DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

PROGRAM ANNOUNCEMENT

Agency Name:
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

Funding Opportunity Title:
Money Follows the Person Rebalancing Demonstration

Announcement Type: Initial Announcement

Funding Opportunity No.:
HHS-2007-CMS-RCMFTP-0003

Catalog of Federal Domestic Assistance No. (CFDA): 93-779

Applicable Dates:

Applicants' Informational Teleconference:	August 22, 2006
Voluntary Notice of Intent to Apply:	September 5, 2006
Proposal Due Date:	November 1, 11:59 pm, EST
Financial Assistance Awards:	January 1, 2007
Project Period Begins:	January 1, 2007

Demonstration Grant Period of Performance/Budget Period:
January 1, 2007 to September 30, 2011

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PART ONE: OVERVIEW INFORMATION

Department of Health and Human Services

Centers for Medicare & Medicaid Services

MEDICAID PROGRAM:

DEMONSTRATION PROJECT:

Initial Announcement

Invitation to Apply for FY2007: **MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION**

Agency Funding Opportunity Numbers

HHS-2007-CMS-RCMFTP-0003

CFDA 93-779

July 26, 2006

<u>Applicable Dates:</u>

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For more details and news about events relevant to this and other related grant opportunities, please periodically consult our Web site at www.grants.gov.
http://www.cms.hhs.gov/NewFreedomInitiative/02_WhatsNew.asp

This information collection requirement is subject to the Paperwork Reduction Act. The burden for this collection requirement is currently approved under OMB control number 0938-0836 with a current expiration date of 1/31/2007.

Full Text of Announcement

I. FUNDING OPPORTUNITY DESCRIPTION

1. Background

Evolution of Home and Community-based Services

Prior to 1980, long-term care services in the United States were delivered almost exclusively in institutional settings. In 1981, President Ronald Reagan signed into law Public Law 97-35. Section 2176 of PL 97-35 established section 1915(c) of the Social Security Act, the Medicaid Home and Community-Based Services (HCBS) Waiver program. Prior to the passage of this legislation, Medicaid long-term care benefits were limited to home health, personal care services, and to institutional facilities: hospitals, nursing facilities (NF), and Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR). For the first time, the HCBS legislation provided a vehicle for States to offer additional services not otherwise available through their Medicaid programs to serve people in their own homes and communities. HCBS waivers afford States the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation. The HCBS waiver program recognizes that many individuals at risk of being placed in these facilities can be served in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Over the past 25 years, many States have created long-term care systems that enable people with disabilities or long-term illnesses to live in their own homes or other non-institutional settings. However, while expenditures on home and community services have increased, in most States, expenditures on nursing facilities still account for the majority of Medicaid LTC spending. In fiscal year 2005, spending for HCBS waiver programs, personal care, and home health services accounted for just over one-third (37%) of all Medicaid long-term care expenditures. Despite an increasing use of home and community services long-term care systems, the organization, financing, and delivery of Medicaid-funded long-term care services remains biased towards institutional care.

Support for States' Efforts to Rebalance

Recognizing the challenges that States face in rebalancing their LTC systems, Congress provided funds for the Real Choice Systems Change (RCSC) Grants program. The RCSC grants are designed to assist States and others in building infrastructure that will result in effective and enduring improvements in long-term support systems. These system changes are designed to enable children and adults of any age, with any payer source, who have a disability or long-term illness to:

- Live in the most integrated community setting appropriate to their individual support requirements and preferences;

- Exercise meaningful choices about their living environment, the providers of services they receive, the types of supports they use, and the manner by which services are provided; and

- Obtain quality services in a manner as consistent as possible with their community living preferences and priorities.

Since the inception of the RCSC grant program in FY2001, CMS has awarded grants of approximately $245 million to all fifty States, the District of Columbia, and two territories to help develop programs that enable people of all ages with disabilities or long-term illnesses to live meaningful lives in the community. With this support, States are continuing to address issues such as personal assistance services, direct service worker shortages, transitions from institutions to the community, respite service for caregivers and family members, better transportation options, and quality assurance. In collaboration with the Administration on Aging (AoA), CMS has awarded 43 Aging and Disability Resource Center grants of up to $800,000 each to help States develop one-stop shopping centers for seniors and people with disabilities who need long-term care information.

A number of the RCSC grants awarded in FY2003 were specifically targeted to assist States implementing Money Follows the Person (MFP) initiatives. CMS specified that the purpose of these grants was "to enable States to develop and implement strategies to reform the financing and service designs of State long-term support systems so that a coherent package of State Plan and HCBS waiver services is available in a manner that permits funding to 'follow the person' to the most appropriate and preferred setting, and financing arrangements enable transition services for individuals who transition between institution and community settings." A report on the experiences of the FY2003 MFP grantees may be found at www.cms.hhs.gov/RealChoice. Also during FY2003, CMS also commissioned a 3-year research study with CNA Corporation and the University of Minnesota to examine the eight States' rebalancing efforts. Specifically, the project will identify and describe management processes that States use to shift long-term care resources to community services, and the effects of these rebalancing efforts on utilization and cost of services, as well as quality of care. Preliminary findings from this study may be found at www.cms.hhs.gov/medicaid/NewFreedom/initiative.

To further assist with States' efforts, CMS published two State Medicaid Director Letters (August 13, 2002 and September 17, 2003) that highlighted methods some States have used to retool their community-support systems to offer citizens an effective balance of both community and institutional services and enable money to follow the person across long-term settings and providers. More information about these letters is available at http://www.cms.hhs.gov/newfreedom/nfi12303pr.asp.

A third State Medicaid Director Letter, issued on August 17, 2004, expressed continued commitment to assisting States in implementing the principles of MFP under existing authority and addressed areas of confusion that may be impeding efforts to rebalance long-term support systems. More information about this letter is available at http://www.cms.hhs.gov/states/letters/smd081704.pdf.

In addition, to increase the standard of living of those who live in their communities, the Ticket to Work and Work Incentives Improvement Act was passed in 1999 to provide incentives for individuals with disabilities to participate in the workforce. Under this authority, CMS has awarded more than $125 million in Medicaid Infrastructure Grant funding to States to make improvements to their Medicaid programs to better serve those with disabilities who are working. Many States have enhanced their Medicaid personal assistance services and developed pilots to test alternative programs. Thirty-two States have created Medicaid buy-in programs which enable individuals with disabilities who are working to purchase Medicaid coverage, maintaining their health care benefits even as their increased earnings disqualify them for cash assistance. These efforts are important in the overall context of rebalancing as increased community integration should foster improved employment outcomes.

State Experience with Making "Money Follow the Person"

CMS has historically defined MFP as "a system of flexible financing for long-term services and supports that enable available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change." This approach has two major components. One component is a financial system that allows sufficient Medicaid funds to be spent on home and community-based services when individuals move to the community. This often involves a redistribution of State funds between the LTC institutional and waiver programs. The second component is a nursing facility transition program that identifies consumers in institutions who wish to transition to the community and helps them do so.

Several States receiving the FY2003 MFP RCSC grants see MFP as either having or working toward some form of a global State budget for long term care that would eliminate budgetary distinctions between institutional and non-institutional services. Conversely, some States, especially those without large institutional populations, have defined MFP broadly as the improvement of community-based services, community integration, or the elimination of barriers in programs, procedures and policies so that financing, services and supports move with the person to the most appropriate and preferred setting. Some States have also included diversion from admission to an institution in their MFP implementation efforts.

Based on state experience to date, CMS's current perspective on the critical elements necessary to maintain a system in which "money follows the person" has evolved. Appendix A includes a description of these elements. 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 exhaustive.

The Deficit Reduction Act of 2005 Bolsters States' Efforts

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of the Deficit Reduction Act (DRA) of 2005, States now have new options to rebalance their long-term support programs to allow their Medicaid programs to be more sustainable while helping individuals achieve independence. The DRA reflects a growing consensus that long-term supports must be transformed from being institutionally-based and provider-driven to "person-centered" and consumer-controlled. The DRA provisions reflect a long-awaited commitment to independence, choice, and dignity for countless Americans who

want to have control of their lives. And, it gives States many of the tools they need to "rebalance" their long-term support programs.

To assist individuals with disabilities and older individuals in need of longer term care services and supports, through the DRA and other initiatives, a State now can:

Expand coverage for individuals with disabilities by allowing families with disabled children to purchase Medicaid and by adopting health coverage options for working individuals with disabilities.

Increase access to community supports so that disabled and elderly individuals have true choice of a range of quality options by offering HCBS without waivers; applying for grants to "rebalance" their long-term support systems; and applying for demonstration projects to offer home and community-based alternatives to psychiatric residential treatment facilities for children.

Promote personal responsibility, independence and choice by offering a State plan benefit for self-directed personal care services without a waiver; and opting to participate in the State Long-Term Care Term Care Partnership Program.

