SOUTH DAKOTA

Money Follows the Person

Operational Protocol

Version 1.2

Submitted by:

South Dakota Department of Social Services

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A. PROJECT INTRODUCTION

A.1 Organization and Administration

a. Systems Assessment and Gap Analysis

In 2006, the Governor's Healthcare Commission established a Long Term Care and Medicaid Subcommittee to evaluate the long-term care system and infrastructure, including Medicaid funding for services, and to make recommendations to the Commission regarding health care policy. The Subcommittee recommended that a comprehensive study of the state's long-term care system be conducted. House Bill 1156 was introduced and passed with overwhelming support by the 2006 Legislature. The bill required a study of the long-term care system, to include:

- Long-term care financing, including long-term care insurance;
- Costs of providing long-term care;
- Alternative approaches to providing long-term care;
- Barriers to the provision of quality long-term care services;
- Programs and techniques employed in other states for providing long-term care; and
- Other issues appropriate to the study of the continuum of care.

The study, conducted by a national consulting firm, included consideration and analysis of extensive state and federal data, as well as interviews with over 100 individuals representing over 50 groups, institutions, organizations, and tribal representatives across the state. The study was undertaken within the framework of four tasks:

1. Evaluate South Dakota's long-term care system in terms of utilization, cost, quality of services and outcomes for the elderly residents of the state across the continuum of care.
2. Project future long-term care needs and future capacity.
3. Identify policy options based on practices in other states.
4. Form policy recommendations.

The study was completed in November 2007 and resulted in a series of key findings. Among the key findings were:

- Growth in the elderly population will fuel a rising demand for services;
- South Dakota needs to rebalance and replace nursing facility capacity;
- South Dakota needs to target assisted living capacity towards growing regions
- South Dakota needs to expand home health care services; and
- South Dakota needs to expand Home and Community-based Services (HCBS)

Following the completion of the study, the Department of Social Services (DSS), as an umbrella agency to both the State Medicaid Agency and the State Unit on Aging, convened a large task force of stakeholders to develop recommendations to implement the findings identified in the Long Term Care Study. The task force included representatives from nursing facilities, assisted living centers, home care providers, provider associations, legislators, tribes, advocates, and state agencies. The task force was comprised of three subcommittees, each with a focus – 1.) Expanding Home and Community-based Services; 2.) Right Sizing; and 3.) Financing. The resulting recommendations of the task force included, but were not limited to:

- South Dakota needs to develop a single point of entry system to make access to information, assessment and referral to appropriate service providers easier;
- The Task Force recommends the State of South Dakota expand existing home and community-based services in order to better meet the needs of seniors throughout the state by supporting them to stay in their own homes and communities as long as possible;
- The Task Force recommends the State of South Dakota enhance existing home and community-based services to ensure services are comprehensive and meet the needs of the elderly in South Dakota; and
- South Dakota should right size the nursing facility industry by realigning moratorium bed levels to reflect projected demand for nursing facility services.

Since the final report was released in November 2008, South Dakota has taken steps to complete many of the task force recommendations. In 2011, South Dakota fully implemented its Aging and Disability Resource Center (ADRC) model for the elderly and physically disabled over the age of 18. Five single entry point call centers now conduct intake and screening, provide information and referrals, authorize basic services, or determine the caller needs an in-home assessment.

In addition, three of the four South Dakota 1915(c) HCBS waivers have been renewed within the past year. The renewal process provided impetus for the state to examine the services offered by each waiver and make changes that would allow more people to remain living in the community.

The state also took steps to right size the nursing home industry by filing Senate Bill 196 during the 2012 Legislative Session. The bill was proposed in an effort to realign available nursing home beds with the changing needs for nursing facility placements across the state. A moratorium on nursing facility beds has been in place since 2005. SB 196, which has since been signed into law, states that the "Department of Health may authorize the increase in the number of beds in an existing nursing facility or may authorize the construction of a new nursing facility, so long as the total number of nursing facility beds statewide does not exceed the total number of beds in existence statewide on July 1, 2005.

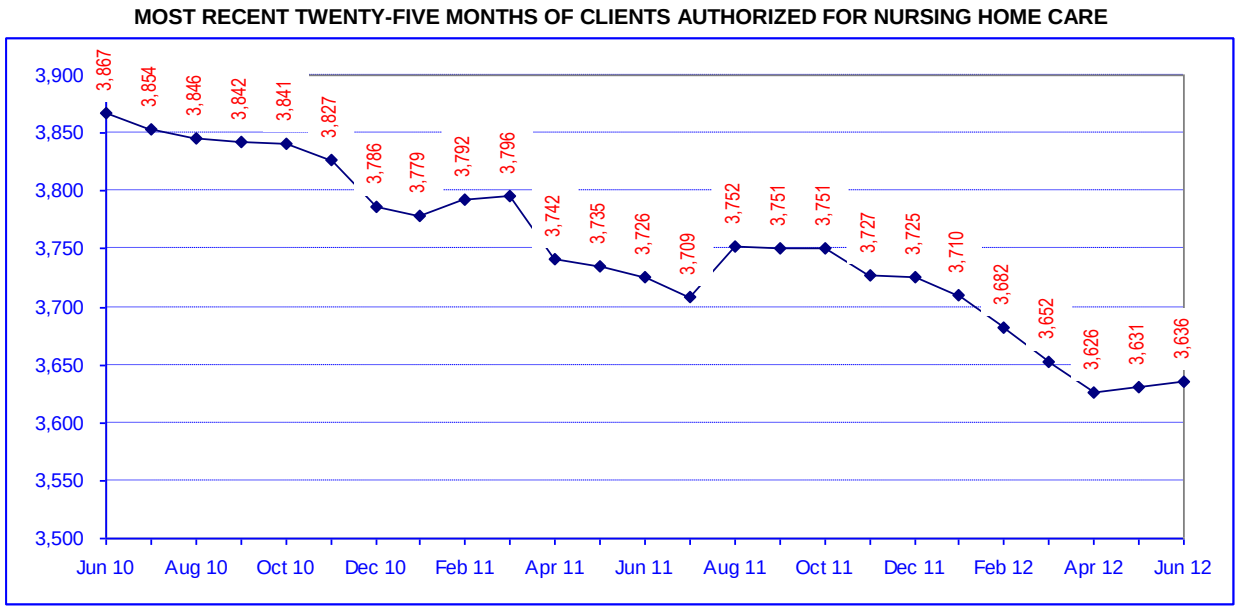
The Department of Health, with assistance from the Department of Social Services, may annually consider the need for additional nursing facility beds or additional new nursing facilities or both in defined areas of the state. In doing so, the following factors shall be taken into consideration:

- The current number of available nursing facility beds and nursing facilities in the defined area;
- The current and projected future need for additional nursing facility beds and nursing facilities in the defined area and the current long-term care needs of the population to be served;
- The potential impact on existing nursing facilities; and
- Any additional costs to the state that may result.

This law allows the state to continue to provide nursing facility care to those whose needs warrant that level of care, while simultaneously continuing to rebalance the long term supports and services system.

In CY2011, Medicaid authorized an average of 3,749 Medicaid recipients in nursing facilities per month. Exhibit 1 displays the number of recipients authorized for nursing home care per month from June 2010 to June 2012. As is clearly demonstrated, the number has steadily declined over the past two years. This decline can be attributed to a number of factors, not the least of which is the growing desire and demand to receive services in the community versus in an institutional setting.

Exhibit 1:



In addition to providing nursing facility services to adults as a mandatory service in the State Medicaid Plan, the state supports individuals who require institutionalization in ICFs and ICF/IDs. Services in these settings are primarily authorized through the Department of Human Services. The state has one public ICF/ID – the South Dakota Developmental Center (SDDC) in Redfield, SD. The SDDC is home to approximately 140 residents at a given time. The state also contracts with one private ICF/ID – the Children's Care Hospital and School (CCHS) in Sioux Falls,

SD. CCHS is currently providing residential treatment services to 50 youth from South Dakota and 15 youth from out of state.

Home and community based services in South Dakota have been historically provided through four 1915(c) HCBS Waivers. Each waiver targets a specific population and provides a menu of services to meet the needs of the target group. The state also includes Personal Care as an optional service in the Medicaid State Plan. The Personal Care service is managed by the Division of Adult Services and Aging (ASA) and is primarily used to serve those Medicaid eligible consumers who do not meet eligibility for waiver services. The most common reason for ineligibility is that the consumer does not meet waiver level of care. If a consumer meets level of care and other waiver eligibility criteria, the most appropriate waiver is used as the service delivery system.

Adult Services and Aging (ASA) Waiver – this waiver is administered by the Division of Adult Services and Aging, a Division of the Department of Social Services, which also encompasses Medicaid. The ASA Waiver targets consumers 65 and older, and consumers 18 and older with a qualifying disability who meet nursing facility level of care. The ASA waiver was renewed by CMS on October 1, 2011 and, at that time, was expanded to include two new services – Adult Companion Services and Environmental Accessibility Adaptation.

Assisted Daily Living Services (ADLS) Waiver – this waiver is operated by the Department of Human Services, Division of Rehabilitation Services, with administrative oversight by the Department of Social Services. It was renewed by CMS on June 1, 2012. The ADLS Waiver targets consumers 65 and older, and consumers 18 and older with a physical disability. Consumers must have quadriplegia due to or resulting from ataxia, cerebral palsy, rheumatoid

arthritis, muscular dystrophy, multiple sclerosis, traumatic brain injury, a congenital condition, an accident or injury to the spinal cord, or another neuromuscular or cerebral condition or disease other than traumatic brain injury; or the individual has four limbs absent due to disease, trauma, or congenital conditions.

Consumers qualified for the ADLS Waiver must meet nursing facility level of care. ADLS Waiver consumers have the responsibility to self-direct their personal attendant care.

Family Support 360 Waiver – this waiver is operated by the Department of Human Services, Division of Developmental Disabilities, with administrative oversight by the Department of Social Services. This waiver was also renewed by CMS on June 1, 2012. The Family Support 360 Waiver targets Individuals with an intellectual disability and/or a developmental disability of any age and offers participants the opportunity to self-direct some or all of their services. Consumers are children living with natural, adopted, step-families or relatives who act in a parental capacity; adults living independently in the community; or adults living with a family member, legal guardian, or advocate. These individuals meet must ICF/ID Level of Care.

CHOICES Waiver – this waiver is operated by the Department of Human Services, Division of Developmental Disabilities, with administrative oversight by the Department of Social Services. The CHOICES Waiver serves individuals of any age with ID and/or DD. Individuals on the CHOICES Waiver must meet ICF/ID Level of Care. This waiver is due for renewal on June 1, 2013.

The services associated with each of the four 1915(c) HCBS Waivers are listed in Exhibit 13 in B.5 Benefits and Services.

The state is continually looking for ways to best serve consumers and provide a wide array of choices and opportunities for long term supports and services. During the 2011 Legislative Session, South Dakota Governor Dennis Daugaard established the Medicaid Solutions Work Group. The Medicaid Solutions Work Group was charged with examining the status of Medicaid in South Dakota and developing a series of recommendations for improvement and cost-efficiency. The Medicaid Solutions Work Group's Final Report was released in November 2011 and included eleven formal recommendations. Three of the Medicaid Solutions Work Group's recommendations stemmed from the Home and Community Based Services (HCBS) Subcommittee:

1. Evaluate implementation of the Community First Choice Option (1915(k);
2. Evaluate the Agency Model Domiciliary Care Initiative; and
3. Evaluate the Money Follows the Person option.

