

Part 1 Overview Information

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services**

Center for Medicaid and CHIP Services

**Initial Announcement
Invitation to Apply for FY2012**

Money Follows the Person Rebalancing Grant Demonstration

**Funding Opportunity Number: CMS-1LI-13-001
Competition ID Number: CMS-1LI-13-001-013945**

CFDA 93.791

Date: February 8, 2012

Applicable Dates:

Voluntary Notice of Intent to Apply:	April 2, 2012
Electronic Grant Application Due Date:	August 8, 2012
Anticipated Issuance of Notice of Awards:	September 5, 2012
Anticipated Grant Period of Performance/Budget Period:	September 5, 2012 – March 31, 2016

Applicants Teleconference: To Be Determined

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I. FUNDING OPPORTUNITY DESCRIPTION

A. Background

The Money Follows the Person Rebalancing (MFP) Demonstration provides critical tools to address gaps in the availability of community services for individuals with disabilities. The opportunity to serve more individuals in home and community-based settings through MFP can help States implement the integration mandate of the American Disability Act (ADA as required by the Olmstead decision.

Money Follows the Person Rebalancing Demonstration

The MFP Rebalancing Demonstration Program was authorized by Congress in section 6071 of the Deficit Reduction Act of 2005 (DRA) and was designed to assist States to balance their long-term care systems and help Medicaid enrollees transition from institutions to the community. The MFP Demonstration Program reflects a growing consensus that long-term supports must be transformed from being institutionally based and provider-driven to “person-centered” consumer directed and community-based. Congress initially authorized up to \$1.75 billion in Federal funds through fiscal year (FY) 2011 to:

1. Increase the use of Home and Community Based Services (HCBS) and reduce the use of institutionally-based services;
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;
3. Strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and,
4. Ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.

Currently, forty three States and the District of Columbia are implementing MFP Demonstration Programs. Section 2403 of the Affordable Care Act (ACA) provides an opportunity for those States that are presently participating in the program to continue building and strengthening their MFP Demonstration Programs and for additional States to participate.

Section 2403 of ACA amended the Deficit Reduction Act of 2005 (DRA) by:

1. Extending the demonstration authority under Section 6071 of the DRA through September 30, 2016, and for each fiscal year (FY) of the extension, FY 2012-2016, authorizes \$450 million in additional DRA appropriations totaling \$2.25 billion. Grant awards made in any appropriation year are available for expenditures in the fiscal year in which the award was received and for four additional fiscal years. After the initial grant award, States may request and receive supplemental grant awards for each fiscal year through FY 2016. As

such, MFP grant awards made in FY 2016 would be available to the States for expenditures through FY2020.

Advantages to Participating States

The MFP Rebalancing Demonstration requires strong leadership from the Governor and all of the participating departments and services to use the resources provided by this opportunity to affect the systems change necessary to bring about an effective cost efficient balanced long-term care system.

The MFP Demonstration Program provides the following opportunities to develop unique demonstration services to help individuals make the transition from costly institutional care to quality, person-centered, home and community-based (HCBS) long-term care services:

Enhanced Federal Medical Assistance Percentage (FMAP): The MFP Demonstration Program provides an FMAP rate for qualified services, which includes HCBS services and demonstration services. (The enhanced rate is calculated as ½ of the state share for example a 50% FMAP State would receive 75% FMAP) The enhanced FMAP funding, as well as significant financial resources to support the administration of the demonstration are available for the implementation of broader infrastructure investments. These investments include initiatives such as creating systems for performance improvement and quality assurance, developing housing initiatives, supporting staff for key transition activities, improving the direct care workforce, and building “no wrong door” access to care systems.

Supplemental Services: Reimbursement is provided for services that will only be available for the MFP Demonstration Program period and are not covered by Medicaid. These services are reimbursed at the State’s published FMAP.

100% Reimbursement for Specific Administrative Costs: Reimbursement associated with the operation of the MFP grant may be provided after the submission, review, and approval of the grant application’s Operational Protocol. Examples of eligible reimbursable items that may be considered in a State application’s Operational Protocols are key personnel; MFP travel, training, outreach and marketing; IT infrastructure to accommodate the MFP financial and evaluation reporting requirements; and completing the Quality of Life survey requirements.

National Technical Assistance (TA): CMS has contracted with experts in the long-term care field to assist grantees, at no cost to the State, by providing the support and expertise necessary to enable the States to work through problems and barriers to implementation. The TA providers, along with support from the CMS Project Officers are available to ensure success.

Aging & Disability Resource Center Funding Initiative: The primary goal of this opportunity is to facilitate and strengthen the roles of ADRCs with respects to rebalancing the delivery of long-term services and supports by coordinating transitions from nursing homes (and other MFP qualified institutional settings) to community based settings for older adults and people with disabilities or chronic conditions. Specifically, AoA and CMS are interested in promoting increased partnership between State MFP programs and ADRCs to advance

transition work within the MFP demonstration.

Additional financial resources at of 100% federal grant funds will be available to strengthen ADRC roles in:

1. Building ADRC infrastructure and capacity to support transition efforts within MFP programs;
2. Promoting partnering activities between the State Medicaid Agency, State Unit on Aging, State Disability Agency, State and local Ombudsman program and other relevant stakeholders; and,
3. Utilizing and continuing to support the implementation of the Minimum Data Set (MDS) 3.0, Section Q for all MFP populations as well as Veterans and privately paying individuals.

It is expected that this funding will help ADRCs that will be involved in MFP initiatives expand their efforts; encourage MFP programs to partner with ADRCs to begin collaborative work; and, help advance federal transition initiatives. Once awarded a MFP grant, States will be able to submit proposals of up to \$400,000 for up to two years to implement this initiative.

Coming Soon: American Indians and Alaska Natives (AI-ANs) MFP Initiative: MFP Financial Assistance to Increase Access to Home and Community-based Services for American Indians and Alaska Natives: American Indians and Alaska Natives (AI/ANs) continue to be subject to significant disparities in their health status, even while the Indian Health Service (IHS) works to improve the quality of care in AI/AN communities. The system, however, is severely underfunded. Nowhere is it more evident that in community based long term services and supports, where the funding remains fragmented and difficult to acquire. The Indian Health Care Improvement Act (IHCIA), S. 1790, was enacted and reauthorized by section 10221 of the Affordable Care Act, Pub. L. 111-148Section 124 of S. 1790. It includes new authorities for hospice care, assisted living, long term care, and home and community based services for disabled and elderly AI/AN persons with specific functional eligibility requirements. However, no additional funding was appropriated to implement Section 124 other than funding contained in IHS appropriations. It is unlikely that tribes will be able to implement these authorizations without additional funding sources.

The MFP grant program will be offering substantial administrative financial resources to develop viable Medicaid programs to transition tribal elders out of nursing homes and into home and community based services (HCBS). MFP funding will be provided to Tribes through States to identify and demonstrate various acceptable HCBS models. The design of such programs would need to adhere to a 1996 Memorandum of Agreement entered into between CMS and IHS, which extends 100 percent FMAP for Medicaid services, which includes the provision of Medicaid home and community-based services to Indians by the IHS or by Tribes or Tribal organizations operating health programs under the Indian Self-Determination and Education Assistance Act (ISDEAA).

Supplemental funding will be awarded to State Medicaid Agencies in cooperation with eligible ISDEAA Tribes and Tribal Organizations. The supplemental funding may be used for the

development of long term services and supports initiatives using single or a variety of HCBS Medicaid authorities. It will also support a structure that enables Tribes or Tribal organizations to design a package of long term community based services and supports, and perform delegated administrative responsibilities on behalf of State Medicaid agencies. Specifically, the delegated functions could include conducting intakes, service coordination, day to day management of an HCBS program (i.e., operating agency functions), planning, designing and/or operating various aspects of home and community based services. State Medicaid agencies would continue to maintain their role as defined in the Single Medicaid Authority for the oversight of the program implementation (Social Security Act, Section 1902(a)(5)).

While MFP AI-AN supplemental funding opportunity is not currently available through this solicitation, States submitting an application in response to this 2012 MFP Solicitation and receive awards will have the opportunity to submit proposals for this funding opportunity in November 2012. Funds to implement the AI-AN MFP INITIATIVE will be available to States beginning in January 2013, through the yearly MFP supplemental grant award request process.

B. Demonstration Requirements

CMS will accept one application from each State interested in participating in the MFP demonstration program. The Single State Medicaid Agency must be the lead applicant. In making awards, CMS will give preference to States that include multiple target groups in their application, including individuals over 65 and under 21 with mental illness and aged individuals, and that propose the delivery of self-directed services. The number of demonstration programs approved by CMS depends on the scope (i.e., proposed enrollment and breadth of services) and quality of the proposed programs.

1. Demonstration Duration and Scope

The grant period of performance will be from the date of award through FFY 2016. However, supplemental funding awarded in FFY 2016 will be available for expenditures through FFY 2020. State applicants have the flexibility to propose the scope and focus of their demonstration program within that timeframe.

2. Demonstration Design and Development

The MFP statute clearly defines the key objectives of the demonstration, which include:

1. Increase the use of home and community-based, rather than institutional, long-term care services;
2. Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice;
3. Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting; and

4. Ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

In response to the statutory objectives, States will be required to submit a Draft Operational Protocol (OP) as the core section of the application package that both addresses the key demonstration objectives outlined above and provides a detailed description of the proposed demonstration project. The Draft OP is expected to address how the State will meet the MFP objectives.

All of the key operational elements listed below must be addressed within the Draft OP for an application to be considered complete. Of note, the Draft OP that is submitted must be organized by the headings below.

3. **Demonstration Operational Elements**

- Organization and Administration
- Benchmarks
- Participant recruitment and enrollment
- Informed consent and guardianship
- Outreach/marketing/education
- Stakeholder involvement
- Benefits and services
- Consumer supports
- Self-direction
- Quality
- Housing
- Continuity of care post-transition
- Budget (MFP Excel Worksheet for Proposed Budget, Administrative Budget, Administrative Budget Narrative)

Further instructions on developing the Draft OP are provided within Part IV of the application (Application and Submission Information, Application Narrative) and Appendix B (Draft Operational Protocol Instruction Guide).

Applicant's Teleconference Information regarding the date, time and call-in number for an open applicants' teleconference will be available on the MFP Home page at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html>. Please check the website for details. Examples of approved MFP Draft OPs can be accessed at:

- **Ohio:** <http://jfs.ohio.gov/OHP/HomeChoice/protocol.pdf>
- **Maryland:** <http://www.dhmh.state.md.us/mma/mfp/pdf/2010/Maryland-MFP-Protocol-2009-Final.pdf>

- **Texas:**
http://www.dads.state.tx.us/providers/pi/mfp_demonstration/operationalprotocol/index.html

Note: Applicants are **not** required to submit case studies if they are found in the example OPs.

4. **Demonstration Technical Elements**

a) *Participant Eligibility Requirements*

Within the Draft OP, States must specify the participant target group(s) they plan to recruit and enroll in the demonstration program. Individuals targeted for program participation must meet statutorily defined requirements outlined within Section 6071 of the DRA and amended by Section 2403 of the ACA. According to the statute, States must transition “eligible individuals” into a “qualified residence” from an “inpatient facility (qualified institution)”. The following defines the key eligibility criteria included within the MFP statute:

As defined in Section 6071(b)(2) of the DRA amended by Section 2403 of the ACA, the term “eligible individual” means, with respect to an MFP demonstration project of a State, an individual in the State who, immediately before beginning participation in the MFP demonstration project:

- Resides (and has resided, for a period of not less than 90 consecutive days in an inpatient facility. “Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i).”
- is receiving Medicaid benefits for inpatient services furnished by such inpatient facility and,
- with respect to whom a determination has been made that, but for the provision of HCBS long-term care services, the individual would continue to require the level of care provided in an inpatient facility. In any case in which the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, the individual must continue to require at least the level of care which had resulted in admission to the institution. (For more detail on eligible individual and level of care see-Demonstration Implementation Policies and Procedures, Participant Recruitment and Enrollment, Draft Operational Protocol Section I, A., Part#2, B, 1, f).

Additionally, Section 6071(d)(3) expressly waives the income and resource eligibility rules (Section 1902(a)(10)(C)(i)(III)) in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.

As defined by Section 6071(b)(6) of the DRA, the term “qualified residence” means, with respect to an eligible individual:

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

In addition, consistent with Section 6071(c)(6), CMS will require that individuals targeted as potential demonstration participants have been provided with individual choice regarding participation in the demonstration. Specific requirements must be addressed in the Draft OP, for assurances and proposed processes that:

- each eligible individual or the individual’s authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP demonstration project; and,
- each eligible individual or the individual’s authorized representative will have input into, and approve the selection of the qualified residence in which the individual will reside and the setting in which the individual will receive HCBS.

As defined in Section 6071(b)(3) of the DRA, the term “inpatient facility (qualified institution)” means a hospital, nursing facility, or intermediate care facility for persons with mental retardation. An institution for mental diseases (IMDs) which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) only to the extent medical assistance is available under the State Medicaid plan for services provided by such institution. Medicaid payments may only be applied to persons in IMDs who are over 65 or under 21 years of age.

b) Defining Services and Rates

The “MFP-enhanced FMAP” for a State, for a fiscal year (as defined in Section 6071 of the DRA), is equal to the published FMAP for the State, increased by a number of percentage points equal to 50 percent of the number of percentage points by which the FMAP for the State, is less than 100 percent; but, in no case shall the MFP-enhanced FMAP for a State exceed 90 percent.

For example, a State has a published FMAP of 50%. MFP calculates the rate as 100% minus the 50% and then divides that difference by two providing that State with an enhanced MFP-FMAP rate of 75%. If another State had a published FMAP of 86%.,

MFP calculates the rate as 100% minus the 86% and then divides that difference by two (equals 7%) providing that State with an enhanced MFP-FMAP rate of 93%- 3% to reduce the enhanced FMAP to the maximum 90%

Several service packages and rate structures are allowable under the demonstration program. The service packages are outlined below, along with a description of the match rates allowable for the various service packages under the demonstration program. Both fee-for-service and managed care service delivery models may be employed in this demonstration. The service packages include:

- Qualified HCBS Services- State Plan HCBS and waiver services that receive an enhanced rate
- Demonstration Services- Specialized HCBS services that may receive an enhanced rate
- Supplemental Services- Services not long-term care in nature and are one-time transition costs or services only offered during the demonstration and are reimbursed at the standard FMAP rate.
- CMS recognizes that many States offer long-term care services through a managed care or capitated model. Money Follows the Person Demonstrations can include managed care service delivery systems. In drafting their Operational Protocols, States may contemplate how enhanced FMAP will interface with capitated-funded models. This may include, but is not limited to, the use of the demonstration or supplemental service options as part of the 365-days demonstration period, in addition to enhanced FMAP for [home and community based](#) services offered through an established managed care or capitated model. A State may also request an MFP-specific [home and community based](#) service managed care rate for MFP participants only. CMS encourages States to determine what mechanism would work best within their State to support the successful transition of MFP participants as estimated in their benchmarks.

(1) Qualified Home & Community-based Services

The “qualified HCBS” program is the Medicaid service package(s) that the State will make available to a demonstration participant when they move to a community-based residence. This program can be comprised of any Medicaid home and community-based State Plan and waiver authority services and program packages. Under the demonstration, States are permitted to claim an enhanced match rate for the first 365-day post-transition period for qualified HCBS for demonstration participants who transition from an institutional setting into the community. States are also required to continue the qualified HCBS service provision after the conclusion of the demonstration program. For a comprehensive list of services that may be offered under the HCBS waiver program, see Appendix C: Participant Services and/or access the following link to the Home and

Community-Based Waiver [Version 3.5] Instructions, Technical Guide and Review Criteria: <https://www.hcbswaivers.net/CMS/faces/portal.jsp> (Also see Appendix B, Sub-Appendix V)

Of note, the MFP statute provides waiver authority for four provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of the demonstration. These provisions are:

- Statewideness (Section 1902(a)(1) of the Social Security Act) - in order to permit implementation of a State initiative in a selected area or areas of the State.
- Comparability (Section 1902(a)(10)(B) - in order to permit a State initiative to assist a selected category or categories of individuals enrolled in the demonstration.
- Income and Resource Eligibility (Section 1902(a)(10)(C)(i)(III) – in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.
- Provider agreement (Section 1902(a)(27)) - in order to permit a State to implement self-direction services in a cost-effective manner for purposes of this demonstration program

(2) Demonstration Services

States may also choose to offer additional services specific to the MFP demonstration program, such as “demonstration HCBS” program services. These services are also eligible for an enhanced match rate, but are different from the qualified HCBS program services in that they are not required to continue after the conclusion of the demonstration program or for the participant, at the end of the 365-day enrollment period. This service package may be helpful to States that do not have comprehensive transition services included in certain 1915(c) waivers or in the State Plan, as it would allow for the provision of transition services to demonstration participants outside the auspices of the waiver or the State Plan. States may ultimately choose to amend their waivers and/or State plans to include the demonstration services.

(3) Supplemental Services

In addition to qualified HCBS and unique demonstration services, a State may choose to offer “supplemental demonstration services” at the standard FMAP rate. The State may propose these services because they are essential for successful transition to the community. These services should only be required during the transition period, or be a one-time cost to the program. These services are not expected to be continued after the demonstration period. Examples of these services are given in Appendix B, Sub-Appendix VII.

(a) Upon approval of the Operational Protocol

All “qualified HCBS and demonstration service expenditures” will be eligible for the enhanced match rate specified in the statute. The enhanced rate for qualified HCBS services and demonstration services can only be applied to services furnished during the 365-day period beginning on the date the individual is discharged from an inpatient facility. All other Medicaid services (including physician, prescriptions, inpatient, etc.) are reimbursed at the standard FMAP rate via the existing Medicaid claims process throughout the course of the demonstration and not paid out of MFP grant award funding.

States must submit a package of services to be delivered under the demonstration as part of the Draft OP included in their application. CMS also expects applicants to address in detail how the waiver authorities and other Medicaid HCBS will be utilized as part of the Draft OP. The benefit package will be subject to CMS approval. For more detail on Benefits and Services see-Demonstration Implementation Policies and Procedures, Operational Protocol Section I, A., Part#2, B, 5.)

c) Stakeholder Involvement

Meaningful stakeholder involvement in the form of support, collaboration, and guidance is required by statute and is critical to the success of the demonstration program. The applicant must consider the resources, unique aspects of the State, and the available opportunities when considering how to implement this demonstration program.

Stakeholders can provide critical targeted assistance and support to with transition work because of their unique experience, resources, and care history with the individuals who want to transition to the community. The applicant, the State Medicaid Agency along with the partnering program agency/agencies must enlist a range of stakeholders, including but not limited to: other State agencies, Public Housing Authorities, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) providers, nursing home providers, Psychiatric Hospitals and Psychiatric Residential treatment Facilities, Centers for Independent Living, Area Agencies on Aging, self-advocacy organizations, other stakeholder groups and most importantly, consumers and their families.

