Going Home – Keys to Systems Success in Supporting the Return of People to Their Communities from State Facilities

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October, 2006

Purpose

This paper was supported by the People Can’t Wait project of the North Carolina Council on Developmental Disabilities. It is intended to:

• Provide a summary of the keys to systems success in states that have made significant progress in returning all or most individuals with developmental disabilities to their communities;
• Provide more detailed case studies of two states’ experience in downsizing (Indiana and Alabama): and,
• Share a variety of resources and strategies North Carolina might consider as it continues to work towards supporting people to return to community from state facilities.

Background

In 1989, for the first time in history, spending for home and community-based services for people with developmental disabilities surpassed spending on institutional services. The trend has continued with the community spending of 49 states, including North Carolina, significantly exceeding spending for public and private institutions, according to 2004 statistics.

North Carolina ranks 16th in the nation for the number of individuals served per 100,000 of population in the HCBS waiver program. The number of individuals served in the community in North Carolina is above the average rate. The state ranks 43rd in “level of effort,” behind poorer states such as Louisiana, Idaho, Alabama, Arizona, Maine, Tennessee and South Dakota. Level of effort is a measure of the states’ commitments to fund MR/DD services that controls for differences in states' wealth or economic capacity. It is defined as a state's spending for MR/DD services from federal, state, and local sources, per $1,000 of aggregate state personal income.

While North Carolina has reduced reliance on large state-operated facilities, the state still lags behind others in reducing reliance on these facilities. In 1980, 3,103 people were served in large state facilities, dropping to 1,801 in 2004. Although this represents a 41.9% decline in the use of state institutions, the national average decrease is 67.9%.

2 Braddock, p. 32.
Some states have completely closed all their state-operated settings. To date, Alaska, Maine, Rhode Island, West Virginia, Oregon, New Hampshire, Vermont, Hawaii, New Mexico, and the District of Columbia no longer operate state institutions. A significant number of other states, including California, Minnesota, Indiana, Alabama, Michigan and Nevada have nearly eliminated their state-operated settings for people with developmental disabilities. As of May 2005, 10 states had announced facility closures during the 2005-2007 period, some, such as Massachusetts and Washington, despite serious opposition to the planning. Twelve states have fewer than 200 individuals still residing in state-operated settings.

The process of reducing reliance on large state-operated facilities continues throughout the nation, while community systems, primarily financed by the Medicaid home and community-based services waiver program continue to grow.

**Keys to Success**

There are several common themes among states that have been successful in transitioning individuals from large state-operated facilities to community services:

1. **Political culture and will.** The support for and leadership by key decision makers is the critical factor in successful reduction of state-operated institutions. This finding is clearly articulated in an excellent study by Susan L. Parrish, School of Social Work, University of North Carolina at Chapel Hill. The study provides a comparison of two state systems—Illinois and Michigan—and dissects why one state, Michigan, has reduced their reliance on state-operated facilities while Illinois—a similar state economically and demographically—has been less successful. A second study conducted by the Institute on Disability and Human Development at the University of Illinois, linked political culture to why states rely—and don’t rely—on institutional settings.

2. **Leadership at every level**—from legislators, to state officials, to advocates, to individuals with disabilities and their families. The willingness and ability of leaders to articulate a clear, well-founded set of values that undergird a competent, community-based services system sets the framework for and guides decision making. (See Parrish also.)

3. **A clearly understood and predictable funding source** is essential to enable funding agencies (e.g., Local Management Entities in North Carolina), providers, individuals, families and guardians to plan effectively and confidently in helping the transition back to community. Typically this means a home and community-based services waiver that is designed for or has resources dedicated to enabling funding to “follow” individuals from institutions to the community.

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4 Rizzolo, Mary Kay “Predictors of Use of Nursing Homes and Institutions for Persons with DD,” Rehabilitation Research and Training Center on Aging with Developmental Disabilities, Department of Disability & Human Development, College of Applied Health Sciences, University of Illinois at Chicago, 2004.
4. A recognition of the **short and long-term fiscal realities** of reducing institutional populations and the ability and willingness to look at any near-term costs as investments for the future. The next section of this paper outlines the components of fiscal planning.

5. The ability to broker a reasonable and respectful transition for state employees affected by the downsizing or closures.

6. The involvement of those most affected—both those who reside in institutions or have family members residing at institutions—and those who face the prospect of institutional care due to the limitations in existing community supports and services.

7. Real investments, both financial and human resources, in growing and sustaining the capacity of the community service system to support individuals with significant medical and behavioral challenges.

8. Creating open dialogue and building trust among all those invested in and affected by the downsizing or closure of facilities.

9. Learning from those who have gone before but tailoring decisions and solutions to what makes sense to the stakeholders in each state.

**Financing the Transition**

The financial challenge of downsizing is to assure adequate funding to cover all of the costs that will be incurred in terms of (a) managing the placement process, (b) supporting newly placed individuals in the community, and (c) supporting the costs of any provider program infrastructure that might need to be developed. All this needs to occur while balancing the continued operational costs of the institution.

Fixed institutional costs initially remain while a state reduces the census (see section below on Designing a Financial Plan), so that the average cost per person actually rises during downsizing or closure. The costs of transitioning individuals into the community can also be high, although all states have shown that it is not as great as maintaining the same individuals in institutions. Housing costs and furnishings, staff, and specialized equipment and adaptations that need to be put in place to assure a smooth transition are all costly.

Financing can be one of the biggest barriers or the main impetus for downsizing. Some states were able to get legislative appropriations to cover the short-term costs of returning people to the community from institutions. Obviously the availability of short-term funds to cover the transition costs the system is certainly the best solution to the issue of continuing to run an institutional system while also downsizing and/or closing. In any case, having a predictable and understandable funding source dedicated specifically to enabling individuals to receive community services when leaving institutions is essential.
States have taken a variety of paths to secure the resources needed to effect downsizing and closure—and not all states have had the luxury of new money to do so. Certainly states like California have benefited enormously from new appropriations to increase investments in community housing and services, helping fund the transition costs in the ongoing closure of the Agnews Developmental Center. But some states such as Indiana and Alabama have been able to make substantial inroads into reducing state-operated institutional capacity without large infusions of new funding.

**Designing a Financial Plan**

The fiscal and programmatic success of any downsizing and/or consolidation plan rests on the articulated and enforced policy that long-term institutional admissions are frozen. In order to achieve net reductions, the “front door” to the institutional system has to close, while the “back door” swings wide open. This takes significant political will along with the community capacity to assure that individuals can be supported in the community.

One of the largest barriers to institutional downsizing is what Lakin and Stancliffe term “diseconomies of scale,” the increase in the institutional per diem costs as reductions in census occur. This is of course due to the problem that institutions have fixed and “semi-fixed” costs that do not go away as the census is reduced. Costs associated with the facility—such as building and grounds, laundry or food service—still have to operate regardless of the census. Other costs such as professional staff positions required to meet federal licensure standards must also be maintained and can only be reduced so much—and direct care staffing ratios must be preserved to assure meeting federal and state health and safety requirements.

Lakin and Stancliffe note that, based on their findings, there is a 1% increase in per-diem rates for every 6% annual decline in the number of residents. And the effects compound over time. According to Lakin and Stancliffe, the diseconomies of scale increase if a state chooses to keep a facility open with a very small portion of the original population, resulting in extremely high per-diem costs. They cite Hawaii as an example whose state-operated ICF-MR per diem reached $733/day as they kept the facility open with only a handful of residents. This same scenario occurred in Oregon with the closure of Fairview. Thus, in planning for closure, the number of people moved and the pace that this is done can significantly impact the costs of closure. Careful planning to assure closure and consolidation of populations when the residual population is small is critical to achieving cost containment.

*Anything that accelerates placement and consolidation frees up funds for community placements.* Typically, significant institutional savings only occur when the facility closes a unit and reduces the number of staff positions associated with its operation. Most states develop a plan to consolidate and close buildings or units as soon as a significant number of people move. Unfortunately this may mean that some individuals experience more than one disruption—they move from unit to unit and then move to the community. This approach may compromise.

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individualizing the placements, so it is important to keep in consideration person-centered planning and the impact of multiple moves on individuals when planning unit or building closures.

Lakin and Stancliffe also describe another relevant finding in looking at the total institutional expenditures in what they term “high-change” and “low-change” states—states that significantly reduced their reliance on large state-operated settings and those that did not. Although the per-diem costs in the high-change states climbed very rapidly, these costs were offset by the reductions in population. Stancliffe and Lakin’s analysis found that if a state moves a significant enough portion of their institutional population, the overall costs of institutional services can decline despite the rise in institutional per diems due to diseconomies of scale. 6

This is a compelling argument to make to legislatures: Although the per diem costs rose, the overall expenditures declined as long as enough individuals are placed. They found that the institutional population must be reduced by at least 6% per year in order to achieve any decline in expenditures. Their work offers a set of assumptions that a state can test against its own plans, substituting different assumptions (such as the average annual inflationary increase in costs) in order to model the effects of out placements.