The MFP Rebalancing Demonstration is a part of a comprehensive, coordinated strategy to assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems. With the history and strength of the RCSC grants as a foundation, this initiative will assist States in their efforts to reduce their reliance on institutional care while developing community-based long-term care opportunities, enabling the elderly and people with disabilities to fully participate in their communities.

Introduction

The Centers for Medicare & Medicaid Services (CMS) is soliciting proposals from States to participate in the Money Follows the Person Rebalancing Demonstration (MFP Demo). This demonstration, created by section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171), supports State efforts to "rebalance" their long-term support systems by offering $1.75 billion over 5 years in competitive grants to States. Specifically, the demonstration will support State efforts to:

a) Rebalance their long-term support system so that individuals have a choice of where they live and receive services.
b) Transition individuals from institutions who want to live in the community.
c) Promote a strategic approach to implement a system that provides person centered, appropriate, needs based, quality of care and quality of life services and a quality management strategy that ensures the provision of, and improvement of such services in both home and community-based settings and institutions.

Demonstration grants will be awarded to States from January 1, 2007 through September 30, 2011.

The demonstration provides for enhanced federal medical assistance percentage (FMAP) for 12 months for qualified home and community-based services for each person transitioned from an

institution to the community during the demonstration period. Eligibility for transition is dependent upon residence in a qualified institution. The State may establish the minimum timeframe for residence between 6 months and two years as required by Section 6071(b)(2)(A) of the DRA. The State must continue to provide community-based services after the 12 month period for as long as the person needs community services and is Medicaid eligible.

CMS will accept one proposal from each State interested in participating in the demonstration program. The Single State Medicaid Agency must be the lead applicant. States must propose a demonstration period of no less than two consecutive fiscal years but no greater than five years. The State will indicate in its application the targeted group(s) and number of individuals it intends to transition. In making awards, CMS will give preference to States if they include multiple target groups including older individuals, and if they propose to deliver self-directed services. The number of demonstration projects approved by CMS depends largely on the scope (i.e., proposed enrollment and breadth of services) and quality of the proposed projects.

Under the demonstration project, the State must propose a system of Medicaid home and community-based care that will be sustained after the demonstration period and is deemed qualified by the Secretary. Specifically, the program must be conducted in conjunction with a "qualified HCBS program" which is a program that is in operation (or approved) in the State for such individuals in a manner that assures continuity of Medicaid coverage of services in the 'qualified HCBS program for eligible individuals. States may also propose to enhance the services they will provide during the demonstration period to achieve greater success with transition.

The phrase "home and community-based long-term care services" means, "with respect to a State Medicaid program, home and community-based services (including home health and personal care services) that are provided under the State's qualified HCB program or that could be provided under such a program but are otherwise provided under the Medicaid program."

States will be required to participate in a national qualitative and quantitative evaluation conducted by CMS. Data collected on a national level will help evaluate the core objectives of the statute that are listed below.

2. Overview of Funding

A. Fundamentals of the Demonstration

a. Objectives

The following objectives for this demonstration are outlined in statute:

- Increase the use of home and community-based, rather than institutional, long-term care services;

- 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;

- 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

- 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.

b. Demonstration Design and Development

1.) Demonstration Structure

Under this demonstration, States are required to employ a full-time Project Director employed by the Medicaid Agency to implement the demonstration. As such, the Project Director will be responsible for executing the two phases of the demonstration.

Phase One: Pre-implementation: The State will be given a period of no less than the first three months and no greater than the first twelve months of the project period to engage in formal planning for the demonstration. During this time, the State should formally engage all needed stakeholders as required by section 6071(c)(1) of the DRA, finalize the design for the demonstration, and plan for the operational changes that are necessary to further the delivery of community-based long-term care services.

In addition, during this Pre-Implementation phase, the State must develop, and submit to CMS for approval no later than 12 months from the date of approval, the Operational Protocol which will guide the implementation and management of the demonstration.

The Operational Protocol, developed during this phase, will address key issues such as target population(s), participant selection mechanisms, a detailed service delivery plan, and a quality management system. It must be approved by CMS before the State can begin Phase Two: Implementation. Final requirements for the Operational Protocol will be delivered to States in the terms and conditions of the funding award package for the demonstration. Appendix D contains elements that are *likely to be* included in the Operational Protocol requirements.

Costs incurred by the State during the pre-implementation phase, including the cost of a full-time Project Director and other staff, will be reimbursed under the grant at the regular administrative match under Medicaid.

Phase Two: Implementation: Once the Operational Protocol has been approved by CMS, a grantee will be permitted to claim the enhanced match rate for HCB services for demonstration participants transitioned from the institutional settings into the community for 12 months post-transition. During this phase, all “qualified expenditures” will be eligible for FMAP at the enhanced rate specified in the statute.

Qualified expenditures are expenditures on HCB long term care services. These services may be both included under the State's "qualified home and community-based program" or otherwise delivered as part of the demonstration. Qualified expenditures may be made from the date of transition into the community through 12 months after that transition date. Qualified expenditures are expenditures on services in the first two categories in the chart below. For a comprehensive list of services that may be offered under the HCBS waiver program, see (http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp . Service Section is on pages 127- 158 of the Technical Guide)

The "***qualified home and community-based program***" is the Medicaid service package(s) that the State will make available to a demonstration participant when they move to their community-based residence exclusive of demonstration services. This program can be comprised of 1915(b), 1915(c) and/or state plan services. The "qualified home and community-based program" is not necessarily exclusive to demonstration participants, but the enhanced FMAP is exclusive to demonstration participants. The "qualified home and community-based program" is a program of services that the state offers during the demonstration and will continue to offer after the demonstration through the state's Medicaid program. It does not include any demonstration services unless the state has amended its waivers or SPA to include those demonstration services to all who qualify (not just former demonstration participants).

Additionally, States may choose to otherwise offer ***HCB demonstration services*** at the enhanced match rate by increasing the home and community-based services that it delivers during the demonstration period. Services that are offered under this category of "HCB demonstration services" are not required to be continued at the termination of the demonstration period. This service category may be helpful to states that do not have comprehensive transition services included in certain 1915(c) waivers. This service category would allow the demonstration to provide these transition services outside of the waiver to the demonstration participants. States will, however, be scored on the basis of sufficient continuity of care. States may choose, for example, to use this service category to provide more expansive limits on the number of hours of personal care or respite care for the demonstration period but the state should be able to justify who the increase is needed only during the 12 month demonstration period.

Lastly, a State may receive regular match for ***supplemental demonstration services*** that it wishes to add for the demonstration period. These services are not long-term care in nature, but the State may propose them because they are essential for successful transition to the community. These services will not be continued after the demonstration period. Examples of these services are given in Appendix C.

States must submit a finalized package of services to be delivered under the demonstration as part of the operational protocol. The benefit package will be subject to CMS approval.

In summary:

Service Category	**Match rate for 12-month demonstration period**	**Requirement for continuity at demonstration end**
"Qualified HCB program" services	Enhanced match	Must be continued through waivers or the

		State plan
HCB demonstration services	Enhanced match	No requirement to continue
Supplemental Demonstration services	Regular FMAP rate	May not be continued

Waivers

To promote effective outcomes from the demonstration, the 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:

(1) 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.
(2) 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.
(3) 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.
(4) 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
.

CMS expects States to address how these waiver authorities will be utilized in both the grant application (a preliminary summary) and in detail as part of the Operational Protocol if awarded a grant.

Project Period and Scope

The applicant shall specify the period of the MFP demonstration, which shall include at least 2 consecutive years (but no more than 5 years) in the 5-year period beginning with start date of the demonstration (on or about January 1, 2007.) States have the flexibility to propose the scope and focus of their transition efforts within that timeframe. The State must specify the service area or areas of the MFP demonstration, which may be a statewide area or one or more geographic areas of the State. For example, the State may propose to implement their demonstration in geographic area A for target population A during Year 1, but then expand to target populations B and C in geographic area A, B and C in Year 2.

The application must specify the targeted groups and number of individuals served. Specifically, the applicant will specify:

1. The targeted groups of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of the demonstration.
2. The projected numbers of eligible individuals in each targeted group of eligible individuals to be assisted during each year of the demonstration.
3. The estimated total annual qualified expenditures for each fiscal year of the demonstration.

Qualified Expenditures

The term "qualified expenditures" means expenditures by the State under its MFP demonstration project for home and community-based long-term care services for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility. Qualified expenditures include expenditures on both "qualified ***HCB program" services*** and any ***demonstration HCB services*** the state chooses to add to its qualified HCBS program during the demonstration (as detailed in the previous section of this solicitation). 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.

