

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

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



Money Follows the Person Demonstration Project
Operational Protocol

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Project Introduction

Increase the Use of Home and Community Based Services

New Jersey over the past 25 years has created long-term care (LTC) systems to enable people of all ages with disabilities and long-term illnesses to live outside of institutions. These systems are managed by the Divisions of Aging Services (DoAS), Disability Services (DDS) and Developmental Disabilities (DDD) in the Department of Human Services (DHS). Administrative and fiscal oversight is delegated by DHS, the single State Medicaid Authority, to its Division of Medical Assistance and Health Services (DMAHS). Together these state agencies operate 2 waivers, state plan services and other state-funded services that make up New Jersey's Home and Community-Based Services System. The system serves the elderly and people of all ages with a physical and/or developmental disability. The LTC system is in the midst of rebalancing, i.e., moving toward a community-based system of care. Since July 1999, DDD has increased the number of people served in the community by 74% from 23,174 to 40,382; HCBS waiver recipients have increased by 52% from 6635 to 9454. Since 1990, DDD has decreased the number of people served in its seven (ICF-MR) Developmental Centers by 98% (2523 people) from 5110 to 2587 people. DoAS more than tripled the number of people served by the waiver programs and currently supports 11,138 people under the Global Options waiver. State Plan Adult Day Health services increased from less than 6000 in 1997 to 12,677 in FY 2012. The number of people served in nursing facilities decreased by approximately 4300 people from almost 32,000 in 1997 to 27,700 in FY 2012. At the same time DoAS reduced the percentage of funding spent on nursing homes from 92.7% in 1997 to 72% in 2009. (Source: 2010 Independence Dignity and Choice in Long-Term Care Act Annual Governors Report). The rebalancing percentage in each case supported community services.

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

The DDD began a systems change effort with the release of the **Strategic Plan, "New and Expanded Options for Individual's with Developmental Disabilities and their Families."** While adopting a philosophy of person-centered planning, DDD provided more options for self-direction through a series of budget initiatives that increased state resources for HCBS. These efforts included ensuring that recipients of DDD LTC services receive and maintain Medicaid HCBS Waiver eligibility (as well as Social Security and SSI eligibility).

These administrative practice changes were accompanied by the creation of a more efficient, automated infrastructure for claiming federal match for state funded services. The Governor and Legislature supported these efforts allowing the reinvestment of new revenues and further expansion of HCBS.

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

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

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

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

New Jersey is witnessing a fundamental change in its long-term care policy for older adults and persons with disabilities across all incomes. It is a transformation that is directed at giving more people more control over their care and providing more support for community living. The plan for New Jersey is a “Money Follows the Person” long-term care system: a

person-centered approach of providing service delivery promoting dignity, choice and independence in the most integrated community setting.

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

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

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

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

While adopting a philosophy of person-centered planning, DDD provided more options for self-direction through a series of budget initiatives that increased state resources for HCBS. These efforts included ensuring that recipients of DDD LTC services receive and maintain Medicaid HCBS Waiver eligibility (as well as Social Security and SSI eligibility). These administrative practice changes were accompanied by the creation of a more efficient, automated infrastructure for claiming federal match for state funded services. The Governor and

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

Legislature supported these efforts allowing the reinvestment of new revenues and further expansion of HCBS.

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

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

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

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

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

Building service capacity, particularly in challenging areas such as mental health and housing, has been a priority activity. Within the DDD system, statewide expansion of mental health treatment tailored to meet the needs of individuals with developmental disabilities will help to reduce the number of referrals to developmental centers and will aid in supporting individuals who are moving from centers into the community. Examples of these mental health services include consultation to mental health emergency and psychiatric hospital screening services to assure effective intervention with this population in the community; a DD inpatient unit in a community hospital; Integrated Service Delivery Teams, and Mobile Mental Health - Behavioral Crises Teams and Clinical Resource Teams.

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

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

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

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

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

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

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

Benchmarks

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

Benchmark #1:

Projected number of individuals in each target group to be assisted in transitioning to the community: New Jersey has committed to increase MFP transitions from 305 over the next five (5) years to 2361 over the next five (5) years (2011 – 2016). The numbers are reflected in the chart below.

PROJECTION FOR CY CYCLES

	Elderly	IDD	Physically Disabled	Total of Populations	functional time	Operational Grant Period
CY 2007	0	0	0	0		
CY 2008*	3	10	5	18	6 months	Period 1 7/1/08 - 12/31/08
CY 2009	51	97	32	180	12 months	Period 2 1/1/09 - 12/31/09
CY 2010	25	31	6	62	12 months	Period 3 1/1/10 - 12/31/10
CY 2011	50	44	30	124	12 months	Period 4 1/1/11 - 12/31/11
CY 2012	150	172	75	397	12 months	Period 5 1/1/12 - 12/31/12
CY 2013	160	147	80	387	12 months	Period 6 1/1/13 - 12/31/13
CY 2014	167	180	85	432	12 months	Period 7 1/1/14 - 12/31/14
CY 2015	106	128	53	287	12 months	Period 8 1/1/15 - 12/31/15
CY 2016	114	81	57	252	12 months	Period 9 1/1/16 - 12/31/16
CY 2017	114	75	57	246	12 months	Period 10 1/1/17 - 12/31/17
CY 2018	114	75	57	246	12 months	Period 11 1/1/18 - 12/31/18
Total Count	1054	1040	537	2631		

Note: The Olmstead lawsuit filed by Disability Rights NJ against the State of NJ-Department of Human Services was settled. The agreement states that DDD must provide placements for at least 600 individuals residing in developmental centers between FY 2013 and FY 2017 according to the following schedule:

Between 7/1/2012 and 6/30/2013: 90 (FY 13: 167 individuals were transitioned during this time frame);

By 6/30/2014: cumulative total equivalent to 205

By 6/30/2015: cumulative total equivalent to 320

By 6/30/2016: cumulative total equivalent to 435

By 6/30/2017: cumulative total equivalent to 600

Note: Even with the Olmstead Settlement, the ID/DD transition numbers decrease in 2015 and 2016 because it is anticipated that those remaining in the Developmental Centers will be the individuals that have very acute care needs with intense behaviors in both type and frequency such as Pedophilia, aggression, SIB, PICA, etc. Since provider agencies are slow to offer support to individuals with these very acute care needs, NJ is in the process of cultivating its provider pool to be able to provide the needed care to these individuals. Some steps NJ is taking to improve the provider base for this group are:

- Targeted work to expand pool for sex offenders;
- Targeted work to expand pool for PICA;
- Advising the provider pool of the support their agencies can receive from the MFP Resource Teams through trainings and presentations.

Benchmark #2:

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

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

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

2012 – 2016: Increase in Qualified HCBS Expenditures:

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

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

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

Benchmark #3:

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

The number of agencies offering continuing education through use of the College of Direct Support will increase by at least 10 agencies per year from 2012 through 2016.			
	First 6-month target	Second 6-month target	Full year target
2012	30	30	60
2013	35	35	70
2014	40	40	80
2015	45	45	90
2016	50	50	100
2017	55	55	110
2018	60	60	120

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

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

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

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

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

In July 2010, utilizing state funding, New Jersey purchased the College of Direct Support for statewide implementation under the Division of Developmental Disabilities (DDD). New Jersey made a commitment to statewide implementation and completed the statewide implementation of the College of Direct Support in June 2011. DDD service providers across the state now are able to provide cutting edge, easily accessible, competency based online training to their staff. This availability of enhanced training opportunities is aimed at improvements in the quality of services provided and the professionalism of today's direct support workforce. Continued funding for the College of Direct Support will be funded through New Jersey's MFP rebalancing fund.

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

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

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

In an attempt to further increase an available and trained community workforce, New Jersey's MFP Program received approval to add, at 100% administrative match funding, a Training Team within the Division of Developmental Disabilities (DDD) to increase the competence of provider agency staff who will be serving individuals placed in community programs from institutional settings that meet New Jersey's MFP eligibility criteria. The Training Team will be composed of state staff as opposed to a contracted provider. The reasoning behind utilizing state staff as opposed to a contracted provider is as follows:

- Contracting would have involved a Request For Proposal process which would have had the potential to delay the implementation of the Training Team;
- NJ had available, existing positions to utilize;

- State staff enables DDD the benefit of greater control over subject matter and implementation.

Specific skill areas of competence to be enhanced are Physical/Nutritional Management and Behavioral Support with the primary goal of enhancing overall support skill levels and reducing the risks of critical incidents and re-institutionalizations.

The Training Team is designed to provide generic, but highly technical training that is consistent with best practices in the areas of Physical/Nutritional Management and Behavioral Supports. The recipients of this training will be providers of service for individuals who are placed in community programs from institutional settings. This may involve residential service providers as well as other ancillary services such as work and day programs.

The Team will be in communication with the Transitional Case Managers, who will alert them to the specific provider programs that have and/or will be receiving individuals with prominent needs in the areas of Physical/Nutritional Management and/or Behavioral Support.

The Training Team may develop new curriculums or use/modify existing curriculums depending on the assessed needs of the individuals and service providers. The Training Team may provide training and training activities through a variety of methods including;

- Large didactic workshops or seminars.
- Small group presentations.
- Discussion groups.
- Small group, hands on demonstrations.
- Video demonstrations and training programs.
- Training modules through print and electronic media.
- Outlines, manuals, guides and audio-visual aids.
- Application of competency based training principles when appropriate.

Service providers may request retraining anytime they feel it is needed. Further, through agreements with providers, the Training Team may also provide some quality assurance “like” functions to assess if there is a need for refresher or additional training. This would involve observational visits to programs and an assessment of levels of competence being demonstrated in the target areas. Presentations may also be given to parents, guardians, and family members of individuals who are living in institutions and are considering community placement.

The Training Team may also work with executive management of the Division of Developmental Disabilities and the community provider network to enhance current training requirements for service providers based on training outcomes assessed by the Team.

Measure 2: 95% or more of the community work force attending the Olmstead Training Resource Team modules will report ‘Yes’ when asked if they learned something from the training.

	First 6-month target	Second 6-month target	Full year target
2015	95% or higher	95% or higher	95% or higher
2016	95% or higher	95% or higher	95% or higher
2017	95% or higher	95% or higher	95% or higher
2018	95% or higher	95% or higher	95% or higher

Rewarding Work Resources, Inc., a 501(c) (3) nonprofit corporation, developed the Rewarding Work Website which gives the elderly and individuals with disabilities the choice of hiring staff directly and allows them control of the process of hiring personal assistants.

The site also provides private agencies a resource to assist in recruitment of direct support professionals and other staff. The list is maintained in a secure database and each user must establish an account and pay a subscription fee to access the list of potential direct care workers. The subscription fee allows the individual unlimited access to all the names of available care providers for a period of one month, three months, six months, or one year depending upon the subscription fee that was chosen by the individual.

Benchmark #4:

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

NJ Division of Developmental Disabilities

To ensure the health and welfare of MFP participants as well as all individuals with IDD who have transitioned from a Developmental Center (DC) to community living, DDD case managers are required to complete an Olmstead Review Survey every 30, 60, and 90 days after discharge on all individuals discharged from the DC's. 100% compliance and timely submission is mandatory. The Olmstead Survey addresses the following core indicators:

- home satisfaction;
- home staff satisfaction;
- day program satisfaction;
- day program staff satisfaction;
- making new friends;
- community participation;
- contact with friends and family;
- identifying issues that need resolving.

The MFP Quality Assurance Specialist (QAS) is responsible for tracking the receipt of these surveys by each geographical region and interpreting the data obtained from these surveys. Quarterly reports are developed from the interpretation of the data and presented to DDD executive management and the Olmstead Advisory Council.

Measure 1 - Olmstead Review Surveys will be completed and submitted on time for all MFP participants with IDD 100% of the time.			
	First 6-month target	Second 6-month target	Full year target
2015	100%	100%	100%
2016	100%	100%	100%
2017	100%	100%	100%
2018	100%	100%	100%

NJ's MFP Program created a Risk Review Form to be utilized by the MFP Quality of Life (QOL) surveyors when surveying an MFP participant. The Risk Review Form contains questions from the QOL survey if answered in a specific way, would indicate the individual's health and safety may be in jeopardy. The Quality of Life surveyors are required to circle the question and answer on the Risk Review Form that indicates the individual may be at risk and submit the form along with the survey to the MFP Project Director. The Risk Review Form is then forwarded to the MFP Quality Assurance Specialist (QAS) who is responsible for notifying the appropriate staff person that issues have arisen for an MFP participant they support. For MFP participants with IDD, the community case manager is responsible for the follow-up and resolution to all issues and concerns expressed by the MFP participant and/or QOL surveyor. For MFP participants who are older adults and those with physical disabilities, beginning July 1,

2014, the Managed Care Organization care manager will be responsible for the follow-up and resolution to all issues and concerns expressed by the MFP participant and/or QOL surveyor. NJ's MFP Program expects the case/care manager to contact the MFP participant and provide follow-up and resolution to their issues and concerns and notify the MFP QAS of the outcome within thirty (30) days of the receipt of the Risk Review Form. All issues, responses and resolutions will be documented by the MFP QAS.

The purpose of the Risk Review Form is ultimately to improve service delivery to all MFP participants. History shows that NJ's MFP Program receives a Risk Review Form for 14% of those MFP participants surveyed in a one year period.

Measure 2 - Responses to the issues and concerns noted in the Risk Review Form will be submitted to the MFP QAS from the appropriate staff person within thirty (30) days of the receipt of the Risk Review Form 100% of the time.			
	First 6-month target	Second 6-month target	Full year target
2015	100%	100%	100%
2016	100%	100%	100%
2017	100%	100%	100%
2018	100%	100%	100%

The NJ Division of Aging Services:

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

The MLTSS program is integrated into the Managed Care Organization’s Quality Assessment Performance Improvement (QAPI) program pursuant to the standards set forth by the State. The State retains the right to add, delete or revise performance measures. A Quality of Life survey must be implemented by the Managed Care Organizations on or after January 1, 2015.

The following performance measures have been selected by the State for implementation by the Managed Care Organizations within the first year of the MLTSS Program.

- Participant Access Measures
 - Level of Care
- Participant-Centered Service Planning and Delivery
 - Plan of Care
- Provider Capacity and Capabilities

- Provider Networks
- Participant Safeguards
 - Critical Incident Management System
- Participant Rights and Responsibilities
 - Complaints, Grievance and Appeals
- Measuring Effectiveness of MLTSS activities

NJ's MFP Program has chosen to monitor one aspect of the effectiveness of the newly implemented MLTSS Program by tracking how many MFP participants are re-institutionalized within ninety (90) days of discharge from the nursing facility. Prior to the implementation of MLTSS, approximately 9% of MFP participants were re-institutionalized within ninety (90) days of discharge from the nursing facility.

DoAS/DDS Measure 3 – As a result of the implementation of MLTSS by the Managed Care Organizations, 0% of MFP participants will be re-institutionalized within ninety (90) days of discharge from the nursing facility.			
	First 6-month target	Second 6-month target	Full year target
2015	0	0	0
2016	0	0	0
2017	0	0	0
2018	0	0	0

Benchmark #5:

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

Measure 1: MFP Statewide Housing Coordinator will meet with targeted individuals or entities to advance housing opportunities for ICHNJ-eligible individuals. Examples include encouraging PHAs to amend their Administrative Plans to give ICHNJ preferences; promoting the MFPHPP to interested housing developers; promoting ICHNJ tenants to municipalities, community development corporations, realtors, etc.			
	First 6-month target	Second 6-month target	Full year target
2016	7	8	15
2017	7	8	15
2018	7	8	15

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

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

NJ has found meetings with Public Housing Authorities throughout the state to be less than productive. PHAs, although receptive to the message and program, often have no active housing opportunities to which to connect our participants and have no other means of collaborating with our Program. NJ has had great success in meeting with housing developers, our partners at NJ HMFA, Supportive Housing Association members, and others, with concrete actions resulting from those collaborations. With CMS approval, NJ is expanding this benchmark to include more entities and individuals who are involved in housing policy and housing creation in New Jersey.

Benchmark #6:

Provision of Informational Materials on Community Based Options

In 2011, a new collaborative partnership was formed between the state's MFP program and the Office of the Ombudsman for the Institutional Elderly ("OOIE"). OOIE is playing a critical role in educating older adults and those with physical disabilities and their families about community living options available to them. Since 2011, OOIE has implemented a comprehensive, multi-layered marketing and outreach plan that features strategies for facility-based marketing and education as well as focused messaging to the larger community with the tag line, "A Nursing Home May Not Be the Only Option". During this time, New Jersey rebranded its MFP Program which is now called "I Choose Home NJ" (ICHNJ).

Since 2011, OOIE Education and Advocacy Coordinators OOIE were responsible for educating residents, family members and facility staff about the range of community choice options available in that catchment area. They distributed MFP marketing materials to residents and family members via personal contact or through family and resident council meetings; followed up with Section Q referrals; made referrals to the Offices of Community Choice Options; informed and educated nursing facility staff and community groups about MFP; visited nursing facilities in their catchment area and during those visits contacted each new admission and made presentations to staff or resident/family members. Given the turnover frequency of Nursing Facility staff, in between the Coordinator visits, the OOIE volunteers ensured that outreach, marketing and educational materials continued to be properly displayed, notified the Coordinator in that catchment area of any change in Social Service staff and alerted the Coordinator to any new resident that may meet the MFP eligibility criteria.

Over the past year, OOIE Education and Advocacy Coordinators have found that NJ nursing homes are now quite saturated with the I Choose Home NJ message. Representatives from the Department of Human Services, managed care organizations, and OOIE are all active in spreading the message in the course of their normal work activities. As such, the vast majority of NJ nursing homes are receptive, educated, and engaged in community transitions.

However, there still exist a smaller percentage of facilities that are less receptive – often those with high staff turnover, unreceptive management/staff, high concentrations of MFP-eligible individuals, lower CMS ratings, etc.

In addition, there are a growing number of individuals who have been found eligible for ICHNJ but who do not have housing. These individuals often lack resources, motivation, and supports to move their transition forward, especially if they face additional barriers such as credit history problems, criminal backgrounds, etc.

With CMS approval, OOIE is revising its nursing facility-related benchmarks to focus on the aforementioned lower-performing/less-receptive facilities and to work more individually with people who, but for housing, would be able to transition to community living.

OOIE Measure 1: MFP Outreach and Advocacy Coordinators will contact every nursing facility in the State at least one time per calendar year, reviewing program requirements with the social worker and inquiring about any potential ICHNJ candidates.

	First 6-month target facility contacts per Coordinator:	Second 6-month target facility contacts per Coordinator:	Full year target facility contacts per Coordinator:
2016	45	45	90
2017	45	45	90
2018	45	45	90

OOIE Measure 2 –MFP Outreach and Advocacy Coordinators will visit 25% of all nursing facilities annually to provide in-services for staff and/or residents and to search for ICHNJ candidates. Staff will select these facilities based on CMS performance criteria (star rating system), institutional knowledge of facility culture (e.g. unresponsiveness, high turnover, high concentration of ICHNJ-eligible individuals), housing search intake data, Section Q compliance, absence of OOIE Volunteer Advocate, and other relevant factors.

