Aging & Disability Resource Center
An Initiative of the U.S. Department of Health and Human Services

TECHNICAL ASSISTANCE EXCHANGE

Building a Collaborative Partnership between the Money Follows the Person Rebalancing Demonstration and Aging and Disability Resource Centers: A Toolkit

MONEY FOLLOWS THE PERSON

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Date: December, 2011

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Overview

June 22, 2009 marked the 10th anniversary of the *Olmstead v. L.C.* Decision. President Obama affirmed the Administration's commitment to Americans with disabilities by announcing the "Year of Community Living". U.S. Department of Health and Human Services (HHS) Secretary Sebelius created the Community Living Initiative and an HHS Coordinating Council comprised of the Administration on Aging (AoA), Centers for Medicare and Medicaid Services (CMS), the Office for Civil Rights, the Office of the Assistant Secretary of planning and Evaluation, and the Substance Abuse and Mental Health Services Administration and led by the Office of Disability, was formed. Progress is evident. Various federal agencies have encouraged system change to afford Americans with disabilities greater choice and control. Progress is still needed however and for the first time, these same federal agencies are working together to accomplish common goals. For example, under the Community Living Initiative, HHS built a partnership with the U.S. Department of Housing and Urban Development (HUD) to identify ways to improve housing and supports for persons participating in the MFP Transition program resulting in a Notice of Funding Availability in the Fall of 2010. Additionally, the two federal agencies are hosting open forums in 2011 to expand housing options for people with disabilities. The leadership at the federal level is also present at the state level. State health and human service programs are struggling with economic and social policy constraints resulting in an ever increasing need for partnership within and across public and private programs. The need for overall long term services and supports system change is more critical than ever. Not only do Americans with disabilities seek such change, so do federal, state and local systems in search of greater quality and efficiency across the continuum of health and human services and supports.

This toolkit provides partnership support to both Aging and Disability Resource Centers and Money Follows the Person Rebalancing Demonstration programs and contains useful information and helpful tools organized by section.

Use the below "Table of Tools" to navigate through the Toolkit.

Type of Information	Tools Available	Sections
Historical Progress	▶ Key Community Living Advances ▶ Affordable Care Act Provisions ▶ Olmstead Timelines/Resources ▶ Rebalancing Impact Statistics ▶ ADRC/MFP Shared Vision	I.-VI.
Process to Reform Services and Services	▶ Community Living System Change Cycle ▶ Community Living System Change Cycle Tracking Worksheet	VII.
State Model Programs	▶ Snapshot of multiple state experiences and lessons learned	VIII.
ADRC & MFP Partnership Steps	▶ Scoring Grid and Steps regarding ADRC & MFP Partnership ▶ Helpful Hints to build a ADRC/MFP Collaborative Partnership	IX.
Components of Fully Functional Aging and Disability Resource Centers & How MFP & ADRC can help each other	▶ Information, Referral and Awareness ▶ Options Counseling ▶ Person-Centered Transitions ▶ Consumer Populations, Partnerships, and Stakeholder Involvement ▶ Quality Assurance and Evaluation	X.

Section I. Key Advances during the Year of Community Living and ACA Provisions

Over the course of several years, the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) have worked together to help states move toward a person-centered delivery system for persons who are aging and/or have disabilities. The Patient Protection and Affordable Care Act (PPACA - P.L. 111-148 also known as the ACA) provides further opportunities for system reform and enables States to combine multiple initiatives to move toward a person centered long term services and supports delivery system. The cornerstone of the Money Follows the Person (MFP) program is the ability to use the transition program (and the enhanced federal dollars earned) as a catalyst to system change. The front door (namely Aging and Disability Resource Centers-ADRC) is a key element of system change. The ACA enables MFP programs to have greater latitude in the testing of new ideas and the implementation of key policy changes. Given that MFP and ADRC are complementary initiatives, it makes logical sense to partner across agencies and programs to take full advantage of all the opportunities afforded under the ACA to ultimately move toward the vision for long term services and supports.

Key Advances During the Year of Community Living

Opening doors to partners……stakeholder dialogue

In 2010, HHS hosted four open dialogue forums with several stakeholders within state and local systems to gain critical input to inform public policy and practice decisions. Additionally, HHS continues to gather critical input through the Notice of Proposed Rulemaking (NPRM) process.

Advancing state partnership

CMS released the "Community Living Initiative Letter" to State Medicaid Directors to affirm the commitment to Olmstead and offer tools and information to states.

Increasing access to housing

HHS is partnering with Housing and Urban Development (HUD) in three key areas; 1.) HHS/HUD leveraged 5,300 housing choice vouchers for non-elderly persons with disabilities living in the community or transitioning out of institutional care, 2.) HHS/HUD launched the Housing Capacity Building Initiative for Community Living to support state and local entities by providing technical assistance to plan and implement effective program options linking housing and long term services and supports with special focus on bridging gaps between services and the creation of accessible and affordable housing, and 3.) Once collaborative relationships are formed, HHS plans to support MFP grantees to establish Housing Resource Coordinators to sustain relationships, to identify the housing needs, and facilitate the use of information to inform future working relationships between human services and housing agencies at local and state levels.

Empowering people to make informed choices

AoA and CMS expanded the Aging and Disability Resource Centers to include two competitive funding opportunities to strengthen Options Counseling and Assistance Programs and Evidence Based Care Transition Models. Additionally, existing MFP grantees had the opportunity to receive supplemental funding to strengthen the capacity of nursing home transition and diversion programs.

Making the "money follows the person" to the community

Congress extended the MFP grant for an additional five years to 2016 with additional appropriation of $2.250 billion. An additional 13 states were awarded the grant in February 2011 bringing the total to 43 plus the District of Columbia. The Patient Protection and Affordable Care Act also modified the law to allow transitions to occur faster by reducing the length of stay requirements from 180 days to 90 days.

Building the infrastructure for research on disability services

The Office on Disability awarded Mathematica Policy Research Inc. a two year contract to establish a Center of Excellence in Research on Disability Services, Care Coordination, and Integration. The contract will create a data infrastructure to support the development of comparative effectiveness research on services and supports and models of care for persons with disabilities.

Ensuring the rights of people with disabilities

The U.S. Department of Health and Human Services Office for Civil Rights (OCR) remains committed to the enforcement of the ADA and the Olmstead decision. OCR has collaborated with the Department of Justice (DOJ) to ensure consistent interpretation of law in resolving complaints and seeking ADA compliance. The DOJ is actively intervening in federal court cases and filing amicus briefs in district and appellate courts. The DOJ is also actively pursuing system reform for persons with mental health needs by supporting ADA complaints.

Effective discharge planning – paving the way to community living

On October 1, 2010, the Minimum Data Set (MDS) 3.0 was released. The new Section Q provisions now require nursing facilities to ask residents directly whether they are "interested in learning about the possibility of returning to the community". If a resident indicates "yes", the facility is required to make referrals to local contact agencies such as ADRCs. Additionally, CMS established a National Preadmission Screening and Resident Review (PASRR) Technical Assistance Center to provide technical assistance to states at no cost to ensure that persons with developmental disabilities and/or mental health needs are evaluated to determine the most integrated setting to meet their needs. CMS connected MDS and PASRR to assure a person-centered process.

Partnerships to advance employment of people with disabilities

CMS and the Office of the Assistant Secretary for Planning and Evaluation are collaborating with the Rehabilitation Services Administration, Social Security Administration, Department of Labor, and Substance Abuse and Mental Health Services Administration to develop a guide for the federal financing of supported and customized employment.

Visit the Department of Health & Human Services at: http://www.hhs.gov/od/topics/community/index.html for further information about the Community Living Initiative. The Community Living Initiative provides the foundation to the Money Follows the Person (MFP) Rebalancing Demonstration, Aging and Disability Resource Centers (ADRC) and many other system change initiatives referenced within the chart below.

Patient Protection and Affordable Care Act Provisions with impact on Rebalancing the Long Term Services and Supports System for Persons who are aging and/or have disabilities [i] [ii] [iii] [iv] [v]

For more information on each of the provisions below, visit Healthcare.gov, a website managed by the U.S. Department of Health and Human Services. http://www.healthcare.gov/law/about/The%20Full%20Law%20by%20Section/bysection.html.