By completing the third recommendation and formally implementing a Money Follows the Person rebalancing demonstration project, the state will further display its intentions to expand home and community based services and provide services to consumers where they want to live.

b. Administrative Structure

The Department of Social Services (DSS) is the South Dakota State Medicaid Agency and has the overall responsibility for the MFP rebalancing demonstration. Within DSS, the Division of Medical Services is responsible for the administration of the Medicaid program and is led by the State Medicaid Director. The Division of Medical Services will be the lead entity for the MFP Rebalancing Demonstration and the State Medicaid Director will have direct line supervision for the MFP Demonstration Coordinator (Project Director).

The search for a permanent, full-time MFP Demonstration Coordinator will begin in spring 2013. The FTE request is a component of the Department of Social Services' SFY2014 budget request and was approved during the 2013 Legislative Session. The MFP Demonstration Coordinator will be responsible for general project administration, including data collection, analysis, and reporting to CMS. A job description for the MFP Demonstration Coordinator is included in Appendix C.

The Division of Adult Services and Aging (ASA) is the State Unit on Aging and, as such, will play a significant role in the implementation and service provision of MFP. ASA is home to South Dakota's Aging and Disability Resource Centers (ADRC), the 1915(c) HCBS Waiver serving the elderly and those with a qualifying disability, and the Long-Term Care Ombudsman.

Given the significant opportunities for coordination between MFP and the ADRC, the state aims to integrate activities of the two in order to more effectively and efficiently serve MFP participants. Integration is expected to be complete by the end of CY2014. Measurement of progress toward integration will be based on completion of the following activities:

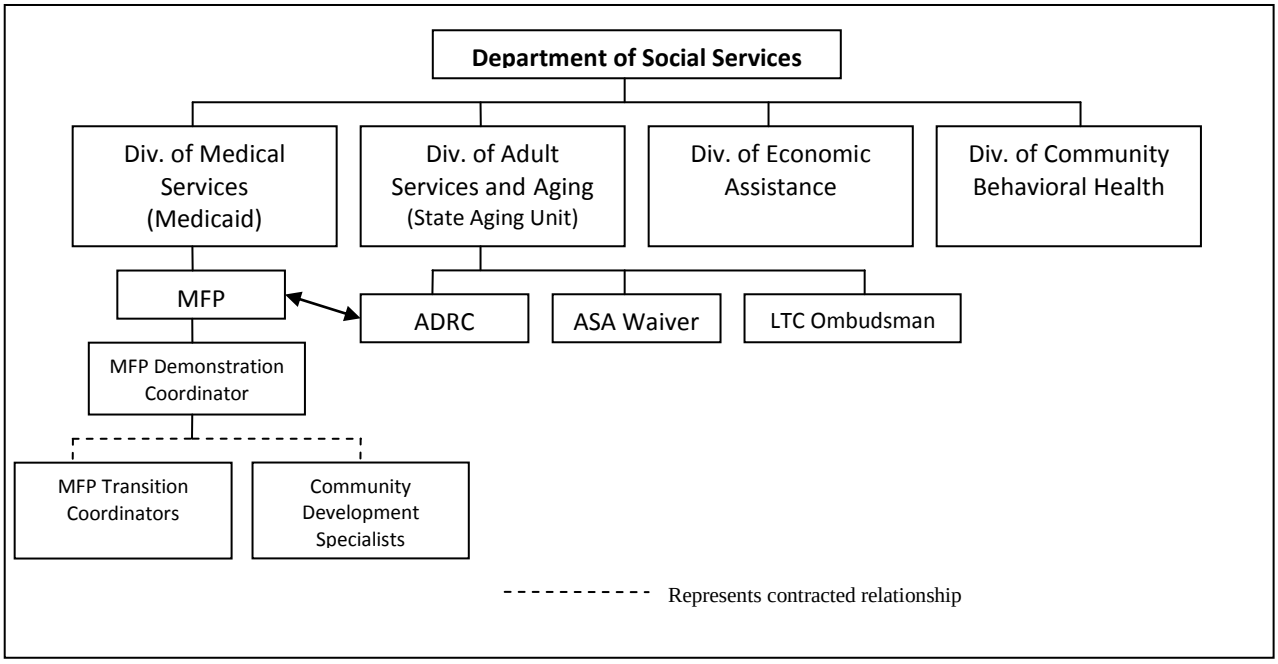
Exhibit 2: MFP/ADRC Integration activities

MFP/ADRC Integration activities
• 100% of ASA and ADRC staff are trained on Money Follows the Person
• MFP referrals received by the ADRC are tracked according to outcome -- Participation in MFP -- Voluntarily declined MFP, but received other services through the ADRC -- Received Options Counseling -- Provided information and referral
• MFP is added to list of service options in ADRC materials and on ADRC Resource Directory
• Use of SAMS participant database, in use to track consumer activities through the ADRC, to manage MFP participant activities.
• Integration with ADRC Options Counseling

Additionally, the Division of Economic Assistance and the Division of Community Behavioral Health are housed within DSS. The Division of Economic Assistance will be responsible for determining Medicaid eligibility for MFP participants, and the Division of Community Behavioral Health, through its contracted providers – the Community Mental Health Centers – will help provide training and resources to MFP participants and the HCBS providers who support them in the community.

The Office of Finance, which encompasses the Office of Provider Reimbursements and Audits, will provide financial management and reporting support to the MFP rebalancing demonstration.

Exhibit 3: Administrative Structure

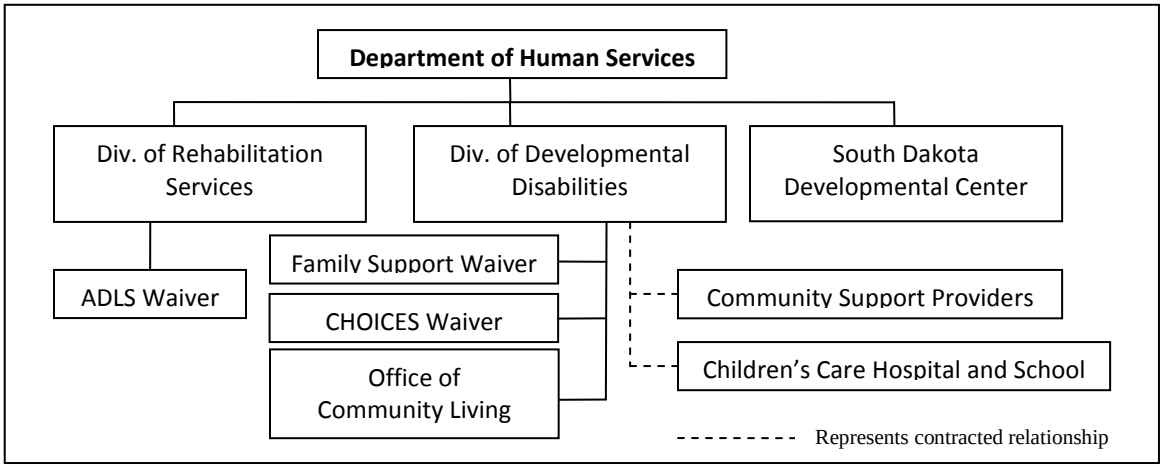


Although the South Dakota MFP rebalancing demonstration will be led by the Department of Social Services, DSS will work collaboratively with the Department of Human Services to ensure inclusion of all eligible participants. The Department of Human Services (DHS) is home to the Division of Developmental Disabilities, the Division of Rehabilitation Services, the Office for Community Living, and the state's only public ICF/ID, the South Dakota Developmental Center (SDDC).

The DHS also has a contract with the Children's Care Hospital and School (CCHS), a private ICF/ID providing a broad continuum of healthcare and educational services for children from birth through age 21. Youth from CCHS age 18 and over will be able to participate in MFP if they meet all eligibility criteria.

DHS will play a significant role in MFP, both as a source of referrals and as a source of services for participants who are developmentally disabled and those who have quadriplegia. While a limited number of referrals are expected to be generated directly by the Division of Developmental Disabilities or the Division of Rehabilitation Services, it is expected that referrals will come directly from the institutions – the SDDC and CCHS. When a referral is received by MFP and the participant is identified as a person who would benefit from the services and/or waivers managed by the DHS, the appropriate DHS staff will be engaged on the Transition Team.

Exhibit 4: Department of Human Services (*in relation to MFP*)



There are a number of existing Memoranda of Understanding (MOU) between the two Departments. If it is determined a MOU is needed to distinguish the role of each agency in the MFP rebalancing demonstration, one will be established. By working collaboratively, the Departments of Social Services and Human Services can ensure successful transitions to community settings for participants with a variety of backgrounds and needs.

A.2 Benchmarks

Five benchmarks will be measured to assess South Dakota's progress in transitioning individuals to the community and rebalancing its long-term care system. The five benchmarks, two required by CMS and three proposed by South Dakota, will be measured though data collection and analysis on an annual, calendar year basis. The MFP Demonstration Coordinator will be responsible for the data collection, analysis, and reporting.

Benchmark 1 (required) – Meet the projected number of eligible individuals transitioned into each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.

Exhibit 5 presents the projected numbers of MFP-eligible individuals (by target group) who will be assisted to transition to qualified residences in each calendar year of the demonstration. Benchmark 1 will be measured by assessing the number of unduplicated participants projected to transition in each target group during the calendar year against the number of unduplicated participants projected to transition in the same time frame.

Exhibit 5: Projection of MFP participants

Calendar Year	Older Adults (65 and over)	MR/DD	Physically Disabled	Total per year
CY 2013	0	0	0	0
CY 2014	6	5	0	11
CY 2015	8	6	6	20
CY 2016	12	10	12	34
CY 2017	10	10	10	30
CY 2018	9	8	8	25
Total per category	45	39	36	120

The older adults and majority of the physically disabled population will be served by the ASA Waiver, with a small percentage of the physically disabled likely to be eligible for the ADLS Waiver. The ID/DD population is most likely to be served by the CHOICES Waiver.

No transitions are projected to be completed in CY2012 as it is anticipated that it will take the remainder of CY2012 to conduct the implementation activities

Benchmark 2 (required) – Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.

Exhibit 6: HCBS spending

Calendar Year	HCBS Spending
CY2011	$113,427,828
CY2012	$118,154,676
CY2013	$123.158,780
CY2014	$125,937,806
CY2015	$130,093,754
CY2016	$133,996,567
CY 2017	$138,016,464

The actual expenditures and projected expenditures in Exhibit 6 comprise the spending and anticipated spending for home and community based services provided through four 1915(c) waivers and Personal Care State Plan services.

Benchmark 3 (optional) – Annual increase in the percentage of MFP participants that remain in the community for at least one year following transition.

South Dakota aims, through its MFP Demonstration Project, to conduct meaningful, long-term transitions through the broad-focused coordination of supports and services the participant needs to remain successfully in the community. This benchmark will be measured by calculating, annually, the percentage of transitioned participants who remain in the community for at least one year following transition against the total number of participants transitioned. The state has set a benchmark of 75 percent for those who transition during CY2013 (measured in CY2014) and will seek to annually increase the percentage through its continuous quality improvement processes. This will allow the state to implement improvements to the MFP

transition process in order to provide more effective opportunities for long-term community placement to participants.