The State has the option to include in its proposal ***supplemental demonstration services*** that are necessary to transition an individual to the community. These services may not be long-term care in nature and are not otherwise considered Medicaid services, but are essential to successful community living. For example, if the participant needs an adapted vehicle and the waiver to which he/she is being transitioned does not cover vehicle modifications and the State has not chosen to enhance its HCBS program with vehicle modifications, the State could propose to include this as a supplemental demonstration service. These services should only be needed during the transition period, or be one-time costs. These supplemental demonstration services will be reimbursed at the State's regular FMAP rate from demonstration funds. Appendix C contains some examples of "supplemental demonstration services" but is not meant to be an exhaustive list or to guarantee approval of services in a final Operational Protocol.

2.) Participant Recruitment

The State must specify the targeted groups and number of "eligible individuals" to be transitioned to a "qualified residence" from an "inpatient facility" each year, as well as the methodology and procedures that will be utilized for targeting and recruiting individuals for transition.

As defined in Section 6071(b)(2) of the DRA, 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:

> (i) resides (and has resided, for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State) in an inpatient facility;
>
> (ii) is receiving Medicaid benefits for inpatient services furnished by such inpatient facility; and
>
> (iii) with respect to whom a determination has been made that, but for the provision of home and community-based long-term care services, the individual would continue to require the level of care provided in an inpatient facility and, 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.

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 in Section 6071(b)(3) of the DRA, the term "inpatient facility" means a hospital, nursing facility, or intermediate care facility for persons with mental retardation. An institution for mental diseases (IMDs) is included 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.

For purposes of this demonstration, the term "Medicaid" is defined at Section 6071(b)(4) of the DRA as the State program under title XIX of the Social Security Act (including any waiver or demonstration under such title or under section 1115 of such Act relating to such title). The term "qualified HCBS program," defined at Section 6071(b)(5) of the DRA means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority.

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

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; or

(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

In addition, consistent with Section 6071©(6), CMS will require that individuals targeted as potential demonstration participants have been provided with individual choice regarding participation in the demonstration. While specific requirements will be addressed in the operational protocol, the State must provide, in the application, assurances and proposed processes that address:

- 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.

- each eligible individual or the individual's authorized representative will choose the qualified residence in which the individual will reside and the setting in which the individual will receive home and community-based long-term care services.

3.) Funding Requirements

Federal Medical Assistance Percentage

All qualified HCBS expenditures are eligible for enhanced FMAP. The term "qualified expenditures" defined in Section 6071(b)(7) of the DRA, means expenditures by the State under its MFP demonstration project for home and community-based long-term care services for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility.

The enhanced FMAP that each State will receive is equal to the standard FMAP plus the number of percentage points that is 50 percent of the regular State share. Therefore, if a State's regular State share is 50 percent, the enhanced demonstration FMAP = 50% + .5(50%) or 75%. If a State's share is 30 percent, the enhanced demonstration FMAP =70% + .5(30%) or 85%. In no case shall the MFP enhanced FMAP for a State exceed 90 percent.

Supplemental demonstration services (refer to Appendix C for examples) will be reimbursed at regular FMAP rates from demonstration funds.

Administrative costs related to this demonstration, including participation in the national evaluation, will be reimbursed according to the requirements of 42 CFR §433.15. Please refer to section C of the Application for a §1915(c) Home and Community Based Waiver for more information regarding reimbursement of administrative costs.

Funds Available for the Demonstration
The following funds are made available in each respective fiscal year:

FY 2007 $250,000,000 (Available January 1, 2007)
FY 2008 $300,000,000
FY 2009 $350,000,000
FY 2010 $400,000,000
FY 2011 $450,000,000

Awards
The state may propose a project period of up to five years, which shall include at least 2 consecutive fiscal years. The process for on-going awards, including the possible use of supplemental award or continuation requests, will be clarified when initial awards are made on or about January 1, 2007.

Grantees will be required to submit Maintenance of Effort statements (see Attachment 4) on an annual basis.

Carryover of Unused Funds
Any portion of a State grant award for a fiscal year under this section remaining at the end of each fiscal year shall remain available to the State for the entire project period, subject to the following:

"In the case of a State that the Secretary determines pursuant to Section 6071 (d) (4) of the DRA has failed to meet the conditions for continuation of a MFP demonstration project, in a succeeding year or years, the Secretary shall rescind the grant awards for such succeeding year or years, together with any unspent portion of an award for prior years, and shall add such amounts to the appropriation for the immediately succeeding fiscal year for grants under this section."

Preventing Duplication of Payment

The payment under a MFP demonstration project, with respect to qualified expenditures, shall be in lieu of any payment with respect to such expenditures that could otherwise be paid under Medicaid, including under section 1903(a) of the Social Security Act. Nothing in the previous sentence shall be construed as preventing the payment under Medicaid for such expenditures in a grant year after amounts available to pay for such expenditures under the MFP demonstration project have been exhausted.

Disbursement of Awarded Funds

This funding will only be released, for access by States, if States have an approved Operational Protocol. If States submit an Operation Protocol for review, and it is approved prior to the required submission deadline, that State may access federal fund reimbursement described above any time after approval according to the conditions set forth in the Operational Protocol and Budget.

Service dollars will be distributed to States through access to a master Money Follows the Person Account. When the State receives approval to draw down service dollars, they will receive access to the national account through a sub-account set aside for the State capped by the State's spending ceiling. Once the State reaches 80 percent of its ceiling the State is responsible for notifying CMS. If funding permits, CMS may at that time renegotiate the State's budget to accommodate increased need. When spending in the national account reaches 80 percent of its funding amount, CMS is responsible for notifying participating States of the projections for sufficiency of future funding. If necessary, new enrollment for all participating States would be terminated and the funding would be used to complete payments for individuals already being served by the demonstration. CMS does not anticipate needing to employ this procedure.

All States participating in this demonstration will agree to draw down funding for all demonstration expenses quarterly. States will write all contracts to reflect this requirement as CMS will not be responsible for obligations that are not paid timely.

4.) Financial Reporting

All grantees will be required to submit a Financial Status Report, form (SF-269). This report, submitted on a semi-annual basis, accounts for all uses of grant monies during each reporting period. In addition, at the end of each demonstration grant year, States will be required to produce documentation that they have not exceeded the determined budget ceiling and have met all CMS financial requirements. Additional formats of financial reporting will be determined during the Implementation Phase of the Demonstration.

Once demonstration awards have been made, CMS will establish award amount limitations using the estimates from the awarded applications reflecting anticipated administrative, participant demonstration service dollars and enhanced FMAP costs. Although administrative costs,

participant demonstration service dollars and the enhanced FMAP services will have different FMAPs, they will be included in the award amount established and will require separate reporting.

In order to receive enhanced FMAP, CMS will require quarterly reports. CMS will determine the final quarterly reporting mechanisms based on elements developed jointly with the awardees.

c.) Semi-Annual Progress Reports

CMS requires web-based progress reports to be submitted on a semi-annual basis. The report format and content will be developed, by CMS with the assistance of a national MFP Technical Assistance evaluation contractor, and with input from the MFP demonstration participants. The elements to be collected may include the following:

- **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 SPA 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.

Applicants will be required to provide, in the Operational Protocol, a proposed minimum data set. The final minimum data set will be determined by CMS, with input from the CMS evaluation contractor and the State participants in the project. The applicant and evaluator must demonstrate that they can collect, maintain, and access person-specific data in order to evaluate the project.

d.) Quality Assurance and Improvement, Technical Assistance and Oversight

Included in the Money Follows the Person Demonstration project, was the directive to the Secretary, that CMS provide technical assistance and oversight to the MFP demonstration States, for the purpose of upgrading their quality management strategy under Medicaid HCBS waivers, including:

- Dissemination of information on promising practices;
- Guidance on systems design elements that address the unique needs of participating beneficiaries;

- Ongoing consultation on quality, including assistance in developing necessary tools, resources, and monitoring systems; and
- Guidance on remedying programmatic and systemic problems

CMS has been allocated $2,400,000 for these technical assistance activities. These funds will be available throughout the duration of the demonstration (beginning January 1, 2007 and ending September 30, 2011). CMS expects to issue a contract with a non-government entity for this specific technical assistance activity. The state must cooperate in any quality assurance/improvement activities determined necessary by CMS.

Under this demonstration, a State's MFP Quality Management Strategy must build on the existing HCBS strategy and meet current and future quality requirements. The Strategy must ensure the health and safety of demonstration participants before, during and after transition to the community. In addition, the State must ensure health and safety and those remaining in the institution.

e.) National Evaluation

CMS will acquire the services of a national evaluation contractor to conduct an ongoing and final national evaluation of the MFP Demonstration Project. Also included in the tasks of this contract will be consultation with the MFP grantees regarding the development of their operational plans as well as the development of the minimum set of data elements and benchmarks required of the grantees.

