine will develop a statewide outreach campaign targeting institutional facility residents and staff, family members, community providers, and other interested parties.

NURSING FACILITY STAFF

To reach nursing facility staff, the Department will enlist the Maine Health Care Association and the Long Term Care Ombudsman to distribute marketing materials and host informational sessions. In addition, DHHS has modified its MDS Section Q referral protocol so that nursing facility staff will be aware of the MFP Demonstration project as an alternative following Local Contact Agency referral. AMHS Field Nurses and OADS' Long Term Care Behavioral Management Consultant will also have a hand in sharing information about the demonstration with nursing facility staff.

NURSING FACILITY RESIDENTS AND FAMILY MEMBERS

DHHS will rely on several strategies for conducting outreach with residents and family members. First, it will enlist the Maine Long Term Care Ombudsman Program to disseminate materials and make referrals. The Assessing Services Agency, which administers the MED Assessment/Level of Care Determination at admission, will also be asked to disseminate materials. Nursing facility social workers will be provided with informational materials as well.

COMMUNITY PROVIDERS AND COMMUNITY MEMBERS

DHHS will work with hospital discharge staff, the ADRCs and others to provide information about the demonstration, so that they can make appropriate referrals. In addition, DHHS will enlist the ADRCs in disseminating marketing materials to community members and community providers, including hospital discharge staff.

ADDITIONAL OUTREACH ACTIVITIES

With funds available through the ADRC Supplemental Funding opportunity, In addition to MFP related Outreach and Education, DHHS will work with long term care system partners (ADRCs, Maine's LTCOP, and CIL) to support implementation of MFP by building an integrated system to support seamless person-centered long term care transition, raising visibility and access of long term care transition planning options and increasing the capacity of ADRCs to provide Options Counseling, with a focus on persons in the hospital setting.

OUTREACH MATERIALS

Simple informational resources will be available, providing an overview of the Money Follows the Person program including program eligibility, available services and supports, and contact information for getting more information. Outreach materials will take many different forms, including brochures and pamphlets disseminated at informational sessions, association and provider meetings, consumer and family groups, advocacy groups, institutional and community providers.

Outreach materials will also be disseminated through the MFP web-based portal. A website, hosted by DHHS will serve as a portal to all informational resources as well as operational tools and resources. For example, the website will include downloadable brochures, factsheets, and other outreach materials. In addition, the Operational Protocol and related forms will be available. Participants and family members will be able to access information packets, educational materials and tools. A resource library will also be available to help participants and providers to learn more about available services, providers, and other resources.

TRAINING AND EDUCATION

The Demonstration Director will oversee the development of training curriculum for Transition Coordinators. The content of the training curriculum for Transition Coordinators is described under Transition Staff under Participant Recruitment and Enrollment. The Demonstration Director will oversee implementation of training for the Transition Coordinators.

In addition, the Demonstration Director will oversee the development of training and outreach materials for nursing facility staff, hospital discharge staff and others on the availability of home and community-based services for persons and on referral protocols, including referrals under Section Q and referrals to the MFP Demonstration.

DHHS's Specialty Nurses will provide individualized training and support to community provider staff serving persons with complex needs. It is expected that this individualized training will increase the willingness of community providers to provide services to persons with complex needs. This educational component will be part of a larger initiative to address the barriers community providers face in serving persons with complex needs.

BILINGUAL TRANSLATIONS

Maine's brochure will be made available in French as well as other languages determined most relevant to potential demonstration participants, in consultation with DHHS's Office of Multicultural Affairs. Translation of other documents and use of interpreter services will be provided consistent with DHHS Language Access Policy for individuals whose primary language is not English and individuals who are deaf or hard of hearing to ensure equal access to programs and benefits.⁵

COST SHARING INFORMATION

Cost-sharing information will be shared, as applicable, as part of the informational packets provided during the Preliminary Assessment process, the Transition Planning process, and at Transition. See discussion of Educational Materials under Consumer Supports.

STAKEHOLDER INVOLVEMENT

STAKEHOLDER ADVISORY GROUPS

Maine will build upon the stakeholder process developed for the MFP planning process which included a DHHS steering committee, the Adult Services Consortium; an internal working group, and an external advisory group. During the MFP Demonstration, the roles of these bodies will shift slightly but the configuration and relationship will stay the same.

THE ADULT SERVICES CONSORTIUM

An Adult Services Consortium, comprising the Office Directors for all adult services programs and the Office of MaineCare Services provided overall guidance and direction to the project in the planning stage. While the Adult Services Consortium no longer exists in name, the Office Directors of the Adult Service Programs continue in an oversight role reviewing performance reports, ensuring that Demonstration activities are coordinated across the Department, and addressing problems and recommendations as they emerge.

THE INTERNAL HOMEWARD BOUND OPERATIONS GROUP

⁵ DHHS' Language Access Policy can be found at: <http://www.maine.gov/dhhs/policies/dhhslanguageaccess.pdf>.

The Internal MFP will continue as a modified version of the internal working group that addressed many of the operational details described in this Operational Protocol. This group will be chaired by the MFP Demonstration Director and other key DHHS and contract staff as necessary to ensure the smooth implementation of demonstration activities. In the first year, this group will work in close collaboration with the External Advisory Group in developing many of the tools and resources necessary for implementation. The Internal Operations Group will also address systemic barriers to providing integrated services to persons with complex needs, including regulatory and reimbursement requirements, and develop strategies for overcoming these barriers. Once transitions are underway, the Operations group will continue to collaborate with the Advisory Group on identifying and addressing problems as they arise, monitoring quality and performance and developing recommendations for improvements.

THE EXTERNAL HOMEWARD BOUND ADVISORY GROUP

The External MFP Advisory Group had a significantly expanded role under the MFP Demonstration. During the three-month planning phase, this group played an important role in informing the development of this protocol. During the first year of the Demonstration, the Advisory Group will guide the development of outreach tools, informational packets, and transition planning tools. The advisory group will also play a role in developing the quality management tools, including the risk assessment tool, the emergency back-up protocol and the tracking tools and reportable events tool. In later years, the advisory group will monitor performance and quality management reports and develop recommendations for improving the demonstration. In addition, as Maine's rebalancing funds accumulate, the advisory group will take the lead in setting priorities for how Maine can use these funds to address structural barriers to community services.

The advisory group will also play a role in policy and structural reform of Maine's long term services and support system. Building on the work of the Blue Ribbon Commission, it will assist the Department in defining the appropriate balance between home and community-based services in Maine, given demographic trends and fiscal realities. The Advisory Group will also assist in identifying regulatory and reimbursement barriers that limit the ability to integrate services for persons with complex needs. It will also help to identify regulatory barriers to achieving those goals. The Advisory Group will also assist the Department in developing a long term strategy for addressing housing needs.

The Advisory Group will continue its current membership which has strong representation from community and institutional providers and advocacy organizations including the Long Term Care Ombudsman Program; the Disability Rights Center; Legal Services for the Elderly; Maine Equal Justice Partners; MaineHousing; the nursing facility provider association; the service coordination providers for Maine's in home service programs; AARP; Maine's center for independent living; advocates for persons with brain injury, Alzheimer's, and others; a variety of community service providers; and representation from Maine's consumer council for persons with mental illness.

During the brief planning phase, consumer representation on the Advisory Group was not as strong as desired. The Demonstration Director will be responsible for enhancing consumer participation in the Advisory Group process. The Demonstration Director will support member participation in the stakeholder group by preparing accessible meeting materials, arranging for accommodations, tailoring meeting format to optimize member engagement, and actively engaging members outside of meetings. The Demonstration Director, will also be responsible for going to consumer groups to seek input on specific questions or problems. Questions and issues will include topics such as outreach strategies, barriers to transition, and barriers to successfully remaining in the community.

CONSUMER OUTREACH

The Demonstration Director, in collaboration with consumer advocacy groups, will conduct outreach activities to consumers which will simultaneously be used as opportunities for gathering consumer input. Consumers will be invited to provide input on outreach strategies, barriers to transition, transition services, and post-transition

needs. In addition, the Demonstration Director will use these opportunities to seek feedback on structural reforms and other initiatives related to the MFP Demonstration.

PARTICIPANT INPUT

Participants will also be invited to participate in the improvement and design of services. Through the demonstration's quality management strategies, Maine will be collecting data on barriers to transition so that we can consider modifications to our transition services; for those that do decide to transition, data will be collected on the services and community resources that made transition possible, to better understand which demonstration services should be sustained post-demonstration.

In addition, Maine will conduct case studies involving participants, to identify issues and barriers that will need to be addressed in the transition to managed care. Information gathered from participants will inform the requirements for the managed care contract as well as case examples that can be used to evaluate the managed care organization's readiness for the serving this population group.

OPERATIONAL ACTIVITIES

Institutional and community providers and consumers will be involved in outreach activities. Institutional and community providers will provide referrals to the MFP Demonstration. Institutional providers will participate in transition planning.

BENEFITS AND SERVICES

DELIVERY SYSTEM

MEDICAID AUTHORITY FOR PROVIDING SERVICES

MEDICAID WAIVER SERVICES

Older Adults and Adults with Physical Disabilities are likely to access the Elderly and Adults with Disabilities waiver. Individuals with complex needs will access the Other Related Conditions Waiver (in effect starting July, 2013) or the Brain Injury Waiver (in effect starting November 2014). See below for list of all Qualified HCBS and Demonstration Services.

MEDICAID STATE PLAN SERVICES

While demonstration participants may access state plan home and community-based services, Maine has opted not to incorporate State Plan Services as qualified HCBS under MFP.

THE DELIVERY MECHANISM

Currently Maine's Medicaid program is principally fee-for-service.

- Community long term care services and supports for older adults and adults with disabilities are accessed through a service coordinating agency, which coordinates access to home care services based on the individual's authorized care plan. The authorized care plan is developed through Maine's single assessment entry point for its nursing facility services and all of its home and community-based services for older adults and adults with disabilities. For persons who choose to self-direct their personal care services, the service coordination agency provides skills training and other support.
- Community support services for adults with mental illness and mental health treatment are provided through community agencies. Persons may self-refer to these services. The Community Support worker may also facilitate access to other mental health services. Utilization of these services is currently managed through a vendor who provides prior authorization for Community Support and most Residential Services and continued review for all community mental health services.

The Transition Coordinator will assist the participant in accessing necessary services as part of the transition planning. The Transition Coordinator must already be qualified to provide existing community case management services. They will access and arrange for waiver and state plan demonstration services in the same way they would for non-demonstration services. Homeward Bound demonstration services will be authorized through the Transition Manager.

QUALIFIED HOME AND COMMUNITY-BASED SERVICES

Demonstration participants may access a combination of Home and Community Based Waiver and Demonstration Services. Services will be provided by qualified Medicaid providers as required in Maine’s MaineCare Benefit Manual, Chapter II and reimbursed in accordance with MaineCare Benefit Manual, Chapter III.

SERVICES	Elderly and Adults w/ Disabilities Waiver	Other Related Conditions Waiver	Brain Injury Waiver	Homeward Bound
Adult Day Health	√			
Care/Case Management	√	√		
Environmental Modifications	√	√		
Home Health Services	√			
Nursing	√			
Physical Therapy	√	√		
Occupational Therapy	√	√		
Speech-Language Therapy	√	√		
Home Health Aide/Certified Nursing Assistant Services	√			
Medical Social Services	√			
Agency-Based Personal Support	√	√		
Consumer Directed Personal Support	√			
Personal Emergency Response Systems	√			
Transportation Services	√			
Respite Services	√			
Non-Traditional Communication		√		
Assistive Technology		√	√	

SERVICES	Elderly and Adults w/ Disabilities Waiver	Other Related Conditions Waiver	Brain Injury Waiver	Homeward Bound
Consultation-Behavioral		√		
Consultation-Psychological		√		
Work Support (Supported Employment)		√	√	
Home Support (Residential Habilitation)		√	√	
Employment Specialist Services (Habilitation-Supported Employment)		√	√	
Community Support (Day Habilitation)		√		
Specialized Medical Equipment		√		
Communication Aids		√		
Career Planning (Habilitation, prevocational)			√	
Community/Work Reintegration-Individual			√	
Community/Work Reintegration-group			√	
Self-Care/Home Management Reintegration			√	
Transition Assistance				√
Clinical Assessments				√
Independent Living Assistance				√
Household Start-Up				√
Enhanced Care Coordination				√
Planning Services				√
Remote Support				√

DEMONSTRATION SERVICES

Demonstration participants may access the following demonstration services as necessary and according to the eligibility criteria specified below:

- Transition Assistance
- Specialized Clinical Assessments
- Independent Living Assistance
- Household Start-Up
- Enhanced Care Coordination
- Planning Services
- Remote Support

TRANSITION ASSISTANCE (TA)

Transition Assistance is available to persons enrolled in Transition Planning or the Transition phases of the MFP Demonstration. Transition Assistance includes but is not limited to:

- Developing the Individualized Transition Plan.
- Arrange for necessary assessments.
- Assisting the demonstration participant with the preparation of applications, arranging for eligibility determinations and enrolling into services and programs.
- Providing the participant with the information needed to make informed decisions about the transition, related services and supports, and other options.
- Setting up and arranging services and the community residence.
- Planning for and executing an orderly and successful transition from a Qualified Institution to a Qualified Residence.

Transition Assistance is provided, arranged, or overseen by the Transition Coordinator.

Eligibility: Persons enrolled in the Transition Planning or Transition phases of the MFP Demonstration up to 180 consecutive days prior to discharge. Utilization of Transition Assistance exceeding 180 days or 68.75 hours (275 units) must be authorized in advance by the Transition Manager.

Qualified Provider: Transition Coordinator may be:

- A registered nurse licensed to practice nursing in the State of Maine.
- An occupational therapist licensed to practice occupational therapy in the State of Maine.
- A licensed social worker and licensed by the State of Maine as a licensed social worker.
- A person certified by DHHS as a Mental Health Rehabilitation Specialist/Community (MHRT-C).

The Transition Coordinator must also be a qualified provider of community-based case management or service coordination services under §§17, 19, 20 or 22 of the MaineCare Benefit Manual.

Billable Unit: 15 minute increments

Rate: \$17.

SPECIALIZED CLINICAL ASSESSMENTS

Funds will be made available for specialized assessments when necessary to develop a plan for successful transition to living in the community or to prevent re-institutionalization.

Eligibility: Persons enrolled in the MFP Demonstration. Specialized Clinical Assessments must not be covered or available under any other funding source and must be necessary for a successful transition to the community or to prevent re-institutionalization as determined by the Transition Team and approved in advance by the Transition Manager.