Exhibit 7: Percent of MFP participants who remain in the community for at least one year following transition:

Transition during Calendar Year	Percent remaining in community at least one year
CY2013	75%
CY2014	80%
CY2015	82%
CY2016	84%

<u>Benchmark 4 (optional)</u> – Annual increase in the percentage of MFP participants who receive help by another person feel their helper(s) treats them the way they want to be treated.

Many variables factor into success of a transition. One of the most important factors is the satisfaction of the individual who has transitioned from institutional living to the community. If the participant feels that he/she is being treated with the respect and dignity expected, he/she will be more satisfied. As a result, the participant and their natural supports are more likely to take the steps needed to remain in the community versus returning to the institution. This, in turn, supports the goal of rebalancing long-term supports and services.

Data used to measure Benchmark 4 will be collected from Question 22 on the 11 month and 24 month MFP Quality of Life surveys. The numerator will be the number of participants who respond "yes" to Question 22 and the denominator will be the total number of survey respondents who responded "yes" and "no".

Exhibit 8: Percent of MFP participants who feel their helper(s) treat them the way they want to be treated

Calendar Year	Percent who feel they are treated well
CY2013	n/a

CY2014	80%
CY2015	82%
CY2016	84%

The state proposes in Benchmark 5 to expand the training those working in long term supports and services receive. Curriculum development will include a focus on person-centered care and service provision. As the training reaches a broader audience, it is expected that a higher percentage of participants will feel they are treated the way they want to be treated. Additionally, data analysis will demonstrate any patterns in "no" responses that will help the program provide targeted education and assistance.

<u>Benchmark 5 (optional)</u> – Implementation of a training structure that results in an annual increase by 10 percentage points in the percent of HCBS and LTC work force who receive training on long term supports and services (LTSS) topics.

Through the MFP Demonstration project, the state aims to harness the broad base of expertise amongst HCBS, LTC, and other LTSS stakeholders, including state programs and staff, by more fully coordinating the training opportunities provided in each to reach a wider audience. This would be done, in part, by building integration of training already occurring through the HCBS waivers, ADRC, Long Term Care Ombudsman program and the Department of Human Services' Office of Community Living with training needs of the work force and provider agencies. Development of the model will begin by completing a needs assessment. The needs assessment will analyze the needs for training among the providers serving the MFP participant populations, as well as the corresponding expertise existing within provider groups, including nursing facilities, the SDDC, and other institutions from which participants are transitioned and the state. The assessment will also gauge the expanse of the LTSS workforce in South Dakota

and the current contractual training requirements for each position type so training provided through this model is not duplicative.

The model will allow for a building of expertise in a number of critical HCBS and LTSS topic areas across a wide variety of provider types. Given the State's small population and wide geographical area, this model will empower providers to build the capacity needed within their organization to effectively manage the diverse and extensive needs of MFP participants and other recipients of LTSS. This would, in part, be done by the curriculum development in CY2014 and ongoing. A complete list of curriculum to be developed will result from the needs assessment.

Measurement of Benchmark 5 will be conducted by assessing completion of the needs assessment and initial curriculum development. Then, in CY2015 and CY2016, the state will compare the total size of the LTSS work force with the number of people who received training in excess of their contractual requirements through increased coordination.

Exhibit 9: Percentage of LTSS work force receiving training in each calendar year

Calendar Year	Percentage
CY 2013	Needs assessment
CY 2014	Curriculum development
CY 2015	Roll-out – 30% trained
CY 2016	40% trained

Development and implementation of the provider-training-provider model will be completed as a result of the following activities, among others:

Exhibit 10: Training model development and implementation activities

Provider-Training-Provider Model development and implementation activities
• Assessment of provider-identified training needs
• Analyze expanse of LTTS workforce
• Assess current contractual training requirements
• Identification of provider-based expertise
• Identification of training mediums (in-person, web-based) appropriate for each subject matter
• Develop provider-expertise database
• Explore competency-based training opportunities
• Curriculum development
• Develop standard training evaluation with which to measure training effectiveness
• Establish connections between need and expertise

B. DEMONSTRATION IMPLEMENTATION POLICIES AND PROCEDURES

B.1 Participant Recruitment and Enrollment

Participation in South Dakota's MFP Demonstration Project will be open to any adult, age 18 or older, who meets the following eligibility criteria:

1. Is a South Dakota resident;
2. Has been residing in a nursing facility, ICF/ID or other qualifying institution for more than 90 consecutive days;
3. Meets Medicaid level of care and financial eligibility criteria at least one day prior to transition;
4. Has at least one paid Medicaid day in a qualified institution;
5. Will reside in qualified housing upon transition;
6. Is willing to enroll in and can be supported in the community through the provision of an existing 1915(c)HCBS waiver; and
7. Expresses a desire to live and receive services in a home and community based setting.

While all adults who meet the above criteria can participate in the South Dakota MFP rebalancing demonstration, during the first full calendar year the demonstration will conduct targeted outreach to residents who are under the age of 65 and physically disabled, who reside in a nursing facility or an acute care/rehabilitative settings. The reason for this targeting is two-fold. First, this population has historically expressed the strongest desire to move home and receive services in the community. Second, this population has a variety of needs that have, in the past, presented barriers to community living. The MFP rebalancing demonstration is an opportunity for the state and HCBS providers to build the infrastructure needed to successfully

support this population in the community. A Letter of Endorsement from the South Dakota Health Care Association, an association representing nursing facilities statewide, voices its support for this initial targeting. This targeted outreach does not exclude others who meet the eligibility criteria from participating.

The state anticipates identifying service providers just as it identifies providers of home and community based waiver services. The process varies given the HCBS waiver and target population, but MFP will benefit from long-standing state-provider relationships that have been in place, in some cases, for decades. The state will work hand in hand with a wide variety of community-based provider organizations, agencies and associations. The South Dakota Centers for Independent Living have been engaged in the MFP planning process and will continue to be instrumental in MFP given their wealth of knowledge in both supporting people in the community and facilitating institution to community transitions.

As noted above, any person who meets the eligibility criteria can participate in MFP. Initially the state will conduct targeted outreach to individuals under 65 with a physical disability residing in nursing facilities or acute care/rehabilitative settings. The state will use several methods to identify the target population who may benefit from the MFP Demonstration.

1. Long-Term Care Ombudsman – the South Dakota Long-Term Care Ombudsman Program is located within the Division of Adult Services and Aging. The program provides education, support, and training to nursing facilities across the state. The state's current Long-Term Care Ombudsman has visited every nursing facility in South Dakota and has developed collaborative relationships with many administrators, staff, and residents. The MFP Demonstration Coordinator and Transition Coordinators will build upon these

relationships by accompanying the Long-Term Care Ombudsman on facility visits to present MFP, its goals, and its process. The Long-Term Care Ombudsman will also be fully versed in MFP and will include it in the informational sessions and training provided on a regular basis. Training provided by the Long-Term Care Ombudsman will be measured in Benchmark 5.

2. Minimum Data Set (MDS) Section Q – the Division of Adult Services and Aging is the lead contact agency for MDS Section Q. When a nursing facility resident indicates an interest in returning home, a referral will be made through the ADRC. The referral will be passed to the MFP Demonstration Coordinator.
3. Other MDS data – during the planning stages of developing the MFP OP, the Nurse Consultant Program Manager, located within the Division of Adult Services and Aging, reviewed MDS data for all nursing facility residents under the age 60. Through that analysis, a list of potential MFP participants was created. The Nurse Consultant Program Manager took into account primary diagnosis, age, length of time in facility, daily cares and Brief Interview for Mental Status (BIMS) score. Continuation of this kind of analysis – expanding parameters, broadening focus areas, and examining data for other groups of people – will help provide additional information regarding the nursing facility population, individual nursing facility residents, and how each may benefit from MFP.
4. Collaboration with nursing facilities – the state works very closely with long-term care providers serving Medicaid recipients. By educating the administration and staff of nursing facilities about the MFP Demonstration project and the potentially beneficial impact it could have on those who desire to transition, the state can build a referral

network from the nursing facilities to MFP. In this vein, the state included two nursing facility administrators on the HCBS Work Group involved in the planning process, while simultaneously engaging the SD Health Care Association, which represents nursing facilities. These discussions will continue as their membership is educated about MFP and they continue to recognize the critical role they play in the success of transitions.

5. Department of Human Services – in addition to those transitioning from nursing facilities, residents of the State's public ICF/ID and private ICF could be eligible for the MFP rebalancing demonstration. The South Dakota Developmental Center (SDDC) is home to approximately 140 residents at a given time. The SDDC currently provides transition services to residents. MFP will provide the supports and services currently unavailable to help ensure community transitions are successful in the short and long-term. The state also contracts with one private ICF – the Children's Care Hospital and School (CCHS) in Sioux Falls, SD. CCHS currently provides services to 50 South Dakota youth and 15 youth from out of state.

Marketing materials defining the MFP rebalancing demonstration, its eligibility criteria, and its goals will be developed and used to inform a wide variety of audiences, including potential participants. The materials will be designed with the audience in mind, providing large easy to read print, clear and concise information, as well as a variety of ways (i.e., phone, email, and website) to contact MFP staff. More detailed materials will be developed for those who request additional information, including a Frequently Asked Questions document and specifics about the HCBS available through MFP and the four 1915(c) HCBS waivers. Although no

materials have been developed at this time, materials developed will be shared with CMS for review prior to use and included as in the OP appendices.

The state will distribute recruitment and enrollment materials as widely as possible, using existing relationships with provider agencies, the Long-Term Care Ombudsman program, the Office of Community Living, and nursing facilities. The Transition Coordinators and Community Development Specialists will participate in the distribution of materials.

Over the period of the MFP Demonstration project, participants will be primarily transitioning from nursing facilities and the South Dakota Developmental Center. It is, however, possible that transitions could also occur from a hospital setting. The state is not limiting MFP to a specific population and will, therefore, provide opportunities for transition to any person who meets the eligibility criteria.

Patients in a hospital setting may be identified by the Medicaid nurse consultants who follow inpatient stays of 6 days or more and provide support to the hospital throughout discharge planning. While very few inpatient hospital stays become stays of 90 days or more, there are unique, isolated situations in which MFP could be utilized to help a patient transition from a hospital inpatient stay back into the community. This may include transitions of South Dakota residents who are receiving care in out-of-state hospitals or other acute care settings.

South Dakota will target individuals who have been residing in a qualified institutional facility for 90 or more consecutive days, not including the period of time the individual may have been admitted solely for purposes of receiving short-term rehabilitative services. The MFP Demonstration Coordinator and/or the Transition Coordinator assigned to the potential

participant will be responsible for verifying the length of stay and eligibility for each potential participant, as well as other eligibility criteria.

The Medicaid eligibility of the potential MFP participant will be determined by the Division of Economic Assistance, housed within the Department of Social Services. The Division of Economic Assistance determines eligibility for all Medicaid and 1915(c) HCBS Waiver participants. The determination will be requested by the potential participant, with help from the Transition Coordinator or the MFP Demonstration Coordinator, in the early stages of transition planning. If, at a later time, there is a question about a participant's continued eligibility, the Transition Coordinator will request an eligibility review. Medicaid recipients are required to submit information documenting any change in financial status. In the absence of such documentation, Medicaid eligibility is re-determined annually.