Some specific areas in which the State can work collaboratively with their stakeholders include:

- Information regarding the HCBS capacity and capability that is needed in order to provide supports and services to those individuals transitioned to the community;
- The availability of stakeholder resources to identify those eligible to transition and how those resources may be leveraged under the demonstration;

- Coordination with State Licensing and Survey and Certification entity/agency on the identification of, and whether to target chronically poor performing facilities, or facilities that are identified for closure for transitioning of individuals;
- Assistance with the process for identification of populations and individuals for transitioning;
- Access to assessment data and other information across settings, including nursing home Minimum Data Set 3.0, Section “Q” to assist in the identification of individuals for transitioning;
- Cross training of Provider staff to assist with transitions and provide care in the community to individuals transitioned; and
- Mechanisms to create and/or expand access to needed HCBS via ICF/MR, NH, Psychiatric Hospital and PRTF provider diversification, adaptation and development of the capability and capacity to provide Medicaid services to those transitioned to the community. For more detail on Stakeholder Involvement see-Demonstration Implementation Policies and Procedures, Operational Protocol Section I, A., Part#2, B, 4.)

d) Technical Assistance and Quality Assurance and Improvement

Section 6071 of the DRA directed the provision of quality assurance and improvement, technical assistance, and oversight to those States with an MFP demonstration for supporting grantees in their system reform efforts. The MFP program has a national technical assistance contract that provides States with general and individualized technical assistance on a variety of topics, including but not limited to: mental health, housing, employment, HCBS quality, Medicaid financing authorities, transition coordination, stakeholder involvement/partnerships, data management strategies, and direct service workforce.

The national technical assistance contract uses a “single entry point” model where one technical assistance team member serves as the technical assistance lead for each MFP State. The technical assistance leads work with their States to identify pressing needs, and subsequently, customize an effective mix of technical assistance approaches to address the needs. The “state-driven” technical assistance is provided to MFP grantees through a variety of methods, including:

- Developing mentoring relationship across States;
- Strategic planning and visioning with State leadership;
- Organizing peer workgroups across States;
- Organizing audio conference, webinars, and webcast;
- Providing on-site consultation and facilitation of partner/stakeholder meetings;
- Providing example materials, program tools, and best practices; and,
- A variety of other strategies to help States meet their goals.

The national technical assistance contract also hosts a robust website that functions as a vehicle for resource dissemination and information exchanged between the technical assistance team, the MFP States, and CMS. The website has (1) clickable program maps linking to general information about State programs and progress, (2) resources, research, reports, program materials, examples from the field, and tolls cross-indexed by topic area, state, and consumer population, and (3) a calendar of events with information about upcoming program events, meetings, calls, and other items of interest.

Technical assistance will be available through a national contract until the conclusion of the demonstration program. MFP States must participate in all technical assistance activities and cooperate in any quality assurance/improvement activities determined necessary by CMS.

(For more detail on Quality see-Demonstration Implementation Policies and Procedures, Operational Protocol Section I, A., Part#2, B, 8.)

e) National Evaluation

CMS has a national evaluation contract to conduct an ongoing and final national evaluation of the MFP Demonstration Project. The national evaluation will assess whether the demonstration program has met its goals to (1) increase the number and proportion of institutionalized Medicaid enrollees who can be transitioned to live successfully in the community, and (2) rebalance the State's long-term care system by developing the required infrastructure and increasing expenditures on HCBS and decreasing expenditures on Medicaid institutional services. The national evaluation contractor will be collecting data on the demonstration programs to answer the following questions:

1. What evidence is there that the MFP demonstration has maintained and/or improved the quality of care and quality of life for individuals who have transitioned from institutions to the community?

Quality of Life Survey: The MFP program requires that Quality of Life surveys (QoL) be administered and data submitted to our National Evaluator. The QoL is designed to collect information from Medicaid beneficiaries transitioning out of institutional care as a result of the MFP program and measure how quality of life is affected by the transition program. The QoL survey assesses MFP participant status across seven domains: living situation, choice and control, access to personal care, respect/dignity, community integration and inclusion, overall satisfaction with life, and health status. The instrument is largely based upon the Participant Experience Survey, although a few items are drawn from other instruments.¹ The MFP-QoL survey is designed to be administered at three points in time:

- At “baseline” – after the individual has been accepted into the MFP program but just prior to transition to the community
- First follow-up conducted 11 months post-transition to the community
- Second follow-up conducted 24 months post-transition to the community

The MFP-QoL is administered by grantees through in-person interviews with participants or their proxy using survey and data collection instruments provided by the national MFP evaluator. MFP funding to conduct the surveys is provided at \$100-\$125 survey and 100% administrative funding for administering the QoL survey process and data submission.

2. What evidence is there that the States have rebalanced resources to provide more Medicaid consumers LTC supports in the community instead of in an institution? Specifically, how many consumers have been successfully transitioned? Of those transitioned, how many are now enrolled in waiver programs, and have remained in the community in the 2 years following the initial 12 month transitioned period? What were the reasons for no longer being in the community, including preventable and unpreventable reasons for re-institutionalization?
3. What evidence is there that the MFP program has eliminated barriers that prevented and/or restricted the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive appropriate and necessary long term care services in the setting of their choice? Have States implemented sustainable systems?
4. What sustainable processes and systems’ changes have resulted in transitions of individuals to the community; diversion of individuals to unnecessary institutionalization; implementation of the flexible use of Medicaid funds; continuity of services after transitioned; and assurance of the health and safety of transitioned individuals?
5. What quality assurance and quality improvement procedures and outcomes demonstrate that needed services are being provided in the community? How is the health and safety of participants being assured while also providing consumer choice?
6. What are the costs of providing HCBS to populations and individuals who have transitioned from institutions to the community and how does that cost compare to the same level of cost of care and services provided in institutions?

Grantees may also choose to conduct their own independent evaluation to either assist in the establishment of a formative learning process and/or to serve as the interface between the grantee and the CMS national evaluation contractor. The

grantee and their evaluation contractor (if the grantee chooses to engage one) will be required to cooperate fully with CMS and the national evaluation contractor.

Costs associated with participating in the demonstration evaluation and the submission of both financial and programmatic data, if approved, may be reimbursed at 100% through grant funding.

States will need to provide individual-level data on program participants prior to the transition of the individual and during the demonstration period. This information must come from official administrative records and not from self-reported information. The individual data required are defined in the MFP Evaluation Design. Use and access to this data will be limited to the specific research purposes of these projects and shall adhere to all CMS provisions concerning data release policies, the Privacy Act of 1974, and the Health Insurance Portability and Accountability Act of 1996.

(For more detail on the National Evaluation see-Demonstration Implementation Policies and Procedures, Operational Protocol Section I, A., Part#2, D.)

f) Programmatic Reporting Requirements

All grantees will be required to submit semi-annual web-based reports that address various aspects of program implementation. The data collected in the reports will provide the national evaluation contractor with information on:

- **Structure** – implemented program changes to rebalance resources and transition and maintain individuals in the community, i.e., systems changes, agency changes;
- **Process** – implemented strategies and procedures of the MFP program including Quality Management Strategy ;
- **Output** – products of the MFP program, i.e., waiver and State plan amendments, State legislation, agency changes; new policies, new procedures;
- **Outcomes**—results of the MFP program, i.e., what changed, who was transitioned, what populations, community settings where transitioned individuals moved; and
- **Impact** – Consumer outcomes, i.e., continuity of services, appropriateness of services delivered based on assessment, utilization of services after transition, length of stay in the community, consumer satisfaction.

g) Financial Reporting Requirements

All grantees will be required to submit financial reporting forms on a quarterly, semi-annual, or annual basis. Below are brief descriptions of the required forms:

1. **CMS 64.9i, 9Pi and 64.10i, 10Pi** - These forms, submitted on a quarterly basis, allow the State and CMS to track expenditures associated with the demonstration participants. The various forms feed into the Medicaid Budget and Expenditure System (MBES), but are not used to draw down funding. They are informational

forms that will provide a mechanism for adequately projecting estimates on expenditures once the participant leaves the demonstration.

2. **MFP Program Files** – This files will be submitted quarterly to the national evaluation contractor. The files will be used to track program enrollment patterns, participant quality of life, and Medicaid claims records extracted from the Medicaid Statistical Information System (MSIS) for each demonstration participant. The quarterly files will be sent to the national Evaluation contractor via the Gentran system.
3. **MFP Financial Reporting Forms (A, B, C, and D)** - The MFP Financial Reporting Forms, submitted on a quarterly basis, are modified from the CMS 64. The forms provide a mechanism for tracking expenditures for Qualified HCBS, Demonstration and Supplemental, Services offered under the demonstration, as well as administrative claims that will require reimbursement from demonstration funds.
4. **Federal Financial Report (FFR or SF-425)** - All MFP grantees are required to submit the SF-425 on a semi-annual basis with the first report due on July 31st covering the reporting period of January through June, and the second report due on January 31st covering the reporting period of July through December. For year one (first report due on July 31, 2012), will only cover April 2012 through June 2012. The SF-425 consolidates and replaces the SF 269 (Financial Status Report) and the PSC-272 (Federal Cash Transactions Report) with a single electronic report. For more information, please visit the Division of Payment Management's website at <http://www.dpm.psc.gov/Default.aspx>.
5. **Maintenance of Effort (MOE) Form** – This form is due yearly on January 31st and will capture all LTC expenditures (both community and institutional) annually to ensure that the State has maintained its financial effort taking into account all service costs, administrative costs, and rebalancing investments.
6. **MFP Worksheet for Proposed Budget** – This form, submitted initially within the Draft Operational Protocol and subsequently on an annual basis on January 31st, will provide CMS with a standardized report of each State's high level budget information, as well as projected transition benchmark information.

(For more detail on Budget see-Demonstration Implementation Policies and Procedures, Operational Protocol Section I, A., Part#2, E.)

II. AWARD INFORMATION

A. Amount of Funding

Total funding for the MFP demonstration through 2016 equals \$4 billion. All funding that is awarded may be expended in that fiscal year of award and four additional years (see: DRA Section 6071, (e)(1) & (e)(2)).

Awards made will be federal grants, with 3-7 anticipated awards. There are no minimum or maximum grant awards per State; however, CMS reserves the right to negotiate the size of any award based on the number of transitions and the development of the necessary infrastructure to implement the demonstration program.

B. Period of Performance

The project period is initially from 2012 through 2016 pending the terms and conditions of participation in the grant program are met. CMS will approve funding for the State's MFP program in the grant award letter. The first year funding will be available at the time of award. Each year in January, States will request supplemental funding based on their proposed budget and benchmarks.

When the terms and conditions of the program are met, CMS grants final approval of the Draft OP, and States transmit the required evaluation and financial data, they may begin to transition eligible individuals.

At any point during the demonstration program, if a State fails to meet the two required annual numerical benchmarks and the Health and Welfare requirements (see (d)(4) (A) & (B) that were declared in the application Draft OP and approved by CMS, CMS may rescind the grant award—including all un-obligated balances, and issue the unspent grant funds to other projects or withhold supplemental funding until the benchmarks are met.

III. ELIGIBILITY INFORMATION

A. Eligible Applicants

Any single State Medicaid Agency not currently participating in the MFP Rebalancing Demonstration may apply. By "State", we refer to the definition provided under 45 CFR §74.2 as "any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments." By "territory or possession", we mean Guam, the U. S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands. Only one application can be submitted for a given State. Territories should note that any increased FMAP received, as part of the MFP demonstration program, would contribute to their total Medicaid allotment.

CMS expects that the Single State Medicaid Agency will collaborate with local governments, other agencies and service providers who contribute to successful community living in the State. However, since the Single State Medicaid Agency is responsible for contributing the State match for Medicaid home and community-based services provided under the demonstration, they must be the lead applicant for the project.

Applicants are strongly encouraged to include, in an appendix, letters of support from major partners, including consumers and advocacy groups. These letters and memorandums of agreement give substantive support to the applicant's systems readiness. Applicants should include all such letters as part of their application package as instructed in this solicitation (Please see Section IV subsection 2, D). CMS will disregard any letter received outside of the submitted application. Letters should be included as a PDF file as instructed in the requirements of the application submission.

B. Cost Sharing or Matching

There is no discretionary federal cost sharing requirement. However, home and community based long-term care costs will be reimbursed at the enhanced FMAP rate established by this demonstration. A State's MFP FMAP cannot exceed 90%.

The State will be required to include in the Draft OP a section that addresses the State share of the demonstration costs. The State will be under obligation to have secured the State share of funding prior to receiving approval to expend funding on services.

Administrative costs, including the costs of participating in the national evaluation, will be reimbursed according to the requirements of 42 CFR §433.15. States may request full reimbursement for administrative costs such as key personnel, MFP travel, in state and out-of-state, training, outreach and marketing, IT infrastructure to accommodate the MFP reporting requirements and for completing the required Quality of Life Surveys. All requested reimbursement for administrative expenses must be presented in the Worksheet for Proposed Budget and described in detail in the Budget Narrative.

C. Eligibility - Threshold Criteria

Applications not received by the application deadline will not be reviewed. Even though an application may be reviewed and scored, it will not be funded if the application fails to meet any of the requirements as outlined in Section III., Eligibility Information, and Section IV., Application Submission Information.

Applicants are strongly encouraged to use the review criteria information provided in Section V., Application Review Information, to help ensure that all the criteria that will be used in evaluating the proposals are adequately addressed.

D. Foreign and International Organizations

Foreign and International Organizations are ineligible to apply.

E. Faith-based Organizations

Faith-based Organizations are ineligible to apply.

IV. APPLICATION AND SUBMISSION INFORMATION

A. Address to Request Application Package

Applicants must submit their applications electronically through <http://www.grants.gov>. A complete electronic application package including all required forms for this demonstration grant are available at www.grants.gov.

B. Content and Form of Application Submission

1. Form of Application Submission

The only acceptable formatting is 8.5” x 11” letter-size pages with 1” margins (top, bottom, and sides). The Excel spreadsheet for MFP Budget Worksheet must be in the form provided and can be sent electronically.

- All pages of the project narrative must be paginated in a single sequence.
- Font size must be no smaller than 12-point with an average character density no greater than 14 characters per inch.
- The narrative portions of the application must be DOUBLE SPACED.
- The Project Abstract is restricted to a one-page summary, single spaced.
- The titles and sequence of the headings must coincide with the sequencing of the elements in the Draft Operational Protocol Instructions (See Appendix B).

2. Required Contents

For the Money Follows the Person Demonstration, a complete application consists of the following materials organized in the following sequence:

a) Standard Forms (SF)

The following standard forms must be completed with an original signature and enclosed as part of the proposal:

- Application for Federal Assistance (SF-424)
- Budget Information – Non Construction Programs (SF-424A)
- Assurances - Non-Construction Programs (SF-424B)
- Disclosure of Lobbying Activities (SF-LLL)
- Additional Assurances Certifications (SSA)
- Project Narrative Form
- Budget Narrative Form
- Project Abstract Form

Note: When completing the required financial forms, SF 424 and SF 424A, please adhere to the following:

Application for Federal Assistance (SF-424)

- SF 424, Section 8B-Applicant Information: Enter the legal name and Employer Identification Number (EIN) as assigned by the Internal Revenue Service (IRS). Please note that the legal name and EIN listed on this application must match what is assigned by the IRS. If you have been selected for an award and the legal name and EIN do not match what is assigned by the IRS, this will cause major delays with receiving Federal funds.
- SF 424, Section 18-Estimated Funding: Enter the amount requested during the first funding/budget period of Sept. 2012 through Dec. 2013.
- SF 424, EO 12372 Review: Check “No” as review by State Executive Order 12372 does not apply to these grants.

Budget Information-Non Construction Programs (SF-424A)

- SF 424A, Section B-Budget Categories: In column one, enter the first funding/budget period of Sept. 2012 through Dec. 2013 by object class category. On the Budget Narrative, provide justification for the costs of year one only of Sept. 2012 through Dec. 2013, listed by the object class categories (personnel, fringe, travel, equipment, contractual, etc.) with a total. In column two of the SF-424a, Section B, enter estimated costs for the second funding/budget period of Jan. 2014 through Dec. 2014. In column three, enter estimated costs for the third funding/budget period of Jan. 2015 through Dec. 2015. And in column four, enter estimated costs for the fourth and final funding/budget period of Jan. 2016 through Mar 2016.
- SF 424A, Section C-Non-Federal Resources: Enter the amount of federal funds needed by quarter during the first year.
- Sections A, D, E, and F of the SF 424A are **NOT** to be completed.

b) Cover Letter

A letter from the State Medicaid Director identifying the Medicaid agency as serving as the lead organization, indicating the title of the project, the principal contact person, amount of funding requested, and the name of the Agency that will administer the grant under the Medicaid office and all major partners, departments, divisions, services and organizations actively collaborating in the project is required.

This letter should be uploaded in the application and should be addressed to: Mary Greene, CMS Grants Management Officer, Centers for Medicare & Medicaid Services Office of Acquisition and Grants Management Mail Stop B3-30-03, 7500 Security Boulevard Baltimore, Maryland 21244-1850

c) Project Abstract (maximum of one page)

The project abstract should serve as a succinct description of the proposed project and should include the goals of the project, the total budget, the number of projected

transitions, and a description of how the grant will be used to help rebalance the State's LTC system. Please use the standard Project Abstract Form.

d) Required Letters of Endorsement

Letters of endorsement from the major partners that are not the lead agency (e.g. Department of Mental Health Services, Department of Developmental Disabilities, local Areas Agencies on Aging, Independent Living Centers, Advocacy Organizations & Consumer Groups, etc.), but will be integrally involved in developing and implementing the demonstration grant to the target population(s) are expected. Please submit all letters in support and Memoranda/letters of Agreement for your application in an Application Appendix with a table of contents for all included documents.

e) Application Narrative:

The application submission is comprised of the following:

Draft Operational Protocol

In response to the statutory objectives of the MFP demonstration, States will be required to submit a Draft OP. The OP is expected to address how the State will implement the demonstration program, and ultimately, meet the MFP statutory objectives.

The required elements (sections) of the OP are listed below. Also provided is a brief description of the type of information required to be addressed within the various sections. The OP must be organized by these headings, noted as the operational element sections, outlined below. A Detailed Instruction Guide for developing an OP can be found in Appendix B.

(a) Organization and Administration

The OP must include a description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration. The tasks to be conducted by each component also must be described. All identified elements under Systems Assessment and Gap Analysis must be addressed

(b) Benchmarks

The OP must list and describe five proposed annual benchmarks that will empirically measure the State's progress in transitioning individuals to the community and rebalancing its long-term care system. Two benchmarks are required by statute (number of transitions and qualified HCBS expenditures), but the State has the option of choosing a minimum of three additional benchmarks that specifically address rebalancing.

(c) Participant Recruitment and Enrollment

The OP must describe the target population(s) that will be transitioned and the recruitment strategies and processes that will be implemented under the

demonstration. The OP may include samples of recruitment and enrollment materials and/or a detailed plan that includes the strategies that will be employed.