**Institutional Payment Rates**

Probably the first challenge is assuring the current institutional payment rate actually covers the full cost of providing state-operated institutional services. Surprisingly, in revenue maximization reviews, consultants frequently find that states supplement the ICF-MR rates with state dollars or use rate-setting methods that do not fully capture the costs of providing care. This gap between the Medicaid reimbursement and the costs may sometimes occur if the actual cost of state-operated ICFs-MR exceeds what is known as the Medicare “upper payment limit” (UPL).

The Medicare UPL requires that state payments to a particular group of providers (such as publicly-owned nursing homes) may not, in the aggregate, exceed the amount that Medicare would have paid to this group using Medicare rate methodology. Section §1902(a)(30)(A) of the Social Security Act is the regulation governing the Medicare upper-limit test. Centers for Medicare and Medicaid Services (CMS) has also added regulations to this UPL that restrict states from claiming what it deems are “excessive” costs through loopholes such as the intergovernmental transfers and provider donations and taxes.

While this gap may exist, it is not cited as an obstacle to states in capturing the full costs of operating their ICFs-MR. The Medicare upper limit allows states to use 150% of what Medicare would pay if Medicare payment methodologies were applied to ICFs-MR.

Basically, states have wide latitude to determine the basis and methodology for state-operated ICF-MR payment rates. Some states develop individual rates for each facility. For example, Illinois uses a facility-specific, cost-based billing rate for its state-operated developmental centers. Facility reimbursement rates are calculated for each fiscal year by dividing the projected operating expenditures of each facility by the projected number of “care days.” This approach creates a baseline to which facility-specific capital expenditures and a pro-rated allocation of
developmental center and central office administrative costs can be added to create the prospective billing rate for each fiscal year. The state then bills periodically throughout the year for each day of service (care day) recorded over the course of the fiscal year. At the end of the fiscal year, the “actual” expenditures and actual recorded care days are used to reconcile billings and payments with each developmental center’s documented expenditures and utilization for the year. This approach to rate setting is commonly referred to as a “cost-based” or “cost-settlement” methodology.

CMS permits states to use another method called “cost-related” payments. Under this method, the state establishes and “certifies” a base year for institutional expenditures that is satisfactory to CMS. At this time, certain assumptions regarding the manner in which base expenditures can be modified each year are also agreed upon by the state and CMS. These assumptions must be tied to actual historical expenditure experience or to industry standards acceptable to CMS. Thus, federal reimbursement is triggered by the impact of the relationship between changes in a facility’s census (or utilization) and these agreed-upon modifiers (i.e., fixed v. variable expenditure factors, trend factors, etc.), rather than expenditures recorded each year.

This cost-related approach can be quite advantageous in states involved in significant downsizing and/or closure initiatives within their institutional service sectors because the payment method takes fully into account the changing census while providing a predictable revenue stream. While it is not within the scope of this paper to fully analyze North Carolina’s current reimbursement methods and the potential for securing additional, predictable revenues through other sources, this may be an area worth examining in the context of an overall downsizing and closure plan.

Other Potential Financing Aids

Beyond establishing an ICF-MR rate that fully covers costs and allows for increases in the per diems as placements occur and pacing the consolidation and closure so that enough people move quickly enough to offset some of the rise in per diems, there are other potential resources that can assist a state to close facilities.

1. Claim Medicaid for case management activities

On July 25, 2000, CMS issued Olmstead Update No. 3 containing Attachment 3-b, Community Transition (a copy of which is attached as Appendix 1A). This document offered several new policies regarding Medicaid-financed activities intended to support individuals moving from institutional settings into the community. CMS indicated that states can claim the costs of providing State-plan, optional, targeted, case-management services to individuals for up to 180 days prior to moving from an institution into the community. In the past, CMS only allowed claiming for up to 60 days. CMS recognized that planning for community placements for many individuals takes significantly longer than the previously permitted 60 days. With this extended time period, more activities of community case managers on behalf of institutionalized individuals can be reimbursed under Medicaid.

2. Claim the cost of transition services
On May 9, 2002, CMS issued a State Medicaid director letter offering states the option of including a new service under their 1915(c) home and community-based services waivers intended to cover the costs of moving into the community from institutions (attached). CMS also issued question-and-answer documents (Appendix 1B attached) that detail this service. The CMS letter indicated that states may pay the reasonable costs of community transition services, including some or all of the following components:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile;
- Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

CMS has indicated that a security deposit would not be considered “rent” and thus can be covered under transition services. Additional detailed information on this service can be found in the CMS Application for a §1915(c) Home and Community-Based Waiver [Version 3.3] Instructions, Technical Guide and Review Criteria, pages 147-48 (Appendix 1C attached).

This resource is particularly worthwhile in assisting individuals to live in their own homes since community transition services may not be used to furnish or set up living arrangements that are owned or leased by a waiver provider.

3. Apply for a Money-Follows-the-Person Rebalancing Demonstration Grant

The 2005 Deficit Reduction Act includes new monies (beginning in 2007) to assist states in “rebalancing” their services systems by transitioning individuals out of nursing homes and institutions. The purpose of these new funds is to give states the “bridge” money they need to fund placements while they are still operating—although reducing—their institutional placements.

Section 6071 of the legislation authorizes the Secretary of Health and Human Services to award grants on a competitive basis to assist states in: (a) expanding the availability of home and community-based services and simultaneously reducing their reliance on institutional long-term care services; (b) eliminating barriers that “… restrict or prevent the use of Medicaid funds” to provide long-term services and support consistent with the eligible individual’s choice; (c) improving states’ capacity to maintain the continuity of home and community-based services to former institutional residents; and (d) enhancing the states’ capacity to monitor and improve the quality of HCBS services. The grants can be available for up to four years.

The grants provide for an enhanced Federal Medical Assistance Percentage (FMAP) rate for services for one year after each person moves into the community rate for all qualified

6 Since this paper was drafted and shared with state officials in August, North Carolina has begun work upon a Money Follows the Person grant application.
expenditures. The enhanced rate will be equal to the state’s existing FMAP rate increased by a number of percentage points that equal 50% of the difference between 100% and the state’s existing FMAP rate. Under this formula, a state with a minimum 50% FMAP rate, for example, would have a 75% MFP-enhanced FMAP rate, while a state with a 70% FMAP rate would have an 85% MFP-enhanced FMAP rate. No state, however, could have an enhanced FMAP rate higher than 90%. For North Carolina, the projected FMAP rate for FY 2007 is 64.52%, thus the enhanced rate with the federal matching would be 82.26%. A detailed description of the project prepared by Bob Gettings, executive director of NASDDDS, Inc. of the Money Follows the Person Grants is attached as Appendix 2. A wealth of other materials are now available following the recent federal release of this grant application.

4. **Dedicate any positive fund balance from the institution budget to placement activities (rather than returning funds to the general fund)**

Depending on North Carolina’s policies, any positive fund balances remaining in the institutions’ account at the end of the fiscal year may be able to be transferred in the following fiscal year to the community service budget as a general fund item. These funds could then be used to match federal Medicaid dollars to cover the costs of people coming out of the institution. This funding could jumpstart the process for a few months until a unit is closed and could cover the costs of support for some individuals as resources are transferred from the institution.

**Case Studies**

The following are two brief studies of states that have significantly reduced their reliance on state operated ICFs-MR without infusions of new funding. While as previously noted, all states have unique barriers and opportunities within them, it is particularly instructive that these closures and downsizings occurred in states that are not particularly wealthy and do not necessarily have a national presence in terms of best practices. We often hear about states such as Vermont and New Hampshire—small, homogeneous states—that have been successful with innovative practices. But Alabama and Indiana are not often cited for being in the forefront of innovation nor for having large infusions of new moneys to support the expansion of community services. This makes their accomplishments that much more notable.

**Indiana**

Indiana and North Carolina have some similarities. In 2004, North Carolina ranked 11th in population, Indiana 14th. However, North Carolina is gaining population more rapidly than Indiana. North Carolina’s 2006 FMAP rate is 63.49% compared to Indiana’s 62.98% making North Carolina a bit wealthier. While the percentage of people living in poverty in North Carolina is greater than Indiana, the two states are in range of each other. Both states have large urban areas, some smaller cities and significant rural portions. But between 2000 and 2004, Indiana added 7,726 individuals to their HCBS waivers for a total of 9,307 people served. During the same period North Carolina added 647 people for a total of 6,011 individuals served despite
the fact that the population of North Carolina exceeds Indiana’s by over two million people (2004 census). 7

History

In 1980, Indiana had an average daily population in large state-operated facilities of 2,592 individuals. By April, 2006, this number had been reduced to 166 individuals at the Fort Wayne State Developmental Center (FWSDC) which is slated for closure, and approximately 200 other individuals with co-occurring disabilities (mental health and developmental disabilities) living in other state facilities.