CMS

- ❑ Money Follows the Person Demonstration (Section 2403)
- ❑ Medicaid Integrated Care Hospitalization Demonstration Program (Section 2704)
- ❑ Community Living Assistance Services and Supports (CLASS) Program—Section 8000 and 8001 of the PPACA
- ❑ Medicaid Waiver Demonstration Projects for Dual Eligibles (Section 2601)
- ❑ Medicaid Emergency Psychiatric Demonstration Project (section 2707)
- ❑ State Balancing Incentive Payments Program (Section 10202)
- ❑ Community Choice First Option—Medicaid State Plan Option for Attendant Services and Supports—Section 1915k of the SSA and Section 2401 of the PPACA
- ❑ Health Homes for individuals with chronic conditions (Section 2703)
- ❑ National Pilot Program on Payment Bundling (Section 3023 and modified by Section 10308)
- ❑ Independence at Home Medicare Demonstration (Section 3024)
- ❑ National independent monitor demonstration project - nursing home disclosure of ownership and controlling interests (Section 6112)
- ❑ National demonstration projects on culture change and use of information technology in nursing homes (Section 6114)
- ❑ Nationwide program for national and state background checks on direct patient access employees of long term care facilities and providers (Section 6201)
- ❑ Enhancement of Long Term Care—Technology grants for long term care facilities and grants and incentives to enhance training, recruitment, and retention of long term care staff (Section 2041—in coordination with the Department of Labor)
- ❑ National training institute for surveyors and enhanced complaint investigations (Section 6703)
- ❑ Medicare demonstration based on the study of home health agencies (Section 10315)
- ❑ Community Based Care Transitions Program (Section 3026)

PPACA Amendments to existing Medicaid provisions:

- ❑ Modifications to 1915c home and community based waiver programs (e.g. ability to merge target groups within same waiver)
- ❑ Amended the 1915i (home and community based state plan option) and 1915j (self-directed personal assistance) to broaden service package scope, serve targeted groups of people, develop needs based criteria not tied to institutional care, and remove ability to establish enrollment ceilings.
- ❑ Use of 1915c and 1915i waivers to serve children and adults with behavioral health need
- ❑ Enhanced self-direction opportunities through 1915c, 1915i, or 1915j.
- ❑ Support, training, and respite care for caregivers within home and community based waivers and state plan options
- ❑ Application of Spousal Impoverishment Rules to Home and Community Based Services
- ❑ Medicare Special Needs Plans reauthorized

AoA

- ❑ Aging and Disability Resource Centers (Section 2405)
- ❑ Funding outreach and assistance to low-income programs including ADRCs, Options Counseling and Assistance, Nursing Home Transition and Diversion, Evidenced Based Care Transitions (Section 3306)
- ❑ Adult Protective Services (Section 2042)
- ❑ Long Term Care Ombudsmen (Section 2043)
- ❑ Provision of information regarding, and evaluations of, elder justice programs (Section 2044)
- ❑ Forensic Centers for detecting elder abuse, neglect and exploitation (Section 2031)

HRSA

- ❑ State Health Care Workforce Development and Implementation Grants (Section 5102)
- ❑ Grants for Training to mid-career Public and Allied Professionals (Section 5206)
- ❑ Training opportunities for Direct Care Workers (Section 5302)
- ❑ Geriatric Workforce Grants (Section 5305)
- ❑ Mental and Behavioral Health Education and Training Grants (Section 5306)
- ❑ Grants for cultural competency, prevention, public health, and working with individuals with disabilities (Section 5307)
- ❑ Nurse education, practice, and retention grants (Section 5309)
- ❑ Grants to promote the community health workforce (Section 5313)
- ❑ Demonstration projects to address health professions workforce needs—personal and home health aide competencies (Section 5507)
- ❑ Family to Family Health Information Centers—outreach, peer support and benefits counseling (Section 5507)

SAMHSA

- ❑ Co-locating primary and specialty care in in community based mental health settings (Section 5604)

Section II. Olmstead Timeline and Resources

Olmstead Timeline

The *Americans with Disabilities Act of 1999* and the *Olmstead v. L.C. decision* have had a profound impact on persons with disabilities and continue to serve as a foundation to system change efforts. This section highlights the changes enacted by the federal government including resources promoted through State Medicaid Director letters since the decision. These tools are helpful as states implement system change initiatives and are included within this toolkit as a resource.

1999 .... Americans with Disabilities Act
1999 .... Ticket to Work and Work Incentives Improvement Act (*Medicaid Infrastructure Grants*)
1999 .... Olmstead Decision
2001 .... New Freedom Initiative (NFI)
2001 .... Real Choice Systems Change Grants
2003 .... Aging and Disability Resource Centers
2005 .... Deficit Reduction Act
2006 .... Older Americans Act Reauthorization
2007 .... Money Follows the Person Rebalancing Demonstration
2007 .... Community Living Program
2008 .... Veterans-Directed HCBS
2009 .... Year of Community Living
2009 .... HHS Coordinating Council formed
2010 .... Patient Protection and Affordable Care Act (PPACA)

Olmstead Resources

State Medicaid Director Letters are located at the following website: http://www.cms.gov/SMDL/SMD/list.asp#TopofPage.

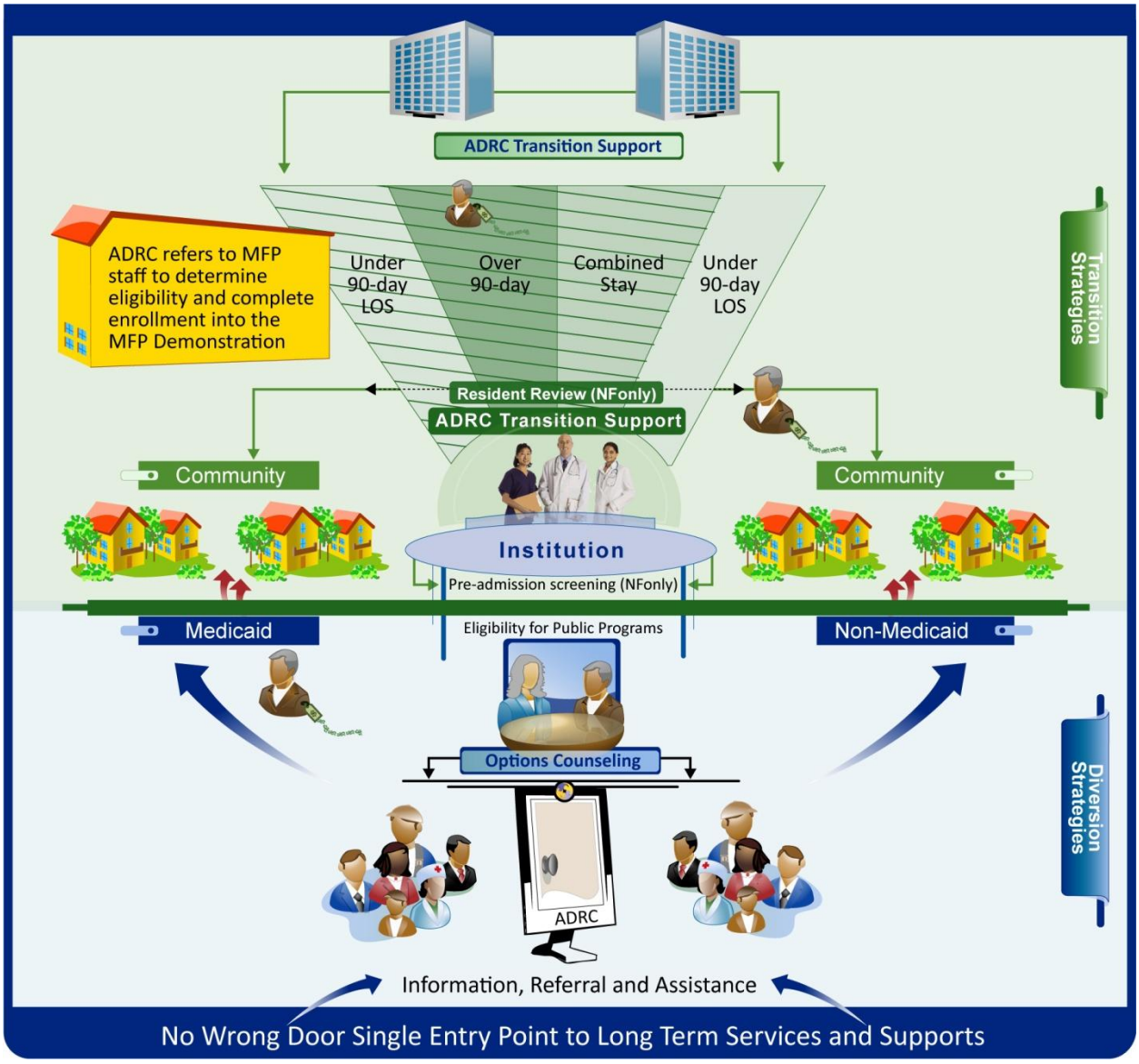
When you arrive at the page, click the button that looks like: "☐ Show Only". Then, click the button that looks like: "☐ Show only items containing the following word". Next, enter the word "Olmstead" in the space provided that looks like this: [ ]. Then, click the Show Items submit button that looks like: "[Show Items]".

The following State Medicaid Director Letters will pull up on the webpage.