(d) Informed Consent and Guardianship

The OP must describe the procedures that will be used to obtain informed consent. The Protocol must include proposed samples of forms, letters, and other documents or Statements that will be used to inform potential participants/authorized representatives about the demonstration program and the process to obtain informed consent.

(e) Outreach / Marketing / Education

The OP must describe the State's outreach, marketing, education, and staff training strategy.

(f) Stakeholder Involvement

The OP must describe how the State will involve stakeholders in the initial implementation of the demonstration program, and how stakeholders will continue to be meaningfully involved throughout the life of the program.

(g) Benefits and Services

The OP must provide a detailed description of the service delivery system(s) used for each target population under the demonstration. The OP must describe the delivery mechanism (fee-for-service, managed care, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the conclusion of the demonstration program. The Protocol must also define a unit of service and the cost per unit for each service for each service category-(HCBS, Demonstration & Supplemental services).

(h) Consumer Supports

The OP must describe the process and activities that the State will implement to ensure that demonstration participants have access to all of the support services available under the demonstration, not just those that are part of the usual HCBS package of services. The service package for each population must include services that will demonstrate to enhance the State's success in transitioning of the participants and promote an improved quality of life.

(i) Self-Direction

The OP must describe any self-direction opportunities available under the demonstration. See Appendix F for more detailed information on self-direction.

(j) Quality

The OP must describe the quality management system that will be used for demonstration participants during the 365-day transition period and after the MFP period is completed. The Protocol must also describe the continuous quality

improvement activities that will be used to discover and remediate problems that arise.

(k) Housing

The OP must describe how the State will partner with MFP stakeholders and the local Housing Authorities to identify and promote available, affordable, and accessible housing for participants.

(l) Continuity of Care Post-Transition

The OP must describe how the various Medicaid service packages within the State will be available to ensure continuity of care and promote sustained demonstration outcomes.

Although not a required component of the MFP demonstration, applicants may propose to evaluate unique design elements from their proposed MFP program. If the State wishes to conduct an independent evaluation, then the Draft OP must include detailed information on the evaluator, evaluation design, variables, and process evaluation.

f) Proposed Budget (Services & Administrative costs) & Staffing Plan

Request for electronic copies of all budget forms (other than Standard Forms) can be sent to MFPDEMO@cms.hhs.gov. In the subject line, please enter “Request for Budget Forms”.

(1) Completed MFP Excel Worksheet for Proposed Budget

(2) Completed and Signed Maintenance of Effort Form

(3) Budget Narrative

For the budget recorded on form SF 424A (Budget Information Non-Construction Programs in Section B-Budget Categories), a budget narrative must be included and provide detail on all requests to fund administrative costs for each budget line item. If the request is to fund a line item at 100% Federal reimbursement, the detail must be specific on how these costs will help the State to meet the proposed benchmarks in the Draft OP. State personnel and personnel contract costs must include detailed salary and fringe benefit costs broken out for review. A State may request reimbursement for 100 percent of administrative costs up to 20 percent of the total award. States may be reimbursed for administrative costs such as key personnel, MFP travel, training, outreach and marketing and IT infrastructure to capture the required data and report generation to accomplish the MFP reporting requirements. All requested reimbursement for administrative expenses must be presented in the Worksheet for Proposed Budget as well as be described in detail in the Budget Narrative.

(4) Staffing Plan

The applicant must provide a preliminary staffing plan. The following key components must be addressed:

(a) Organizational Structure

Provide an organizational chart that describes the entity that is responsible for the management of this grant. Describe how that entity relates to all other departments, agencies and service systems that will provide care and services and have interface with the eligible beneficiaries under the demonstration.

(b) Narrative Staffing Plan

- The number, title and if known, the names of staff that will be dedicated to the demonstration program. Percentage of time each individual/position is dedicated to the grant.
- Brief description of role/responsibilities of each position.
- Identify any positions providing IN-KIND support to the grant.
 - Percentage of time each position will provide to the grant.
 - Brief description of role/responsibilities of each position.
- Number of contracted individuals supporting the grant.
- A resume or bio-sketch of the proposed Project Director.

C. Submission Dates and Times

1. Applicants Teleconference

Applicant's Teleconference Information regarding the date, time and call-in number for an open applicants' teleconference will be available on the MFP Home page at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html>. Please check the website for details.

2. Notice of Intent to Apply

Applicants are encouraged to submit a non-binding Notice of Intent to Apply. Notices of Intent to Apply are not required and a State's submission or failure to submit a notice has no bearing on the scoring of proposals received. However, receipt of such notices enables CMS to better plan for the application review process. Please complete and return a *Notice of Intent to Apply*, no later than April 2, 2012 via email as a PDF file to MFPDemo@cms.hhs.gov.

3. Grant Applications

All grant applications are due by August 8, 2012. Applications submitted through <http://www.grants.gov> until 12 p.m. (noon) Baltimore MD Time will be considered "on time." All applications will receive an automatic time stamp upon submission and applicants will receive an automatic e-mail reply acknowledging the application's receipt. Late applications will not be reviewed.

4. Grant Awards

All grant awards are anticipated to be made by September 5, 2012. The Demonstration Grants awarded under this funding opportunity will have a preliminary budget period through March 2016.

D. Intergovernmental Review

Applications for these grants are not subject to review by States under Executive Order 12372, “Intergovernmental Review of Federal Programs” (45 CFR 100).

E. Funding Restrictions

1. Indirect Costs

The provisions of the OMB Circular A-87 govern reimbursement of indirect costs under this solicitation. A copy of OMB Circular A-87 is available online at http://www.whitehouse.gov/omb/circulars_a087_2004 . **Please submit a PDF copy of the most recent Indirect Cost Rate Agreement if requesting indirect costs. Otherwise, indirect costs are limited to ten percent (10%) of salaries and wages.**

2. Direct Services

The object of this grant is to provide Federal Fund reimbursement for direct services from the grant awards.

3. Reimbursement of Pre-Award Costs

No grant funds awarded under this solicitation may be used to reimburse pre-award costs.

F. Other Submission Requirements

All applications must be submitted electronically. No applications will be accepted through US postal mail, hand delivery or by email. The deadline for all applications to be submitted through <http://www.grants.gov> is August 8, 2012. For information on how to get started with Grants.gov, please visit http://www.grants.gov/applicants/get_registered.jsp. We strongly recommend that you do not wait until the application deadline date to begin the application process through Grants.gov. We recommend you visit Grants.gov at least 30 days prior to filing your application to understand fully the process and requirements. We encourage applicants to submit well before the closing date so that if difficulties are encountered, an applicant will have time to solicit help.

The registration process for an Organization can take an extensive period of time if not all steps are completed in a timely manner, so it is advisable to register early! Applications not submitted “on time” due to applicant’s failure to complete the entire grants.gov registration process in a timely manner will not be accepted.

Grants.gov Registration in Brief:

Effective October 1, 2010, the U.S. Department of Health and Human Services (HHS) requires all entities (except those outlined in the non-applicability section of the policy) that plan to apply for and ultimately receive Federal grant funds from any HHS

Operating/Staff Division (OPDIV) or receive sub awards directly from recipients of those grant funds to:

- Be registered in the CCR prior to submitting an application or plan;
- Maintain an active CCR registration with current information at all times during which it has an active award or an application or plan under consideration by an Federal Agency; and
- Provide its DUNS number in each application or plan it submits to the Federal Agency.

a) STEP 1: Obtain DUNS Number

Same day - If requested by phone (1.866.705.5711) DUNS is provided immediately. If requesting via web, you will need to go to the DUN & Bradstreet website at <http://fedgov.dnb.com/webform> to obtain the number.

Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet in Item 8c on the Form SF-424, Application for Federal Assistance.

b) STEP 2: Register with CCR

Please allow up to 2 weeks or more. If you already have a Taxpayer Identification Number, your Central Contractor Registration (CCR) registration could take 3-5 business days or longer to process. If you are applying for an Employee Identification Number (EIN), please allow up to 2 weeks or more. Ensure that your organization is registered with the CCR at <http://www.ccr.gov>. If your organization is not registered, an authorizing official of your organization must register.

c) STEP 3: Username & Password

Same day - Complete your Authorized Organization Representative (AOR) profile on Grants.gov. and create your username and password. You will need to use your organization's DUNS Number to complete this step. <https://apply07.grants.gov/apply/OrcRegister>.

d) STEP 4: AOR Authorization

The E-Business Point of Contact (E-BIZ POC) at your organization must login to Grants.gov to confirm you as an AOR. Please note that there can be more than one AOR for your organization. In some cases, the E-BIZ POC is also the AOR for an organization.

e) STEP 5: Track AOR Status

At any time, you can track your AOR status by logging in with your username and password. Login as an Applicant (enter your username & password you obtained in Step 3) using the following link: http://www.grants.gov/applicants/applicant_profile.jsp.

Submit Your Application Early! CMS strongly encourages applicants to submit well before the closing date and time so that if your application is rejected due to errors, an applicant will have time to correct the errors and/or to solicit help from grants.gov. Please note: Validation or rejection of your application by grants.gov may take up to 2 business

days after submission. Please consider this in developing your submission timeline and submit as early as possible.

For issues including, but not limited to, downloading the application, retrieving your password, or understanding error messages, please contact grants.gov directly at 1-800-518-4726 or support@grants.gov. Hours of Operation: 24 hours a day, 7 days a week, closed on Federal Holidays. Please have the following information available when contacting grants.gov to help expedite your inquiry:

- Funding Opportunity Number (FON)
- Name of Agency to Which You Are Applying
- Specific Area of Concern

For assistance with the Grants.Gov on-line process, including registration, installing the PureEdge viewer, up-loading documents and password problems, please contact grants.gov directly at 1-800-518-4726.

V. APPLICATION REVIEW INFORMATION

A. Review Criteria

This section fully describes the evaluation criteria for this demonstration project.

In preparing applications, applicants are strongly encouraged to review the programmatic requirements detailed in, Section I, Funding Opportunity Description. The OP must be organized as detailed in, Section IV, Application and Submission, of this solicitation.

The following criteria will be used to evaluate applications received in response to this solicitation. Applications will be scored with a total of 100 points available.

1. Organization and Administration (10 points)

Did the OP include a description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration? Did the applicant adequately describe the tasks to be conducted by each component? Did the applicant identify all of the elements under systems Assessment and Gap Analysis?

2. Benchmarks (10 points)

Did the applicant list and describe five proposed annual benchmarks that will empirically measure the State's progress in transitioning individuals to the community and rebalancing its long-term care system? Did the applicant address the two benchmarks are required by statute (number of transitions and qualified HCBS expenditures)? Did the State choose a minimum of 3 additional benchmarks that specifically address rebalancing?

3. Participant Recruitment and Enrollment (5 points)

Did the applicant adequately describe the target population(s) that will be transitioned and the recruitment strategies and processes that will be implemented under the demonstration?
Did the applicant include the strategies that will be employed?

4. Informed Consent and Guardianship (3 points)

Did the applicant adequately describe the procedures that will be used to obtain informed consent? Did the applicant include proposed samples of forms, letters, and other documents or statements that will be used to inform potential participants/authorized representatives about the demonstration program and the process to obtain informed consent?

5. Outreach / Marketing / Education (7 points)

Did the applicant adequately describe the State's outreach, marketing, education, and staff training strategy?

6. Stakeholder Involvement (7 points)

Did the applicant adequately describe how the State will involve stakeholders in the initial implementation of the demonstration program, and how stakeholders will continue to be involved meaningfully throughout the life of the program.

7. Benefits and Services (5 points)

Did the applicant adequately provide a detailed description of the service delivery system(s) used for each target population under the demonstration that includes a description of the service delivery mechanism (fee-for-service, managed care, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the conclusion of the demonstration program? Did the applicant adequately define a unit of service and the cost per unit for each service for each service category-(HCBS, Demonstration & Supplemental services)?

8. Consumer Supports (5 points)

Did the applicant adequately describe the process and activities that the State will implement to ensure that demonstration participants have access to all of the support services available under the demonstration, not just those that are part of the usual HCBS package of services? Did the applicant include services to enhance the State's success in transitioning of the participants and promote an improved quality of life?

9. Self-Direction (3 points)

Did the applicant adequately describe any self-direction opportunities available under the demonstration? If so, did the State submit a Completed Sub-Appendix I?

10. Quality (7 points)

Did the applicant adequately describe the quality management system that will be used for demonstration participants during the 365-day transition period and after the MFP period is completed? Did the applicant also adequately describe the continuous quality improvement activities that will be used to discover and remediate problems?

11. Housing (5 points)

Did the applicant adequately describe how the State would partner with MFP stakeholders and the local Housing Authorities to identify and promote available, affordable, and accessible housing for participants?

12. Continuity of Care Post-Transition (3 points)

Did the applicant adequately describe how the various Medicaid service packages within the State would be available to ensure continuity of care and promote sustained demonstration outcomes?

13. Budget and Staffing (30 points)

- Did the applicant accurately complete The MFP Excel Worksheet for Proposed Budget?
- Did the applicant accurately complete the Maintenance of Effort Forms?
- Did the applicant provide a detailed budget narrative including a detail request to fund administrative cost claims for each budget line item?
- Did the applicant request funding any line items at 100% Federal reimbursement, and if so, did the detail specifically show how these costs will help the State to meet the proposed benchmarks in the Draft OP?
- Did the applicant provide a detail of the State personnel, personnel contract costs including salary, and fringe benefit costs broken out for review?
- Did the applicant provide a preliminary staffing plan addressing the following key components?

a) *Organizational Structure:*

Did the applicant provide an organizational chart that describes the entity that is responsible for the management of this grant. Did they describe how that entity relates to all other departments, agencies and service systems that will provide care and services and have interface with the eligible beneficiaries under the demonstration?

b) *Narrative Staffing Plan:*

Did the applicant include the number, title and if known, the names of staff that will be dedicated to the demonstration program? Did they indicate the following the percentage of time each individual/position is dedicated to the grant, the roles/responsibilities of each position, and positions providing IN-KIND support to the grant, and the percentage of time each position will provide to the grant?

- Brief description of role/responsibilities of each position.
- Number of contracted individuals supporting the grant.
- A resume or bio-sketch of the proposed Project Director.

B. Review and Selection Process

An independent review of all applications will be conducted by a panel of experts. The review panel will assess each application to determine the merits of the proposal and the extent to which it furthers the purposes of the demonstration program. CMS reserves the right to request that States revise or otherwise modify certain sections of their proposals based on the recommendations of the panel and the budget. Final approval of demonstration projects will be made by the Administrator of CMS after consideration of the comments and recommendations of the review panelists, program office recommendations, and the availability of funds. CMS reserves the right to approve or deny any or all proposals for funding.

C. Anticipated Announcement and Award Date

Awards are anticipated to be announced and awarded by September 5, 2012.

AWARD ADMINISTRATION INFORMATION

D. Award Notices

Successful applicants will receive a Notice of Award (NoA) signed and dated by the CMS Grants Management Officer. The NoA is the document authorizing the grant award and will be sent through the U.S. Postal Service to the authorized representative as listed in Section 21 of the SF- 424, Application for Federal Assistance. Any communication between CMS and applicants prior to issuance of the NoA is not an authorization to begin performance of a project.

Unsuccessful applicants will be notified by letter, sent through the U.S. Postal Service to the authorized representative as listed in Section 21 of the SF- 424, Application for Federal Assistance after September 2012.

E. Administrative and National Policy Requirements

1. General Requirements

Specific administrative and policy requirements of grantees as outlined in 45 CFR 74 and 45 CFR 92, apply to this grant opportunity. All grantees receiving awards under these grant programs must meet the requirements of:

- 1) Title VI of the Civil Rights Act of 1964,
- 2) Section 504 of the Rehabilitation Act of 1973,
- 3) The Age Discrimination Act of 1975,
- 4) Hill-Burton Community Service nondiscrimination provisions, and
- 5) Title II Subtitle A of the Americans with Disabilities Act of 1990.
- 6) All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the grantee's original Operational Protocol or agreed upon subsequently with CMS in a revised Operational Protocol, and may not be used for any prohibited uses.

- 7) Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.
- 8) State grantees must coordinate their project activities with other State, local and federal agencies that serve the population targeted by their application (e.g., Administration for Children and Families, Administration for Developmental Disabilities, Department of Education, etc.). CMS also encourages collaboration with a broad range of public and private organizations whose primary purpose is advocating for children, volunteer groups, faith-based service providers, private philanthropic organizations, and other community-based organizations.
- 9) HHS Grants Management Policy Statement:
<http://dhhs.gov/asfr/ogapa/grantinformation/hhsgps107.pdf>

2. Terms and Conditions

A funding opportunity award with CMS will include standard terms and conditions and may include additional specific grant “special” terms and conditions that will address the requirement to revise the Draft Operational Protocol until an approval by CMS is achieved. Potential applicants should be aware that special requirements could apply to grant awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the review panel.

3. Prohibited Uses of Grant Funds

Money Follows the Person Rebalancing Grant funds may not be used for any of the following:

- 1) To match any other Federal funds.
- 2) To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- 3) To supplant existing State, local, or private funding of infrastructure or services such as staff salaries for programs and purposes other than those disclosed in the application for the MFP Rebalancing Grant Demonstration, etc.
- 4) To be used for expenses that will not primarily benefit individuals of any age who have a disability or long-term illness.

4. Reporting

Grantees must agree to cooperate with any Federal evaluation of the program and provide all of the quarterly, semi-annual (every 6 months), annual and final (at the end of the grant period) reports in a form prescribed by CMS (including the SF 425 “Federal Financial Report due semi-annually). Reports will be submitted electronically. These reports will outline how grant funds were used, describe program progress, and describe any barriers and measurable outcomes. CMS will provide the format for program reporting and

technical assistance necessary to complete required report forms. Grantees must also agree to respond to requests that are necessary for the evaluation of the national efforts and provide data on key elements of their own grant activities.

A financial Reporting Protocol will be provided to all applicants in addition to all electronic forms required to submit an application.

VI. AGENCY CONTACTS

A. Programmatic Content

Programmatic questions about the Money Follows the Person Demonstration program may be directed to an e-mail address that multiple people access, so that someone will respond even if others are unexpectedly absent during critical periods. This e-mail address is MFPDemo@cms.hhs.gov.

B. Administrative Questions

Grant and solicitation administrative questions concerning this grant opportunity may be directed to the following mailbox: MFPDemo@cms.hhs.gov. Answers will be posted on on the MFP Home page at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html>. Please check the website for details. Questions submitted telephonically will not be honored.

Applicant's Teleconference Information regarding the date, time and call-in number for an open applicants' teleconference will be available on the MFP Home page at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html>. Please check the website for details.