In addition, at the sole discretion of the grantee, State resources can be utilized to conduct independent State evaluations, assist in the establishment of a formative learning process and documentation systems, 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. These activities will be reimbursed as administrative costs as referenced in 42 CFR §433.15.

Demonstration States will be held accountable to collect and report to CMS a minimum set of data elements via a web-based reporting system. The report format and content will be developed by CMS with the assistance of the national MFP evaluation contractor and with input from the MFP demonstration States. The report will include benchmark information, quantitative and qualitative information for systems changes, (e.g., legislation, flexible funding, global budgeting, SPA or waiver amendments), demonstration outputs, and consumer outcomes (e.g., number of individuals transitioned, appropriateness of services provided based on assessment, and consumer satisfaction).

For each participant, the State should be prepared to provide individual-level data prior to the transition of the individual and during the demonstration period. This information should come from official administrative records and not from self-reported information. Generally, demographic information need only be provided at enrollment and should include, name, address, Social Security Number, date of birth, race, ethnicity, disabling condition(s), and any prior public assistance. Use and access to these 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.

CMS expects that the national evaluation contractor may address this broader set of research questions:

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

2. What evidence is there that the State has rebalanced its resources to provide more Medicaid consumers LTC supports in the community instead of in institutions. 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 State 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 HCB services 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?

II. AWARD INFORMATION

1. Amount of Funding

Congress provided $1.75 billion in funding for The Money Follows the Person Demonstration. These funds may be awarded to States through fiscal year 2011.

There are no minimum or maximum grant awards per State; however, CMS reserves the right to negotiate the size of any demonstration project proposed by a State.

In the event the projected demonstration awards are sufficiently less than the amount authorized by Congress, CMS may offer a second solicitation for this demonstration program in Fiscal Years 2007 or 2008.

2. Period of Performance

The project period is for five years. Funding is available to be awarded January 1, 2007 through September 30, 2011. A State must specify the demonstration period of at least two consecutive years in the five year period beginning in FY 2007.

If a State fails to meet annual numerical benchmarks that it proposed in its application and are agreed to by CMS, CMS may rescind the grant award including all un-obligated balances, and issue the unspent grant funds to other projects.

CMS will approve funding for the totality of the State's project in the grant approval letter. The State will be prohibited through the grant's terms and conditions from spending any funding for services until CMS approves the State's Operational Protocol.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Any single State Medicaid Agency may apply for the Money Follows the Person Rebalancing Demonstration. 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 be mindful that the increased FMAP received, as part of the MFP demonstration program, will contribute to their total Medicaid allotment.

CMS expects that the Single State Medicaid Agency will partner 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, additional letters of support and/or current memorandums of understanding from major partners, including consumers. These letters and memorandums give substantive support to the applicant's project narrative and describe the extent of partnering in the community and the involvement of consumers. Applicants should include all such letters as part of their application package. CMS cannot guarantee that any letters submitted separately will be matched with the correct application.

2. Cost Sharing

Home and community based long-term care costs will be reimbursed at the enhanced FMAP rate established by this demonstration. The enhanced FMAP that each State will receive is equal to the standard FMAP plus the number of percentage points that is 50 percent of the regular State share. If a State's FMAP is 50 percent, the enhanced demonstration FMAP = 50% + .5(50%) or 75%. If a State's FMAP is 30 percent, the enhanced demonstration FMAP =70% + .5(30%) or 85%. This FMAP will apply to all "qualified expenditures."

The State will be required to include, in the Operational Protocol, 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.

3. 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.

IV. APPLICATION AND SUBMISSION INFORMATION

Applicants must submit their applications electronically through http://www.grants.gov. Please note when submitting your application electronically, you are required, additionally, to ***mail*** a signed SF 424 to Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Operations Management, Acquisition and Grants Group, C2-21-15 Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850. The mailed SF 424 form may be received at the Centers for Medicare & Medicaid Services within two (2) business days of the application closing date.

1. Address to Request Application Package

- A complete electronic application package, including all required forms for this demonstration grant is available at: http://www.grants.gov/agencies/forms_repository_information.jsp
- Standard application forms and related instructions are available online at http://www.cms.hhs.gov/GrantOpportunities/ (please use this web link).
- Standard application forms and related instructions may also be requested from Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Operations Management, Acquisition and Grants Group, C2-21-15 Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850, by e-mail only at Nicole.Nicholson@cms.hhs.gov.

2. Content and Form of Application Submission

2a.) Form of Application Submission

The only acceptable formatting is 8.5" x 11" letter-size pages with 1" margins (top, bottom, and sides).

- All pages of the project narrative must be paginated in a single sequence. The proposed budget must directly follow the narrative and be paged within the same page sequencing.
- 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 should be no more than one page long.
- The titles and sequence of the headings in the project narrative must coincide with the wording and sequencing used in the solicitation.
- The Project Narrative and Proposed Budget portions of the application are limited to the following number of (double-spaced, single-sided) pages: 55 pages.

2b.) Required Contents

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

(1) 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. But receipt of such notices enables CMS to better plan for the application review process. These may be submitted in any format; however, a sample is included in Attachment 1. Notices of Intent to Apply are due September 5, 2006 and should be faxed to Sona Stepp at 410-786-9004.

(2) Standard Forms (SF)

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

SF 424: Official Application for Federal Assistance (see Note below*)
SF 424A: Budget Information
SF 424B: Assurances—Non-Construction Programs
SF LLL: Disclosure of Lobbying Activities
Additional Certifications – can be found at the following website:
http://apply.grants.gov/agency/forms/sample/SSA_additionalassurances_VI.0.pdf

Note: On SF 424 "Application for Federal Assistance":

*Check "No" to item 16b, as Review by State Executive Order 12372 does not apply to these grants.

(3) Required Letters of Endorsement

Letters of endorsement from the major partners that are not the lead agency (Department of Mental Health Services, Department of Developmental Disabilities, local Areas Agencies on Aging, Independent Living Centers, etc.), but are integrally involved in the services provided to the target population(s) are expected.

(4) Project Abstract and Profile

The one-page abstract should serve as a succinct description of the proposed project and should include the goals of the project, the total budget, a description of how the grant will be used to develop or improve community-integrated services, and the ultimate outcomes and products.

An accompanying two page project profile, as described in Attachment 2, must also be submitted with the application.

(5) 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 names of the major partners actively collaborating in the project.

This letter should be addressed to:

Judith Norris
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

(6) Application Narrative

The application narrative is comprised of 4 parts. Applicants shall complete the application in no more than 55 double-space, single-sided pages with the page limit guidance as articulated below:

Part 1: Systems Assessment and Gap Analysis
Part 2: Demonstration Design
Part 3: Preliminary Operational Plan and Budget
Part 4: Assurances

Part I: Systems Assessment and Gap Analysis – (20 page limit)

An applicant's Systems Assessment and Gap Analysis should describe the current long-term support delivery system in the State, including progress to date and "gaps" that will need to be addressed in order to "rebalance" the system so that individuals have a true

choice of a range of quality options. This assessment should focus on the totality of agencies and providers (both community and institutional) that participate in the long-term care delivery system in the State. Although we expect emphasis to be placed on targeted populations, the state must describe systems of care for all populations with long-term care needs regardless of which population(s) the State will choose to transition.

The assessment must describe how the State conducted the analysis, including who participated in developing the list of needs to rebalance the State's system. It shall include:

1. 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.

2. An assessment of what is in place and working to rebalance the State's resources, i.e. to increase the use of home and community based rather than institutional, long term care services.

3. A description of current funding mechanisms, including those that restrict the flexible use of Medicaid funds to support individuals living in the community.

4. A description of the various systems of care, waivers, and SPAs that are utilized by the State to provide home and community-based supports and services;

5. Current expenditures on long-term and community-based care as well as other measures such as the number of institutional beds versus community placements.

6. A description of any current efforts to provide individuals with opportunities to self-direct their services and supports.

7. An overall description of any institutional diversion and/or transitions programs or processes that are currently in operation.

8. An analysis of what shortcomings – "gaps" in the system the State intends to address in the demonstration program.

9. An analysis of what collaboration among the various programs in the State is necessary to ensure the success of the demonstration program.

10. What systems, procedures and policies are in place to monitor and address, (i.e., track, identify, and correct) deficiencies related to quality assurance for eligible individuals receiving Medicaid HCBS and provide for continuous quality improvement in such services.

11. What State legislative and other changes are necessary (and accompanying timelines) to implement the MFP demonstration.

Application Part 2: Demonstration Design (25 page limit)

This portion of the application should provide a description of the State's plans to meet the goals and objectives of the demonstration. Specifically, **for each target population to be transitioned**, the demonstration design must describe:

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1.) The Pre-implementation Phase, including the interventions and length of time expected to put in place the infrastructure needed (including legislation) to expand their community-based long-term care capacity and sustain the demonstration participants in community-based care settings. The applicant should use the list of Elements included in Attachment A as background information as they discuss their systems assessment and demonstration design. Applicants are not required to address each element if they are not applicable to their State system.