	First 6-month target facility visits:	Second 6-month target facility visits:	Full year target facility visits:
2016	45	45	90
2017	45	45	90
2018	45	45	90

OOIE Measure 3 –MFP Outreach and Advocacy Coordinators will conduct targeted resident rights/ICHNJ trainings at resident council meetings. Facilities will be selected according to criteria set forth in Measure 2. These trainings will increase by 10% per year.

	First 6-month resident council meeting target	Second 6-month resident council meeting target	Full year resident council meeting target
2016	15	15	30
2017	17	17	33
2018	18	19	37

OOIE Measure 4 – MFP Outreach and Advocacy coordinators will advocate for individuals who have been found MFP-eligible but who are in need of housing. We will serve as a facilitator and catalysis to advance the resident’s housing search. We will also ensure that the resident’s desire to move out is reflected in the resident’s care plan in the facility (e.g. PT/OT, skills training, etc.) and that the resident’s dignity is maximized until transition is possible.

	First 6-month target of ICH-eligible residents receiving OOIE advocacy while in housing search	Second 6-month target of ICH-eligible residents receiving OOIE advocacy while in housing search	Full year target of residents receiving OOIE advocacy while in housing search
2016	100%	100%	100%
2017	100%	100%	100%
2018	100%	100%	100%

OOIE Measure 5 – MFP Outreach and Advocacy Coordinators will regularly attend community events directed at I Choose Home populations, including but not limited to elder/disability expos and fairs, senior days, faith-based events, etc. MFP presence/attendance at such events will increase by approximately 10% each year (10% more events attended each year).

	First 6-month target	Second 6-month target	Full year target
2014	12	12	24
2015	13	13	26
2016	14	15	29
2017	16	16	32
2018	18	18	36

OOIE Measure 6 – MFP Ombudsman staff will develop more speaking/presentation opportunities at community and professional events, conferences, and institutions of higher learning (including social work, nursing, etc.). The number of speaking engagements should increase by at least 10% per year.

	First 6-month target	Second 6-month target	Full year target
2014	10	10	20
2015	11	11	22
2016	13	13	26
2017	15	15	30
2018	17	17	34

OOIE Measure 7 – The number of consumer contacts made through the I Choose Home hotline phone number, email inquiries, social media and website visits should increase at a rate of at least 15% per year.

	First 6-month target	Second 6-month target	Full year target
2014	1500	1500	3000
2015	1725	1725	3450
2016	1984	1984	3968
2017	2282	2282	4564
2018	2625	2625	5250

ICHNJ Educational Materials

The ICHNJ Program has devoted and will continue to devote administrative funds to develop educational and promotional materials for I Choose Home NJ. These materials educate consumers, their family/support persons, facility staff, and other relevant professionals about the I Choose Home program/process and the availability of home- and community-based service options.

The I Choose Home NJ materials are available in English and other widely spoken languages in NJ, and in various formats. OOIE also worked with web designers to create a website (www.IChooseHome.NJ.gov) which contains all necessary information about the program and serves as a resource to consumers, their families, and professionals to advance the transition goals of the ICHNJ Program.

As of May 2014, available ICHNJ educational/informational materials include:

- Flyer (multiple languages)*
- Fact sheet (multiple languages)*
- Infographic (for consumers)*
- Infographic (for policymakers)*
- Website (www.IChooseHome.NJ.Gov)*
- Videos of successful participants*
(see <http://www.ichoosehome.nj.gov/ooie/ichoose/successstories.shtml>)

*These materials can be viewed/downloaded from the www.IChooseHome.NJ.Gov website, on the “Success Stories” and “Resources” pages.

Benchmark #7:

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

With CMS approval, New Jersey hired an MFP Employment Specialist who assists transitioning individuals interested in entering the workforce upon discharge from an institutional setting. Upon enrollment into the MFP Program, the MFP Project Director will refer each individual between the ages of 18-70 to the Employment Specialist who will then send an Employment Resource Packet to each of those individuals. The MFP Project Director will also refer any other MFP participant interested in employment/volunteerism as noted in their Quality of Life survey to the Employment Specialist for the receipt of the Employment Resource Packet. The Employment Resource Packet contains resource materials for individuals interested in work or volunteering.

The MFP Employment Specialist will pre-screen the individuals to determine their readiness to seek employment. Once an initial pre-screening has been completed, all individuals in categories A and B will receive comprehensive supported employment services before starting work. The Employment Specialist will address the issues of transportation, child care, appropriate wardrobe, accessibility, accommodations and the need for healthcare, medical benefits, and the New Jersey WorkAbility Medicaid Buy-In Program. Individuals falling into category C will receive an initial evaluation and follow up services as needed such as job readiness, interviewing skills and job searching techniques. Individuals falling into category D will not require follow up services after the initial screening. The four readiness categories are defined as follows:

- **Category A:** Employable individuals with the ability and desire to work; have a work history, volunteer experience, college degree and the ability to travel and access public transportation.
- **Category B:** Potentially employable individuals with limited work experience, that have employment potential and may have some or no college or professional training. Individuals working with the Employment Specialist and Peer Mentor to help develop soft skills and are updating or creating a working resume.
- **Category C:** Interested individuals who want to work but may not necessarily have a work history/experience or a way to travel; individuals in need of basic employment supports from the Employment Specialist or Peer Mentor.
- **Category D:** Individuals not interested in employment at this time or due to recent serious illness, physical limitations and those who have no desire to work at all.

NJ's MFP Program has received approval from CMS to use rebalancing dollars for the purpose of providing employment support services in the form of scholarships for online

educational/computer skills enrichment courses for twenty (20) eligible MFP employment referrals (B & C) so that they can become more marketable while seeking employment. Most of these individuals have been out of the employment arena for many years while in long term care facilities or at home and many lack the necessary (often times) basic skill sets to perform in today’s technological work environment. These scholarships will consist of full course tuition and the use of a laptop (on loan) while the class is being completed. Once the course(s) have been completed by an individual, the laptop will be returned to the state per prior written agreement. The courses are specifically designed to address the employability of persons with disabilities and hopefully resolve a glaring issue in obtaining employment for these individuals who are attempting to enter or re-enter the job market.

Three Peer Mentors will be hired from each of the MFP target populations and will serve to provide mentorship to the 40% of interested individuals as they transition and seek employment. They will also serve as a guide as New Jersey moves forward with its “Employment First” effort. The Peer Mentors will provide each interested MFP participant with an informal support mechanism to lessen any anxiety around issues of transition and employment and serve as a facilitator between the participant and the professional staff. Peer Mentors will be individuals who through their own self advocacy, have successfully transitioned from an institution or facility with support or avoided placement in an institution or facility and have become successful in the community and in the workforce.

Goal: All MFP participants that have expressed an interest in working or volunteering in a community setting will be afforded the opportunity to do so through comprehensive supported employment services.

Measure 1: 100% of all MFP participants between the ages of 18-70 and any other MFP participant interested in employment/volunteerism will receive an Employment Resource Packet from the MFP Employment Specialist. The MFP Employment Specialist will pre-screen the individual to determine their readiness to seek employment.				
	First 6-month target	Second 6-month target	Full year target	
2015	100%	100%	100%	
2016	100%	100%	100%	
2017	100%	100%	100%	
2018	100%	100%	100%	

Measure 2: Of those MFP participants deemed ready to seek employment (categories A and B), 100% of these individuals will receive comprehensive supported employment services and assigned a peer mentor.				
	First 6-month target	Second 6-month target	Full year target	
2015	100%	100%	100%	
2016	100%	100%	100%	
2017	100%	100%	100%	
2018	100%	100%	100%	

Measure 3: As a result of comprehensive supported employment services, MFP participants will become employed or obtain a volunteer position.				
	First 6-month target	Second 6-month target	Full year target	
2015	2	2	4	
2016	3	3	6	
2017	4	4	8	
2018	5	5	10	

The Employment Specialist will partner with the OOIE Education and Advocacy Coordinators to provide in-service presentations to nursing facility residents, staff and the community at large about employment resources and work incentives.

The outreach plan is designed to provide a better understanding of the positive benefits of employment so that individuals have the opportunity to be productive, earn a living, and feel a sense of personal fulfillment.

The Employment Specialist will create and provide a one page fact sheet handout as a point of reference promoting the benefits of employment to which individuals and staff can utilize to their advantage when considering work as part of their transition into the community. This extended plan of outreach will provide direct assistance to as many individuals as possible who are or have a desire to seek employment.

Measure 4: In coordination with the OOIE Education and Advocacy Coordinators, the MFP Employment Specialist will provide in-service presentations to nursing facility residents and staff as well as the community at large about the comprehensive supported employment services available through the MFP Program.				
	First 6-month target	Second 6-month target	Full year target	
2015	5	5	10	
2016	5	5	10	
2017	5	5	10	
2018	5	5	10	

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

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

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

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

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

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

The Division of Disability Services (DDS) has been one of the lead agencies, administering New Jersey's Medicaid Infrastructure Grant, and thereby supporting the employment of individuals with disabilities in New Jersey and believing that people with disabilities are an integral part of the labor force and are active and valuable participants in the economic growth and vitality of the state.

The Employment Specialist will provide follow up technical assistance and supports both directly to MFP participants and to community agencies who work with participants who are transitioning to the community or who have successfully transitioned and are now seeking to explore employment as a second phase of their integration. Follow up services by the Employment Specialist will be case specific. Some individuals will take the Employment Packet and "run with it"; others may need more assistance with finding resources and making connections; some may need to be driven and accompanied to their local VR office. The follow up and assistance will be driven by whatever barriers are determined. The level of support will be based upon the individual's own unique needs.

To date, sixty per cent of the employment referrals to the Employment Specialist have said that they really don't want to go back to work. The Employment Specialist and current Peer Mentor are currently working with forty per cent of the employment referrals of which most

are actively seeking employment in their communities and throughout the state by way of job applications and direct interviews. In 2012, 10% of the individuals referred for employment began volunteer and paid working positions and 45% of those referred stated they were not interested in employment. In 2013, 40% of the individuals referred for employment have been actively interviewing and applying for various positions and 30% of those referred stated they were not interested in working at this time.

As of July 1, 2014, the funding that the Division of Developmental Disabilities (DDD) previously provided for sheltered workshops has been transferred to the Division of Vocational Rehabilitation Services (DVRS). Individuals previously receiving that service through DDD now receive it through DVRS. The main function of DVRS is to assist individuals with disabilities in finding competitive employment in the general workforce.

DDD is in the process of transitioning from a contract-based model of provider reimbursement to a Medicaid-based, fee-for-service model. The system-wide shift to Fee for Service (FFS) is expected to take place in July, 2015.

Once the new system is in place, adults seeking Division-funded services, including employment services, must be enrolled in one of two Medicaid waiver programs: the Supports Program or the Community Care Waiver.

Since all individuals with intellectual/developmental disabilities transitioning from an institutional environment to a community setting (present and future) are enrolled in the Community Care Waiver on day one of discharge, these individuals will be able to access Employment Services.

This shift will enable the expansion of employment services to include Supported Employment (individual and group), Career Planning, and Prevocational Training. To access services in the Fee for Service system, including employment services, all participants must maintain Medicaid eligibility.

Implementation Policies and Procedures

New Jersey's request for a new Medicaid section 1115(a) demonstration, entitled "New Jersey Comprehensive Waiver" was approved by the Centers for Medicare & Medicaid Services (CMS) effective from October 1, 2012 through June 30, 2017. Under this demonstration, New Jersey will operate a statewide health reform effort that will expand existing managed care programs to include managed long term services and supports (MLTSS) and expand home and community based services. This demonstration builds upon existing managed acute and primary care programs and established provider networks. The 1115 demonstration also combines, under a single demonstration, authority for several existing 1915(c) Medicaid waivers (Global Options, Traumatic Brain Injury and Community Resources for People with Disabilities) associated with NJ's MFP Program. In addition, it establishes a funding pool to promote health delivery system transformation.

Effective July 1, 2014, NJ will implement MLTSS by allowing the Managed Care Organizations to manage HCBS and behavioral health services for enrollees in all of these programs.

Participant Recruitment and Enrollment

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

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

Older Adults/Physically Disabled

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

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

Impact: If eligible individuals are not referred properly, the enhanced federal match will not be provided under MFP.

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

1. Individuals who are clinically and financially eligible for Medicaid and wishing to return to the community must meet the MFP eligibility criteria which means the individual must:
 - Meet Nursing Facility Level of Care (State maintains responsibility for LOC determination);
 - Reside in a Nursing Facility for a minimum of 90 consecutive days receiving long term care services (Medicare rehab days do not count towards the 90 day stay);
 - Be eligible for Medicaid at least 1 day prior to transitioning out of the Nursing Facility;
 - Transition to a Qualified Residence as defined by CMS;
 - Sign an Informed Consent to participate in the MFP Program;
 - Complete a baseline Quality of Life survey prior to transition;
 - Be enrolled in MLTSS prior to or day one of discharge.

2. Individuals who are not eligible for MFP are those who:
 - Are assessed as appropriate for the Medicaid Hospice benefit;
 - Are chronically mentally ill;
 - Are Medically Needy (Medically Needy Program is a special program that provides limited health coverage to aged, blind or disabled people who do not qualify for regular New Jersey Medicaid because their income or financial resources are too high).

Roles and Responsibility for Effective Referral

1. When the NF Social Worker knows that a NF resident is interested in participating in MFP, s/he contacts the Regional Office of Community Choice Options (OCCO) for MFP screening using the CP-2 as a referral form. The NF Social Worker may also reach out to the Outreach and Advocacy Coordinator from the Ombudsman's Office who has in-serviced that facility. Referrals from the NF for Section Q should also trigger referrals for MFP. The Managed Care Organizations (MCO) will also identify possible MFP participants through their assessments of their members and from referrals sent to them from the Ombudsman's Outreach and Advocacy Coordinator covering that facility.
2. MCO Care Manager identifies an individual in the Nursing Facility who wishes to transition to the community and sends an MFP 77 to the Regional Office for MFP Screening.
3. The MFP Liaison or Community Choice Counselors (CCC) from the Regional Office of Community Choice Options are assigned to nursing homes and will on a periodic basis reassess the elderly and physically disabled on Fee for Service Medicaid. It is the MCO's responsibility to reassess elderly and/or disabled MLTSS individuals on a periodic basis to identify the potential for discharge as well as their acute care population in NFs. Individuals are also referred by themselves, family members, nursing home social workers, and Ombudsman Outreach and Advocacy Coordinators. If someone meets the clinical, financial, and resident time frame criteria for MFP, the program is explained, and wish to participate is confirmed. The MCO Care Manager sets up an Interdisciplinary

Team meeting with the resident, family members, MCO Care Manager, relevant NF staff, NF Social Worker, OCCO/MFP Liaison and a transition plan is developed as per MCO policy and procedure.

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

Ombudsman (OOIE) Role and Responsibility for Effective Referral:

Candidate Referrals to OCCO:

1. When an OOIE Outreach and Advocacy Coordinator identifies a person who appears to meet MFP eligibility, s/he gathers all necessary information from the resident on a referral form. This form includes basic identifying information, clinical diagnoses, Medicaid status, family information, housing needs, length of NF stay, any current state involvement to transition the person, etc. There is a section to include additional information that the Coordinator deems important about the individual's circumstances and wishes. The Coordinator attempts to collect as much information possible so that OCCO can quickly assess for likelihood of MFP eligibility.
2. The Coordinator then faxes the referral form directly to the appropriate OCCO office. At the same time, the Coordinator instructs the facility social worker to submit a Section Q referral for the individual to the local contact agency (Office of Community Choice Options/OCCO in New Jersey) so that the individual's needs are also explored through that track as well.

OOIE's Outreach and Advocacy Coordinators do not only advocate for those who appear MFP eligible. For any resident who desires to transition to the community, NJ's MFP Program will insist that:

1. Section Q of the MDS 3.0 be submitted immediately;
2. Consult with the MFP Housing Coordinator to provide basic housing information to that resident;
3. Provide general advocacy to make sure that facility staff are aware that the resident desires community placement;
4. Follow up with the resident to ensure the resident's wishes have been heard and are being acted upon; especially in facilities where facility staff are not very responsive.

Managed Care Referrals

Many, but not all, of New Jersey's long-term care nursing home residents receiving Medicaid will move into managed care on July 1, 2014. This means that the nursing home population of Medicaid recipients, depending on when they achieved Medicaid eligibility, will be split into two groups – those that are managed by a managed care organization (MCO) and those whose Medicaid services continue to be managed by the State of NJ.

1. For those managed by the State of NJ, the process is described above;
2. For those who come under managed care, Outreach and Advocacy Coordinators will follow the same process, except that referrals for MCO members will be sent directly to the plan's designated MFP Liaison for their transition follow-up. Coordinators will still insist the facility submit Section Q for those MCO-managed individuals as well.

Ombudsman Post-Referral Advocacy and Follow Up

The Director of Outreach and Advocacy receives feedback on all OOIE Coordinator referrals from OCCO and the managed care organizations (MCOs). If OCCO or the MCO declines to pursue transition for a referral and the Coordinator who made the referral disagrees with OCCO/MCO feedback, the Director of Outreach and Advocacy will advocate on behalf of the resident for additional assessment and reconsideration. The Director will sometimes seek more input and information from the Coordinator about s/he perception of the resident and feasibility of transition. Some of these situations involve individuals who appear borderline for meeting level of care, who lack community support, who have mental illness that appeared to the Coordinator to be well managed, etc. In these situations, OOIE Advocacy Coordinators err on the side of inclusion and push for transition where possible.

OOIE staff work with the MFP Statewide Housing Coordinator to seek housing options for residents whose transitions are pending because they have no community housing. As housing opportunities arise in a certain location:

1. The Housing Coordinator sends an email to the Director of Outreach and Advocacy alerting her to available housing;
2. The Director references that information with recent referrals and alerts the Coordinator in that region to provide the information to residents in housing search and his/her social worker or family member helping to advance the housing search and the resident's chances of moving out more quickly.

The Initial MFP-Nursing Facility Transition Screening Process For New to Medicaid or Fee for Service Medicaid Individuals

1. The goal for the MFP Liaison/CCC is to complete the PAS within 14 calendar days of receiving a MFP referral.
2. The CCC will review the individual's NF chart, the current PAS, and visit the resident to:
 - Determine his or her desire to return to the community;
 - Verify that all eligibility criteria for MFP are met; and
 - Establish the extent to which the resident wishes to participate in the Interdisciplinary Team (IDT) meeting.
3. If resident is a candidate for MFP, the CCC will:
 - Discuss the full range of services offered under MFP and determine if the resident wants to re-locate. If the resident is interested in an Adult Family Care (AFC) home, then the resident must be informed that there is a potential cost share responsibility and Room and Board fee;

- Update clinical information in the NJ Choice-HC database;
 - Obtain the resident's signature on the Release of Information form;
 - Counsel on choosing a Medicaid Managed Care Organization (MCO);
 - Initiate the MCO enrollment process;
 - Notify the MCO Contact and inform them of the pending transition;
 - The MCO Care Manager will identify the appropriate IDT participants/agencies including the family, nursing social worker/discharge planner, Centers for Independent Living (CIL if applicable), the OCCO MFP Liaison/ CCC, Occupational or Physical Therapist, AFC provider (if applicable), or the Office of the Public Guardian (if applicable);
 - The MCO Care Manager will contact the IDT participants to coordinate and arrange the meeting date(s), providing at least seven working days' notice of the meeting
4. If the resident does not meet MFP eligibility criteria, the CCC will:
- Counsel the person on other LTC options including State funded programs, Medicare services, Older American Act programs, MLTSS and private pay options.
 - Notify the individual who made the referral that the resident is not eligible for MFP and the reasons for the ineligibility.