The Indiana Bureau of Developmental Disabilities, reported that 1,500 fewer individuals are living in publicly and privately operated ICFs/MR than resided in such facilities 10 years ago. The state has closed five public developmental centers and eight large, privately operated ICFs-MR. And the move to community services continues with the newly announced closure of the Silvercrest Children’s Developmental Center.

The Move for Closure

State officials attribute the drive to close and downsize large facilities to a variety of factors, including: (a) multiple, highly publicized incidents affecting the health and safety of residents that occurred in the late 1990s and beyond, (b) a CRIPA suit filed by the U.S. Department of Justice, (c) the availability of financing community services through the HCBS waiver program, and (d) the reports by two state study commissions, including one study by a blue-ribbon task force empowered by the legislature that recommended the state move the system to community-based services. (The July 1998 report can be found at: http://www.in.gov/fssa/servicedisabl/ddars/317plan.html.)

The confluence of these factors has led Indiana to the decision that running state facilities no longer was in the best interest of Indiana’s citizens with developmental disabilities. Mitch Roob, Indiana’s Family and Social Services Administration Secretary, cited the nationwide trend of closing institutions and providing services to individuals with developmental disabilities in the community saying, “Services in the community facilitate flexibility, individualization, and the inclusion of consumers in society. Closing the facility,” he added, is “the right thing to do.”8

The current population at the Fort Wayne State Developmental Center (FWSDC) is 166 with a target date for final closure of July 1, 2007. Indiana still has some developmental disabilities certified units within its state hospital system, so about 200 individuals with co-occurring disabilities are still residing in these settings.

Funding

7 The source of these utilization figures for the HCBS waiver is, “Residential Services for Persons with Developmental Disabilities; Status and Trends Through 2004,” RTCCL, Institute on Community Integration, University of Minnesota, July 2005, p.99.
8 Quoted in “Beyond the Beltway,” November 2, 2005, NASDDDS, Inc.
As noted earlier in this report, the costs associated with closure are often cited as the barrier to closure. But Indiana did not have any new funds to achieve the closures of their facilities. William (Randy) Krieble, the state official with the Bureau of State Operated Services overseeing the closures, notes that as an example, during the closing of Muscatatuck State Developmental Center (MSDC), Indiana used the budgeted funds available to the facility to both run—and close—the facility. The state submitted cost reports and rates increased based on expenditures to reflect the growing daily costs as the census declined.

Krieble reported the same process for the closure of the Fort Wayne State Developmental Center except that the operations were contracted to Liberty Healthcare, a medical management company, in May 2005. In the words of Secretary Roob, “Allegations of abuse and neglect have plagued this facility. Due to a consent decree, the U.S. Department of Justice routinely monitors the facility for a variety of issues, including abuse and neglect. Based on these concerns, we brought in new management [Liberty Healthcare]...”FWSDC employed nearly 1,000 people. (Liberty assisted the state to regain the facility’s ICF/MR certification, that had been lost due to the health and safety violations.) As reported in the NASDDDS publication, Liberty Healthcare employees will serve in their positions until the facility closes, at which time all those who passed the drug screen and criminal background check will be offered positions with Liberty Health Care with the hopes that these highly skilled individuals will be able to continue their work in community settings.

In these closures, the funds “follow the individual” from the facility into the community, providing the resources needed to pay for community placement. State officials and members of INARF (a provider trade association) noted that serving consumers in the community is less expensive than providing care in an institution. Indiana taxpayers are paying as much as $860 per day to serve people with developmental disabilities at FWSDC, whereas the costs of community services are in the $150 to $400 per-day range. As an example, individuals who went into supported living arrangements (supported living service arrangements may not serve more than four unrelated individuals) funded by the waiver averaged $392.38 per day. An additional $14.38 per day in state funds was provided to supplement room and board costs. Some individuals formerly supported at FWSDC went to four-bed group homes for people who are medically fragile, with an established rate of about $400.00 per day.

Most recently, Indiana has announced the closure of Silvercrest Children’s Developmental Center which houses about 60 children with developmental disabilities. The planning around the closure of Silvercrest includes using the $8 million dollars in state funds, previously used to operate the Center, as Medicaid match funds to initiate and create a single-point-of-entry, community-based care model to address the needs of children.

**What Worked in Indiana?**

1. **New use for old buildings**

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9 Quoted in “Beyond the Beltway,” October 2, 2005, NASDDDS. Inc.
One of the most unique features of the closure of the Muscatatuck SDC was the conversion of the facility, including all the buildings and grounds, into a National Guard Homeland Security training center. Muscatatuck, consisting of 66 buildings and 850 acres, would have cost the state an estimated $35 million to demolish. The conversion also created new jobs.

2. **Thoughtfully planned transition**

Careful attention was given to the issues of transitioning individuals. Placements have been developed individually. Indiana has been very successful in transitioning individuals to community placements, rather than moving them to other large, congregate settings. For example, from January 1, 1999 to May 1, 2005, a total of 322 Muscatatuck residents were moved out and now live in the following settings:

- 227 are in supported living homes in the community
- 74 live in small, community-based intermediate care facilities for persons with intellectual disabilities (ICFs/MR)
- 11 reside in nursing homes
- 6 reside in state-supported facilities
- 2 live at home with their families
- 2 are no longer in the state.

FWSDC had a designated transition team that worked with individuals and their family members to assist them in choosing various community service options. These opportunities were built around their needs, rather than just fitting people into existing programs and settings. Individuals had the opportunity to select their case managers and with whom they wished to live. Individuals also had the opportunity to visit their new homes before moving. New community providers were required to spend time at FWSDC to become familiar with residents and learn about their specific needs. Providers were afforded what was termed “supplemental training” in order to support individuals with challenging behavioral or medical needs.

As a result of this process, the Bureau of Developmental Disabilities reports that only 17 out of the 700 persons placed out of state centers over the past ten years have had to be returned to a state facility. Eventually, appropriate community settings were found for a majority of these individuals as well. Information about the FWSDC transition process can be found at: [http://www.fwsdc.com/aboutfortwayne](http://www.fwsdc.com/aboutfortwayne).

3. **On-going and active quality monitoring**

After each person moved, Indiana's Bureau of Quality Improvement Services (BQIS) completed follow-up visits to make sure the individual's support plan was implemented. These visits happened seven days after the move and, again, at the 30-day mark. Planned, on-going oversight and mentioning includes agency surveys, consumer satisfaction surveys, incident reports, and site visits to track the progress.

4. **Supports to manage medical and behavioral crises.**
A crisis management system, modeled on New Mexico’s system, enabled the state to furnish proactive technical assistance and training for staff on preventing crisis situations from occurring. The state also helped individuals acclimate to community settings through the provision of in-home technical assistance and 24-hour out-of-home crisis management services. These services were provided for those individuals who needed to move to a different location in order to adjust. Then, the individuals returned to their homes or to a more appropriate residential setting (see Appendix 3, “Regional Outreach Team for Individuals with Developmental Disabilities, Mission, Role and Function”).

The Bureau of Developmental Disabilities sponsors numerous training events for community provider agency staff and is currently working on a comprehensive training curriculum for direct support professionals. Also, a bill has been introduced in the legislature that would direct the Center for Excellence at Indiana University to create a comprehensive training curriculum for community DD agency staff members. Indiana does report that their providers are “stretched”—the need for intensive on-going supports has put strains on their system, but they remain committed to keeping individuals in the community and they continue to seek out best practices in supporting individuals with challenging behaviors and medical needs.

**Alabama**

Although North Carolina and Alabama are sister southern states, they are substantially different. By way of contrast, as noted earlier, North Carolina’s FY 2006 FMAP is 63.49%. Compare this to Alabama’s FMAP of 69.51% and it becomes evident that Alabama is one of our nation’s poorer states. With nearly 4.5 million people, Alabama’s population is about half that of North Carolina. As of 2004, Alabama served about 5,000 individuals with the HCBS waiver for persons with developmental disabilities -- only about 1,000 fewer individuals than the number served in North Carolina, a state with double the population of Alabama. According to the last census, North Carolina ranks 14th in the number of individuals in poverty, while Alabama ranks 8th in the nation.

**History**

In 1980, Alabama had 1,651 individuals living in large state-operated settings. By 2002, this number had declined to 632 to around 200 today. Between August 2003 and March 2004, Alabama closed three (Wallace, Brewer and Tarwater Developmental Centers) of its four state developmental centers. Wallace closed in October 2003, Tarwater closed in January 2004 and Brewer closed March 2004. State officials report that 48 people moved from the facilities being closed to the remaining state operated center. The census of the state’s only remaining MR facility, the Partlow Center, increased from 153 to 200 as a result of this institutional consolidation initiative. With the exception of the residents who were transferred to Partlow, all of the residents were placed in community living arrangements.