Qualified Providers: A MaineCare qualified provider operating within the scope of his or her license.

Billable Unit: Completed assessment.

Rate: At existing MaineCare reimbursement rates.

INDEPENDENT LIVING ASSISTANCE (ILA)

Funds will be made available up to a maximum of \$9,000 for the purchase of Independent Living Assistance necessary to enable the participant to successfully transition to and remain in the community by creating an accessible environment, enabling greater independent activity, reducing unnecessary dependency on formal or informal supports, or improving the participant's quality of life. These funds can be used for expenses relating to:

Environmental modifications include physical modifications to the participant's Qualified Residence, authorized in the member's Transition Plan, which are necessary to ensure the health and welfare of the member, or which enable the member to function with greater independence in the home. Modifications include, but are not limited to:

- Ramps;
- Lifts, such as porch or stair lifts and hydraulic, manual or other electronic lifts;
- Modifications to bathroom facilities such as: roll-in showers, sink, bathtub, toilet and plumbing modifications, water faucet controls, floor urinal and bidet adaptations and turn-around space adaptations;
- Modifications to kitchen facilities such as: sink modifications, sink cut-outs, and water faucet controls, turn-around space adaptations, surface adjustments/additions and cabinetry adjustments/additions; and
- Specialized accessibility/safety adaptations such as: door-widening, electrical wiring, grab bars and handrails, automatic door openers/doorbells, voice activated, light activated, motion activated and electronic devices, fire safety adaptations, medically necessary air filtering devices, low-pile carpeting, and smooth or non-skid flooring needed to assure safe ambulation or wheelchair mobility.
- Environmental modifications do not include major re-modeling or construction.
- Vehicle modification to a vehicle privately owned by the participant or the participant's family. Modifications may include a hydraulic lift, ramps, special seats and other internal modifications necessary to enable the participant's access into and out of the vehicle or the participant's operation of the vehicle.
- Adaptive or assistive technology and devices, including any item, piece of equipment, or product system, whether acquired commercially, modified, or customized that is used to increase, maintain, or improve the functional capabilities of the participant including communication. These services are not otherwise covered under Durable Medical Supplies and Equipment, §60 of the MaineCare Benefits Manual, and are necessary to enable a successful transition or to avoid re-institutionalization.

Eligibility: Persons enrolled in the MFP Demonstration, who need ILA to address an identified need in the participant's service plan, when not covered or available under any other funding source (including environmental modifications which are the obligations of a landlord). ILA must enable the participant to interact more independently, enhance the participant's quality of life, and reduce the participant's dependency on formal or informal supports and be otherwise necessary for a successful transition to the community, as determined by the Transition Team and approved in advance by the Transition Manager.

Qualified Provider: The Transition Coordinator arranges for the provision of ILA services. All ILA must be provided in accordance with applicable federal, state or local law and codes and, if applicable, performed by, supervised by or provided by a State licensed, certified or approved professionals.

Maximum Allowance: \$9,000 per demonstration period.

HOUSEHOLD START-UP

Household start-up funds, up to a maximum of \$5000, will be available to persons transitioning to a Qualified Residence. These funds can be used for expenses related to arranging for and setting up a household, when necessary to ensure a successful transition or to enable the participant to maintain residency in the community. Household Start-Up may include reasonable expenses related to:

- Transportation related to housing search
- Moving expenses
- Rental security deposits
- Initial month's rent
- Utility deposits
- Household goods and supplies. (The purchase of any food is capped at \$200 over the period of the demonstration and is limited to basic pantry items required for household start-up.)
- Household furnishing including purchase of table, chairs, bed, desk, dressers, or large appliances that are needed in the house or apartment and are necessary to set up a home. Household furnishings do not include televisions, computers or other electronic devices.

Eligibility: Persons enrolled in the MFP Demonstration, who need Household Start-Up services, as determined by the Transition Team and approved in advance by the Transition Manager.

Qualified Provider: The Transition Coordinator arranges for the provision of Housing Start-Up services.

Maximum Allowance: \$5000

ENHANCED CARE COORDINATION

Enhanced Care Coordination services are provided by the Community Coordinator and include care coordination to supplement care coordination services provided as a Qualified HCBS Service. The Community Coordinator provides up to 68.75 post-transitional hours (275 units). The purpose of these contacts is to ensure that the individual is receiving appropriate services and to assist with adjustments in service needs. The type of contact will be determined on an individual basis and may be face-to-face, by telephone, or a collateral contact.

Eligibility: Persons enrolled in the MFP Demonstration who transition to the community.

Qualified Provider: The Transition Coordinator must also be a qualified provider of community-based case management or service coordination services under §§17, 19, 20 or 22 of the MaineCare Benefit Manual.

Billable Unit: 15 minute increments

Rate: \$17

PLANNING CONSULTATION SERVICES

Funds will be made available up to a maximum of \$1,000 for the purchase of consultation services during the post-transition period. These funds will reimburse providers for participating in multi-disciplinary quarterly reviews of the transition plan, as necessary to assure a successful transition and prevent re-institutionalization.

Eligibility: Persons enrolled in the MFP Demonstration. Planning Consultation Services must not be covered or available under any other funding source and must be necessary for a successful transition to the community, as determined by the Transition Coordinator and approved in advance by the Transition Manager.

Qualified Provider: The Transition Coordinator arranges for the provision of Planning Consultation Services through MaineCare qualified providers operating within the scope of their license. Planning Consultation Services may be provided by a physician, psychiatrist, psychologist, neuropsychologist, licensed clinical social

worker, licensed clinical professional counselor, licensed professional counselor, registered nurse, licensed practical nurse, nurse specialist, nurse practitioner, psychiatric nurse, speech pathologist, licensed alcohol and drug counselor, occupational therapist, personal care assistant, physical therapist, non-traditional communication, employment specialist, rehabilitation counselor, certified therapeutic rehabilitation specialist, or other qualified staff.

Maximum Allowance: \$1,000 per demonstration participant.

REMOTE SUPPORT

Remote Support includes the provision of in-home computers, sensors, video cameras and internet connections linked to a community care coordination provider, to enable 24/7 monitoring and daily or frequent contact as necessary to enable the participant to successfully and safely remain in the community and avoid re-institutionalization.

Eligibility: Remote Support Services are available to participants who would otherwise require extensive routine supervision in order to live in the community and avoid re-institutionalization as determined by the Transition Team and approved in advance by the Transition Manager.

Qualified Provider: Remote Support Services may be arranged through the Community Coordinator or through a home care provider or another qualified MaineCare provider.

Maximum Allowable: \$6000 for the 365-day demonstration period. Reimbursement is limited to the installation fee, the monthly charge for equipment rental and monitoring services.

CONSUMER SUPPORTS

EDUCATIONAL MATERIALS

MFP participants will actively participate in each phase of the enrollment and transition process. Throughout this process the Referral Manager, and later the Transition Coordinator, will educate the participant (or guardian, agent or surrogate) about community services and supports, risk assessment and mitigation, and emergency back-up plans. Part of this educational process will involve providing a Participant Handbook which provides detailed information about the process and what can be expected.

EMERGENCY BACK-UP SYSTEMS

The participant's emergency back-up plan will depend on the target population and the services to which the individual transitions. The emergency back-up system may include a number of different elements appropriate to the individual's needs, abilities, and informal supports. Elements of the emergency back-up plan will include as appropriate:

- A specific plan for back-up support when scheduled services are not provided documented in the participant's 24-HOUR BACK-UP PLAN. The plan may rely on agency staff, a contractor or informal supports.
- Personal Emergency Response Services (a covered service under the Elderly and Adults with Disabilities Waiver).
- Remote Support (a demonstration service covered as described above).
- Specific instructions on how to access services after business hours.
- A crisis plan, for persons with severe and persistent mental illness
- Hotline numbers for accessing crisis services, reporting neglect, abuse, and exploitation; and filing complaints against service providers, as appropriate. (Maine has a single statewide crisis hotline, and a single hotline for reporting abuse of adults and older adults. The Division of Licensing and Regulatory Services maintains a hotline for emergencies and for reporting complaints against home health agencies.)

Participants will be instructed to call 911 when there is an immediate threat to their health or safety or when there is a failure of essential equipment posing an immediate threat to their health or safety.

TRANSPORTATION

Transportation to medical appointments is a covered service under the Medicaid state plan. The Transition Coordinator will provide the participant with information on how to access these services in their community.

DIRECT SERVICE WORKERS

The Transition Coordinator will ensure that each participant has a specific plan in place for when scheduled direct services are not provided. Back-up services may be provided by an agency employee, a contractor, or informal support person designated by the participant. When the plan includes a commitment from informal supports, such as family members, friends, and neighbors, the informal support person who will be asked to sign a written agreement acknowledging his or her role as a back-up provider.

REPAIR AND REPLACEMENT FOR EQUIPMENT

The Transition Coordinator will provide the participant with instructions on who to contact when they experience a problem with durable medical equipment or other equipment. The participant will be instructed to call 911 when there is a failure of essential equipment posing an immediate threat to health or safety.

ACCESS TO MEDICAL CARE

The Care Coordinator will provide assistance making appointments, accessing medical care and resolving issues relating to medical care. Telehealth services are covered under MaineCare.

THE COMPLAINT AND GRIEVANCE PROCESS

The complaint and grievance process will depend on the target population and the services received.

GENERALLY

In general, the participant will be provided guidance on their options for having their complaints addressed as follows:

- Through the provider, whenever possible and appropriate. The participant will be encouraged to pursue this avenue, as a first step, whenever the participant feels comfortable doing so. Some agencies, such as home health, are required to have procedures in place for the review of complaints within two business days of each complaint received by the administrator or the administrator's designee.⁶
- Through the Care Coordinator. When the participant is not satisfied with the home care agency's response, or is not comfortable for any reason raising a complaint directly with the service provider, the participant may file a complaint with the Care Coordinator who will be required to respond timely to complaints from MFP participants.
- Through the Transition Manager. The Transition Manager will have procedures in place to respond timely to complaints from MFP participants.

PERSONS RECEIVING MENTAL HEALTH SERVICES OR COMMUNITY SUPPORTS

For participants receiving mental health services, it is possible that the member may file the complaint as a formal grievance governed under the Rights of Recipients of Mental Health Services.⁷ Under these rules, a grievance relating to the "the development, substantive terms, or implementation of [individualized support plans] or hospital treatment and discharge plans" is considered an "urgent grievance" and must be forwarded within one working day to the Director of the Office of Adult Mental Health Services or his or her designee and the Office of Advocacy. The Director or the Director's designee must hear the grievance within three working days or immediately refer it to Level I grievance review (at the provider level) for a response.⁸ For the purposes of the MFP Demonstration, a grievance relating to mental health or community support services provided pursuant to an individualized transition plan will be resolved in compliance with these requirements; the Director may designate the Transition Manager to hear the grievance or oversee its resolution.

⁶ 144 CMR Chapter 119, Regulations Governing the Licensing and Functioning of Home Health Care Services, Section 3(B)(8).

⁷ 14 CMR 193, Chapter 1, Rights of Recipients of Mental Health Services. <http://www.maine.gov/dhhs/mh/rights-legal/recipients/index.shtml>.

⁸ 14 CMR 193, Chapter 1, Rights of Recipients of Mental Health Services, Part A(VII)(J)(2).

SELF-DIRECTION

Maine does not expect significant numbers of participants to self-direct services. The predominant model for consumer directed services, the Consumer Directed Personal Assistance waiver for the Physically Disabled (§22 of the MaineCare Benefits Manual) has a waiting list and does not provide the package of service mostly likely needed for participants. While there is no waiting list for state plan Consumer Directed Personal Assistance Services (§12 of the MaineCare Benefits Manual), these services also do not offer the package or level of service mostly likely needed for participants. Utilization of the Family Provider Service Option under the Elderly and Adults with Disabilities Waiver has historically been low, especially in comparison to traditional agency utilization. The Department is currently working on an initiative to create a single design for self-directed/representative-directed care to better allow access to this service option for consumers. Utilization of this service option may increase at that time. See Appendix B for the completed Sub-Appendix I relating to consumer directed options in Maine.

VOLUNTARY TERMINATION OF SELF-DIRECTION

If a participant chooses to terminate the self-directed option, the Community Coordinator will assist the participant in accessing their services through the traditional agency model. All efforts will be made to transition the person without any gap in service.

INVOLUNTARY TERMINATION OF SELF-DIRECTION

CONSUMER DIRECTED PERSONAL ASSISTANCE

For Consumer Directed Personal Assistance, services may be involuntarily terminated when:

- The member experiences a significant change in medical, functional, or cognitive status and the Department determines that appropriate services can no longer be provided under the consumer directed program.
- The Department determines that the health and welfare of the member is endangered should he or she remain at home receiving services under the consumer directed program.
- The Community Coordinator documents the member fails to manage an attendant consistent with the requirements of the consumer directed program.
- The member is accessing duplicative services

The Community Coordinator will assist the participant in accessing their Personal Care Services through the traditional agency model. All efforts will be made to transition the person without any gap in service.

FAMILY PROVIDER SERVICE OPTION

For the Family Provider Service Option (FPSO), participation will be involuntarily terminated when:

- The FPSO fails to meet quality standards set by the Home Care Coordinating Agency
- The FPSO fails to comply with the terms of the Memorandum of Agreement with the Home Care Coordinating Agency governing the use of a Fiscal Intermediary
- If the participant is the registered FPSO and the participant does not have the required cognitive capacity as indicated by the participant's most recent Medical Eligibility Determination assessment or the clinical judgment of the Home Care Coordinating Agency.

The Community Coordinator will assist the participant in accessing their Personal Care Services through the traditional agency model. All efforts will be made to transition the person without any gap in service.

NUMBER OF PARTICIPANTS WHO WILL SELF-DIRECT

For the reasons discussed above, Maine anticipates that the number of participants choosing to self-direct their services will be relatively low. Once the Family Provider Service Option (FPSO) has been modified, consumer direction may increase. The number of participants to self-direct under the demonstration project is expected to be more than 7.

QUALITY

Maine will enhance its current Quality Improvement System (QIS) for the MFP Demonstration. The MFP Quality Improvement System will be structured to meet the CMS quality assurances found in the HCBS 3.5 version of the 1915(c) waiver application. Indicators have been identified to measure level of care determination, service plan development and delivery, qualified providers, health and welfare, financial accountability, and administrative authority. These indicators are based on those stated in Maine's 1915c Elder and Adults with Disabilities waiver, control number 0276.R03.00, approved in July 2008. The Quality Monitoring matrix lists the indicators, monitoring processes, methods, measures, and reporting requirements that will be used. See Table 9.