The process for determining that the provision of HCBS to a participant will enable them to transition from a qualified institution will be managed by the Transition Coordinator and the Transition Team. Upon referral, the MFP Demonstration Coordinator will assign a Transition Coordinator to work with the potential participant. The Transition Coordinator will meet with the potential participant and the participant's guardian or other representative as appropriate, and conduct an Initial Interview to begin to verify that the individual meets the eligibility criteria or will meet eligibility criteria prior to actual transition. The Initial Interview will follow a standard format and will gather details that will help the Transition Coordinator and participant identify next steps. The Initial Interview will guide the participant through a series of questions that will enable the Transition Coordinator to gather important details about the individual's institutionalization, desired place to live, and potential barriers to transition during

this initial meeting. Based on the outcome of the Initial Interview, the Transition Coordinator will work with the participant to assemble a Transition Team. The Transition Team will be comprised, initially, of the Transition Coordinator, the participant, a representative of the institution the participant will transition from, and, whenever possible, at least one natural support identified by the participant. The Transition Team will expand as transition planning continues and may grow to include a Community Development Specialist, a physician or other medical professional, a behavioral health specialist, and the HCBS providers who will support the participant in the community post-transition. This Transition Team will be partially responsible for ongoing assessment of the participant's capacity to succeed in the community through the provision of HCBS in lieu of the services provided in the institution.

In order to participate in MFP, the participants must be willing to enroll in and be supported in the community through the provision of an existing 1915(c) HCBS waiver, in addition to demonstration services available only for the first 365 days. Therefore, the ensuing assessment process will closely resemble the process for determining level of care for the HCBS waivers. The process will vary depending on the HCBS waiver the participant will utilize and will be informed by the input from the Transition Team. The level of care determination processes for each HCBS waiver is as follows:

ASA Waiver – Participants transitioning from nursing facilities are most likely to be served by the HCBS waiver managed by the Division of Adult Services and Aging (ASA). In this case, an ASA Specialist would participate on the Transition Team. The standard assessment used to evaluate the needs of all ASA consumers receiving hands-on care in their homes would be used to assess potential MFP participants that would most benefit from the ASA waiver for their

qualified services. The Community Health Assessment (CHA) was developed by InterRAI, an international collaborative to improve the quality of life of vulnerable persons through a seamless comprehensive assessment system. The CHA, coupled with a Physician's Report/Order, are evaluated by an objective Medical Review Team to determine level of care.

ADLS Waiver – The Transition Teams for those participants most appropriate for the ADLS Waiver will include a provider case manager and the Division of Rehabilitative Services (DRS) Program Specialist. The DRS utilization review team (URT) conducts the initial level of care evaluation. The URT consists of a provider case manager and the DRS Program Specialist who has a minimum of 2 years experience working with individuals with disabilities. The ADLS Assessment is the primary instrument used to determine level of care. The assessment gathers information that will be used by the URT team to determine if the participant meets or continues to meet the waiver and program requirements. Also assessed is the individual's ability to manage and self direct their personal attendant services.

The first portion of the assessment asks the individual a series of questions that gathers information that is used to determine their ability to manage and self direct their services. Other information taken into account may be a social history and natural supports available to the individual.

The second portion assesses the individual's physical functional status such as eating, bathing, grooming, dressing, transferring, bladder/bowel, managing money, telephone use, preparing meals, laundry, housework, activities outside the home, routine health activities, special health activities, and their ability to be alone. The assessment also includes a medication list, and personal goals the individual would like to achieve. It also includes information on medical

services and other supportive services the individual needs or is currently utilizing. Other sections of the assessment include the participant rights/fair hearing/freedom of choice form, and the personal attendant service plan.

Family Support 360 Waiver and CHOICES Waiver – The Level of Care determination processes for these two waivers are nearly identical. The Transition Team for an individual identified as benefiting from Family Support 360 Waiver or CHOICES Waiver would include a Division of Developmental Disabilities Qualified Mental Retardation Professional (QMRP) and/or other qualified Division of Developmental Disabilities staff. The criteria for entrance into an ICF-IID are as follows:

- The individual must be developmentally disabled and;
- Following review, the utilization review team has approved the individual's eligibility.

Level of care criteria used to evaluate whether an individual needs HCBS waiver services are:

- Inventory for Client and Agency Planning (ICAP) eligibility with a minimum of 3 functional limitations;
- Service Plan;
- Psychological or psycho educational evaluation

By mirroring the level of care processes already present in the HCBS waivers, the Transition Teams can be assured that the participant both qualifies for the HCBS waiver and can be supported in a community setting through the provision of participant-centered services.

The South Dakota MFP demonstration project will mirror its policy and procedures on reenrolling a participant after the participant is readmitted to an institution both during and after the participant's demonstration period on MFP Policy Guidance. If, during the

participant's demonstration period, he/she is readmitted to an inpatient facility for a period of 30 days or less, the individual will remain enrolled in MFP. If the institutional stay is more than 30 days, the MFP program will reenroll the participant without re-establishing the 90-day institutional residency requirement.

If, after a MFP participant completes 12 months of demonstration services, the participant is readmitted to an institution, that participant could become a candidate for another 12 months of demonstration services. During the second transition planning process, the Transition Coordinator and Transition Team, including the participant and natural supports, would evaluate the circumstances leading to the re-institutionalization and reassess the participant's ability to remain in the community. The Transition Team would also identify what, if any, additional services could be implemented to reduce the factors that previously led to the unsuccessful community placement.

To prevent future readmission to the institution, the Transition Coordinator would work closely with the Transition Team to establish ongoing communication with the participant and at least annual reassessment. The participant and/or representatives will play an active role in all conversations about returning to the community and other decisions. Ultimately, it is the choice of the participant and participants who want to live in the community and meet the eligibility criteria will be encouraged to do so.

The Transition Coordinators, supported by the MFP Demonstration Coordinator, will be responsible for ensuring MFP participants and their family members have the requisite information to make informed choices about supports and services. Self-advocacy will begin upon referral when the Transition Coordinator meets with the potential participant to conduct

the Initial Interview and discuss development of the Transition Team. At that time, the Transition Coordinator will begin sharing information about demonstration services, home and community based waiver services, and other supports available in the community where the participant desires to live.

As the transition planning progresses, each member of the Transition Team will play a role in training – by either training another provider or training the participant and family. The cross-sector provider–training–provider model (Benchmark 5) will be accessed as needed throughout the transition process. Additionally, South Dakota has proposed Consumer Preparation as a demonstration service, providing the Transition Coordinator and Transition Team flexibility in identifying the types of education and knowledge building the participant requires to achieve a sustainable transition. Consumer Preparation is defined in Section B.5 Benefits and Services. Training will be provided throughout the transition process and during first 365-days post-transition. The Transition Coordinator and Transition Team will continue to be actively involved in the participant's life, at established intervals and through methods determined by the participant with the input of the Transition Team, ensuring the participant has the ongoing supports and information needed to remain in the community beyond the 365-day demonstration period.

B.2 Informed Consent and Guardianship

All participants (or as appropriate, family members or guardians) will be required to sign an Informed Consent form (Appendix A) to enroll in South Dakota's MFP rebalancing demonstration program. By signing the Informed Consent, participants acknowledge that they have voluntarily chosen to participate, are aware of the eligibility requirements, have been informed about all aspects of the transition process, have full knowledge of the services and supports to be provided during the demonstration year and thereafter, are aware of the waiver requirements and were informed of their rights and responsibilities as a participant in the demonstration program.

All interested parties will be provided with an MFP Transition packet of information, which will include a (1) Cover Letter, including MFP contact information; (2) Informed Consent form; (3) Brochure/FAQ Sheet; (4) Eligibility criteria; and (5) Information about the 1915(c) Waivers. The information listed above will be developed as part of the Outreach and Marketing strategy by the MFP Demonstration Coordinator, in collaboration with the DSS Communications Director, the ADRC Project Director, and others. The packets will be provided in person whenever possible. If the applicant requests that the packet be mailed, follow-up contact will be made after the informational materials are sent to schedule an in-person meeting that may include the Initial Interview. The transition packets may also be distributed by the Long-Term Care Ombudsman, SDDC, CCHS or DHS staff. In the event one of these entities provides the packet during a facility visit, a request for permission to share the individual's name and contact information with the Demonstration Coordinator for follow-up will be made.

The Transition Coordinator will thoroughly review the contents of the packet during the first in-person informational transition meeting with a potential participant and his/her guardian and other natural supports. The meeting with the Transition Coordinator will provide an opportunity for specific dialogue focused on all aspects of the MFP process, including pre- and post-transition activities and the development of the Transition Team. The participant and/or guardian will also receive a clear explanation about their rights and responsibilities and procedures for incident reporting. The Transition Coordinator will answer questions and address concerns about the program.

Potential participants who are interested in transitioning to the community and who do not have a formal guardian or representative will sign the MFP Informed Consent Form. In the event the participant requires a representative to provide informed consent for the MFP demonstration, the consent for participation may be provided by the participant's family member, caregiver, a health care agent named in a health care power of attorney, an attorney-in-fact named in a durable power of attorney, or the legal representative or surrogate decision-maker who has responsibility for the individual's living arrangement. In situations where there is a legal representative/surrogate decision maker, the Transition Coordinator will review legal documentation to ensure the individual possesses the authority to make decisions dealing specifically with a participant's living arrangement and receipt of services/treatment.

When an MFP participant has a guardian, the Transition Coordinator will verify the guardian's appointment by either viewing the guardianship papers or by contacting the court system. The Transition Coordinator will require a guardian's signature on all forms and documents pertaining to the program participant.

Guardians will be invited to all transition meetings and other pertinent encounters with the participant. Guardian participation will be encouraged throughout the process. The Transition Coordinator will be responsible for educating the guardian about the MFP rebalancing demonstration and the pre- and post-transition processes and services. The guardian will be an integral member of the Transition Team and, as such, will play an important role in the education and support of the participant during the transition, for the 365-day demonstration period, and beyond. To remain in compliance with state statute, the guardian shall maintain sufficient contact with the participant to know of the participant's capabilities, limitations, needs, and opportunities. The guardian should encourage maximum self-reliance on the part of the person under guardianship and bring any potential concerns to the attention of the Transition Coordinator and to other Transition Team members, as applicable.

In South Dakota, it would be extremely rare for an institution or employee of the institution to be a resident's guardian. If a situation did arise, the Department of Social Services would institute a judicial review to ensure the individual's best interests are being considered in decision making.