C. Attachments:

Attachment 1: Notice of Intent to Apply

Appendix A: Elements of a System in Which Money Can Follow the Person

Appendix B: Operational Protocol (OP) Instructions

- Sub-Appendix I: Self-Direction
- Sub-Appendix II: Types of Supported Housing
- Sub-Appendix III: MFP Maintenance of Effort (MOE) Form Instructions
- Sub-Appendix IV: Worksheet for Proposed Budget and Instructions
- Sub-Appendix V: Service Definitions
- Sub-Appendix VI: Qualified Residence Guidance
- Sub-Appendix VII: Examples of Supplemental Demonstration Services
- Sub-Appendix VIII: Provider and Interagency Collaboration

ATTACHMENT 1: Notice of Intent to Apply

Please complete and return *Notice of Intent to Apply*, no later than **April 1, 2012** via:

- EMAIL – as a PDF file to MFPDemo@cms.hhs.gov

Name of State: _____

Applicant Agency/Organization: _____

Contact Name and Title: _____

Address: _____

Phone: _____ Fax: _____

E-mail address: _____

Appendix A: Elements of a System in Which Money Can Follow the Person

A system in which “money follows the person” has several key elements that have been described below. While the list is comprehensive and gleaned from the research and experience of States that are currently working towards a more balanced long-term care system, it is certainly not an exhaustive list. The applicant should use this description as background information as they discuss their systems assessment and demonstration design. Applicants are not required to address each element.

Element 1: Trusted, Visible, and Reliable System for Accessing Information and Services

Long-term care systems must be easily recognized and accessible when an individual needs information, assistance, and help in selecting a long-term support option. Once the individual makes an informed choice, clear pathways from the application to implementation are needed. Mature long-term support systems designate one entity (physically and/or virtually organized) to support individuals and family members from the initial contact or request for information to the implementation of a service plan for individuals that choose to receive services in the community. Entities that consolidate all these functions are referred to as “one-stops,” “comprehensive entry points,” “single entry points,” etc.

From Fiscal Years 2003-2006, Aging and Disability Resource Centers (ADRCs) have been funded in partnership by the CMS and the Administration on Aging (AoA) to improve access to information and assistance to support consumer choice. ADRCs provide a “one-stop” process for obtaining information about community services and other important programs such as SSI, disability assistance, housing, employment, and in-home services, and in particular the Medicaid program. More information on the ADRC initiative can be found at http://www.aoa.gov/AoAroot/AoA_Programs/HCLTC/ADRC/index.aspx.

Element 2: Screening, Identifying, and Assessing Persons Who Are Candidates for Transitioning to the Community

Systems to screen persons who are likely to successfully transition to the community are critical. The screening tool should include such factors as the consumers’ preferences, functional status, and length of time in facility, estimated cost of a community care plan, and potential availability of community supports, such as informal support givers and formal health, housing and transportation services.

States should use (and develop, if necessary) survey or assessment data (e.g. Minimum Data Set) to help identify eligible consumers based on the screening factors developed. Local public/private partnerships (e.g. relationships with State Units on Aging, Centers for Independent Living, institutional providers, and Aging and Disability Resource Centers) can facilitate identification of eligible transition candidates.

After identifying potentially eligible consumers, States should develop an assessment instrument to determine the community services and supports needed to leave institutions. In addition, States must address what procedures and processes will be in place to ensure that:

- Necessary services and supports are in place to meet the individual’s assessed need; and

- A risk mitigation assessment has been performed to determine what safeguards need to be in place, including indicators that may signal if reassessment is necessary.

Element 3: Mechanisms for Flexible Financing

Flexible financing is an important key to balancing State long-term support systems. Financing strategies can be designed to support choice and create balance while bridging the differences between Medicaid State plan and HCBS waiver programs. We note global budget strategies (sometimes called pooled financing) and budget transfer strategies can allow “money to follow the person.”

Element 4: Available and Accessible Supportive Services

Balanced long-term care systems offer individuals choice of a full array of health care services in both the community and the institution. Medicaid State plan services, home, and HCBS waivers are the core sources of public funding for long-term care services. In general, waiver services must supplement and not duplicate State plan services.

In order to transition individuals to the community, from an institution, there may be many one time “transition costs” needed throughout the first year after transition. Transition Services are covered services under the Section 1915(c) and Section 1115 waivers. CMS recognized the importance of covering these needs and issued a State Medicaid Directors Letter on May 9, 2002 explaining how States can cover Community Transition Services under HCBS waivers. The letter allows States to pay the reasonable costs of community transition services for such things as security deposits that are required to obtain a lease on an apartment or home and essential furnishings (e.g., beds, chairs, tables, kitchen items). The letter can be found on the CMS website at:

<http://www.cms.hhs.gov/smdl/downloads/smd050902a.pdf>

One of the lessons learned by CMS and the State Medicaid Agencies that were awarded prior nursing home transition and rebalancing grants was that without the availability of affordable and accessible housing, transitioning people to the community would be met with limited success. The MFP solicitation considers increasing the capacity of and access to affordable housing as an essential element for all grantees to undertake. Additionally, collaboration of the often-disparate housing and health sectors has to occur. Such efforts need to be made early and continuously in the State’s MFP activities. Refer to Appendix C for background information and an understanding of what housing activities can be funded under the CMS MFP demonstration.

For persons transitioned to the community, the availability of transportation and other social services such as Meals on Wheels, food stamps, and recreational activities are integral to remaining in the community and having choices. Accessibility to transportation services is one of the most fragmented services, yet when persons with disabilities discuss barriers to community living it is one of the most commonly cited barriers mentioned. Ease of access to transportation for medical and social purposes is critical, but in some communities it can be difficult to obtain due to; 1) limited reimbursement for the transportation (e.g., for nonmedical purposes), 2) lack of coordination, 3) inefficient scheduling systems, 4) a plurality of small uncoordinated transportation providers, 5) high liability insurances, and 6) sheer lack of a system or transport providers, such as in rural areas. As a result, persons are unable to navigate in their community and may have difficulty getting to medical appointments as well as community functions, which promote social integration. Isolation of persons at home can precipitate depression and other emotional difficulties. Rural transportation barriers are often the most

challenging. Creative solutions, such as volunteer-based transportation organizations, are one solution that has been used to help overcome the lack of rural-based public transportation. Purchases of medical equipment are typically made after the individual has moved into the community. However, the delay in receiving and adapting such equipment often causes hardships for the individual and/or caregiver(s). The delay may introduce unnecessary hazards into the transition and the first few weeks of community dwelling. In addition, the equipment is most effectively employed if it is obtained prior to institutional discharge and tested with the individual to ensure proper fit, use, adaptability to individual requirements, and appropriateness for the particular community environment to which the person will move.

Therefore, a CMS State Medicaid Director's letter issued on July 14, 2003, clarified that waiver funds could be utilized to purchase medical equipment for individuals living in an institution who are planning to move to the community under specific conditions. To review of the letter, refer to <http://www.cms.hhs.gov/smdl/downloads/smd071403.pdf>.

Element 5: Community Workforce

Quality of care, and at a broader level a well-balanced system, requires an available and trained workforce, including direct care workers and informal caregivers. For direct care workers, low pay, demanding roles, lack of benefits, and often-inconvenient hours of employment lead to high turnover rates and unfilled positions at a time when demand is rising. Yet, direct care workers provide most of the paid long-term services to persons with disabilities of all ages. In the community, these workers are comprised mostly of home health and personnel care aides. Persons with disabilities rely on these workers for the most basic and daily tasks. Equally, important, informal support givers provide more care than any other type of caregiver and provider. Without informal support givers, the demand on the Medicaid program and other public programs to supply and pay for direct care workers would escalate to levels that could not be met. While the increase in self-directed services should help alleviate the shortage of direct care workers, more direct interventions need to be undertaken by the State Medicaid programs and other government agencies (e.g., Departments of Labor and Education) in collaboration with private sector providers, employment agencies, vocational schools, and persons with disabilities to make the vocation of a direct care worker be a more desirable career ladder.

Element 6 Self-Directed Services

Self-direction of Medicaid services means that the participant (or representative) has the decision-making authority over some or all of his/her services and takes responsibility for taking the direct role in managing them with the assistance of needed supports. Self-direction is an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with a person-centered planning process. Self-direction promotes personal choice and control over the delivery of services, including who provides services and how they are delivered. For example, the participant may be afforded the opportunity as well as the necessary supports to recruit, hire, and supervise individuals who furnish supports. When a service is provider-managed, a provider selected by the participant carries out these responsibilities. See Appendix F for more information regarding components of a self-directed service delivery system.

While participant choice is a fundamental construct within Medicaid, participants may need assistance and support in order to exercise this freedom effectively. CMS and States must continue to explore options that expand the opportunities for Medicaid eligible persons to either directly, or through

representation, to express preferences and desires and hence self-direct their services and supports. It is the responsibility of the Medicaid program to ensure the provision of the necessary supports (either paid or unpaid) to people who are eligible to self-direct within a State.

Element 7: Transition Coordinators

Moving to the community requires coordination and timing to ensure that all the supports and services are in place. Important tasks include: establishing Medicaid financial eligibility in the community, establishing functional eligibility for the HCBS waiver, identifying State plan or other services, coordinating the array of services and providers that will be needed on or shortly after the move; and arranging the time sensitive transition services that are needed in order for the consumer to move. In some instances, case managers may deliver these services. If that is not in place, the State must develop this capacity.

Element 8: Quality Management

The statute requires an MFP demonstration to have a comprehensive and integrated quality management strategy. The presence of such a strategy enhances the State's capacity to assure that the long-term supports system operates as designed and that the critical processes of discovery, remediation, and systems improvement occur in a structured and routine manner.

Specifically, the targeted system performance requirements to which the critical processes apply are those assurances defined within the 1915(c) home and community based services program that include 1) State conducts level of care need determinations consistent with the need for institutionalization; 2) Plans of Care are responsive to waiver participant needs; 3) Qualified Providers Serve Waiver Participants; 4) Maintain the Health and Welfare of Waiver Participants; and, (5) State Medicaid Agency Retains Administrative Authority Over the Waiver Program; and 6. State Provides Financial Accountability for the Waiver.

Element 9: Health Information Technology (HIT)

Development of a comprehensive HIT system to support a rebalanced system is complex, incremental, and critically important. Functions of HIT, in a rebalanced system, include development of functions to accommodate the business needs of multiple organizations that provide services to the same populations, including:

- Providing the HIT infrastructure to support single point of entry functions;
- Identifying, assessing, and tracking persons who have transitioned in the community across service providers (while meeting Federal privacy and confidentiality requirements);
- Supporting the flexible financing structure required to support the MFP principles;
- Designing, developing, or modifying HIT applications to support the program processes that are individual-centered, enable consumer control over services and budgets, and allow for measurement of participant satisfactions and outcomes;
- Building, or significantly enhancing existing, data warehouses and/or data marts used to collect, store, analyze and report trends and comparisons on the quality and outcomes of services rendered in non-institutionalized long term care settings, and,
- Building systems that accommodate the business needs of multiple organizations that provide services to the same target populations.

Element 10: Cultural Competence

Cultural and linguistic knowledge should be an ongoing developmental process at all levels of the long-term care service delivery system. In general, long-term care should be provided in a manner that is compatible with the cultural health beliefs and practices and the preferred language of the participant.

CMS recommends that grantees meet the following standards as quality performance criteria for the provision of services to participants in the project:

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer). Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area. In order to ensure that above standards are consistently met, States should engage in ongoing assessment and quality improvement activities related to cultural and linguistic competency. These activities should include stakeholder input, integration of measures into internal audits, and evaluations of services and programs.

For more information, see “National Standards for Culturally and Linguistically Appropriate Services” at the Department of Health and Human Services Office of Minority Health website:

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

Element 11: Interagency and Public/Private Collaboration

In order for the State to maximize the success of its MFP Demonstration Project, it is critical to enlist the support of and collaboration with other agencies, private entities, consumer and advocacy organizations, and the institutional provider community. Successful collaboration was demonstrated by a number of States awarded Nursing Facility Transition (NFT) Grants in 2001 and 2002. For in-depth information on the outcomes and success of these NFT Grants, see the RTI report “Preliminary Report for the 2001 and 2002 Real Choice Systems Change Nursing Facility Transition Grants” on www.hcbs.org.

A. Mental Health

There are particular challenges Medicaid presents to providing home and community-based care to those with mental illness. The application review criteria, for this demonstration project, gives preference to States that include multiple population groups. CMS encourages States to include those with mental illness even though developing a qualified home and community-based program may be more challenging. People with mental illnesses reside in a variety of institutional settings targeted under this demonstration, including nursing facilities, hospitals, and institutions for mental disease where State plan services are provided. Institutions for Mental Disease (IMDs) include psychiatric inpatient facilities over sixteen beds serving patients over 65 and 21 and under in age and include Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTFs)

Recovery from serious mental illness involves regaining a sense of purpose and control over one's life that overcomes, to the extent possible, limitations imposed by the illness. Research in this field has identified a set of outcomes that result from the recovery process. Outcomes include the establishment of meaningful relationships and social roles, the development of a sense of hopefulness and purpose in life, symptom remission, improved or restored vocational functioning, independent living, and economic security.

States wishing to provide services and supports designed to assist people in their recovery process must provide an array of mental health services appropriate to the population to be served. For background on evidence-based practices see the Substance Abuse and Mental Health Services Administration (SAMHSA) website on evidence based practices see <http://nrepp.samhsa.gov>. Services should be supported by research-based evidence of their effectiveness.

The application review criteria, for this demonstration, will give preference to States that are willing to permit participants to self-direct some or all of their services. Persons with mental illness are among the few remaining populations where self-direction has not been widely implemented. Self-directed services must be designed reflecting the elements in the Draft Operational Protocol under "Self-Direction."

The following includes several options States can use to develop community-based services, including self-direction programs for persons with mental illness:

- Develop a new section 1115 waiver, or modify an existing one.
- Use the rehabilitation option to provide psychiatric rehabilitation to children and adults.
- Enhance the State's Preadmission Screening and Resident Review (PASRR) process to identify persons with mental illnesses applying to or residing in nursing facilities whose needs could be met in community based settings and to assess the community supports they need.
- 1915(c), and 1915(b) waiver authority could be used to develop self-directed alternatives.
- Fully implement the Federal requirements under 42 CFR 483.100-138 (with particular emphasis on 42 CFR 483.134(b)(5)), to administer Level I and II screenings for all individuals with mental illnesses and mental retardation or related conditions who apply to or reside in a nursing facility.
- Obtain partnerships with the State mental health authority, in its required PASRR responsibilities.
- Use data gathered from PASRR screens to understand service gaps and develop community based alternatives for persons with mental illnesses who would otherwise reside in a nursing facility.
- Use other sections of the Deficit Reduction Act of 2005 (e.g. Section 2087, section 6044) to develop self-direction programs using the full range of home and community based services.

B. Dementia

CMS is concerned that the requirement that individuals must be transitioned to a residence that has lockable access and egress and living, sleeping, bathing, and cooking areas over which the individual or individual's family has domain and control will discourage States from including individuals with dementia or other cognitive impairments in the demonstration.

CMS encourages States to serve the needs of individuals with dementia or other cognitive impairments. To that end, CMS believes that there are models of quality community based care, which States may

propose, to address the needs of individuals with dementia. CMS encourages applicants, serving the needs of individuals with dementia and other cognitive impairments, to propose a service package, which well serves the needs of these particular individuals.

Appendix B – Operational Protocol (OP) Instructions

INSTRUCTION GUIDE FOR DRAFTING THE OPERATIONAL PROTOCOL

1. Introduction and Timeline

This document is the official instruction guide and template for the development of Operational Protocols (OP) by the States who apply for a 2012 Money Follows the Person (MFP) Rebalancing Demonstration Grant award. This guide should provide instruction on the required elements of the State's Operational Protocol. States will be required to submit a Draft OP as a required component of the grant application. If awarded an MFP grant, OPs needing revision to meet the terms and conditions of the grant must be modified and resubmitted until approved by CMS. Only after approval, may a State enroll participants and request reimbursement for services. After receiving a grant award, administrative claims funding at 100% reimbursement up to \$600,000 is available until the OP is approved. Costs incurred by the State during the pre-implementation phase, including the costs of a full-time Project Director and other staff, can be reimbursed with grant award dollars with 100% grant funding with an approved budget.

The Draft Operational Protocol should provide enough information that:

- CMS and other federal and State officials may use this document to understand the operation of the demonstration.
- The State Project Director will use it as the manual for program implementation; and
- It is available to external stakeholders who may use it to understand the operation of the demonstration.

Elements of the Draft Operational Protocol (Data submission requirements) that need approval from Institutional Review Boards (IRBs) should not be submitted to the IRBs before CMS approves the protocol. If the State seeks IRB approval prior to CMS approval the State subjects itself to the possibility of needing to submit revised documents to the IRB later.

Once the Operational Protocol has final approval by CMS, grantees can begin the implementation phase of the demonstration and be permitted to claim the enhanced match rate for CMS approved home and community-based services (HCBS) for demonstration participants transitioned from institutional settings into the community for the first 365 days of community-based care. During this phase, all "qualified expenditures" will be eligible for Federal Medical Assistance Percentage (FMAP) at the enhanced rate specified in the statute. The State will be able to claim the regular published FMAP match rate under the demonstration for any services approved and delivered to demonstration participants as supplemental services. States may continue to submit administrative claims for the approved administrative budget at the approved rate.

2. Required Contents of the Operational Protocol

In order to submit a Draft Operational Protocol, a State must include a response to each of the elements in this section. Operational Protocols that do not include responses to each section below will not be considered responsive to the solicitation and will not be considered for award.

a) Project Introduction

(1) Organization and Administration

(a) Systems Assessment and Gap Analysis (please keep this section to 10 pages)

An applicant's Systems Readiness Assessment should describe the current long-term support delivery system in the State (include all populations- individuals who are Aged, MR/DD, MH, Physically disabled, TBI and any other), including progress to date and "gaps" that will need to be addressed in order to "rebalance" the system. This assessment should focus on the system of long-term care service delivery including the departments, agencies and providers (both community and institutional) that participate in the long-term care delivery system in the State. It must include:

- A description of the current LTC support systems that provide institutional and home and community-based services, including any major legislative initiatives that have affected the system. What State legislative and/or regulatory changes need to be made to further rebalance the LTC system and promote HCBS?
- An assessment of what Medicaid programs and services are working together to rebalance the State's resources and a description of any institutional diversion and/or transitions programs or processes that are currently in operation. What additional Medicaid programs and services are needed to increase HCBS and decrease the use of institutional care?
- A description of the number of potential participants who are now living in institutions including the number of residents in nursing homes who have indicated they would like to transition into the community.
- A description of any current efforts to provide individuals with opportunities to self-direct their services and supports. Would your State be developing additional opportunities for participants to self-direct?
- Describe the stakeholder involvement in your LTC system. How will you include consumers and families as well as other stakeholders in the implementation of the MFP program?

(b) Description of the Demo's Administrative Structure

Describe the Administrative structure that will oversee the demonstration. Include the oversight of the Medicaid Director, which agency will be the lead agency, all departments and services that will partner together, the administrative support agencies that will provide data and finance support and what formal linkages will be made and by what method, (i.e. Memorandum of Agreement, reorganization).