Measures specific to Homeward Bound, including participant satisfaction, service monitoring and process effectiveness have been added to provide additional quality assurance related to the transition process and post-transition success in the community. It is expected that the indicators related to service plan development and delivery that are employed in this demonstration will continue beyond the demonstration period, both under the existing waiver and in the programs that serve the complex case target group.

A tracking system developed under this program will house the additional data to measure outcomes within the different components of the transition process. These measures include choices made by participants, use of demonstration services, review of risk assessments, backup plans, and reportable events, and post transition status. All participant contacts will be logged in this tracking system.

In addition to the attached Quality Monitoring matrix, the current infrastructure of Maine's claims management system will ensure the fiscal integrity of the MFP program. Claims data will track MFP enrollee status and service utilization. It will assist in verifying that services authorized were delivered by qualified MFP providers. And it will provide information on the rebalancing efforts of the demonstration.

The QIS Quarterly reports and ongoing feedback will guide the state in its systemic discovery and remediation activities and help identify areas for improvement. Aggregate measures will provide data on the MFP Demonstration Project's overall performance.

Individual remediation will occur as needed throughout the demonstration period. It will be documented in the case record and on the Health and Welfare Case Review form.

Through analysis of the Quality of Life Survey Maine will be able to measure participant satisfaction and successful transition to the community.

Use of MFP Demonstration services will be monitored for their effectiveness in removing barriers to community living, the potential for their continued availability beyond the demonstration, their cost and the possible fiscal impact they might have if included as a covered service under the waiver or state plan. This allows the state a mechanism to consider sustainability beyond the demonstration period.

ROLES AND RESPONSIBILITIES RELATED TO QUALITY

OFFICE OF AGING AND DISABILITY SERVICES

OADS is the operating agency within DHHS for the 1915(c) Elder and Adults with Disabilities waiver.

THE MFP DEMONSTRATION DIRECTOR

The MFP Demonstration Director reports to OADS, has overall responsibility for monitoring and reporting quality findings to OADS LTC director and Office of MaineCare Services (OMS).

TRANSITION MANAGER

To begin, the Demonstration Director will serve as Transition Manager. In later years, the Transition Management may be provided by a contractor or a DHHS employee. The Transition Manager is responsible for ongoing quality assurance activities, ensuring the integrity of the MFP process. Successful facilitation of each step in the transition process rests with the Transition Manager. In addition, the Transition Manager's responsibilities include approval of enrollment into MFP, review and approval of ITPs, oversight of discharge process, monitoring of service delivery and approval of any ITP change requests. The Transition Manager's use of the Tracking Database provides the documentation and data that will track enrollee eligibility status, choices made, and ITP changes and approval.

REFERRAL AND ADVOCACY MANAGER

The Long Term Care Ombudsman will serve as Referral/Advocacy Manager. They are responsible for the responding to all referrals for Homeward Bound and for facilitation of the application and enrollment in Transition Planning phase of the process. They attend transition planning meetings, serving in an advocacy capacity as desired and directed by the participant.

TRANSITION COORDINATOR

Transition Coordinators have the front-line responsibility for development and implementation of the Individualized Transition Plan (ITP). They work with the participant to develop an ITP that addresses each need, identifies any risks with plans to mitigate such risks, and fully describes an adequate and appropriate backup plan. Transition Coordinators' documentation provides the data that will track choices made, changes to the ITP, etc.

COMMUNITY COORDINATOR

The Community Coordinator is responsible for monitoring the implementation and continuing effectiveness of the participant's Individualized Service Plan. During the post-transition period, the Community Coordinator will monitor any changes or unmet needs of each individual through monthly contacts conducted by the Care Coordinator. These contacts will include completion of the Health and Welfare Case Review form that documents individual's needs and actions taken to resolve issues that may arise. Service plans may be revised or an MDT may be convened to address needs of the individual.

Pre-transition level of care and service plan information will be obtained from the most recent MDS assessment conducted by the nursing facility. Threshold criteria will be verified prior to enrollment in the MFP Demonstration.

If, through the transition planning process, there is evidence of a lack of qualified providers for a particular service, the Demonstration Director will work to recruit providers to fill this need, provide demonstration services as applicable, and identify gaps in the service system required for successful transition.

If an MFP participant's needs are met through 1915 c waiver services that are incorporated in the MFP Service package (see Benefits and Services section), that individual will transition to the waiver upon discharge from the

nursing facility. MFP Demonstration services may be accessed during the first year to aid in the transition process. Prior to the end of the individual's first year in the community, their service plan will be reviewed to determine what demonstration services are needed on an ongoing basis and what resources may be accessed to replace the demonstration services.

The table and the flowcharts on the next several pages describe roles and responsibilities and data sources at each step in the process.

REPORTABLE EVENTS

The Demonstration Director will be responsible for coordinating the following incident reporting systems for MFP participants:

- Generally, Maine law mandates that certain persons acting in a professional capacity report suspicions of abuse, neglect or exploitation to the Department for an incapacitated or dependent adult. These reports are investigated by Adult Protective Services (APS) according to defined procedures. APS, within the Office of Aging and Disability Services, will coordinate its investigation with the Demonstration Director where MFP participants are involved.
- Care Coordinators will be responsible for submitting a completed Reportable Event form, or its equivalent, to the Department within 24 hours of a reportable event. The Demonstration Director, within the Office of Aging and Disability Services, will triage and investigate the reportable event, ensuring that appropriate referrals are made to Adult Protective Services, law enforcement, emergency personnel, Division of Licensing and Regulatory Services or other relevant agency; and that other necessary follow-up activities are performed appropriately.
- The Rights of Recipients of Mental Health Services⁹ governs violations of rights. A grievance is first addressed at the provider level and if not resolved there may be reviewed by the Office of Adult Mental Health Services, and if not resolved there may be reviewed by the Commissioner. The Demonstration Director will coordinate with the Office of Substance Abuse and Mental Health Services to monitor the appropriate resolution of grievances for MFP participants.

24-HOUR BACK-UP AND RISK MITIGATION

The 24-hour Back-Up Plan and the Risk Assessment and Mitigation plan will both be documented in the Individualized Transition Plan. The Transition Manager reviews and approves the transition plans and their required elements prior to transition. The Community Coordinator completes a "Health and Welfare Case Review" (or its equivalent) form at every home visit and case review in order to identify unmet need and risks. The Transition Manager reviews the Health and Welfare Case Review form to make sure that identified unmet needs and risks have been adequately addressed.

At a systems level, the Demonstration Director will review quarterly reports aggregating data on the number and percent of action items appearing on Health and Welfare Case Review forms (or their equivalent), the number and percent of participants referred to Adult Protective Services, and the number and percent of participants referred to the Long Term Care Ombudsman Program..

⁹ 14 CMR 193, Chapter 1.

TABLE 9: QUALITY ASSURANCE MONITORING

The Demonstration Director¹⁰ will have responsibility for monitoring performance measures. Sampling will be 100% for all measures.

<i>CMS Assurance MFP Quality Indicator</i>	<i>Step in Process</i>	<i>Process Details</i>	<i>Monitoring method</i>	<i>Data Source Document</i>	<i>Performance Measure</i>	<i>Frequency of Data Collection</i>	<i>Frequency of data aggregation and analysis</i>
CMS-Appendix B: Participant Access and Eligibility MFP-Participant Eligibility							
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities	<ul style="list-style-type: none"> • Preliminary Assessment Process • Transition Planning Process • Transition Process 	<p>TM keeps track of referrals by facility /by region and report to Office of Aging and Disability Services (OADS);</p> <p>TM verifies eligibility threshold criteria for MFP Demonstration</p> <p>TM keeps track of first assessment, timelines and outcomes and report to OADS</p>	TM reviews reports and follows up as necessary	Tracking form	<p># of referrals by region and by surrogate or legal guardian</p> <p># and % of individuals at each step in process based on status and choice</p> <p># Appeals or complaints related to eligibility within process</p> <p>Average time from start of process to transition discharge</p>	Continuous	Quarterly

¹⁰ To begin, the Demonstration Director will also be acting as Transition Manager. During this time period references to the Transition Manager and the Demonstration Director are referring to the same person.

CMS-Appendix B.6: Evaluation & Reevaluation of Level of Care MFP-Waiver, State Plan, Complex Case Level of Care								
Sub-assurance a. - An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	<ul style="list-style-type: none"> • Preliminary Assessment Process • Transition Planning Process • Transition Process 	Determine NF LOC at time of transition; TC assigns to appropriate Assessing Services Agency (ASA) based on service needs (waiver or complex case services)	TM reviews LOC, MDS, readiness assessment, and self-assessment	Tracking form	# enrolled by target group (type of needs (ADLs, nursing, complex) Reason for non-enrollment	Continuous	Monthly	
CMS-Appendix D: Participant-Centered Planning and Service Delivery MFP-Individual Transition Plan (ITP)								
Sub-assurance a. - Service plans address all participant needs and personal goals either by provision of waiver services or through other means	<ul style="list-style-type: none"> • Transition Planning Process 	TC develops comprehensive Individual Transition Plan (ITP) that includes Risk Assessment, Backup Plan, and all support services needed; Convenes MDT as needed; ITP documented in a tracking system	TM reviews and approves transition plan. TM documents approval in tracking system.	ITP	% of plans that meet needs and personal goals; # where needs cannot be met, reasons needs cannot be met % of services by category (HCBS, informal, Medicare, MFP Demonstration services, etc.)	Ongoing	Monthly and Quarterly	
Sub-assurance b. - State monitors service plan development in accordance with its policies and procedures	<ul style="list-style-type: none"> • Transition Planning Process • Transition Process 	TC follows checklist procedure for completing all aspects of transition plan, including timeline for transition, service delivery, and follow-up evaluation.	TM reviews checklist, service plan and risk assessment prior to discharge.	Transition checklist ITP	# and % by transition outcome	Ongoing	Monthly and Quarterly	

<p>Sub-assurance c. - Service plans updated/revised at least annually or when warranted by waiver participant needs</p>	<ul style="list-style-type: none"> • Transition Process • Post Transition 	<p>CC conducts reevaluation of plan prior to day 365 of MFP Demonstration for all participants.</p> <p>Additionally, the CC reviews the ITP, at least quarterly, and updates the plan as needed, based on a change in the participant's needs.</p>	<p>Document any unmet needs.</p> <p>Develop plan to address unmet needs.</p> <p>All requests for change in ITP go through TM</p>	<p>Change Request form</p> <p>Health & Welfare Case Review form</p>	<p># and % of service plan change requests</p> <p># and % increases, reductions, terminations due to change in needs</p> <p>Reasons for termination from MFP</p>	<p>Ongoing</p>	<p>Quarterly</p>
<p>Sub-assurance d. - Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.</p>	<ul style="list-style-type: none"> • Transition Process • Post Transition 	<p>TC follows up with participant on a monthly basis for first year to determine if all needs are being met and transition plan is working.</p> <p>TM follows-up with participant by phone at least quarterly.</p> <p>OADS tracks claims data for MFP participants</p>	<p>TM verifies discharge plan with all services in place</p> <p>Compare authorized plan to services delivered.</p>	<p>Discharge Plan</p> <p>QoL survey</p> <p>Health & Welfare Case Review form</p>	<p>Total number of participants within given time frame</p> <p>QoL analysis</p> <p>Claims analysis</p>	<p>QoL and Health & Welfare = Ongoing</p> <p>Claims =Quarterly</p>	<p>Quarterly</p>
<p>Sub-assurance e. - Participants are afforded choice: Between waiver services and institutional care; and between /among waiver services and providers.</p>	<ul style="list-style-type: none"> • Preliminary Assessment Process • Transition Planning Process • Transition Process 	<p>TM or TC will describe MFP process and receive informed consent at each step in MFP process; at initial meeting; at time of transition planning process; and at time of transition process.</p> <p>TC will receive choice letter at time of enrollment into transition</p>	<p>TM and TC offer choice as indicated in process steps.</p> <p>TC documents participant's choice of provider.</p>	<p>Choice letters</p>	<p># and % by choice at each step in process</p> <p>Choice of provider documented on ITP</p>	<p>Ongoing</p>	<p>Quarterly</p>

process.

TC solicits participant's choice in selecting services and providers.

**CMS-Appendix G: Participant Safeguards – Health & Welfare
MFP-Risk Mitigation and Health & Welfare Case Review**

Sub-assurance a. - The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.	<ul style="list-style-type: none"> • Transition Planning Process • Transition Process • Post Transition 	<p>Documentation of backup plan in ITP</p> <p>CC completes Health and Welfare Case Review form (or equivalent) at every home visit and case review once person in community.</p> <p>Form documents action taken when unmet need or risk identified.</p> <p>All reportable events are logged on Reportable Event Form.</p>	<p>Verify adequate backup plan in ITP</p> <p>TM reviews Health & Welfare Case Review forms</p>	<p>ITP Backup Plan</p> <p>Health & Welfare Case Review forms</p>	<p># and % of Health & Welfare form by action items.</p> <p># and % of MFP participants referred to APS</p> <p># and % referrals, complaints handled by LTCOP for MFP population</p>	<p>Aggregate data from H & W form provided to TM on quarterly basis.</p> <p>Request quarterly report from MAPSIS of all MFP referrals from Care Coordination Agencies</p>	<p>Quarterly</p> <p>Annual qualitative summary of sources of backup support</p>
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Abbreviations

APS - Adult Protective Services

ASA – Assessing Services Agency

CC – Community Coordinator

ITP - Individual Transition Plan

LOC – Level of Care

LTCOP – Long Term Care Ombudsman Program

MDS – Minimum Data Set (nursing facility assessment tool)

NF – Nursing Facility

OADS – Office of Aging and Disability Services

QM – Quality Management

TC – Transition Coordinator

TM – Transition Manager

HOUSING

QUALIFIED RESIDENCES

The Housing Consultant will have responsibility for confirming that participants are transitioning to Qualified Residences. Verification may be based on a visit to a home, a report of the participant or the participant's representative, information obtained by a property manager or landlord, a review of a lease, licensing information, or information from a local housing authority. In addition, the Housing Consultant will support DHHS in collaboration with housing partners to expand the supply of rental assistance and supported housing options. Demonstration participants will transition to any of these qualified residences:

THE INDIVIDUAL'S OWN HOME OR THAT OF A FAMILY MEMBER

These homes will be owned or leased by the individual or the individual's family member. Efforts will be made to identify potential demonstration participants upon admission to a nursing facility to help residents preserve their current living situation whenever possible.