B.3 Outreach/Marketing/Education

South Dakota believes that the outreach, marketing, and education strategies for the MFP rebalancing demonstration are critical elements for the success and duration of the program. The state will use a variety of methods to involve stakeholders, market the program, and educate participants and all who are interested in the demonstration. Outreach, marketing and education strategies will be conducted statewide. Upon award of the grant, the following steps will be taken to introduce the project, market to various groups and individuals, and provide the information on all aspects of the program:

- A press release will be distributed to all daily and weekly newspapers to announce the grant award, including a general description of the demonstration and its objectives;
- A MFP rebalancing demonstration website will be created within the structure of the DSS website. A link to the MFP website will be provided from the Department of Human Services' website. The website will provide access to the Operational Protocol, Transition packet, Informed Consent, eligibility criteria, informational materials, and success stories. The website will be updated on a regular basis. Once the provider-training-provider model is implemented, any training sessions provided via webinar will be recorded and posted on the website for future viewing;
- South Dakota will develop materials that meet the needs of the audience, taking into consideration language, format, and reading level. Additionally, South Dakota uses telephonic interpreter services to help staff meet the needs of those who do not speak English. This has been successful for South Dakota;

- The materials will be designed with the audience in mind, providing large easy to read print, clear and concise information, as well as a variety of ways (i.e., phone, email, and website) to contact MFP staff;
- Once hired, the MFP Demonstration Coordinator will work with the Department of Social Services' Communications Director to finalize development of a brochure, fact sheets, and Frequently Asked Questions document targeted to potential enrollees, nursing facilities, HCBS provider agencies, senior centers, hospitals, and other stakeholders. The brochure will contain information on MFP, the transition process, eligibility criteria, and contact information. The fact sheets will be targeted to specific audiences, providing information on the demonstration and home and community based waiver services that would most benefit the potential participant;
- The MFP Demonstration Coordinator will also work with the DSS Communications Director to pursue Public Service Announcements and paid advertising opportunities to promote the MFP rebalancing demonstration;
- The MFP Demonstration Coordinator will develop the Transition Packets to be distributed to potential participants;
- DSS will integrate the marketing materials into the Aging and Disability Resource Connections (ADRC), and provide training to the ADRC staff;
- The MFP Demonstration Coordinator will engage stakeholder agencies in the dissemination of information. It is anticipated that information about the MFP rebalancing demonstration will be included in provider newsletters, as a link on websites, and distributed amongst membership and staff;

- The MFP Demonstration Coordinator will also work with stakeholders to provide verbal or written presentations of MFP information at annual conferences, conventions, board meetings, and other gatherings to continually inform people about the MFP rebalancing demonstration. Organizations include AARP, the South Dakota Association of Healthcare Organizations, the South Dakota Health Care Association, the Community Support Providers of South Dakota, and the SD Council of Mental health Centers, among others.
- Once contracts are put in place with the MFP Transition Coordinators they will be responsible for making regular contact with nursing facility administrators and residents, centers for independent living, community-based service providers, and others to obtain information and promote MFP;
- The Transition Coordinators will also conduct focus groups/informational meetings for potential participants, family members, and service providers on an ongoing basis to educate people on the MFP rebalancing demonstration;
- The MFP Demonstration Coordinator will begin working on development of the provider training collaborative. Through development activities, the MFP Demonstration Coordinator will provide information about MFP and the variety of ways stakeholders can participate in its success, including the provision of training to the LTSS work force;
- The Department of Social Services will form an MFP Advisory Group. The group will be updated on MFP implementation development and continuous quality improvement activities, including progress towards the achieving the Benchmarks. Those meetings will also be used to solicit feedback and gain input;

- The MFP Demonstration Coordinator will collaborate with the primary state agencies (DSS and DHS) to train non-MFP staff on the MFP rebalancing demonstration. This type of information sharing will allow all staff to provide accurate information to the public upon request.
- Staff within the Department of Social Services and Department of Human Services who will use MFP outreach materials to engage potential participants and/or their representatives will be provided training prior to doing so. In addition to reviewing the MFP Operational Protocol and all project materials, the training will include the purpose and benchmarks of the MFP program, information about the tools that will be used by staff in administering the program, and the rights and responsibilities of Medicaid recipients and MFP participants.

B.4 Stakeholder Involvement

Stakeholder involvement and input into the MFP rebalancing demonstration are crucial to the success of transitions. As noted in Section A.1, during the 2011 Legislative Session South Dakota Governor Dennis Daugaard established the Medicaid Solutions Work Group. The Medicaid Solutions Work Group was stakeholder driven and charged with examining the status of Medicaid in South Dakota and developing a series of recommendations for improvement and cost efficiency. One of the group's formal recommendations was to evaluate the Money Follows the Person Option. The state applied for and was awarded a MFP Planning Grant in April 2012.

In May 2012, the first meeting of the HCBS Work Group was convened. This group was formed to evaluate the HCBS recommendations of the Medicaid Solutions Work Group. The group is comprised of staff from the Department of Social Services, the Department of Human Services, a state legislator, and HCBS providers and consumers. The HCBS Work Group focused its May and July 2012 meetings on Money Follows the Person planning activities, providing input on target population, barriers, benchmarks, benefits and services, self-direction, and transition processes already occurring in the state. The HCBS Work Group ended its work in September 2012.

In addition to discussing MFP protocols and processes, members of the HCBS Work Group identified important players to engage during both the planning and implementation stages of the demonstration.

The Department of Social Services will form an MFP Advisory Group to support and inform the work of the rebalancing demonstration during the demonstration period. The group will

consist of HCBS and other long term supports and services providers, Staff of the Departments of Social Services and Human Services, MFP participants and/or family members, advocacy groups, and other interested parties. The work of the MFP Advisory Group will be three-fold. First, the group will provide technical assistance, guidance, and feedback during the development, implementation and continuous quality improvement phases of the policies and procedures. Second, the group will help address barriers to successful transition, most importantly adequate housing and HCBS delivery in rural areas among others. Finally, the group will review data and data analysis to help identify trends, determine effectiveness, and recommend change as needed.

During the planning period, a number of meetings were held with stakeholders separate from the HCBS Work Group to gain additional support and input. These stakeholders helped identify barriers and possible resolutions, the supports lacking in community settings – both for consumers and for providers, and how stakeholders should be involved in every stage of the demonstration. Exhibit 11 identifies the stakeholders, public and private, who have been engaged in the conversation about MFP.

Exhibit 11: MFP Stakeholders

Public Stakeholders	Letter of Support
Department of Social Services	(applying agency)
Division of Adult Services and Aging	(Division of applying agency)
SD Long-Term Care Ombudsman	X
Division of Economic Assistance	(Division of applying agency)
Division of Medical Services	(Division of applying agency)
Department of Human Services	X
Division of Developmental Disabilities	X
Division of Rehabilitative Services	X

SD Developmental Center	X
State Senator Jean Hunhoff, Chair, Health and Human Services Committee	X

Private Stakeholders	Letter of Support
Ability Building Services	X
Black Hills Works	X
Consumers/Family members	
Good Samaritan Society	X
Independent Living Choices	X
Lutheran Social Services	X
Sioux Falls Housing and Redevelopment Commission	X
SD Association of Healthcare Organizations	X
SD Coalition of Citizens with Disabilities	X
SD Council of Mental Health Centers	X
SD Health Care Association	X
SD Housing Development Authority	X
USDA Rural Development	X
Volunteers of America	X
Westhills Village	X

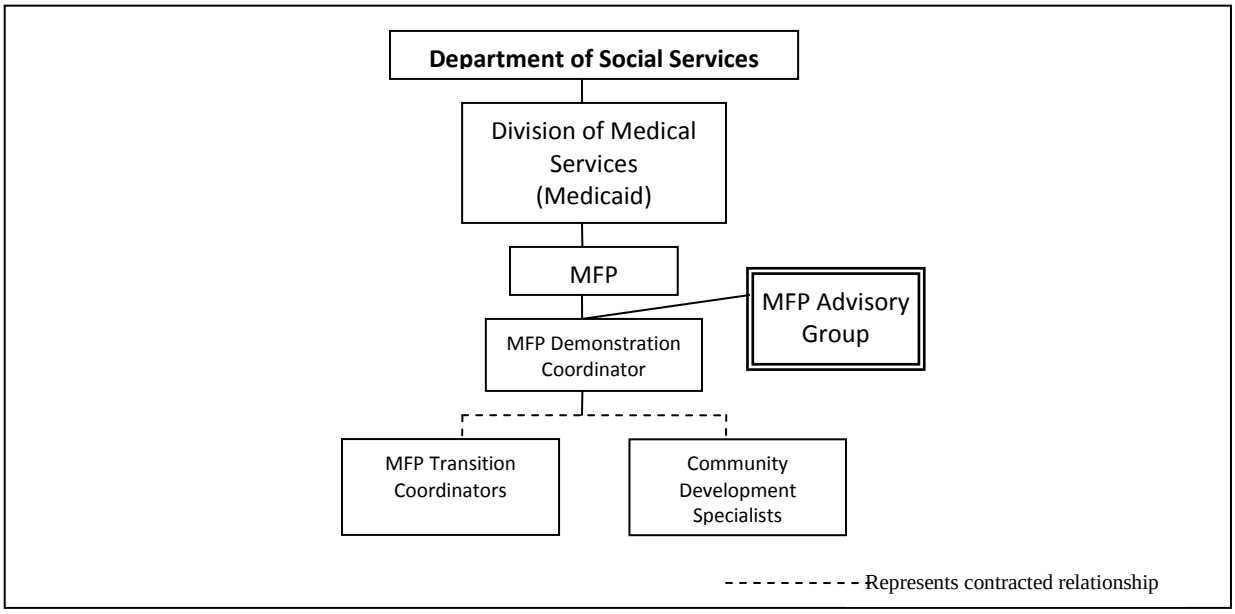
It should also be noted that South Dakota's ADRC has a statewide work group that is engaged in discussions about ADRC implementation, improvement, and expansion. As part of the efforts to integrate the MFP and ADRC, this group – as well as others related to the ADRC – will receive information about MFP and be asked to provide input.

In addition to involving institutional and community-based providers in the planning discussions, the state reached out to individuals who had already transitioned from an institution themselves, as well as to current residents of institutions. Conversations took place in the consumer's place of residence and revolved around the consumer's transition experience or the expected experience should transition be chosen. These conversations solidified the

need for a number of the services that had been identified by the provider stakeholders and allowed the state to gauge the reaction of institutional residents to a program like MFP. Stakeholder involvement will continue to play a significant role in MFP throughout the implementation and demonstration periods.

Exhibit 12 demonstrates how the MFP Advisory Group is connected to the organizational structure of the rebalancing demonstration project.

Exhibit 12: Stakeholder relation to organizational structure



B.5 Benefits and Services

South Dakota's MFP rebalancing demonstration participants will be enrolled in one of the current 1915(c) HCBS Waivers. In two of the four waivers, payment for waiver services is made using a fee-for-service model that will continue to be used for the MFP rebalancing demonstration. The CHOICES waiver has a comprehensive service based rate that it pays to Community Support Providers to develop comprehensive care plans that integrate the waiver elements the participant needs. Two of the four waivers offer participants the opportunity to self-direct components of their services.

The provider network for the MFP demonstration will very closely resemble the provider networks currently in place to support HCBS waiver participants. As a small state, South Dakota is uniquely positioned to conduct regular, ongoing communication within its network of HCBS providers.

Waiver services are provided by external service providers that enroll to provide waiver services through the Medicaid Provider Enrollment system. All agency and organization providers submit a signed Provider Agreement and complete all additional enrollment activities as specified in Appendix C: Participant Services of Version 3.5 of the 1915(c) HCBA Waiver application.