(2) Benchmarks

Please note that the MFP Program, benchmarks and all financial reports must be developed based on the CALENDAR year not the Federal fiscal year or your State's fiscal year.

Provide a list of proposed annual benchmarks that establish empirical measures to assess the State's progress in transitioning individuals to the community and rebalancing its long-term care system. In the application, two specific benchmarks were required by all awardees. These two benchmarks are:

- Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.

- Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.

In addition, awardees must propose, at a minimum, three additional measurable benchmarks, which address elements of rebalancing. These benchmarks should be measures of the progress made by the State to direct savings from the enhanced FMAP provided by this project towards the development of systems improvements and enhancing ways in which money can follow the person into the community. These additional measurable benchmarks may include, but are not limited to:

- A percentage increase in HCBS versus institutional long-term care expenditures under Medicaid for each year of the demonstration program.
- Establishment and utilization rates for a system for accessing information and services by a date certain (i.e., the establishment or expansion of one-stop shops, single point of entry).
- Establishment and utilization rates for a screening, identification, and assessment process for persons who are candidates for transitioning to the community that are put into use in the general Medicaid program beyond recruitment for the MFP demonstration.
- Progress directed by the State to achieve flexible financing strategies, such as global or pooled financing or other budget transfer strategies that allow “money to follow the person”.
- Increases in available and accessible supportive services (i.e., progress directed by the State in achieving the full array of health services and community supports for consumers, including the use of “one-time” transition services, purchase and adaptation of medical equipment, environmental modifications, housing and transportation services beyond those used for MFP transition participants).
- Increases in an available and trained community workforce (i.e., direct interventions, undertaken by the State, to increase the quality, the quantity and the empowerment of direct care workers).
- Increases in the availability of self-directed services (i.e., progress directed either by the State to expand the opportunities for Medicaid eligible persons beyond those in the MFP transition program to directly, or through representation, to express preferences and desires to self-direct their services and supports).
- Increases in the utilization of transition coordinators used to assist individuals in Medicaid find appropriate services and supports in the community.
- Improvements in quality management systems (i.e., direct interventions undertaken by the State to ensure the health and welfare of participants is protected while also maintaining consumer choice).
- Expansions to and improvements in health information technology (i.e., progress directed by the State to build systems that accommodate the business needs of multiple organizations that serve the same populations).
- Improvements in cultural and linguistic competence (i.e., language assistance services, including patient-related written materials).
- Interagency consumer and public/private collaboration (i.e., direct interventions undertaken by the State to achieve a higher level of collaboration with the private entities, consumer and advocacy organizations, and the institutional providers needed to achieve a rebalanced long-term care system).

The benchmarks proposed will be evaluated against the funding requested by the State through the demonstration proposed budget. The State has agreed to maintain its effort through the life of the Demonstration program and should propose rebalancing efforts that will be sustained in the Medicaid system beyond the life of the Money Follows the Person Rebalancing Demonstration.

The benchmarks must be stated as measurable, annual outcomes. All Benchmarks should begin in 2012 and will continue through 2016. The Operational Protocols will be revised in 2016 to reflect the continued use of awarded funding in federal fiscal year 2016 through 2020.

b) Demonstration Implementation Policies and Procedures

(1) Participant Recruitment and Enrollment

Describe the target population(s) that will be transitioned, and the recruitment strategies and processes that will be implemented under the demonstration. Specifically, please include a narrative description that addresses the issues below. In addition, the Draft OP may include samples of a few recruitment and enrollment materials that will be disseminated to enrollees if developed. (please limit the pages of your application to those required) Your OP may include materials developed as appendices after the grant award is made and before the final approval of the OP.

- a. How will the service provider be selected and does the State intend to engage the State's Centers for Independent Living in some role in the transition process.
- b. The participant selection mechanism including the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence. Please include a discussion of:
 - the information/data that will be utilized (i.e., use of MDS Section "Q" or other institutional data);
 - how access to facilities and residents will be accomplished
 - the information that will be provided to individuals to explain the transition process and their options, as well as the state process for dissemination of such information.
- c. The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting. If targeting certain facilities, the names of the identified facilities and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.
- d. The minimum residency period to conform to the changes made to Section 6071 by the ACA reducing the minimum number of consecutive days to 90 in an institutional setting with the statutory exception noted in the ACA; and who is responsible for assuring that the requirement has been met.
- e. The process (who and when) for assuring that the MFP participant has been eligible for Medicaid at least one day prior to transition from the institution to the community.
- f. The process for determining that the provision of HCBS to a participant enables that participant to be transitioned from a qualified institution. Formal Level of Care determinations are not required prior to transitioning into the MFP program for the 365-day period. States may elect to develop an assessment of eligibility that takes into

consideration the readiness for an individual to transition into the community with identified transition services and appropriate long-term care services.

- g. The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that led to re-institutionalization in order to assure a sustainable transition.
- h. The State's procedures and processes to ensure those participants, and their families will have the requisite information to make informed choices about supports and services. The description shall address:
 - How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation, including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.
 - Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished.

(2) Informed Consent and Guardianship

- a. Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.
- b. Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf of these participants. The policy should specify the level of interaction that is required by the State.

(3) Outreach / Marketing / Education

Submit the State's outreach, marketing, education, and staff training strategy. NOTE: The OP Draft required in this application does not require a State to submit marketing materials at this time. *All marketing materials will be submitted during the final approval process for the Operational Protocol.* Please provide:

- a. The information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);
- b. Types of media to be used;
- c. Specific geographical areas to be targeted;
- d. Locations where such information will be disseminated;
- e. Staff training plans, plans for State forums or seminars to educate the public;

- f. The availability of bilingual materials/interpretation services and services for individuals with special needs; and
- g. A description of how eligible individuals will be informed of cost sharing responsibilities.

(4) Stakeholder Involvement

Describe how the State will involve stakeholders including consumer representatives in the Implementation Phase of this demonstration, and how these stakeholders will be meaningfully involved throughout the life of the demonstration grant. Please include:

- a. A chart that reflects how the stakeholders relate to the organizational structure of the grant and how they influence the project.
- b. A brief description of how consumers' will be involved in the demonstration.
- c. A brief description of community and institutional providers' involvement in the demonstration.
- d. A description of the consumers' and community and institutional providers' roles and responsibilities throughout the demonstration.
- e. The operational activities in which the consumers, community, and institutional providers are involved.

(5) Benefits and Services

- a. Provide a description of the service delivery system(s) used for each population that the State will serve through the Money Follows the Person Rebalancing Demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (1915 a, b, c or combination waiver, 1115 demonstration, Medicaid State Plan, 1915i and 1915j,etc.). For all HCBS demonstration services and supplemental demonstration services State must detail the plan for providers or the network used to deliver these services. Some demonstration services may be added to existing 1915 waivers during the MFP program period, but the services that are not added and the supplemental services not paid for through Medicaid will end at the 365th day for each individual participant.
- b. List the service package that will be available to each population served by the Demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). Do not include acute care service or institutional services that will be paid for through the regular Medicaid program. In a chart, divide the service list(s) into Qualified Home and Community-Based Program Services, HCBS demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. If any qualified Home and Community-based Services are not currently available to Medicaid recipients in the State (and are, therefore, not included in the State's maintenance of effort calculations), provide a detailed account of when and how they will be added to the Medicaid program. For HCBS demonstration services and supplemental demonstration services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.

(6) Consumer Supports

Describe the process and activities that the state will implement to ensure that the participants have access to the assistance and support that is available under the demonstration including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services. Please provide:

- a. A description of the educational materials used to convey procedures the State will implement in order for demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available;
- b. A description of any 24-hour backup systems accessible by demonstration participants including critical services and supports that are available and how the demonstration participants can access the information (such as a toll free telephone number and/or website). Include information for back-up systems including but not limited to:
 - Transportation
 - Direct service workers;
 - Repair and replacement for durable medical and other equipment (and provision of loan equipment while repairs are made); and
 - Access to medical care: individual is assisted with initial appointments, how to make appointments and deal with problems and issues with appointments and how to get care issues resolved.
- c. A copy of the complaint and resolution process when the back-up systems and supports do not work and how remediation to address such issues will occur.

(7) Self-Direction (See Appendix A)

Sub-Appendix I is considered part of the Operational Protocol and is required for States using self-direction for MFP demonstration participants. An electronic copy of the form will be made available to applicants. CMS requires that adequate and effective self-directed supports be in place. Provide a description of the self-direction opportunities under the demonstration before the Institutional Review Board (IRB) approval.

In addition to completing Appendix A, please respond to the following:

- a. Describe how the State accommodates a participant who voluntarily terminates self-direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method.
- b. Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition.
- c. Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.

(8) Quality

Provide a description of the State's quality Improvement system (QI S) for demonstration participants during the demonstration year and a description of what system they will be transitioned to after the 365-day demonstration period. Regardless of the financing and/or

service delivery structure proposed under the demonstration, states must demonstrate how services during the 365-day transition period will:

- be utilized to inform the CMS evaluation of the state's MFP demonstration; and
- Meet or exceed the guidance for a QIS set forth in version 3.5 of the 1915(c) HCBS waiver application.

Please follow the guidelines set forth below for completion of this section of the OP:

- a. If the State plans to integrate the MFP demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration program will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waiver application during the transition and during the 12 month demonstration period in the community.

The state need not provide documentation of the quality management system already in place that will be utilized for the demonstration. However, rather provide assurances in the OP that:

- This system will be employed under the demonstration; and
- The items in section (C) below are addressed.

In addition, the state should provide a brief narrative regarding how the existing waiver QIS is already or will be modified to ensure adequate oversight/monitoring of those demonstration participants that are recently transitioned.

- b. If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community. The state must provide a written narrative in this section of the OP regarding how the proposed service delivery structure (1915(b), State Plan Amendment, or 1115) will address the items in section (c) below.
- c. The Quality Improvement System under the MFP demonstration must address the waiver assurances articulated in version 3.5 of the 1915(c) HCBS waiver application and include:
 - Level of care determinations;
 - Service plan description;
 - Identification of qualified HCBS providers for those participants being transitioned;
 - Health and welfare;
 - Administrative authority; and
 - Financial accountability.
- d. If the State provides supplemental demonstration services (SDS), the State must provide:
 - A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,
 - A description of the remediation and improvement process.

(9) Housing

- a. Describe the State’s process for documenting the type of residence in which each participant is living (See chart for examples in Sub-Appendix II). The process should categorize each setting in which an MFP participant resides by its type of “qualified residence” and by how the State defines the supported housing setting, such as:
- Owned or rented by individual,
 - Group home,
 - Adult foster care home,
 - Assisted living facility, etc. (Please see the Policy Guidance in Sub-Appendix VI)

If appropriate, identify how each setting is regulated.

- b. Describe how the State will plan to achieve a supply of qualified residences so that each eligible individual or the individual’s authorized representative can choose a qualified residence prior to transitioning. This narrative must:
- Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions; and
 - Explain how the State will plan to address any identified housing shortages for persons transitioning under the MFP demonstration grant, including:
 - Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet these needs; and
 - Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants.

(10) Continuity of Care Post-Demonstration

To the extent necessary to enable a State initiative to meet the demonstration requirements and accomplish the purposes of the demonstration, provide a description of how the following waiver provisions or amendments to the State plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care:

- a. Managed Care/Freedom of Choice (Section 1915(b)) – for participants eligible for managed care/freedom of choice services, provides evidence that:
- 1915(b) waivers and managed care contracts are amended to include the necessary services
 - appropriate HCBS are ensured for the eligible participants; or
 - A new waiver will be created.
- b. Home and Community-Based (Section 1915(c)) – for participants eligible for “qualified home and community-based program” services, provide evidence that:
- capacity is available under the cap;
 - A new waiver will be created; or
 - There is a mechanism to reserve a specified capacity for people via an amendment to the current 1915(c) waiver.
- c. Research and Demonstration (Section 1115) – for participants eligible for the research and demonstration waiver services, provide evidence that:
- Slots are available under the cap;

- A new waiver will be created; or
 - There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver.
- d. State Plan and Plan Amendments - for participants eligible for the State plan optional HCBS services, provide evidence that there is a mechanism where there would be no disruption of services when transitioning eligible participants from the demonstration program

c) Project Administration

Provide a description of the day to day organizational and structural project administration that will be in place to implement, monitor, and operate the demonstration. Please include the following:

1. **Organizational Chart** – Provide an organizational chart that describes the entity that is responsible for the day-to-day management of this grant and how that entity relates to all other departments, agencies and service systems that will provide care and supports and have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.
2. **Staffing Plan** – Provide a staffing plan that includes:
 - a. A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director’s resume or Job Description including performance evaluation criteria (CMS pays 100% of the cost of this position, CMS will have input into the approval of the person hired. At any time, CMS feels that the individual is not performing up to our expectations, CMS may request that a new Project Officer be assigned.)
 - b. The number and title of dedicated positions paid for by the grant and a justification of need. Please indicate the key staff assigned to the grant, if they have been identified.
 - c. Percentage of time each individual/position is dedicated to the grant.
 - d. Brief description of role/responsibilities of each position.
 - e. Identify any positions providing in-kind support to the grant.
 - f. Number of contracted individuals supporting the grant.
 - g. Provide a detailed staffing timeline.
 - h. Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.
3. **Billing and Reimbursement Procedures** – Describe procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.

d) Evaluation

Although not required as a component of the MFP demonstration, States may propose to evaluate unique design elements from their proposed MFP program. If these activities are undertaken by the State, the following information must be provided to CMS:

1. **Evaluator** – If an evaluator has been identified, name the evaluator and provide a resume of the principle investigator in an indexed appendix. Provide a description of the process that will be used to secure an evaluator if one has not yet been identified. Also, provide a description of how the State will assure that the evaluator will possess the necessary expertise to conduct a

- high quality evaluation. Provide a brief description of the organizational and structural administration that will be in place to implement, monitor and operate the evaluation.
2. **Evaluation Design** – Provide a description of the State’s evaluation design. The description should include the following:
 - a. A discussion of the demonstration hypotheses that will be tested;
 - b. The outcome measures that will be included to evaluate the impact of the demonstration;
 - c. The data source that will be utilized;
 - d. An analysis of the methods used for data collection;
 - e. The control variables (independent variables) that will be used to measure the actual effects (dependent variables) of the demonstration;
 - f. The method that will be utilized to isolate the effects of the demonstration from other state initiatives and state characteristics (e.g. per capita income and/or population);
 - g. Any other information pertinent to the State’s evaluative or formative research via the demonstration operations; and
 - h. Any plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction.)
 3. **Variables** – Describe the demographic, health care, and functional outcome variables you propose to collect in the demonstration. Provide a copy in an indexed appendix to the application. Describe the instruments and provide a rationale for their use in the evaluation including reliability, validity and appropriateness for use on the study population.
 4. **Process Evaluation** – Please describe how process measures will be evaluated. Include a description of how infrastructure changes will be evaluated as well as any pilot programs.

e) Budget

1. **Administrative Budget Presentation** –Please address the following items:
 - a. Personnel
 - b. Fringe benefits
 - c. Contractual costs, including consultant contracts.
 - d. Indirect Charges, by federal regulation.
 - e. Travel
 - f. Supplies
 - g. Equipment
 - h. Other costs
2. **Administrative Budget** – Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Please indicate any administrative fund request to be reimbursed fully through the grant. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.
3. **Evaluation Budget** – Please include annual estimated costs of the evaluation activities the State is proposing.

Sub-Appendix I: Self-Direction

Components of Self-Direction from the 1915(c), 3.5 Waiver Application

Participant direction of waiver services means that the participant has the authority to exercise decision-making authority over some or all of her/his services and accepts the responsibility for taking a direct role in managing them. Participant direction is an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the participant-centered service plan. Participant direction promotes personal choice and control over the delivery of waiver services, including who provides services and how they are delivered. For example, the participant may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who furnish daily supports. When a service is provider-managed, a provider selected by the participant carries out these responsibilities.

Incorporating participant direction involves several interrelated dimensions. The following is an overview of the main dimensions of participant direction:

3. Participant Choice

Self-direction may permit participants to direct some or all of their services or opt instead to receive provider-managed services exclusively. Decision making authority, references to the participant mean: (a) the participant acting independently on her/his own; (b) the parent(s) of a minor child who is a waiver participant acting on behalf of the child; (c) a legal representative when the representative has the authority to make pertinent decisions on behalf of the participant; and, (d) when permitted by the state, a non-legal representative who has been freely chosen by the participant to make decisions on the participant's behalf.

4. Participant Direction Opportunities

There are two basic participant direction opportunities. These opportunities may be and often are used in combination and are not mutually exclusive. The opportunities are:

- a) ***Participant Employer Authority*** – *Under the Employer Authority, the participant is supported to recruit, hire, supervise and direct the workers who furnish supports. The participant functions as the common law employer or the co-employer of these workers. When the Employer Authority is utilized, the participant rather than a provider agency carries out employer responsibilities for workers.*
- b) ***Participant Budget Authority*** – *Under the Budget Authority, the participant has the authority and accepts the responsibility to manage a participant-directed budget. Depending on the dimensions of the budget authority, it permits the participant to make decisions about the acquisition of goods and services that are authorized in the service plan and to manage the dollars included in a participant-directed budget.*

5. Supports for Participant Direction

Two types of supports may be made available to facilitate participant direction. These supports may be furnished as a service under a Medicaid payment authority (principally as a Medicaid administrative activity).

- a) ***Information and Assistance in Support of Participant Direction*** – *These supports are made available to participants to help them manage their waiver services. For example, assistance might be provided to help the participant locate workers who furnish direct supports or in designing the service plan. The type and extent of the supports that must be available to participants depends on the nature of the participant direction opportunities provided.*

b) **Financial Management Services** – These services are furnished for two purposes: (a) to address Federal, state and local employment tax, labor and workers’ compensation insurance rules and other requirements that apply when the participant functions as the employer of workers and (b) to make financial transactions on behalf of the participant when the participant has budget authority. There are two types of FMS services that may be employed to support participants who exercise the Employer Authority: (1) Fiscal/Employer Agent (Government or Vendor) where the entity is the agent to the common law employer who is either the participant or his or her representative or (2) Agency with Choice, where the participant and the agency function as co-employers of the participant’s worker(s). While their main purpose is to facilitate participant direction of services, these supports also provide important protections and safeguards for participants who direct their own waiver services.

CMS Funding Sources

Self-Direction can be funded by a variety of mechanisms by CMS, including funding authorities such as section 1915(c) home and community-based services waiver programs and section 1915(b) managed care, waiver programs. The Deficit Reduction Act of 2005 added new options for self-directed services States that wish to continue self-direction beyond the grant period for individuals will need to consider which authority to use. These options are summarized in the table below. (Note: section 1915(c) waiver authority policy on self-direction was developed in conjunction with the 1915(c) waiver application and is comprehensively documented in the Instructions, Technical Guide and Review Criteria for the application found at the following website:

[http://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915\(c\).asp](http://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp).

