Program Guidance:

2013 MFP TRIBAL INITIATIVE

Funding Opportunity

I. INITIATIVE DESCRIPTION

The purpose of the Centers for Medicare & Medicaid Services (CMS) Money Follows the Person Tribal Initiative (TI) is to offer states and tribes the resources to build sustainable community-based long term services and supports specifically for Indian country. The funds are subject to all the terms and conditions of the MFP Program[1]. The TI may be used to advance the development of an infrastructure required to implement community-based long term services and supports (LTSS) for American Indians and Alaska Natives (AI/AN) using a single, or a variety of applicable Medicaid authorities [2]. Funding is intended to support the planning and development of:

1) An in-state Medicaid program of community-based LTSS (as an alternative to institutional care) tailored for AI/AN who are presently receiving services in an institution; and
2) A service delivery structure that includes a set of administrative functions delegated by the state Medicaid agency to Tribes or Tribal organizations (T/TOs), such as enabling tribe(s) to design an effective program or package of Medicaid community-based LTSS, and operating day to day functions pertaining to the LTSS program(s).

The TI may be used to cover costs necessary to plan and implement activities consistent with the objectives of this funding and within Federal grant regulations. See Appendix B for detailed information on the technical components of the full 2012 MFP grant solicitation.

MFP Administrative Funding: Funding for the administrative costs of this initiative will be included in the administrative claims portion of the existing MFP grants but will not be calculated into the 20% administrative funding cap calculation.

[1] http://www.grants.gov/search/search.do?mode=VIEW&oppId=142933

[2] Community-based long-term services and supports 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.

MFP Service Funding: ***Enhanced Federal Medical Assistance Percentage (FMAP):*** MFP offers an enhanced FMAP rate[3] for qualified HCBS and demonstration services. States are permitted to claim the MFP enhanced federal match rate for the first 365-day post-transition period for qualified demonstration participants. States are also required to continue the qualified HCBS service provision after the conclusion of the demonstration program. NOTE: since the first 365 days of services are covered by MFP grant funds, they do not fall under the auspices of IHS and may not be subject to the 100% CMS FMAP. Beyond the first 365 days of placement, however, all individual service claims are expected to be eligible for enhanced federal match in accordance with the 1996 Memorandum of Understanding (MOU) between the Indian Health Service (IHS) and CMS [4].

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

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

Reporting

CMS will not require new reporting processes for grantees. However, CMS will make minor adjustments to the current web-based reporting processes for the TI to capture information related to the goals and objectives of this funding opportunity. Specifically, the semi-annual web-based report template currently required of State MFP programs is expanded to include additional text boxes to report on formal partnerships with T/TOs, and the number of individuals transitioned into the community through this initiative. Additionally, expenditure reports will be sent to the State MFP Project Officers, with a copy to the Tribal liaison for Medicaid long term services and supports (LTSS), Anita Yuskauskas (Anita.Yuskauskas@cms.hhs.gov). The report will include a separate expenditure breakdown for each quarter.

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

[4] Medicaid services delivered by tribal programs are eligible for 100% FMAP if: 1) The services are provided by a tribal facility, tribal facility employees, or contractual agency of the tribal facility, even if not on the premises of the facility, 2) The service is considered a "facility service," - that is , one within the proper scope of services which can be claimed by that facility under IHS authorities; and 3) The service is claimed by the IHS facility as a service of that facility - that is, included in the funding agreement with the IHS under the Indian Self-Determination and Education Assistance Act, P.L.93-638 (ISDEAA).

Use of Grant Funds

MFP tribal funding will be available to existing MFP States, with the clear expectation that the state will identify and formally partner with T/TOs. **States without a written partnership commitment with T/TOs for this initiative will not be considered for this funding**. The ultimate goals of the partnership are to transition eligible and interested tribal members with chronic and disabling conditions to their communities, and to expand the leadership role of tribes in the design and operations of Medicaid LTSS programs tailored for tribal members.