Participants may share their home or lease with other private individuals, including other participants. If the participant sublets or accepts a boarder in his or her home, the lease must grant the other individual exclusive possession to the space being leased or sublet. The participant may also enter into a co-ownership or co-leasing arrangement, in which case all parties must retain independent and equal legal rights to enforcement of the lease or ownership responsibilities.

AN INDIVIDUAL APARTMENT

The apartments will have an individual lease, with lockable access and egress, and will include living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.

ASSISTED LIVING

To determine whether or not an Assisted Living program is a Qualified Residence, Maine can rely to some degree on licensing regulations, which require many of the characteristics specified in CMS' Qualified Residence Guidance. For those areas not adequately addressed by licensing regulations, the Housing Consultant will review each Assisted Living arrangement to determine whether the other conditions are met.

Maine's licensing regulations for Assisted Living programs¹¹ specifically address a number of characteristics of a Qualified Residence. In most, but not all, cases these regulations are consistent with CMS requirements.

To be licensed as an Assisted Living program, the program provides assisted living services in a "private apartment," defined by regulation to be "a private dwelling unit with an individual bathroom, bedroom and a food preparation area." Each private apartment must have lockable doors.

The Assisted Living program may be licensed to provide two levels of service. Type I provides medication administration directly or indirectly through contracts; Type II provides medication administration and nursing services, including direct nursing services, or oversight of services provided by unlicensed assistive personnel.

The Standard Provider Contract required for all Assisted Living programs anticipates that the resident may have a separate lease with a Landlord different from the Assisted Living provider.

The Standard Provider Contract allows the resident to purchase Housing and Services or Housing Only and identifies the services to be provided by the Assisted Living program and purchased by the resident.

¹¹ 10-144 CMR Chapter 113.

The licensing regulations require the Assisted Living Program to allow the resident to select a provider of his or her choice for services and supplies not provided by the Assisted Living program.

The licensing regulations allow a resident to be involuntarily discharged when “the assisted living program cannot meet the needs of the consumer as the program is fundamentally designed.”

The Housing Consultant will confirm that any Assisted Living arrangement for any MFP participant:

- Conveys the right to use or occupy the property.
- Specifies the term of the lease and the rights of termination for the participant and the provider and that the participant’s residency can only be terminated for non-payment of rent, posing a direct threat to others, or property damage.
- Requires that any conditions that limit a person’s activities are addressed in the plan of care, are related to risks to the participant’s health and welfare, and are agreed to by the participant or the participant’s guardian, agent or surrogate in writing.
- Does not require notice of absences from the facility except as permitted under the MFP Qualified Residence Guidance.
- Permits the participant to bring in additional services when the Assisted Living program cannot meet the participant’s needs, to the degree permitted by state regulation.

FOUR-BED HOME

Maine anticipates that a number of persons with complex needs will transition to small homes in which no more than four unrelated individuals will reside. These residences will have 24/7 staffing.

A residential care facility or private non-medical institution¹² licensed under 10-144 CMR Chapter 113: Regulations Governing the Licensing and Functioning of Assisted Housing Programs will be considered a Qualified Residence when the setting has no more than four unrelated individuals residing in the setting and is not part of a larger congregate or campus setting.

The Transition Coordinator will document that the residence is a Qualified Residence under the MFP Demonstration requirements.

DEVELOPMENT OF HOUSING RESOURCES

Identifying housing resources will be challenging for those participants that do not already have a home to return to.

EXISTING HOUSING RESOURCES

PRIVATE HOUSING CAPACITY

The ability to locate affordable accessible apartments is greatly enhanced by MaineHousingSearch, a housing registry jointly developed by MaineHousing and DHHS. This registry provides a searchable online rental listing service that includes affordable and market rate rental properties and information about advertised vacancies.¹³ However, there are a wide range of barriers to finding affordable, accessible and appropriate private housing in Maine that must be taken into account when evaluating the private housing options available to demonstration participants.

¹² “Private non-medical institutional services” is the Medicaid funding mechanism Maine uses to pay for services provided in a group home of any size and type.

¹³ The Housing Registry can be accessed at: <http://www.mainehousingsearch.org/>.

RURALITY

Maine's rurality will limit the private housing options available to participants. According to U.S. Census Bureau statistics, Maine ranks 38th nationally in population density and is one of three states, (Maine, Vermont and West Virginia) with the highest proportion of population classified as rural. In Year 2000, 60% of Maine's population was living in rural areas compared to 20% nationally. Rural residents face particular challenges including fewer health care providers per capita and increased transportation barriers.¹⁴ Only a few Maine cities have public transportation, meaning that transportation will be an important consideration when finding housing. Preventing isolation and promoting independence will mean that demonstration participants will need easy access to amenities and informal and formal supports, as well as needed health care providers.

AFFORDABILITY

Affordability is a significant issue in Maine. According to accepted national standards (i.e., the Rental Affordability Index), 55.3% of Maine's rental households are unable to afford the average 2-bedroom rent. In 2009, 85,411 rental households were paying more than 30% of their gross income for housing.

Access to subsidized housing is severely limited. Maine continues to experience a serious shortage of affordable and accessible tenant and project-based housing units, especially for people with disabilities.

MaineHousing reports that it has 12,000 subsidized housing vouchers statewide, 4,000 are for persons with mental illness. Currently there are 7000 applicants waiting for vouchers to "turn over."

Maine has 8000 units of project-based Section 8 housing, each having their own wait lists. Most wait lists are very long.

MaineHousing has set-aside seven Mainstream Section 8 vouchers for people receiving HCBS services under 1915 (c). This program is oversubscribed.

The shortage of housing options is particularly acute because for special populations, HUD, MaineHousing and local PHAs, give first preference for rental assistance to people who are homeless and second preference to homeless people with disabilities. Most of the HUD-funded Supportive Housing Programs (Transitional Housing, Permanent Housing for Persons with Disabilities, Safe Haven, and Innovative Supportive Housing) apply the same preferences.

QUALITY

The quality of Maine's housing stock also significantly limits options. According to Maine's Consolidated Five-Year Plan, "Maine's pre-1940 constructed housing stock is similar to the rest of New England but is nearly double the national percentage. Adverse conditions of aging housing stock may include outdated heating systems, inadequate plumbing, electrical systems, insulation, structural decay, inadequate accessibility design, and lack of appropriate health and safety systems."¹⁵

¹⁴ Source: <http://www.maine.gov/dhhs/files/hm2010/oppforall/b09res.pdf>.

¹⁵ Maine Housing and Maine Department of Economic and Community Development, Maine Consolidated Plan: Five Year Plan 2010 – 2014. (November 2010).

FACILITY-BASED SUBSIDIZED HOUSING.

MaineHousing reports that Maine has a total of 27,998 subsidized units funded by MaineHousing, HUD, USDA Rural Development, and local housing authorities, 51% of which serve seniors and a little over 8% serve disabled and special needs populations.

There are 131 Section 811 units, in 17 facilities statewide, for low income people with disabilities. These facilities also have very long waiting lists

There are 652 units in Section 202 facilities statewide for low income persons who are elderly. Again, these facilities have very long waiting lists.

ASSISTED LIVING

Maine has 38 assisted living facilities, 24 of which are private pay and 7 of which accept Medicaid funding.¹⁶

RESIDENTIAL FACILITIES

Of Maine's 606 assisted housing facilities, 282 facilities have 4 beds or fewer according to DHHS' Division of Licensing and Regulatory Services Assisted Housing List which can be accessed through DHHS' searchable online database of licensed residential facilities.¹⁷

EXPANDING HOUSING RESOURCES FOR DEMONSTRATION PARTICIPANTS

Over the years DHHS has worked with many public and private organizations to develop and subsidize housing for persons with disabilities and to ensure that individuals are eligible for and receive long-term support services. Principal among these are MaineHousing; the federal Department of Housing and Urban Development (HUD); local Public Housing Authorities (PHAs); affordable housing developers; and a network of service providers.

Over the course of the demonstration, the Housing Consultant will work with MaineHousing and others to:

INCREASE SET-ASIDES FOR MFP PARTICIPANTS.

MaineHousing and local housing authorities select applicants from waiting lists for admission to Section 8 Housing Choice Voucher and project-based voucher programs in an established order of preference. For special populations, that order is homeless people first and homeless people with disabilities second. While it can be challenging to balance all interests, MaineHousing and local housing authorities can petition their Boards to set aside vouchers for particular populations. DHHS will work with MaineHousing, PHAs and other partners to petition boards to dedicate up to 75 rental vouchers for MFP participants under the Section 8 (Choice & Mainstream vouchers); Sections 811 and 202 (project-based); and State HOME funds (tenant and project-based).

APPLY FOR NEW HUD RENTAL ASSISTANCE FUNDS

MaineHousing has indicated that it will again apply for HUD's "Rental Assistance for Non-elderly Persons with Disabilities Program" targeted for individuals currently living in nursing homes and other health care institutions if Congress appropriates the funds.

¹⁶ Seven of the assisted living facilities do not specify payment source. DHHS' database of licensed facilities can be accessed at: https://portalxw.bisoex.state.me.us/dhhs-apps/rcare/fac_list.asp.

¹⁷ Source: <https://portalxw.bisoex.state.me.us/dhhs-apps/rcare/>.

FOSTER DEVELOPMENT OF FOUR-BED RESIDENTIAL SETTINGS

MaineHousing issues RFPs for the development of housing targeted to the needs of households with special needs under their annual “Housing for Special Needs Population” Program. In 2010 it collaborated with Maine DHHS to set aside funds for projects serving DHHS consumers.¹⁸ Starting in the 2012 funding cycle, DHHS, in partnership with interested housing developers and service providers, will request that MaineHousing set aside funds under the Housing for Special Needs Population Program for the construction or substantial rehabilitation of up to five four-bed affordable rental housing units to serve MFP participants with complex needs.

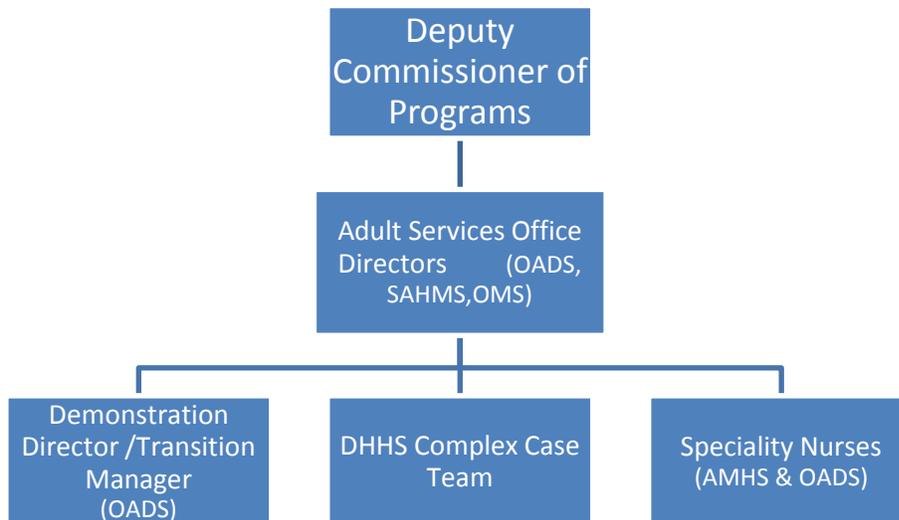
CONTINUITY OF CARE POST THE DEMONSTRATION

Demonstration participants will receive home and community-based waiver services through existing waivers or Medicaid state plan services. Most demonstration services are not expected to be needed beyond the demonstration period. For those that might (Enhanced Care Coordination and Remote Support Services), prior to the end of the participant’s first year in the community, the Transition Coordinator will review the participant’s plan to determine what services are needed on an ongoing basis and what resources may be accessed to replace these service. DHHS will evaluate the feasibility of modifying existing waiver and state plan services to add demonstration services for the target populations.

Maine does not plan to waive the level of care determination or the financial eligibility criteria for demonstration participants transitioning to home and community-based Medicaid services. In this way, the Department will ensure continuity of services following the end of the demonstration period.

PROJECT ADMINISTRATION

Figure 7: Project Administration Organizational Chart



¹⁸ Source: <http://www.mainehousing.org/Documents%5CRFPs%5CRFP-2010HousingforSpecialNeedsPops.pdf>.

THE ADULT SERVICES OFFICE DIRECTORS

The MFP Demonstration is integrated across adult programs and jointly managed through the oversight activities of the Adult Services Office Directors. Office Directors will contribute their time as an in-kind contribution.

DEMONSTRATION DIRECTOR

DHHS has hired a full-time Demonstration Director to oversee the MFP Demonstration Grant. The Demonstration Director will report to the Director of Long Term Care, within the Office of Aging and Disability Services. The Demonstration Director will have responsibility for:

- The day-to-day management of Money Follows the Person Demonstration activities.
- Serving as liaison with CMS in all grant-related activities, including preparation and submittal of all CMS and state required reports.
- Developing or overseeing the development of all MFP protocols, tools, outreach materials, contracts, etc.
- Collaborating with internal and external stakeholder groups and advisory groups to guide implementation of the MFP Demonstration.
- Gathering information and data and monitoring quality assurance performance measures to identify opportunities for improvement as related to the MFP Demonstration, the larger long term service and support systems, and the integrated care provided through the managed care program.
- Conducting outreach and educational programs to educate institutional and community providers, potential participants and family members about the MFP Demonstration.
- Managing administrative processes essential to the success of the Money Follows the Person Demonstration including the RFP process for contracted services; programmatic reviews and audits, monitoring, quality assurance, and quality improvement; review and approval of contract deliverables; monitoring grant expenditures against approved limits; working with DHHS program staff and rate-setting staff to set reimbursement rates and establish prior authorization limits
- Working with DHHS staff to establish program requirements and reviews participant service plans to ensure program requirements are met. Performs utilization management functions and reviews consumer surveys data

The Demonstration Director's job description is attached at Appendix C.

TRANSITION MANAGER

The Demonstration Director will serve as Transition Manager in the first years of the demonstration. In the spring of 2014 will be arranged through contract with the Long Term care Ombudsman's Program. The Transition Manager will oversee the Transition Planning process, approve Individualized Transition Plans, authorize services, monitor the success of transitions, and track demonstration participants. The Transition Manager's roles and responsibilities are defined under Transition Staff under Participant Selection and Enrollment.