Services provided by the CHOICES waiver are primarily provided through Community Support Providers (CSPs). The nineteen CSPs located across the state are certified by the Division of Developmental Disabilities and provide services to over 3,000 people in a variety of settings. Providers remain certified by compliance with Administrative Rules of South Dakota reviews conducted by the Division of Developmental Disabilities and remain accredited by the Council

on Quality and Leadership for quality assurance accreditation.

CSPs provide services which may include residential, vocational, service coordination, and nursing care. CSPs provide support to consumers that ranges from 24/7 monitoring to minimal check-ins. These supports are provided for those who are living on their own or are working toward that goal, as well as those living with others. Vocational opportunities may include day habilitation, pre-vocational training, and/or supported employment to participants.

Participants of the Family Support 360 waiver purchase their services via community resources and hire their own providers.

The ASA Waiver works with a wide variety of providers to serve its participants. Providers include senior centers, private and hospital-based in-home service providers, Durable Medical Equipment suppliers, senior meals providers, and others. In addition to the Medicaid provider enrollment process, providers of in-home services through the ASA waiver must submit a Provider Self-Assessment annually.

The ADLS waiver allows for the provision of services by a legally responsible individual, including a spouse, parent, or adult child. The individual must be employed by a provider agency and meet all of the qualifications and training requirements for a personal attendant. A legally responsible individual must also adhere to the approved service plan. The case manager is responsible for ensuring that the services provided by a legally responsible individual constitute extraordinary care not typically provided by a spouse, parent or adult child. If a MFP participant was eligible for and elected to receive services through the ADLS waiver, he/she would be able to identify a legally responsible individual to provide personal attendant services.

In all other cases, the participant will choose a service provider from a list of options in their community.

Upon termination of the demonstration period, individuals will continue to receive qualified HCBS through a HCBS Waiver as long as the eligibility requirements of the waiver are met. Pursuant to the terms and conditions of the grant, MFP demonstration services will not be available after the 365-day demonstration period. South Dakota is not proposing to offer any supplemental services as part of the MFP demonstration.

Qualified Services:

Under the HCBS waivers, fee-for-service providers, Community Support Providers, and individuals acting under the consumer/surrogate direction option provide the home and community-based services authorized under the participant's care plan. This same system will be in effect for the MFP rebalancing demonstration. Claims from providers will be submitted and reimbursed by the state's MMIS payment system in accordance with requirements and fee schedules in effect for each service.

A participant's qualified services will vary according to the waiver the consumer enters. A list of services available through each of South Dakota's four waivers is in Exhibit 13. The state does not propose to add any additional Qualified HCBS as part of the MFP rebalancing demonstration.

Exhibit 13: South Dakota 1915(c) Waiver Services

ASA Waiver:

Adult Day Services
Homemaker
Personal Care
Respite Care
Specialized Medical Equipment
Specialized Medical Supplies
Adult Companion Services
Assisted Living
Environmental Accessibility Adaptations
In-Home Nursing Services
Meals and Nutritional Supplements
Personal Emergency Response System (PERS)

Assisted Daily Living Services (ADLS) Waiver:

Case Management
Personal Attendant Care
Ancillary Services - emergency response devices
Ancillary Services - Private Duty Nursing
Consumer Preparation Specialist Services
Specialized Medical Supplies

Family Support 360 Waiver:

Personal Care
Respite
Support Coordination
Supported Employment
Personal Care 2
Companion Care
Environmental accessibility adaptations
Nutritional Supplements
Specialized Medical Adaptive Equipment and Supplies
Vehicle Modification

CHOICES Waiver:

Day Habilitation
Prevocational Services
Residential Habilitation
Service Coordination
Supported Employment
Medical Equipment and Drugs
Nursing
Other Medically Related Services - Speech, Hearing & Language

Demonstration Services:

South Dakota will introduce five demonstration services to be in place during the 365-days immediately following transition only.

Transition Services will be available to individuals who are moving from a qualifying institution to a community setting or other qualified residence where the participant is directly responsible for his/her own living expenses. Transition Services funding will be broken into two components and each will be available to participants one-time only. This funding must be accessed within 90 days of the first day of transition.

- The first component of Transition Services will be funding to help a participant secure housing. This will primarily take the form of a security deposit and/or a utility deposit and will be limited to a one-time payment up to $1,000.
- The second component of Transition Services is the household items a participant may need to live successfully in their own residence. This could include items such as furniture, bedding, and kitchen supplies. This component is limited to a one-time payment up to $1,500.

Sound judgment will be used when approving services to ensure purchases are modest and reasonable.

Non-Medical Transportation Services shall include, but is not limited to, transportation between the participant's home and non-medical services or resources as defined in the participant's transition plan. Examples include shopping, dentist appointments, counseling sessions, and adult day care. Transportation can be provided by a taxi, public transit, or other

provider of transportation depending on available community resources. This service is limited to $500 per participant.

Consumer Preparation Services are available in one of the state's HCBS waivers, but the state will introduce it as a demonstration service to be used in concert with the other three waivers. Consumer Preparation Services covered during the demonstration may include:

(1) Instructing participants in the methods of identifying personal needs and effectively communicating those needs to the appropriate service provider;

(2) Instructing the participant in personal health maintenance tasks;

(3) Instructing the participant on the appropriate personal and professional relationships to be maintained by the participant and the participant's service providers;

(4) Instructing the participant in safety measures, abuse and neglect reporting, emergency response systems, and resources available in the community.

This service will be provided by service providers that are currently providing personal care and homemaker-type services. The billable rate will be $5.98 per 15-minute unit in CY2013. The rate will be adjusted in accordance with annual rate changes. Each participant will be limited to $300 or 50 units (12.5 hours) of service.

Assistive Technology is provided for, in at least a limited way, in each of the four waivers. By introducing Assistive Technology as a demonstration service, the state aims to expand its definition for the first 365-days post-transition. Assistive Technology could include personal emergency response systems, medication dispensing devices, telehealth, and sensors in the participant's home to monitor sleep patterns, bathing habits, and motion. Assistive Technology is purposely broad to allow for items not listed here that would significantly benefit a specific

participant, as well as allow for the advances in technology over the demonstration period. Assistive Technology will be available as a demonstration service to the extent it is not available as a waiver or State Plan service. The ASA Waiver offers a broad definition of Specialized Medical Equipment that is meant to encompass Assistive Technology. Therefore, MFP participants who enroll in the ASA Waiver will receive these services through the waiver rather than the MFP demonstration.

Based on estimates from providers of Assistive Technology services, the average monthly expense of a comprehensive package of devices is $430 – or $5,150 annually. $5,150 will then be put in place as the maximum limit on expenditures for this service for an individual participant during the 365-days post-transition period. It is likely participants, with input from the Transition Team, will choose one or two devices that will most benefit them, thus resulting in a lower annual cost.

Behavior Crisis Intervention Services would be accessed in those transitions where a participant's behavior is identified as one of the primary barriers to successful community living. This service would allow for individual Behavior Crisis Intervention during the 365-days immediately following transition. Providers of this service would be agency-based Behavior Crisis experts who agree to provide this service to those transitioning. The rate will be $26.17 per unit ($104.68 per hour) in CY2013. The rate will be adjusted in accordance with annual rate changes. We have estimated that the participants who do use this service will receive, on average, 25 hours of Intervention. The state aims to build capacity within the HCBS provider community during the MFP demonstration period through Benchmark 5. Building capacity within the agencies serving MFP participants and others requiring long term supports and

services will give them the tools to continue to provide behavior crisis intervention beyond the 365-day demonstration period and the MFP grant.

Exhibit 14 portrays the full range of services – qualified and demonstration – available to each target population during the MFP rebalancing demonstration.

Exhibit 14:

ASA Waiver
Target Population: Consumers 65 and older, and consumers 18 and older with a qualifying disability

Service	Type	Unit	Rate
Adult Day Services	Qualified	15 min.	$1.25
Homemaker	Qualified	15 min.	$5.48
Personal Care	Qualified	15 min.	$5.48
Respite Care	Qualified	15 min.	$5.48
Specialized Medical Equipment	Qualified	purchase	$300 max
Specialized Medical Supplies	Qualified	month	$300 max
Adult Companion Services	Qualified	15 min.	$5.48
Assisted Living	Qualified	Day	$35.15
Environmental Accessibility Adaptations	Qualified	adaptation	$4,000 max
In-Home Nursing Services	Qualified	15 min.	$9.06
Meals and Nutritional Supplements	Qualified	meal	$5.90
Personal Emergency Response System (PERS)	Qualified	Month	$45 max
Behavior Crisis Intervention	Demonstration	15 min.	$26.17
Consumer Preparation Services	Demonstration	15 min.	$5.98
Non-Medical Transportation	Demonstration	transition	$500 max
Transition	Demonstration	transition	$2,500 max

Assisted Daily Living Services (ADLS) waiver:
Target Population: Consumers 65 and older, and consumers 18 and older with a physical disability. Consumers must have quadriplegia due to or resulting from ataxia, cerebral palsy, rheumatoid arthritis, muscular dystrophy, multiple sclerosis, traumatic brain injury, a congenital condition, an accident or injury to the spinal cord, or another neuromuscular or cerebral

condition or disease other than traumatic brain injury; or the individual has four limbs absent due to disease, trauma, or congenital conditions

Service	Type	Unit	Rate
Case Management	Qualified	15 min.	$14.64
Personal Attendant Care	Qualified	15 min.	$4.69
Ancillary Services - emergency response devices	Qualified	month	$45 max
Ancillary Services - Private Duty Nursing	Qualified	15 min.	$9.06
Consumer Preparation Specialist Services	Qualified	15 min.	$9.28
Specialized Medical Supplies	Qualified	month	$100 max
Assistive Technology	Demonstration	transition	$5,150 max
Behavior Crisis Intervention	Demonstration	15 min.	$26.17
Non-Medical Transportation	Demonstration	transition	$500 max
Transition	Demonstration	transition	$2,500 max

Family Support 360 waiver:
Target Population: Individuals with an intellectual disability and/or a developmental disability of any age

Service	Type	Unit	Rate
Personal Care	Qualified		Negotiated
Respite	Qualified		Negotiated
Support Coordination	Qualified	15 min.	$14.96
Supported Employment	Qualified		Negotiated
Personal Care 2	Qualified		Negotiated
Companion Care	Qualified		Negotiated
Environmental accessibility adaptations	Qualified		Market rate
Nutritional Supplements	Qualified		Market rate
Specialized Medical Adaptive Equipment	Qualified		Market rate
Specialized Medical Supplies	Qualified		Market rate
Vehicle Modification	Qualified		Market rate
Assistive Technology	Demonstration	transition	$5,150 max
Behavior Crisis Intervention	Demonstration	15 min.	$26.17
Consumer Preparation Services	Demonstration	15 min.	$5.98

Non-Medical Transportation	Demonstration	transition	$500 max
Transition	Demonstration	transition	$2,500 max

The negotiated and market rate qualified services provided through Family Support 360 do not have a cap. The amount a participant may need is determined at the time of the annual planning meeting to. If a need is identified during the plan year a goal is added and an amount is determined at that time.