Relevant activities that may be paid for through MFP supplemental grant funds include, but are not limited to, the following:

- Transitioning AI/AN to their communities from institutions;
- Building T/TO LTSS infrastructure and capacity to support MFP implementation;
- Strengthening partnerships between the state Medicaid agency and T/TO in support of state deinstitutionalization initiatives;
- Developing roles the T/TO and state Medicaid agencies will play in the design and operations of the TI program;
- Deciding on geographic area of the state where the collaboration activities will be implemented;
- Defining a program model and a set of services tailored to AI/AN populations consistent with the parameters of the MOU between CMS and IHS;
- Identifying T/TO community provider capacity-building needs, including IT systems changes and training, to achieve a sustainable model.

The project activities should build upon current MFP and tribal work within the state. By integrating with other related initiatives, the expected result is a sustained program of LTSS for AI/AN within the state by the end of the Federal MFP grant funding.

The project has four distinct phases as follows:

Phase One: Concept Paper
Phase Two: Operational Protocol: Detailed Timeline and Activities
Phase Three: Execution of Operational Protocol and Program Submittal
Phase Four: Program Implementation

Each phase must be approved by CMS prior to grantee advancing to the next phase.

Phase One: Concept Paper

Phase One will consist of two major activities: partnership commitment and relevant tribal population characteristics. The concept paper describing these activities consists of a brief proposal of how the T/TOs and state will work together on the initiative, a general description of the scope of the tribal institutional populations and identifying characteristics of this target group (including existing needs assessments for involved tribal communities), if available. Also required is a signed commitment agreement between the state and T/TOs.

Phase One will culminate when the State and T/TO receive approval from CMS on 1) a concept paper that outlines state-tribal partnerships, 2) a commitment agreement between the State and T/TOs to pursue the initiative, and 3) a description of relevant tribal characteristics in the state, including a tribal needs-assessment and population details, as available.

Phase Two: Operational Protocol: Detailed Timeline and Activities

In Phase Two the parties will generally define the content details of agreements between the state and T/TO relative to their respective roles (including Medicaid delegated functions), commitments among tribes or between tribes, goals and parameters of the desired program, the development of tribal administrative structures to address delegated functions, and mechanisms to assure and oversee quality.

Additional specific activities under Phase Two should include the identification of:

- More detailed information on Medicaid-eligible tribal members interested in being discharged into the community from an institution and individuals at high risk of an extended institutional placement;
- State and tribal roles in Medicaid administration, and respective interest and capacity to fulfill those roles over the life of the project and after its conclusion;
- Tribal community-based LTSS preferences, and unique design elements of interest to the T/TO;
- Medicaid statutory program authorities or state plan services that may address the identified tribal needs;
- Delegated administrative responsibilities that allow T/TOs significant leadership roles in the design and operations of a Medicaid LTSS program for tribal members.

In Phase Two, grantees will provide a clear delineation of the roles and responsibilities of state and tribal staff participating in the TI, the T/TO role in the planning, design, and operations of the initiative, and consultants and partner organizations directly relevant to the project. This

section should also identify challenges and barriers that might arise through this collaboration and processes by which they will be addressed.

During Phase Two CMS will provide technical assistance related to both tribal matters and Medicaid LTSS programs to assist states and tribes to work together and develop partnerships and roles in the operation of the TI.

Phase Two will culminate when the State and T/TO submit a detailed operational protocol and timeline that includes processes and activities related to the goals and parameters of the desired program, details related to respective roles, the development of tribal administrative structures to address delegated functions, and mechanisms to assure and oversee quality. The *CMS must approve this prior to movement to Phase Three.*

Phase Three: Execution of Operational Protocol and Program Submittal

Phase Three involves the execution of the approved operational protocol and the submittal of a program application to meet the goals and objectives of the funding opportunity. It may also include implementation of partnership agreements or Memoranda of Understanding (if not already initiated). Phase Three will identify viable program authorities and barriers that require resolution, including the identification of state and federal policy issues that must be addressed in order to realize progress and success.