2.) The Implementation Phase, including the population(s) to be served (including the minimum length of time they have received institutional care), the number of individuals the State will transition, the site(s) of the demonstration, the institutions from which they will be transitioned, the "qualified residences" to which they will be transitioned, and the services that they will be offered broken down according to the chart in section 2A, Fundamentals of the Demonstration.

3.) Anticipated requests for the waivers necessary to operate its program, including modifications to existing waivers and State plan amendments.

4.) A description of methods that will be used by the state for each fiscal year to increase the dollar amount and percentage of expenditures for HCBS.

5.) A list of proposed benchmarks to establish empirical measures to assess the States progress in rebalancing its long-term care system. The proposed benchmarks must conform the to requirements specified in Section 6071(d)(4)(a).

6.) Processes for how the State intends to target and recruit individuals to transition from institutional settings to the community, including specific strategies and procedures.

7.) A description of the cross agency and cross service delivery system collaboration that will need to occur to ensure success of the State's transition program. This description should focus on the role of the other agencies and service sectors in developing the grant application, making commitments for systems improvement, and participating in service delivery during the demonstration program as well as after the demonstration ends.

8.) A description of the "qualified home and community-based program" which will be available to individuals following the year they receive services through the demonstration program. The final list of services under the "qualified home and community-based program" will be submitted by the State with their Operational Protocol and must be approved by CMS.

9.) A description of the State's preliminary design of a proposed Quality Management Strategy that encompasses both the program participants and the qualified home and community based program that will be in place when the demonstration is finished. The State's MFP Quality Management Strategy should include the program design elements as well as the processes for assessment, discovery/identification of problems and/or ineffective strategies, remediation of such identified problems/ineffective strategies, and ongoing systemic improvements for each component of the MFP program. For examples, see the CMS website: www.cms.hhs.gov/HCBS under Quality Oversight. Specifically, there are three documents that provide further guidance: Interim Procedural Guidance, Guide for Assisting States for Providing Evidence, and Worksheet for Reviewing States Evidentiary Information.

A description of how the State will ensure the health and safety of both demonstration participants and institutional residents.

Additional processes and program areas states need to consider including in their quality management strategy:

- HCBS Preparedness, i.e., capacity and capability to provide HCB services before and after individuals are transitioned;

- Delivery of necessary quality of care and quality of life services to individuals who are transitioned, such as medical, dental, family respite, social and community activities, work or volunteer activities, transportation, DME services, and other informal and formal supports;

More information about the CMS requirements for a quality management system may be found at http://www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf.

10.) An overall description of the State's current quality management system, where the gaps are and what will be developed and implemented in order to ensure the health and safety of consumers who are transitioned and the continuous improvement of HCBS and institutional care.

11.) A brief description of barriers that prevent the flexible use of Medicaid funds so that money follows the person and a summary of strategies the state will employ under the demonstration to eliminate those barriers.

12.) An analysis of how the State will use or enhance existing IT systems to address identification of MFP participants including:

- Demographic information identifying Medicaid and MFP participation eligibility prior to transition.

- Financial information to be reported for services eligible for enhanced FMAP according to the MFP demonstration.

- Assessment data to monitor quality of services post transition.

Application Part 3: Preliminary Budget and Organizational Staffing Plan (5 page limit)

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

1. 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.

2. Staffing Plan

Provide a staffing plan that includes:

   a. The number, title and names of staff dedicated to the demonstration program. In addition, please indicate:
      - Percentage of time each individual/position is dedicated to the grant.
      - Brief description of role/responsibilities of each position.
   b. 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.
   c. Number of contracted individuals supporting the grant.
      - Percentage of time each individual will provide to the grant.
      - Brief description of role/responsibilities.
3. Budget Presentation and Narrative
   a. Provide completed *Demonstration Funding Request and Maintenance of Effort* Forms.
   b. Provide a narrative defining the costs and the methodology used to determine the costs related to each fiscal year of the project period based on the number of anticipated enrollees in the demonstration:
      i. Medicaid Administrative costs.
      ii. Qualified HCB Services
      iii. HCB Demonstration Services
      iv. Supplemental Demonstration Services
4. In addition to the budget presentation and narrative, the applicant must submit required financial form, SF-424 and SF-424a. When completely these forms, please adhere to the following guidelines:
   When completing the SF-424, Section 18 and SF-424a, Sections B and C:
   - SF-424, Section 18: Please include the total for <u>all</u> years of the project.
   - SF-424a, Section B: Please include the categorical breakdown total for <u>all</u> years of the project. For example, if the proposal is for five years, the amounts shown in each category should be the total of <u>all</u> five years of the project.

- SF-424 Section C: Please include the total of all years for each non-Federal Resource that is applicable.
- Sections A, D, and E of the SF-424a are not to be completed.

Application Part 4: Assurances (5 page limit)

The state must include a discussion of the procedures that will be used to ensure informed consent for participants or their authorized representative in the demonstration project. The state must discuss the ways in which it will assure that participants have choice in selecting their community-based residence.

States must engage in a public process for the design, development and evaluation of the MFP demonstration project. Provide a description of the public development process that was used to develop the application as well as ongoing processes to allow for input from eligible individuals, their families, authorized representatives and other key stakeholders parties.

The state must include a plan to demonstrate maintenance of effort. The plan must include total expenditures under the State Medicaid program for home and community-based long-term care services for fiscal year 2005 or any succeeding fiscal year before the first year of the demonstration project.

The state must assure reports specified by CMS that will permit reliable comparisons of MFP projects across states and an effective evaluation of the MFP demonstration will be submitted timely and according to specifications established by CMS.

(h) Appendices

All documents that are in support of your Systems Assessment and Gap Analysis should be placed as an appendix to your application. This includes letters in support of your application. Please include a table of contents.

(7) Required Attachments (Placed in Appendix)

Cross reference in text

Attachment 1: Notice of Intent to Apply (Faxed to CMS as instructed in C-1 of this section)
Attachment 2: Prohibited Use of Grant Funds
Attachment 3: Resumes (key project staff)

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

3. Anticipated Announcement and Award Dates

A. Applicant's Teleconference

Information regarding the time and call-in number for an open applicant's teleconference is available on the CMS website at www.cms.hhs.gov/newfreedominitiative. The applicant teleconference is scheduled for August 22, 2006.

B. Notices of Intent to Apply

Notices of Intent to Apply for a grant are due by September 5, 2006 and should be faxed to Sona Stepp at 410-786-9004. It is not mandatory for an applicant to submit a Notice of Intent to Apply; however, such submissions help CMS plan its review process, including its review panels. Submission of a Notice of Intent to Apply does not bind the applicant to apply; nor will it cause a proposal to be reviewed more favorably.

C. Grant Applications

All grant applications are due by November 1, 2006. Applications submitted through http://www.grants.gov until 11:59 p.m. Eastern time on November 1, 2006 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.

Please note when submitting your application electronically, you are required, to mail a signed SF 424 to Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Operations Management, Acquisition and Grants Group, C2-21-15 Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850. The mailed SF 424 form may be received at the Centers for Medicare & Medicaid Services within two (2) business days of the application closing date**.**

D. Late applications will not be reviewed.

Grant Awards: Time frame

All grant awards will be made in early January, 2007. The Demonstration Grants awarded under this funding opportunity will have a budget period of not less that 24 months and no greater than 60 months, as specified by the applicant.

4. 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).

5. Funding Restrictions

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/a087.html

Reimbursement of Pre-Award Costs

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

6. Direct Services

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

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7. Reimbursement of Pre-Award Costs

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

8. Other Submission Requirements

Electronic Applications

The deadline for all applications to be submitted through http://www.grants.gov is November 1, 2006. 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 fully understand the process and requirements. We encourage applicants to submit well before the closing date.

Also visit the following website: http://Grants.gov/resources/newsletter.jsp for all of the latest information about the benefits and success of this initiative.

In order to submit their applications electronically, applicants will need to:

- Download and install PureEdge Viewer: http://www.grants.gov/agencies/forms_repository_information.jsp
- Download the complete electronic grant application package from https://apply.grants.gov/forms_apps_idx.html. *You will need to enter the Funding Opportunity number, HHS-2007-CMS-RCMFTP-0003, to access the application package and instructions.*
- For all Grants.gov related questions, including but not limited to, the registration process, downloading the PureEdge Viewer, uploading documents, and password issues, please contact Grants.gov directly at 1-800-518-4726. Do not call CMS for Grants.gov guidance.

The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the following Website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in the block with the applicant's name and address on the cover page of the application (Item 5 on the Form SF-424, Application for Federal Assistance), with the annotation "DUNS" followed by the DUNS number that identified the applicant. The name and address in the application should be exactly as given for the DUNS number.