SPECIALTY NURSES

Maine's three Field Nurses, within the Office of Substance Abuse and Mental Health Services, and Maine Long Term Care Behavioral Management Consultant, within the Office of Aging and Disability Services will conduct outreach and referral for the MFP program, conduct ANSA assessments as part of the preliminary assessment process, and will participate in consultation, training and transition planning for persons with complex needs, as needed. The combined level of effort is expected to total 15% of one FTE. This support will be provided as an in-kind contribution.

THE DHHS COMPLEX CASE TEAM

DHHS' Complex Case Team will provide consultation and guidance in transition planning for persons with complex needs. Membership will include the Demonstration Director and the Transition Manager, if different.

OTHER STAFFING

HOUSING SPECIALIST

DHHS will contract for Housing Specialist Services to support housing resource development and to facilitate access to housing for demonstration participants. The Housing Specialist will provide information about the types of housing options, the availability of housing, and the housing subsidy system. The Housing Specialist will also provide intensive support in locating housing for demonstration participants and securing housing and housing assistance. The Housing Specialist will also be responsible for working with the Maine Housing Authority to improve the availability of affordable and accessible housing for persons with disabilities, including the development of four-bed homes. The Demonstration Director will be responsible for assessing the Housing Specialist's performance.

INFORMATION TECHNOLOGY SUPPORT

Information Technology support will be provided through a variety of mechanisms:

- Maine's claims management system, the Maine Integrated Health Management Solutions (MIHMS) is managed by Molina Medicaid Solutions. Maine requested a modification to MIHMS to accommodate the Homeward Bound /MFP program. This Change Order to MIHMS was completed in early February 2014. Changes included adding a coverage code for MFP program participants to indicate their eligibility status, incorporating MFP services into MIHMS to allow for direct billing of services through the MMIS, and creating an interface between MeCare, the medical eligibility and service authorization system, and MIHMS, that provides the prior authorization needed for billing of all MFP services.
- MeCare, Maine's electronic medical eligibility determination assessment and plan of care tool for older adults and adults with disabilities, was enhanced to include a module for Homeward Bound MFP to enable entry of the Homeward Bound/MFP service plan and prior authorization of MFP services that are then sent to Maine's MMIS claims management system, MIHMS.
- Data extract files have been created and will be used to produce the data files (Finders File, Program Participation File, and the Services File) required for quarterly submission.
- A Participant Tracking Database has been developed and refined in order to track demonstration participants, quality measures and outcomes. The Tracking Database captures elements necessary for day to day program management and provides summary data on program status as needed.

OUTREACH

Maine will contract with the Long Term Care Ombudsman and other community groups to conduct outreach.

FINANCIAL/ACCOUNTING SPECIALISTS

Financial management and accounting services will be provided through existing MaineCare Finance and other financial management staff. This support will be provided on an in-kind basis.

BILLING AND REIMBURSEMENT PROCEDURES

Billing for services under this demonstration will be processed through Maine's new claims system, the Maine Integrated Health Management Solution (MIHMS). A person enrolled under Money Follows the Person will be

assigned a program eligibility coverage code, indicating participation in this grant. Services related to this demonstration will be prior authorized by the Transition Manager.

MIHMS is Maine's new claims management system implemented on September 1, 2010. It has built in controls that prevent duplication of payment for demonstration and Medicaid program services. MIHMS assures that medical and financial eligibility determinations and prior authorizations have occurred and are valid for the dates of service billed.

In order for a claim to be paid, financial and medical eligibility must be in place and, in addition, appropriate service authorizations must be reflected. A claim will not be paid if the claim submitted is for the same service, same service dates, and same provider. If a claim is denied, remedial action is taken to determine the accuracy of the invoice and verify services rendered.

Fraud control occurs through the billing process, provider enrollment, and complaint resolution. Qualified providers, enrolled to deliver specified covered services, will be selected from the active provider list. The Office of Licensing and Certification is responsible for ensuring providers meet their licensing provider qualifications.

In addition, Program Integrity (PI), within the Division of Audit in DHHS, is responsible for monitoring and safeguarding the MaineCare (Medicaid) Program against fraud, abuse and waste. It conducts analysis of MaineCare billings to detect utilization patterns or trends that may indicate fraud, abuse or waste. Based on data analysis or referrals/complaints received from other state agencies, health care providers or members, PI may perform retrospective audits/reviews of MaineCare Providers and members to validate the allegations of fraud, abuse or waste.

EVALUATION

OADS will arrange for administration the Quality of Life surveys on a contractual basis. The Demonstration Director will be responsible for ensuring that Maine's participation in the national evaluation for the MFP Demonstration is in compliance with federal regulations governing human subjects research. The Demonstration Director is also responsible for ensuring that the quarterly reports for the national evaluation are completed and submitted on time.

APPENDIX A: DHHS ORGANIZATIONAL CHART

CURRENT ORGANIZATIONAL CHART MAY BE ACCESSED ON THE DHHS WEB PAGE.

<http://www.maine.gov/dhhs/org-chart.shtml>

APPENDIX B: SUB-APPENDIX I

Self-Direction Submittal Form

I. Participant Centered Service Plan Development

a. **Responsibility for Service Plan Development. Specify who is responsible for the development of the service plan and the qualifications of these individuals (check each that applies):**

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Licensed physician (M.D. or D.O)
- Case Manager. *Specify qualifications:*
- Social Worker. *Specify qualifications:*
- Other (*specify the individuals and their qualifications*): *Transition Team and manager as defined in Operational Protocol.*

b. **Service Plan Development Safeguards. Select one**

- Entities and/or individuals that have responsibility for service plan development may not provide other services to the participant.
- Entities and/or individuals that have responsibility for service plan development may provide other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:

c. **Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.**

At the time of initial enrollment, the transition manager conducts a preliminary meeting with the potential participant, legal representative if applicable and any support person identified by the participant. During the transition planning process, the transition coordinator describes the community options and services that are available under MFP. Once participant is in the community, the Service Coordination Agency (SCA) ensures continuing active engagement by the participant, family member(s) identified by the participant, and/or the participant's legal representative as the service plan is implemented.

- d. Service Plan Development Process In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):**

(a) The enrollment process will take place in three stages and information gathered at each stage will lead to development of the individualized transition plan (ITP) by the Transition Team, as described below and in the OP. The Transition Manager (TM) must approve the ITP. During the Preliminary Assessment Process, the participant conducts a self-assessment designed to optimize the resident's control of the transition process and help identify his or her preferred outcome. If the participant moves on to the Transition Planning Process, the relevant Transition Coordinator (TC) continues to work with the participant and will be responsible for implementing or overseeing implementation of the individualized transition plan (ITP) based on the recommendations of the Transition Team. The Transition Team is comprised of the participant, support persons and/or legal representatives, Housing Specialist as necessary, multidisciplinary team and the TC. The TC will assist participant in applying for necessary services and ensure that the participant meets functional or clinical eligibility for services and arrange for a level of care determination for persons transitioning to a HCBS waiver.

(b) The ITP is developed by the transition team and is based on preliminary assessments as described above, including a self-assessment by the participant completed during the Preliminary Assessment Process. At that time, the TM also completes a Readiness Assessment and when indicated, will arrange for a field nurse to conduct an Adult Needs and Strengths Assessment (ANSA) to gauge complexity and level of need. If participant moves on to the Transition Planning Process phase, the transition team will identify the type and frequency of services and supports necessary to meet the participant's goals, through a combination of MFP services, MaineCare services, state-funded and community resources, and informal supports. Depending on the services identified, an assessment may be completed by an RN assessor as part of existing program guidelines to determine level of need for program eligibility and authorization of a plan of care for applicable MaineCare program services.

(c) The TM and TC inform the participant of services available under the MFP demonstration and other community resources that may be available to meet his or her needs.

(d) The participant is actively engaged throughout the planning process as she/he contributes information about his/her preferences, strengths, potential barriers and need for support services. In addition, once the transition occurs, the service coordination agency (SCA) will continue to assist the participant with locating providers and obtaining authorized services based on his or her choice of provider. The SCA will monitor service utilization each month to assure effectiveness of plan in meeting participant's needs and compliance of service delivery with program requirements.

(e) The transition team will identify the type and frequency of services and supports necessary to meet the participant's goals, through a combination of MFP services, MaineCare services, state-funded and community resources, and informal supports. The TC will assist participant in applying for necessary services and ensure that the participant meets functional or clinical eligibility for services and arrange for a level of care determination for persons transitioning to a HCBS waiver. The TC also works with the Community Service Coordinator to ensure a seamless handoff of responsibility during the transition process, no later than the date of transition.

(f) The ITP checklist will describe the monitoring process for plan implementation and the post-transition period. It must document the assignments, follow up plans and have required transition team signatures. It is the responsibility of the TC to ensure that each action item in the ITP has been assigned to the appropriate individual based on the timelines developed by the Transition Team. Following the transition, the Community Service Coordinator (CC) is responsible for monitoring the implementation of the service plan and identifying needed modifications. The CC will notify the TM of any change in status or any needed modifications in the ITP. The TM will contact the participant quarterly to confirm on-going success of the transition.

(g) The participant or his or her legal representative if applicable, will receive a copy of the ITP.

- e. 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 backup plans and the arrangements that are used for backup.**

The planning process includes the completion of a risk assessment and the ITP must identify risks and describe the plan for managing those risks. It also describes the participant's emergency backup plan for needed services and supports. In order for the Transition team to decide that the transition may occur, the team must be satisfied that the identified risks associated with the transfer can be effectively mitigated according to

the Risk Mitigation Plan. In addition, if participant transfers to a HCBS waiver, there are several items in the MED assessment that determines functional eligibility for the waiver may indicate potential risks to the participant. These items may include frequency of falls, availability of informal supports, medication administration and compliance, cognitive and behavioral issues, and an environmental assessment. Services authorized and information about community resources (such as caregiver support, pharmacy assistance) may help to mitigate the risks identified. The Service Coordination Agency is advised of the risks when person is transitioned. They discuss arrangements for backup with the participant when support services are not available. At the time of the face-to-face care monitoring visit by the Service Coordination Agency, the plan of care is reviewed for its effectiveness in meeting the needs of the participant, including its ability to address any existing risk factors or health and welfare concerns.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

As part of the Transition Planning Process, the participant will be provided information regarding the availability of qualified providers in their area. Information on self-direction will also be provided and discussed.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

The Transition Manager (TM) within DHHS approves the ITP, working under the supervision of the Project Director. DHHS assumes ultimate authority for the approved plan.

Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years' time (the three years of the demo plus one additional year.) Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other (*specify*):

II. Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.**

The ITP will describe the monitoring process for plan implementation and the post-transition period. Following the transition, the Community Care Coordinator (CC) is responsible for monitoring the implementation of the service plan and identifying needed modifications. The CC will notify the TM of any change in status, any reportable events, needed modifications in the ITP and any requests for additional services. The CC will be responsible for reviewing the ITP at least quarterly and more frequently if necessary. The participant's multi-disciplinary team will be involved when necessary. The TM will contact the participant quarterly to confirm on-going success of the transition. Contact with participant shall be through home visits and by telephone.

- b. **Monitoring Safeguards. Select one:**

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

III. Overview of Self-Direction

- a. **Description of Self-Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.**

(a) Self-direction of personal care services is an option available under the following State Plan and waiver programs: Section 96 of the MaineCare Benefits Manual (MBM)(Private Duty Nursing and Personal Care Services); Section 12 of the MBM(Consumer Directed Personal Assistance Services); Section 19 of the MBM (Elderly and Adult with Disabilities waiver); and Section 22 of the MBM(Consumer Directed Personal Assistance waiver for Physically Disabled).

The planning process for the MFP Demonstration is conducted in a manner that retains for the participant as much personal responsibility and self-determination as possible and desired; thus, opportunities for self-direction are discussed with the participant as part of the planning stage prior to transition. Consumer directed and Family Provider Services Option (FPSO) are through HCB waiver and State plan services, both of which

allow for direction of personal care services. The self-directed programs allow individuals to hire their own direct care workers and eligibility is conditioned on the individual's cognitive capacity to self-direct. The FPSO model allows an individual, 21 years or older, to register as a personal care agency solely for the purpose of managing the individual's own personal care services or the services of up to 2 family members.

(b) If a participant or their family member is interested in one of these options, the TC will provide additional information about available options, answer any questions, and make a referral to the Service Coordination Agency. The Service Coordination Agency provides additional information and any required training about consumer direction and the Family Provider Service Option to the participant and his/her representative (if any) and also facilitates the process of registering as a Personal Support Services Agency. In order to participate in this option, the participant or family member must register as a "Personal Support Services Agency" with the Department of Health and Human Services pursuant to Title 22 MRSA §1717.

(c) The Service Coordination Agency provides on-going support for participants who self-direct or choose to utilize the FPSO. The participant will work with a Fiscal Intermediary to coordinate payroll services for their Personal Care workers. The Fiscal Intermediary provides administrative and payroll services for these workers. These services include preparing payroll and withholding taxes, and ensuring compliance with State and Federal tax and labor regulations.

(d) The following is additional relevant information about the MFP demonstration's approach to participant direction:

DHHS is currently working on an initiative to create a single design for the self-direction/FPSO programs that will provide greater consistency and ease of transition for participants.

The Consumer Directed Personal Assistance waiver for the Physically Disabled (Section 22 of the MaineCare Benefits Manual (MBM)) currently has a waitlist and generally does not provide the package of services most likely needed for Demonstration participants. It is therefore expected that most participants who choose to self-direct will do so using the FPSO model (Section 19 of the MBM).

Currently for the FPSO model, the Service Coordination Agency must:

- Check the CNA Registry and conduct a criminal background check on the individual who registers as a Family Provider Agency;
- Establish a monthly cost limit based on the authorized plan of care; and
- Manage professional and/or other waiver services other than Personal Care Services.

The participant or family member who is registered as the Family Provider Agency:

- Must conduct a criminal history background check if required by Title 22 MRSA §1717 and check the CNA registry for any individual hired as a Personal Care Attendant (PCA).
- May not employ an individual who is prohibited from employment under Title 22 MRSA §1717(3).
- May not be paid to provide care to the participant.
- Must use a Fiscal Intermediary, approved byDHHS, as a payroll agent.
- Must provide adequate orientation for the PCA to meet the needs of the participant(s), as specified in the ITP.
- Must document the provision of orientation, including specific dates and the content matter of the orientation, in the employee's personnel file.
- Must document the competency of the PCA in all required tasks.

A participant who does not have cognitive capacity may not register as a Family Provider Agency. A participant's guardian may not be paid to provide care to the participant.