The Initial MFP-Nursing Facility Transition Screening Process for Individuals on MLTSS

- 1 The goal for the MCO Care Manager is to identify individuals who wish to transition from the Nursing Facility to the community. The MCO Care Manager will assess the NF resident at least annually for their desire to transition to the community.
- 2 As per the MCO policy of transitions, the MCO assessor will complete the NJ Choice Assessment for NJ NF Level of Care and submit to the appropriate OCCO Regional Office for eligibility determination. If the resident is authorized for NF Level of Care, the MCO assessor will fax the MFP-77 to the OCCO Regional Office for an MFP eligibility screening.
 - The OCCO MFP Liaison will then assess the individual to determine s/he desire to return to the community;
 - Verify that all eligibility criteria for MFP are met; and
 - Establish the extent to which the resident wishes to participate in the Interdisciplinary Team (IDT) meeting;
 - If the individual meets the clinical, financial, and resident time frame criteria for MFP, the program is explained, and wish to participate is confirmed.
- 3 The MCO Care Manager sets up an Interdisciplinary Team meeting with the resident, family members, relevant NF staff, NF Social Worker, MFP Liaison/ CCC and a transition plan is developed as per MCO policy and procedure.

The Interdisciplinary Team (IDT)

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

Potential MFP participants are identified prior to the IDT. The OCCO MFP Liaison/CCC or MCO CM completes an assessment for a resident referred. If the resident seems a likely candidate, MFP will be discussed in depth. If it is the resident's choice to return to the community, an IDT would be scheduled.

Roles & Responsibilities of IDT Members

1. Resident/Designee:

- Directs the IDT process to the extent s/he wishes;
- Defines personal goals and preferences;
- Identifies the potential informal and formal support systems;
- Completes tasks assigned at the IDT meeting;
- Signs the required documents.

2. Medicaid Managed Care Organization Care Manager

- Facilitates the IDT process;
- Identifies Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL) needs to be met in the community;
- Assists in locating and gaining access to needed medical, social, educational and other services identified in the Transition Plan;
- Writes the Transition Plan;
- Estimates the cost of services identified in the Transition Plan;
- Arranges DME if the need is identified post discharge;
- Arranges for Community Transition Services as necessary;
- Locates and arranges the housing/facility;
- Summarizes the results of the IDT meeting with next steps, including additional IDT meetings, and identifies the tentative date for discharge.

3. OCCO MFP Liaison/ CCC

- Serves as the timekeeper for the IDT meeting and ensures that it does not exceed one and a half hours;
- Supports the resident/designee to engage in the IDT process;
- When appropriate, advocates and negotiates on behalf of the resident;
- Serves as a subject matter expert on the transitional process and community resources;
- Assists in the writing of the Transition Plan;
- Assures all MFP paperwork is completed and signed.

4. **Nursing Facility Discharge Planner/Social Worker:**

- Reviews and updates relevant documents in NF Client Record and reconciles information with MCO CM;
- Secures meeting area for the IDT;
- Notifies Social Security of change in address and other participant-related matters;
- Arranges for prescription drugs;
- Arranges for and schedules post discharge Medicare services;
- Working with the care manager, coordinates and links discharge services;
- Arranges for Durable Medical Equipment (DME) if the need is identified prior to discharge

5. **Other Possible Members of the IDT**

- Occupational Therapist;
- Physical Therapist;
- Speech Therapist;
- Representative from Center for Independent Living;
- Social Worker or other representative from the Assisted Living Provider/Adult Family Care Program;
- Representative from the Office of Public Guardian;
- Outreach and Advocacy Coordinator (Ombudsman's Office);
- Housing advocate;
- Friend or other designee.

The IDT Pre-Meeting

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

The IDT Meeting:

1. To qualify as an IDT meeting, the resident/family or responsible party, MFP Liaison/ CCC, nursing facility social worker/discharge planner and MCO care manager must be present.
2. Limited circumstances permit IDT participation by conference call:
 - For current ALP/AFC Medicaid Waiver participants that will be returning to the same facility as a MFP participant, an ALP/AFC designee may participate in the IDT meeting via a conference call.
 - For new MFP participants, who will be entering AFC for the first time, an AFC designee must meet the resident prior to discharge and contact the MFP Liaison/ CCC to confirm the AFC's acceptance of the resident on MFP as of the date of discharge from the nursing facility.
 - If the AFC designee is unable to attend the IDT, the MCO Care Manager will forward a copy of the Transition Plan to the AFC designee which outlines the specific needs of the participant.

3. The IDT reviews:
 - ADLs/IADLs;
 - Cognitive status;
 - Personal goals and preferences;
 - Service needs;
 - Backup plan;
 - Cost effectiveness analysis;
 - Informal support system;
 - Environmental safety, including barriers and needed adaptations;
 - Evaluation of risk factors.
4. The team discusses the options and choices:
 - All MLTSS and state plan services; and
 - Available providers.
5. The participant who selects AFC is counseled about his or her cost share.
6. The IDT develops the Transition Plan and estimates the cost of services and decides on a tentative discharge date.

The Transition Plan

1. The Transition Plan serves as the Plan of Care for discharge planning purposes and is completed by the MCO CM in conjunction with the MFP Liaison/ CCC.
2. The Transition Plan must include the following:
 - Personal goals, cultural preferences, and strengths and weaknesses;
 - Desired outcomes;
 - State Plan and Waiver Services to meet assessed needs;
 - Community Transition Services (one-time purchases, security deposits) that must be arranged prior to discharge,
 - Informal supports;
 - Potential agencies to provide services and supports;
 - Number of hours approved for each service (State Plan and Waiver); frequency, and cost per unit;
 - Estimated budget based upon approved services, rates, and hours within the cost threshold guidelines;
 - Consumer Risk Factors,
 - Identification of environmental barriers in the participant's home that might affect the transition;
 - Back-up plans to address risk factors and member service preference level;
 - Consumer Choices and Responsibilities;
 - Signatures of all IDT members;
 - Individual's signature on Plan of Care.

Services should begin within 24-48 hours of discharge. If the individual agrees to a delay of services and understands the risks of the delay, it must be documented in the Plan of Care.

Individualized Budgets

1. The individualized budget is based upon the level of care needs as determined by OCCO's review of the NJ Choice.
2. The Budget must be within the cost effectiveness guidelines.

Community Transition Services

1. The MCO will pay for the one-time expenses related to relocation such as moving related costs, furniture, household items, other incidentals, and security deposits for apartments/utilities as per their company policy and procedure.

Arranging for Environmental Accessibility Adaptations (EAA) not covered by Medicaid State Plan.

If the IDT identifies environmental barriers in the participant's home such as entryways or bathrooms that are not wheelchair accessible that need to be corrected. The MCO CM will follow their company policy and procedure on arranging for environmental accessibility adaptations.

Forms Associated With IDT Process

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

- 1.Nursing Facility Check-off List (IDT professional members). This form is optional.
- 2.MDS-HC & Interim Plan of Care/Service Authorization - completed by CCC (CM receives a copy if applicable). If the MCO completes the assessment, they will have it but OCCO must authorize it.
- 3.Transition Plan - completed by the CCC & CM (all IDT members receive copies).
- 4.The MCO transition forms.
- 5.Proof of Medicaid Financial Eligibility CP-2 or SINQ for SSI residents (CM receives copy).
- 6.Cost-share introductory letter for AL/AFC, when appropriate (resident/designee receive copy)

Discharge from the Nursing Facility to MFP

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

Roles and Responsibilities for Effective Discharge

- **Nursing Facility Discharge Planner:**
 - Assures that the discharge is planned, coordinated and executed;
 - Assures that tasks assigned to IDT members are completed;

- Notifies the MFP Liaison/Community Choice Counselor (CCC) and the MCO Care Manager (CM) of the participant's actual date of discharge, or if changed, the new date of discharge and the reasons for the delay;
 - Assures that the Transition Plan is modified to incorporate changes since the IDT;
 - Returns any Personal Needs Allowance (PNA) to the participant;
 - Ensures that the Zero PA-3L(PR-1) is completed so that the participant will have his or her last month's income returned as part of the Month-of-Discharge Exemption;
 - Arrange for Medicare services post NF.
- **MFP Liaison/ Community Choice Counselor:**
 - Contacts the MFP participant within 48 hours to verify that services have been delivered, and that he or she is adjusting to the community;
 - Assures all MFP paperwork (MFP 75, baseline survey and signed consent form) is completed, signed and delivered to the MFP Associate Project Director/Designee in a timely manner.
- **OCCO MFP Associate Project Director**
 - Once the MFP Enrollment Packets have been received, reviews the MFP Enrollment Packet for accuracy and completeness and assures the resident has met the MFP eligibility criteria by initialing the MFP 75;
 - Sends/delivers the MFP Enrollment Packets to the MFP Project Director by the 10th of each month (i.e. for residents transitioned in May, the Enrollment Packets should be received by June 10th).
- **MCO Care Manager:**
 - Within 5 days of discharge, makes initial contact with the participant;
 - Within 10 days makes a face to face visit:
 - To affirm that the services and supports identified in the Transition Plan are appropriate;
 - Incorporates Transition Plan and any changes to the Plan of Care;
 - Finalizes the POC and obtains signatures of the participant/designee, CM, and CM's supervisor;

Transition of the Elderly/Physically Disabled from NFs under the MFP will build upon the collaborative practice of having all relevant parties participate in the Interdisciplinary Team meetings necessary to transition an individual to the community. The MCO Care Manager will become the primary Care Manager for the implementation of the Plan of Care for waiver services. Beginning July 1, 2014, all MFP participants receive their Care Management services from the MCO. The MCO Care Manager coordinates services between State Plan and Waiver services. Conflict free care management is employed uniformly to assist residents in gaining access to LTSS regardless of the funding source.

Performance Standards and Outcome Measures

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

- Services and supports identified in Transition Plan are scheduled prior to discharge;
- The MFP Liaison/CCC and MCO CM are notified when the participant is discharged or

- when the discharge is delayed;
- The MFP Liaison/ CCC contacts the MFP participant/designee within 48 hours of discharge;
- The MCO CM is contacted when the MFP Liaison/CCC identifies problems/issues with participant and/or Transition Plan;
- The MCO CM visits the MFP participant/designee and finalizes the Plan of Care within the contracted time frames;
- The MCO CM reports all critical incidents of a participant through the SAMS system;
- The MCO CM or designee reports all required data to the MFP Project Director within the contracted time frames.

Administrative Responsibilities

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

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

IDD Recruitment and Enrollment

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

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

Hunterdon Developmental Center – Hunterdon County
 Green Brook Regional Center – Somerset County
 New Lisbon Developmental Center – Burlington County
 Vineland Developmental Center – Cumberland County
 Woodbine Developmental Center – Cape May County

Process to identify eligible individuals each year.

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

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

Criteria for Community Placement from the Developmental Center

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

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

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

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

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

Additional Criteria for MFP Participants

- The institution the person is coming from must be an ICF/IDD facility.
- The person must live 90 consecutive days or more in a DC.
- Medicaid eligibility must be obtained 1 day before the person moves.
- The individual must move into a qualified residential program
 - Own home or family home.
 - Apartment where the lease is in the person's name and they have control of life domains and who enters and exits the home.
 - Setting with no more than 4 (including the person in MFP) unrelated individuals.

- Person is HCBS Waiver eligible on the day he/she moves.
- Person/Guardian must sign consent agreeing to MFP participation, including follow-up interviews as part of evaluation.

Information Used

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

The assessment provides the Division with:

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

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

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

4. Making it work: Moving to the community and monitoring for success;
 5. Community Providers – in development
- Provider Market Fairs (annually) – Connecting Consumers and Families with Community Providers
 - DDD Today (Email newsletter) – formerly “Olmstead Newsletter” – sample contained in this section

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

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

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

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

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

Training for participants on protection from abuse, neglect, exploitation

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

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

Manager, Transition Case Manager, Social Worker, Support Coordinator, Psychologist or other professionals) in order to report concerns of abuse, neglect, and exploitation.

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

MFP Policy for Reenrollment

In all cases:

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

To re-enroll in MFP

In all cases:

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

Informed Consent

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DIVISION CIRCULAR #7 – GUARDIANSHIP SERVICES

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

EFFECTIVE DATE: March 19, 2001

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

I. TITLE: Guardianship Services

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

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

IV. POLICIES:

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

V. GENERAL STANDARDS:

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

Deborah Trub Wehrlen

Director

SUBCHAPTER 1. GENERAL PROVISIONS

10:45-1.1 Authority

- (a) The Department of Human Services is directed to provide comprehensive services, specifically including guardianship services, to eligible developmentally disabled persons, in order that they may be provided with adequate training, care and protection (see N.J.S.A. 30:4-165.1).
- (b) The Division of Developmental Disabilities is directed to perform such services for adults who are incapacitated, for whom no guardian has been appointed, as would otherwise be rendered by a guardian of the person (see N.J.S.A. 30:4-165.5).
- (c) The Commissioner of the Department of Human Services is mandated to make all reasonable and necessary provisions to insure the health, safety, welfare and earliest appropriate release of persons admitted to residential services for the developmentally disabled (see N.J.S.A. 30:4-25.7).
- (d) The Bureau of Guardianship Services within the Division of Developmental Disabilities has been assigned the responsibility of providing guardianship services by the Division Director. Guardianship services are limited to guardianship of the person only and not property.

10:45-1.2 Definitions

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

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

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

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

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

“Division” means the Division of Developmental Disabilities.

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

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

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

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

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

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

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

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

SUBCHAPTER 2. ELIGIBILITY REQUIREMENTS FOR GUARDIANSHIP SERVICES

10:45-2.1 Eligibility requirements for adults

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

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

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

10:45-2.2 Eligibility requirements for children

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

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

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

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

i. Notice in the primary language of the guardian, if known, by regular mail and follow-up by certified mail, return receipt requested, to the guardian’s last known address, with no response received within 45 days of forwarding the certified letter;

ii. Documented inquiry among any known relatives, friends and current or former employers of the guardian(s); and

iii. Documented inquiries, unless restricted by law, using the guardian’s last known or suspected address, to the local post office, the Division of Motor Vehicles, and any social service and law enforcement agencies known to have had contact with the guardian(s) both in New Jersey and in

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

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

SUBCHAPTER 3. CONTINUATION OF ELIGIBILITY FOR GUARDIANSHIP SERVICES

10:45-3.1 Continuation of eligibility for adults

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

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

10:45-3.2 Continuation of eligibility for children

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

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

SUBCHAPTER 4. ROLE AND RESPONSIBILITIES OF BUREAU OF GUARDIANSHIP SERVICES

10:45-4.1 Distinct role of BGS staff

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

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

10:45-4.2 Functions and duties of BGS staff

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

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

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

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

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

Such consent shall be premised upon:

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

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

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

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

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

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

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

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

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

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

10:45-4.3 Duty to inform

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

SUBCHAPTER 5. LIMITATIONS OF AUTHORITY BUREAU OF GUARDIANSHIP SERVICES

10:45-5.1 Guardianship of person

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

10:45-5.2 Procedures requiring court approval

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

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

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

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

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

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

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

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

APPENDIX

A. Referral Package

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

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

B. BGS offices assigned to receive referrals for guardianship services

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

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

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

C. BGS Staff shall the responsibility and authority to:

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

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

8. Approve, disapprove or restrict visits and vacations;

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

D. Functional Services

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

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

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

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

iii. Missing status or failure to return from vacation;

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

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

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

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

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

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

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

DIVISION CIRCULAR #41 – INFORMED CONSENT

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES**

EFFECTIVE DATE: December 12, 2003

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

I. TITLE: Informed Consent

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

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

IV. POLICIES:

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

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

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

D. Informed consent shall not be coerced.

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

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

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

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

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

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

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

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

V. GENERAL STANDARDS:

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

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

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

VI. PROCEDURES:

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

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

James W. Smith, Jr.
Director



STATE OF NEW JERSEY
 DEPARTMENT OF HUMAN SERVICES
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 Deputy Commissioner

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

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

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

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

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

BENEFITS OF THE MFP DEMONSTRATION

Potential benefits of my participation in the MFP demonstration include:

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

POTENTIAL RISKS

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

- For individuals transitioning out of NJ's developmental centers, the goal of the NJ Division of Developmental Disabilities is to maintain an individual's community placement so that a person can 'age in place' and not have to move if their needs change. To that end, all efforts to maintain a community placement will be made.

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

RESEARCH PARTICIPATION

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

CONFIDENTIALITY

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

VOLUNTARY WITHDRAWAL FROM THE PROJECT

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

COMPLAINTS

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

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

CONSENT

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

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

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

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

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

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

SIGNATURE – Guardian (if applicable)

Date Signed

Address (Street, City, State, Zip Code)

Telephone Number

() -

MFP Transition Coordinator Acknowledgement

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

SIGNATURE – MFP Transition Coordinator

Date Signed

Name of Agency

Telephone Number

() -

Outreach, Marketing and Education

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

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

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

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

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

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

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

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

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

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

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

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

Office of the Ombudsman (OOIE):

The first point of contact for many nursing facility residents, their families, and nursing facility staff are the Ombudsman's Outreach and Advocacy staff NJ's MFP Program entitled, "I Choose Home NJ". The Coordinators visit each NJ nursing facility every year providing training to nursing facility staff as well as information to residents and their families. Coordinators visit approximately 15-20 nursing facilities each week, providing in-services to social workers, speaking with residents suggested by the social worker, and speaking at random to individuals and their family members.

In addition, Coordinators provide information in response to calls and emails from NF residents, family members, and NF staff several times per week. This information is relayed by phone, email, or in person, depending on the request.

Outreach Coordinators also provide targeted education and training outside of nursing homes - at professional conferences, community events, colleges, universities and the like. Coordinators attend 5-10 such events per month, often as speakers.

Finally, the Ombudsman's Office developed a website, www.IChooseHome.NJ.gov, which houses all information about I Choose Home that providers, participants, families, and prospective participants can access at any time.

Division of Aging Services (DoAS):

Seniors and adults with disabilities in need of long-term services and supports have information and easy access to community-based alternatives through an enhanced service delivery system known as the Aging and Disability Resource Connection (ADRC). The ADRC is a state initiative with the 21 Area Agencies on Aging who serve as the county lead agencies with other state and local governmental and nonprofit agencies in the aging and disability services networks. In addition, there is a link to the "I Choose Home NJ" web site on the home page of the Division of Aging Services.