Phase Three culminates in the submittal of a comprehensive program application/proposal for a LTSS program or state plan service(s) to CMS. The program must be consistent with terms of the Agreement between CMS and Indian Health Services (IHS) as follows:

1) The services are provided by a tribal facility, tribal facility employees, or contractual agency of the tribal facility, even if not on the premises of the facility;
2) The service is considered a "facility service," - that is , one within the proper scope of services which can be claimed by that facility under IHS authorities; and
3) The service is claimed by the IHS facility as a service of that facility - that is, included in the funding agreement with the IHS under the Indian Self-Determination and Education Assistance Act, P.L.93-638 (ISDEAA).

The state and T/TOs will require approval from CMS for the submitted program or service application.

Phase Three activities by the State and/or T/TO include finalization of the following:

- The scope and details of delegated administrative functions handled by the T/TO and portions, if any, that will be contracted out;
- The details of the participating tribe or tribal collaborative and methods by

which they will organize to implement administrative functions;
- Selected Medicaid program authority (or authorities) for the program structure that will address the AI/AN needs identified;
- The methods by which the Medicaid program is crafted to assure adherence to terms of the CMS-IHS MOA relative to federal match;
- Development of program parameters to specifically address the unique needs of AI/AN, including but not limited to service delivery model, service definitions, provider qualifications, rate structure, eligibility criteria, and other factors as required in the program application;
- Development and submittal of a program proposal and/or application; and
- Program negotiations with CMS as part of the submission process leading to the approval of the Medicaid LTSS program.

Phase Three will culminate when the State and T/TO have implemented partnership agreements, engaged in necessary program development activities, and, as needed, created administrative structures for tribes to implement delegated administrative functions on behalf of the State Medicaid Agency. These program activities result in a proposal for Medicaid community based LTSS tailored to the needs of AI/AN, and consistent with the terms of the CMS-IHS MOA relative to federal match rate. The final step in this phase is the submittal of a program proposal to and approval by CMS.

Phase Four: Program Implementation

Phase Four involves implementation of the CMS approved Medicaid LTSS, meeting the conditions outlined herein. The implementation phase includes primarily 1) transition activities related to eligible individuals moving from institutions to their communities, and 2) administrative activities related to program operations.

In this phase MFP resources may be used for the following:
- Administrative costs: Continued administrative functions related to transition, operations, and development of a sustainability plan, and
- Service costs: MFP offers an MFP enhanced federal match rate for transitioned individuals for the first 365 days. Additionally, the qualified residence requirement applies to any services for which the enhanced MFP FMAP is claimed.
- NOTE: Following the initial 365 day transition period all individual service claims associated with this initiative are expected to be eligible for federal reimbursement in accordance with the 1996 Memorandum of Understanding (MOU) between the Indian Health Service (IHS) and CMS[5].

[5] Medicaid services delivered by tribal programs are eligible for 100% FMAP if: 1) The services are provided by a tribal facility, tribal facility employees, or contractual agency of the tribal facility, even if not on the premises of the facility, 2) The service is

The expected administrative activities in the Implementation Phase include but are not limited to the following:

- Education of potential individual participants, their family members or legal representatives, and facility staff about community-based LTSS options, including the development of outreach and information materials;
- Transition support services to individuals through the discharge process from nursing facilities, ICF/DDs, and hospitals;
- The establishment of community supports and resources in Indian country, which may include:
    - Identifying housing resources;
    - Teaching individuals to be their own advocates as they engage with all of the people involved in a transition;
    - Promoting participant directed service models and assisting individuals who choose participant-directed model of services;
    - Teaching individuals the skills necessary to live in the community including the promotion of successful employment outcomes;
    - Meeting the needs of AI/AN individuals with multiple chronic conditions;
    - Helping individuals to identify community resources;
    - Assisting all parties with necessary paperwork and documentation;
    - Helping individuals find appropriate personal assistants or nursing care;
    - Ensuring necessary adaptive and/or assistive technology devices are available and in place; and
    - Helping individuals access resources for minor home modifications, when necessary.
- Quality monitoring and oversight activities including regular contact post-transition to ensure adequate supports are fully in place after a return to the community;
- Execution of tasks associated with MFP and other institutional transition/diversion initiatives;
- Partnerships with public housing authorities and other organizations to link individuals with appropriate housing in the community/ies;
- Execution of data use agreements and processes necessary to effectively share required data;
- Development and/or implementation of training for Aging and Disability Resource Center (ADRC) staff, Ombudsman personnel, or other key staff when necessary, on options counseling and person-centered planning or other core competency skills directly related to the TI and other institutional transition/diversion initiatives;