The use of a Fiscal Intermediary is required under the Family Provider Service Option. The Fiscal Intermediary acts as an agent of the employer in accordance with Federal Internal Revenue Service Codes and procedures in matters related to the employment of support workers.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the demonstration. *Select one:*

- Participant – Employer Authority.** As specified in **Appendix E-2, Item a**, the participant (or the participant's representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant – Budget Authority.** As specified in **Appendix E-2, Item b**, the participant (or the participant's representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The demonstration provides for both participant direction opportunities as specified in **Appendix E-2**. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
- Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
- The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

NOTE: For individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor, availability of self-direction/FPSO depends on nature of the residence. Self-direction is currently not allowed in most residential care settings.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria:***

Self-direction of personal care services is an option available to participants who receive the following waiver or state plan services: Section 96 of the MaineCare Benefits Manual (MBM), (Private Duty Nursing and Personal Care Services); Section 12 of the MBM, (Consumer Directed Personal Assistance Services); Section 19 of the MBM, (Elderly and Adult with Disabilities waiver); and Section 22 of the MBM, (Consumer Directed Personal Assistance waiver for Physically Disabled).

The Self-directed option allows a participant with cognitive capacity to self-direct personal care services. The Family Provider Service Option allows a participant or family member the option to direct the

participant's Personal Care Services. Other waiver services are provided through the traditional agency model of service delivery facilitated through the Service Coordination Agency.

A participant who desires to direct his or her own Personal Care Services must have cognitive capacity, as determined by the MED assessment. A participant determined not to have cognitive capacity may access the Family Provider Service Option through a family member acting as his or her delegated representative.

Any participants who decide not to direct their Personal Care Services are able to access these services through the traditional agency model of service delivery facilitated through the Service Coordination Agency.

- e. **Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.**

FAQ sheets are provided by the Transition Coordinator during the transition planning process that describe the Family Provider Service Option, which allows a participant expected to enroll in a waiver or State plan service program the opportunity to direct the participant's Personal Care Services or have a family member direct those services. The TC will also answer any questions or provide additional information to the participant if he or she is interested. If the participant or family member expresses an interest in this option, the TC will assist participant/family member in taking steps necessary to access this option.

- f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of demonstration services by a representative (*select one*):

- The State does not provide for the direction of demonstration services by a representative.
 - The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: (*check each that applies*):
 - Demonstration services may be directed by a legal representative of the participant.
 - Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply .
- NOTE: The Family Provider Service Option allows personal care services to be directed by a family member, defined as individuals**

related by blood or marriage or adoption as well as two (2) unmarried adults who are domiciled together under a long-term arrangement that evidences a commitment to remain responsible indefinitely for each other's welfare.

- g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities), available for each demonstration service. (Check the opportunity or opportunities available for each service**

Self-direction is not available for the demonstration services but is an option available to individuals participating in the MFP Demonstration as follows:

Personal care Services under Section 96 of the MaineCare Benefits Manual (MBM), (Private Duty Nursing and Personal Care Services); Section 12 of the MBM, (Consumer Directed Personal Assistance Services); Section 19 of the MBM, (Elderly and Adult with Disabilities waiver); and Section 22 of the MBM, (Consumer Directed Personal Assistance waiver for Physically Disabled).

- h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. Select one**

- Yes.** Financial Management Services are furnished through a third party entity. *(Complete item E-1-i). Specify whether governmental and/or private entities furnish these services. Check each that applies:*
- Governmental entities
- Private entities
- No.** Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. *Select one:*

- FMS are covered as a Demonstration service. Fill out i. through iv. below:
- FMS are provided as an administrative activity. Fill out i. through iv. below:
 - i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services: *The Fiscal Intermediary acts as an agent of the employer in accordance with Federal Internal Revenue Service Codes and procedures in matters related to the employment of support workers. The use of a Fiscal Intermediary is required. The Service Coordination Agency assists participants with selection of FMS.*
 - ii. Payment for FMS.** Specify how FMS entities are compensated for the activities that they perform: *Payment is made on a per member/per month basis*

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide (check each that applies):

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status
- Collect and process timesheets of support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Other (specify): *assists with obtaining background check on workers*

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's self-directed budget
- Track and report participant funds, disbursements and the balance of participant funds
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the self-directed budget
- Other services and supports (specify):

Additional functions/activities:

- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Other (specify):

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed:

Billing of personal support hours is based on authorized plan of care. Quarterly reports from the FMS are provided to verify compliance with hours authorized and delivered. Consumer survey of participants includes questions related to experience of participant with the FMS.

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:*

Response: Care coordinators provide information and assistance in support of Self Direction for participants interested in or accessing the Family Provider Service Option. This service assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the care coordinator is available to assist in accessing identified supports and services (including access to other waiver services such as nursing, PERS, therapies, adult day services as authorized in the participant's plan). Practical skills training is offered to enable families and participants to independently direct and manage waiver personal care services. Information given to participants of the Family Provider Service Option ensures that participants understand the responsibilities involved with directing their services.

- Demonstration Service Coverage.** Information and assistance in support of participant direction are provided through the demonstration service coverage (s)
- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. **Independent Advocacy** (select one).

- Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy:*

Response: Participants are informed of support available to them through Legal Services for the Elderly and the Long-Term Care Ombudsman Program. These contacts are listed on the due process notice issued at the time of reduction, denial or termination of services. They are also provided by the Transition Coordinator when a participant enrolls.

- No.** Arrangements have not been made for independent advocacy.

l. **Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order

to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

If a participant chooses to terminate the Family Provider Service Option the case manager will assist the participant in accessing their Personal Care Services through the traditional agency model. All efforts will be made to transition the person without any gap in service.

- m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition**

If the use of the Family Provider Service Option or self-direction is involuntarily terminated for a participant, the care coordinator will assist the participant in accessing their Personal Care Services through the traditional agency model. All efforts will be made to transition the person without any gap in service. When this option is involuntarily terminated, due process is issued to allow the participant to access a fair hearing regarding the decision to terminate this service delivery option.

- n. Goals for Participant Direction. In the following table, provide the State’s goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.**

Demonstration Year /Number	Number of Participants
Year 1	0
Year 2 : 1	1
Year 3 : 2	2
Year 4 : 2	2
Year 5 : 2	2

Participant Employer

a. Participant – Employer Authority *(Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b) 71*

- 1. Participant Employer Status. Specify the participant’s employer status under the demonstration. *Check each that applies***

- Participant/Co-Employer.** The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law

employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:*

- Participant/Common Law Employer.** The participant (or the participant’s representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

2. Participant Decision Making Authority. The participant (or the participant’s representative) has decision making authority over workers who provide demonstration services. Check the decision making authorities that participants exercise:

- Recruit staff
- Refer staff to agency for hiring (co-employer)
- Select staff from worker registry

- Hire staff (common law employer)

- Verify staff qualifications

- Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated: *paid by FI*
- Specify additional staff qualifications based on participant needs and preferences
- Determine staff duties consistent with the service specifications

- Determine staff wages and benefits subject to applicable State limits

- Schedule staff

- Orient and instruct staff in duties

- Supervise staff

- Evaluate staff performance

- Verify time worked by staff and approve time sheets

- Discharge staff (common law employer)

- Discharge staff from providing services (co-employer)
- Other (*specify*):

b. Participant – Budget Authority (Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)

3. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Check all that apply:

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State’s established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications
- Specify how services are provided,
- Identify service providers and refer for provider enrollment
- Authorize payment for demonstration goods and services
- Review and approve provider invoices for services rendered
- Other (*specify*):

4. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

5. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

6. Participant Exercise of Budget Flexibility. Select one:

- The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the

service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

- Modifications to the participant-directed budget must be preceded by a change in the service plan.

7. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:



APPENDIX C: DEMONSTRATION DIRECTOR'S JOB DESCRIPTION

DIRECTOR SPECIAL PROJECTS

(Money Follows the Person Demonstration Director)

CODE: CA 28 PAY GRADE: 28 (confidential)

Agency Information

The Department of Health and Human Services (DHHS) protects and preserves the health and welfare of Maine citizens by administering a wide-ranging system of programs in health, behavioral health, social services, income maintenance, public health, and medical services. The Office of Elder Services (OES) within DHHS oversees a broad range of community services for older persons, adult protective services, and long-term services and supports. With a staff of 90, OES is directly responsible for an annual operating budget of more than \$400 million in state and federal funds. DHHS has received federal funding for a **Money Follows the Person Rebalancing Demonstration** grant, known as Homeward Bound here in Maine. The Demonstration is expected to run at least until 2016. This is a Medicaid program designed to support state efforts to rebalance their Medicaid long-term care programs by shifting service provision to the community and away from institutionalized care. Homeward Bound involves developing and implementing a program to transition eligible persons in nursing facilities and hospitals to eligible home and community-based settings. This position will be located in Augusta.

Job Duties

1. Serves as key communicator relating to Homeward Bound:
 - a. Serves as liaison with CMS in all grant-related activities,
 - b. Provides ongoing guidance and coordination across offices within and beyond DHHS.
 - c. Prepares and shares information with a broad range of external stakeholders.
2. Provides leadership and coordination in systems change work:

- a. Gathers and analyzes information to better understand target populations, including identifying barriers that have prevented transition to the community.
 - b. Works closely with consumers, advocates and providers to identify needed systemic improvements.
 - c. Analyzes state/federal legislation, public policy, and best practices in order to recommend how best to assure that people are able to return to or remain in their homes and communities.
3. Oversees transition process for Homeward Bound participants:
- a. Receives referrals of potential participants from a variety of referral sources.
 - b. Provides information and educational resources to potential participants, family members, and other interested parties.
 - c. Conducts Preliminary Assessment Process for potential participants.
 - d. Confirms eligibility of participants for Homeward Bound and provides appropriate notification to each participant of that determination.
 - e. Ensures informed choice and consent of all potential and enrolled participants.
 - f. Refers participants to a Transition Coordinator based on the needs of each participant.
4. Coordinates quality management functions:
- a. Works with DHHS staff to establish program requirements and reviews participant service plans to ensure program requirements are met.
 - b. Reviews consumer surveys data.
 - c. Monitors the Transition Planning Process to hold Transition Coordinator and Transition Team accountable for development/implementation of Individualized Transition Plan.
 - d. Monitors health and welfare of participants.
 - e. Identifies areas of unmet need among participants.
5. Manages other administrative tasks involved with Homeward Bound:
- a. Works with other OES and DHHS staff to develop specifications for contracted services.
 - b. Oversees contracts for Homeward Bound services.
 - c. Responsible for preparation and submittal of CMS and state required reports.

REQUIREMENTS

To qualify you must have a Bachelor's Degree and four (4) years of progressively responsible experience in the development, delivery or administration of social service programs. At least three (3) years of the required experience must be in a supervisory and/or administrative capacity. Equivalent related work experience may be substituted for education on a year-for-year basis. The background of well-qualified candidates will demonstrate expertise in the following areas:

1. Exceptional leadership and organizational skills.
2. Knowledge of and the ability to plan, manage and evaluate services and policies for elders and others who receive/need long-term care services and supports.
3. Prior experience in preparing and overseeing grants and service provider contracts.
4. The ability to establish and maintain effective, collaborative working relationships with other state officials, federal officials, private organizations, consumers, and advocates.

APPENDIX D : History, Background and Agency Structure

This section was included in the Original Operational Protocol for background purposes

Over the last several decades, through a series of major reform initiatives, Maine has dramatically reduced its reliance on institutional services for persons with disabilities and older adults:

- In 1983 Maine established its ID waiver program; in 1996 Maine closed its state-operated ICFs-IIDs.
- Starting in the 1970s, Maine began reducing the number of people in its state-operated IMDs and developing its community-based mental health services. Maine has now reconfigured its state-operated IMDs to provide only acute psychiatric and forensic hospitalization services.
- In the 1990s, Maine's initiated several reforms including the targeting of nursing home admissions to those most in need by raising the medical eligibility threshold. Maine's Legislature established a law requiring that anyone seeking admission to a nursing facility, regardless of payment source, be assessed for medical eligibility, based on a standardized assessment conducted by an independent assessing agency. The law provides a financial disincentive for a nursing facility to admit a resident, even if private pay, who does not meet Medicaid medical eligibility at the time of admission. This same assessment tool is used to determine medical eligibility for a wide range of Medicaid and state funded home and community-based services for older adults and adults with disabilities. As a result of these reforms, between 1995 and 2000, the number of MaineCare members in nursing homes, on average in a month, dropped almost 18% while the number of people receiving HCBS waiver services increased 13%.
- Maine has no institutional level of care for children with emotional disturbance and does not have any Psychiatric Residential Treatment Facilities. Maine has reduced the median length of stay for a child entering a residential treatment facility from 212 days in 2003 to 111 days in 2009. Maine has also reduced the number of children in out-of-state hospitals and residential treatment programs by almost two-thirds, from 75 in 2002 to 25 in 2010.
- Maine recently converted its one state-operated ICF-IID for children to private ownership. This ICF-IID serves medically fragile children with 16 long term beds and 4 respite beds; four ICF-IID beds are available through another private provider.
- Children are not served in nursing facilities. Children needing nursing facility level of care may access home and community-based services through the Katie Beckett eligibility option.

As a result of these reforms, Maine has successfully reduced utilization of institutional services for many persons with disabilities. For example, according to Maine's State Profile Tool report,¹⁹ among those with a long term or continuing need for services and supports, 9% of adults with intellectual disabilities or autism, 4% of adults with severe and persistent mental illness, 5% of children with developmental disabilities, and 6% of children accessed any institutional services in State Fiscal Year 2008. For some populations, however, utilization of institutional services remains relatively high. For example, according to that same report, 25% of adults with brain injury, and 57% of older adults and adults with disabilities, used institutional services that year.²⁰ Maine also continues to

¹⁹ Muskie School of Public Service at the University of Southern Maine. *Cross System Profile of Maine's Long Term Support System: A New View of Maine's Long Term Supports and Services and the People Served* (March 2009).

²⁰ This report developed population definitions intended to identify only persons with a continuing need for long term services and supports (*i.e.*, excluding people with only a short term need for institutional or other long term services and supports). Institutional services were defined to include nursing facilities, intermediate care facilities and hospitals. (Because Maine's IMDs are not intended to provide long term services, they were not included in the definition of institutional services.)

rely on hospitalizations and out-of-state institutional placements when Maine providers are unable to serve persons with complex needs at in-state rates.