5/20/10	Community Living Initiative – Olmstead
7/14/03	Transition of Individuals from institutional to community settings
5/09/02	Transitioning waivers
5/09/02	Independence Plus
1/10/01	Olmstead Update #5
1/10/01	Olmstead Update #4
7/25/00	Olmstead Update #3
7/25/00	Olmstead Update #2
1/14/00	The recent Supreme Court Decision in Olmstead V. L.C., 119 S. Ct. 2176 (1999)
1/14/00	We have made great strides for the disables to participate in communities
7/29/98	Americans with Disabilities Act

Section III. The Role of ADRC and MFP within Transition Pathways

The Figure below depicts the transition pathways (line of movement from setting to setting) and available transition supports for older adults and persons with disabilities who enter and re-enter the public/private long term services and supports system through a no wrong door single entry point. The figure below illustrates the various roles of Aging and Disability Resource Centers and Money Follows the Person Transition Programs in helping people transition from setting to setting highlighting the importance of collaboration between the two federal initiatives.

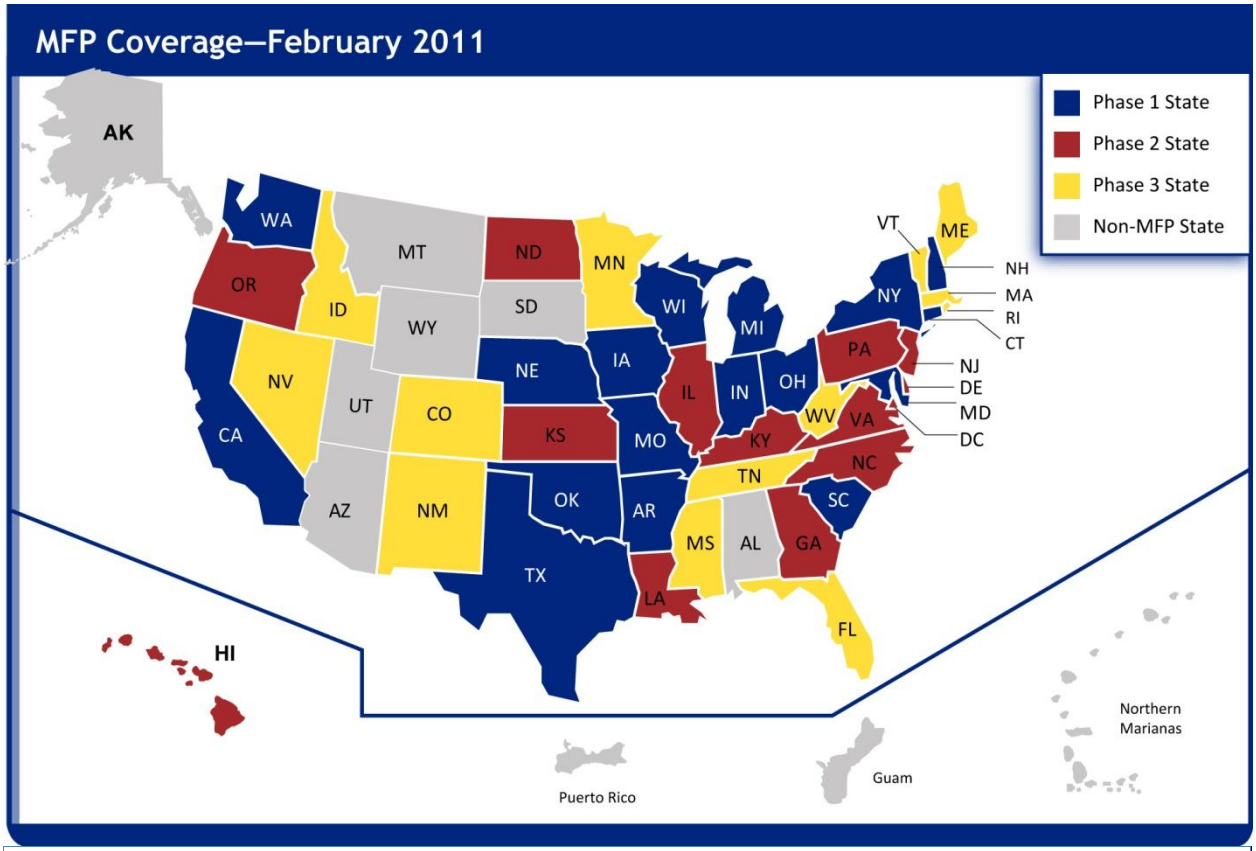


Section IV. Overview of the MFP Rebalancing Demonstration

The MFP program was initially authorized by Congress in section 6071 of the Deficit Reduction Act of 2005 (DRA) and amended in March 2010 through the Patient Protection and Affordable Care Act (Section 2403). The law is designed to assist states in rebalancing long term services and supports systems and help Medicaid enrollees' transition from institutions to community living. Congress initially authorized up to $1.75 billion in Federal funds through fiscal year (FY) 2011 to:

- **Goal #1:** Increase the use of HCBS and reduce the use of institutionally-based services;
- **Goal #2:** Eliminate barriers and mechanisms in State law, State Medicaid plans, or State budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice;
- **Goal #3:** Strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and
- **Goal #4:** Ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.

Section 2403 of the PPACA appropriates an additional $2.25 billion and extends the program to 2016 and potentially 2020 if funds remain available. The states participating in the program are illustrated in the map below.

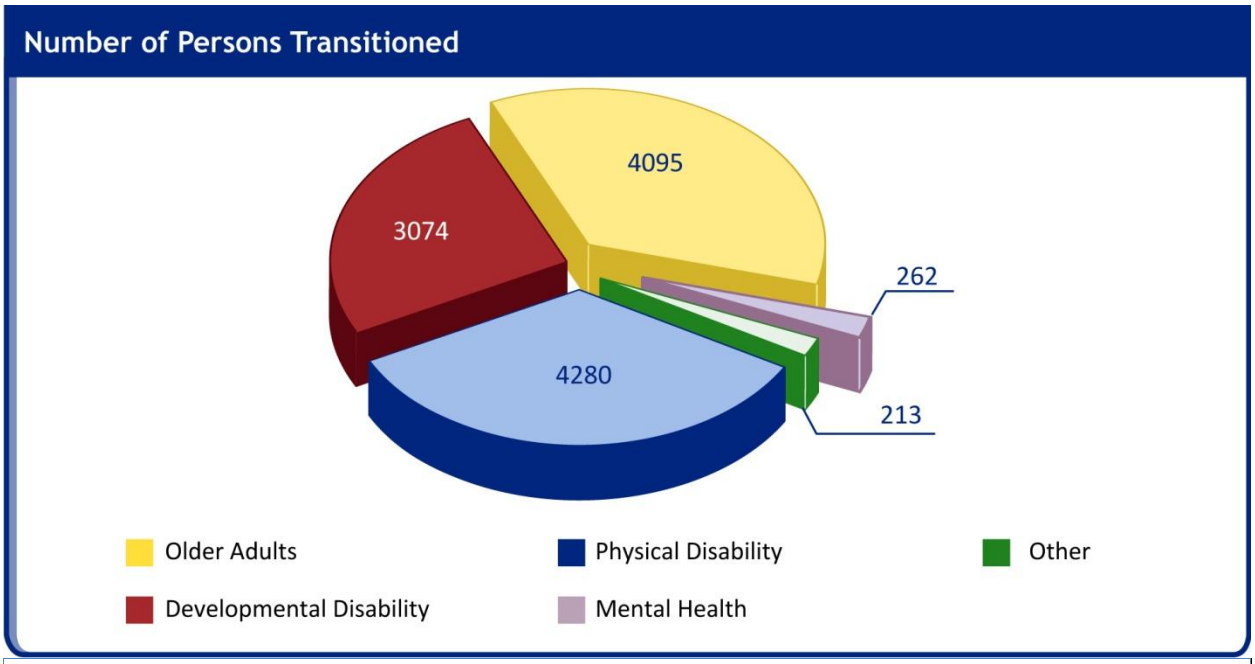


Note: Phase 1 states were awarded the grant in January 2007, Phase 2 states in May 2007 and Phase 3 states in February 2011.

Goal #2 described above is a critical element of the MFP program. Many states are using the MFP program as a catalyst to greater system change beyond Medicaid. Medicaid is often a starting point for system change, but the ability to create a person-centered delivery system is contingent on the ability to develop a system that crosses all ages and all payer sources. MFP programs are required to have a system change plan within the Operational Protocol approved by CMS. The plan must address how the state intends to use the funds earned through the program to eliminate barriers and mechanisms that prevent or restrict persons from receiving services and supports in settings of their choice with quality and continuity of care. Often, MFP is viewed through the lens of the transition program, but it is critical to remember that the MFP program is much more. MFP provides states with an opportunity to plan strategically, to test new ideas with limited risk, and invest in meaningful system change that incrementally moves toward a state of balance with the person at the center of the services and supports system.