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considered a “facility service,” - that is , one within the proper scope of services which can be claimed by that facility under IHS authorities; and 3) The service is claimed by the IHS facility as a service of that facility - that is, included in the funding agreement with the IHS under the Indian Self-Determination and Education Assistance Act, P.L.93-638 (ISDEAA).

- Creation of data systems and management infrastructures necessary to implement the TI; and
- Creation of a sustainability plan that continues support for the successful activities of the TI after funding has concluded.

Phase Four activities will commence with the implementation of a sustainable community based service model as an alternative to institutional care for tribal members, the transition of AI-AN from institutions, and the associated activities that support AI/AN to move from institutions to their communities.

II. MFP TRIBAL SUPPLEMENTAL FUNDING INFORMATION

Period of Support:	April 1, 2013 through September 30, 2016
Award Amount:	
• Phase One	$100,000 to $300,000
• Phase Two	$100,000 to $300,000
• Phase Three	$400,000 to $1,000,000
• Phase Four	$ 250,000 to $600,000
Est. Number of Awards:	Approximately 10
Est. Project Start Date:	April 1, 2013
Eligible Applicants:	Money Follows the Person (MFP) Demonstration states in partnership with tribes and/or tribal organizations
Period of Performance:	42 months

The deadline for submission is March 22, 2013. All applications must be submitted to the respective state's CMS Project Officer via email.

MFP States granted MFP Tribal supplemental budget funding will be required to submit a modified OP, adding each TI phase as an addendum, subject to the approval of the CMS Project Officer, and as appropriate, the CMS Office of Acquisitions and Grants Management (OAGM).

Participating awardees will be expected to maintain regular contact with their CMS Project Officer and to cooperate with the CMS Technical Assistance and Evaluation contractors. Grantees will also be expected to report to CMS on all significant products and activities. Because of the nature and scope of work proposed, initiatives will vary across applications and funding levels. CMS reserves the right to offer a funding level that differs from the requested amount, including amounts less than the applicants have requested, where applicable.

III. ELIGIBILITY INFORMATION

Eligible Applicants

Only states already participating in the MFP grant program may apply for this funding. The Grantee must also have an active partnership with the participating T/TO within the state for purposes of this initiative.

IV. APPLICATION AND SUBMISSION INFORMATION

A. Project Narrative (80 total points)

Phase One - Concept: Submit a concept paper consisting of no more than 5 pages containing the following:

- A concept that outlines state- tribal commitment. The concept should establish the general blueprint for both the state and the tribal partnership. (40 points)
- A preliminary signed agreement between the state and T/TOs. (20 points)
- A tribal needs-assessment and/or tribal population details contributing to the creation of a program design. (20 points)

B. Budget (20 total points)

Phase One Budget totals between $100,000 to a $300,000. The budget should be prepared using the SF 425 and Budget Narrative for justification, and include a delineation of funding using the SF-425 budget line items to complete Phase One.

C. Submission Dates and Times

The deadline for the submission of completed applications under this program guidance is March 22, 2013. All applications must be submitted to Anita Yuskauskas (Anita.Yuskauskas@cms.hhs.gov) by 11:59 p.m. Eastern Time, March 22, 2013.