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10 The source of these utilization figures for the HCBS waiver is “Residential Services for Persons with Developmental Disabilities; Status and Trends Through 2004”, RTCCL, Institute on Community Integration, University of Minnesota, July 2005, p.99.
The Move for Closure

According to Eranell MacIntosh-Wilson, Associate Commissioner of the Alabama Department of Mental Health and Mental Retardation (DMHMR), the initial impetus to downsize the state facility population came from the state’s long-running class action lawsuit, the Wyatt litigation begun in the 1970’s. This lawsuit was finally terminated after 33 years in early 2004. Continued health and safety problems at the state facilities that were widely publicized and resulted in several lawsuits that added pressure to close the facilities. As an example, the Brewer Center became the focus of at least nine lawsuits related to abuse and neglect of its residents in recent years.

But as one state official noted, what really made for closure was the confluence of events—(and we paraphrase here—it was a bit more colorful):

‘...an outspoken Governor who used power carefully, a take charge cabinet-level Commissioner who is also clinically sound (i.e., knows the system and what it can and cannot do), a bird-dogging Division Director who will call each key player at least once a day and bug them to do the right thing on time, some players inside the facilities as well as skilled positions outside the facilities, a robust and public plan where everybody knows what's going on and can comment and complain about it. ’

Funding

Alabama’s outplacement process was “jump-started” by the Wyatt settlement under which they were funded and required to outplace individuals. After three years of making placements, Alabama met and actually exceeded their court-ordered placement goals in three of the four state-operated facilities. This resulted in three of the facilities having less than seventy residents. The costs in the three small facilities were rising, and estimates were made that the state could save between $21-$30 million by closing the three facilities. The Commissioner and the new Governor seized the opportunity to consolidate and this resulted in closing three of the four developmental centers.

The DMHMR did not receive a specific allocation of funding for actual closures. They did, however, have access to Medicaid Home and Community Based Waiver funding sufficient to enable the placement of facility residents. Because of the earlier funding made available for placement under the Wyatt settlement, a considerable number of individuals had already been placed under court order. This enabled the state to relatively quickly close facilities. Closure did not create immediate savings, as institutional rates kept rising while community placements were being funded. Over time, state officials indicated cost savings will be accrued as the on-going costs of community placements are less than the projected costs of those same individuals remaining in state facilities.

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11 This experience follows that of other states that, unlike Alabama, did not publicly announce closures but continued to quietly open the back door and close the front door until the facility was too small and the costs too high to sustain. The key, of course, is closing the front door.
What Worked in Alabama?

1. The Plan

The Alabama Consolidation Plan put to paper the guiding principles of the service system. It is a very bold document that squarely takes on the often competing interests of various groups. The document makes it very clear that there was opposition to the consolidation. However, the evidence was overwhelming that community services were the preferred and desired services for people with mental illnesses and intellectual disabilities. The Plan notes:

“While there has already been organized opposition to this plan by families and employees affected by consolidation, it must be noted that the plan has received unanimous support and endorsements from all major state organizations associated with Alabama’s mental health and mental retardation system. State organizations such as the Arc of Alabama, National Alliance for the Mentally Ill of Alabama, Mental Health Association of Alabama, Alabama Disabilities and Advocacy Program, People First, Alabama Council of Community Mental Health Boards, Alabama Association of Mental Retardation/ Developmental Disabilities Boards, Alabama Family Ties, Alabama Hospital Association, and others have submitted letters and mobilized their memberships in support of consolidation of Alabama’s state facilities.

Such broad and diverse support is unprecedented and further evidences the need and timeliness for realignment of the State’s public mental health and mental retardation system. The Department of Mental Health and Mental Retardation will remain committed to encouraging all Alabamians to embrace people with mental illness and mental retardation in the educational, social, and economic life of the community.”

This type of bold statement and the clear cut commitment of those in leadership positions in the state made the difference in moving forward with the consolidation and closure.

2. Regional development teams

In a presentation to the NASDDDS ICF/MR Facility Closure group, an Alabama state official noted that the key to the placement process were regional developmental teams. A team was created for each facility and each included a PhD psychologist, an MA psychologist, a bachelors-level psychologist, a consulting psychiatrist, a dentist and a masters-level social worker. The team worked with each individual and their family to find the most integrated placement possible. Of the 287 individuals who were included in the Department of Mental Health’s placement data base, 167 had behavioral challenges, 49 had significant, chronic health

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12 A copy of this plan may be found at [http://www.mh.state.al.us/admin/downloads/Commissioner/CP_2003DMHConsolidationPlanGovernorApproved02.pdf](http://www.mh.state.al.us/admin/downloads/Commissioner/CP_2003DMHConsolidationPlanGovernorApproved02.pdf)
conditions, 74 had psychiatric conditions, and 73 needed dental services. The developmental team leaders were responsible for organizing training sessions for community provider staff.

3. Assisting displaced workers

The Alabama DMHMR took a number of steps to assist state workers who were displaced as a result of the consolidation and closure plan. They made strong efforts to advertise vacant positions system-wide in order to cushion the impact of the closure/consolidation initiative, and covered relocation expenses for staff who chose to move to retain their positions.

DMHMR also scheduled job fairs where local provider agencies, nursing homes, and private businesses, as well as county and state agencies, were invited to participate and discuss the career opportunities available to qualified applicants. Since many private, non-profit community service agencies in Alabama participate in the state’s retirement system, department officials believed that a significant number of former facility employees would accept positions with private agencies. No early retirement package was offered to displaced workers, although eligible workers could choose to retire and did.

DMHMR officials met with other state agencies in an effort to link Brewster, Decatur and Wallace employees up with the employment notices issued by agencies like the Department of Transportation, the Department of Health and the Department of Public Resources. Their aim was to set up a system where displaced facility workers had access to new/vacant position notices that were issued by state agencies.

As the facilities closed, state officials reported that employee morale was surprisingly good. They attributed the lack of serious morale problems to the three facility directors, who had been keeping in close touch with employees in their respective facilities. Also, these employees had been aware and participating in an aggressive outplacement program over the three prior years (due to the Wyatt settlement) and were aware that the facility would no longer be needed.

Of the 500 DMHMR employees who were affected by the closure of the three state centers, state officials reported that all but 15 (eight at Wallace Center and seven at Tarwater Center) were offered other jobs with the state. Some of these employees elected to seek private jobs (some with community MR agencies), but many accepted positions in other DMHMR facilities or jobs with other state agencies.

Final Thoughts

There are obvious differences between the environments in Indiana and Alabama that created an impetus for facility closure, and the current environment in North Carolina. The purpose of including these two particular states as case studies is simply to point out the practical aspects of downsizing facilities within typical developmental disability systems. These elements apply whether or not closure is an explicit goal.
The move to closure in Alabama and Indiana was driven by a variety of factors, including a factor that is less salient in North Carolina: the negative and problematic care provided in the state facilities. These states took bold steps to reduce their reliance on institutional settings rather than attempting to “fix” these institutions. Alabama had already met the requirements of their lawsuit and was not required to move forward to close the facilities, however, the evidence of their success in community placements, the rising costs of continued institutional care and the movement across the country to support people in the community, added pressure and gave credibility to the move to reduce institutional capacity.

In both states the decision to create a system that could prevent the need for admissions to state facilities and provide for the transition of individuals from those facilities to the community took vested leadership and a willingness to address the valid concerns of parents, institutionalized individuals, state employees, and community providers unsure of their ability to support individuals with challenging medical and behavioral issues. The reward for this hard work in these and other states has been the development of a stronger system, better able to meet people’s needs in their families and communities.

There is much to be learned from other states, as was summarized in the Keys to Success section earlier in this paper. The purpose of this paper is not, however, to suggest that North Carolina emulate any particular state strategy. Our intent is simply to share what is doable, to note that states with no greater and arguably less capacity than North Carolina have been successful in this regard, and to suggest potential avenues to consider as North Carolina continues its effort to more effectively assist individuals to transition from state facilities to their communities, and to improve the quality of life for all its citizens with developmental disabilities.
Appendix 1A

Olmstead Update No: 3
Subject: HCFA Update
Date: July 25, 2000

Attachment 3-b
Subject: Community Transition --
Policy Change
Date: July 25, 2000

This attachment explains some of the ways that Medicaid funding may be used to help elderly people and individuals with a disability make the transition from an institution to a community residence. We focus particularly on case management services, and removal of environmental barriers.

Medicaid home and community-based services (HCBS) waivers are statutory alternatives to institutional care. Many States have found HCBS waivers to be a cost-effective means to provide comprehensive community services in the most integrated setting appropriate to the needs of the individuals enrolled.

Nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) likewise play important roles in our long term care system. They are particularly important for short-term rehabilitation, sub-acute care, and crisis management that enable timely hospital discharge. However, short-term stays often become long term residence when complicated planning is required for a return home, special housing or housing modification needs to be arranged, or exceptional one-time expenses must be paid.