Register with the Credential Provider—Applicants must register with the Credential Provider to receive a username and password to securely submit their grant application.

Register with http://www.grants.gov—Registering with Grants.gov is required to submit grant applications electronically on behalf of your organization. After completing the registration process, applicants will receive e-mail notification confirming their ability to submit applications through Grants.gov. (Technical support for Grants.Gov is available Monday-Friday from 7:00 a.m. to 9:00 p.m. Eastern time.)

- Upon submission of the grant application to http://www.grants.gov, applicants will receive an e-mail confirming that the application was received. In the event that the electronic submission of the application has failed through www.grants.gov, please mail the application to Nicole Nicholson. Please include a copy of the failed submission notice from www.grants.gov with the paper application as evidence of attempted submission. If you have successfully submitted an electronic application through grants.gov, please do not mail in the application as well. Only the signed SF-424 form should be mailed.

  Applicants may not submit the same application in more than one format, and the choice of one application format over another will not cause an application to be reviewed more favorably. All standard application forms may be obtained as detailed in, Section V.A*, Address to Request Application Package,* of this solicitation.

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. Please do not contact CMS regarding grants.gov related issues.

V. APPLICATION REVIEW INFORMATION

1. 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 Project Narrative **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.

A. Rebalancing (20 Percent)

One of the major objectives of the Money Follows the Person Rebalancing demonstration as set out by Congress was, "to increase the use of home and community-based, rather than institutional, long-term care services." The application will be evaluated for how strongly all the sections convey that the state has accepted this as a core purpose of the project. Reviewers will be instructed to pay particular emphasis to certain sections that should be key indicators of the state's intentions with regard to rebalancing. The particular sections will include the state's Systems Assessment and Gap Analysis, and the state's proposed benchmarks.

B. Strength and Appropriateness of the "Qualified Home and Community-Based Services Program" (15 Percent)

The Qualified Home and Community Based Services Program is by definition the service system that the state commits to keep in place at the termination of the demonstration period (12

months). This system may be comprised of waivers and/or state plan services including the newly available State plan options under the Deficit Reduction Act. Because this package of services represents the sustained service delivery system for demonstration participants and other consumers, significant scoring emphasis will be placed on it.

C. Transition Demonstration Proposal (15 Percent)

The scoring for this section will follow the intent of Congress to give preference to applications that proposed transitioning multiple population groups (either concurrently or sequentially) during the demonstration period (5 percent), and to applications that propose to employ a self-directed service delivery system (5 percent). See Appendix F for the components of a self-directed service delivery system. The remaining 5 percent will be awarded based on the quality of the proposals in:

- Identifying the target populations;
- The use of screening and assessment tools;
- Proposing services (both HCBS and demonstration services) that meet the needs of the target population(s); and
- The use of appropriate and thorough informed consent mechanisms.

D. Emphasis on Consumers (10 Percent)

The scoring for consumer emphasis will be broken down into two components. First, reviewers will evaluate evidence provided in the application that consumers and consumer-run organizations will have a role in the design, development and implementation of the demonstration. To maximize scoring in this area, the consumer and/or consumer-run organization must participate in ways that go beyond advice giving. Maximum credit will go to proposals that show evidence of some form of consumer decision making.

Second, in the demonstration itself, preference will be given to States that propose mechanisms to track consumer satisfaction during the demonstration.

E. Housing (5 Percent)

The advancement of home and community-based long term care services requires increased community housing options. States that plan to operate long-term efforts to rebalance their systems must engage in the housing planning processes that occur in their States and local communities. CMS will reward States that demonstrate plans to work with Housing Finance Agencies to:

- Incorporate a needs assessment of accessible and affordable community housing for persons with disabilities/chronic conditions into the “Consolidated Plan housing needs assessment”, or
- Convene a Housing Task Force, or similar entity, comprised of the Medicaid Agency, Public Housing Authority(s), Housing Finance Agency, and other MFP stakeholders, including advocates and consumers. The Task Force will as part of an overall systems assessment, include a needs assessment of accessible and affordable community housing for the proposed number of persons transitioning under the MFP grant.
- Identify how any housing shortages will be addressed.

F. Collaboration with Institutional Providers (5 Percent)

Successfully rebalancing a State's long term care system to favor home and community-based services will not be done without the engagement of the institutional providers in the State. Transitioning individuals out of institutions requires active institutional cooperation in screening, planning and conducting needs assessments. Additionally, true rebalancing of the systems will involve discussions about bed/institutional closure and conversion. State proposals must include a thorough plan of engagement to maximize effectiveness.

G. Project Administration (10 Percent)

The adequacy of the State's staffing plan, including whether or not they have a full-time project director, will be assessed. Specifically, reviewers will assess whether or not the proposed staffing plan reflects the needs and timeframes of increased activity (e.g. use of enrollment coordinators employed during the period of recruitment and enrollment.) Further, administrative costs for the operation of the implementation period will be examined to determine if they are in-line with the scope of the proposed demonstration, and whether or not the State has refrained from combining regular Medicaid administrative expenses with demonstration administrative expenses.

H. Quality (10 Percent)

The 1915(c) waiver application contains the most current information on what CMS endorses as core elements of quality in the delivery of home and community-based services. Scoring emphasis will be placed on proposals that include these elements of quality in their service delivery system. Reviewers will need to receive clear information on the quality improvement mechanisms that a state plans to employ when operating its qualified home and community-based services program.

I. Financial Review Criteria (10 Percent)

The applications will be reviewed to ensure:

The following forms (see Attachment 4) were completed and included:

- Demonstration Funding Request Form (See Attachment 4)
- Maintenance of Effort Form

Did the Applicant provide a budget narrative that defines the costs in the following categories:

- Administrative costs to implement the demonstration
- Qualified HCB program services
- HCB demonstration services
- Supplemental demonstration services

A reasonable methodology to determine the costs for project period based on the three types of allowable costs and the appropriate FMAP that is defined in this demonstration was included.

2. Review and Selection Process

An independent review of all applications will be conducted by a panel of experts including members of the disability community, advocates, providers and staff from State and Federal agencies including CMS. 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. The panel will evaluate each application for further review by CMS. 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. A low score in one or two areas, even if offset by high scores in other areas, may result in a rejection of the proposal. 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.

CMS seeks to achieve reasonable balance among the grants to be awarded in a particular category in terms of key factors such as geographic distribution and broad target group representation. CMS may redistribute grant funds (as detailed in the "Award Information" section of this solicitation) based upon the number and quality of applications received. (e.g., to adjust the minimum or maximum awards permitted or adjust the aggregate amount of Federal funds allotted to a particular category of grants).

3. Anticipated Announcement and Award Date

Awards will be announced and awarded in January, 2007.

Date of Issue	July 26, 2006
Proposal Due Date	November 1, 2006 11:59pm Eastern Standard Time
Demonstration Period	January 1, 2007 – September 30, 2011

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive a Financial Assistance Award (FAA) signed and dated by the CMS Grants Management Officer. The FAA is the document authorizing the grant award and will be sent through the U.S. Postal Service to the applicant organization as listed on its SF 424. Any communication between CMS and applicants prior to issuance of the FAA 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 applicant organization as listed on its SF 424, after November 1, 2006.

2. Administrative and National Policy Requirements

Usual Requirements

a) Specific administrative and policy requirements of grantees as outlined in 45 CFR 74 and 45 CFR 92, apply to this grant opportunity.
b) All grantees receiving awards under these grant programs must meet the requirements of:
c) Title VI of the Civil Rights Act of 1964,
d) Section 504 of the Rehabilitation Act of 1973,
e) The Age Discrimination Act of 1975,
f) Hill-Burton Community Service nondiscrimination provisions, and
g) Title II Subtitle A of the Americans with Disabilities Act of 1990.
h) All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the grantee's original grant application or agreed upon subsequently with CMS, and may not be used for any prohibited uses.
i) Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.
j) 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.

Terms and Conditions
A funding opportunity award with CMS will include standard terms and conditions and may also include additional specific grant "special" terms and conditions. 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 or CMS.

3. Reporting

Grantees must agree to cooperate with any Federal evaluation of the program and provide semi-annual (every 6 months) and final (at the end of the grant period) reports in a form prescribed by CMS (including the SF 269a "Financial Status Report" forms). 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 a format for 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.

VII. AGENCY CONTACTS

1. 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.

In addition, inquiries may be directed to Cathy Cope, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, DEHPG/DCSI, Mail Stop S2-14-26, 7500 Security Boulevard, Baltimore, MD 21244-1850, 410-786-8287 (voice), or 410-786-9004 (fax)

2. Administrative Questions

Administrative questions about the Money Follows the Person Demonstration program may be directed to Nicole Nicholson via email only at Nicole.Nicholson@cms.hhs.gov. Questions submitted telephonically will not be honored.