Our experience suggests that these problems are the result of some continuing weaknesses in our current system:

- While Maine has been very effective at diverting all but the most medically needy from nursing facilities, for those who are admitted, there are no dedicated resources to help with the return home. Several factors make it harder for Maine people to return to their communities. As a largely rural state, many communities have no public transportation, limited access to services, and many live long distances from family, neighbors and friends. Maine's housing stock is old and less likely to be accessible to persons with disabilities, making it harder to return home for people with new injuries or disabilities. And the migration of the younger generation looking for better jobs means that many older adults in Maine have no adult children nearby to take on the role of caregiver.
- Diagnosis driven eligibility criteria create uneven access to home and community-based services for individuals with complex needs. For people who need a high level of care but do not meet eligibility criteria for diagnosis-based programs providing that level of care, the nursing facility is often the only available option. Further complicating the matter, many services are designed on the premise that a person has only one diagnosis at a time. For people with a complex combination of conditions, a blending of services and multi-disciplinary expertise is needed. Because no individual program provides the right fit, again, the nursing facility or hospital (and many times, out-of-state institutions) become the default option. Even when service eligibility is not a factor, provider expertise and capacity can be. Many community providers report they cannot provide services to persons with complex needs because they do not have the right combination of expertise or they cannot provide the appropriate level of services at in-state Medicaid rates.

Through Homeward Bound, Maine's Money Follows the Person Demonstration Project, the Maine Department of Health and Human Services (DHHS) will begin to address these challenges. Through this demonstration, Maine plans to transition 122 persons residing in either in-state or out-of-state nursing facilities or hospitals who fall into either of these three target populations:

- Older adults
- Adults with physical disabilities
- Persons with any complex combination of medical, behavioral and cognitive impairment

This project will allow Maine to test several strategies aimed at addressing some of the barriers to better serving these groups in the community

- Developing an "early intervention" system to identify upon admission people who could return to the community, but are at risk of losing sight of that goal. Through this process, we will work with the individual and family to preserve the option of returning home, maintain the focus on that goal, and address needs and barriers.
- Developing the provider capacity to provide transition services as well as demonstrating the value of these services both in terms of reducing utilization of costly nursing facility services and making it possible for people who prefer to live at home to do so. Currently, transition services are not funded services for older adults/adults with disabilities or for persons with brain injury. In the current fiscal environment, Maine is not able to commit to incorporating transition services into our existing service array without evidence that these services will actually reduce costs. Homeward Bound will provide us with the means to develop that evidence.

- Exploring the value of technology and other community supports. Maine is a largely rural state and many people in Maine have seen family members move to other parts of the state or country to find work. We would like to determine whether technology can help to address concerns about a person’s vulnerability when living alone. Through Homeward Bound, we will test the feasibility of in-home technology to enable transitions that might not otherwise be possible. Again, Maine has experienced successive years of budget shortfalls, so expanding services without solid evidence that they will actually reduce costs, is not an option right now. Homeward Bound provides us with the means of doing so.
- Persons with brain injury, comprising a large number of the persons with complex needs residing in out-of-state facilities and in-state nursing facilities, do not have access to case management services. This demonstration project provides us with an opportunity to provide those services both pre- and post-transition.
- We will expand the range of housing options available to persons with complex needs. Through the MFP demonstration project, DHHS will work with Maine Housing to tailor their housing development initiatives to address this need. We expect the MFP Demonstration project to result in the “bricks and mortar” of new housing stock as well as a new, stronger, collaborative relationship with Maine Housing.
- Through the MFP demonstration we will use rebalancing funds to provide individualized and more general training for community providers and Informal support persons to expand their capacity to support individuals with complex needs. In the long term, we anticipate that this increased community capacity will make it possible for some people with complex needs to avoid admission to a nursing facility altogether.

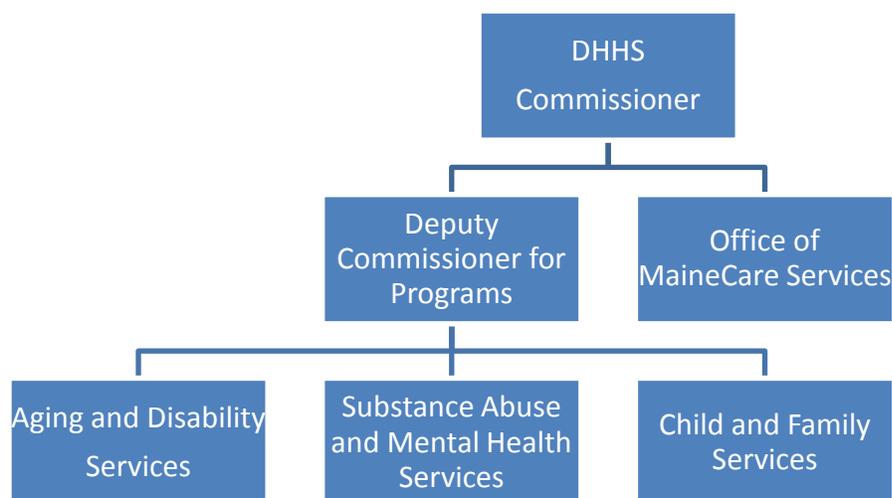
ORGANIZATION AND ADMINISTRATION

SYSTEM ASSESSMENT AND GAP ANALYSIS

MAINE'S LONG TERM SERVICES AND SUPPORT SYSTEM

DHHS administers all institutional, residential and home and community-based services for persons with disabilities all under the direction of the Deputy Commissioner for Integrated Services. The Office of MaineCare Services sets policy for MaineCare, Maine's Medicaid program, including long term services and support. The organizational chart in FIGURE 1 shows the organizational relationships among Maine's long term supports and service programs and is current as of September, 2012.²¹

FIGURE 8: DHHS LTSS PROGRAMS AND THE OFFICE OF MAINECARE SERVICES



OLDER ADULTS AND ADULTS WITH DISABILITIES

At the time the original Operational Protocol was created, The Office of Elder Services (OES) and the Office of Adults with Cognitive and Physical Disability Services (OACPDS) administered programs and services for older adults and adults with disabilities. OES administered the largest programs including a home and community-based waiver, state plan services, and state-funded services. OES set policy for assisted living services, adult family care homes, independent housing with services, adult foster care homes, and residential care services and defines the medical eligibility criteria for nursing facility services. OACPDS administered the waiver, state-plan and state-funded consumer-directed programs for adults with physical disabilities (*i.e.*, persons having the cognitive capacity to direct their own care). In September 2012, OES and OACPDS merged to form the Office of Aging and Disability Services (OADS).

All services described above are currently administered under OADS.

Access to all of these services except residential services and adult family care homes is through the Medical Eligibility Determination (MED) assessment conducted by a single, independent, statewide assessing agency.

²¹ See APPENDIX A for a fuller version of the organizational chart for DHHS

OADS home and community-based services are managed by a home care coordinating agency which is responsible for helping consumers implement an array of home care services. Consumer directed services are supported by a home care coordinating agency which provides training and support for consumers selecting and paying their employees.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

Maine's Office of Adult Mental Health Services (OAMHS) recently merged with the Office of Substance Abuse to form the Office of Substance Abuse and Mental Health Services (SAMHS). SAMHS administers Maine's mental health services, including mental health treatment, community support services, residential and hospital services. Access to community support and residential services is primarily limited to persons with serious and persistent mental illness.

Maine has three tiers of psychiatric hospitals. Community hospitals provide psychiatric services and several have specialized psychiatric units. These hospitals serve people with short term acute care needs. Maine also has two regional private psychiatric hospitals which serve people whose needs exceed the community hospital's capacity. Maine's state-operated facilities serve people with a longer term need for hospitalization. Maine also has three nursing facilities providing specialized services for adults with severe and persistent mental illness who also have physical health conditions that make them eligible for nursing care.

Most adult mental health services are funded through MaineCare, which offers two levels of benefits: people who are categorically eligible for Medicaid have access to a more comprehensive benefit package; Maine also has a waiver making available a limited benefit package for "non-categorically eligible" adults. People may also be eligible for state-funded services which can supplement MaineCare services, when appropriate.

ADULTS WITH BRAIN INJURY

DHHS continues to build services to people with brain injury. In 2005, the Legislature designated DHHS as the state agency responsible for acquired brain injury services.²² In the past legislative session Maine authorized DHHS to take the next step in developing a brain injury program. With the recent reorganization, services now sit within the Office of Aging and Disability Services

DHHS covers three groups of services specially designed for persons with brain injury, all of which are MaineCare funded:

- Outpatient Neurorehabilitation services
- Specialized residential services
- Specialized nursing facility services

When eligible, people with brain injury may also access services available through other programs.

ADULTS WITH INTELLECTUAL DISABILITIES OR AUTISM

OADS administers services for adults with intellectual disabilities or autism, including case management, home and community-based waiver services, residential services, and ICF-IID services. Maine's comprehensive waiver program for persons with intellectual disabilities or autism was developed in 1983 to serve people moving out of Pineland, Maine's state-operated institution serving people with intellectual disabilities or

²² 22 MRSA §3089.

autism. It provides a comprehensive package of services, including residential services and today serves up to 2860. DHHS recently developed a second waiver package that assumes that the individual is already living independently or with a natural support system; this waiver provides community supports and employment services and can serve up to 2000 people. There are long waiting lists for both of these waivers and persons in need of protective services have first priority.

CHILDREN'S SERVICES

DHHS provides an array of services to children with behavioral health and developmental needs, including case management services, respite, outpatient treatment, medication management, crisis services, homeless outreach services and early intervention services. Children with serious emotional disturbance have access to Assertive Community Treatment and Home and Community-Based Treatment. Children with intellectual disabilities or autism spectrum disorder may access Rehabilitative and Community Support Services. CMS has recently approved Maine's request to develop a Home & Community-Based Waiver Program for children with Intellectual Disabilities and/or Pervasive Developmental Disorders. Residential services are also available but are designed to provide intensive short-term treatment.

SYSTEM REBALANCING AND INSTITUTIONAL DIVERSION

COMMUNITY CAPACITY

Maine continues to improve and strengthen its home and community-based resources.

The demographics of Maine's population will continue to drive the use of long term care services in Maine. In 2007, Maine ranked fourth in the nation with the percent of people over age 65 (14.8%) and by 2030, Maine will have the second highest percentage (26.5%) of people age 65 or over. To prepare itself for this wave, in 2007, OES commissioned a study of actual and projected utilization and expenditures for long term services and supports.²³ This tool provides OES with a better understanding of the likely need for long term supports and services in Maine and can also be used to project the impact of policy changes.

Through Maine's State Profile Tool project, Maine has conducted a survey of residential providers to capture better information about the characteristics of residential settings, including the level of privacy and autonomy residents have and the "look and feel" of the facility. The results from this survey will be used to develop measures for distinguishing those residential facilities that are "homelike" and those residential facilities that look and feel more like an institutional setting.

DHHS collaborated with Maine Housing to develop a housing registry, providing a searchable database for currently available rental housing.

Maine's five Area Agencies on Aging are now also Aging and Disability Resource Centers, providing information and referral and other services to all adults with disabilities and to older adults.

Maine recently received a Personal and Home Care Aide State Training Program grant from HRSA to develop a core curriculum for direct support staff providing services to older adults and adults with physical disabilities, adults with intellectual disabilities or autism, and adults with serious and persistent mental illness. In addition to increasing the mobility and flexibility of Maine's direct support workforce, this initiative will greatly facilitate the ability to cross-train, to increase Maine's capacity to serve persons with complex needs.

²³ The Lewin Group and the Muskie School of Public Service. 2008. *Projections of State and County Level Long Term Care Need and Use in Maine, 2006-2015*.

SMOOTHING THE BOUNDARIES

In the early years of de-institutionalization, Maine's primary focus was on the availability of home and community services. As these services evolved, the quality of services became a higher priority, with an increasing emphasis on evidence-based services and quality and performance measurement. Along the way, the State also improved its management of resources to make sure that services are available to those who need them most. All of these reforms have been guided by the goal of ensuring that home and community services are a meaningful alternative to institutional care. By many measures, these efforts have been largely successful.

In recent years, however, it has become increasingly apparent that where Maine's long term service and support system fails it is often because this system is, in fact, not one system but many systems. Many systems of different types, including acute and long term services, behavioral health and physical health, children's services and adult services. When things breaks down, it is often on the boundary between these systems, when a person tries to transition from one system or care setting to another or when a person needs to access services from multiple systems.

At the program level, DHHS has taken significant steps toward smoothing the boundaries across systems. Starting with the 2004 merger of its two legacy departments, the Maine Department of Health and Human Services has incrementally taken significant steps toward better integration across programs. Further consolidation is expected to continue in the current administration.

To support the integration of Adult Services, the previous administration formed an Adult Services Consortium. The Adult Services Consortium is a collective body of DHHS programs that includes the leadership of all adult programs, including Adults with Cognitive and Physical Disabilities, Adult Mental Health Services, Elder Services, and Substance Abuse Services. The Director and leaders of the Office of MaineCare Services also participate in the bi-weekly meetings of the Consortium. The Adult Services Consortium is the forum for identifying, analyzing, discussing and resolving complicated and challenging issues (involving both individual Mainers and the programs/systems created to serve individuals) that cut across the various elder and adult populations served by DHHS programs.

Other initiatives to improve coordination and integration of services:

- Overseen by DHHS Deputy Commissioner a Complex Case Team addresses the needs of persons with a complex combination of needs, focusing on function rather than diagnosis. This team, which has been in existence for three years, includes representatives from each program office .. Integrated service coordination involves collaboration with individuals, state agencies, provider agencies, families and physicians, negotiating for resources and coordination across multiple service systems, state and private. The team has been instrumental in removing people from danger, obtaining guardianship for incapacitated individuals, and arranging for the provision of needed services.
- Under Maine's Co-Occurring State Incentive Grant, Maine has been working to change the state's infrastructure and provider practice to integrate mental health and substance abuse treatment.
- Maine is developing core licensing standards common to all behavioral health provider programs, including mental health and substance abuse treatment providers for adults and children.
- Maine's State Profile Tool developed common vocabulary for describing services across systems. The State Profile Tool has provided a foundation for bridging differences across programs and identifying opportunities for greater collaboration and consistency.