DoAS also has a web page dedicated to Managed Long Term Services and Supports (MLTSS) which includes resources and training materials for individuals and providers such as:

- [MLTSS Consumer Communications](#)
- [MLTSS Frequently Asked Questions \(FAQs\)](#)

- Frequently Asked Questions (FAQs) for Dual Eligible Special Needs Plans (D-SNP) and MLTSS Consumers
- NJ FamilyCare Managed Care Health Plans
- Program of All-inclusive Care for the Elderly (PACE)
- The Comprehensive Medicaid Waiver

Slide Presentations include:

- MLTSS: The Choice is Yours

Resources for Providers include:

- MLTSS Provider Communications
- The Comprehensive Medicaid Waiver

MLTSS Training Materials include:

- MLTSS Training Videos and Presentations

Division of Developmental Disabilities (DDD):

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

Through the Rutgers School of Public Health, the Community Living Education Project (CLEP) is committed to providing education to individuals, families, and staff about the full range of resources that are available in community living for people with developmental disabilities in New Jersey. CLEP is supported by the New Jersey Department of Human Services, Division of Developmental Disabilities (DDD). CLEP serves as the liaison between individuals, families, DDD, developmental center staff and other agencies in the developmental disabilities community.

CLEP is also part of the implementation of the NJ Olmstead Plan under the direction of the New Jersey Department of Human Services, Division of Developmental Disabilities (DDD). CLEP provides information and support about community transition to families of individuals living in any developmental center in NJ in accordance with the Olmstead Plan. CLEP works closely with individuals who reside in developmental centers and their family members informing them on the supports, services, resources and residential options that are available for a life in the community. CLEP team members provide direct support through phone calls, individual visits with families, and accompanying families on visits to community providers to see existing homes.

CLEP Educational Events

- **Staff Pictures of Community Living Events (POCLE):** the purpose is to provide a picture of how people with developmental disabilities are currently being supported in community settings in New Jersey to developmental center staff members. Stories of individuals are used to discuss community housing, medical and behavioral supports, and oversight among other topics. Roles and responsibilities of community provider staff are also presented in this overview. When available, community provider agencies present how their agency support individuals in their care by sharing individual stories of people who have successfully transitioned including their struggles and achievements.
- **Family Pictures of Community Living Events (POCLE):** the purpose is to provide a picture of how people with developmental disabilities are currently being supported in community settings in New Jersey. Stories of individuals are used to discuss community housing, medical and behavioral supports, and oversight among other topics. Roles and responsibilities of community provider staff are also presented in this overview. When available, community provider agencies present how their agency support individuals in their care by sharing individual stories of people who have successfully transitioned including their struggles and achievements. An additional highlight of the Family POCLE is the opportunity to meet and network with other families who are considering living and/or have begun the process. Participation is open to families of any individual living in a developmental center in NJ.

CLEP Publications include:

- ***My Life Now magazine:*** an annual magazine that highlights stories of individuals who have transitioned to the community from a developmental center to show individuals, families, and the public that community living is possible for anyone living with a developmental disability.
- ***New Beginnings in Community Living:*** a bi-annual newsletter which features articles pertaining to community transition, latest news updates, CLEP's calendar of project events, and other resources for families. The purpose of the newsletter is to serve as a community outreach tool, educating and engaging the developmental disabilities community on the possibilities that are available in community living.
- ***Mini Updates e-Newsletter:*** a monthly online newsletter featuring CLEP updates, calendar of events, and highlights from recent learning events. Newsletter can be obtained via email.

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

Types of media to be used.

As of May 2014, available ICHNJ educational/informational materials include:

In Print

- Flyer (multiple languages)*
- Fact sheet (multiple languages)*
- Infographic (for consumers)*
- Infographic (for policymakers)*

Online

- Website (www.IChooseHome.NJ.Gov)*
- Videos of successful participants*
(see <http://www.ichoosehome.nj.gov/ooie/ichoose/successstories.shtml>)

*These materials can be viewed/downloaded from the www.IChooseHome.NJ.Gov website, on the “Success Stories” and “Resources” pages.

Radio, Television, News Publications, and Other Media

In 2013, ICH/MFP developed and began to implement a public education media strategy with the tagline “A Nursing Home May Not Be the Only Option” to generate referrals/inquiries/possible participants to the program. Ombudsman Outreach and Advocacy Coordinators appeared on local radio stations and participated in interviews (Spanish and English) and appeared in regional television spots such as Comcast Newsmakers. A radio ad ran throughout the state and in targeted counties for several weeks in early 2014. The Ombudsman wrote letters to the editor in the Spring of 2014 that appeared in several regional newspapers.

Future media plans include:

- Spanish-language media buy (print and radio)
- Interviews on local talk radio stations
- Advertisement in regional senior publications
- Featuring success stories in prominent newspapers (Star Ledger and Philadelphia Inquirer)

Specific geographical areas to be targeted.

All 21 New Jersey counties.

Locations where such information will be disseminated.

Information will be disseminated at every nursing facility in the state by the four (4) Outreach and Advocacy Coordinators from the Office of the Ombudsman as each Coordinator is expected to visit every nursing home in his/her regionally assigned area at least once per year.

Outreach Coordinators also provide targeted education and training outside of nursing homes at venues such as professional conferences, community events, colleges, universities and the like. Coordinators attend 5-10 such events per month, often as speakers.

Informational materials are available to Developmental Center staff through the MFP Project Director and will be available through CLEP in Fall 2014.

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

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

The I Choose Home NJ materials (developed by OOIE) are available in English and other widely spoken languages in NJ, and in various formats. OOIE also worked with web designers to create a website (www.IChooseHome.NJ.gov) which contains all necessary information about the program and serves as a resource to consumers, their families, and professionals to advance our transition goals. Those viewing this web site can click on a tab entitled “Translate this Page”.

The I Choose Home NJ Outreach and Advocacy director is bilingual (English/Spanish) and at least one of the Outreach Coordinators are bilingual as well.

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

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

Institutional Providers

In 2012 and 2013, OOIE hired one (1) full-time Director of Outreach and Advocacy, four (4) Outreach and Advocacy Coordinators, one (1) part-time Communications Specialist, and one (1) Administrative Support Specialist.

This ICHNJ staff within OOIE is responsible for:

- Targeted outreach to and recruitment of ICHNJ candidates within facilities; and
- General community education outside of facilities.

Each of the four (4) Outreach and Advocacy Coordinators is responsible for a regional area containing approximately 80-100 nursing facilities. Each Coordinator is expected to visit every nursing home in his/her area at least once per year.

At each facility visit, the Coordinator meets with the social worker, administrator, Director of Nursing, and other appropriate individuals to educate/re-educate them about ICHNJ (its purpose, eligibility requirements, HCBS options, Section Q compliance, etc.) and to ask them to identify potential candidates within their facility who wish to transition to community living. The Coordinator provides them with a folder of ICHNJ materials, including ICHNJ PowerPoint, Fact Sheets, Flyers, information about MLTSS and ADRC information and contacts.

The Coordinator visits one-on-one with any resident who was identified by NF staff as having the desire to move to the community and who generally meets the program requirements. Coordinators do not rely solely on interactions/recommendations of staff, but also spend time walking around the NF, speaking with residents directly about the program and distributing materials throughout the facility.

If a facility is not receptive, unwilling to advance the de-institutionalization message or are unwilling to suggest potential candidates, the Coordinator, using OOIE authority, may convene a Residents' Rights BINGO game shortly after the visit to educate all facility residents about their rights, including their right to live where they choose. This is usually very effective in getting the attention and buy-in of management in problem facilities.

In all facilities, Outreach and Advocacy Coordinators insist that facility staff post ICHNJ flyers and fact sheets adjacent to OOIE posters, which facilities are required to post under federal and state law, and will often walk around with staff to ensure this is done during their visit.

Facilities are strategically targeted based on the larger Ombudsman's Office institutional knowledge about quality and responsiveness of care, staffing levels, past interactions, and Section Q compliance. Advocacy Coordinators, by virtue of the fact that they are housed in OOIE, receive "inside" information about facilities from the Director of Advocacy and Outreach, Ombudsman Investigators, and the Ombudsman himself that helps in prioritizing certain facilities and flag the need for stronger/more adversarial advocacy.

If a Coordinator receives any complaints other than those related to deinstitutionalization during their visit, the information is sent to the Ombudsman's Office (OOIE) so that an investigator or OOIE volunteer may be assigned accordingly.

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

Examples of NJ's I Choose Home marketing and informational materials can be viewed on the following pages:

- Page 72: Flyer
- Page 73: Fact Sheet
- Page 74: Web Site Screen Shot
- Page 75: Infographic (Nursing Facility Transition)
- Page 76: Infographic (Developmental Center Transition)

A Nursing Home May Not Be the Only Option.





We can help you move back into the community with free or low-cost services in your home.



If you or someone you know is living in a nursing home, and is interested in moving back into the community, please contact us:

1-855- HOME-005
(4 6 6 3)

I  Choose Home

Funded by a grant from the Centers for Medicare and Medicaid 

Department of Human Services NJ
Jennifer Velez, Commissioner

State of New Jersey
Chris Christie, Governor
Kim Guadagno, Lt. Governor
www.IChooseHome.nj.gov

Office of the Ombudsman
for the Institutionalized Elderly
James W. McCracken, Ombudsman



FACT SHEET



Information about I Choose Home - NJ (ICH-NJ)

What Is I Choose Home – NJ (ICH-NJ)?

I Choose Home – NJ (also known as Money Follows the Person) is a Federal program with two main goals:

- move people out of nursing homes and developmental centers back into the community with proper supports and services; and
- re-invest Medicaid dollars saved back into home and community-based services

Who Is Eligible?

NJ residents may be eligible if they:

- Have lived 90+ days in a nursing home or developmental center;
- Are interested in moving back to the community; and
- Are eligible for Medicaid (clinical and financial) at least one (1) day prior to leaving the facility.

What kinds of services are available through ICH-NJ?

Services are specific to the Medicaid program in which the person is enrolled. Examples of possible services include adult day care, home health aides, transportation, and meal delivery. An interdisciplinary team, including the individual, family members, social workers, discharge planners and others, meets to decide what services are necessary. The team develops an individualized plan of care, including important case and care management services.

How does ICH-NJ benefit New Jersey?

New Jersey receives an enhanced federal Medicaid match for the first year that each transitioned individual resides in the community. Those extra funds are then reinvested to create more possibilities for others to remain in their homes with the services they need.

How do I apply for ICH-NJ or get more information?

Call **1-855-HOME-005** and we will refer you to an I Choose Home – NJ outreach specialist.
(4663)

A NURSING HOME MAY NOT BE THE ONLY OPTION

1-855 HOME-005
1-855 466-3005



If you or someone you know:

- Is living in a nursing home or developmental center
- Has or will be there for 90 days or more
- Is eligible for Medicaid
- Wants to move back into the community

The **I Choose Home NJ** Program may be able to help you move back into the community with low- or no-cost in-home services.

Upcoming Events

Oct. 19 (table)
South Brunswick Senior Expo @ South Brunswick Senior Center – 9am to 2:30pm

Oct. 19
Warren County Senior Expo (Washington, NJ)

Oct. 24
Bridgewater Fall Senior Health Fair @

Follow/Connect:   

900+ Transitions Since 2007

\$5 Million Saved



State of New Jersey
Department of Human Services
Jennifer Velez, Commissioner

State of New Jersey
Chris Christie, Governor
Kim Guadagno, Lt. Governor

Office of the Ombudsman
for the Institutionalized Elderly
James W. McCracken, Ombudsman



New Jersey's Money Follows the Person Program is

I Choose Home NJ



A Nursing Home May Not Be The Only Option

"I was so glad to get home. You're around all the things you love. Your kids can run in and out to come see you. I don't ever want to go to a nursing home. As long as I can, I will be here."

- Mary, Ocean County, moved home October 2011



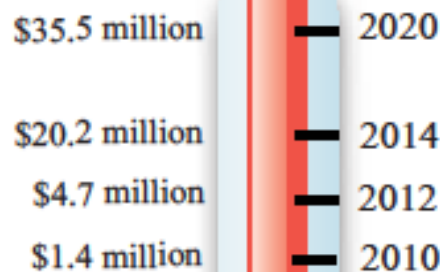
I Choose Home – NJ (ICH-NJ) also known as Money Follows the Person (MFP), is a Federal program with two main goals:

- to move people out of **HIGH-COST** nursing homes and developmental centers;
- to invest Medicaid dollars saved back into **LOWER COST, HIGH QUALITY** home- and community-based services (HCBS).

Residents who are eligible for Medicaid and have been living in a nursing home or developmental center for 90 days or more may be able to participate in I Choose Home.

New Jersey receives an extra 25% Medicaid reimbursement for the first year an individual successfully transitions home under this program. These savings are then reinvested in home- and community-based services, so that more people can remain at home with the assistance they need.

Total Savings to NJ Taxpayers



\$35.5 million

Contact Us:

1-855- HOME-005
(4663)



More than 950 individuals have successfully transitioned back into the community since 2008. That number is expected to exceed 2,200 by 2016.





New Jersey's Money Follows the Person Program is

I Choose Home NJ



A Developmental Center May Not Be The Only Option

"I lived in a developmental center for a long time until I moved into my own home. I have my own key to my house and my own bedroom. My staff understand me."

- Sharon, Camden County, moved home October 2010



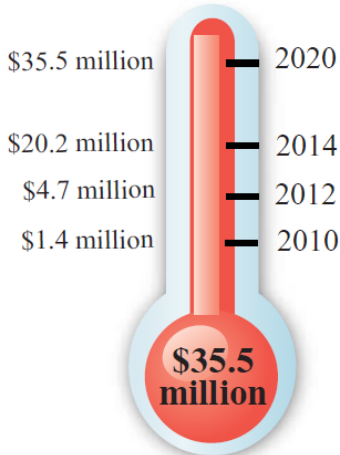
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Stakeholder Involvement

Consumer Dialogue

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

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

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

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

Consumers/Providers/Stakeholders:

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

Consumer Involvement

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

Ongoing consumer involvement in the implementation of MFP will be achieved through the use of consumers to provide the service of Peer and Family Mentor, becoming a part of the “MFP Road Show” as the MFP Project Director travels NJ delivering training and information on MFP.

Currently NJ has an active stakeholder group whose Mission Statement is as follows:

Advise policy makers on how to develop a system of community-based care and supports that is consumer-focused and promotes self-direction and choice for people who have been or are currently living in facilities (nursing homes/developmental centers) and are transitioning to living in a community based environment.

The group is comprised of consumers, families, Social Service organizations, Provider agencies, housing developers and a Managed Care Organization. The Stakeholder Group is always seeking to add current and former MFP participants to the group. An application to join the group can be obtained by contacting the MFP Project Director.

The role of the group is to evaluate existing services, identify unmet needs, recommend systemic improvements and continually monitor service delivery.

The Stakeholder Group will solicit feedback and suggestions from consumers, providers, family members and other key stakeholders about the effectiveness of both NJ’s MFP Program and the state’s overall effort to move from an institutional to a more community-based system of care and support.

This group of individuals has a vested interest in system transformation. They are uniquely qualified to help policy makers understand the importance of making services available in the least restrictive environment possible for people living in institutional settings; whether a nursing home or a developmental center. The Stakeholder Group has an open application

process. Anyone can join at any time. The Stakeholder Group consistently seeks additional consumers to join the group.

Since MFP in NJ does not operate outside of the two main transition initiatives within the state, the following advisory groups associated with these initiatives impact and support NJ's MFP participants:

Olmstead Advisory Council: DDD employs a full-time Olmstead project manager. This administrative capacity together with the Olmstead Advisory Council (which includes individuals with intellectual and developmental disabilities and their families who are or have made the transition from DCs) ensures the state continues to make progress toward the "Path to Progress" Plan goals. The Path to Progress outlines the process of transitioning individuals with intellectual and developmental disabilities from developmental centers (DCs) to the community.

Managed Long Term Services and Supports Steering Committee: Beginning July 1, 2014, NJ will be implementing Managed Long Term Care Services and Supports. A steering committee was established to provide stakeholder input and advice regarding the implementation of the New Jersey Medicaid Managed Long Term Services and Supports (MLTSS) Program. The Steering Committee was comprised of members of the Medicaid Long Term Care Funding Advisory Council, consumers, providers, and representatives of the New Jersey Medicaid managed care organizations and the Program of All-Inclusive Care for the Elderly (PACE). The Steering Committee established workgroups that met at least twice a month from mid-March through June 2012 to develop recommendations for the consideration of leadership of the Department of Human Services before implementation of the MLTSS portion of the Comprehensive Medicaid Waiver.

Following the transition to MLTSS on July 1, 2014, the state has maintained its efforts to ensure that consumers, stakeholders, MCO's, providers and other community-based organizations have learned and are knowledgeable about the move to managed care. The State has depended on its relationships with stakeholder groups to inform consumers about the implementation of MLTSS. In turn, stakeholders have relayed accurate information to consumers. This strategy has continued in the post-implementation phase after July 1st.

The MLTSS Steering Committee met will continue to meet at least quarterly through June 2017, with representation from stakeholders, consumers, providers, MCO's and state staff members. While each meeting typically provides an update on MLTSS and covers operational items, there is also time on the agenda to secure feedback on trends and issues from the Committee members and hear directly from the MCOs.

Medicaid Long Term Care Funding Advisory Council: began meeting in November 2006 to provide input on the process to reallocate Medicaid long-term care expenditures and develop a more appropriate funding balance between nursing home care and home and community based services. DHS Commissioner in consultation with the Council presents an annual report that covers progress made in rebalancing New Jersey's long-term care system. Councils members include individuals from AARP; the New Jersey Association of Area Agencies on Aging, the New Jersey Association of County Offices for the Disabled; the Health Care Association of New

Jersey; the New Jersey Association of Non-Profit Homes for the Aging; the New Jersey Hospital Association; the Rutgers Center for State Health Policy; the New Jersey Elder Rights Coalition; the County Welfare Directors Association of New Jersey; the New Jersey Adult Day Services Association; a labor union that represents home and community-based health care workers; and a representative of the home care industry.

Benefits and Services

Service Delivery System

The MFP program will be operated through the coordinated efforts of the NJ Department of Human Services (DHS): Divisions of Developmental Disabilities (DDD), Disability Services (DDS), Medical Assistance and Health Services (DMAHS) and Aging Services (DoAS). Also partnering with these divisions in operating the MFP Program is the Office of the Ombudsman for the Institutionalized Elderly.

NJ DHS is the single State Medicaid Agency. DMAHS is the designated entity within DHS responsible for oversight of the Medicaid program. DMAHS, DoAS and DDS are responsible for the day to day operation and implementation of the 1115 Comprehensive Medicaid Waiver and DDD is responsible for the day to day operation and implementation of the 1915(c) Community Care Waiver program.

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

Target Populations

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

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

IDD participants will access services through the Community Care Waiver (CCW) through DDD. These participants will be recruited from the six state run developmental centers throughout the state.