CMS MFP Tribal Project Officer
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244-1850
Attn: Anita Yuskauskas
E-mail: anita.yuskauskas@cms.hhs.gov

D. Funding Restrictions

The following activities cannot be funded:

- Construction and/or major rehabilitation of buildings;

- Basic research (e.g. scientific or medical experiments); and,
- Continuation of existing projects without expansion or new and innovative approaches.
- Activities otherwise funded through the MOU between CMS and IHS covering services to Medicaid eligible AI/AN (see attached)

E. Review and Selection Process

The CMS Project Officer along with other involved federal employees will evaluate applications based on the criteria in the previous section.

VI. AWARD ADMINISTRATION INFORMATION

Award Notices

Notification of TI funding will be on or after April 1, 2013. Grantees will receive one Notice of Award (NoA) that will include both the MFP supplemental budget request and the TI funding, if approved.

VII. AGENCY CONTACTS

CMS MFP Tribal Project Officer:
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244-1850
Attn: Anita Yuskauskas
E-mail: Anita.Yuskauskas@cms.hhs.gov

APPENDIX A

QUESTIONS AND ANSWERS

MONEY FOLLOWS THE PERSON TRIBAL INITIATIVE
QUESTIONS AND ANSWERS
January, 2013

Money Follows the Person Purpose:

The purpose of the Money Follows the Person (MFP) Rebalancing Demonstration is to assist Medicaid enrollees eligible for long-term services and supports (LTSS) to transition from institutions to the community.

Tribal Context:

The Indian Health Care Improvement Act (IHCIA) was reauthorized and amended by section 10221 of the Affordable Care Act, Pub. L. 111-148. Section 205 of IHCIA (25 U.S.C. § 1621d) and specifically authorizes the Indian Health Services (IHS) to provide hospice care, assisted living, long term care, and home and community based services for disabled and elderly American Indian/Alaska Native (AI/AN) persons with specific functional eligibility requirements.

What is the MFP tribal initiative?

The MFP tribal initiative (TI) provides administrative resources to eligible tribes and tribal organizations (T/TO) through existing MFP state grantees to transition eligible tribal members with disabling and chronic conditions out of institutions or inpatient facilities[6] and into a program of community-based LTSS tailored to meet the needs of AI/AN. The additional MFP resources may be used to increase the availability of LTSS in Indian country, to expand the tribal role in state Medicaid programs, and to improve community integration of AI/AN in need of LTSS.

States are expected to work with T/TOs to design a package of Medicaid LTSS in which tribes perform delegated administrative responsibilities on behalf of state Medicaid agencies. Funding support will be awarded to state Medicaid agencies working in collaboration with eligible T/TOs. For the first 365-day post-transition period MFP offers an enhanced FMAP rate for qualified HCBS services and demonstration services[7].

[6] The term `inpatient facility' means a hospital, nursing facility, or intermediate care facility for the individuals with intellectual disabilities. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

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

Following the initial 365 day transition period all individual service claims associated with this initiative are expected to be eligible for federal reimbursement in accordance with the 1996 Memorandum of Understanding (MOU) between the Indian Health Service (IHS) and CMS[8]. Correspondingly States are required to continue the qualified HCBS service provision after the conclusion of the demonstration program.

Who is eligible to apply?

States with existing MFP awards, in partnership with compacted or contracted T/TOs, are eligible to submit proposals. Proposals for the additional funding may be submitted through an MFP supplemental budget request.

How much funding is available for the MFP T/TO?

Each proposal will be judged on its own merit and the scope of its proposal. However, we are estimating that total awards may be in the range of $500,000 to $2,000,000. Additional funding may be granted based on the number of tribes that participate together, the scope and design of the LTSS program, and the delegated responsibilities.

How will these funds be used?

The funds included in the supplemental budget request for the tribal MFP initiative may be used to advance the development of the infrastructure needed to implement community-based LTSS for AI/AN using a single or a variety of applicable Medicaid authorities[9]. The LTSS may include but are not limited to those provided through the following Medicaid program authorities: Section 1915(c), 1915(i), 1915(b)(c), state plan personal care, Section 1915(j), or Section 1115.