Reading the provisions in the 1915(c) waiver template are a good starting point for all self-direction initiatives. Various restrictions are present under this and other authorities and CMS should be consulted if you have questions about the authority that is best suited to your circumstances. The following table summarizes significant issues under the various authorities.

	Component		Funding Authority		
	1915(c)	1915(b)	Benchmarks (DRA 6044)	Section 1915(i) (DRA 6086)	Section 1915(j) (DRA 6087)
Services	See Appendix C of the waiver instructions for service options	Includes ability to use savings from managed care programs to fund alternative services	Includes ability to create enhanced service packages	Includes HCBS allowed under 1915(c)	Can self-direct either State plan PCS or HCBS under 1915(c)
Statewide	May waive	May waive	May waive	Cannot	States may disregard
Comparability	States may waive	States may waive	States may waive	Cannot	States may disregard
Populations	Populations who meet a Medicaid institutional level of care	Includes all populations	Includes all populations	Includes all populations	Includes all populations
Authority to Manage Cash	Cannot manage cash	Cannot manage cash	May not manage cash	May not manage cash	Allowed, at State’s option

Limit #s of people	May limit numbers	May limit numbers	May limit numbers	May not limit numbers	May limit numbers
Institutional Eligibility Rules	May waive	May waive	May waive	May waive	Does not change person's eligibility for either State plan PCS or HCBS waiver services
[1902(a)(10)(c)(i)(III)] Provider Agreements [1902(a)(27)]	May not waive	May not waive	May not waive	May not waive	May not waive

Self-Direction Submittal Form

I. Participant Centered Service Plan Development

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

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input type="checkbox"/>	Case Manager. <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>):

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

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

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

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

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

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

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

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

<input type="checkbox"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):

II. Service Plan Implementation and Monitoring

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

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

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

III. Overview of Self-Direction

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

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

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

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

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

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

<input type="radio"/>	The demonstration is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

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

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

<input type="radio"/>	The State does not provide for the direction of demonstration services by a representative.
<input type="radio"/>	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: (<i>check each that applies</i>):
<input type="checkbox"/>	Demonstration services may be directed by a legal representative of the participant.
<input type="checkbox"/>	Demonstration services may be directed by a non-legal representative freely chosen by an

		adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

<input type="radio"/>	FMS are covered as a Demonstration service	Fill out i. through iv. below:
<input type="radio"/>	FMS are provided as an administrative activity.	Fill out i. through iv. below:
	i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:
	ii.	Payment for FMS. Specify how FMS entities are compensated for the activities that they perform:
	iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i>
		<i>Supports furnished when the participant is the employer of direct support workers:</i>
	<input type="checkbox"/>	Assist participant in verifying support worker citizenship status
	<input type="checkbox"/>	Collect and process timesheets of support workers
	<input type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

	<input type="checkbox"/>	Other (<i>specify</i>):
	<i>Supports furnished when the participant exercises budget authority:</i>	
	<input type="checkbox"/>	Maintain a separate account for each participant's self-directed budget
	<input type="checkbox"/>	Track and report participant funds, disbursements and the balance—of participant funds
	<input type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
	<input type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the self-directed budget
	<input type="checkbox"/>	Other services and supports (<i>specify</i>):
	<i>Additional functions/activities:</i>	
	<input type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
<input type="checkbox"/>	Other (<i>specify</i>):	
iv.	Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

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

<input type="checkbox"/>	Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:</i>
<input type="checkbox"/>	Demonstration Service Coverage. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled: _____
<input type="checkbox"/>	Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i>

k. Independent Advocacy (*select one*).

<input type="radio"/>	Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>
<input type="radio"/>	No. Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

--

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

--

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

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Demonstration Year	Number of Participants	Number of Participants
Year 1		
Year 2		
Year 3		
Year 4		
Year 5		

Participant Employer

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

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

<input type="checkbox"/>	Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

<input type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input type="checkbox"/>	Hire staff (common law employer)
<input type="checkbox"/>	Verify staff qualifications
<input type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
<input type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences
<input type="checkbox"/>	Determine staff duties consistent with the service specifications
<input type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input type="checkbox"/>	Schedule staff
<input type="checkbox"/>	Orient and instruct-staff in duties
<input type="checkbox"/>	Supervise staff
<input type="checkbox"/>	Evaluate staff performance
<input type="checkbox"/>	Verify time worked by staff and approve time sheets
<input type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (specify):

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

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

<input type="checkbox"/>	Reallocate funds among services included in the budget
<input type="checkbox"/>	Determine the amount paid for services within the State's established limits
<input type="checkbox"/>	Substitute service providers
<input type="checkbox"/>	Schedule the provision of services
<input type="checkbox"/>	Specify additional service provider qualifications
<input type="checkbox"/>	Specify how services are provided,
<input type="checkbox"/>	Identify service providers and refer for provider enrollment
<input type="checkbox"/>	Authorize payment for demonstration goods and services
<input type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (<i>specify</i>):

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

--

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

--

4. **Participant Exercise of Budget Flexibility. Select one:**

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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

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Sub-Appendix II: Types of Supported Housing

Type of Qualified Residence	Number of Each Type of Qualified Residences*	State Definition of Housing Settings & Number of Each*	Number of Each Settings*	How Regulated*
Home owned or leased by individual or individual's family member	477	<ul style="list-style-type: none"> • Home leased by individual or family • Home owned by individual • Home owned by family 	<ul style="list-style-type: none"> • 100 • 200 • 177 	<ul style="list-style-type: none"> • Lease with landlord • N/A • N/A
Apartment with an individual lease, lockable access & egress, & which includes living, sleeping, bathing, & cooking areas over which the individual or the individual's family has domain & control.	477	<ul style="list-style-type: none"> • Apartment building • Assisted living • Public housing units 	<ul style="list-style-type: none"> • 200 • 127 • 150 	<ul style="list-style-type: none"> • Lease with landlord • State regulations • Public Housing Agency
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.	477	<ul style="list-style-type: none"> • Adult foster care • Group home 	<ul style="list-style-type: none"> • 239 • 238 	<ul style="list-style-type: none"> • State / agency licensing regulations • Agency regulations

*Numbers and terms are examples only.

Sub-Appendix III: MFP Maintenance of Effort (MOE) Form Instructions

D. Background

Section 6071(c)(9) the Deficit Reduction Act of 2005 requires the States to provide information and assurances that total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the Money Follows the Person (MFP) demonstration project than for the greater of such expenditures for fiscal year 2005 or any succeeding fiscal year before the first of the year of the MFP demonstration project. The Centers for Medicare and Medicaid Services (CMS) has clarified this to mean that maintenance of effort (MOE) will be monitored by comparing spending in the baseline year (2005 for grantees applying in 2006) to future years. The spending will be in aggregate and will include spending on all 1915(c) and 1915(b) (c) waivers as well as spending on certain State plan long-term care services including personal care and home health. The expenses that should be reported for MOE should be based on statewide spending for all populations. In other words, the MOE expenditures should not be limited to demonstration service areas or to demonstration populations. These expenditures will be collected annually by CMS and verified through the administrative data reported to the central and regional offices.

After consulting with states and reviewing the pros and cons of available administrative data reported to the CMS (Form CMS-64, 372 form and the Medical Statistical Information System (MSIS)), CMS elected to use a modified version of Form CMS-64 for the purposes of monitoring MOE. This is because the amounts reported on Form CMS-64 and its attachments are the actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. Form CMS-64 is a statement of expenditures for which States are entitled to Federal reimbursement under Title XIX and which reconciles the monetary advance made based on Form CMS-37 filed previously for the same quarter. Consequently, the amount claimed on the Form CMS-64 is a summary of expenditures derived from source documents such as invoices, cost reports and eligibility records. All summary statements or descriptions of each claim must identify the claim and source documentation. Claims developed using sampling, projections, or other estimating techniques are considered estimates and are not allowable under any circumstances.

E. Instructions for Completing the MFP MOE Form

For the purposes of attaining the baseline expenditures for fiscal year 2005 for the MOE under this demonstration, the State will report the most recent fiscal year 2005 Medicaid expenditures through two MFP MOE Forms: (1) a MFP MOE Base Form and (2) a MFP MOE Waiver Form. The MFP MOE Forms list the demonstration services and their appropriate match rates for reimbursement. States should report both institutional and community-based long-term care spending on these MFP MOE Forms.

These forms will be for purposes of demonstration administration and monitoring only and will be an internal document for use by the demonstration team at the state and federal levels. As discussed in section II.D. of the Operational Protocol, reimbursement for the demonstration will actually occur through the SF-425 that is submitted to the Payment Management System by the State. The SF-425 form will reflect the aggregate service expenditures and the MFP Financial Reporting Forms (appendix E) will provide service specific details.

F. MFP MOE State Plan Services

- Lines 1 through 4 are the same figures that the State would report on the MFP MOE Form - BASE.
- For Line 2, please specify if your State provides institutions for mental disease (IMD) services for the MFP population in the MFP MOE NARRATIVE.
- Line 5 (Clinic Services) is the amount found in Line 10 of the MFP MOE Form - BASE. The State should provide an explanation of these services (e.g. the State provides Adult Day Health services and the actual expenditures for this should be provided).
- Line 6 (Targeted Case Management for Long Term Care) is the amount found in Line 24 of the MFP MOE Form - BASE.
- Line 7 (PACE) is the amount found in Line 22 of the MFP MOE Form - BASE. The State should provide the total aggregate Medicaid rate.
- Line 8 (Rehabilitation Services) is an optional Medicaid State plan service and the State should provide additional information on the MFP MOE NARRATIVE to explain the services if the State chooses to provide these services for the MFP population.
- Line 9 (Home Health Services) is the amount found in Line 12 of the MFP MOE Form - BASE.
- Line 10 (Hospice) is the amount found in Line 26 of the MFP MOE Form - BASE.
- Line 11 (Personal Care Services) is the amount found in Line 23 of the MFP MOE Form - BASE.
- Line 12 (Other) is the actual expenditures by the State on long-term care services under the State plan. An explanation of the expenditures and the long-term care services provided should be presented on the MFP MOE NARRATIVE form.

G. MFP MOE Form - Waiver

This form breaks out the services that would be reported in aggregate on Line 19 (Home and Community-Based Services). If the State has more than one approved home and community-based services (HCBS) waiver, the State would usually attach a schedule to the FORM CMS-64.9P WAIVER form showing expenditures for each approved waiver. The expenditures found on this schedule may provide the appropriate amounts to complete the MFP MOE WAIVER form.

Listed services (Lines 1 through 13) are statutory services specifically mentioned in §1915(c) of the Social Security Act and 42 CFR §440.180. The alternate service titles should be noted in the MFP MOE NARRATIVE.

For additional information and to provide an explanation for Line 14 (Other), States should use the MFP MOE NARRATIVE to explain why the services listed in this category is not part of the services listed in numbers 1 through 13. The information should list both institutional and community-based long-term care services and the expenditures for fiscal year 2005.

H. MFP MOE Narrative

The State should use the MFP MOE Narrative Form to provide further information on services provided under the demonstration. For States that establish a waiver mid-year, those States should annualize any partial year services and provide an explanation in the MFP MOE Narrative Form.

For the MFP MOE Narrative, the State should report a listing of all the optional State plan services that the State will provide for the MFP population and optional waiver services that are both institutional and community-based long-term care services along with the expenditures for those listed. This is in

addition to the further explanation of services and expenditures provided for services listed under both the MFP MOE BASE and MFP MOE WAIVER forms.



CERTIFICATION REGARDING MAINTENANCE OF EFFORT

In accordance with the applicable program statute(s) and regulation(s), the undersigned certifies that financial assistance provided by the Centers for Medicare and Medicaid Services, for the specified activities to be performed under the _____ Program by (Applicant Organization), will be in addition to, and not in substitution for, comparable activities previously carried on without Federal assistance.

Signature of Authorized Certifying Official

Title

Date

Budget Narrative / Justification For Year One – Sample Template

State A is requesting \$5 million for the entire project period and is allowed up to 20% of that total for administrative costs. State A may request \$1 million in administrative costs and \$4 million for services.

Request for electronic copy of form can be sent to MFPDEMO@cms.hhs.gov

Object Class Category	Federal Funds	100%	90%	50%	In-Kind	Justification (must be reasonable and have detailed information)
Personnel	\$375,000	X				Project Director, Assistant Project Director, (2) Housing Coordinators, (2) Transition Coordinators
Fringe Benefits	\$120,000	X				Fringe rate at 32%
Travel	\$50,000	X				To provide transportation and lodging for stakeholder meetings-must include location, cost per person, etc.
Equipment	\$200,000					To update MMIS, include cost per item
Supplies	\$5,000					List supplies
Contractual	\$200,000	X				Contracted positions (need to include salary and fringe, title and duration (12 months) full time, travel is applicable, and deliverables
Other (services)	\$50,000	X				Transition 1 person
Indirect Charges						Submit copy of most recent Indirect Cost Rate Agreement
TOTAL						All totals must add correctly

Sub-Appendix IV: Worksheet for Proposed Budget (revised Dec 2011)

Instructions for Completing the MFP Worksheet for Proposed Budget (WFPB)

Revised Dec. 2011

Request for electronic copy of form can be sent to MFPDEMO@cms.hhs.gov

Step 1 – Fill in the following highlighted cells: (1) Date of Report, (2) State, (3) Award Number (your Award Number is located on the *Federal Award Amounts* worksheet tab within this workbook), (4) Preparer Name (person who completed the form and can be contacted if questions), (5) Preparer phone number, and (6) Preparer email address.

Step 2 – In the FMAP Table, enter your Original FMAP rate for each quarter in column 1. Enter the ARRA Increased FMAP rate for each quarter in column 3. FMAP rates are available in the *State FMAPs* worksheet tab within this workbook. The State Enhanced FMAP (column 2) and the Allowed Enhanced FMAP (column 4) will automatically populate. For new States that have received a MFP grant in 2011, enter your Original and ARRA Increased FMAP rates starting in FFY 2012 and enter zero in all previous years.

Step 3 – Fill in/update the Population Transitions Chart. For years 2007-2011, enter actual transitions for each population, which should be the same numbers entered in your semi-annual progress reports submitted in Jan/Feb for the previous calendar year. For years 2012-2016, enter projected transitions for each population. Please note that you must enter the *Unduplicated Count* for each calendar year by population as specified in the most recent version of your Operational Protocol. Each individual is only counted once in the year that they physically transition. The "Other" column includes any populations that do not fit one of the other targeted populations. Once you complete this table, proceed to Step 4. The Total Expenditures table, Rebalancing Fund Calculations, and Per Capita Costs will auto populate after you fill in actual and projected expenditures for all Calendar Years.

Step 4 – For CY 2007, enter the Federal Award Amount that your State received. The Federal Award Amount for 2007 is located in the *Federal Award Amounts* worksheet tab within this spreadsheet. Once you have entered the Federal Award Amount, enter the actual 2007 expenditures in the yellow highlighted cells. The 2007 Actual Total and 2007 Federal Unobligated Balance will automatically calculate. If your State has a 2007 unobligated balance, it will carry forward into CY 2008 automatically.

Step 5 - Repeat Step 4 for years 2008-2011 by entering actual 2008-2011 expenditures, which should reflect the sum of the year's quarterly MFP Financial Reporting Forms (ABCD forms) submitted to CMS. For CY 2011, CMS understands that many States are unable to provide a full year of expenditures within 30 days after the end of the calendar year. Therefore, please provide a best estimate and add a note to the worksheet that indicates as such. CMS expects that CY 2011 expenditures will be updated with actual expenditures with the next year's supplemental budget request. For States that received their first MFP award in 2011, enter the Federal Award Amount for 2011 only and enter zero in all previous years for the Federal Award Amount and actual expenditures in the yellow highlighted cells.

Step 6 – For CY 2012, enter projected expenditures in the yellow highlighted cells. The 2012 Federal Supplemental Request amount will auto populate. Please note that if you have a prior year(s) unobligated balance, you are required to show separate budgets for the entire unobligated balance

and the 2012 supplemental request on the modified SF-424a (section B) and the Budget Narrative. The unobligated balance and 2012 supplemental request amounts must all match on the Worksheet for Proposed Budget, the modified SF-424a, and Budget Narrative.

Step 7 – For CY 2013-2016, enter projected expenditures in the yellow highlighted cells. States have the flexibility to adjust out year projections to meet the 20% Administrative Cap.

WORKSHEET FOR PROPOSED BUGET

Instructions: Please fill in only the cells highlighted in YELLOW. All other cells will auto populate and are locked.

Please note: The enhance rate for FFY2009 thru FFY2011 is based on the increased FMAP rate related to the implementation of the Recovery Act of 2009 & the Education, Jobs and Medicaid Assistance Act of 2010. Budget calculations for the last quarter of CY2008 thru the first two quarters of CY2011 use these rates. **Request for electronic copy of form can be sent to MFPDEMO@cms.hhs.gov**

Date of Report:	
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Preparer Name:	
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State:	
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Preparer Phone:	
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Award Number:	
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Preparer Email:	
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Original and ARRA Increased Federal Medicaid Assistance Percentages (FMAP) are provided in the State FMAPs worksheet tab.

FMAP Table	Column 1	Column 2	Column 3	Column 4	Column 5
Please express FMAP as a decimal (example: 68.32%=.6832)	Original State FMAP	State Enhanced FMAP (1.00 - Reg FMAP / 2 + Reg FMAP)	ARRA Increased FMAP (Oct 2008 - Jun 2011)	ALLOWED Enhanced FMAP Not to Exceed 90%	Calculated Enhanced FMAP (Oct 2008 - Dec 2010)
	FFY 2007	0.5000		0.5000	
	FFY 2008	0.5000		0.5000	
Oct-Dec 2008	FFY 2009 Q1	0.5000		0.5000	0.5000
Jan-Mar 2009	FFY 2009 Q2	0.5000		0.5000	0.5000
Apr-Jun 2009	FFY 2009 Q3	0.5000		0.5000	0.5000
Jul-Sept 2009	FFY 2009 Q4	0.5000		0.5000	0.5000
Oct-Dec 2009	FFY 2010 Q1	0.5000		0.5000	0.5000
Jan-Mar 2010	FFY 2010 Q2	0.5000		0.5000	0.5000
Apr-Jun 2010	FFY 2010 Q3	0.5000		0.5000	0.5000
Jul-Sept 2010	FFY 2010 Q4	0.5000		0.5000	0.5000
Oct-Dec 2010	FFY 2011 Q1	0.5000		0.5000	0.5000
Jan-Mar 2011	FFY 2011 Q2	0.5000		0.5000	0.5000
Apr-Jun 2011	FFY 2011 Q3	0.5000		0.5000	0.5000
Jul-Dec 2011	FFY 2011 Q4	0.5000		0.5000	0.5000
	FFY 2012	0.5000		0.5000	
	FFY 2013	0.5000		0.5000	
	FFY 2014	0.5000		0.5000	
	FFY 2015	0.5000		0.5000	
	FFY 2016	0.5000		0.5000	

Populations Transitions Chart (unduplicated count)

- *Unduplicated Count* - Each individual is only counted once in the year that they physically transition.
- All population counts and budget estimates are based on the *Calendar Year (CY)*.
- The State is held accountable for the current year populations to be transitioned and actual numbers should be consistent with semi-annual reports submitted in Jan/Feb for the previous calendar year.