This attachment explains several means by which Medicaid may assist States to overcome these barriers to community transition. It addresses the following:

A. Case Management
   1. Targeted Case Management Under the State Plan
   2. HCBS Case Management
   3. Administrative Case Management

B. Assessments for Accessibility

C. Environmental Modifications

D. Modifications Interrupted due to Death
A. **Case management.** Case management services are defined under section 1915(g)(2) of the Social Security Act (the Act) as “services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational, and other services.” Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community. There are several ways that case management services may be furnished under the Medicaid program:

1) **Targeted case management (TCM),** defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community. We are revising our guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person’s institutional stay, if provided for the purpose of community transition. States may specify a shorter time period or other conditions under which targeted case management may be provided. Of course, FFP is not available for any Medicaid service, including targeted case management services, provided to persons who are receiving services in an institution for mental disease (IMD), except for services provided to elderly individuals and children under the age of 21 who are receiving inpatient psychiatric services.

2) **HCBS Case Management** may be furnished as a service under the authority of section 1915(c) when this service is included in an approved HCBS waiver. Persons served under the waiver may receive case management services while they are still institutionalized, for up to 180 consecutive days prior to discharge. However, Federal financial participation (FFP) is available on the date when the person leaves the institution and is enrolled in the waiver. In such cases, the case management service begun while the person was institutionalized is not considered complete until the person leaves the institution and is enrolled in the waiver. In these cases, the cumulative total amount paid is claimed as a special single unit of transitional case management. To claim FFP for case management services under the waiver, the State may consider the unit of service complete on the date the person leaves the facility and is enrolled in the waiver, and claim FFP for this unit of case management services furnished on that date. The cost of case management furnished as a HCBS waiver service must be estimated in factor D of the waiver’s cost-neutrality formula.

3) **Administrative Case Management** may be furnished as an administrative activity, necessary for the proper and efficient administration of the State Medicaid plan. When case management is furnished in this fashion, FFP is available at the administrative rate, but may only be claimed for the establishment and coordination of Medicaid services that are not services funded by other payors for which the individual may qualify. Case management furnished as an administrative expense may be eligible for FFP even if the person is not eventually served in the community (e.g., due to death, the individual’s choice not to receive waiver services, loss of Medicaid eligibility, etc.). This is because
the service is performed in support of the proper and efficient administration of the State plan.

When a State elects to provide case management as both an administrative and a service expense (either under the targeted case management State plan authority, or as a service under a HCBS waiver), the State must have a policy on file with HCFA that clearly delineates the circumstances under which case management is billed as either an administrative or a service expense. This information must be included in the supporting documentation that the State forwards with its State plan or waiver request.

B. Assessments for Accessibility. Environmental modifications are often crucial to a State’s ability to serve an individual in the most integrated setting appropriate to his/her needs. The State may assess the accessibility and need for modification in a person’s home or vehicle at any time. FFP may be available in the costs of this assessment under several categories:

1) Administrative Expense: FFP may be claimed at the administrative rate for assessments to determine whether the person’s home or vehicle may require modifications to ensure the health and welfare of the HCBS waiver participant. When the assessment is performed to determine whether the individual’s needs can be met under an HCBS waiver, the administrative costs of the assessment may qualify for FFP regardless of whether or not the person is eventually served under the waiver;

2) Included in Environmental Modifications: The cost of environmental assessment may be included in the cost of environmental modification under an HCBS waiver; or

3) Included in a Relevant Service: The assessment may be performed by another service provider, such as a home health agency or an occupational therapist. FFP would be available at the service match rate when these providers perform assessments in addition to their other duties.

When a State elects to provide assessments for accessibility as a service expense under a HCBS waiver, the State must have a policy on file with HCFA that clearly delineates the circumstances under which these assessments are billed as either an administrative or a service expense. This information must be included in the supporting documentation that the State forwards in support of its HCBS waiver request.

The cost of reassessment may also be found eligible for FFP. Reassessment may be performed to determine whether new or additional modifications are needed, or whether existing (or newly installed) arrangements continue to be sufficient to meet the individual’s needs.
C. Environmental Modifications: It may be necessary to make environmental modifications to an individual’s home before an individual transitions from an institution to the community. For example, a wheelchair ramp may need to be built and doors may need to be widened to permit the individual to access his/her home. In such cases, the home modification begun while the person was institutionalized is not considered complete until the date the individual leaves the institution and is enrolled in the waiver. A State may claim FFP for home modifications (including actual construction costs) furnished as a waiver service for up to 180 days prior to discharge when (a) these modifications have been initiated before the individual leaves the institution and enrolls in HCBS waiver, (b) home modifications are included in the approved HCBS waiver. The claim for FFP must indicate the date the individual leaves the institution and enrolls in the waiver as the date of service for allowable expenses incurred during the previous 180 days.

D. Policy change: Modifications Interrupted by Recipient’s Death: The HCBS waivers serve a vulnerable population. Individuals who have chosen to relocate from an institutional to a community residence sometimes die before the relocation can occur. We believe that it would have a chilling effect if States were denied FFP for environmental assessments or modifications for individuals who died before their transition to home or community-based services. Therefore, we will allow the State to claim FFP at the administrative rate for services which would have been necessary for relocation to have taken place when the person has:

1) applied for waiver services,

2) been found eligible for the waiver by the State (but for the person’s status as an inpatient in an institution), but

3) died before the actual delivery of the waiver services.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-5918.
This letter clarifies some methods by which HCBS waivers under section 1915(c) may aid in the transitioning of individuals from institutional settings to their own home in the community through coverage of one-time transitional expenses. This clarification was promised in the HHS New Freedom Report to the President.

Dear State Medicaid Director:

Medicaid home and community-based services (HCBS) waivers are the statutory alternative to institutional care. Many states have found in HCBS waivers a cost-effective means to implement a comprehensive plan to provide services in the most integrated setting appropriate to the needs of individuals with disabilities.

However, individuals seeking a return to the community from institutions are faced with many one-time expenses, and many states are unclear about the extent to which waivers cover transition costs. Examples of those expenses include the cost of furnishing an apartment, the expense of security deposits, utility set-up fees, etc. Other states have expressed interest in having the waivers pay for apartment/housing rent. This letter is designed to answer such questions.

Federal funding under Medicaid HCBS waivers is not available to cover the cost of rent. States may offset rental expenses from state-only funds that augment federal HCBS resources, but federal financial participation (FFP) for such a purpose is not available for any apartment/housing rental expenses.

As the HHS Report for the President’s New Freedom Initiative stated, however, states may secure federal matching funds under HCBS waivers for one-time, set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community, such as security deposits, that do not constitute payment for housing rent.
States may pay the reasonable costs of community transition services, including some or all of the following components:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile;
- Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupany.

By reasonable costs, we mean necessary expenses in the judgment of the state for an individual to establish his or her basic living arrangement. For example, essential furnishings in the above context would refer to necessary items for an individual to establish his or her basic living arrangement, such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items. We would not consider essential furnishings to include diversional or recreational items such as televisions, cable TV access or VCRs.

States that choose to include community transition services in their HCBS waivers must demonstrate that this service, in combination with other services furnished under the waiver, would be cost-neutral to the Medicaid program. (In the streamlined HCBS waiver format, this cost neutrality is demonstrated in appendix G.) To be eligible for FFP, the service must be included in the individual’s written plan of care (service plan) and fit within the service definitions established by the state.

For more than three years CMS has awarded “Nursing Facility Transition Grants” to states in which transition costs have been paid from grant funds. Those states found that coverage of transition expenses has been manageable, cost-effective and has greatly facilitated the expeditious integration of individuals into their communities from prior institutional living arrangements. Contacts and other relevant information about those states may be found on the CMS website.

Any questions concerning this letter may be referred to Mary Jean Duckett at (410) 786-3294.

Sincerely,

Dennis G. Smith Director
Appendix 1C

Instructions: Version 3.3 HCBS Waiver Application
p. 147-8

Community Transition Services

Core Service Definition:

Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual’s health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diverstional/recreational purposes.

Instructions

• Supplement or modify the core definition as appropriate to reflect the specific community transition services that are included under the waiver.
• The service definition may be modified as necessary to reflect specific items and services that are included or excluded.
• Community Transition Services may not include payment for room and board. The payment of a security deposit is not considered rent.

Guidance

• See State Medicaid Director Letter #02-008 (Attachment D to Instructions) for further information.
• When Community Transition Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves
the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost.

- At the state’s option Community Transition Services may be furnished as a waiver service to individuals who transition from provider-operated settings other than Medicaid reimbursable institutions to their own private residence in the community.
- Community Transition Services may not be used to furnish or set up living arrangements that are owned or leased by a waiver provider.
Appendix 2

Money-Follows-the-Person Rebalancing Demonstration Program

Information prepared by: Robert Gettings, NASDDDS, Inc.