Over a three year period the funding supports four distinct phases of activity for planning and developing a structure that enables Tribes or Tribal organizations, operating in cooperation with the State Medicaid agency, to play a significant role in the design and administrative operations of a package of Medicaid community-based LTSS tailored for AI/AN.

What administrative functions could tribes perform?

[8] Medicaid services delivered by tribal programs are eligible for 100% FMAP if: 1) The services are provided by a tribal facility, tribal facility employees, or contractual agency of the tribal facility, even if not on the premises of the facility, 2) The service is considered a "facility service," - that is , one within the proper scope of services which can be claimed by that facility under IHS authorities; and 3) The service is claimed by the IHS facility as a service of that facility - that is, included in the funding agreement with the IHS under the Indian Self-Determination and Education Assistance Act, P.L.93-638 (ISDEAA).

[9] Community-based long-term services and supports 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.

Tribes could perform specifically defined administrative tasks under agreement or in partnership with the single State Medicaid Agency. Those tasks typically involve planning, designing and managing program operations (i.e., constructing program details based on stakeholder feedback that includes service definitions, provider qualifications and rate structures), conducting intakes, providing service coordination, overseeing the provider network and quality of services provided, and a host of other day to day operational management activities of an LTSS program (i.e., operating agency functions). State Medicaid Agencies would continue to maintain their role as the single State agency for the oversight of the administrative functions performed by tribes, including oversight of the administration of program implementation.

When will funds be available?

Funds to implement the tribal MFP initiative will be available to states beginning in April 2013, through an MFP supplemental budget request process.

Will states and tribes be eligible for a planning grant, similar to past MFP grant programs?

This funding is essentially a planning grant, designed to support the planning and development of sustainable LTSS for AI/AN. The TI award is largely intended to support programs into which eligible AI/AN individuals may transition from nursing homes, and which can then be sustained through 100% FMAP. Because services delivered under the state's LTSS program, i.e., those provided through facilities operated by tribes and tribal organizations under a contract or compact with the IHS, are expected to be eligible for 100% federal match rate, the MFP dollars for direct services are provided only in Phase Four.

Is help available to tribes and states to work through the planning and development of this initiative?

CMS intends to provide technical assistance (TA) via contractors and CMS staff to both tribes and states to work through the anticipated complexities involved in this initiative. The TA will include expert knowledge of Medicaid LTSS authorities, MFP, and tribal health care. We anticipate the TA contractors will act as a support to tribes, states and CMS in identifying and resolving barriers and policy issues, and facilitating accomplishment.

How will we know this program worked?

CMS intends to contract with an evaluator to assess the outcomes of this program. Grantees utilizing this funding are expected to participate in the evaluation.

What are the expected outcomes of this Program?

- To transition tribal elders and other eligible AI/AN persons out of institutions and to their home communities.
- To demonstrate effective models of LTSS tailored to AI/AN persons.
- To sanction and demonstrate a leadership role in Medicaid programs for eligible tribes and tribal organizations in the performance of delegated administrative functions related to tribal LTSS.
- To add a mechanism to serve eligible AI/AN persons, who experience significant health disparities and challenges in accessing LTSS through a sustainable (100 percent federal match) and tailored Medicaid LTSS program.
- To demonstrate and document replicable models of Medicaid LTSS for eligible AI/AN persons, receiving LTSS in programs eligible for 100percent federal match, and which can serve as a blueprint for additional tribal-state partnerships and AI/AN tailored programs.
- To create transparency by identifying, resolving, and disseminating Medicaid policy issues that create barriers to the approval and implementation of Medicaid LTSS services for AI/AN eligible for 100 percent federal match.