VIII. OTHER INFORMATION

Applicant's Teleconference
Information regarding the date, time and call-in number for an open applicants' teleconference is available on the CMS website at http://www.cms.hhs.gov/NewFreedomInitiative/. Please check the CMS Web site for more details.

ATTACHMENT 1

Notice of Intent to Apply

Submission by Facsimile Preferred
Fax: 410-786-9004

Please complete and return, by **September 5, 2006**, to:

Sona Stepp
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Phone: 410-786-6815, Fax: 410-786-9004

1. **Name of State: ____**

2. **Applicant Agency/Organization: ______________________________________**

3. **Contact Name and Title**:____

4. **Address:**____

5. **Phone: _________________________ Fax: ________________________________**

6. **E-mail address: ____**

ATTACHMENT 2

State Profile and Summary of Project

Name of State:

Primary Contact Name and Title:

	Year 1 (200X)	Year 2 (200X)	Year 3 (200X)	Year 4 (200X)	Year 5 (200X)
Populations to be transitioned					
Estimated number of individuals to be transitioned					
Geographic Areas to be covered					
Qualified Institutional Settings					
Qualified Community Settings					
Qualified HCB Services					
HCB Demonstration Services					
Supplemental Demonstration Services					
Total Annual Budget Request					

ATTACHMENT 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 provide infrastructure for which Federal Medicaid matching funds are available at the 90/10 matching rate, such as certain information systems projects.

4. To supplant existing State, local, or private funding of infrastructure or services such as staff salaries, etc.

5. To be used for expenses that will not primarily benefit individuals of any age who have a disability or long-term illness.

Attachment 4
Budget and Maintenance of Effort (MOE) Forms

Money Follows the Person Demonstration Grant Budget Estimate Presentation *Maintenance of Effort*		
Fiscal Year	**HCBS Expenditures – Year**	**HCBS Estimated Expenditures for the Demonstration per Award Year**
2005		------------------
2006		------------------
2007	------------------	
2008	------------------	
2009	------------------	
2010	------------------	
2011	------------------	
GRAND TOTAL:	------------------	

Note: only fill in cells that are blank. If you do not have expenditure data from FY2006, please leave this cell blank.

Money Follows the Person Demonstration Grant Budget Estimate Presentation *Demonstration Funding Request*				
Fiscal Year	**Enhanced FMAP for HCBS**	**Medicaid Administrative Costs**	**Supplemental Demonstration Service Costs**	**Total FY Estimated Funding Request**
2007				**$**
2008				**$**
2009				**$**
2010				**$**
2011				**$**
TOTAL:	**$**	**$**	**$**	**$**

Money Follows the Person Demonstration Grant ***Maintenance of Effort – Long-Term Care Services***		
Fiscal Year	**% of Long Term-Care Institutional Expenditures**	**% of Long-Term Care HCBS Expenditures**
2005		
2006		
2007	**------------------**	**------------------**
2008	**------------------**	**------------------**
2009	**------------------**	**------------------**
2010	**------------------**	**------------------**
2011	**------------------**	**------------------**

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 www.adrc-tae.com.

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 flexibly 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 turn over 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 effectively exercise this freedom. 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; 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 provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

- 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://www.omhrc.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

The State needs to consider the resources, unique aspects of their State, and the available opportunities when considering how to go about enlisting collaboration and support in developing and implementing a successful MFP demonstration project.

Appendix B

Other Information

CMS is providing information in this section concerning particular challenges raised by this demonstration.

<u>Mental Health</u>

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.

The Final Report of President Bush's New Freedom Commission, "Achieving the Promise: Transforming Mental Health Care in America," supports the philosophy of recovery through its Recommendation # 2.2 to "Involve consumers and families fully in orienting the mental health system toward recovery."

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://modelprograms.samhsa.gov/template.cfm?page=nrepbutton, and http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp. 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. However, the President's New Freedom Commission on Mental Health explicitly supports self-direction as a promising avenue toward independence. 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. (See Goal 5, objective 4 for additional PASRR information). 1915(c), 1115, 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 CRF 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. More information regarding PASRR can be obtained by accessing: (http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA01-3543/default.asp
- 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.

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 C

Examples of Supplemental Demonstration Services

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 12-month 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.

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 is 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.

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 are one-time skills that may improve transition for some individuals.

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 of time 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.

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 either tied to 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.

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.

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.

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.

Appendix D

Operational Protocol

This appendix provides draft guidance regarding the Demonstration Operational Protocol which will be required of all approved applications. Grantees will not be allowed to proceed with the implementation of their demonstration project until their Demonstration Operational Protocol has been approved by CMS. The following guidance is considered as draft as successful grantees will receive final guidance as part of their terms and conditions for grant award.

Preparation and Approval of Demonstration Protocol
The State will prepare a demonstration protocol document that represents all policies, operating procedures, and the evaluation plan applicable to this demonstration, and will submit the protocol along with a final budget to CMS for approval. The grantee must receive approval of this document before the demonstration portion of the project may be implemented. This approval will trigger the release of funding for the operation of the demonstration. In no event may this period be longer than 12 months. The State acknowledges that CMS reserves the right not to approve an operational protocol in the event that it does not comply with the Terms and Conditions of Approval.

Timelines and requirements
The Demonstration Protocol will be submitted to CMS no later than 60 days prior to the planned program implementation date or 13 months after the Award Date, whichever is earlier. CMS will respond within 45 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the terms and conditions of approval. Services provided prior to approval of the operational protocol are not eligible for Federal reimbursement. Once the protocol is approved and the grantee has submitted a formal progress report on the operation of the grant, CMS will notify the grantee that service funding may be utilized. Subsequent changes in the protocol, including major changes in policy and operating procedures, must be submitted for review by CMS 30 days prior to the date of implementation of the change.

Budget
Include a detailed annual budget divided into Medicaid home and community-based services (those eligible for enhanced FMAP) other Medicaid services, other services and supports, infrastructure development, administration, evaluation, and other costs. In each service costs section, provide cost estimates for the maximum number of participants in the demonstration project and their projected annual service costs. If the State has chosen to require premiums, indicate the expected premium collections. Additionally, provide an administrative budget including routine administration and monitoring activities directly related to the provision of services and benefits. Finally, provide an estimate of the cost of the evaluation activities the State is proposing. Please indicate the CMS and non-CMS shares of each budget category and provide the commitment of the State to support the non-CMS share of the Medicaid plan services. Indicate any additional actions that are required to secure State funding (appropriation by the legislature, etc.)

The operational protocol should be submitted with a final budget. Below are links to the required forms to include with the protocols:

http://www.whitehouse.gov/omb/grants/sf424.pdf (Application for Federal Assistance SF-424)

http://www.whitehouse.gov/omb/grants/sf424a.pdf (Budget Information Sheets)

http://www.whitehouse.gov/omb/grants/sf424b.pdf (Assurances-Non Construction SF-424B)

http://www.cms.hhs.gov/states/letters/certns.pdf (Additional Assurances)

http://www.whitehouse.gov/omb/grants/sflll.pdf (Disclosures for Lobbying Activities)

Sample Elements for the Demonstration Operational Protocol

Operations

1. Organization and structural administration. The protocol 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 or person will also be described in the operational protocol.

2. Reporting items. The operational protocol will contain a description of the content and frequency of the required reports to be submitted, as required by the terms and conditions of the demonstration project.

3. Benefits and services description, including unit costs. The protocol will provide detailed descriptions of the medical assistance and other supports to be provided under the demonstration project. Included will be the definition of a unit of service and the cost per unit for each service.

4. Outreach/Marketing/Education. Provide a description of the State's outreach, marketing, education, and staff training strategy.

5. Eligibility/enrollment. The protocol must provide a description of the population of individuals eligible for the demonstration (and eligibility exclusions) and procedures for population phase-in and phase-out.

6. Service provision procedures. The State will describe how the participant will access the assistance and support available under the demonstration.

7. Billing and reimbursement procedures. Describe the procedures that will be used for providers to bill and be reimbursed and for the State to request Federal reimbursement.

8. Quality. The protocol must provide a description of the overall quality assurance monitoring plan. Quality improvement must be developed as an ongoing function used to monitor, evaluate and improve the effectiveness, efficiency, quality and cost of the services being provided.

9. Participant Protections. The protocol must include documentation that the participants will not be subjected to unusual or untested medical or other procedures.

11. Informed Consent. The State will describe the procedures to be put in place to assure that participants have the requisite information to provide informed consent to participate in the demonstration and make choices about their care. All forms, letters, and other documents or statements involving participants will be included.

12. Revised Budget: The operational protocol will be accompanied by a revised project budget. This budget will be subject to CMS approval.