Older adults and physically disabled participants will be recruited from nursing facilities throughout the state. Older adults and physically disabled participants will access services through Managed Long Term Services and Supports (MLTSS) under the 1115 Comprehensive Medicaid Waiver authority. MLTSS refers to the delivery of long-term services and supports through New Jersey Medicaid's NJ FamilyCare managed care program. MLTSS is designed to expand home and community-based services, promote community inclusion and ensure quality and efficiency.

Beginning July 1, 2014, participants in the MFP Medicaid waiver programs listed below will be automatically enrolled in the Managed Long Term Services and Supports (MLTSS) program through their current Medicaid managed care organization (MCO), also known as a health plan:

Global Options for Long-Term Care (GO);
Community Resources for People with Disabilities (CRPD); or,
Traumatic Brain Injury (TBI) Waiver.

MFP Service Package

The MFP services will vary based on the individual needs for services identified through the transition planning process. All MFP participants will be eligible for services contained within the MFP services package. Medicaid State Plan services will be available to MFP participants, per the limitations, authorized by CMS, of the waiver program providing services. Medicaid state plan services are not being claimed for enhanced match under MFP. Transition Case Managers, Support Coordinators, MFP Nurse Liaisons and MCO Care Managers will work with participants, support networks and service providers to develop transition plans that meet the needs of the participant.

DDD has received approval to provide specialized habilitation services for individuals being placed from institutional settings into community residences who meet the MFP eligibility criteria. These services include clinical assessment, development of treatment plans, training and monitoring for individuals experiencing significant problems in the areas of physical and/or nutritional management. Utilizing 100% administrative match funding and as part of a Physical/Nutritional Resource Team, a Speech and Language Pathologist as well as an Occupational or Physical therapist were hired to render these services.

DDD has received approval to utilize 100% administrative funding to add a Behavioral Support Services Team to provide consultative support to behavioral staff/consultant(s) at provider agencies receiving individuals from institutional settings who have a documented history of behavioral involvement and said involvement has the potential to threaten the success of their community placement. Behavioral supports provided shall focus primarily on relaying proactive and/or preventive strategies to relevant agency staff. Services may include Critical Incident Response. Individuals receiving services from this resource must meet the MFP eligibility criteria.

The intention is to utilize both the Physical/Nutritional Management Team as well as the Behavioral Supports Services Team after the termination of MFP. The challenge will be to see how the service could be funded while the individual is still residing in the Developmental Center while the funding of the service post discharge could be funded through DDD's 1915(c) Community Care Waiver (CCW). However, by the time MFP ends, it would be the expectation that these teams would move into more of a maintenance role, only training new providers.

DDD's 1915(c) Community Care Waiver (CCW) expired on 9/30/2013. The waiver renewal was submitted to CMS in July 2013. CMS has received the state's CCW Renewal application and has asked for additional information. DDD has been given a 90 day extension of the current CCW. New added services will include: behavioral supports, habilitative physical therapy, occupational therapy and speech therapies, prevocational training and career planning.

DDS has received approval to add Assistive Technology Assessments as a Demonstration Service in order to determine the need for environmental modifications and other technology advancements to enable greater independence and accessibility in a community setting for those individuals that meet the MFP eligibility criteria.

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

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

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

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

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

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

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

Demonstration (DDS)	Units	Cost
Assistive Technology (AT) assessments not covered under MLTSS	27	\$21,600

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

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

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

Services

Money Follows the Person

Department / Division	Human Services (DoAS and DDS)	Human Services (DDD)
POPULATION	Elderly/Physically Disabled	ID/DD
Waiver	-Comprehensive Medicaid Waiver: MLTSS	- Community Care Waiver (CCW) Control #NJ.0031.R01.00
Qualified HCB Services Existing WAIVER Services	<ul style="list-style-type: none"> • Care Management • Respite • Residential Modifications • Special medical equip. and supplies • Chore services • PERS • Home delivered meals • Caregiver/recipient training • Social Adult Day Care • Home Based Supportive Care • Non-medical Transportation • Community Transition Services • Assisted Living Program • Adult Family Care • TBI Behavioral Management (Group and Individual) • Cognitive Therapy (Individual and Group) • Community Residential Services • Habilitative physical therapy • Habilitative occupational therapy • Habilitative speech therapy • Private Duty Nursing (Adult) • Structured Day Program (TBI) • Supported Day Services (TBI) • Vehicle Modifications 	<ul style="list-style-type: none"> • Case Management • Support Coordination (Self-Directed Services) • Day Habilitation services • Supported Employment • Individual supports (PCA) • Environmental./Vehicle accessibility adaptation • Assistive Technology Services • PERS • Respite care • Transportation (non-medical) • Behavioral Supports • Habilitative physical therapy • Habilitative occupational therapy • Habilitative speech therapy • Prevocational training • Career planning • Community Transition Services <ul style="list-style-type: none"> ○ Security deposits ○ Utility set-up/installation ○ Furnishings ○ Moving expenses ○ 1x food ○ 1x clothing

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Department/ Division	Human Services (DoAS)	Human Services (DDD)	Human Services (DDS)
POPULATION	Elderly/Physically Disabled	MR/DD	Elderly/Physically Disabled
HCBS Demonstration Services		<ul style="list-style-type: none"> • Individual Goods and Services 	Assistive Technology (AT) assessments not covered under MLTSS
Supplemental Demonstration Services		<ul style="list-style-type: none"> • 1x Groceries • 1x Clothing 	

Consumer Supports

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

Complaint Resolution

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

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

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

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

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

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

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

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

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

<http://www.state.nj.us/ooie/>

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

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

24-Hour Back Up System

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

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

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

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

For Older Adults and Physically Disabled Populations

No one is discharged from a Nursing Facility via Money Follows the Person into the MLTSS Comprehensive Medicaid Waiver without an Interdisciplinary Team/Round Table Meeting. The applicant/NF resident conducts the meeting as much as he or she is capable of doing or wishes to do. All relevant parties including the MFP Liaison/ Community Choice Counselor from the Regional OCCO, NF Social Worker, Applicant's representative, MCO Care Manager, therapy staff, doctors, and nurses as necessary participate. Risk Factors, those that pertain to Health and Welfare, should a service not be delivered as planned, are identified and Back-up Plans are created. Each IDT participant understands the responsibilities and signs off on the Transition Plan, Backup plan, and Risk Agreement (as applicable) as confirmation that s/he has participated in the Transition Plan and agree with its contents.

With the implementation of MLTSS on July 1, 2014, the Managed Care Organization (MCO) Care Managers will be responsible for completing Back-up Plans for those MFP participants who will receive any of the following essential HCBS services that allow the individual remain in their home:

- Personal Home Based Supportive Care, including participant directed services;
- Attendant Care Services, including participant directed services;
- In-home Respite;
- Skilled Nursing; and/or
- Private Duty Nursing

The implementation of the Back-up Plan is triggered when the individual, caregiver, provider or the Care Manager becomes aware of a gap in care or when a caregiver identifies an unsafe or threatening environment at the individual's residence. The Care Manager must assist the individual in engaging the Back-up Plan. An individual's informal support system will not be considered the primary source of assistance in the event of a gap, unless this is the individual's/family's choice.

The Back-up Plan must include:

- Information about actions that the individual should take to report any gaps in care to the MCO Care Manager;
- The telephone numbers for the provider and/or the MCO contact person who will respond to the individual promptly; twenty-four (24) hours per day, seven (7) days per week, and will allow for referrals and services to be authorized as necessary;

- Individual's service preference levels which are based on the most essential in-home service that is authorized for the individual. The individual's service preference level indicates how quickly the individual chooses to have a service gap filled if the scheduled caregiver of that essential service is not available.

The MCO Care Manager will assist the individual in determining the individual's service preference level by discussing the individual's care giving needs associated with his/her Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), abilities and cognitive, behavioral and medical status.

The MCO Care Manager must ensure the individual has considered all factors in deciding the service preference level. The individual is not required to take into account the presence of an informal support system when determining the service preference level. An individual can change the service preference level from a previously determined service preference level at the time of the service gap, depending on the circumstances at the time. The provider agency or MCO must discuss the current circumstances with the individual or representative at the time the gap is reported to determine if there is a change in the service preference level. The plan to resolve the service gap will address the individual's choice at the time the gap is reported.

The MCO Care Manager is responsible for reviewing the Back-up Plan with the individual at least quarterly. A copy of the Back-up Plan will be given to the individual when developed and if changes occur.

Self-Direction

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

*Demonstration and Supplemental Demonstration Categories of service are outside of self-direction. MFP participants will not self-direct these services. They will self-direct only those services available through DDS upon discharge from the Nursing Facility.

Participant Direction, also known as consumer direction or self-direction is a service delivery mechanism model that emphasizes autonomy and empowerment by expanding the participant's degree of choice and control over their long-term services and supports. It allows participants and their designated family Members (Representative) to serve as the common law employer, responsible for directly hiring, training, supervising, and firing their paid care givers. Participants/Representatives are given the proper training and guidance to make informed decisions about their own care. Participants/Representatives become the experts on their own care and direct the approved services and supports that best meet their personal care needs. This model offers participants greater control, flexibility and freedom over their care. Participants can choose who provides their care, what type of care they want and need, when they want care to be provided and where the care will be provided. Care givers or service providers become accountable to the participant/representative.

Individuals participating in MFP who wish to self-direct their services will have the option of participating in the Personal Preference Program (PPP). The Personal Preference Program (PPP) began as New Jersey's Cash & Counseling Program in 1999, as part of a national research and demonstration project. The project goal was to find new and different ways for individuals to receive their Medicaid Personal Care Assistance (PCA) services, giving them more choice.

Personal Care Assistant (PCA) services are non-emergency, health related tasks. Tasks include help with activities of daily living (ADLs) and with household duties essential to the patient's health and comfort, such as bathing, dressing, meal preparation, and light housekeeping.

Using a "Cash & Counseling" approach, along with the idea of "consumer direction," PPP allows elderly and disabled adult Medicaid recipients to direct and manage their own Medicaid PCA services.

With a monthly cash allowance, participants work with a consultant to develop a Cash Management Plan (CMP). This plan helps them decide the services they need and the individuals and/or agencies they can hire to provide those services. Individuals who are cognitively impaired or unable to make their own decisions can choose a representative to make decisions on their behalf.

PPP also includes Fiscal Management (FM) services to help participants with the financial aspects of the program. The FM handles all payroll responsibilities for participants and acts as a bookkeeping service.

The Personal Preference Program requires greater individual responsibility. But in return, it offers individuals more control, flexibility and choice over the services they receive.

Personal Preference lets individuals:

- Choose the services they need and want
- Hire anyone they want: relatives, friends, neighbors
- Design a service plan to meet their schedule
- Buy equipment, devices, make home modifications
- Exercise greater control, flexibility and choice over their personal care

As a Personal Preference participant, an individual can use their cash allowance to:

- Purchase services from an agency
- Pay a friend or relative to help them
- Make modifications to your home, such as a ramp or chair lift, that help you live more independently
- Buy equipment, appliances, technology or other items that increase your independence, such as a microwave oven, or front loading washing machine that you can reach from your wheelchair

*Note: PPP is a State Plan service and therefore not eligible for the enhanced FMAP through MFP. An individual participating in MFP can receive State Plan services in addition to MLTSS.

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

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

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

All individuals residing in DDD's Developmental Centers have an assessment completed when the individual, guardian/family and their Inter-Disciplinary Team (IDT) choose community living. Once the CCW Waiver receives final approval by CMS, the New Jersey Comprehensive Assessment Tool or NJCAT, (formerly the Developmental Disabilities Resource Tool) will be utilized to collect information regarding the individual's support needs. Currently the Developmental Disabilities Resource Tool is still being utilized.

Individuals are assessed in seven key areas namely, Disability, Sensory/Motor, Cognitive Abilities, Communication, Self-Care, Behavior, Health/Medical. The data collected from each survey is then tabulated to provide three distinct scores in the areas of Self Care, Behavior and Medical.

Description of Scores:

Self-Care

Self-Care is scored as I, II, III or IV.

Level I - Lowest Support Time Needed.

Description: A majority of people can do all activities of daily living, but may need help with public transportation.

Level II - Low Support Time Needed.

Description: A majority of people can eat, drink, toilet, care for clothing, make bed, clean room, use microwave, prepare foods, and wash dishes. Not able to shop, count change, or do laundry.

Level III - Medium Support Time Needed.

Description: A majority of people can eat, drink, toilet, and dress. Not able to care for own clothing, use money, or count change. Caregivers spend a lot of time supporting individuals.

Level IV - High Support Time Needed.

Description: Many people may not be able to do anything for themselves, but a majority can eat and drink. Unable to toilet or dress themselves. Caregivers spend most time providing support.

Behavior

Behavior is scored as I, II, III or IV.

Level I - No On-Site Specialized Behavioral Supports Required.

Description: Persons do not currently exhibit any inappropriate/rule violating, property destruction, self-injurious, or aggressive behaviors.

Level II - Minimal Behavioral Supports Required.

Description: Persons may exhibit some inappropriate/rule violating behaviors, including, but not limited to self-stimulation (body rocking/hand flashing), noises or other inappropriate vocalizations, non-compliance, and/or being disruptive, but no special behavioral support or environmental modifications are required by day and residential support staff.

Level III - Formal Behavioral Supports Required.

Description: Persons have one or more inappropriate/rule violating, self-injurious, or aggressive behaviors and these conditions require special behavioral support and/or environmental modifications by on-site day and residential staff who have received appropriate training. Support may include redirection, providing additional supervision, personal controls, and implementation of a formal behavioral plan. Behaviors may include, but are not limited to, having tantrums/outbursts, smearing feces, hitting own body/face/head, hitting others, property destruction, and/or kicking others. Agency is responsible for determining type and intensity of behavioral supports needed according to regulations developed by DDD. Agency is also responsible for preparing formal behavioral plans and providing staff training as needed.

Level IV - Intensive Behavioral Supports Required.

Description: Persons have one or more inappropriate/rule violating, self-injurious, or aggressive behaviors and these conditions require a very high level of behavioral support and environmental modifications by on-site day and residential staff who have received appropriate training. Support may include providing one-on-one supervision, personal controls, and implementation of a formal behavioral plan. Behaviors may include, but are not limited to, sexual predatory behaviors, running away, eating or mouthing inedible objects, scratching self/others, hitting self/others, biting self/others, head-butting others, choking others, and/or kicking others. Agency is responsible for determining type and intensity of behavioral supports needed according to regulations developed by DDD. Agency is also responsible for preparing formal behavioral plans and providing staff training as needed.

Medical

Medical is scored as I, II, III, IV, V or VI.

Level I - No On-Site Specialized Medical and No Ambulation Support Required.

Description: Persons may have one or more medical conditions (i.e., high blood pressure, asthma, ulcers, etc.), but no special medical attention is needed on-site besides that normally provided by day and residential support staff such as, but not limited to, medication administration, scheduling of medical appointments, transportation to doctor's appointments, etc. Persons are able to walk independently with or without corrective devices and/or independently use wheelchairs – needing no assistance transferring or moving from place to place.

Level II - No On-Site Specialized Medical, but Ambulation Support Required.

Description: Persons may have one or more medical conditions (i.e., high blood pressure, asthma, ulcers, etc.), but no special medical attention is needed on-site besides that normally provided by day and residential support staff such as, but not limited to, medication administration, scheduling of medical appointments, transportation to doctor's appointments, etc. However, persons can walk only with assistance from another person and/or use wheelchairs and need assistance from staff when transferring and/or moving from place to place.

Level III - Specialized Medical Supports Required, but No Ambulation Support Required.

Description: Persons have one or more medical conditions (i.e., respiratory, digestive, cardiovascular, etc.) and these conditions require special medical attention by on-site day and residential staff (non-nursing) who have received appropriate training. Treatments may include, but are not limited to, dressing or wound care; catheter or colostomy emptying and maintenance; monitoring of oxygen use; insulin administration; turning and positioning; use of Epi Pen for allergic reactions; and administration of enemas. Agency is responsible for providing and maintaining the appropriate medical training for staff. Training may be accessed through and/or provided by local Visiting Nurses' Associations (VNAs), agency nurses, hospitals, Persons' physicians, etc. Persons are able to walk independently with or without corrective devices and/or independently use wheelchairs – needing no assistance transferring or moving from place to place

Level IV - Specialized Medical and Ambulation Support Required.

Description: Persons have one or more medical conditions (i.e., respiratory, digestive, cardiovascular, etc.) and these conditions require special medical attention by on-site day and residential staff (non-nursing) who have received appropriate training. Treatments may include, but are not limited to, dressing or wound care; catheter or colostomy emptying and maintenance; monitoring of oxygen use; insulin administration; turning and positioning; use of Epi Pen for allergic reactions; and administration of enemas. Agency is responsible for providing and maintaining the appropriate medical training for staff. Training may be accessed through and/or provided by local Visiting Nurses' Associations (VNAs), agency nurses, hospitals, Persons' physicians, etc. Persons can walk only with assistance from another person and/or use wheelchairs and need assistance from staff when transferring and/or moving from place to place.

Level V - Specialized On-Site Nursing, but No Ambulation Support Required

Description: Persons have one or more medical conditions (i.e., respiratory, digestive, cardiovascular, etc.) and these conditions require on-site nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Treatments may include, but are not limited to: oral and/or nasal suctioning; Intravenous medications; tube feeding; and catheterization. Nurses may also be responsible for overseeing medication administration, and medical management of Person care with off-site medical providers. Agency is responsible for providing and maintaining the appropriate medical training for staff. Training may be accessed through and/or provided by local Visiting Nurses' Associations (VNAs), agency nurses, hospitals, Persons' physicians, etc. Persons are able to walk independently with or without corrective devices and/or independently use wheelchairs – needing no assistance transferring or moving from place to place.

Level VI - Specialized On-Site Nursing and Ambulation Support Required.

Description: Persons have one or more medical conditions (i.e., respiratory, digestive, cardiovascular, etc.) and these conditions require on-site nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Treatments may include, but are not limited to: oral and/or nasal suctioning; Intravenous medications; tube feeding; and catheterization. Nurses may also be responsible for overseeing medication administration, and medical management of Person care with off-site medical providers. Agency is responsible for providing and maintaining the appropriate medical training for staff. Training may be accessed through and/or provided by local Visiting Nurses' Associations (VNAs), agency nurses, hospitals, Persons' physicians, etc. Persons can walk only with assistance from another person and/or use wheelchairs and need assistance from staff when transferring and/or moving from place to place.

The combination of these scores equate to an 'up to' budget that is used by the individual and their guardian/family to purchase services and supports as outlined in their service plan (currently the Individual Habilitation Plan/IHP and Essential Lifestyle Plan (ELP).

When an individual is seeking placement from a DC to the community, they can select from two options in terms of the level of oversight they or their guardian/family desire. These options are Self-Direction and Provider Managed:

Self-Direction

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

Provider Managed

Individuals who participate in the Provider Managed option generally do not have a family support network that can assist in Self-Direction and/or do not desire to do so themselves. In this instance, the individual and family still exercise choice.