	Elderly	ID/DD	Physical Disability	Mental Illness	Other	Total per CY
CY 2007 (actuals)						0
CY 2008 (actuals)						0
CY 2009 (actuals)						0
CY 2010 (actuals)						0
CY 2011 (actuals)						0
CY 2012 (projected)						0
CY 2013 (projected)						0
CY 2014 (projected)						0
CY 2015 (projected)						0
CY 2016 (projected)						0
Total Count	0	0	0	0	0	0

Demonstration Budget Summary-All Years

- *Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services* are defined in the MFP Solicitation.
- *Administration - Normal* - costs that adhere to CFR Title 42, Section 433(b)(7);
- *Administrative - 75%* - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10);
- *Administrative - 90%* - costs that adhere to CFR Title 42 Section 433(b)(3)
- *Federal Evaluation Supports* - costs related to administering the Quality of Life Survey (reimbursed @ \$100 per survey).
- *Rebalancing Fund* - is a calculation devised by CMS to estimate the amount of State savings attributed to the Enhanced FMAP Rate that could be reinvested into rebalancing benchmarks.
- *Other* - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2016)	Total Costs (Fed & State)	Federal	State
Qualified HCBS	\$	\$	\$
Demonstration HCBS	\$	\$	\$
Supplemental	\$	\$	\$
Administrative - Normal	\$	\$	\$
Administrative - 75%	\$	\$	\$
Administrative - 90%	\$	\$	\$
<i>Federal Evaluation Supports</i>	\$	\$	\$
Administrative (Other) - 100%	\$	\$	\$
State Evaluation	\$	\$	\$
ADRC Funding	\$	\$	\$
Total	\$	\$	\$

Administrative 20% Cap Calculation		Estimated Rebalancing Fund Calculation*	
Total Costs (Fed & State less Fed Eval & ADRC)	\$	CY 2007	\$
Total Administrative Costs (Fed & State)	\$	CY 2008	\$
Admin. to Services Percentage (20% Max)		CY 2009	\$
		CY 2010	\$
		CY 2011	\$
		CY 2012	\$
		CY 2013	\$
		CY 2014	\$
		CY 2015	\$
		CY 2016	\$
		Rebalancing Fund Total	\$

Total Costs (Fed & State) Per Capita	
Service Costs	
Admin Costs	

*It is the State's responsibility to keep track of their Rebalancing Funds.

If necessary, please update actual expenditures for all past years.					Enter CY 2007 Comments Here
2007 Federal Award					
<u>CY 2007</u>	Rate	Total Costs (actual expenditures)	Federal (actual expenditures)	State (actual expenditures)	
Qualified HCBS	0.5000	\$	\$	\$	
Demonstration HCBS	0.5000	\$	\$	\$	
Supplemental	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	1.0000	\$	\$	\$	
CY 2007 Actual Total		\$	\$	\$	
CY 2007 FEDERAL Unobligated Balance		\$	\$	\$	

2007 Federal Unobligated Balance					Enter CY 2008 Comments Here
2008 Federal Award					
Total 2008 Federal Budget (2007 unobligated balance plus 2008 Fed award)					
<u>CY 2008</u> (including Partial Year Increased FMAP)	Rate	Total Costs (actual expenditures)	Federal (actual expenditures)	State (actual expenditures)	
Qualified HCBS (Jan - Sept)	0.5000	\$	\$	\$	
Qualified HCBS (Oct - Dec increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Jan - Sept)	0.5000	\$	\$	\$	
Demonstration HCBS (Oct - Dec increased FMAP)	0.5000	\$	\$	\$	
Supplemental (Jan - Sept)	0.0000	\$	\$	\$	
Supplemental (Oct - Dec increased FMAP)	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	1.0000	\$	\$	\$	
CY 2008 Actual Total		\$	\$	\$	
CY 2008 FEDERAL Unobligated Balance		\$	\$	\$	

2008 Federal Unobligated Balance		\$			Enter CY 2009 Comments Here
2009 Federal Award		\$			
Total 2009 Federal Budget (2008 Unobligated balance plus 2009 Fed award)		\$			
CY 2009 (using Increased FMAP)	Rate	Total Costs (actual expenditures)	Federal (actual expenditures)	State (actual expenditures)	
Qualified HCBS (Jan-Mar increased FMAP)	0.5000	\$	\$	\$	
Qualified HCBS (Apr-Jun increased FMAP)	0.5000	\$	\$	\$	
Qualified HCBS (Jul- Sep increased FMAP)	0.5000	\$	\$	\$	
Qualified HCBS (Oct - Dec increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Jan-Mar increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Apr-Jun increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Jul- Sep increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Oct - Dec increased FMAP)	0.5000	\$	\$	\$	
Supplemental (Jan-Mar increased FMAP)	0.0000	\$	\$	\$	
Supplemental (Apr-Jun increased FMAP)	0.0000	\$	\$	\$	
Supplemental (Jul- Sep increased FMAP)	0.0000	\$	\$	\$	
Supplemental (Oct - Dec increased FMAP)	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	1.0000	\$	\$	\$	
CY 2009 Actual Total		\$	\$	\$	
CY 2009 FEDERAL Unobligated Balance		\$			

2009 Federal Unobligated Balance		\$			Enter CY 2010 Comments Here
2010 Federal Award		\$			
Total 2010 Federal Budget (2009 Unobligated balance plus 2010 Fed award)		\$			
CY 2010 (using increased FMAP)	Rate	Total Costs (actual expenditures)	Federal (actual expenditures)	State (actual expenditures)	
Qualified HCBS (Jan-Mar increased FMAP)	0.5000	\$	\$	\$	
Qualified HCBS (Apr-Jun increased FMAP)	0.5000	\$	\$	\$	
Qualified HCBS (Jul- Sep increased FMAP)	0.5000	\$	\$	\$	
Qualified HCBS (Oct - Dec increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Jan-Mar increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Apr-Jun increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Jul- Sep increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Oct - Dec increased FMAP)	0.5000	\$	\$	\$	
Supplemental (Jan-Mar increased FMAP)	0.0000	\$	\$	\$	
Supplemental (Apr-Jun increased FMAP)	0.0000	\$	\$	\$	
Supplemental (Jul- Sep increased FMAP)	0.0000	\$	\$	\$	
Supplemental (Oct - Dec increased FMAP)	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	1.0000	\$	\$	\$	
CY 2010 Actual Total		\$	\$	\$	
CY 2010 FEDERAL Unobligated Balance		\$			

Please refer to the most recent ABCD Forms for Actual Expenditures. Totals may be "provisional" for last quarter (Oct-Dec) pending receipt and payment of all claims.					Enter CY 2011 Comments Here
2010 Federal Remaining Balance			\$		
2011 Federal Award			\$		
Total 2011 Federal Budget (2010 remaining balance plus 2011 Fed award)			\$		
<u>CY 2011</u> (using partial year increased FMAP)	Rate	Total Costs (actual expenditures)	Federal (actual expenditures)	State (actual expenditures)	
Qualified HCBS (Jan-Mar increased FMAP)	0.5000	\$	\$	\$	
Qualified HCBS (Apr-Jun increased FMAP)	0.5000	\$	\$	\$	
Qualified HCBS (Jul- Dec)	0.5000	\$	\$	\$	
Demonstration HCBS (Jan-Mar increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Apr-Jun increased FMAP)	0.5000	\$	\$	\$	
Demonstration HCBS (Jul- Dec)	0.5000	\$	\$	\$	
Supplemental (Jan-Mar increased FMAP)	0.0000	\$	\$	\$	
Supplemental (Apr-Jun increased FMAP)	0.0000	\$	\$	\$	
Supplemental (Jul- Dec)	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	1.0000	\$	\$	\$	
CY 2011 Actual Totals			\$	\$	
CY 2011 FEDERAL Unobligated Balance			\$		

For CY 2012, Report PROJECTED Expenditures					Enter CY 2012 Comments Here
<u>CY 2012</u>	Rate	Total Costs (projected expenditures)	Federal (projected expenditures)	State (projected expenditures)	
Qualified HCBS	0.5000	\$	\$	\$	
Demonstration HCBS	0.5000	\$	\$	\$	
Supplemental	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	1.0000	\$	\$	\$	
CY 2012 Projected Totals			\$	\$	
2011 Federal Remaining Balance			\$		
2012 Federal Supplemental Request			\$		
The SF-424a must show separate budgets for (1) unobligated balance, if applicable and (2) 2012 supplemental request.					

For CY 2013, Report PROJECTED Expenditures					Enter CY 2013 Comments Here
<u>CY 2013</u>	Rate	Total Costs (projected expenditures)	Federal (projected expenditures)	State (projected expenditures)	
Qualified HCBS	0.5000	\$	\$	\$	
Demonstration HCBS	0.5000	\$	\$	\$	
Supplemental	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	1.0000	\$	\$	\$	
CY 2013 Projected Totals			\$	\$	
2013 Federal Supplemental Request			\$		

For CY 2014, Report PROJECTED Expenditures					Enter CY 2014 Comments Here
<u>CY 2014</u>	Rate	Total Costs (projected expenditures)	Federal (projected expenditures)	State (projected expenditures)	
Qualified HCBS	0.5000	\$	\$	\$	
Demonstration HCBS	0.5000	\$	\$	\$	
Supplemental	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	1.0000	\$	\$	\$	
CY 2014 Projected Totals		\$	\$	\$	
2014 Federal Supplemental Request			\$		

For CY 2015, Report PROJECTED Expenditures					Enter CY 2015 Comments Here
<u>CY 2015</u>	Rate	Total Costs (projected expenditures)	Federal (projected expenditures)	State (projected expenditures)	
Qualified HCBS	0.5000	\$	\$	\$	
Demonstration HCBS	0.5000	\$	\$	\$	
Supplemental	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	\$	\$	\$	\$	
CY 2015 Projected Totals		\$	\$	\$	
2015 Federal Supplemental Request			\$		

For CY 2016, Report PROJECTED Expenditures					Enter CY 2016 Comments Here
<u>CY 2016</u>	Rate	Total Costs (projected expenditures)	Federal (projected expenditures)	State (projected expenditures)	
Qualified HCBS	0.5000	\$	\$	\$	
Demonstration HCBS	0.5000	\$	\$	\$	
Supplemental	0.0000	\$	\$	\$	
Administrative - Normal	0.5000	\$	\$	\$	
Administrative - 75%	0.7500	\$	\$	\$	
Administrative - 90%	0.9000	\$	\$	\$	
Federal Evaluation Supports	1.0000	\$	\$	\$	
Administrative (Other) - 100%	1.0000	\$	\$	\$	
State Evaluation (if approved)	0.5000	\$	\$	\$	
ADRC Funding	1.0000	\$	\$	\$	
CY 2016 Projected Totals		\$	\$	\$	
2016 Federal Supplemental Request			\$		

Total Federal Funds Awarded to Date thru 2011	\$
Total Federal Funds Expended to Date thru 2011	\$
Remaining Federal Funds	\$

Sub-Appendix V: Service Definitions

I. Service Definitions

The following service definitions are from the Social Security Act or the Code of Federal Regulations governing Medicaid. They are excerpted because they are thought to represent the majority of services available under the Medicaid State Plan that is used to provide long-term care. Some of these services (e.g. Clinic services) include components that are not long-term care. The only portion of the service that should be billed to the MFP demonstration and included on the MFP financial reporting forms is the long-term care components of the service.

1. HCBS STATE PLAN SERVICE DEFINITIONS

a) *Clinic Services* means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

- Services furnished at the clinic by or under the direction of a physician or dentist.
- Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

b) *Targeted Case Management for Long Term Care*: are services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

c) *PACE (Program for ALL Inclusive Care for the Elderly)*: For a detailed explanation of PACE, please refer to Title 42 CFR § 460.

d) *Rehabilitative Services*: means any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

e) *Home health services (42 CFR § 440.70)*:

- a) means the services in paragraph (b) of this section that are provided to a recipient
 - (1) At his place of residence, as specified in paragraph (c) of this section; and
 - (2) On his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except as specified in paragraph (b)(3) of this section.
- b) Home health services include the following services and items. Those listed in paragraphs (b) (1), (2) and (3) of this section are required services; those in paragraph (b)(4) of this section are optional.
 - (1) Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency as defined in paragraph (d) of this section, or if there is no agency in the area, a registered nurse who
 - i. Is currently licensed to practice in the State;
 - ii. Receives written orders from the patient's physician;

- iii. Documents the care and services provided; and
 - iv. Has had orientation to acceptable clinical and administrative recordkeeping from a health department nurse.
- (2) Home health aide service provided by a home health agency,
- (3) Medical supplies, equipment, and appliances suitable for use in the home.
- i. A recipient's need for medical supplies, equipment, and appliances must be reviewed by a physician annually.
 - ii. Frequency of further physician review of a recipient's continuing need for the items is determined on a case-by-case basis, based on the nature of the item prescribed;
- (4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services. (See Sec. 441.15 of this subchapter)
- c) A recipient's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded, except for home health services in an intermediate care facility for the mentally retarded that are not required to be provided by the facility under subpart I of part 483. For example, a registered nurse may provide short-term care for a recipient in an intermediate care facility for the mentally retarded during an acute illness to avoid the recipient's transfer to a nursing facility.
- d) "Home health agency" means a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in Medicare, including the capitalization requirements under Sec. 489.28 of this chapter.
- e) A "facility licensed by the State to provide medical rehabilitation services" means a facility that
- (1) Provides therapy services for the primary purpose of assisting in the rehabilitation of disabled individuals through an integrated program of
 - i. Medical evaluation and services; and
 - ii. Psychological, social, or vocational evaluation and services; and
 - (2) Is operated under competent medical supervision either
 - i. In connection with a hospital; or
 - ii. As a facility in which all medical and related health services are prescribed by or under the direction of individuals licensed to practice medicine or surgery in the State.
- f) **Hospice:** *The hospice service benefit is an optional benefit, which States may choose to make available under the Medicaid program. The purpose of the hospice benefit is to provide for the palliation or management of the terminal illness and related conditions. Under Federal guidelines, the hospice benefit is available to individuals who have been certified by a physician to be terminally ill. An individual is considered terminally ill if he/she has a medical prognosis that his or her life expectancy is 6 months or less. Individuals who meet these requirements can elect the Medicaid hospice benefit. In order to receive payment under Medicaid, a hospice must meet the Medicare conditions of participation applicable to hospices and have a valid provider agreement. The provision of care is generally in the home to avoid an institutional setting and to improve the individual's quality of life until he or she dies.*

- g) **Personal care services (42 CFR § 440.167):** *Unless defined differently by a State agency for purposes of a waiver granted under part 441, subpart G of this chapter*
- a) Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are
 - (1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;
 - (2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and
 - (3) Furnished in a home, and at the State's option, in another location.
 - b) For purposes of this section, family member means a legally responsible relative.

2. **HCBS WAIVER SERVICE DEFINITIONS**

Case Management services. Services that will assist individuals served by a HCBS program in gaining access to needed HCBS and other State plan services, as well as needed medical, social, educational and other services, without regard to the payment source for the services to which access is gained. Components of case management may also include assessment, development of service plans, referral and related activities, oversight, quality monitoring, and participation in activities related to remediation.

Homemaker services may include either or both of the following components:

- (1) Basic homemaker services means general household activities (meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home; or
- (2) Chore Services needed to maintain a clean, sanitary and safe environment in the home, provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Home health aide services, referenced in §440.70, provided in addition to home health aide services furnished under the approved State plan, provided inside or outside the home.

Personal care services consist of any or all of the following options, as specified by the State:

- (1) Assistance with eating, bathing, dressing, personal hygiene, activities of daily living and health related services. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. Personal care services may also include such housekeeping chores as bed making, dusting and vacuuming, that are essential to the health and welfare of the individual, and health-related services to the extent permitted by State law
- (2) A range of human assistance to enable program participants to accomplish tasks that they would normally perform for themselves if they did not have a disability. This may take

the form of hands-on assistance, performing a task on behalf of the person, shadowing, or cueing to prompt the person to perform a task. Personal care services may be episodic, or provided on a continuing basis. Assistance most often relates to the performance of activities of daily living (bathing, dressing, toileting, transferring, eating, maintaining continence) and instrumental activities of daily living (more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication and money management).

- (3) Attendant services that include supportive and health-related services, specific to the needs of an individual with disabilities. Supportive services are those that reinforce the individual's strengths, while substituting or compensating for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant services incorporate and respond to the individual's preferences and priorities, and may include health-related services to the extent permitted by State law.
- (4) Adult Companion Services means non-medical care, supervision and socialization, and health-related services provided to an adult with functional disabilities. Health-related services incidental to the provision of adult companion services may be included to the extent permitted by State law. Providers may also perform light housekeeping tasks incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care.
- (5) Personal Emergency Response Systems (PERS) consist of an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to a telephone and programmed to signal a response center, staffed by trained individuals, once the "help" button is activated.
- (6) Assistive technology means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.
- (7) Assisted living services means personal care and supportive services (homemaker, chore, attendant services, meal preparation), including 24 hour on-site response capability to meet scheduled or unscheduled needs and to provide supervision, safety and security, for individuals residing in a homelike, non-institutional setting. Services also include social and recreational activities, and medication assistance, to the extent permitted under state law. Assisted living services do not include any component of the cost of room and board. Assisted living services must be provided pursuant to a written residency agreement or contract that specifies the rights and responsibilities of the individual, including the following:
 - the right to privacy;
 - consistent with state regulations, the right to assume risk as specified in the contract with the provider,
 - consistent with the ability and willingness to understand and assume responsibility for the consequences of that risk;
 - the right to receive services in a way that promotes maximum respect, dignity, independence, and respects the individual;
 - the rights of the provider,
 - the type and services, including the degree of nursing and/or medical oversight to be furnished, and

- the terms or arrangements under which services are to be provided.

Assisted living services provided by third parties must be coordinated with the assisted living provider. An assisted living setting must include the following physical characteristics:

- (1) Individual living units (which may include dually occupied units, at the consent of both individuals). Each unit must be separate and distinct from each other, and contain a bedroom and toilet facilities.
- (2) Individual living units that may be locked at the discretion of the individual, except where it conflicts with fire code, or when a physician or mental health professional has certified in writing that the individual is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door.
- (3) A central common area that may serve multiple purposes, such as dining and parlor space.