GAPS IN SERVICES

In spite of these efforts, Maine continues to face gaps in the system:

- Persons with brain injury experience significant gaps in covered services appropriate to their needs including service coordination or case management services; home and community-based personal support supports to address cognitive and behavioral needs, psychosocial rehabilitative services and no “step down” supported housing – people with brain injury may be served in intensive residential rehabilitation facilities or at home.
- Home care coordination services for older adults and adults with disabilities are capped at 18 hours per year. While this is adequate for most, for others the 18 hours is insufficient to provide the level of care coordination needed.
- Persons in nursing facilities are unable to access the specialized clinical assessments needed to develop a transition plan, including assessments needed to shape the plan for community-based behavioral health services and occupational and other therapies.
- Many community providers are reluctant to serve persons with complex needs because they do not have access to the kind of support and training they need to serve persons with complex needs – there is not a one-stop point of access for addressing the problems and barriers that they fear they will encounter, as they try to address the problems they are likely to confront – whether the problems are related to treatment, reimbursement or licensing.

POTENTIAL DEMONSTRATION PARTICIPANTS

A survey of Maine’s institutional settings shows that the greatest number of potential demonstration participants can be found in nursing facilities.

NURSING FACILITIES

According to the MDS assessment completed as of September 1, 2010 (a total of 6,256 completed assessments), 4,939 nursing facility residents had a length of residency greater than 90 days. Of those, 3,846 residents had Medicaid as a source of reimbursement.²⁴

Of all potential demonstration participants (n=3,846), the majority were over age 75. The data also revealed that younger adults residing in nursing facilities had longer lengths of stay, had higher levels of acuity as measured by Maine’s case mix index, and required greater assistance with activities of daily living. See TABLE 1.

²⁴ McGuire, Cathy. Money Follows the Person (MFP) Project: MaineCare Nursing Facility Residents Meeting MFP Criteria, Working Document, Muskie School of Public Service (November 22, 2010).

TABLE 1. SELECTED STATISTICS FOR MAINECARE NURSING FACILITY RESIDENTS WITH LENGTH OF RESIDENCY OVER 90 DAYS (MOST RECENT ASSESSMENT AS OF SEPTEMBER 1, 2010)²⁵

Age Group	Residents	Percent	Length of Residency in Years	Case Mix Index	ADL Score
< 50	82	2.1%	5.0	1.829	15.5
51 – 59	153	4.0%	4.9	1.669	14.5
60 – 64	141	3.7%	6.3	1.578	14.6
65 – 74	457	11.9%	3.6	1.515	14.7
75 – 84	1,128	29.3%	2.8	1.462	14.8
85+	1,885	49.0%	2.9	1.441	14.8
Total	3,846	100.0%	3.2	1.478	14.8

The data also showed that younger adults were less likely to exhibit cognitive impairment as measured by the cognitive performance scale (CPS); roughly half of the younger adult residents (under 60) had a CPS score of 3 or greater, compared to over 70% for older residents.

Section Q Respondents. Of the 3,846 potential demonstration participants, 6.5% (n=251) expressed a preference to return to the community; 7.5% (n=287) had a support person who was positive towards discharge; 2.9% (n=113) had both a preference to return to the community and a support person who was positive towards discharge.

For this last group, those individuals who both indicated a preference for returning to the community and had a support person who was positive towards discharge (n=113):

The length of stay in the nursing facility was of significantly shorter duration compared to the larger group: 73.4% have been in a nursing facility for less than a year, compared to 25.4% for the larger population. The average length of residency was 1.0 years compared to 3.2 years for the larger population.

The level of acuity as measured by Maine’s Case Mix Index tended to be lower.

The need for assistance with Activities of Daily Living was less.

See TABLE 2 below.

This group was also less likely to have Alzheimer’s disease or another dementia but more likely to have medical conditions such as diabetes and anemia. The group was also significantly less likely to exhibit a cognitive impairment compared to the larger group; 68.1% of all persons in this subset were cognitively intact compared to 31.9% for the larger group.

²⁵ Two outliers were removed where values were 8000 or more days. Length of Residency calculated based on the difference between the date of admission and 9/1/2010. The Case Mix Index is a measure of intensity of resource use. MaineCare uses a case mix adjustment for reimbursement of the direct care component of nursing facilities’ rates. For more details on calculating the case mix groups see <http://muskie.usm.maine.edu/mds/>. Activities of daily living (ADL) score is calculated based on a resident’s self-performance in five ADLs -- bed mobility, transfer, eating, grooming, toilet use and bathing. Score ranges from 0 independent to 18 totally dependent.

TABLE 2. SELECTED STATISTICS FOR MAINECARE RESIDENTS WITH PREFERENCE TO RETURN TO COMMUNITY AND HAVING A SUPPORT PERSON POSITIVE TOWARDS RETURN AND LENGTH OF RESIDENCY OVER 90 DAYS (MOST RECENT ASSESSMENT AS OF SEPTEMBER 1, 2010)²⁶

Age Group	Residents	Percent	Length of Residency in Years	Case Mix Index	ADL Score
< 50	15	13.3%	1.2	1.885	14.5
51 – 59	14	12.4%	0.7	1.752	14.1
60 – 64	9	8.0%	1.3	1.545	12.8
65 – 74	17	15.0%	1.5	1.533	14.4
75 – 84	25	22.1%	0.9	1.496	14.1
85+	33	29.2%	0.8	1.451	13.4
Total	113	100.0%	1.0	1.576	13.9

Younger Adults. The number of nursing facility residents younger than 60 was 235. Younger adults were more likely to prefer living in the community (18.7% compared to 6.5% for the larger group) and were more likely to have a support person who was positive toward discharge (15.7% compared to 7.5% for the larger group). However, this sub-population tends to have distinctly different challenges from the larger group. While younger adults were less likely to have Alzheimer’s or other dementia, and less likely to have cardiac diseases, they were more likely to have a brain injury, Cerebral Palsy, Multiple Sclerosis, paraplegia, hemiplegia, quadriplegia, or seizure disorder. Younger adults were also slightly more likely to have manic depression and schizophrenia than the larger population group. See Table 3. The younger group is also more likely to require extensive services, special care, or a higher level of physical assistance, as measured by Maine’s Resource Utilization Groups.

INTERMEDIATE CARE FACILITIES – PERSONS WITH INTELLECTUAL DISABILITIES OR AUTISM (ICFS-IID)

Maine has nine private ICFs-IID licensed at the group level, with a total of 52 beds; and 12 ICFs-IID licensed at the nursing level, with a total of 164 beds.²⁷ Maine currently has about 185 residents in these ICFs-IID. Because Maine’s ICFs-ID’s tend to have a significant nursing component it is difficult to construct alternative community-placements. (Maine’s waivers for this group do not include nursing as a covered service.) For this reason and because the numbers are relatively small, Maine has chosen not to focus its MFP Demonstration on this group.

²⁶ See footnote 7 for an explanation of the data.

²⁷ Obtained from a search of the Division of Licensing and Regulatory Services’ Health Facilities database accessed at: <https://portalxw.bisoex.state.me.us/dhhs-apps/LicCert/pgDetails.asp> on February 7, 2009.

Table 3. Diagnoses for MaineCare Nursing Facility Residents with Length of Residency Over 90 Days (Most Recent Assessment as of September 1, 2010)

Diagnosis	All		Under 60	
	Residents	Percent	Residents	Percent
Mental Health Conditions				
Other Dementia	1,912	49.7	48	20.4
Alzheimer's Disease	824	21.4	7	3.0
Manic Depression	180	4.7	27	11.5
Schizophrenia	174	4.5	19	8.1
Depression	2,415	62.8	147	62.6
Anxiety	1,152	30.0	76	32.3
Medical Conditions				
Hypertension	2,726	70.9	106	45.1
Arthritis	1579	41.1	31	13.2
Anemia	1,282	33.3	66	28.1
Osteo	1,264	32.9	50	21.3
Diabetes	1,241	32.3	66	28.1
Other Cardio	1073	27.9	35	14.9
Hypothyroidism	975	25.4	56	23.8
Stroke	867	22.5	45	19.1
Cardiac Dysrhythmia	801	20.8	18	7.7
Chronic Obstructive Pulmonary Disease	789	20.5	28	11.9
Congestive Heart Failure	787	20.5	13	5.5
Arteriosclerotic Heart Disease	708	18.4	18	7.7
Renal Failure	345	9.0	20	8.5
Parkinson's	343	8.9	2	0.9
Cancer	309	8.0	11	4.7
Seizure Disorder	398	10.3	66	28.1
Hemiplegia	462	12.0	48	20.4
Multiple Sclerosis	107	2.8	39	16.6
Traumatic Brain Injury	78	2.0	37	15.7
Quadriplegia	37	1.0	27	11.5
Cerebral Palsy	69	1.8	22	9.4
Paraplegia	48	1.2	18	7.7
Missing Limb	72	1.9	11	4.7
Total	3,846		235	

HOSPITALS

Persons in hospitals for extended stays often no longer have an acute need for hospital services but no appropriate community option can be identified. People in this situation can often end up in an out-of-state institutional setting, at much higher rates than would be paid for in-state services, when no suitable in-state placement can be identified. According to a MaineCare report, 21 MaineCare members were hospitalized for more than 90 days in State Fiscal Year 2010. Of those, seven were age one or younger and fourteen were between the ages of 23 and 63. Four MaineCare members were hospitalized in out-of-state hospitals for more than 90 days.

INSTITUTIONS FOR MENTAL DISEASE

Maine has two state-operated Institutions for Mental Disease. Of these, as of October 2010, only one reported having any residents age 65 or older who might qualify for the demonstration. However, one of these residents is a forensic patient for whom discharge is not likely. The other desires placement out-of-state, closer to a family member. Maine does not have any children in its state-operated IMDs. Maine also has two privately operated IMDs. Patients do not typically stay in these IMDs for more than 90 days although children with intellectual disabilities or autism spectrum disorder may have longer stays in the IMD with a specialized unit for this group.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Maine does not have any Psychiatric Residential Treatment Facilities as that term is defined by Title 42 CFR Section 483.352.

OUT-OF-STATE INSTITUTIONS

The Department is currently working on an initiative to bring people home from out-of-state nursing facilities. One individual has successfully transitioned into an in-state residential facility for persons with brain injury. There are seven individuals remaining in out-of-state nursing facilities. Two are vent dependent. One is an individual with Huntington's disease and mental illness. The remaining individuals have a combination of dementia and brain injury. Barriers to return home include challenging behaviors, the use of physical and chemical restraints, and current regulations.

SELF-DIRECTION IN MAINE

Maine has two options for accessing self-directed services.

CONSUMER-DIRECTED PERSONAL ASSISTANCE

Starting with a state-funded consumer-directed program created in the late 1970s, Maine has long had consumer-directed personal assistance services for persons with physical disabilities. Over the last few decades Maine has also made these services available through a home and community-based waiver program²⁸ and Medicaid state plan services.²⁹ These programs allow consumers to hire their own direct care workers. Eligibility for this program is conditioned on the individual's cognitive capacity to self-direct. A Service Coordination Agency provides training and other support for consumers recruiting, hiring and firing their own workers and serves as the fiscal intermediary for payroll and other employer functions. In 2010, 403 people were being served under the state program and 141 are served on the waiver. There was a waiting list of 106.

FAMILY PROVIDER SERVICE OPTION

²⁸ 10-144 CMR Chapter 101, MaineCare Benefits Manual, Chapter II, §22.

²⁹ 10-144 CMR Chapter 101, MaineCare Benefits Manual, Chapter II, §12.

A Family Provider Service Option is available for people receiving services under the HCB Waiver for the Elderly and Adults with Disabilities waiver³⁰ and the Medicaid state plan Private Duty Nursing and Personal Care Services.³¹ The Family Provider Service Option (FPSO) allows an individual, 21 years or older, to register as a personal care agency solely for the purpose of managing the individual's own services or the services of up to two family members. The FPSO Employer hires and directs workers, works with a fiscal intermediary to provide payment to workers, keeps consumer and personnel records, maintains workers' compensation insurance (paid for with program funds) and works closely with the Service Coordination Agency care coordinator, which also oversees service plan implementation for agency-based home care services. To participate, the individual or family member must register as a Personal Care Attendant Agency with the Division of Licensing and Regulatory Services and participate in a 4-hour training program. In 2010, 192 people were using this option.

The Department is currently working on an initiative to create a single design for self-directed/representative-directed care to be used across the OADS programs. The intent is to provide greater consistency and ease of transition between programs for consumers and their families.

STAKEHOLDER INVOLVEMENT IN MAINE'S LONG TERM SERVICES AND SUPPORTS SYSTEM

Stakeholders guide the design and improvement of Maine's long term services and support system in a variety of ways:

- On an ongoing basis, OADS solicits feedback from stakeholders through its Office of Elder Services Advisory Committee. In addition, in 2006 and 2008 OADS sponsored statewide conferences on aging. These conferences were an opportunity for delegates to set policy priorities relating to caregivers (paid and unpaid), community involvement and volunteerism, creative housing and services, elder abuse, employment, healthy aging, and transportation. OADS also engages stakeholders through public hearings on its State Plan on Aging, which is developed every four years.
- In 2008, DHHS established a statewide system of consumer councils to participate in quality assurance activities and make recommendations for systems change for the adult mental health system. The consumer councils participate in the assessment of the quality, accessibility, and adequacy of services within their regions. The Consumer Council System of Maine is funded by AMHS.³² In addition, consumers participate on the Community Service Networks (CSNs) that are responsible for fostering coordination within the local service delivery system.
- DHHS provides administrative support to the Acquired Brain Injury Advisory Council, which is legislatively authorized to make recommendations for improving brain injury services.³³ Membership on the BIAC includes consumers, family members, providers and representation from Maine's vocational rehabilitation program and the Maine Center for Disease Control and Prevention. In addition, DHHS has conducted extensive public forums to hear from consumers and others about the needs of people with brain injury.
- DHHS provides support to Speaking Up for Us (SUFU), a self-advocacy group supporting persons with intellectual disabilities or autism. DHHS invites SUFU members to inform policymaking by providing feedback on policy changes or assisting in the development of tools and resources. In recent years these

³⁰ 10-144 CMR Chapter 101, MaineCare Benefits Manual, Chapter II, §19.

³¹ 10-144 CMR Chapter 101, MaineCare Benefits Manual, Chapter II, §96.

³² Consumer Council System of Maine. <http://www.transformationinme.org/welcome.html> accessed March 13, 2009.

³³ 34-B MRSA §19001.

initiatives have included a community inclusion pilot, a health and wellness initiative, and the development of standardized rates for services.

The Office of Child and Family Services involves families in planning and policymaking through a variety of mechanisms including membership on the governing council for its Wraparound Maine initiative, the governing council for Maine's trauma-informed system of care initiative, and the children's subcommittee of the Statewide Quality Improvement Council for mental health services. Children's Behavioral Health Services has also supported five statewide and two county family organizations.