A Transitional Case Manager (TCM) is assigned to the individual who works with them and the DC to identify the needed supports and services the individual needs to be successful in the community. They also inquire with the individual and their guardian/family as to what geographic area of New Jersey they wish to live in. The TCM then engages with qualified providers who do business in that area of the state and are interested in serving the individual. Interested agencies complete proposals for the person which are reviewed by the TCM for completeness and forwarded to the individual/guardian for review. The individual/guardian ultimately selects which proposal best suits their needs and have the opportunity to ask questions and interview providers if they wish. After selection of an agency through this process, the agency engages in procurement of housing, hiring of staff and transition planning with the individual, guardian/family, TCM and team of treating professionals from the DC to affect their move into their new home in the community.

If, at any point, an individual is not satisfied with any component of their services, a meeting with their Inter-Disciplinary Team (IDT) is held to discuss and come to a resolution. This can include the acquisition of a new service provider.

Quality Management Strategy for Money Follows the Person (MFP)

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

Division of Aging Services

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

The Quality Management Strategy for MLTSS Comprehensive Medicaid Waiver

The following provides evidence as to the implementation of the quality management and improvement strategy for the MLTSS Comprehensive Medicaid Waiver program. The State demonstrated through its approved Interim Procedural Guidance that adequate and effective mechanisms for finding and resolving compliance issues on an ongoing basis are in place and where appropriate, remediation efforts and timelines for each assurance are indicated as well. The MLTSS Comprehensive Waiver Application was submitted to and approved by CMS with the effective date as July 1, 2014.

Quality Management Strategy Overview

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

MLTSS Measures in Year One (1)

		Measure	Method	Frequency	Data Source	Who Calculates	STC Requirement
Participant Access Measures							
Level of Care							
1	Number of Members receiving HCBS and NF services just prior to implementation	Number of Members receiving HCBS and NF services just prior to implementation	Division of Aging Services will run report	Once	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Requirement
2	NF LOC conducted prior to enrollment into MLTSS	Numerator, denominator and % of new MLTSS enrollees in MCO with NF LOC evaluation prior to receipt of services	Division of Aging Services will run report	Monthly initially (State automated system not in place)	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	X
3	NF LOC: Members who were referred for NF LOC who were determined to have met NF LOC by OCCO	Numerator, denominator and % of Members referred for NF LOC who OCCO determined met NF LOC	Division of Aging Services will run report	Monthly	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	
4	Timeliness of NF LOC	Numerator, denominator and % of MLTSS Members who received an evaluation for NF LOC determination within 30 days of referral	Division of Aging Services will run report	Monthly	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	
5	Timeliness of NF LOC re-determination	Numerator, denominator and % of MLTSS Members who received NF LOC within 12 months of initial/subsequent NF LOC determination	Division of Aging Services will run report	Monthly	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	X
6	Options Counseling	Numerator, denominator and % of MLTSS Members who received options counseling	Division of Aging Services will review individual NJ Choice assessment system results for evidence of Members being offered Options Counseling and will run report	Monthly	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Requirement
7	Members are offered choice between institutional and HCBS	Numerator, denominator and % of MLTSS Members who indicated that they were offered a choice between institutional and HCBS	Division of Aging Services will review individual NJ Choice assessment system results for evidence of Members being offered choice between institutional and HCBS and will run report	Monthly	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	X
Participant-Centered Service Planning and Delivery							
Plan of Care							
8	POCs established within required timeframe	Numerator, denominator and % of care plans for MLTSS Members that are developed within 30 days of enrollment into MLTSS	Record review of sample of Member care plans	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X
9	POC reviewed annually within 30 days of Members anniversary and as necessary	Numerator, denominator and % of care plans for MLTSS Members that are reviewed annually, at a minimum, or more frequently, as appropriate	Record of a sample of Member care plans	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X
10	POCs are aligned with Member needs based on the results of the NJ Choice Assessment System assessment system and CNA in type, scope, amount and frequency.	Numerator, denominator and % of MLTSS Members whose services and supports aligned with assessed need, including health and safety	Record review of sample of Member care plans	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Requirement
11	POC are developed using person-center principles	Numerator, denominator and % of POC for MLTSS Members that are developed in accordance with the Member's unique needs, expressed preferences and decisions concerning their life in the community	Record review of sample of Member care plans	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/EQRO	X
12	POCs include a Back-up Plan	Numerator, denominator and % of MLTSS Members receiving HCBS services who have a POC that includes a Back-up Plan	Record review of Member sample of Member care plans	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/EQRO	X
13	Services are delivered in accordance with POC including the type, scope, amount and frequency.	Numerator, denominator and % of POCs for MLTSS Members in which the services and supports are delivered in type, scope, amount and frequency	Record review of sample of Member care plans	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/EQRO	X
Provider Capacity and Capabilities							
Provider Network							
14	Member Access to MLTSS services	Compliance with provider network standards. MCO network has adequate number and type of participating traditional and non-traditional providers	State review of MCO network submission	Quarterly and Annually	State reviews MCO provider file data and geo access	DMAHS/EQRO	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Requirement
15	MCO MLTSS providers are credentialed/re-credentialed timely	Compliance with credentialing and re-credentialing requirements	Review of sample of provider records	Annually by EQRO as part of Annual Assessment	EQRO reviews credentialing/re-credentialing files	DMAHS/EQRO	X
Participant Safeguards							
Critical Incident Management System							
16	Training on identifying/reporting Critical Incidents	Numerator, denominator and % of MLTSS Members (or family Members/authorized representative) receive information/education at least annually on how to identify and report abuse, neglect and exploitation	Record review of sample of Member care plans	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/EQRO	X
17	Timeliness of Critical Incident reporting (Verbally one (1) business day. and in writing two (2) business days.)	Numerator, denominator and % of CIs re: MLTSS Members reported on a timely basis. (Verbally 24 hours within learning of the CI and in writing within 48 hours)	State review of Critical Incident report	Daily, as necessary	MCO submits individual critical incident information	DMAHS	X
18	Quarterly and Annual Critical Incident reporting	Quarterly: numerator, denominator and % of Critical incidents re: MLTSS Members by incident type. Annually: Summary of incidents occurring during the calendar year and MCO interventions.	State review of critical incident report and Summary	Quarterly and Annually (summary)	MCO submits quarterly critical incident report and annual summary	TBD	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Requirement
Participant Rights and Responsibilities							
Complaints, Grievance and Appeals							
19	Timelines	Numerator, denominator and % of complaints, grievances and appeals re: MLTSS Members that are addressed within appropriate timeframes	State reviews the CTR and Table 3 A	Quarterly	State reviews CTR (state complaint) database and MCO-submitted Table 3A report	DMAHS	X
Measuring effectiveness of MLTSS activities							
20	Total number of MLTSS Members receiving MLTSS services	Total number of MLTSS Members receiving any HCBS and/or NF services during each 12 month period	State reviews report	Quarterly and Annually	MCO submits report MCO submits annual summary of results and interventions	DMAHS	X
21	MLTSS Members transitioned from NF to Community	Numerator, denominator and % of MLTSS Members who transitioned from NF to the community	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X
22	New MLTSS Members admitted to NF during 12 month period	Numerator, denominator and % of new MLTSS Members admitted to NFs during 12 month period	State review report	Annually	MCO submits report	DMAHS	X
23	MLTSS Members transitioned from NF to Community who returned to the NF within 90 days	Numerator, denominator and % of MLTSS Members transitioning from NF to community who returned to the NF within 90 days	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	

		Measure	Method	Frequency	Data Source	Who Calculates	STC Requirement
24	MLTSS Members transitioned from the Community to the NF for greater than 180 days	Numerator, denominator and % of HCBS Members transitioning from the community to the NF for a stay of greater than 180 days	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X
25	HCBS Members transitioned from the Community to NF for less than or equal to 180 days (Short Stay)	Numerator, denominator and % of HCBS Members transitioning from the community to NF for a stay of less than or equal to 180 days. (NF Short Stay)	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X
26	HCBS Members admitted to Hospital- each instance of hospitalization (not unique Members)	Numerator, denominator and % of HCBS Members who were admitted to the Hospital	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X
27	NF Members admitted to Hospital- each instance of hospitalization (not unique Members)	Numerator, denominator and % of NF Members who were admitted to the Hospital	State reviews report	Quarterly and Annually	MCO submits report beginning 3rd Quarter 2014		
28	HCBS Members re-admitted to Hospital within 30 days of last hospitalization- each instance of re-hospitalization (not unique Members)	Numerator, denominator and % of HCBS Members who were re-admitted to the Hospital within 30 days of last hospitalization	State reviews report	Quarterly and Annually	MCO submits report		

		Measure	Method	Frequency	Data Source	Who Calculates	STC Requirement
29	NF Members re-admitted to Hospital within 30 days of last hospitalization each instance of re-hospitalization (not unique Members)	Numerator, denominator and % of NF Members who were re- admitted to the Hospital within 30 days of last hospitalization	State reviews report	Quarterly and Annually	MCO submits report beginning 3rd Quarter 2014		
30	HCBS Members with ER utilization-each instance of ER utilization- not unique Members	Numerator, denominator and % of HCBS Members who had ER utilization	State reviews report	Quarterly and Annually	MCO submits report	DMAHS	X
31	NF Members with ER utilization-each instance of ER utilization- not unique Members	Numerator, denominator and % of NF Members who had ER utilization	State reviews report	Quarterly and Annually	MCO submits report beginning 3rd Quarter 2014	DMAHS	
32	Self Direction	Numerator, denominator and % of MLTSS Members opting to use self direction	State reviews report	Annually	TBD	DDS	X
33	HCBS Members receiving only PCA services (out of all the possible MLTSS services available to them)	Numerator, denominator and % of HCBS Members receiving only PCA services within last 6 months (out of all the possible MLTSS services available to them)	State reviews report	Semi Annually	MCO submits report	DMAHS	

		Measure	Method	Frequency	Data Source	Who Calculates	STC Requirement
34	HCBS Members receiving only Medical Day Care services (out of all the possible MLTSS services available to them)	Numerator, denominator and % of HCBS Members receiving only Medical Day Care services within last 6 months (Out of all the possible MLTSS services available to them) Report by Adult; Pediatric; and Total	State reviews report	Semi Annually	MCO submits report	DMAHS	

The Contractor shall develop and implement policies and procedures for monitoring compliance with the State’s MFP Operational Protocol. On a monthly basis the Contractor shall report to the MFP Program Director, in a manner prescribed by the State, the following information:

1. All non-MFP qualified transitions by the following age-bands:
 - a. MLTSS non-MFP transitions for Members less than sixty-five (65) years of age,
 - b. MLTSS non-MFP transitions for Members greater than or equal to sixty-five (65) years of age.
2. All individuals who qualified for MFP but did not transition due to not meeting the Cost Efficiency of Care.
3. Additional quality and outcomes measures as required by the MFP Operational Protocol.

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

No one is discharged from a Nursing Facility via Money Follows the Person onto the MLTSS Comprehensive Medicaid Waiver without an Interdisciplinary Team/Round Table Meeting. The applicant/NF resident conducts the meeting as much as he or she is capable of doing or wishes to do. All relevant parties including the MFP Liaison/ Community Choice Counselor from the Regional OCCO, NF Social Worker, Applicant's representative, MCO Care Manager, therapy staff, doctors, and nurses as necessary participate. Risk Factors, those that pertain to Health and Welfare, should a service not be delivered as planned, are identified and Back-up Plans are created. Each IDT participant understands the responsibilities and signs off on the Transition Plan, Backup plan, and Risk Agreement (as applicable) as confirmation that he or she has participated in the Transition Plan and agree with its contents.

Plan of Care Development Process

The Plan of Care development requirements are outlined in the Contract between the state and the Managed Care Organizations. These contractual guidelines fully addresses the standards established for all participant-centered service plans.

a) The Plan of Care is developed by the participant (to the degree desired), his or her representative/legal representative (as requested by the participant) and the Care Manager. A fully developed Plan of Care must be finalized and signed by the participant, his or her representative/legal representative, Care Manager, and Care Manager's Supervisor prior to discharge from the facility. The Care Manager has 30 days to update the Plan of Care based on the actual needs of the member once in the community. For those individuals who are discharged from a nursing facility to MLTSS for Home and Community Based services, an Interdisciplinary Team, directed by the applicant (as much as he or she desires or is capable of) and including his or her representative/legal representative, MCO MLTSS Care Manager, MFP Liaison/Community Choice Counselor, Nursing Facility Social Worker, and other relevant professionals, may develop a transition plan based on an updated evaluation and input of the team, which can also serve as an interim Plan of Care to initiate services before the development of a full Plan of Care.

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

Before developing the Plan of Care, the Care Manager reviews the Clinical Assessment Protocol (CAPS) to assist with identifying individual's needs and completes the Interim plan of Care with the individual. The individual's Comprehensive Evaluation used to determine nursing facility level of care is also used in developing the Plan of Care.

MLTSS services are authorized by the Care Manager. All authorized services, which are identified in the participants Plan of Care, are based on an individual's assessed needs. Waiver services are arranged to complement and/or supplement (not replace) the services that are already available to participants through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide. Upon enrollment, a comprehensive Plan of Care is developed by the MLTSS participant and his or her Care Manager. The State Mandated PCA tool was developed and is utilized as a consistent and objective means of assisting Care Managers (CM) in determining the hours of PCA services a MLTSS participant requires. The PCA tool is used to assist Care Managers in determining a MLTSS participant's care needs when developing the initial Plan of Care, the annual Plan of Care or when there has been a significant change in the participant's functional abilities or a significant change in caregiver status requiring a revision to the Plan of Care. MLTSS participants are provided services based on the information recorded on the comprehensive evaluation and the PCA tool while also considering the professional judgment of the Care Manager in determining hours of service. The PCA tool is used in conjunction with the following documents, as applicable: The NJ Choice HC assessment system.

The state must provide for the consistent, uniform administration and operation of the Waiver across all geographic areas where the Waiver is in operation, which for the MLTSS Waiver is statewide. Absent a waiver of 'Statewideness', it is expected that the MLTSS waiver will be administered and operated in a consistent fashion in all parts of the state of NJ and, thereby, ensure that waiver services are provided on a comparable basis to the entire group of MLTSS waiver participants in compliance with 42 CFR §440.240(b) (comparability of services for groups).

The PCA tool assists the state in demonstrating that services available are equal in amount, duration, and scope for all MLTSS participants based on their individual assessed needs. The MLTSS Waiver is managed in a manner to promote the cost-effective delivery of home and community-based services. If the Waiver Participant or his/her Authorized Representative does not agree to the hours determined by the PCA tool and the professional judgment of the Care Manager, he/she has a right to appeal.

c) The MCO MLTSS Participant Handbook and a web-based Fact Sheet list all the services that are available in the MLTSS program. In addition, a thorough MLTSS Service Definitions and Special Considerations was distributed to all MCO's, which describes each service, its standards, requirements and limitations. At the time of the initial inquiry into service availability and potential program enrollment, designated Staff provides Options Counseling to applicants about the services available through the MLTSS Waiver and other home and community service programs. For those individuals in an institutional setting who are seeking

relocation to the community, the MFP Liaison/ Community Choice Counselor and or MCO Care Manager will discuss MLTSS with eligible candidates.

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

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

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

g) There is a participant signature line on the Plan of Care for the participant and/or his or her representative/legal representative to acknowledge his or her agreement with the Plan of Care process and that he/she had choice in services and providers.

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

Risk Assessment and Mitigation

- A. Care Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request.
- B. Contractors shall ensure that there is a structure in place to provide uniform training to all Care Managers, including formal training classes as well as mentoring-type opportunities for newly hired Care Managers.
- C. Newly hired Care Managers shall be provided orientation and training in a minimum of the following areas:
 - 1. The role of the Care Manager in utilizing a person-centered approach to MLTSS Care Management, including involving the Member and the Member's family in decision-making and service planning.
 - 2. The principle of most integrated, least restrictive settings for Member placement.
 - 3. All Member rights and responsibilities.
 - 4. Care management responsibilities as outlined in this section, including, but not limited to, service planning, back-up plans, reporting service gaps and Notices of Action.
 - 5. Care management procedures specific to the Contractor.
 - 6. An overview of MLTSS benefit structure.
 - 7. The continuum of MLTSS services, including available service settings and service restrictions/limitations.
 - 8. The Contractor provider network by location, service type and capacity and should include information about community resources for non-MLTSS covered services.
 - 9. Information on local resources for housing, education and employment services/program.

10. Responsibilities related to monitoring for and reporting of quality of care concerns and critical incidents, including, but not limited to, suspected fraud, waste, abuse, neglect and/or exploitation.
 11. General medical information, such as symptoms, medications and treatments for diagnostic categories common to the MLTSS population serviced by the Contractor.
 12. General social service information, such as family dynamics, care contracting, dealing with difficult people.
 13. Behavioral health information, including identification of Member's behavioral health needs, covered behavioral health services, the process for accessing those services within the Contractor's network and the requirement to at least quarterly communicate with the PCP and behavioral health providers involved in the Member's care.
 14. Level I and Level II Pre-Admission Screening and Resident Review (PASRR) processes.
 15. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards for Members under the age of 21.
 16. Care management techniques for managing special needs populations.
 17. Federal and State rules and regulations as they apply to human services programs.
 18. Information systems and tools necessary to manage the assigned case load.
 19. NF/SCNF and Assisted living patient payment liability and Member share of cost.
 20. Participant direction service delivery model.
- D. All Care Managers responsible for using and completing the NJ Choice assessment system initial and re-evaluations shall be trained and certified by the State, or its designee, in fielding the NJ Choice assessment system and completing Options Counseling. Care Managers shall be re-certified on an annual or more frequent basis, as determined by DMAHS.
- E. The Contractor shall develop a system to track compliance with Care Management training and certification requirements.

F. In addition to review of areas covered in orientation, all Care Managers shall also be provided with regular ongoing training on topics relevant to the population(s) served. The following topics that shall be covered include but are not limited to:

1. Assessment/observation skills,
2. Cultural competency,
3. Interviewing skills,
4. Medical/behavioral health issues,
5. Medications – side effects, contraindications, poly-pharmacy issues, and prescription abuse,
6. Member rights and responsibilities,
7. New or emerging developments in MLTSS,
8. Policy updates and new procedures,
9. Refresher training for areas found deficient through the Contractor's internal monitoring process,
10. Addiction/substance abuse,
11. How to identify potential fraud, waste, abuse, neglect and/or exploitation.

G. Training shall include how to collaborate with the following external sources, including, but not be limited to:

1. Adult protective services,
2. Accredited training agencies,

3. Area Agencies on Aging/Aging and Disability Resource Centers,
4. Consumer advocacy groups,
5. County based Emergency Preparedness coordination,
6. PACE organizations,
7. Providers (for example, medical or behavioral health),
8. Public Guardian,
9. Local police departments,
10. MLTSS advocacy groups,
11. Department of Health, Division of Health Facilities Evaluation and Licensing,
12. Department of Children and Families, Division of Children's Protection and Permanency,
13. Ombudsman for Institutionalized Elderly,
14. Department of Human Services, and
15. Bureau of Guardianship Services

H. The Contractor shall ensure that Care Managers have access to an individual or entity who can provide expertise in assisting MLTSS populations in areas such as housing, education and employment issues and who has local community knowledge about other resources available in the Contractor's service area. This individual shall be available to assist Care Managers with up-to-date information

designed to aid Members in making informed decisions about their independent living options.