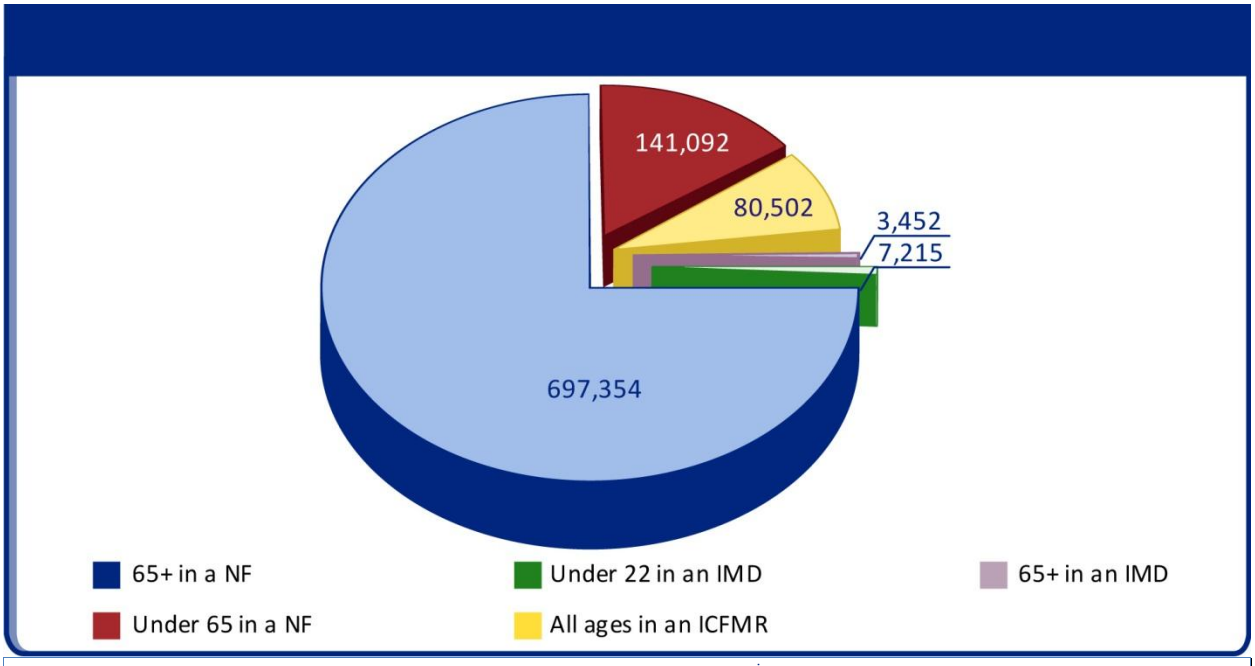
The various figures below provide a snapshot of MFP transition programs.

Figure 1: Number of Persons Transitioned as of December 2010



Note: Based on data from 2007 to 2010 across 30 MFP states
As of February 2011, approximately 66,783 persons are expected to transition from qualified institutional settings across the 43 states and the District of Columbia during the demonstration.

Figure 2: Number of Persons in Institutional Settings



Note: Based on data from the original 30 states between 2007 and December 2010.[vi]
The Mathematica Policy Research Report also indicates that an additional 4,130 persons were transitioned from parallel nursing facility transition programs and 134 persons from parallel ICF/MR transition programs.

Section V. Overview of Aging and Disability Resource Centers

The AoA and CMS established the ADRC initiative in 2003. This collaborative effort seeks to streamline access to long-term supports and services for older adults, all persons with disabilities, family members and long term services and supports providers. Currently, all 50 states and 4 territories (District of Columbia, Guam, Commonwealth of Northern Mariana Islands and Puerto Rico) have implemented or are in the process of implementing a fully-functioning ADRC.

ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities. Sometimes referred to as a "one stop shops" or no wrong door systems, ADRCs address many of the frustrations consumers and their families experience when trying to find needed information, services, and supports. Through integration or coordination of existing aging and disability service systems, ADRC programs raise visibility about the full range of available options, provide objective information, advice, counseling and assistance, empower people to make informed decisions about their long term supports, and help people more easily access public and private long term supports and services programs. With many different information and referral systems available for aging and disability services, understanding options can be very difficult and can lead to individuals entering institutional care facilities, when that may not be the best or most desired option for them.

Over the last two decades, options and services available to the aging and disability populations have increased dramatically in response to the growth of the aging population. This can cause confusion when attempting to determine the best options available for an individual and their family. The implementation of ADRCs in U.S. states and territories has helped make the aging and disability services system easier to navigate.

In addition to assisting older adults, people with disabilities, and their family members and care givers to access the wide range of long-term service and support options, ADRC initiatives focus on restructuring access to and delivery of services. For example, many ADRCs have worked to streamline the application process for Medicaid (e.g. co-location of financial and functional eligibility workers, web-based applications) and other public programs and worked to make Medicaid, Older Americans Act and state revenue-funded programs more flexible and person-centered.

ADRC Snapshot

- 383 local ADRC programs sites in 51 states and territories cover approximately 60% of the U.S. population. 20 states and territories have achieved statewide coverage with their ADRCs.
- 49% of ADRCs are operated through a collaborative partnership among multiple organizations. 71% of ADRCs include an Area Agency on Aging, 24% include a Center for Independent Living, 22% include a County Government or Human Services Agency, and 39% include other types of organizations.
- On average, ADRCs report over a 300% increase in the number of contacts they serve after six months of operation. Put number in context –national or state.
- 37 states have statewide long term supports and services resource directories accessible to the public and professionals via the internet and another 10 are in the process of developing similar statewide capability.
- 40% of individuals contacting ADRCs to date were referred by critical pathway providers, such as hospital discharge planners, physicians, or other health professionals. How about from NFs and ICFMRs?
- On average, over 90% of ADRC users express high satisfaction with ADRC services.

Section VI. An ADRC/MFP Shared Vision

The Year of Community Living is a foundation which fosters the collaboration necessary to further the implementation of the Olmstead decision and assure integration for persons with disabilities as required under the Americans with Disabilities Act.

- **ADRC VISION:** The vision is to have ADRCs in *every* community, *highly visible* and *trusted,* serving people of *all ages and incomes*, providing a *full range* of long term services and supports within a point of entry providing *streamlined access* to services and supports.[vii]
- **MFP VISION:** CMS has a long-standing vision to help States move toward a balanced delivery system. Balance is defined as "a sustainable, *person-driven* long term support system in which people with disabilities and chronic conditions have *choice, control and access* to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life". [viii]

ADRC and MFP share the same vision of:

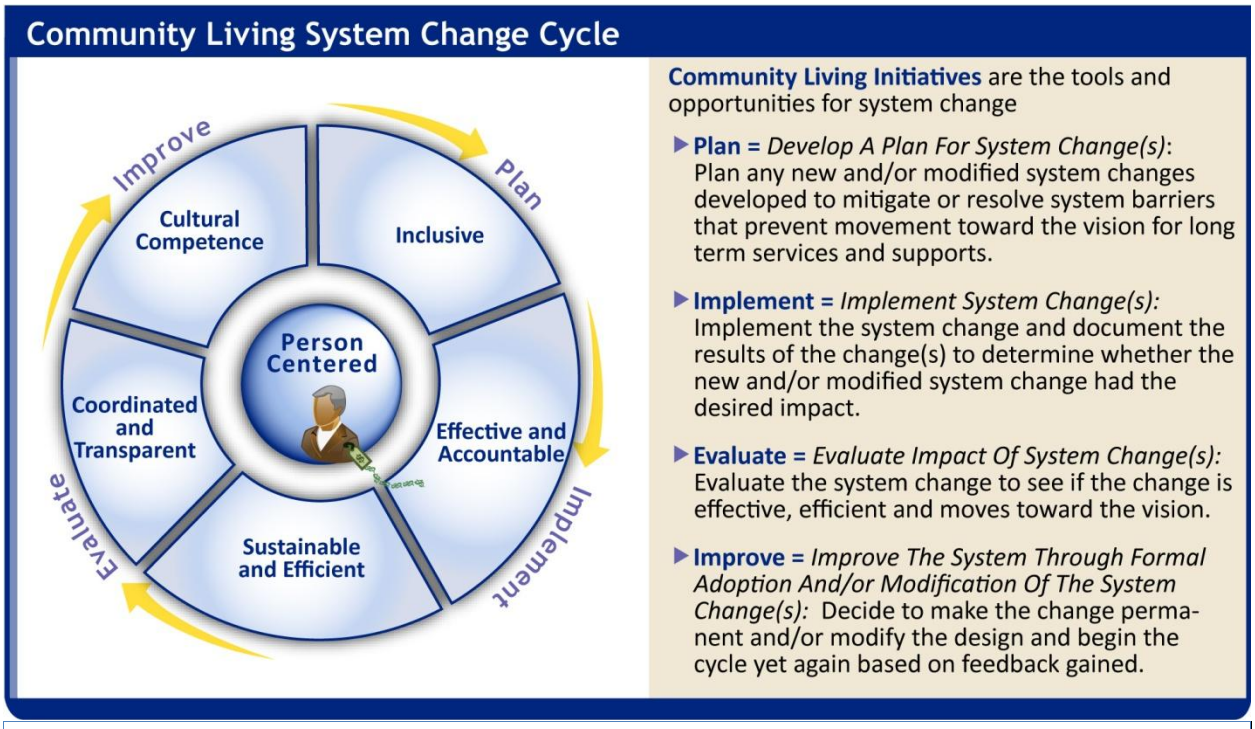
- Person-centered services and supports
- Choice, control and independence
- Access to a full range of services and supports
- Trusted and transparent service delivery, and
- A system that is flexible to serve all people of all ages and all disabilities/conditions

MFP can help ADRCs build the core components of a fully functioning system. ADRCs can help MFP programs move toward a balanced delivery system. The two programs share the same vision and many core goals!