I. Explanation of Legislative Provisions.

Section 6071 of the legislation authorizes the Secretary to award grants on a competitive basis to assist states in: (a) expanding the availability of home and community-based services and simultaneously reducing their reliance on institutional long-term care services; (b) eliminating barriers that “… restrict or prevent the use of Medicaid funds” to provide long-term services and support consistent with the eligible individual’s choice; (c) improving states’ capacity to maintain the continuity of home and community-based services to former institutional residents; and (d) enhancing the states’ capacity to monitor and improve the quality of HCBS services.

Key Definitions. For purposes of Money-Follows-the Person (MFP) demonstration projects, the term “home and community-based long-term care services” means any home and community-based services provided under a state’s Medicaid program, including both state plan services (including home health and personal care services) and services furnished under Secretarially-approved waivers.

The term “eligible individual” for purpose of participating in MFP-funded service activities means persons who are Medicaid-eligible, have resided in a Title XIX-certified institution for not less that six (6) months or longer than two (2) years, as specified by the state, and on whose behalf a determination has been made that, in the absence of HCB services, they would continue to need institutional services.

A “qualified residence” for purposes of participating in MFP-funded service activities is limited to: (a) “a home owned or leased by the individual or the individual’s family member”; (b) “an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual’s family has domain and control”; and (c) “a residence, in a community residential setting, in which no more than 4 unrelated individuals reside” (emphasis added).

The term “qualified expenditures” under a MFP demonstration grant project restricts fundable service activities to “… services furnished [to eligible individuals] during the 12-month period beginning on the date the individual is discharged” from a Title XIX-certified in-patient hospital, nursing facility, or ICF/MR, as well as an institution for
mental diseases (IMD) to the extent that such facility qualifies as a provider of Medicaid-reimbursable services.

The term “self-directed” means, with respect to HCB long-term care, services that are “… planned and purchased under the direction or control of … [the] individual or the individual’s authorized representative …” Self-directed services must:

- be based on an assessment of the individual’s “… needs, capabilities and preferences…;”

- be summarized in an individual service plan that is developed jointly with the individual or his/her authorized representative. This plan must: (a) be based on the findings of the individual assessment; (b) specify the services the individual or his/her authorized representative is responsible for directing; (c) identify the methods to be used in selecting, managing and dismissing service providers; (d) specify the role of family members and others participants in the service planning/delivery process; (e) be developed through a person-centered process that is directed by the individual or his/her authorized representative, builds on the individual's capabilities, promotes the involvement of the individual in community life and respect for the individual’s preferences, choices and abilities, and involves family members, friends and professionals in ways desired by the individual or his/her authorized representative; (f) include appropriate risk management techniques that respect the shared responsibilities of all involved parties; and (g) identify the dollar value of services and supports under the control of the individual or his/her authorized representative, should the state elect to use an individual budgeting process. If a state chooses to develop individual budgets, its budgeting process must: (a) describe the methods to be used in calculating the dollar value of the person’s budget allocation based on reliable cost and service utilization data; (b) specify the process to be used in adjusting individual budgets to reflect changes in the individual’s circumstances; and (c) include a process for evaluating individual budget expenditures.

State Application Process. In submitting an application for a MFP demonstration grant, a state must:

- furnish the Secretary with assurances that it will use an open public participation process in designing, developing and evaluating its project;

- carry out its MFP project in conjunction with the operation of Medicaid-financed HCB services in such a manner that continuity of Medicaid coverage is maintained for project participants;

- request a project period of between two (2) and five (5) years in length;
specify the geographic service area or areas in which the demonstration project will be carried out;

specify the target groups and number of individuals expected to participate in the project, including the number of individuals, by target group, to be deinstitutionalized during each fiscal year of the grant period and the estimated total annual project expenditures during each fiscal year;

include assurances that: (a) each eligible individual or his/her authorized representative will be afforded the opportunity to make an informed choice as to whether to participate in the MFP demonstration project; (b) each eligible individual or his/her authorized representative will choose a “qualified residence” (see definition above) and a setting in which to receive HCB services; and (c) the state will continue to make available HCB services to each MFP participant for as long as the individual qualifies for Medicaid-funded services and the state’s need-based criteria governing the receipt of such services.

include in its application: (a) comparative Medicaid expenditure data on institutional and HCB services during the fiscal year immediately preceding the first year of the demonstration project period; and (b) a description of the methods to be used by the state to increase the percentage of expenditures on HCB services during each year of the demonstration period;

describe the methods the state will use to eliminate legal, budgetary, or other barriers to using Medicaid dollars flexibly to pay for services of the individual’s choice, including costs associated with transitioning from an institutional setting to a qualified residence.

demonstrate that: (a) total expenditures for HCB long-term services won’t be less during any fiscal year during the demonstration period than the greater of: (1) HCB long-term services expenditures during FY 2005; or (2) expenditures any succeeding fiscal year before the first year of the MFP project; and (b) the state would have continued to meet cost effectiveness formulae under existing Section 1915(c) and (d) waiver programs but for the receipt of the MFP demonstration grant.

specify any modifications or adjustments in existing waivers granted under Section 1915 of the Act that will be necessary to carry out the proposed project, including any adjustments in the maximum number of individuals to be served as part of the project and the package of benefits, including one-time transitional services, participants will be eligible to receive.

submit a quality assurance and improvement plan satisfactory to the Secretary. This plan must include provisions to safeguard the health and welfare of participants in the proposed MFP demonstration project. The state also must agree to cooperate in carrying out the Secretary’s responsibility for developing
and implementing continuous quality assurance and quality improvement systems (see additional discussion below);

- describe: (a) how the requirements outlined above (in the definition of “self-directed”) will be met; (b) how the state will afford eligible individuals the choice of self-directed services; and offer (c) assurance that participants who elect to self-direct their services will receive appropriate support, if the state chooses to offer self-directed services as part of its MFP demonstration project;

- furnish the Secretary with information concerning its MFP project, in a form and according to a timetable specified by the Secretary, that permits cross-state comparisons; and agree to participate in and cooperate with a national evaluation of the MFP demonstration program.

**Grant Awards.** The Secretary is directed to award grants under this section on a competitive basis to selected states. In selecting state grantees, the Secretary is instructed to: (a) take into consideration the manner and extent to which the submitting states propose to achieve their grant objectives; (b) seek to achieve “an appropriate national balance” with regard to the number of eligible individuals who are transitioned from institutions to qualified community residences and the geographic distribution of states operating MFP demonstration projects; (c) give preference to state applications that propose to provide transitional assistance to multiple target groups and plan to offer participants the option of self-directing their HCB services; and (d) take the above objectives into account in determining the amounts of grant awards.

**Waiver Authority.** Upon a state’s request, the Secretary is authorized to waive the provisions of Sections 1902(a)(1) (statewideness), 1902(a)(10)(B) (comparability), 1902(a)(10)(C)(i)(III) (income and resources eligibility) and 1902(a)(27) (provider agreements) of the Social Security Act in order to permit a state to carry out its proposed MFP demonstration project.

**Conditional Approval of Out-Year Funding.** The Secretary also is permitted to grant conditional approval of the second and subsequent years of a state’s grant. The receipt of out-year funding will be contingent on a state’s meeting: (a) numerical benchmarks related to the number of individuals transitioned to qualified community residences and the percentage of expenditures on HCBS vs. institutional services, as specified in its grant agreement with the Secretary; and (b) adhering to quality of care requirements, including instituting effective health and welfare safeguards.

**Payments to States.** During each calendar quarter during the grant period, state grantees will receive an amount equal to its MFP-enhanced FMAP rate for all qualified expenditures. A state’s MFP-enhanced FMAP rate will be equal to its existing FMAP rate increased by a number of percentage points that equal 50 percent of the difference between 100 percent and the state’s existing FMAP rate. Under this formula, a state with a minimum 50 percent FMAP rate, for example, would have a 75 percent MFP-enhanced FMAP rate, while a state with a 70 percent FMAP rate would have an 85 percent MFP-
enhanced FMAP rate. No state, however, could have an MFP-enhanced FMAP rate of higher than 90 percent.

Any portion of a state’s grant award that is unused would remain available for carrying out the objectives of the grant project for the next four (4) fiscal years. The Secretary, however, is authorized to rescind a state’s award if it fails to meet the conditions for continued funding outlined above.

Payments under a MFP demonstration project for “qualified expenditures” will be in lieu of payments the state otherwise would be eligible to receive under its Medicaid program. States, however, would not be precluded from claiming FFP at its normal FMAP rate for qualified project-related expenditures that exceed the amounts allowed in the grant.

Quality Assurance and Improvement. The Secretary, acting either directly or under a grant- or contract-funded project, is directed to provide technical assistance to and oversight of state efforts to upgrade their quality assurance and quality improvement systems for Medicaid-funded home and community-based services. Among the types of technical assistance and oversight activities that might be pursued are:

- dissemination of information on promising practices;
- guidance on system design elements addressing the unique needs of participating beneficiaries;
- ongoing consultation on quality, including assistance in developing necessary tools, resources and monitoring systems; and
- guidance on remedying programmatic and systemic problems.