APPENDIX B

MFP TECHNICAL ELEMENTS

Excerpt from 2012 MFP grant announcement

The full 2012 MFP grant announcement is available at:
http://www.grants.gov/search/search.do?mode=VIEW&oppId=142933

Demonstration Technical Elements

a) Participant Eligibility Requirements

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

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

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

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

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

- a home owned or leased by the individual or the individual's family member;

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

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

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

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

b) Defining Services and Rates

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

For example, a State has a published FMAP of 50%. MFP calculates the rate as 100% minus the 50% and then divides that difference by two providing that State with an enhanced MFP-FMAP rate of 75%. If another State had a published FMAP of 86%., MFP calculates the rate as 100% minus the 86% and then divides that difference by two (equals 7%) providing that State with an enhanced MFP-FMAP rate of 93%- 3% to reduce the enhanced FMAP to the maximum 90%

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

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

(1) Qualified Home & Community-based Services

The "qualified HCBS" program is the Medicaid service package(s) that the State will make available to a demonstration participant when they move to a community-based residence. This program can be comprised of any Medicaid home and community-based State Plan and waiver authority services and program packages. Under the demonstration, States are permitted to claim an enhanced match rate for the first 365-day post-transition period for qualified HCBS for demonstration participants who transition from an institutional setting into the community. States are also required to continue the qualified HCBS service provision after the conclusion of the demonstration program. For a comprehensive list of services that may be offered under the HCBS waiver program, see Appendix C: Participant Services and/or access the following link to the Home and Community-Based Waiver [Version 3.5] Instructions, Technical Guide and Review Criteria: http://www.hcbs.org/files/100/4982/Final_Version_3_4_Instructions_Technical_Guide_and_Review_Criteria_Nov_2006.pdf (Also see Appendix B, Sub-Appendix V) Of note, the MFP statute provides waiver authority for four provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of the demonstration. These provisions are:

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

(2) Demonstration Services

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

(3) Supplemental Services

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

(a) Upon approval of the Operational Protocol

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

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

c) Stakeholder Involvement

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

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

- Information regarding the HCBS capacity and capability that is needed in order to provide supports and services to those individuals transitioned to the community;
- The availability of stakeholder resources to identify those eligible to transition and how those resources may be leveraged under the demonstration;
- Coordination with State Licensing and Survey and Certification entity/agency on the identification of, and whether to target chronically poor performing facilities, or facilities that are identified for closure for transitioning of individuals;
- Assistance with the process for identification of populations and individuals for transitioning;
- Access to assessment data and other information across settings, including nursing home Minimum Data Set 3.0, Section "Q" to assist in the identification of individuals for transitioning;
- Cross training of Provider staff to assist with transitions and provide care in the community to individuals transitioned; and
- Mechanisms to create and/or expand access to needed HCBS via ICF/MR, NH, Psychiatric Hospital and PRTF provider diversification, adaptation and development of the capability and capacity to provide Medicaid services to those transitioned to the community. For more detail on Stakeholder Involvement see-Demonstration

Implementation Policies and Procedures, Operational Protocol Section I, A., Part#2, B, 4.)

d) Technical Assistance and Quality Assurance and Improvement

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

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

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

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

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

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

e) National Evaluation

CMS has a national evaluation contract to conduct an ongoing and final national evaluation of the MFP Demonstration Project. The national evaluation will assess

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

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

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

   - At "baseline" – after the individual has been accepted into the MFP program but just
   - prior transition to the community2
   - First follow-up conducted 11 months post-transition to the community
   - Second follow-up conducted 24 months post-transition to the community

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

2. What evidence is there that the States have rebalanced resources to provide more Medicaid consumers LTC supports in the community instead of in an institution? Specifically, how many consumers have been successfully transitioned? Of those transitioned, how many are now enrolled in waiver programs, and have remained in the community in the 2 years following the initial 12 month transitioned period? What were the reasons for no longer being in the community, including preventable and unpreventable reasons for re-institutionalization?

3. What evidence is there that the MFP program has eliminated barriers that prevented and/or restricted the flexible use of Medicaid funds to enable Medicaid-eligible

individuals to receive appropriate and necessary long term care services in the setting of their choice? Have States implemented sustainable systems?