Section VII. Working together to achieve a Person-Centered Delivery System

Whether developing an ADRC, operating an MFP Transition program, reforming the services and supports system, or implementing any of the options available through multiple federal agencies, the goal is the same. The long term services and supports system is in a cycle of continuous quality improvement. By working together, resources are maximized and the system moves at a faster pace toward the shared vision.

Figure 3: Community Living System Change Cycle



Note: The Community Living System Change Cycle is based on Deming's Continuous Quality Improvement (CQI) model used by the National HCBS Quality Enterprise (www.nationalqualityenterprise.net).

The vision is to achieve a long term services and supports system[ix] that is:

- **PERSON-CENTERED:** The system affords older people, people with disabilities and/or chronic illness the opportunity to decide where and with whom they live, to have control over the services they receive and who provides the services, to work and earn money, and to include friends and supports to help them participate in community life.
- **INCLUSIVE:** The system encourages and supports people to live where they want to live with access to a full array of quality services and supports in the community.
- **EFFECTIVE AND ACCOUNTABLE:** The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners and includes personal accountability and planning for long-term care needs, including greater use and awareness of private sources of funding.

- **SUSTAINABLE AND EFFICIENT:** The system achieves economy and efficiency by coordinating and managing a package of services that are appropriate for the beneficiary and paid for by the appropriate party.
- **COORDINATED AND TRANSPARENT:** The system coordinates services from various funding streams to provide a coordinated, seamless package of supports, and makes effective use of health information technology to provide transparent information to consumers, providers and payers.
- **CULTURALLY COMPETENT:** The system provides accessible information and services that take into account people's cultural and linguistic needs.

ADRC and MFP Programs may find the *Community Living System Change Cycle Tracking Worksheet* as a helpful tool when tracking unique system change initiatives.

Community Living System Change Cycle Tracking Worksheet

Change Code (N N+#= New, R+# = Revision)	Plan Component	Funding Source	Implementing Action Step	Date Action Started	Expected Outcome	Date Outcome Measured for Completion	Improvement Adopted or Modified	Date Improvement Adopted or Modified
EXAMPLE								
N1	Housing	XYZ	Develop web-based search tool to locate available and accessible housing in community	May 1, 2012	Persons will have improved access to available and accessible housing in local communities as measured by: 1.) Number of hits on website 2.) Decrease in time between action to move and actual move.	October 1, 2012	Adopted – Web-based tool available on Sept. 1, 2012. Marketing conducted by October 1.	October 15, 2012 – will monitor expected outcomes quarterly
N2	Outreach	ABC	Implement new marketing tools to increase enrollment in ABC program.	October 1, 2012	Persons will know about ABC program and will enroll as measured by: 1.) Increased enrollment in ABC program. 2.) Satisfaction with ABC program enrollment measured through quarterly survey.	March 2013	Modified – Enrollment did not increase as a result of new marketing tools	Modified Approach in April 2013
N2-R1	Outreach	ABC	Implement new marketing tools to increase enrollment in ABC program	May, 1, 2013	Same as N2	October 2013	Adopted	October 2013 – implement marketing strategy and measure outcomes quarterly

Section VIII. ADRC/MFP Partnerships: Target Population Overlap and State Experiences

In the spring of 2011, the Lewin Group conducted analyses of state ADRC and MFP Programs using ADRC semi-annual reporting tool data as well as MFP operational protocol information as resources. Most ADRC and MFP programs serve older adults. Only one state MFP program does not serve older adults. ADRC and MFP programs also are likely to support persons with physical disabilities, however variability between ADRC and MFP programs is more evident for persons with ID/DD and mental health needs.

When viewing the two programs separately, ADRCs are more likely to support older adults (100%) and physical disability groups (100%) and least likely to support the mental health (67%) and ID/DD groups (71%).

MFP programs are more likely to support older adults (97%), physical disability (94%) and ID/DD groups (91%) and least likely to support the mental health (44%) group.

Figure 4: Percentage of MFP and ADRC programs serving Older Adults, Individuals with Physical Disabilities and Individuals with MR/DD/ID

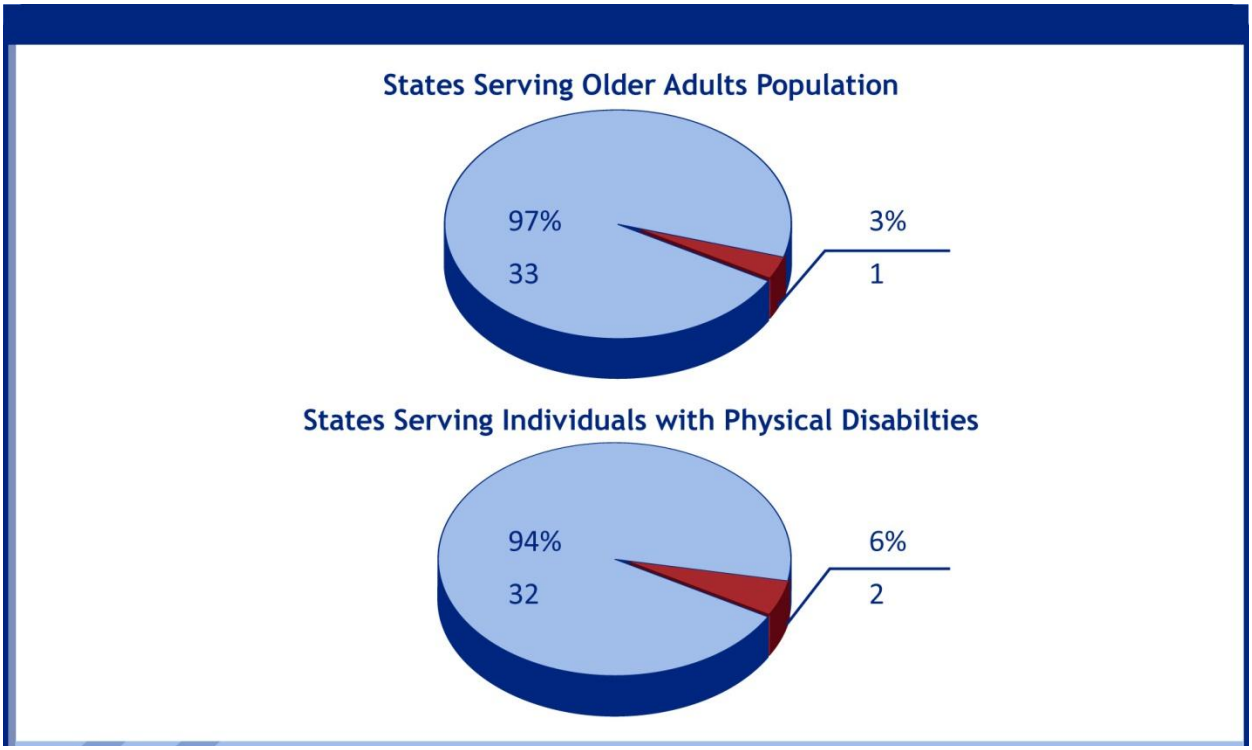
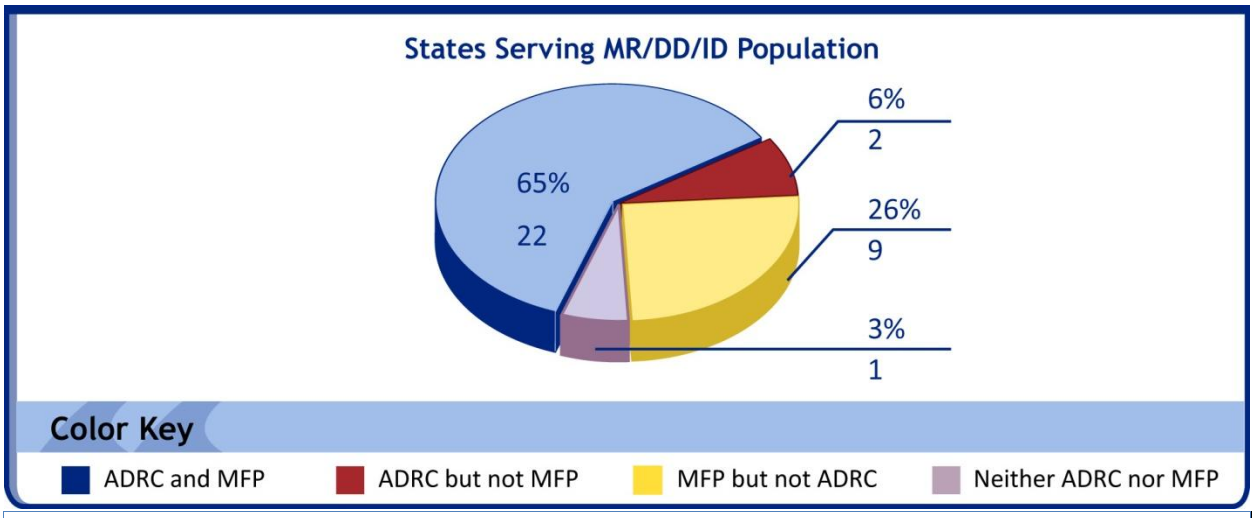