- I. The Contractor shall annually educate all Care Managers and Medical Directors assigned to certain MLTSS populations such as pediatric, geriatric or those with a diagnosis of traumatic brain injury and HIV/AIDS shall have access to and receive ongoing training on evidence based protocols and Care Management standards pertinent to those populations.
- J. The Contractor shall ensure that all Care Managers and medical directors who interface with MLTSS Members and perform care coordination and authorization of services are knowledgeable about the requirements of the Americans with Disabilities Act and the Olmstead Decision of 1999 and its subsequent related cases.

Risk Assessment:

- A. The Contractor shall develop and implement a risk assessment protocol which includes use of the NJ Choice assessment system for the identification of risk factors. The Contractor shall submit supplemental tools and protocol, initially and upon revision, to DMAHS for review and approval.
- B. The Care Manager shall advise the Member of the risk assessment process, including advising the Member that the Member may include family, friends, caregivers, or other individuals in the risk assessment.
- C. The risk assessment shall be completed with the Member, authorized representative and other caregivers utilizing open-ended questions as well as review of medical and other information, interviews with service providers, and direct observation.
- D. The Contractor's Care Manager is responsible for conducting a risk assessment on all MLTSS Members residing in the Member's community home on an annual basis. The risk assessment shall be conducted at the time of annual level of care re-evaluation.
- E. The Risk Management Agreement is a State mandated form which details all items that could potentially affect the Member's health and welfare due to issues associated with living in the community and participating in the MLTSS program. The risk management agreement shall include:
 - 1. Identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks and the responsible party for addressing the risk;
 - 2. Documentation of the Contractor's determination regarding whether the Member's needs can be safely and effectively met in the community; and

3. Signature of the Member or authorized representative indicating agreement with the Contractor's risk management agreement.

F. Contractor Interdisciplinary Team Review: The Contractor shall conduct an Interdisciplinary Team (IDT) Review if, at any time:

1. There is a health or safety risk that cannot be adequately mitigated such that the Contractor believes that the risk to the Member's health or welfare is unreasonable;
2. Prior to the denial or reduction of services due to service need costs exceeding the annual cost threshold;
3. When a member's service needs cost reach the annual need cost threshold trigger level.

The IDT shall consist of, at a minimum, the Care Manager, the Care Manager Supervisor, the MLTSS Member Advocate, the Behavioral Health Administrator, if appropriate, the MLTSS Medical Director, the Member, the member family or representative, and an OCCO representative.

The role of the OCCO representative is to serve as a Transition Subject Matter Expert and to ensure that the Member is provided the opportunity to select HCBS within the parameters of cost effectiveness and to enter into a Risk Management Agreement.

Housing

Defining and Documenting Qualified Residences

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

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

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

Alternative Living Unit

"Alternative living unit" means a residence that:

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

Group Home

"Group home" means a residence that:

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

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

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

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

Assisted Living Services

Assisted Living Program

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

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

Residence Types

Adult Family Care (AFC)

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

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

Shared Housing Association of New Jersey in Somerset County 908-526-4663 and in Hunterdon County 908-237-0650.

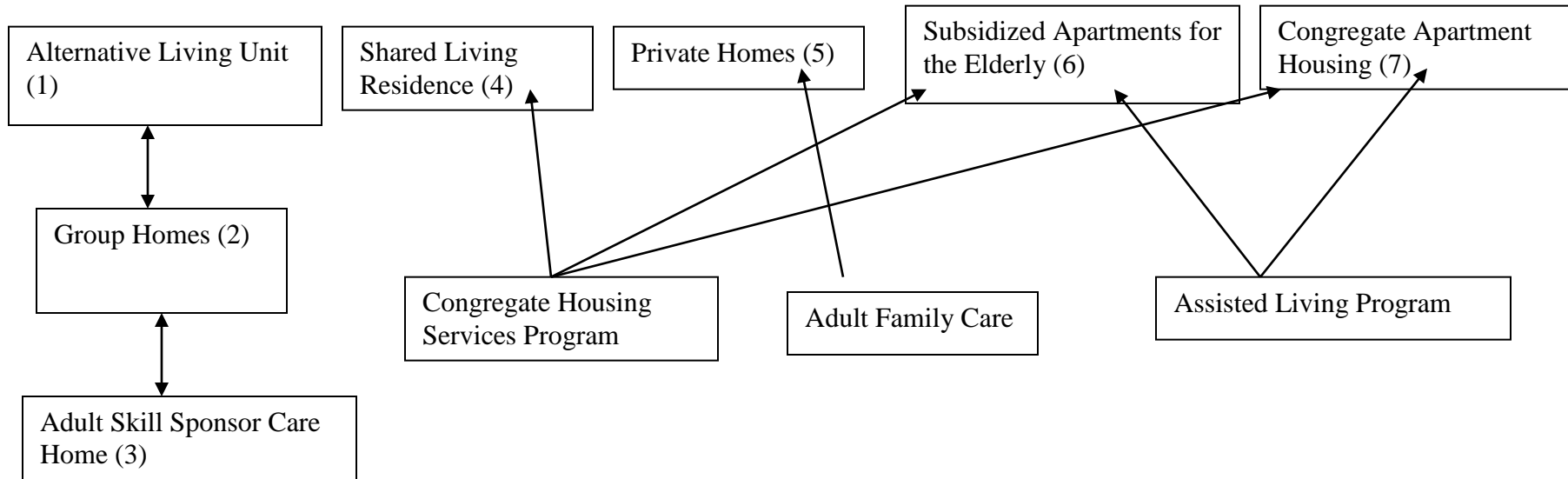
*Shared Living Residences will only be counted as eligible community residences for MFP where 4 or less individuals reside.

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

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

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

Relationship Chart



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

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

Assurance of Sufficient Supply of Qualified Residences

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

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

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

Under the Special Needs Housing Partnership Loan Program (SNHPLP), the New Jersey Housing and Mortgage Finance Agency (NJHMFA), the New Jersey Department of Community Affairs (DCA) and the New Jersey Department of Human Services (DHS), Division of Developmental Disabilities (DDD) will provide financing to create permanent supportive housing and community residences for individuals with developmental disabilities. Loan proceeds may be used for the acquisition and rehabilitation of existing three- to four-bedroom single family houses and first floor three- to four-bedroom condominiums, with acquisition and all rehabilitation to be completed within six (6) months of mortgage closing. New construction, while not encouraged, will be considered on a case-by-case basis provided the Sponsor is able to meet the 6-month threshold requirement. All of the units created must be set-aside for persons with developmental disabilities as approved by DDD and deed restricted for this class of tenants for a term of not less than 20 years.

As of December 2014:

- 36 projects have been completed;
- 1 project has closed on funding and is in construction;
- 10 projects have received commitments and are in closing;
- 7 projects are in the application/pre-application phase;
- Projects are located in 35 municipalities in 16 counties in the state of New Jersey.

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

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

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

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

The New Jersey Department of Community Affairs (DCA) and the New Jersey Housing and Mortgage Finance Agency are the New Jersey state housing finance arm and public housing authorities (PHAs). DCA allocates funding of federal housing funds/programs to local Public Housing Authorities (PHA) in non-participating jurisdictions throughout the state. PHAs in

larger communities receive funding directly from the U.S. Department of Housing and Urban Development (HUD); there are 109 PHAs in New Jersey. PHAs develop their own programs and priorities through their local Consolidated Housing Plans.

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

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

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

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

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

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

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

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

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

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

- Find and list affordable housing
- Help people with disabilities find housing
- Obtain housing information and links

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

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

NJ’s MFP Statewide Housing Coordinator maintains an inventory of accessible and affordable housing by contacting apartment complexes and Public Housing Authorities on a regular basis and enters this information into a spreadsheet that is made available to all Transition Coordinators (OCCO, MCO), nursing facility Social Workers, OOIE Education and Advocacy Coordinators, individuals and/or their families/guardians. The spreadsheet includes information such as: county, apartment complex name and address, phone number, features (i.e. walk-in shower), comments (i.e. length of wait list and whether it is closed or open), rental amount and whether the unit meets the Fair Market Value. The spreadsheet can be sorted by

county and is also available on NJ's MFP Program web site at www.IChooseHome.NJ.gov by clicking on the Resource Tab.

To further address identified housing shortages for persons transitioning under the MFP demonstration, the New Jersey Department of Human Services (DHS), Division of Developmental Disabilities (DDD) has partnered with the New Jersey Housing and Mortgage Finance Agency (NJHMFA) and the New Jersey Department of Community Affairs (DCA) to create the Special Needs Housing Partnership Loan Program (SNHPLP). NJHMFA and the DCA will provide financing to create permanent supportive housing and community residences for individuals with developmental disabilities. Loan proceeds may be used for the acquisition and rehabilitation of existing 3-4 bedroom single-family houses and first floor 3-4 bedroom condominiums, with acquisition and all rehabilitation to be completed within six (6) months of mortgage closing. New construction, while not encouraged, will be considered on a case-by-case basis provided the Sponsor is also able to meet the 6-month threshold requirement.

In another effort to address identified housing shortages for persons transitioning under the MFP demonstration, DDD has received approval to utilize rebalancing funds for capital costs (acquisition and/or rehabilitation) for new development of homes to serve individuals leaving developmental centers. These funds will be allocated through a competitive process among qualified DDD providers, and will be targeted to provide housing for individuals leaving developmental centers with significant challenges as identified by DDD. Up to \$250,000 per 4-bedroom home will be made available through this process, while providers will leverage other resources for the remaining development costs (average total development cost for 4-bedroom group home in NJ is \$400-\$500,000). Providers will be expected to place homes in service within six to nine months of date of award of funds. DDD will secure these funds with a lien or deed restriction to ensure the use of the facility for individuals with developmental disabilities.

The Sandy Special Needs Housing Fund (SSNHF) is another effort by which NJ will address housing shortages within the State. The SSNHF is dedicated to the development of quality, permanent, supportive housing located in the nine most impacted counties by the Sandy Storm and is administered by the New Jersey Housing and Mortgage Finance Agency (HMFA). SSNHF can be used to fund permanent supportive rental housing or community residences in which some or all of the units are affordable to low- and moderate-income special needs residents. Special needs populations include individuals with mental, physical, or developmental disabilities, and other at-risk populations identified by the State.

The program provides loans to developers of projects which combine rental housing and support services. Developers may apply for stand-alone financing or for program funding in conjunction with the Low Income Housing Tax Credit Program, tax-exempt bonds, and/or Fund for Restoration of Multifamily Housing. The State has dedicated \$25,000,000 in CDBG-DR funds to this program.

Eligible applicants are private for profit and nonprofit housing developers and public housing authorities capable of developing and managing the housing projects and providing supportive services directly or indirectly with the service provider to the targeted special needs populations.

Total maximum per unit cap is \$100,000 with a maximum per project cap of \$2,500,000. The maximum total development cost per unit is \$275,000. SSNHF funding is available for hard and soft costs related to acquisition, rehabilitation, and construction.

With CMS' approval, the New Jersey Housing and Mortgage Finance Agency (NJHMFA) is embarking on a new project with the New Jersey Division of Aging Services (DoAS), utilizing Rebalancing dollars as capital funding to create housing units in new developments that are specifically set aside for individuals transitioning out of nursing facilities to community living who are eligible for MFP. Housing developers will access this funding through a process that has already been developed for the Sandy Special Needs Housing Fund ("SSNHF") funds. These funds are provided on a first come first serve basis and housing developers must follow the requirements set forth in program guidelines. The program guidelines will address the following: eligible applicants, eligible locations, eligible projects, project selection criteria, number of set aside units to be financed and subsidy loan amounts. The specific program guidelines will be developed by both DoAS and NJHMFA staff to ensure that the program meets the needs of individuals as well as the HCBS Setting Final Rule.

New Jersey Department of Human Services (DHS) has created an Office of Housing within DHS. This office oversees both DDD and Division of Mental Health and Addiction Services (DMHAS) housing and program development staff. The Office of Housing will develop and implement housing policy and oversee day-to-day housing coordination activities for both Divisions. Key goals for the Office of Housing for FY15 include ensuring sufficient housing to meet DHS's Olmstead obligations (including supporting the closure of Woodbridge Developmental Center) and other needs including housing for individuals who are at risk, in emergent need of housing or on the Community Care Waiting List; development of a plan for compliance with the new CMS Final Rule on Home and Community-Based Settings; and development of a clearinghouse for administration of DHS housing subsidies.

The Division of Developmental Disabilities received approval from CMS to utilize rebalancing dollars to support start-up costs (2015 only) and six years of operating expenses (2015-9/30/2020) for the Supportive Housing Connection (SHC). The SHC is a partnership between the Department of Human Services and the NJ Housing & Mortgage Finance Agency (NJHMFA) to ensure that individuals with special needs can access affordable housing. The SHC will administer new and existing housing subsidies, facilitate DDD's movement to a fee-for-service system and a lease-based housing system as well as its future plans to invest additional funds in new housing subsidies.

The SHC will also support DHS's efforts to create and obtain new housing subsidies by establishing a centralized, efficient entity to administer housing subsidies. The SHC will administer the 206 HUD 811 subsidies recently awarded to NJHMFA and DHS, as well as the 200 DDD subsidies in the proposed SFY16 budget. DDD has also made a commitment to provide new housing subsidies for individuals living in licensed congregate settings who wish to move into more integrated settings and can be appropriately supported there. These subsidies will also be administered by the SHC.

The SHC will perform the following functions for DHS:

- **Recruit new landlords to provide housing for people served by DHS.** NJHMFA currently administers the NJ Housing Resource Center (HRC), an online, searchable database of affordable housing opportunities managed by Social Serv (<http://www.nj.gov/njhrc/>). As part of the function of the SHC, NJHMFA will work with Social Serv to market the HRC to landlords who have rental housing available at affordable levels, to make this database even more robust and useful to people in need of housing. The HRC and the SHC will also provide help for individuals and stakeholders in navigating the HRC and finding housing, through a toll-free phone help line and an online chat tool.
- **Manage existing pool of landlords.** The SHC will serve as the liaison for landlords renting to individuals with DHS rental subsidies. Landlords will sign a landlord agreement with the SHC in which they agree to abide by the policies and procedures of the SHC and to offer housing in a lease-based model compliant with NJ tenant-landlord law. The SHC will answer questions and concerns from landlords, and offer mediation services between landlords and tenants when necessary to assist individuals in sustaining their housing.
- **Inspections of subsidized units.** The SHC will inspect all units supported with a DHS subsidy according to the HUD Housing Quality Standards. Inspections will be performed by qualified, trained inspectors at initial lease-up, and on an annual basis thereafter. Inspections will also be made at tenant or DHS request if there is a need. By providing consistent, regular inspections by trained staff, the SHC will ensure that individuals in the program live in safe, high quality housing.
- **Administration of existing and new subsidies.** The SHC will administer DHS housing subsidies according to DHS policies and procedures, including determining tenant portion of the rent (a percentage of individual's income) and paying rents to landlords on a monthly basis. When fully launched the SHC will also pay other housing costs on DHS's behalf, such as security deposits, utility start-up costs, etc.
- **Tenant mediation services.** The SHC will also serve as a liaison for tenants and landlords, to help mediate any issues that may arise.
- **Communication with landlords, tenants and other stakeholders.** The SHC will communicate with tenants about their participation in the program, sending a welcome letter when a tenant joins the program with a new subsidy, informing them of their rights and responsibilities, assisting them through the lease-up process and through the lease renewal process. The SHC will also communicate with landlords and service providers about participation in the program.
- **Training.** The SHC and the Office of Housing will provide training and technical assistance to individuals, families, providers, landlords and other stakeholders on supportive housing and lease-based housing. CMS has approved the utilization of rebalancing dollars to fund this training.

NJ received 100 Non-Elderly Disabled (NED) vouchers in 2011 and was able to distribute all 100 vouchers within the time frame allotted.

Training Activities

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

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

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

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

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

housing resources. By developing partnerships, coordinating, collaborating, and thinking creatively across state agencies, people with disabilities and seniors in need of subsidies can be supported in the community.

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

The housing task force will also:

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

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

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

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

- **Home Buyer Mortgage Program** – Provides flexible Mortgage terms and conditions to first time home buyers
- **Home Plus Program** - This program is used to purchase a residence and to provide funds for the cost of minor home improvements (up to \$15,000), all included in one loan. Improvements may include retrofitting necessary to make the home handicapped-accessible.
- **Kinship Care Home Loan Program** – seeks to provide affordable housing opportunities for eligible borrowers for eligible grandparents, uncles and aunts, or other close relatives recognized by the Department of Human Services or the Department of Children and Families as qualified “kin”, providing long term care for their displaced grandchildren or nieces and nephews or other minor relatives. To the extent practicable, the Agency will make loans to eligible borrowers through the Agency’s Home Buyer Program.
- **Smart Start Program** - The Smart Start Program is available to participants in the Agency’s first mortgage homebuyers program who are purchasing homes in Smart Growth areas and who earn over the 80% of HMFA’s homebuyer county income limits. The program helps these families by offering a second mortgage for down payment and/or closing costs up to 4% of the first mortgage.
- **Welcome Home Program** – seeks to provide affordable housing opportunities for eligible borrowers formally pursuing adoptions, including providing permanent placement of those children defined as Children with Special Needs. To the extent practicable, the Agency will make loans to eligible borrowers through the Agency’s Home Buyer Program (including the 100% Financing Program).

Continuity of Care Post the Demonstration

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

Participants in NJ's Money Follows the Person Demonstration Project who meet the MFP eligibility criteria will continue to receive access to home and community based services through Managed Long Term Care Services and Supports under the authority of NJ's 1115 Comprehensive Medicaid Waiver or through DDD's Community Care Waiver under the authority of a 1915(c) Home and Community Based Medicaid Waiver program.

They are:

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

2. **Managed Long Term Services and Supports (MLTSS)**: Under the 1115 Comprehensive Medicaid Waiver authority, MLTSS is designed to expand home and community-based services, promote community inclusion and ensure quality and efficiency. Services offered under this waiver include:
 - Care Management
 - Respite

- Residential Modifications
- Special medical equip. and supplies
- Chore services
- PERS
- Home delivered meals
- Caregiver/recipient training
- Social Adult Day Care
- Home Based Supportive Care
- Non-medical Transportation
- Assisted Living Program
- Adult Family Care
- TBI Behavioral Management (Group and Individual)
- Cognitive Therapy (Individual and Group)
- Community Residential Services
- Habilitative physical therapy
- Habilitative occupational therapy
- Habilitative speech therapy
- Private Duty Nursing (Adult)
- Structured Day Program (TBI)
- Supported Day Services (TBI)
- Vehicle Modifications

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

Organization and Administration

Staffing Plan

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

As stated previously in the Benchmark section, New Jersey has committed to increase MFP transitions from 305 over the next five (5) years to 2631 over the next five (5) years. In order to accomplish this goal, New Jersey has requested to utilize 100% administrative match funding to hire the following individuals.