Appendix E

List of Other Resources and Guidance

Relevant Components of the Deficit Reduction Act of 2005 (DRA)
The DRA provides unprecedented flexibility to States in designing innovative options for serving persons with mental illnesses in the community. States are encouraged to use these provisions as tools to help reach their goals under this demonstration. Particular provisions of the DRA that may be useful to States include the following:

- Section 6086 Expanded Access to Home and Community-Based Services for the Elderly and Disabled
- Section 6087 Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling).
- Section 6044 Use of Benchmark Benefit Packages. See the State Medicaid Directors Letter #06-008 at http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS061241

To view specific provisions of the DRA see: http://thomas.loc.gov/cgi-bin/query/D?c109:5:./temp/~c109VfhObq

Guidance on Quality
CMS Quality Framework outlined in the State Medicaid Director's Letter of August 29, 2002 and subsequent correspondence. By way of summary, the framework delineates the following functions of quality: design, discovery, remediation, and improvement, and defines quality through the delineation of desired outcomes for individuals across seven domains. More information about the Quality Framework can be found at http://www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf.

Evidence Based Practices
For background on evidence-based practices see the Substance Abuse and Mental Health Services Administration (SAMHSA) website on evidence based practices see http://modelprograms.samhsa.gov/template.cfm?page=nrepbutton , and http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp

Appendix F

Components of Self-Direction

Background
Over the last several years States have developed self-direction programs under various funding authorities, including 1915 (c), 1115 and 1915(b) waiver programs. Now, for the first time self-direction is fully supported in Medicaid State Plan services through various provisions of the Deficit Reduction Act of 2005, including sections 6044, 6086, and 6087.

The MFP demonstration gives preference to States who decide to offer self-direction options under the grant. This section outlines CMS policy pertaining to self-direction programs.

Principles of Self-Direction
Self-direction of Medicaid services means that the participant (or representative) has the decision making authority over some or all of his/her waiver services and takes responsibility for taking the direct role in management 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 waiver 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.

Self-directed options can support participant choice and control of the services in a number of ways. These include person centered planning processes, opportunities to gain access to, and choose from available providers, the legal options relating to employee supervision, and the degree of control over a specified individual budget. While participant choice is a fundamental construct within Medicaid, participants may need assistance and support in order to effectively exercise this freedom. CMS and States must continue to explore options that expand the opportunities for Medicaid eligible persons to either directly, or through representation, 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.

The following processes and supports provide the basis for ensuring that all participants have the capability to meaningfully execute freedom of choice.

Components of Self-Direction
<u>Person Centered Planning (PCP) and Assessment:</u> A PCP process is directed by the individual, with assistance as needed or desired from a representative of the individual's choosing. It is intended to identify the strengths, capacities, preferences, needs, and desired measurable outcomes of the individual. The process may include other persons, freely chosen by the

individual, who are able to serve as important contributors to the process. The planning process must specify the role of family members and others the individual chooses to participate.

The PCP process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that assist him/her to achieve personally defined outcomes in the most inclusive community settings. Examples of personally defined outcomes and the services and supports to be provided to the individual include personal care, homemaker services, respite care, financial management services, and services brokerage. The planning process must also include appropriate risk management techniques appropriate to the resources and capabilities of the individual or the authorized representative. For example, Psychiatric advance directives must be included in the PCP process for persons with mental illnesses.

The PCP process must result in the development of a service plan that meets the requirements specified in Section 6071(b)(8)(B) of the DRA.

Employer Authority and Budget Authority

CMS recognizes the following two types of authority to exercise control by the participant.

- Participant Employer Authority: Under employer authority, the participant is supported to recruit, hire, supervise and direct the workers who furnish supports. The participant functions as the common law or the co-employer of these workers. When employer authority is used, the participant rather than a provider agency carries out employer responsibilities for workers.

- Participant Budget Authority: Under budget authority, the participant (or representative) has the authority and accepts responsibility to manage a participant-directed budget. States must describe the method for calculating the dollar values of individual budgets based on reliable costs and service utilization. States must also define a process for making adjustments in the dollar amounts that reflect changes in the person centered plan and define a procedure to evaluate expenditures under budget.

- Information and Assistance in Support of Self-Direction: Grantees are required to ensure availability of a range of supports to respond to individual capacity and preference for self-direction. Self-directed supports are defined as a system of activities that inform and assist the individual to develop, implement, and manage the services and supports identified in her/his individual budget. Generally, these activities link the individual with community resources and enhance personal knowledge and skills. The extent to which the individual uses the supports may vary with his/her abilities and preferences.

  To meet this objective, an applicant may design these support activities in a variety of ways, including:

  - combining with existing services,
  - creating a new service category to include all or some of the activities, or
  - identifying them as an administrative function.

  CMS requires that adequate and effective self-directed supports are in place. Examples of self-directed supports include, but are not limited to, the following:

- Provision of information regarding system processes, individual rights and responsibilities, and resources;
- Provision of labor relations information/training such as conflict resolution, hiring and firing practices, anti-discrimination, etc.
- Provision of Financial Management Services (FMS) to assist individuals exercising budget control to:
    - Understand employer related billing and documentation responsibilities;
    - Perform payroll and employer-related responsibilities (can be performed by recipients if they choose).
    - Key employer-related tasks include withholding and filing Federal, state and local income and unemployment taxes, purchasing workers' compensation or other forms of insurance; verifying citizenship and alien status; collecting and processing worker timesheets; calculating and processing benefits; and issuing payroll checks.
    - Purchase approved goods and services;
    - Track and monitor individual budget expenditures; and
    - Identify expenditures that are over or under the budget.
- Provision of Supports Brokerage Services/Counseling/Consultation Services: The supports broker/counselor/consultant serves as a personal agent who works on behalf of the individual and is under the direction of the individual. The broker serves as a link between the individual and the program, assisting the individual with whatever is needed to identify potential personal requirements, resources to meet those requirements, and the services and supports to sustain the individual as she/he directs her/his own services and supports.
- Individual and System Safeguards: CMS requires that grantees provide individualized and system-wide back-up planning, an independent advocate or advocacy system and a system to monitor the FMS operations and individuals' management of their accounts (where applicable) and reconciling of account balances on a regular basis.
    - Optional: Applicants can include information about whether they intend to make criminal background checks available for individuals who desire them.
- Provider Agreements: The MFP statute allows States to waive the provider agreement requirement in Section 1902(a)(27) of the Social Security Act. Please note that the provider agreement waiver expires after the 12 month period that people are eligible for the MFP Demonstration, after which alternative statutory authority will have to be invoked to continue the practice.

CMS Funding Sources

Self-Direction can be funded by a variety of mechanisms by CMS, including traditional funding streams such as 1915(c), 1915(b), and 1115 waiver authority as well as several State plan options provided by the Deficit Reduction Act of 2005. States who 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:

1915(c) Waiver Authority

CMS 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.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp#TopOfPage

However, the provisions in the 1915(c) waiver template are the starting point for all self-direction initiatives. Various restrictions are present under this and other authorities. Many significant issues are summarized in the following table:

Component	**Funding Authority**					
	1915(c)	**1915(b)**	**1115**	**DRA 6044**	**DRA 6086**	**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 broad waiver authority	Includes ability to create enhanced service packages	Includes HCBS services under 1915(c) except the "other" category	Includes HCBS services under 1915(c)
State-wideness	May waive	May waive	May waive	May waive	May waive	May waive
Comparability	States may waive	States may waive	States may waive	States may waive	Cannot waive	States may waive
Populations	Adults with mental illnesses are restricted due to IMD exclusion	Includes all populations	Includes all populations	Includes all populations	Includes all populations	Includes all populations
Authority to Manage Cash	Cannot manage cash	Cannot manage cash	May manage cash	May not manage cash	May not manage cash	Under Development
Limit #s of people	May limit numbers	May limit numbers	May limit numbers	May limit numbers	May limit numbers	May limit numbers
Institutional Eligibility Rules [1902(a)(10)(c)(i)(III)]	May waive	May waive	May waive	May waive	May waive	May not waive
Provider Agreements [1902(a)(27)]	May not waive	May not waive	May waive	May not waive	May not waive	May not waive

Please be aware that CMS policy is not finalized for several sections of the DRA. These sections of the above table have been left blank. Please continue to check CMS issuance for updates.

Adults with Mental Illnesses

Persons with mental illness are among the few remaining populations where self-direction has not been widely implemented. The Final Report of President Bush's New Freedom Commission, "Achieving the Promise: Transforming Mental Health Care in America," supports the philosophy of recovery through its Recommendation # 2.2 to "Involve consumers and families fully in orienting the mental health system toward recovery." Self-direction is explicitly supported in the Final Report.

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 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://modelprograms.samhsa.gov/template.cfm?page=nrepbutton , and http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp , Services must be supported by research-based evidence of their effectiveness. Please note that all proposed services to be reimbursed under this demonstration are subject to CMS approval.

Appendix G

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.