Figure 4: Percentage of MFP and ADRC programs serving Older Adults, Individuals with Physical Disabilities and Individuals with MR/DD/ID (continued)



Note: The following states are included in the above three figures: AR, CA, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MI, MN, MO, NE, NH, NJ, NY, NC, ND, OH, OK, OR, PA, SC, TX, VA, WA, WI

State ADRC and MFP programs are working together in different ways. The table [x] below highlights some of the ways states are collaborating to not only help persons who are aging and/or have disabilities to remain or return to community living, but also to engage in system change to better meet the needs of all ages and disabilities consistent with the ADRC/MFP vision.

State Program	Description of State Experience
Connecticut: Co-Location of ADRC and MFP Staff	Through the ADRC/MFP Supplemental Funding Opportunity C Collaboration Grant Award funds, Connecticut MFP hired three staff to assist with the implementation of MDS 3.0 Section Q. The three staff are located within the same location as ADRC contractors and perform the following functions: Establish relationships with local community providers, local access agencies, local DSS social workers and other organizations; Serve as liaison between the providers, access agencies, DSS social workers, other community based organizations and the State's transition program; Establish relationships with key staff within nursing homes who may assist with identification of individuals who are interested in transitioning; Conduct initial telephonic interview, assessment and complete intake paperwork with persons in nursing homes and or ICF/MR; Provide information regarding community options; Determine need for 1:1 follow up interview and/or priority transition status; Assist each participant with eligibility process for Medicaid; Maintain effective communication with MFP central office staff; Advocate on behalf of the participant; Coordinate initial planning efforts and make referrals to appropriate community resources including transition services.

State Program	Description of State Experience
Maryland: ADRC/MFP Partnership in Support of Stakeholder and Infrastructure Development	The Maryland Access Point (MAP) sites and Area Agencies on Aging (AAA) provide Program Education (Options Counseling), Application Assistance and Transition Case Management for eligible individuals transitioning from nursing facilities. The MAP and AAA sites collaborate with peer mentor organizations (e.g. Centers for Independent Living), for outreach into nursing facilities. The Peer Outreach contractors refer individuals directly to the MAP or AAA. The MAP directors and the State Unit on Aging MAP staff participate in monthly stakeholder groups to evaluate the MFP program and to plan for new initiatives. MFP funding supports the services performed by local MAP and AAA sites as well as the development of new local MAP sites, cross-disability and person centered counseling training and the MAP web-based statewide searchable database (www.marylandaccesspoint.info). Additionally, the state is using the ADRC/MFP Supplemental Funding Opportunity C Grant award to develop standards for peer support programs in the MFP and MDS 3.0 programs. All MAP sites and programs providing long term services and supports are expected to adopt the peer support standards.
Missouri: ADRC/MFP Partnership in Support of MDS 3.0 Section Q Education and Training	The Aging and Disability Resource Center is partnering with the Money Follows the Person initiative to create education and training curricula for those involved in and impacted by the application of the new MDS 3.0, Section Q. The curricula is expected to address three key audiences: 1) Public education materials to inform people in long-term (LTC) care facilities and the general public of their rights and opportunities to pursue transition from LTC facilities to community living; 2) Education curriculum for the court system to inform judges and public administrators involved in guardianship about the rights and options of people either in or at risk of entering the LTC system; 3) Training curriculum for LTC staff to understand the rights of individuals in the LTC system to pursue community living, how to correctly administer the MDS 3.0, Section Q, and responsibilities regarding the proper administration and reporting of MDS 3.0, Section Q. The MFP project director will work in conjunction with participating ADRC staff to review collected MDS Section Q data. This data will be evaluated for appropriate administration and recording, accuracy of response, and changes in individual responses. Nursing facilities exhibiting difficulties with the suitable administration of MDS 3.0 Section Q will be counseled on the discrepant areas and offered further training and technical assistance.

State Program	Description of State Experience
New Jersey: Identifying a Common Purpose and Commitment to Work Together	In early 2011, the MFP Director and Assistant Director met with the ADRC Project Director to share the purpose, function and goals of each initiative. Staff discussed program similarities, like goals and vision and began to brainstorm ways the two initiatives can collaborate in the future. As a result of collaboration, the New Jersey five year ADRC plan includes MFP/ADRC collaboration activities with key objectives and tasks in development. *Objective 1:* Identify and counsel NF residents on alternative HCBS. Key Tasks: 1) Develop and implement integrated training modules on MFP for ADRC staff completing I & A and Screen for Community Services (SCS) and for staff in the Office of Community Choice Options(OCCO) that will be responsible for conducting care needs assessments and options counseling. 2) Within each of the 3 regional OCCO offices, recruit MFP Support Specialist Team leader (RN) to meet regularly with ADRC staff. This task is already underway. 3) Expand the MFP partnerships with other grant-funded programs such as the Medicaid Infrastructure Grant and NJ Workability (DHS, Division of Disability Services) to offer employment alternatives for the MFP and ADRC participants. *Objective 2:* Enhance and refine the Interdisciplinary Team (IDT) approach to ensure appropriate and safe discharges to the community. Key Tasks: 1) Update and implement IDT training curriculum for MFP key team members including ADRC, OCCO, NF discharge planners, community care managers, and other health related professionals. 2) Develop strategies to support consumers and their caregivers to direct their transitional planning process. 3) Create a standardized MFP packet to include MFP fact sheet and brochure, participant handbook, and information on HCBS options. 4) Link MFP consumers to ADRC services post discharge. *Objective 3:* Provide consumers and professionals access to appropriate and accessible housing options Key Tasks: 1) Hire a Statewide Housing Coordinator and DACS Housing Specialist for MFP related activities. This task is complete. 2) Develop and implement training curriculum to educate OCCO and ADRC partners on affordable and accessible housing options. 3) Develop within the ADRC webpage a housing directory for consumers to learn about and locate affordable and accessible housing options.

State Program	Description of State Experience
North Carolina: Developing a Formal Memoranda or Agreement	The Community Resource Connections for Aging and Disabilities (CRC) and the North Carolina Money Follows the Person Demonstration (MFP) staff have partnered in a number of meaningful ways to include the following: 1.) The CRC Project Director facilitated the emerging transition coordination partnership between the MFP and the Division of Vocational Rehabilitation's Independent Living Program; 2.) The MFP Project Director served on a CRC applicant evaluation committee and currently serves on the State's CRC Strategic Planning Committee; 3.) Staff from the Office of Long-term Services and Supports (OLTS) within the Division of Aging and Adult Services, which oversees CRC implementation, and MFP staff are collaborating with the Division of Health Service Regulation to develop and implement protocols for the State's MDS 3.0, Section Q; 4.) The State CRC lead has incorporated MFP-related deliverables into the contract work plan deliverable for local CRC programs; 5.) The CRC and MFP staff have presented at stakeholder meetings for each grant; 6.) The MFP Project Director held a program training session for CRC Annual Coordinator Training; 7.) The OLTS, state lead for CRC and the state lead for MFP are executing an agreement to formalize partnership and collaboration; and 8.) MFP is funding the LCA function which is housed within the ADRC network.
Ohio: Building the "D" In ADRC	The MFP transition coordinators include Centers for Independent Living and Long-term Care Ombudsman, who are also partners in the development of Ohio's Aging and Disability Resource Network. The MFP program supports enhancements to the state's on-line public information and referral portal, Connect Me Ohio, in order to expand the breadth of information included in the tool. The ADRC and MFP project directors, along with key stakeholders, have discussed content for a 'Community Living Guide,' with the intent of including it in some electronic form within Connect Me Ohio. The MFP is developing collaborative activities at the regional level, increasing the connectedness of the aging and disability systems (AAAs, CILs and other community partners) to create local housing and services cooperatives (LHSC) to benefit community living for all persons with disabilities. The LHSCs are led by Centers for Independent Living through an MFP sub-grant agreement and provide resources to integrate the "D" within ADRC. The LHSC model includes development of cooperatives in the following areas: personal care assistance, home modification including development of a temporary ramp and assistive device loan program, housing, and transportation.