4. What sustainable processes and systems' changes have resulted in transitions of individuals to the community; diversion of individuals to unnecessary institutionalization; implementation of the flexible use of Medicaid funds; continuity of services after transitioned; and assurance of the health and safety of transitioned individuals?

5. What quality assurance and quality improvement procedures and outcomes demonstrate that needed services are being provided in the community? How is the health and safety of participants being assured while also providing consumer choice?

6. What are the costs of providing HCBS to populations and individuals who have transitioned from institutions to the community and how does that cost compare to the same level of cost of care and services provided in institutions?
   Grantees may also choose to conduct their own independent evaluation to either assist in the establishment of a formative learning process and/or to serve as the interface between the grantee and the CMS national evaluation contractor. The grantee and their evaluation contractor (if the grantee chooses to engage one) will be required to cooperate fully with CMS and the national evaluation contractor.
   Costs associated with participating in the demonstration evaluation and the submission of both financial and programmatic data, if approved, may be reimbursed at 100% through grant funding.
   States will need to provide individual-level data on program participants prior to the transition of the individual and during the demonstration period. This information must come from official administrative records and not from self-reported information. The individual data required are defined in the MFP Evaluation Design. Use and access to this data will be limited to the specific research purposes of these projects and shall adhere to all CMS provisions concerning data release policies, the Privacy Act of 1974, and the Health Insurance Portability and Accountability Act of 1996.
   (For more detail on the National Evaluation see-Demonstration Implementation Policies and Procedures, Operational Protocol Section I, A., Part#2, D.)

f) Programmatic Reporting Requirements

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

- **Structure** – implemented program changes to rebalance resources and transition and maintain individuals in the community, i.e., systems changes, agency changes;

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

g) Financial Reporting Requirements

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

1. **CMS 64.9i, 9Pi and 64.10i, 10Pi -** These forms, submitted on a quarterly basis, allow the State and CMS to track expenditures associated with the demonstration participants. The various forms feed into the Medicaid Budget and Expenditure System (MBES), but are not used to draw down funding. They are informational forms that will provide a mechanism for adequately projecting estimates on expenditures once the participant leaves the demonstration.
2. **MFP Program Files** – This files will be submitted quarterly to the national evaluation contractor. The files will be used to track program enrollment patterns, participant quality of life, and Medicaid claims records extracted from the Medicaid Statistical Information System MSIS) for each demonstration participant. The quarterly files will be sent to the national Evaluation contractor via the Gentran system.
3. **MFP Financial Reporting Forms (A, B, C, and D) -** The MFP Financial Reporting Forms, submitted on a quarterly basis, are modified from the CMS 64. The forms provide a mechanism for tracking expenditures for Qualified HCBS, Demonstration and Supplemental, Services offered under the demonstration, as well as administrative claims that will require reimbursement from demonstration funds.
4. **Federal Financial Report (FFR or SF-425) -** All MFP grantees are required to submit the SF-425 on a semi-annual basis with the first report due on July 31st covering the reporting period of January through June, and the second report due on January 31st covering the reporting period of July through December. For year one (first report due on July 31, 2012), will only cover April 2012 through June 2012. The SF-425 consolidates and replaces the SF 269 (Financial Status Report) and the PSC-272 (Federal Cash Transactions Report) with a single electronic report. For more information, please visit the Division of Payment Management's website at http://www.dpm.psc.gov/Default.aspx.
5. **Maintenance of Effort (MOE) Form** – This form is due yearly on January 31st and will capture all LTC expenditures (both community and institutional) annually to

ensure that the State has maintained its financial effort taking into account all service costs, administrative costs, and rebalancing investments.

6. **MFP Worksheet for Proposed Budget** – This form, submitted initially within the Draft Operational Protocol and subsequently on an annual basis on January 31st, will provide CMS with a standardized report of each State's high level budget information, as well as projected transition benchmark information.
   (For more detail on Budget see-Demonstration Implementation Policies and Procedures, Operational Protocol Section I, A., Part#2, E.)