The legislation sets aside $2.4 million in FY 2007 and FY 2008 to carry out such QA/QI technical assistance and oversight activities. These funds will taken from the total amount appropriated for the MFP demonstration program (see discussion below) and will be available for expenditure between January 1, 2007 and September 30, 2011.

Research and Evaluation. The Secretary is directed to evaluate and conduct research with respect to the MFP demonstration program, either directly or under a grant or contract. The evaluation must include an analysis of projected savings associated with individuals transitioned from institutions to qualified community residences as a result of the project. A final evaluation report must be filed with the President and Congress by no later than September 30, 2011. A total of $1.1 million is set aside to conduct these research and evaluation activities.

Appropriations. The following sums are appropriated to carry out the activities described above: $250 million for the portion of fiscal year 2007 beginning on January 1, 2007; $300 million for fiscal year 2008; $350 million for fiscal year 2009; $400 million for
fiscal year 2010; and $450 million for fiscal year 2011. Funds make available for this purpose may be used to award grants until no later than September 30, 2011.

II. Ramifications for State MR/DD Agencies.

This new demonstration grant program will be useful primarily to states that continue to serve a significant number of individual in public and private ICFs/MR and are looking for ways of assisting residents who wish to do so to transition to appropriate home and community-based settings. No doubt, these states will find the enhanced federal financial assistance (75% to 90% of the first year costs of each individual move from and institution to a qualified community residence) helpful in pursuing its planned deinstitutionalization initiative. The availability of federal grant funds to organize and administer the initiative also will be helpful. Since, however, MFI grants are to be awarded on a competitive basis and many states have made greater progress in deinstitutionalizing ICFs/MR than they have nursing facilities (NFs), CMS and the states might be inclined to assign priority to submitting and approving grant requests aimed a moving individuals over of nursing homes and back into community homes.
MISSION:
The Regional Outreach Team will work collaboratively with consumers, advocates, providers and state agencies within the region to provide training, technical assistance, consultation and backup service provision as possible to improve quality of life and support individuals with disabilities, their families, service providers and targeted case managers within the region. The Outreach Team will be available to provide phone consultation throughout the state and will make available distance training.

ROLE AND FUNCTION:
The Regional Outreach team will provide formal training regarding contemporary topics and best practices to consumers, their families, service providers, targeted case managers, and state staff in the region. As much as possible training will be provided in the community close to the consumer. Some larger group training will be provided at the Regional Center or in other appropriate settings in the community. Training opportunities will be provided throughout the state via technology. The goal is to have common training topics provided across the state, which will promote consistency. Representatives from the regions and DDARS staff will identify training topics based on identified needs through the analysis and synthesis of quality/risk data, observation and requests for training.

The Regional Outreach team will provide technical assistance, consultation, training and limited back-up services when services are not available in the community regarding state of the art best practices to consumers, their families, service providers, targeted case managers, and state staff in the southeast region of Indiana in the areas of behavior, occupational therapy, physical therapy, speech therapy, nutrition and psychiatry. As much as possible hands on technical assistance will be provided in the community close to the consumer. Consultation will be provided based on identified needs through the analysis and synthesis of quality/risk data and from request from providers and targeted case managers.

Outreach staff will be available to provide consultation via the phone or e-mail in a timely manner. References, resources and current literature will be provided through the Outreach Team and the Indiana Institute on Disabilities and the Community. The Outreach Team will be a local source of information.

TIME UTILIZATION: Percent of time where the Outreach Team members will devote their time on average.

TECHNICAL ASSISTANCE, CONSULTATION, AND TRAINING IN THE COMMUNITY. 40 – 50%

PHONE CONSULTATION 20 – 25%

ON GROUNDS SERVICE PROVISION 5 – 10%
Each outreach team member will provide services in their area of specialty in a collaborative interdisciplinary manner providing analysis of the bio-psycho-social factors of the individuals, and assisting in designing and implementing service plans that address the unique needs of individuals. Each team member will follow the nationally accepted professional practice standards for their area of specialty. Each team member will hold a professional license/certification in Indiana for his or her professional discipline. Outreach team members will require at least five- (5) years experience in working with individuals with developmental disabilities. Since these team members will function as mentors to other professional staff it is expected that they will possess state of the art expertise in their area of discipline. Previous experience in supervision of the provision of services for individuals with developmental disabilities and/ or the provision of technical assistance to staff in their discipline who were providing services to individuals with developmental disabilities is preferred. The team members will work in coordination with other team members to develop training curriculums on topics in the development of a statewide training plan. A common training format_outline will be used to document and provide a guide for future training.

All interdisciplinary team members will have the knowledge and skill to conduct and train staff to carry out quality assurance in their area of discipline.

All team members will:

- Work with practitioners in the general public, within the discipline of the team member, about the unique needs of individuals with developmental disabilities as it pertains to their area of specialization and how the generic community providers can meet their needs.
- Work to educate practitioners in the general public to understand and demonstrate in their practice how to obtain needed information about individuals with developmental disabilities so all aspects of an individual can be assessed and needed supports and services provided.
- Establish relationships with practitioners in clinics, hospitals, private practice and in higher education to understand the needs of and how to treat individuals with developmental disabilities.

Staff will typically work full time. The exception will be the psychiatrist who will provide service on an as needed basis. It is currently our policy to hire and continue to recruit state employees first when possible. Full time staff work 40 hours per week. Staff may be asked to work flexible schedules or take calls on a rotating basis to insure timely and responsive assistance.

Staff of the Outreach Team will follow the prescribed rules, regulations, policies, and procedures required by DDARS and DOA.

Staff of the Outreach Team includes:

1. Coordinator of DD Services
This position provides the direction, supervision, coordination, and administrative functions for individuals with DD in the Region. Specifically, this position is responsible for transitional services provided for individuals with DD leaving a state facility, outreach services for persons with DD, training, technical assistance, and consultation to protect the health, and safety of individuals and improve their quality of life through the provision of information, supports and services to individuals with developmental disabilities, their families, service providers, targeted case managers, and staff in the region.

Minimum requirements are:
Knowledge and ten- (10) years’ management experience in working with individuals who are developmentally disabled with challenging and unique needs. Experience in provision of Technical assistance, consultation and training of staff.

Education: At least a BS degree in human service with graduate degree preferred.

A. Administer the DD Outreach team and Transition team:
Administer the implementation of formal training in contemporary topics that relate to effective service provision in all disciplines
Administrator the provision of technical assistance and consultation
Administer the provision of services by the Outreach and Transitional teams

Administer the selection and provision of state of the art / contemporary information from professional journals and research to staff who work with individuals with DD in the region

B. Administer Financial Aspects
Administer the financial responsibilities of the outreach and transition team including travel, contracts, equipment and supplies, Medicaid reimbursement……

C. Analyzes Risk and Management Data
Insures the quality assurance information obtained through incident reports is analyzed to determine if technical assistance, consultation or training is needed.

2. Outreach Team Manager

This position, under the direction of the Coordinator of DD services, provides direction, supervision, coordination, and administrative functions as well as assist in the actual provision of the outreach services, training, technical assistance, and consultation to protect the health, and safety of individuals and improve their quality of life through the provision of information, supports and services to individuals, their families, service providers and targeted case managers.
Minimum requirements are:
Knowledge and eight- (8) years’ management experience in working with individuals who are developmentally disabled with challenging and unique needs. Experience in provision of Technical assistance, consultation and training of staff.
Education: At least a BS degree in human service with graduate degree preferred.

A. Administer the implementation of formal training in contemporary subjects

B. Administrator the provision of technical assistance and consultation

C. Administer the provision of services by the Outreach team

D. Supervision of Outreach staff including scheduling and observing actual service provision

E. Administer the provision of state of the art contemporary literature to staff who work with individuals with DD in the region
F. Insure the outreach team is fiscally efficient including time, travel, supplies and equipment.

3. Behavioral Clinician (CONTRACT)

This position provides behavior management supports including direct crisis intervention services, training, technical assistance, and consultation to protect the health, and safety of individuals and improve their quality of life through the provision of information, to individuals, their families, service providers and targeted case managers.

Minimum requirements are MS/MA with five (5) years experience with the DD population and in applied behavior analysis, development and implementation of behavior management plans, and completing functional assessment.

A. Conduct formal training in related areas of expertise

B. Conduct the provision of technical assistance and consultation regarding related area of expertise.

C. Provide services in cooperation with the other members of the Outreach team

D. Relay state of the art / contemporary information regarding behavior management to staff who work with individuals with DD in the region, whereby increasing their performance.