State Program	Description of State Experience
Texas: Engaging in Policy and Fiscal Resource Exchange	Texas is funding two ADRCs through 100% administrative funds and two ADRCs through CMS/AoA MDS 3.0 Section Q funding. The two ADRCs funded through 100% funds will serve as the statewide local contact agencies for nursing facility residents who will spend down their resources and become eligible for the Money Follows the Person demonstration. In this role, these two ADRCs serve as "virtual system navigators" assisting individuals by (1) providing options counseling; (2) exploring community options; and (3) facilitating access to services, programs and resources that will assist in the individual's relocation from the nursing facility back into the community. Additionally, these two ADRCs will provide preliminary identification of data needed to establish a formal tracking system and communication network. They will provide information for a future procedure manual and training curriculum. The two ADRCs funded through CMS/AoA MDS 3.0 Section Q funding will serve as local contact agencies along with the relocation contractors for the Medicaid population. In this role, these two ADRCs will develop screening/referral protocols for options counseling practices specific to nursing facility residents who are relocating into the community and work to enhance resource databases associated with the options specific to their needs. Finally, the ADRCs will create "train the trainer" curriculum to assist other Texas ADRCs in replicating these efforts. Doing so will strengthen coordination between other ADRCs, ombudsmen, relocation contractors, area agencies on aging, centers for independent living, mental retardation authorities, mental health authorities, regional long-term services and supports offices, and managed care organizations. Texas is also establishing a new partnership for housing navigation through 100% MFP administrative funds. Four ADRCs will receive grants to develop key relationships with housing partners (e.g. public housing authorities), analyze complex housing policies and procedures, conduct an inventory of independent, integrated, accessible and affordable housing, contribute to local housing policies, and initiate local housing coalitions.

Section IX. Developing an ADRC/MFP Collaborative Partnership Strategy

A "**COLLABORATIVE PARTNERSHIP**" is a *process in which two or more people with diverse interests share knowledge and resources to improve the outcomes, and achieve the goals, of a shared vision*.

Building a collaborative partnership is a process. Both MFP and ADRC share common goals along two parallel paths; helping persons to live and receive services in the right place at the right time from the right people and changing the long term services and supports system to meet the vision of persons who are aging and/or have disabilities. ADRC and MFP programs may find it helpful to use the attached *Collaborative Partnership Scoring Sheet* to determine the level of collaborative partnership strength. Based on the score, ADRC and MFP programs may use the *helpful hints* contained in this section, information contained in *Section X "Building a Collaborative Partnership One Operational Component at a Time"* and ADRC/MFP Partnerships: State Experiences located in Section VIII to strengthen areas in development.

Collaborative Partnership Scale

0 to 10 Your score reflects a need to begin and/or continue dialogue to establish shared values and goals. Please review sections of this tool kit to better understand what you have in common.

11 to 20 You are on your way to developing a collaborative partnership. Think about how you can work toward common goals and possibly share resources to maximize output. Please review sections of this toolkit to apply ideas and innovative practices already experienced by states as well as take advantage of helpful hints to further strengthen your relationship. You will reap the benefits of such collaboration through shared efficiencies and persons who are aging and/or have disabilities will win most of all from the integration of resources and improved quality in programs and services.

21 to 39 You have a strong and positive partnership and likely have innovative practices to share with other states. Take the opportunity to share your experiences with others.

ADRC/MFP Collaborative Partnership Helpful Hints

Did you know that……?

MFP programs…	ADRCs…
❑ can test innovative strategies to resolve system barriers for persons transitioning between an array of settings. ❑ can offer MFP resources to help the ADRC build the front door infrastructure (e.g. using rebalancing or administrative funding to develop a web portal and/or revise assessment tools). ❑ can break down housing barriers (e.g. engage key partners in the development of strategy, provide housing navigation support). ❑ use the experiences of those who transition to learn what policy changes are needed and then often lead and/or engage in system change. ❑ are able to test areas not otherwise allowable under traditional Medicaid (e.g. IMDs and persons with mental illness between age 22 and 64). ❑ can help the ADRC to become a center of excellence for all persons who are aging and/or have disabilities. MFP can help ADRCs develop options counseling tools. ❑ can help ADRCs develop relationships with Medicaid eligibility workers.	❑ serve as an integrated or single entry point into the long term services and supports system. The system is designed to address many of the frustrations individuals and families experience when trying to access needed information, services, and supports and therefore can help MFP programs with transition support and policy change. ❑ must demonstrate competence in serving all persons with disabilities either in house or through formal partnerships with other community organizations to meet a fully functioning status. ❑ Must have solid referral/assistance systems in place to meet people where they are. Often the ADRC has referral protocols with key partners and procedures in place for routine follow-up with individuals and therefore have relationships built to address transition from institutional settings. ❑ Often use the Alliance for Information and Referral Systems (AIRS) standards as guidance. ❑ Seek to integrate intake, assessment, and financial eligibility processes to assure coordination across the public and non-public long term services and supports system making the ADRC a key stakeholder in system change initiatives.

MFP programs…	ADRCs…
❑ are Medicaid demonstrations yet focused on long term services and supports system change for all persons regardless of payer source consistent with the ADRC vision and scope. ❑ can help with transition support (and even limit and/or help us understand how to mitigate the number of transition points in a person's life) and sustainable community living for the most vulnerable, "hardest to transition with cyclical transition history" persons with a history of unstable living, in need of employment, housing, income, critical health services, and coordination across multiple systems of care.	❑ Engage in care transitions and implementation of diversion strategies to help individuals find services at the right time in the right setting at the right time. ❑ Conduct outreach and marketing campaigns with consistent long term services and supports messages for individuals compared to MFP. A large percentage of referrals come through providers in transition pathways. ❑ Often engage actively in care planning, interface frequently with institutional settings, and need the resources (housing, benefit connection, employment assistance) of key partners to assure appropriate service provision.

If you are asking "how", speak with your ADRC and/or MFP program to find out more……..

Section X. Building an ADRC/MFP Collaborative Partnership One Operational Component at a Time

This section highlights the operational components of a fully functional aging and disability resource center and when applicable, notes the impact of the component on MFP programs. Helpful hints, certainly not exhaustive, are included within the chart to reflect how MFP and ADRC can help each other to develop the component of a fully functioning entry to long term services and supports.

Building an ADRC/MFP Collaborative Partnership One Operational Component at a Time	
Operational Component of a Fully Functioning Entry to Long Term Services and Supports	***How MFP and ADRC can help each other***
Information, Referral, and Awareness: Effective ADRCs must develop a comprehensive information, referral, and awareness system, building upon existing I&R in the community. Individuals of all ages and income levels need to know that the ADRC can provide trusted and unbiased information. In order to achieve this goal, fully-functional ADRCs have developed and implemented outreach and marketing strategies. They have also developed comprehensive information and referral/assistance (I&R/A) systems used uniformly by all the organizations comprising the ADRC, whether or not the ADRC has single or multiple entry points. Additionally, each ADRC should have a system in place for conducting consistent follow-ups with individuals who have received I&R/A to determine whether they need more assistance. MFP Programs need effective information, referral and awareness to adequately assist persons residing within qualified institutional settings. From a system change perspective, having a comprehensive information and referral system helps with effective access to services and supports at the right time, in the right amount and in the right setting.	1.) Integrate the MFP Marketing and Outreach strategy with the ADRC Marketing and Outreach strategy. 2.) Leave MFP Marketing Resources with ADRCs to share with persons seeking information and referral. 3.) Designate the ADRC as the local contact agency MDS 3.0 for Section Q. 4.) Designate the ADRC as one, or the only, entry point to MFP referral. 5.) Maximize resources by developing a joint work plan to serve all persons across public and private programs with the MFP transition program as one component of an overarching diversion and transition strategy. See Section III of this toolkit for a visual representation of transition pathways. 6.) Share resources to better serve persons in an "integrated" service delivery model. 7.) Utilize MFP fiscal and policy resources to develop a strong(er) "no wrong door" single entry point structure (e.g. co-lead a workgroup to modify policies related to access, pool fiscal resources to develop an integrated and automated entry system). 8.) Set a goal across both ADRC and MFP programs to serve all persons of all ages. Use MFP to develop the information resources needed to serve all persons regardless of need. Together, you can establish a cross-disability system change plan.