CHOICES waiver:
Target Population: Individuals with an intellectual disability and/or a developmental disability of any age

Service	Type	Unit	Rate
Day Habilitation	Qualified	hour	**
Prevocational Services	Qualified	hour	**
Residential Habilitation	Qualified	hour	**
Service Coordination	Qualified	hour	**
Supported Employment	Qualified	hour	**
Medical Equipment and Drugs	Qualified	day	**
Nursing	Qualified	hour	**
Other Medically Related Services – Speech, Hearing & Language	Qualified	day	**
Assistive Technology	Demonstration	transition	$5,150 max
Behavior Crisis Intervention	Demonstration	15 min.	$26.17
Consumer Preparation Services	Demonstration	15 min.	$5.98
Non-Medical Transportation	Demonstration	transition	$500 max
Transition	Demonstration	transition	$2,500 max

**The CHOICES waiver reimburses providers using a comprehensive service based rate that it pays providers to develop comprehensive care plans that integrate the waiver elements each participant needs.

B.6 Consumer Supports

MFP rebalancing demonstration participants will be enrolled in one of South Dakota's existing waiver programs for the delivery of home and community-based services and supports. The current systems for consumer supports that are approved and in place under each waiver will be used by MFP participants as well, both during the MFP demonstration and thereafter.

As part of this effort, and as discussed in B.2 Informed Consent and Guardianship, each potential MFP participant will receive a Transition packet. The packet will contain information about the supports and services available – both through the MFP rebalancing demonstration and through HCBS Waivers. Information about how participants will access assistance and supports while residing in the community will also be included. The South Dakota Department of Health's beReady booklet will also be used to provide basic information about preparation for bad weather and other situations that may prevent service providers or natural supports from reaching the participant.

The state has introduced Consumer Preparation as a demonstration service in an effort to provide participants the training and information they need to remain safe in their homes. This includes safety when using appliances, when venturing outdoors during inclement weather, and when working with a service provider. The Transition Team, including the participant, will determine what type and to what level the participant requires the Consumer Preparation service prior to transition, immediately upon transition, and ongoing during the first 365-days following transition.

The Transition Team will also be responsible for developing an emergency back-up plan prior to transition. The back-up plan will include the names and contact information (home/work/and

cell phone numbers, email address) for each individual and/or entity that provides back-up services to the participant. This list will vary depending on the consumer. It may include only natural supports, or it may include a combination of natural supports and service providers. The back-up plan will also indicate if a personal emergency response device will be used to provide 24-hour emergency response. This service will be available to every participant as a demonstration service. Two of the four waivers – those serving the elderly and physically disabled - also provide personal emergency response devices as a HCBS waiver service.

A copy of the back-up plan, including contact information, will be posted near the participant's primary phone, or in a mutually-agreed upon location in the home. The Transition Coordinator and members of the Transition Team, which include state staff who manage the waiver service delivery, will also have copies.

Each participant will have access to 24/7 backup services. The levels of back-up will be specified in a participant's back-up plan and could include:

- 24/7 backup as available in the HCBS waiver on which the participant is receiving services;
- South Dakota's helpline (211) is available in several areas of the state and provides multiple types of supports to those needing help;
- An individual or agency that regularly interacts with the participant;
- The Transition Coordinator – if the routine individual or agency are not accessible, the participant will contact the Transition Coordinator or any other member of the Transition Team;

- Behavior Crisis Intervention – the provider agrees to be available to the participant on an as needed basis and provide contact information that is included in the back-up plan;
- Personal Emergency Response device;
- ADRC Call Centers – there are five ADRC call centers across the state. By calling the 1-800 numbers, MFP participants can access an intake worker who provides information and referral or connects the participant to MFP staff. The ADRC is also the resource for making Adult Protection referrals; and
- Other community resources – information about local transportation services, medical providers and services, local Department of Social Services offices, DME providers, and policies on replacement of direct service workers.

In the event a back-up system does not provide the support the participant needs, the participant has a variety of options for registering a complaint. When possible, participants will be asked to work with the staff of the waiver on which they are enrolled when initially registering a complaint. Participants will also be encouraged to register complaints directly with the Transition Coordinator or the MFP Demonstration Coordinator.

In the event a participant chooses not to address a complaint with one of the previous resources, the participant can register a complaint, either via telephone or email, with the Department of Social Services' Constituent Services. These complaints are tracked and every communication receives follow-up.

B.7 Self-Direction

Self-direction in South Dakota's MFP demonstration will be offered to the extent it is offered in the 1915(c) HCBS Waiver the individual enters upon transition. Two of South Dakota's four waivers – the ADLS Waiver and the Family Support 360 Waiver – offer self-direction opportunities. The CHOICES Waiver, which is due for renewal in June 2013, does not currently offer participants the opportunity to self-direct services, but is exploring opportunities for offering this option to its participants. The ASA Waiver does not provide participant direction opportunities. Both waivers that offer self-direction provide participants the opportunity to direct some or all of their services.

ADLS Waiver – Participants in the ADLS Waiver begin directing their services at the time of application. Once an application is received by the ADLS waiver manager, the applicant will receive a list of ADLS providers. From this point forward the applicant is required to contact a program provider and interview providers to determine which provider best meets their needs. Once an applicant has chosen a provider and is determined eligible for the program, they are supported to manage and direct their services to the fullest extent possible. The ADLS program requires participants to manage and self direct their personal attendant care. The ADLS waiver adopts principles of independent living, and the program supports participants to self direct their person attendant services to the highest degree possible.

Participants fully participate in the advertising, interviewing and hiring of their personal attendants. Participants are supported to create their personal attendant schedule, train and determine their personal attendant's proficiency to provide their services, supervise their personal attendants, including discipline and termination if needed.

Participants are assisted to locate a provider of emergency response services. Participants are supported to contact the provider to arrange for installation of the required equipment. Participants also are encouraged and supported to identify a local provider for their incontinence supplies if they chose to access these services. The waiver manager authorizes these services from the state level, but the participant with assistance as needed from their case manager select, purchase and arrange for delivery of their incontinence supplies. Skilled nursing services are decided between the participant and their physician. Nursing services are ordered and monitored by the physician. The participant's case manager receives copies of all pertinent nursing documentation and works with the skilled nursing provider to ensure visits are provided as ordered.

Participants are supported by their case managers and consumer preparation specialists as needed to manage and self direct ADLS services.

Family Support 360 Waiver – Eligible applicants are referred to qualified providers in their geographic locales. Qualified providers assist the applicant/participant in selecting a support coordinator by providing them with biographical information, resumes, and geographic location. The chosen support coordinator then assists the participant in developing a service plan that is participant-centered and prioritizes individual needs.

Participants are afforded employer authority as co-employers of Personal Care 1, Respite Care, Supported Employment and Companion Care providers. They are supported to recruit, refer for hire, train, direct, and manage staff. Qualified providers serving in an Agency With Choice capacity will ensure that employees meet qualifications specified in the waiver and any other standards for employment required by the agency. For example, if an Agency with Choice's

liability carrier requires criminal history checks, the Agency with Choice will monitor applicants based on the agency's standard practices. The participant is also supported in identifying employment criteria related to background and criminal history checks and training. The Agency with Choice as the employer of record ensures compliance with all IRS and federal and state DOL regulations.

Provider rates and units of services are prescribed in the service plan. Personal care attendants may view and submit time cards specific to their services. Participants and support coordinators authorize these services to be paid by the Agency with Choice (AWC).

Participants are supported to choose and evaluate vendors/suppliers of all waiver supplies, equipment and devices. These purchases are authorized in the service plan, and purchased through the qualified provider. Authorized users, including participants, are provided real time utilization information to manage services and budgets. Participants who do not have internet access are provided this information by support coordinators in written copy.

Participants may elect to have a legal representative direct their services. Additionally, participants may elect to not direct their own services.

Families and other people comprising the participant’s natural support system play an integral role in supporting the participant’s self direction. The support coordinator provides support, as requested, to assist the participant to self-direct services. This role is determined by each participant.

As the state is using self-direction opportunities embedded in existing 1915(c) HCBS Waivers, and will not include opportunities for self-direction separately under the MFP rebalancing demonstration, the state is not submitting the Self-Direction Submittal Form.

B.8 Quality

One of the eligibility criteria for the MFP rebalancing demonstration is that the participant is willing to enroll in and can be supported in the community through the provision of an existing HCBS waiver. Each HCBS waiver has a comprehensive continuous quality improvement plan as required by version 3.5 of the 1915(c) HCBS Waiver application. Three of South Dakota's four waivers have been renewed since October 1, 2011, so their quality improvement strategies have been recently evaluated and modified to assure quality service provision to every participant. The CHOICES waiver is due for renewal in June 2013 and has in place a comprehensive quality improvement strategy and an electronic system which tracks each assurance and performance measure.

These existing continuous quality improvement strategies will be utilized during the MFP rebalancing demonstration, ensuring that the demonstration will incorporate, at a minimum, the same level of quality assurance and improvement activities in Appendix H of the existing waivers applications.

The South Dakota MFP rebalancing demonstration will employ the quality management systems already in place through the HCBS waivers. Those existing quality management systems address the waiver assurances articulated in version 3.5 of the 1915(c) HCBS Waiver application, including:

- Level of care determinations;
- Service plan description;
- Qualified HCBS providers;
- Health and welfare;

- Administrative authority; and
- Financial accountability

A quality management system specific to demonstration services, as well as a method for collecting and analyzing the continuous quality improvement information for each participant from the waivers, will be developed in accordance with the requirements of Appendix H of the HCBS 1915(c) waiver application.

Additionally, the state will monitor, assess, and strive to improve the systems required by MFP – risk assessment mitigation, 24/7 backup for critical services, and incident management. This will be done by the MFP Demonstration Coordinator in collaboration with the four HCBS 1915(c) waiver managers. The waiver managers currently convene the Internal Waiver Review Committee (IWRC) quarterly. The IWRC includes the waiver managers, a representative of the Division of Medical Services (State Medicaid Agency), and other DSS and DHS personnel. The MFP Demonstration Coordinator will become a member of the IWRC and review of the continuous quality improvement processes of the demonstration services, as well as waiver services provided to MFP participants, will become a quarterly agenda item. Additionally, that group will discuss and recommend improvements risk assessment mitigation, 24/7 backup for critical services, and incident management.

B.9 Housing

As has been the case with many states, South Dakota has identified housing as one of the foremost barriers to transition. Therefore, the South Dakota MFP rebalancing demonstration will collaborate with housing resources throughout the state to secure a "qualified residence" for each transitioning participant. The state proposes to dedicate a portion of the MFP administrative funding to contracts with external agencies with this type of expertise to act in the role of Community Development Specialist in those transitions where housing and other community resources are going to be considerably difficult to locate. By engaging community agencies in this fashion, MFP will have expanded access to information, connections, and a community-knowledge base. Ultimately, the Transition Coordinator, with support from the MFP Demonstration Coordinator, is responsible for confirming the MFP participant is moving into an MFP qualified residence. The Transition Coordinator is also responsible for ensuring the participant remains in MFP qualified housing throughout the 365-day demonstration period.

There are three types of qualified residence to which a participant could transition from the institution.