Adult day health services means services generally furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. At the option of the State, physical, occupational and speech therapies indicated in the individual's plan of care may be furnished as component parts of this service. Meals may be provided as part of these services, but shall not constitute a "full nutritional regimen" (3 meals per day). Transportation between the individual's place of residence and the adult day health center may be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

Habilitation services means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Supports should be consistent in all settings (including the place where the individual lives), encourage, and reinforce incidental learning and appropriate behavior. For individuals with degenerative conditions, habilitation may include training and supports designed to maintain skills and functioning and to prevent or slow regression to the extent possible. These services may also include any or all of the following components:

Home-based (Residential) habilitation means individually tailored adaptive skill development, assistance with activities of daily living, community inclusion, transportation, social and leisure skill development, that assist an individual to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation may include assistance with personal care activities that the individual is incapable of performing independently (but does not comprise the entirety of the service) furnished to individuals who live in their own homes, or with no more than 2 other unrelated individuals. Home-based habilitation services include routine supervision and oversight incidental to the provision of this service. Home-based habilitation services do not include 24-hour response capability associated with residence in the setting furnishing care. Payment may not be made for the cost of room and board, the cost of building maintenance, upkeep, or improvement.

Day habilitation services are a set of activities, formally identified and incorporated in an individual's plan of care, designed to promote the ability of individuals with disabilities to live

more independently in the community, close to families and friends; and participate in community life. Services are furnished in an environment designed to facilitate acquisition of skills, appropriate behavior, greater independence and personal choice.

Habilitative relief means habilitation services provided to individuals in conjunction with supervision and oversight services furnished by substitute primary caregiver, for a maximum of 30 days per year, because of the absence or need for relief of those persons normally providing unpaid care. The primary focus of habilitative relief is the continued provision of habilitation services required by the individual.

Behavioral habilitation means intensive behavioral interventions that diminish behaviors that interfere with the development and use of language and appropriate social interaction skills.

Expanded habilitation services, which means educational, prevocational and supported employment services provided as described below.

Educational services means special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act (IDEA), to the extent to which they are not available under a program funded by IDEA. Documentation must be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the section 110 of the Rehabilitation Act of 1973, or section 602(16) and (17) of IDEA (20 U.S.C. 1401(16 and 17)).

Prevocational services mean services that prepare an individual for paid or unpaid employment, including teaching such concepts as work behavior, attendance, task completion, problem solving and safety. Prevocational services are directed to habilitative, rather than explicit employment, objectives, and are not job-task oriented, but instead, aimed at a generalized result of meaningful and productive activity for the individual.

Supported Employment means supports and services that facilitate paid employment for persons and who, because of their disabilities, need ongoing support to perform in a work setting. This service includes any combination of special supervisory services, training, transportation, and adaptive equipment that the state finds are essential for persons to engage in paid employment (including self-employment) and that are not typically required for non-disabled persons engaged in competitive employment.

Respite care means services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing care. FFP may not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State.

Day Treatment or Other Partial Hospitalization Services for individuals with chronic mental illness are services necessary for the diagnosis or treatment of an individual's mental illness. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization. This service consists of the following elements:

- (1) individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- (2) occupational therapy, requiring the skills of a qualified occupational therapist,

- (3) services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- (4) drugs and biologicals, not otherwise available to the individual through Medicare, furnished for therapeutic purposes,
- (5) individual activity therapies that are not primarily recreational or diversionary,
- (6) family counseling (the primary purpose of which is treatment of the individual's condition),
- (7) training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- (8) diagnostic services.

Psychosocial rehabilitation services for individuals with chronic mental illness means medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific psychosocial rehabilitation services include the following:

- (1) restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- (2) social skills training in appropriate use of community services;
- (3) development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- (4) telephone monitoring and counseling services

Clinic Services (whether or not furnished in a facility) for individuals with chronic mental illness means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

- (1) Services furnished at the clinic by or under the direction of a physician or dentist.
- (2) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

Live-In Caregiver (42 CFR §441.303(f)(8)) means a personal caregiver who resides with a beneficiary and provides a waiver service to meet the recipient's physical, social, or emotional needs (as opposed to services not directly related to the care of the recipient; that is, housekeeping or chore services). FFP for live-in caregivers is not available if the recipient lives in the caregiver's home or in a residence that is owned or leased by the caregiver. MFP demonstration programs must submit to MFP administration office the method it uses to apportion the costs of rent and food. The method must be explained.

Sub-Appendix VI: Qualified Residence Guidance

The following CMS guidance is intended to help clarify the types of residences in which MFP participants can reside during the MFP Demonstration.

Note that the three categories of qualified residences in this guidance:

- Are mutually exclusive;
- Have the same letter headings as in the statute; and
- Contain bullets with clarifying information.

This guidance does not provide an exhaustive list of all types of living situations; rather, it identifies components that must be present in a qualified residence and conversely, components that would disqualify a residence from consideration for MFP.

CMS recognizes that separation of housing and services often allows for greater levels of self-direction for MFP participants; however, some persons may prefer services and supports that are an integral component of their home in the community. Therefore, this Qualified Residence Guidance is intended to support a variety of living situations, including supportive housing arrangements. However, all residences should honor personal choice and control of the MFP participants' home and afford opportunities for independence and community integration.

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A qualified residence is:

- 1. A home owned or leased by the individual or the individual's family member; the lease/deed must be held by the individual or the individual's family member.**
 - If leased, the leasee must be the MFP participant or a family representative. Leases as defined by Webster's Dictionary are, "Contracts renting property to another for a specified period of time in consideration of rent".
 - If an MFP participant would like to share the home they own or lease with other private individuals, including other MFP participant(s), they may either:

- Sublet or rent their home with a lease granting the other individual(s) exclusive possession to the space being leased or sublet; or
- Enter into a co-ownership or co-leasing arrangement with the other private individual(s).

In either of these circumstances, all parties must retain independent and equal legal rights to enforcement of the lease and/or ownership responsibilities and, if the other parties are MFP participants, those individuals retain responsibility for meeting the qualified residence requirements.

2. A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

- This residence may be owned and operated by a person or organization other than the individual.
- A residence in which no more than 4 unrelated individuals reside and that is part of a larger congregate care setting (campus) separated from typical community dwellings would not be considered a qualified residence.
- Caregivers, such as personal attendants, are not counted in the four maximum unrelated individuals.

3. Qualified Residence Apartment with an individual lease

The CMS MFP Team prepared the following guidance for MFP grantees to help clarify the conditions under which community residential settings, including Assisted Living Facilities or Settings (ALS) may meet the requirements of a “qualified residence” under the MFP statute. CMS believes this guidance preserves the intent of the Money Follows the Person Demonstration to offer participants options to live in apartment settings that promote independence, choice and privacy.

The MFP Team identified seven issues in the MFP Housing Guidance previously distributed by CMS that may limit participation of key community residential and Assisted Living providers in the demonstration. Each of these issues is described below, followed by the conditions which must be met in order for a community residential provider or (hereto referred to as an ALS) to participate in the MFP demonstration as a qualified residence.

ISSUES

1. Must have a lease.

A lease is a contract in which the legal right to use and occupy property is conveyed in exchange for payment or some other form of consideration. It is generally for a fixed period, although it may be a term for life, or may be terminable at any time. States need to evaluate if the following mandatory elements of a lease exist in the ALS resident agreement or contract.

- A provision that specifies that the ALS provider (possessor of real property) conveys the right to use and occupy the property. The ALS may also offer and provide a set of healthcare services and supports in exchange for rent or a fee.
- A provision that specifies the period of time that is governed by the agreement/contract agreed to by the resident and the ALS, including rights of termination by the resident and the provider and document a formal appeal process for resident terminations.

- A written instrument with a conveyance and covenants detailing the services and residence that will be provided in the Assisted Living agreement or Assisted Living contract.
- Provisions that the residents tenancy rights can be terminated only for violations including non-payment of rent, posing a direct threat to others, and property damage.
- The resident is provided sufficient information and opportunity to consider the possession of the ALS residence and related services and supports to be provided.
- The lease/agreement must state that the ALS will meet all Federal and State Fair Housing Laws.

2. Must be an apartment with living, sleeping, bathing and cooking areas

If apartments are not required by the States' ALS licensing regulations, MFP may only contract with ALSs that offer apartment units.

3. Unit must have lockable access and egress.

ALSs that serve participants with cognitive impairments must include design features that maximize the participants' capacity to live as independently as possible. Conditions that limit a person's activities must be addressed in the plan of care, be related to risks to the individual's health and welfare, and agreed to by the individual or caregiver in writing.

The ALS must provide the resident with lockable access and egress to and from the resident's apartment, and means to access or leave the facility. This may include key, ID card, keypad number, electronic scanner, or watchman made available to the participant, family member or guardian based on a person-centered plan of care. Participants who are not cognitively impaired and have a plan of care that indicates the capacity to live independently with supports must have full access and egress from their residence.

4. A qualified residence cannot require that services must be provided as a condition of tenancy or from a specific company for services available in addition to those included in the rate.

Participants have the right to choose their living arrangements, and one residential option is an ALS that meets the requirements of a qualified setting under MFP. While one of the defining characteristics of an ALS is that the landlord is also the provider of services either directly or through contract, participants who choose to live in an ALS have a choice of providers of Medicaid services that are available in addition to the services that are included in the service rate paid to the ALS. Traditional ALS services usually include, depending on the needs of the individual, housekeeping, meal preparation, transportation, personal care, and assistance with medication administration.

For an ALS to be eligible as a MFP qualified residence, the tenant (or responsible party) must participate in the care planning process, and there must be a formal process for resolving care plan differences between the ALS and the tenant. Regulations that provide for managed or negotiated risk meet this requirement. If the regulations do not provide a process for resolving care plan differences between the ALS and the tenant, the agreement/contract must define a process.

The agreement/contract should indicate that when the tenant chooses to pay room and board for a unit, they also choose the ALS as their provider for services that are included in the Medicaid rate. Assisted living must be a voluntary choice made by the consumer. Participants cannot be denied services or ALS due to physical, sensory and/or mental health conditions. Before choosing an ALS, the

individual should be provided with a choice of potential residences and service providers appropriate to their needs. ALS should not be the only option available to a transitioning individual.

5. ALSs may not require notification of absences from the facility.

Notice of absences cannot be a condition of the agreement/contract but can be part of the ALS operating practices as long as the expectation is reasonable, noted in the plan of care, and related to one of the following criteria.

- Notice of absence may be required based on an individual assessment, risk to the tenant and the need to assure health and welfare.
- Notification of absence may be required in order to ensure that Medicaid is not billed for days on which services were not delivered.
- Absences for less than 30 days cannot result in termination/discharge.
- To assure health and welfare requirements, the tenant may have to inform the ALS when the tenant leaves the building. The length of the absence that needs to be communicated to the ALS can vary by the predetermined risk as noted in the care plan.

6. Aging in place must be a common practice of the ALS

An ALS can participate as a qualified residence only if it allows aging in place. This means that a resident contract may not be terminated due to declining health or increased care needs. The state may contract for MFP reimbursed services with ALSs that include aging in place opportunities as provided for in State licensing regulations.

Residents whose service needs cannot be met under the resident agreement or contract may bring in an outside service provider to meet the additional needs if allowed by state regulation; or if able, the ALS may provide the additional services. Additional Medicaid payments to an outside provider would only be made for services that are not included in the rate paid to the ALS

Leases may not reserve the right to assign apartments or change apartment assignments.

Agreements/contracts may not reserve the right to assign apartments or change apartment assignments beyond the normal provisions of landlord tenant law. However, changes based on the plan of care developed with the resident may be made. In such cases, the written agreement should be modified to reflect the new agreement with the tenant.

Sub-Appendix VII: Examples of Supplemental Demonstration Services

J. Background

As part of the New Freedom Initiative, CMS, through grants and other policy directives, including the July 2003 State Medicaid Directors' letter on transition costs, has encouraged the movement of individuals from institutional to community-based settings. The result of this movement is that many States are not in the beginning of a rebalancing process but rather are many years into it. For these States, the easy barriers have been overcome, leaving very difficult barriers to rebalancing.

One of the four Stated purposes of the Money Follows the Person Demonstration program is to “eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the setting of their choice.”

This purpose is a broad mandate to use the demonstration program to overcome the barriers to greater reliance on community-based long-term care services.

The majority of the funding from this demonstration program will be spent to provide home and community-based services that will remain available to individual participants as part of the standard Medicaid program after the demonstration terminates. However, there may be barriers that are unaddressed through the State's “qualified home and community-based program” or through enhanced HCB services that could be addressed by providing one-time services through the demonstration. The ability to provide these services may make it possible for States that are fairly advanced in their transition efforts but have specific barriers to overcome to continue to make progress.

Any services provided, that are not qualified HCB long-term care services must be justified as essential to ensuring the advancement of Medicaid home and community-based care and overall rebalancing. The service costs must be determined on a per person basis and be tied to the population in the demonstration. These services will be reimbursed at the State's regular FMAP rate with demonstration funds. These services will not continue after the termination of the 12month demonstration period. Additionally, CMS will not approve service costs that are the responsibility of other federal agencies. We will however, consider programs that bridge to permanent community-living solutions.

1. Assistive Technology and Durable Medical Equipment

A State's “qualified home and community-based program” and HCB demonstration services may not include a broad definition of assistive technology. However, a person may be more confident about transitioning to the community if they can receive a computer which can be used to access on-line grocery delivery services, make arrangements for accessible transportation, and provide some social interaction. Similarly, an individual considering community living may need approval for a much more functional lightweight wheelchair than what was sufficient in an institutional facility.

2. Nutrition Services

People who have had to reside in institutions generally have not had the responsibility to prepare meals or have lost the skills necessary to handle meal preparation. In the community, nutrition counseling and food preparations skills may be essential to successful community-living including maintenance of health status, yet will not typically be included under the Medicaid service package. These one-time skills may improve transition for some individuals.

3. Substance Abuse

Substance abuse services are in short supply under most State Medicaid programs and individuals who have been medicated for pain, and other reasons, for long periods will have increased need for these services. Assisting individuals with substance abuse issues during the demonstration period will decrease reasons for return to institutional settings.

4. Housing

States, many with long histories of involvement with transition programs, have repeatedly identified housing as a tremendous barrier to participation. These States must make significantly more progress in assuring the availability, affordability, and accessibility of housing, and coordinating or providing it with long-term housing supports, if initiatives transitioning populations from institutions to the community are to succeed.

Activities to promote availability of housing for populations with chronic conditions and disabilities include new construction, acquisition, conversion (such as converting existing public housing to assisted living), and pre-development loans. Activities to promote affordability include rental assistance that is tied to either a building or unit or that which is portable, temporary bridge programs, and homeownership. Finally, activities that promote accessibility include rehabilitation, renovation, and universal design. HUD, Department of Agriculture, and Department of Treasury (IRS) currently support combinations of these activities through a myriad of programs.

However, in order to access these housing resources, States and disability stakeholders must be aware of and engage planning processes that control these resources. To do so frequently takes time and persistence. Equally important, collaboration and the development of partnerships and coalitions with numerous stakeholders across different sectors, such as housing, support services and disability groups, must occur. Currently, States are at varying levels of sophistication in this process.

In addition, several of these housing resources are scarce. For instance, the average waiting time for Section 8 rental housing vouchers (the federal government's program that most closely embodies the element of choice in that it permits the choice of housing) is 24 months, and that is understated since many housing authorities close their waiting lists when they get too long. Therefore, if States are to succeed in transitioning individuals in the MFP program, they will need immediate assistance in securing housing, the missing part of the community-based infrastructure. States may propose to use MFP funding (at the defined grant matching rates), other Medicaid mechanisms, and/or coordinated funding with other agencies (e.g. public housing agency, State finance agency, Federal HUD programs such as the HOME program, nonprofit foundations) to pay for housing-related services for transitioning persons.

To the extent that these housing related services are not included in a States "qualified HCBS program" or in HCB demonstration services, the State may cover these housing related services

under supplemental demonstration services. The services are often one-time transition services and may include:

- the cost of furnishing an apartment;
- the expense of security deposits; utility set-up fees; and
- health and safety assurances, such as pest eradication, allergen control, or one-time cleaning prior to occupancy.
- Home modifications and retrofitting to make housing accessible.
- Adaptive equipment/assistive technology to facilitate sustained community living.

5. Service Animals

Individuals with particular types of disabilities may be advantaged in transitioning if they are accompanied by a service animal. The cost of the animals is high yet they could be extremely instrumental in successful transitioning.

6. Transportation

Non-medical transportation assistance may be identified by a State as a key form of assistance that could be solved through a one-time solution such as a vehicle modification.

7. Family Services

Family support services may be necessary to train the crucial informal support network on service availability, appropriate expectations, health and safety issues, etc.

Sub-Appendix VIII: Provider and Interagency Collaboration

In order for the State to maximize the success of its MFP transition program, it is especially critical for the agency who is implementing the MFP demonstration to work closely with the States' survey and certification agency to ensure the health and safety of Medicaid beneficiaries receiving care across the continuum of long-term care supports. This includes those individuals who transition to the community as well as those individuals who continue to reside in institutions.

It is also important to enlist the support, collaboration, and participation of other agencies, private entities, and the ICF/MR and nursing home (NH) Provider Community. This was demonstrated by a number of States awarded Nursing Facility Transition (NFT) Grants in 2001 and 2002 and were successful because they collaborated with a wide range of stakeholders including the Provider Community with the development and implementation of their nursing facility transition program. For in-depth information on the outcomes and success of the "2001-2002 Real Choice Systems Change Nursing Facility Transition Grants" see the RTI Final Report on the Nursing Facility Transition Grants on www.hcbs.org.

The State needs to consider the resources, unique aspects of their State, and the available opportunities when considering how to go about enlisting other agencies, private entities, and the ICF/MR and NH Provider Community in their MFP program. These stakeholders can provide critical targeted assistance and support to the State with their transition program in a variety of ways because of their unique experience, resources, and care history with the individuals who want to transition to the community. The State should enlist their stakeholders, including ICF/MR and NH Providers, early on to consider and pursue those avenues where collaboration and coordination are most critical and practical.

Some of the areas in which the State can work collaboratively with their stakeholders and the Provider Community include (not all-inclusive):

- Input into the development of their nursing facility transition program;
- Information regarding the HCBS capacity and capability that is needed in order to provide care and services to those individuals transitioned to the community;
- Coordination with State Licensing and Survey and Certification entity/agency on the identification of, and whether to target chronic poor performing facilities for transitioning of individuals;
- Exploration and development of case –mix adjustment and financial incentives and policies for the facilities that support and participate in the transition program and/or who commit to creating more home-like environments in institutions;
- Input into the discussion on whether to close ICF/MR or NH beds after individuals transition and development of policies and procedures to accomplish bed closure;
- Assistance with the process for identification of populations and individuals for transitioning;
- Access to assessment data and other information across settings, including MDS to assist in the identification of individuals for transitioning;
- Cross training of Provider staff to assist with transitions and provide care in the community to individuals transitioned; and

- Mechanisms to create and/or expand access to needed HCB services via ICF/MR and NH provider adaptation and development of the capability and capacity to provide core medical and related services to those transitioned to the community such as medical, dental, therapies, family respite, activities, and other critical quality of care and quality of life services.