Building an ADRC/MFP Collaborative Partnership One Operational Component at a Time

Operational Component of a Fully Functioning Entry to Long Term Services and Supports	*How MFP and ADRC can help each other*
Options Counseling: Every fully-functional ADRC provides Options Counseling and assistance to individuals, their family members, and/or caregivers to support decision-making about long-term service and support choices based on individual preferences, needs and values. Options Counseling and assistance can also result in the development of service plans and arrangement of the delivery of services. When implementing this component, ADRCs must develop standards and protocols for who will be offered options counseling, what the counseling will include, and how outcomes will be tracked. As with I&R/A, consistent follow-up with individuals who have received Options Counseling should be completed to determine the outcome of the Options Counseling and ensure that no further assistance is necessary. Options Counseling is a key component to an effective long term services and supports system.	1.) MFP has four goals; transition, quality, continuity, and system change. Options counseling is critical to not only the MFP participant, but to all persons accessing the long term services and supports system at various points in their lives. The MFP Program benefits from ADRC partnership because help is needed for individuals transitioning and system change is necessary. The best way to change a system is through the work of "on the ground" efforts within local systems. Refer persons in need of transition assistance to MFP when appropriate. Use MFP resources to develop tools, standardize operating procedures, training, curriculum, and assessment instruments, to name a few. 2.) Individuals transitioning through MFP often have critical need for follow-up given that many individuals have lengthy institutional history and/or a history of "cycling" in and out of community living. If MFP and ADRC are integrated, individuals will receive continual follow-up necessary to sustain community living. MFP may be able to provide the resources to assure appropriate follow-up as well as the collection of data to assure quality of care. 3.) Conduct a gap analysis. What skill set and/or expertise is missing from your options counseling model? Think about MFP as a resource to build expertise in housing, mental health, employment, and services to children, to name a few. 4.) Options Counseling can provide decision support. The core competencies and Options Counseling skill set via the national standards are very valuable. Whether the Options Counselor is the person doing the transition work, or a transition coordinator, for example, the skill set and training that Options Counseling brings is a strong foundation.
Streamlined Eligibility Determination for Public Programs: All fully-functional ADRCs provide streamlined eligibility determinations for public programs. This	1.) MFP is led by the Medicaid Agency. Use MFP to begin a conversation with the Medicaid Agency about a streamlined eligibility process. Develop a business case outlining how a streamlined

Building an ADRC/MFP Collaborative Partnership One Operational Component at a Time	
Operational Component of a Fully Functioning Entry to Long Term Services and Supports	***How MFP and ADRC can help each other***
means that an ADRC must be able to serve as a single point of entry to all publicly funded long-term supports, which includes those funded by Medicaid and the Older Americans Act, and other state and federal programs and services. For any of these supports, an ADRC has the necessary staff on-site (or seamlessly connected through electronic systems and formal referral protocols) to conduct intake, screening, assessing an individual's needs, developing service/care plans, determining programmatic and financial eligibility, and ensuring that individuals receive the services for which they are eligible.	eligibility process could result in a more choice-driven and integrated delivery system consistent with Medicaid and Aging and Disability goals. 2.) MFP and ADRC can co-lead a workgroup to modify eligibility determination policies and procedures. 3.) MFP resources may be available to develop tools to streamline and/or automate eligibility processes.
Person-Centered Transitions: A fully-functional ADRC has identified the common ways individuals' transition from one setting of care to another or from one public program to another, and has formal partnerships in place with hospitals, institutions, physicians, and other critical pathway providers to be able to reach out to those individuals with information about home and community-based services. For example, ADRC staff partner with hospital discharge planning programs and institutional transition programs to help individuals in the transition process to make informed choices about their service options. ADRCs should also offer evidence-based care transition services to support people to successfully transition from acute care settings into the community. MFP Programs can not only provide a vital set of services to persons in transition, but also are responsible for system change efforts to assure a balanced and choice driven delivery system.	1.) MFP programs have four goals; transition, quality, continuity, and system change. The MFP grant is not just about helping people move. It is about sustainable community living, breaking down the barriers that prevent natural transitions to occur. MFP is a key resource along the pathway and a mechanism to break down barriers that prevent the pathway from flowing naturally. The loss of housing and lack of appropriate supports in the community may sometimes create a roadblock in natural pathways. Both ADRC and MFP care about removing the barriers and repairing the system to flow. Include MFP staff and partners within person-centered transition planning. MFP programs should use the lessons learned about blockages to alleviate barriers permanently through system change. 2.) Use MFP resources (e.g. re-balancing funds) to develop tools (e.g. shared protocols, checklists, training, local cooperatives) to help individuals divert or transition to/from acute and long term care settings at the right time. 3.) Use MFP resources to develop marketing and/or training materials for physicians, long term care facilities, and hospitals on the value of community living and need to assure a seamless and choice-driven pathway for persons in need of assistance.

Building an ADRC/MFP Collaborative Partnership One Operational Component at a Time

Operational Component of a Fully Functioning Entry to Long Term Services and Supports	*How MFP and ADRC can help each other*
Consumer Populations, Partnerships, and Stakeholder Involvement: Fully-functional ADRCs actively market to and serve people with disabilities of all ages and types and of all income levels. In a continuous effort to effectively serve these groups, ADRCs develop formal partnerships with key stakeholder organizations, like state agencies, advocacy groups, and other community organizations that serve people with a range of disabilities. Consumers must be meaningfully involved in every aspect of the ADRC initiative, including program design, site selection, operations, and evaluation. MFP programs often have relationships with disability organizations such as Centers for Independent Living and may be a good resource for ADRCs in developing the "D" in ADRC	1.) MFP provides an excellent opportunity to encourage stakeholders to work toward a common goal. Join efforts to create efficiency across initiatives. Stakeholders are common across both ADRC and MFP. Leverage the ADRC/MFP knowledge of various systems to establish a cross-disability learning community. 2.) Establish a cross-disability advisory group comprised of persons with disabilities to guide system change efforts. Use MFP resources to fund the travel and aide supports needed for persons to participate in system change activities. 3.) ADRC/MFP partnerships create a strong foundation for the growth of other key partnerships such as with housing finance agencies, continuum's of care within the housing network or with vocational rehabilitation or disability employment partners. The stronger the cross-disability partnership, the greater the leverage across programs to gain growth in all areas of system change needed to assure a choice driven system of care. 4.) Develop a joint budget and/or pool resources in a strategic way to contribute toward an Olmstead oriented conference to provide opportunity for the exchange of ideas and sharing of local best practices. Highlight your strengths and develop a plan of action to mitigate your weaknesses. 5.) Use MFP to develop the "D" in ADRC. Often, MFP programs have positive relationships with Centers for Independent Living and are building infrastructure to better work with persons with mental illness, children, alcohol and drug addiction. In fact, many MFP transition programs offer peer support services. MFP is an excellent foundation to build the D in ADRC. Leverage MFP resources to gain participation with ADRC efforts and to build positive working relationships that will last well beyond both grants. 6.) Come together to form one vision as a state through the use of ADRC/MFP funds to hold focus groups or roundtable events. Use ADRC

Building an ADRC/MFP Collaborative Partnership One Operational Component at a Time	
Operational Component of a Fully Functioning Entry to Long Term Services and Supports	***How MFP and ADRC can help each other***
	and MFP to provide state leadership to needed programs and initiatives.
Quality Assurance and Evaluation: Fully-functional ADRCs incorporate quality assurance and continuous improvement into their systems to ensure that they are providing the highest standard of service and producing measurable results in their communities. In order to do this, ADRCs use electronic information systems to track their customers, services, performance, and costs. ADRCs use formal processes to receive input and feedback from consumers and their families on services rendered. Evaluation of data and feedback addresses ADRC measurable performance goals and indicators and help the ADRC improve operations at both the state and local levels. MFP programs are required to collect data on a set of benchmarks and often have additional program evaluation plans in place in conjunction with the required quality of life survey process. MFP programs collect cost, utilization and outcomes data.	1.) Develop performance metrics (e.g. percent change in distribution between community and institutional expenditures and people served, time to transition from referral to move) that measure progress toward efforts that are shared across ADRC and MFP. Create a dashboard. Establish a reward a system that recognizes success at the local level in all common efforts across MFP and ADRC. Hold an annual "good job" event to highlight best practices and encourage continued forward movement in your joint effort. 2.) MFP is required to collect data on quality of life pre and post transition. ADRC can join in this effort by assisting in implementation of by using the same quality of life questions within ADRC evaluation which enables the state to look across the system beyond just those persons meeting MFP eligibility which guides the state in determining how best to continue to integrate the system and assure choice along every step of the pathways.

For more information about Aging and Disability Resource Centers and the Money Follows the Person Demonstration, please visit the following websites.

Aging and Disability Resource Center

e-mail: adrc-tae@lewin.com
web: www.adrc-tae.org

Money Follows the Person Technical Assistance

e-mail: MFP-TA@NEWEDITIONS.NET
web: http://mfp-tac.com/

Footnotes

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[viii] http://www.cms.gov/CommunityServices/

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[x] Information contained in the table was reported by ADRC grantees in their Spring 2011 Semi-Annual Reports for AoA and CMS.