- A home owned or rented by the individual or the individual's family member;
- An apartment with an individual lease, which could be located in an apartment building, a unit within a private home, a public housing unit, or an assisted living facility. Any apartment, regardless of location, is required to have lockable access and egress, as well as living, sleeping, cooking, and bathing areas over which the participant has domain and control. The ASA Waiver provides Assisted Living services, so participants could

transition to a qualified residence within Assisted Living through that waiver if desired. Assisted Living facilities are regulated by the Department of Health.

- A residence, in a community-based residential setting, in which no more than four unrelated individuals reside. In South Dakota, these residences are typically operated by the Community Support Providers, under contract with the Division of Developmental Disabilities. They will be used in this demonstration, primarily, as a housing resource for those with DD who are transitioning from the state's public or private ICF/MR.

The type of residence in which each participant is living will be monitored on an individual level by the Transition Coordinator during the first 365-days post-transition, and by the MFP Demonstration Coordinator on a project-wide basis.

During the MFP planning process, DSS representatives met with agencies focused on housing needs and development in South Dakota – the South Dakota Housing Development Authority, the Sioux Falls Housing and Redevelopment Authority, and South Dakota USDA Rural Development. During these meetings the housing needs statewide, and in urban centers in particular, became clear.

The state will achieve a supply of qualified residences by conducting the following activities:

- Upon hire, the MFP Demonstration Coordinator will meet with each of the housing resources listed above, as well as others. During the meetings, the Coordinator will develop a clear understanding of the types of public housing, the variances of waiting lists and availability depending on geographical locations, and, additionally, the availability of handicapped or other accessible units compared to non-accessible units.

- With information provided by each entity, the MFP Demonstration Coordinator will compile a list of housing resources and contacts that will be shared with the Transition Coordinator and/or the Community Development Specialists. The list will include qualified residence options for registered sex offenders or other populations for which housing is an even greater need due to individual history or behaviors.
- The MFP Demonstration Coordinator will develop an ongoing collaboration with the SD Housing Development Authority (SDHDA) to identify funding opportunities that could be used to expand housing availability for MFP participants. In July, the SDHDA submitted an application for HUD 811 funding and specifically mentioned the Money Follows the Person demonstration as a partner in the program, to target individuals with chronic mental illness, a developmental disability, and/or a physical disability. While that funding was not granted, the entities will continue to work together to identify options for development of safe, affordable, accessible housing options for MFP participants and others with LTSS needs who want to transition back to or remain in the community. The SDHDA, DSS, and the Department of Human Services have an interagency agreement in place.
- The MFP Demonstration Coordinator will explore the option of using the Governor's House Program as a resource for qualified housing. The Governor's House program was created in 1996 as a way to provide reasonably sized, affordable homes to income-qualified individuals and families.

When preparing for a transition, the Transition Team will weigh the availability of housing in the desired community with the availability of home and community-based services.

Generally, housing is readily available in the state's smaller, rural communities. However, the participant may require services or a level of service delivery that exceeds what is available by providers in that community or region.

B.10 Continuity of Care Post-Demonstration

MFP participants will enroll in a HCBS 1915(c) waiver immediately upon transition to the community. The HCBS waiver will provide the qualified services the participant needs while MFP will support the transition through the provision of demonstration services for the first 365-days post-transition.

Each Transition Team will include a specialist, case manager, or other representative of the waiver in which the participant will enroll. This involvement, from the beginning, of the individual who will be engaged in assessment, care plan development, provision of services, and other transition and waiver activities, both during the demonstration and beyond, will allow for continuity of care post-transition.

South Dakota will not be transitioning to a 1915(b) or 1115 demonstration waiver as part of this demonstration. The state also does not anticipate submitting a State Plan Amendment as part of this demonstration.

While each HCBS 1915(c) Waiver has projected the number of individuals to be served on the waiver in each of the five waiver years, no caps on the number of individuals who can be served by the HCBS waivers has been set by legislative or administrative rule action. Therefore, it will not be necessary to submit a waiver amendment to reserve slots in any of the waivers for MFP participants. If a waiver surpasses its projections, an amendment can be submitted to increase the projections.

If an MFP participant becomes ineligible for waiver services at the end of the demonstration period, or during the demonstration period, the Transition Coordinator will convene the Transition Team to identify an ongoing mechanism for supporting the participant at home. In

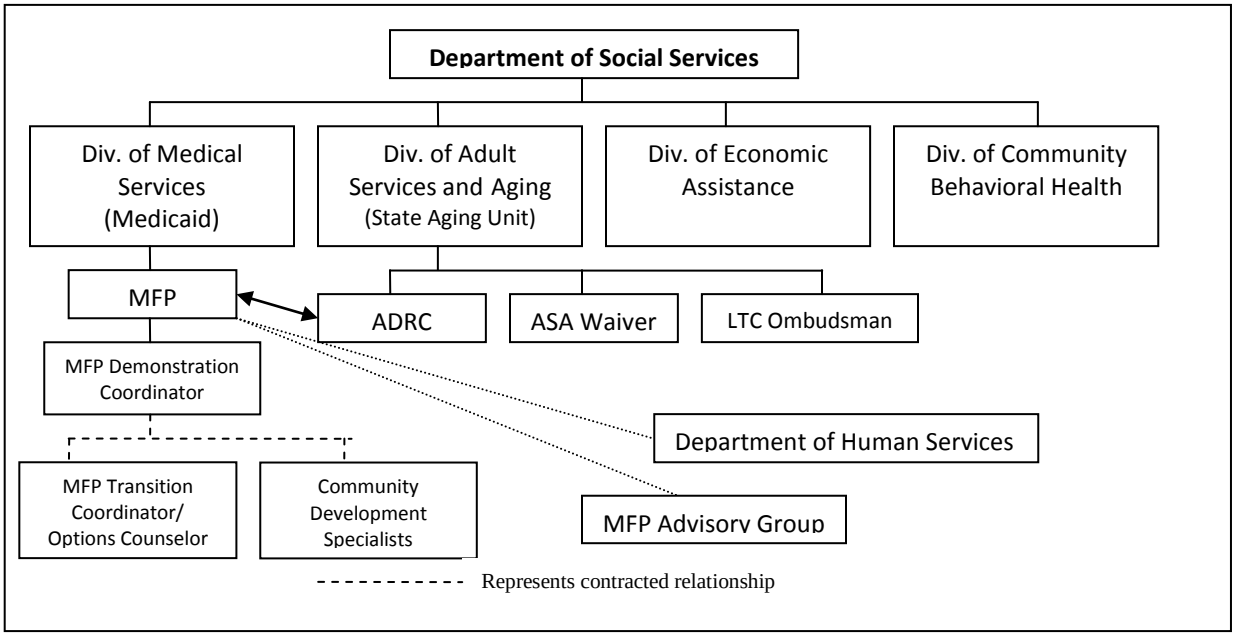
some cases, the loss of waiver eligibility will also mean the loss of Medicaid eligibility. In such cases, the Transition Team would look for natural supports and community-based resources. If the participant remains eligible for Medicaid, he/she could benefit from State Plan services. In all cases, the ADRC would be engaged as the primary resource for referrals and information.

C. PROJECT ADMINISTRATION

C.1 Organizational Chart

Exhibit 15 portrays the administrative structure of the South Dakota Money Follows the Person Rebalancing Demonstration. As described in A.2 Administrative Structure and B.4 Stakeholder Involvement, close connections exist between MFP and the Department of Human Services and the MFP Advisory Group, comprised of DSS and DHS staff, provider agencies representing long-term care/HCBS, and consumers. Frequent collaboration is made possible and necessary by the state's small population and large geographical area. As the State Medicaid Agency, DSS provides administrative authority for the three 1915(c) HCBS Waivers managed by DHS. The two Departments have frequent communication and a common interest in providing comprehensive, person-centered services to participants. The State Medicaid Director, within the Division of Medical Services, provides direct line supervision for the MFP Demonstration.

Exhibit 15: Organizational Chart



C.2 Staffing Plan

The state will employ a full-time Project Director to manage the MFP rebalancing demonstration. This position will be titled the MFP Demonstration Coordinator in accordance with other similar state positions, but will encompass all duties of a Project Director as defined by the Funding Opportunity. The MFP Demonstration Coordinator will be an employee of the Department of Social Services, Division of Medical Services. The MFP Demonstration Coordinator Job Description is included in Appendix C. The search for the MFP Demonstration Coordinator (Project Director) will begin in spring 2013. When a candidate is identified, the state will seek input from CMS prior to making an offer of employment.

The grant will also allow for Transition Coordinators via contractual relationships. The Transition Coordinators will work directly with potential and transitioning participants statewide, and will be responsible for in-person meetings with each participant, coordinating the Transition Team, assisting in the identification of the most appropriate 1915(c) waiver for the participant, and conducting follow-up with participants who have transitioned throughout the 365-day post-transition period. The Transition Coordinators will be located throughout the state ensuring easy accessibility to potential participants. The MFP Demonstration Coordinator will convene regular conference calls with the Transition Coordinators – both individually and as a group – to provide support, technical assistance, and training. The state will undertake a Request for Information process to identify agencies interested in contracting with the state to house a Transition Coordinator within their organization.

The state will also use a portion of the grant award to develop small contracts with community-based agencies to fulfill the role of Community Development Specialists in the MFP rebalancing

demonstration. Contracted services will be engaged as needed, most specifically when the Transition Coordinator and Transition Team identify a unique or significant barrier to transition that requires additional knowledge, experience, and community connections to overcome. It is anticipated that contracts will be developed with several agencies, not individuals, allowing additional flexibility and expanded knowledge. These contracted entities will also be used to support the Transition Coordinator and, when necessary, provide Transition Coordination services that mirror the work of the Transition Coordinator. Contracts will be developed with agencies serving in the Community Development Specialists role. The contracts will be paid on an hourly rate, yet to be determined.

Several staff of the Department of Social Services and the Department of Human Services will provide in-kind support to the grant. These will include, but are not limited to:

- Long-Term Care Ombudsman;
- ADRC Project Director;
- Waiver managers;
- Clerical staff

Ann Schwartz, Deputy Director for the Division of Medical Services, will serve as the Interim MFP Demonstration Coordinator and will have day-to-day responsibility for its operation until a permanent Demonstration Coordinator is identified.

It is desired, but not required, to have the MFP Demonstration Coordinator in place to provide input into the contract selections of the Transition Coordinators and Community Development Specialists.

Upon employment of the MFP Demonstration Coordinator, the search for agencies to act in the role of Community Development Specialists will commence. The MFP Demonstration Coordinator will lead the process, with support from DSS and DHS leadership.

The Deputy Director of the Division of Medical Services will be responsible for the performance assessment of MFP staff.

C.3 Billing and Reimbursement Procedures

Billing and reimbursement will be managed through the systems currently used for the 1915(c) waivers. The Department of Social Services, as the waiver administrative authority, processes all reimbursements through the MMIS system, and submits financial accountability reports to CMS. DSS has fraud control and financial monitoring systems in place. The claims payment system is programmed to deny duplicative claims for waiver services and a similar system will be put in place for demonstration services.

Each waiver is accountable to CMS for a series of performance measures under the Financial Accountability assurance. The continuous quality improvement strategies specified in each waiver will be applicable to services provided through the MFP rebalancing demonstration.

D. EVALUATION

South Dakota is not proposing to conduct an independent evaluation of the demonstration. The state will fully support the national evaluator in accordance with grant requirements.