The staffing plan is as follows:

DDD:

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

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

MFP Quality Assurance Specialist: A full time position responsible for developing a quality assurance process for those individuals who have transitioned from an institution to a community living arrangement. This individual will assure through this process that individuals are receiving the services required in order for them to live safely and happily in the community. These reviews will occur at 30 day intervals for 90 days and then at longer intervals thereafter. This individual will coordinate the findings, collect and analyze data and assure corrections are made in a timely fashion.

Olmstead Resource Team:

- Training Team:
 - 1 Speech and Language Pathologist: Full time position, as a member of the Training Team provides support to Olmstead residential and day service agencies through structured training in an attempt to increase their knowledge base and competence in the areas of Physical/Nutritional Management.
 - 1 Board Certified Behavior Analyst: Full time position, as a member of the Training Team is responsible for increasing the competence of provider agency staff who will be serving individuals placed in community programs from institutional settings that meet New Jersey's MFP eligibility criteria by providing highly technical training that is consistent with best practices in the areas of behavioral support. Primary goal of this

position is to enhance the overall support skill levels of provider agency staff to reduce the risks of critical incidents and re-institutionalizations.

- Physical/Nutritional Management Team:
 - 1 Speech and Language Pathologist: Full time position, as a member of the Physical/Nutritional Management Team, provides transitional support for agency staff that support individuals being placed in community programs from institutional settings who have experienced significant problems in the areas of physical and/or nutritional management. This support is designed to be in place for a maximum of 90 days post placement.

- Behavioral Team:
 - 1 Board Certified Behavior Analyst: Full time position, as a member of the Behavioral Team, provides consultative support to behavioral staff/consultant(s) at provider agencies receiving individuals from institutional settings who have a documented history of behavioral difficulties that may have the potential to threaten the success of their community placement. This support is designed to be in place for a maximum of 90 days post placement, with some exceptions made based on available staffing and evaluation of the individual circumstance.

DoAS and DDS:

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

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

7 Regional MFP Transition Nurses: Full-time positions responsible for identifying Fee for Service (FFS) individuals for MFP residing in nursing facilities; counsel individuals regarding community options and MCO enrollment; refer individuals to the MCO upon enrollment for case management; serve as a subject matter expert at the IDT; completes the MFP Quality of Life Survey and all other MFP paperwork.

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

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

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

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

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

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

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

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

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

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

2 MFP Housing Specialist/Coordinator: Full-time positions responsible for addressing the availability of housing resources, working with housing agencies and other partners to increase amount and type of housing options available to people who wish to transition, and providing assistance to the individual seeking housing by helping them find units that meet their individual needs and desires. These positions will ensure the available housing resources within the state are communicated to all those involved in transitioning individuals from nursing facilities to community living. This position acts a resource to the MFP Nurse Liaisons and MCO staff who encounter individuals for whom housing is the only barrier to transition.

1 Graphic/Social Media Specialist: Part-time position responsible for designing all ICHNJ marketing materials including all publications (brochures, fact sheets, collateral materials) and MFP advertising (bus ads, newspaper/print display advertising). This position will also be responsible for creating consumer-focused videos that showcase ICHNJ success stories and for revamping and expanding the program's social media presence.

Billing and Reimbursement Procedures

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

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

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

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

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

Independent audit of provider agencies on an annual basis is a requirement for agencies operating under contract with the Single State Medicaid Agency (DHS). This requirement is delineated in the State Contract Manual in The Department of Human Services' Policy Circular P2.01. Specifically section 3.09 of this policy requires an annual audit that is agency wide in scope. The audit must be conducted in accordance with the Federal Single Audit Act of 1984, generally accepted auditing standards as specified in the Statements of Auditing Standards issued by the American Institute of Certified Public Accountants (AICPA) and Government Auditing Standards issued by the Comptroller General of the United States. In addition the policy stipulates that at any time an agency may be audited by the Department of Human Services (DHS), the Single State Medicaid Agency, or any other appropriate unit of the state or federal government and/or by a private firm approved by the DHS. In addition, agencies providing Individual Support services in residential settings for Traumatic Brain Injury (TBI) are required by state regulation N.J.A.C. 10:44C to have an agency wide audit conducted annually. DHS does not dictate the auditing corporation selected by a provider agency but rather ensures compliance re: scope and standards for the annual audit. A more detailed explanation of the mandatory audit requirements are documented in DHS Policy Circular P7.06.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For the Division of Disability Services:

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

Money Follows the Person

New Jersey Organizational Structure

Department of Human Services

Acting Commissioner: Elizabeth Connelly

Deputy Commissioner: Dawn Apgar

Deputy Commissioner: Lowell Arye

Division of Medical Assistance and Health Services

Director: Valerie Harr

<i>Division of Aging Services</i>	<i>Division of Developmental Disabilities</i>	<i>Division of Disability Services</i>	<i>Office of the Ombudsman for Institutionalized Elderly</i>
Assistant Commissioner: Nancy Day	Assistant Commissioner: Elizabeth Shea	Director: Joseph Amoroso	Ombudsman: James McCracken
MFP Staff	MFP Staff	MFP Staff	MFP Staff
Associate Project Director	Project Director	Employment Specialist	Marketing Coordinator
Nurse Liaisons (7)	Financial Coordinator	Peer Mentors (3)	Education and Advocacy Supervisor
	Quality Assurance Specialist		Education and Advocacy Coordinators (4)
	Olmstead Resource Teams		Housing Specialists (2)
			Graphic/Social Media Specialist
			Support Staff (1)

TERRE LEWIS

NJ Department of Human Services, Division of Developmental Disabilities | P.O. Box 726 Trenton, NJ 08625

Phone: (609) 689- 0564 | Terre.Lewis@dhs.state.nj.us

EXPERIENCE:

Supervising Community Program Specialist: Division of Developmental Disabilities (DDD), Hamilton Township, New Jersey, (November 22, 2010 – Present)

- Coordinate, implement and expand the Money Follows the Person (MFP) Demonstration Project in the state of New Jersey
- Establish and maintain working business relationships with partnering Divisions within the state of New Jersey associated with the MFP Project
- Maintain a working business relationship with the Centers for Medicare and Medicaid Services (CMS) and their stakeholders
- Coordinate outreach, marketing and education in relation to the MFP Demonstration Project to promote program participation
- Ensure eligibility of all MFP participants
- Maintain database of all MFP participants and interpret data upon request by CMS and their stakeholders
- Develop and prepare proposed MFP Project budget and associated financial reports
- Provide data file reports as well as semi-annual web based reports to assist CMS in the evaluation of the fiscal effectiveness of the MFP Project
- Hire and supervise MFP professional staff
- Plan and assign MFP job duties as appropriate
- Supervise and maintain MFP Project records and files
- Draft correspondence as appropriate
- Attend and participate in conferences and meetings as appropriate

Quality Assurance Specialist: Division of Developmental Disabilities (DDD), Hamilton Township, New Jersey, (October 2004 – November 19, 2010)

- Develop and coordinate qualification process for Real Life Choices, Olmstead Initiative and various Request For Proposals/Request For Qualifications
- Review, analyze and evaluate provider applications and supportive documentation to determine eligibility for qualified status under Real Life Choices
- Review, analyze, interview and evaluate provider applications and recommend potential applicants for qualified status under Olmstead Initiative
- Prepare statistical reports containing findings and analysis of all qualified providers
- Analyze operational problems through review of Real Life Choices plan summaries to develop a course of action for more effective utilization of resources
- Provide technical assistance to Support Coordination and qualified providers pertaining to services and supports eligible for federal reimbursement under the Community Care Waiver
- Provide technical assistance to Support Coordination and qualified providers pertaining to allowable cost guidelines for each service eligible for reimbursement under the Community Care Waiver
- Plan, organize and conduct training for Support Coordination and qualified providers to improve service delivery
- Prepare and direct coordination of information for families and providers posted on the Family Support Center web site pertaining to Real Life Choices

- Coordinate the revision of the Memorandum of Understanding (MOU) between the Division of Vocational Rehabilitation Services (DVRS), the Commission for the Blind and Visually Impaired (CBVI) and the Division of Developmental Disabilities (DDD) to enable all three Divisions to operate in an efficient and successful manner to ensure quality service provision and improve employment outcomes for individuals with developmental disabilities
- Participate in the statewide Integrated Employment Coalition in order to facilitate consistent communication, continued cooperation and continuous improvement in the field of Supported Employment
- Participate in the Policy and Procedure Committee charged with reviewing, analyzing and updating all Division policy and procedures in effort to improve service delivery and be in compliance with Department of Human Services and State of New Jersey rules and regulations
- Participate in the Community Capital Committee charged with reviewing and approving DDD contracted agency's major maintenance packages for group home repair, renovations and purchase.
- Draft correspondence as appropriate
- Supervise maintenance of records and files
- Provide assignment and instruction to support staff

Habilitation Plan Coordinator: Division of Developmental Disabilities (DDD), Freehold, New Jersey, (August 2003 - October 2004).

- Compile and issue a master individual habilitation plan for each individual assigned
- Coordinate, monitor, and audit individual progress in following the individual habilitation plan.
- Recommend, approve, and monitor individual habilitation plans through the interdisciplinary team and sees that these changes are carried out
- Perform monitoring and assessment of individual's residential, program, training, behavior, social, and health needs
- Investigate and follow up on any report of abuse, neglect, or incident which may impact on an individual's well-being
- Monitor sponsors engaged in the operation of community residences for compliance with state licensing standards
- Recommend contract modifications including continuation or termination of alternate living contract
- Coordinate the development of crisis prevention and intervention plans
- Review and analyze case histories and other data concerned with intake, placement, program and referral issues

Clinical Coordinator: Mentor NJ, Moorestown, New Jersey, (April 1999 – August 2003).

- Review and analyze case histories and other data to develop appropriate goals and improve quality of care
- Compile and issue an individual rehabilitation plan for each individual assigned
- Coordinate, monitor, and audit individual progress in following the individual rehabilitation plan.
- Recommend, approve, and monitor individual rehabilitation plans through the interdisciplinary team and see that these changes are carried out
- Investigate and follow up on any report of abuse, neglect, or incident which may impact on an individual's well-being
- Monitor Mentors engaged in the operation of a Mentor home for compliance with DDD licensure standards

- Recommend contract modifications including continuation or termination of Mentor contract
- Complete Risk Management Assessment Form within 30 days of Admission
- Conduct quarterly home safety evaluations on all Mentor homes and provide feedback to the Mentor.
- Provide clinical direction, training and supervision to Mentors
- Complete annual Mentor Home evaluation of services
- Provide supervision of Mentor Information Book and review monthly for maintenance by Mentor Home family
- Audit clinical files

Case Manager: PLUS, Absecon, New Jersey (March 1998 - April 1999).

- Obtain and maintain records/documentation
- Ensure that each individual assigned receives necessary medical, dental, psychiatric and psychological services available through the program as well as in the community.
- Develop quarterly goals and coordinate, monitor and audit the individual's progress in following their plan of care
- Liaison between consumers, families, rehabilitation nurses, professional staff, and insurance carriers
- Ensure quality and efficiency of programs and documentation
- Investigate and follow up on any report of abuse, neglect, or incident which may impact on an individual's well-being
- Coordinate the development of crisis prevention and intervention
- Coordinate discharge and follow up on status following transfer or discharge

Vocational Specialist/Cognitive Retraining Specialist: PLUS, Absecon, New Jersey (January 1997 – March 1998).

- Provide cognitive rehabilitation therapy services through direct services
- Assess cognitive areas, vocational potential, target goals, select tasks and strategies
- Facilitated group sessions designed to enable individuals to participate in various activities such as vocational skills, life skills, personal development and community participation
- Counsel residents in developing appropriate vocational goals
- Evaluate resident's job readiness, assist with developing and improving job seeking skills, prepare resident for job interviews and provide job coaching when job placement occurs
- Facilitate the learning of those skills and functions essential for adaptation and productivity in the work place
- Conduct field visits to provide, evaluate and coordinate necessary services
- Establish and maintain cooperative working relationships with other organizations/agencies whose services may benefit the residents
- Develop, organize and maintain a referral network to inform residents of other appropriate programs, services or resources

Social Worker: HealthSouth Rehabilitation Hospital of NJ, Toms River, New Jersey (March 1996 – October 1996).

- Provide a service plan to restore patient to optimum social and health adjustment
- Arrange for discharge or postoperative care at home
- Assist patient and families through individual or group conferences to understand, accept and follow medical recommendations

- Interview patient and family to obtain information about home environment, family relationship, health history, mutual and personal resources
- Evaluate data to determine appropriate treatment plan
- Attend case conferences to present case history and collaborate on case records
- Provide follow-up after discharge

Clinical Coordinator: HealthSouth Rehabilitation Hospital of NJ, Toms River, New Jersey (January 1995 - July 1996).

- Clinical management of such issues as implementation and coordination of interdisciplinary functions, therapeutic strategies, establishments of discharge dates and recommendations for follow up care
- Supervise and evaluate clinical staff performance and conduct
- Ensure quality and efficiency of program and documentation

Vocational Counselor: HealthSouth Rehabilitation Hospital of NJ, Toms River, New Jersey (November 1993 – October 1996).

- Develop and implement vocational therapy programs in the Long Term Care unit to facilitate rehabilitation
- Counsel residents in developing appropriate vocational goals
- Review and evaluate diagnostic data to determine resident's limitations based upon disability
- Evaluate resident's job readiness, assist with developing and improving job seeking skills, prepare resident for job interviews and provide job coaching when job placement occurs
- Facilitate the learning of those skills and functions essential for adaptation and productivity in the work place
- Conduct field visits to provide, evaluate and coordinate necessary services
- Establish and maintain cooperative working relationships with other organizations/agencies whose services may benefit the residents
- Develop, organize and maintain a referral network to inform residents of other appropriate programs, services or resources

EDUCATION: Lebanon Valley College, Annville, Pennsylvania (September 1973 – May 1977).
Bachelor of Arts: Sociology/Social Work.

Reference Available Upon Request

Alisa Mead: 16 Virginia Ave: Pompton Plains, NJ 07444

Education William Paterson College 1977-1981 Bachelor of Science, Nursing
UMDNJ-Robert Wood Johnson Medical School 1988-1994, Masters of Public Health, Health Care Organization

Experience **State of NJ, DHS, Division of Aging Services**
2014-present- MFP Associate Project Director
Monitor specific program activities to ensure standards and procedures are adhered to and ensure MFP eligibility criteria is met. Supervise OCCO's MFP nurse liaisons. Prepare monthly, quarterly and annual reports on program activities. Establish relationships with Managed Care providers and conduct training on MFP policies. Provide assistance to OCCO staff regarding MFP and promote nursing facility transitions. Assist MFP Project Director in administrative and training projects. Attend and participate in conferences and meetings as appropriate.

State of NJ, DHS, Division of Disability Services
2004-2014-Program Support Specialist 1
Monitored specific program activities to ensure standards and procedures are adhered to and the quality of the program meets standards. Prepared the Case Management procedure manual. Provided technical assistance to community agencies in order to meet standards, resolve differences, and achieve quality service delivery. Completed clinical assessments in home and institutional settings to enroll potential waiver participants. Testifies in fair hearings.

State of NJ, DHS, DMAHS
2003-2004-Regional Staff Nurse
Monitored and evaluated specific programs in psychiatric facilities to ensure that standards and procedures are adhered to and prepared reports as PMR team. Monitored and evaluated health care treatments in accordance with rules & regulations. Promote cost effectiveness by identifying, evaluating, recommending and determining appropriate provision of home health services & medical equipment. Testified in fair hearings.

Arcadian Healthcare
1999-2003-Nurse Case Manager
Conferred with referral source, payer, social service agencies and/or hospital staff to assess appropriate discharge plans and achieve an effective integration of services. Provided caregiver with equipment instruction and coordinated

delivery of services to ensure standards and policies are adhered to. Referred to social service programs as needed.

Pediatric Home Care Associates

1992-1999- Nurse Case Manager

Developed, implemented and supervised the QI program to ensure program compliance with state & federal regulations and policies. Designed customer satisfaction survey instrument and assisted with developing the policy and procedure manual. Provided in-service programs to referral groups, equipment management instruction and communication with insurance and social service case managers. Conferred with human service/assistance programs to promote coordination and delivery of services for medically fragile children.

Blue Cross Blue Shield of New Jersey

1989-1992- Case Coordinator

Provided case management services to catastrophically ill clients, primarily pediatrics. Promoted cost effectiveness by identifying, evaluating, recommending and determining appropriate provision of medical services. Facilitated referrals to social service/assistance programs. Presented information concerning program operations to employer groups, providers and plan employees. Performed on site assessments and developed cost effective plans.

Passaic County Case Management Unit, Special Child Health Services

1986-1989- Case Coordinator

Manager of county unit, under the direction of the Dept. of Health to assure the provision of coordinated and comprehensive services to children with special needs. Developed and evaluated Individual Service Plans to meet identified goals. Facilitated communication among providers actively procured services and assisted in resolving complaints. Developed liaisons with local and regional agencies. Supervised two case managers and secretarial staff. Prepared grant applications, statistical reports and implemented new computer program to maintain client files and statistics. Developed orientation program and prepared policy and procedure manual.

Newark Beth Israel Medical Center

1981-1986 Staff nurse

Worked on pediatric floor and pediatric ICU.

References Personal and professional references available upon request.

Final Project Budget

Budget Narrative/Methodology

NJ will not be conducting an independent state evaluation of MFP.

CMS approval has been received to utilize 100% Administrative Match Funding for the following MFP expenses:

- Personnel:
 - Project Director;
 - Associate Project Director;
 - Financial Coordinator;
 - Statewide Housing Coordinator;
 - Quality Assurance Specialist;
 - Speech and Language Pathologist
 - Occupational or Physical Therapist
 - Physical/Nutritional Management Specialist
 - Behavioral Support Professional
 - Professional Trainer
 - Psychologist
 - Behavior Analyst (Masters Level)
 - Behavioral Analyst (Bachelors Level)
 - Regional Transition Nurses (7);
 - Housing Specialist/Coordinator;
 - Employment Specialist;
 - Peer Mentors (2);
 - Clerk Typist (1);
 - Outreach and Advocacy Coordinators (4);
 - Statewide Outreach and Advocacy Supervisor (bilingual);
 - OOIE Chief of Staff: 100% administrative match funding for 20% of this salary.
- Travel reimbursement for the MFP staff listed above
- Outreach and Marketing
- Administration of Quality of Life Surveys

All other NJ personnel associated with the function of this demonstration project are already reimbursed through the Medicaid program. In keeping with requirements set forth in OMB Circular A-87 regarding consistency of reimbursement, staff activities related to the Money Follows the Person Demonstration Project will be a part of their normal work activities.

Please see Appendix 7 which provides detail on the methodology used by the partner Divisions for developing the budget for MFP.

Please see attached Appendix 8 for the Worksheet for Proposed Budget.