E. Respond to request for assistance in a timely manner and rotate being on call.

F. Monitor the provision of Clinical Supports and Services.

G. Conduct examinations and assessments (psychological assessments, functional analysis)

H. Develop behavior plans and insures effective implementation of these plans in the Support Plans
I. Participate as an interdisciplinary team member

4. Registered Dietitian
This position will provide supports in their area of expertise including direct service, training, technical assistance, and consultation to protect the health, and safety of individuals and improve their quality of life through the provision of information, to individuals, their families, service providers and targeted case managers.

Minimum requirements are Experience and knowledge in working with individuals who are developmentally disabled with challenging and unique swallowing needs. Experience in provision of technical assistance, consultation and training of staff in dysphasia, swallow studies, development of dining plans.

Education: BS/BA Registered Dietitian

A. Conduct formal training in dining programs, dysphasia, special diets, etc.

B. Conduct the provision of technical assistance and consultation regarding related dining programs, dysphasia, special diets, etc.

C. Provide services in cooperation with the other members of the Outreach team

D. Relay state of the art / contemporary information regarding dietetic services to staff who work with individuals with DD in the region, whereby increasing their capacity

E. Respond to request for assistance in a timely manner and rotate being on call.

F. Monitor the provision of clinical dietary supports and services.

G. Conduct examinations and assessments regarding the need for special diets and dining techniques.

H. Develop care plans and insures effective implementation of these plans in the Support Plans

I. Participate as an interdisciplinary team member

5. Occupational Therapist
This position provides restorative and maintenance supports that enable individuals to function more independently. These include direct service, training, technical assistance, and consultation to protect the health, and safety of individuals and improve their quality of life through the provision of information, to individuals, their families, service providers and targeted case managers.
Minimum requirements are ten- (10) year’s experience, and knowledge working with individuals with developmental disabilities who have severe physical disabilities and challenging or unique needs. Experience in provision of Technical assistance, consultation and training of staff.

A. Conduct formal training in assessment, development and implementation restorative and maintenance supports that enables individuals function more independently.

B. Conduct the provision of technical assistance and consultation regarding positioning maintenance and restorative supports.

C. Provide services in cooperation with the other members of the Outreach team

D. Relay state of the art / contemporary information to staff who work with individuals with DD in the region, whereby increasing their capacity to support individuals with severe physical disabilities.

E. Respond to request for assistance in a timely manner and rotate being on call.

F. Monitor the provision of Clinical Supports and Services.

G. Conduct examinations and assessments to determine need for adaptive equipment.

H. Develop care plans and insures effective implementation of these plans in the Support Plans

I. Participate as an interdisciplinary team member

6. Maintenance Repair person for adaptive equipment

This position provides support, in the development adaptive devices that will enable individuals to function more independently. This will include direct service, training, technical assistance, and consultation to protect the health, and safety of individuals and improve their quality of life through the provision of information, to individuals, their families, service providers and targeted case managers.

Minimum requirements are experience in developing, and modifying adaptive equipment. Knowledge and experience in adapting equipment for individuals who are developmentally disabled and have severe physical disabilities with challenging and unique needs. Experience in provision of Technical assistance, consultation and training of staff.

Education: High school

A. Assist Therapy staff in the design of adaptive equipment that is innovative and creative as requested in a timely manner.
B. Develop Adaptive Equipment to meet the identified needs of individuals as requested in a timely manner.

C. Assist Therapy staff in the design to repair adaptive equipment to meet the identified needs of individuals as requested in a timely manner.

D. Repair adaptive equipment for individuals on the residential unit and in the community who have unique needs.

E. Assist Therapy staff in the provision of routine Maintenance on Adaptive Equipment to meet the identified needs of individuals as requested in a timely manner.

F. Assist therapy staff in the provision of consultation and technical assistance that will develop competency of community providers in development, repair and maintenance of adaptive equipment.

7. Training Director

This position provides direction to coordinate the training activities of the outreach staff, including direct service, training, technical assistance, and consultation that will protect the health and safety of individuals and improve their quality of life. This position will assist staff in thorough provision of information, to individuals, their families, service providers and targeted case managers.

Minimum requirements are experience in coordinating and provision of training services and knowledge of contemporary training techniques which will have a positive effect a provision of services for individuals with DD. Extensive knowledge of state of the art electronic techniques and equipment to provide training to large numbers of individuals in efficient manner (i.e. long distance learning, video conferencing, …)

Education: MS/MA in education, adult education, special education, computer science

A. Conduct examinations and assessments of recipients on training topics

B. Train staff to develop care plans and insure effective implementation of these plans in the Support Plans that follow the person centered techniques

C. Train staff to be essential members of an interdisciplinary team.

D. Guide the outreach team in the techniques of providing technical assistance and consultation regarding related area of expertise.

E. Arrange training for the outreach team to enable them to provide state of the art services in cooperation with the other members of the Outreach team
F. Coordinate the provision of state of the art contemporary information to staff who work with individuals with DD in the region, whereby increasing their capacity

G. Respond to request for assistance in a timely manner and rotate being on call.

H. Coordinate and monitor the provision of Technical assistance, consultation, and training by the outreach team to insure competency.

8. Physical Therapist (contract)

This position provides physical therapy supports including direct service, training, technical assistance, and consultation to protect the health, and safety of individuals and improve their quality of life through the provision of information, to individuals, their families, service providers and targeted case managers.

Minimum requirements are license for physical therapy in Indiana knowledge and ten (10) years’ experience providing physical therapy for individuals who are developmentally disabled with challenging and unique physical and medical needs. Experience in provision of Technical assistance, consultation and training of staff. Especially experience in working with individuals who are DD in the areas of Dysphasia, and physical management.

Education: Physical Therapy degree

A. Conduct formal training in provision physical management and the assessment, service development, and implementation of physical therapy services

B. Conduct the provision of technical assistance and consultation regarding provision of physical management and assessment, service development, and implementation of physical therapy services

C. Provide services in cooperation with the other members of the Outreach team

D. Relay state of the art / contemporary information to staff who work with individuals with DD in the region, whereby increasing their capacity of provision of physical management and assessment, service development, and implementation of physical therapy services

E. Respond to request for assistance in a timely manner and rotate being on call.

F. Monitor the provision of physical therapy supports and services.

G. Conduct examinations and assessments to determine individuals needs for physical therapy

H. Develop care plans and insures effective implementation of these plans in the Support Plans
I. Participate as an interdisciplinary team member

9. Psychiatrist part time (contract)

This position provides psychiatric supports including direct service, training, technical assistance, and consultation to protect the health, and safety of individuals and improve their quality of life through the provision of information, to individuals, their families, service providers and targeted case managers.

Minimum requirements are medical degree and specialty in psychiatry, knowledge and five- (5) years’ experience in working with individuals who are developmentally disabled and mentally ill with challenging and unique needs. Experience in provision of Technical assistance, consultation and training of staff.

Education: Medical degree and specialty in psychiatry

A. Conduct formal training in psychiatry

B. Conduct the provision of technical assistance and consultation regarding psychiatry

C. Provide services in cooperation with the other members of the Outreach team

D. Relay state of the art / contemporary information to staff who work with individuals with DD in the region, whereby increasing their capacity in meeting the needs of individuals with DD/MI

E. Respond to request for assistance in a timely manner and rotate being on call.

F. Monitor the provision of Clinical Supports and Services.

G. Conduct psychiatric examinations and assessments

H. Develop care plans and insures effective implementation of these plans in the Support Plans

I. Participate as an interdisciplinary team member

10. Secretary (2)

These positions serve as the administrative secretary and personal assistant to the Coordinator of DD Services and the Outreach Manager. These positions will provide administrative support and schedule activities of the outreach team members.

Minimum requirements are good organizational skills and ability to schedule multiple staff time and activities. Good typing, filing, and computer skills.

Education: High school and computer classes
A. Administrative assistant to the Coordinator of DD Services and/or Outreach Manager

B. Principal liaison/information officer between Coordinator's and Manager's offices, staff, residents, community providers, families and advocates for the region.

C. Coordination and management of individual’s records

D. Coordination of Annual Policy and Procedure Review

E. Tracking incidents and injuries and other management data

F. Develop public relations material for the region.

G. Coordinate and manage correspondence

11. Account Clerk
This position assists in the provision of administrative support and schedule activities of the outreach team members. This position will track the fiscal/financial aspects of the regional DD Staff in accordance with accepted accounting practices.

Minimum requirements are: Knowledge and ability to maintain accounts payable and accounts receivable

Education/training: High School and Training in Basic bookkeeping, Microsoft word excel and access, and budget preparation

A. Coordination of financial records and electronic data management

B. Assistant in the scheduling of staff’s time in the provision of Technical assistance, consultation and training.

C. Principle liaison/information officer between Coordinator of outreach services and others for fiscal matters

D. Management of fiscal/financial data

E. Develop financial reports

F. Manage and document the use of staff time, and travel, and the use of training supplies and equipment

G. Tracks the utilization of all staff’s time and maximizes the obtaining of federal reimbursement.

1-12-04