CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID AND STATE OPERATIONS
DISABLED AND ELDERLY HEALTH PROGRAMS GROUP

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

OPERATIONAL PROTOCOL INSTRUCTION GUIDE

JANUARY 2007

(Distributed as part of the Program Specific Terms and Conditions of grant awards)

MFP OPERATIONAL PROTOCOL INSTRUCTION GUIDE

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Money Follows the Person
OPERATIONAL PROTOCOL INSTRUCTION GUIDE

Introduction and Timeline

This document is the official instruction guide and template for the development of Operational Protocols by the States chosen to participate in the Money Follows the Person (MFP) Rebalancing Demonstration. This guide should provide instruction on the required elements of the State's Operational Protocol which must be submitted and approved before a State may enroll individuals in the State's demonstration program or begin to claim for service dollars.

The Operational Protocol should provide enough information that:

- The CMS Project Officer and other federal officials may use it to understand the operation of the demonstration and/or prepare for potential site visits without needing additional information;
- The State Project Director can use it as the manual for program implementation; and
- External stakeholders may use it to understand the operation of the demonstration.

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

The Operational Protocol will be submitted to the Centers for Medicare & Medicaid Services (CMS) no later than 60 days prior to the planned program implementation date or 12 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.

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

Once the Operational Protocol has been approved by CMS, a grantee will begin the implementation phase of the demonstration and be permitted to claim the enhanced match rate for CMS approved home and community-based services (HCBS) for demonstration participants transitioned from institutional settings into the community for the first 365 days of community-based care. During this phase, all "qualified expenditures" will be eligible for Federal Medical Assistance Percentage (FMAP) at the enhanced rate specified in the statute. Additionally, the State will be able to claim the 50% match rate under the demonstration for any services approved and delivered to demonstration participants as supplemental services.

Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures must be submitted for review and approval by CMS. The State must submit a request to CMS for these changes and, if available, detailed drafts of these proposed changes no later than 60 days prior to the date of implementation of the proposed change(s).

I. Required Contents of the Operational Protocol

In order to submit a complete Operational Protocol, a State must include a response to each of the elements in this section. Operational Protocols that do not include responses to each section below will not be reviewed. Please direct questions regarding the development of the State's Operational Protocol to your CMS Project Officer.

A. Project Introduction

Under this section, the State must present an overview of the demonstration project from the perspective of the consumer. Establishing this perspective, as the project introduction, will enable the reader to stay focused on the major goals of the project, the interventions that will assist in the achievement of the goals as well as the major operational components of the demonstration program. The State should include the elements of these processes that are apparent to the consumer, and how and when the consumer interfaces with the demonstration administration.

The state must address the four key demonstration objectives as outlined in statute in their project introduction. These objectives are to:

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

1. Case Study

Provide a detailed description, from a demonstration participant's perspective, of the overall program and the interventions for transition and rebalancing that the State proposes to use under the demonstration. The case study should walk the reader through every step of the proposed processes. These steps include, but are not limited to, the initial process of participant identification, processes that will occur prior to transition, those processes employed during the actual transition into community life and those processes that will be utilized when the individual has been fully transitioned into a home and community-based program.

CMS recognizes that each transitioned population may require specific programmatic interventions and processes. A single case study may not incorporate all the elements needed to address the unique needs, and resultant processes, for different populations. To that end, within the case study, the awardee is advised to describe those elements that may differ for each proposed population. Please describe the interventions and processes from the participant's

perspective and then indicate if and when separate processes will be utilized to address population-specific elements.

The case study is intended to be a detailed narrative of the interventions employed under the demonstration. Operational procedures need not be included in the case study, as they will be provided in subsequent sections. For example, the State will provide detailed descriptions of eligibility and enrollment processes and mechanisms as part of Section i. Eligibility and Enrollment, in the State's Operational Protocol. Similarly, detailed information regarding the service delivery system, for each population transitioned, will be provided in Section h. Benefits and Services of the State's Operational Protocol.

2. Benchmarks

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

1. The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of the demonstration.
2. Qualified expenditures for HCBS during each year of the demonstration program.

In addition, awardees must propose, at a minimum, 3 additional measurable benchmarks which address some of the elements of rebalancing. These benchmarks should be measures of the progress made by the State to direct savings from the enhanced FMAP provided by this project towards the development of systems improvements, enhancing ways in which money can follow the person (see Appendix A of the grant solicitation). These additional measurable benchmarks may include, but are not limited to:

- A percentage increase in HCBS versus institutional long-term care expenditures under Medicaid for each year of the demonstration program.
- Establishment and utilization rates for a system for accessing information and services by a date certain (i.e., the establishment or expansion of one-stop shops).
- Establishment and utilization rates for a screening, identification, and assessment process for persons who are candidates for transitioning to the community that are put into use in the general Medicaid program beyond recruitment for the MFP demonstration.
- Progress directed by the State to achieve flexible financing strategies, such as global or pooled financing or other budget transfer strategies that allow "money to follow the person".
- Increases in available and accessible supportive services (i.e., progress directed by the State in achieving the full array of health care services for consumers, including the use of "one-time" transition services, purchase and adaptation of medical equipment, housing and transportation services beyond those used for MFP transition participants).
- Increases in an available and trained community workforce (i.e., direct interventions, undertaken by the State, to increase the quality, the quantity and the empowerment of direct care workers).

- Increases in the availability of self-directed services (i.e., progress directed by the State to expand the opportunities for Medicaid eligible persons beyond those in the MFP transition program to either directly, or through representation, to express preferences and desires to self-direct their services and supports).
- Increases in the utilization of transition coordinators used to assist individuals in Medicaid find appropriate services and supports in the community.
- Improvements in quality management systems (i.e., direct inventions undertaken by the State to ensure the health and welfare of participants is protected while also maintaining consumer choice).
- Expansions to and improvements in health information technology (i.e., progress directed by the State to build systems that accommodate the business needs of multiple organizations that serve the same populations).
- Improvements in cultural and linguistic competence (i.e., language assistance services, including patient-related written materials).
- Interagency and public/private collaboration (i.e., direct interventions undertaken by the State to achieve a higher level of collaboration with the private entities, consumer and advocacy organizations, and the institutional providers needed to achieve a rebalanced long-term care system).

The rebalancing benchmarks proposed by the State are subject to CMS approval as part of the approval process for the entire operational protocol. The benchmarks will be evaluated against the funding made available to the State through the enhanced match for transition demonstration participants. The State has agreed to maintain its effort through the life of the Demonstration program and should propose rebalancing efforts that will be sustained in the Medicaid system beyond the life of the Money Follows the Person Rebalancing Demonstration.

The benchmarks must be stated as measurable, annual outcomes. There are no benchmarks required for the FY 2007. Benchmarks should begin in 2008 and will continue through 2011.

B. Demonstration Implementation Policies and Procedures

1. Participant Recruitment and Enrollment.

Describe the target population(s) that will be transitioned, and the recruitment strategies and processes that will be implemented under the demonstration. Specifically, please include a narrative description that addresses the issues below. In addition, the OP must include samples of all recruitment and enrollment materials that will be disseminated to enrollees.

a. The participant selection mechanism including the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence during each fiscal year of the demonstration. Please include a discussion of: the information/data that will be utilized (i.e., use of MDS or other institutional data); how access to facilities and residents will be accomplished; and the information that will be provided to individuals to explain the transition process and their options as well as the state process for dissemination of such information.

b. The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting, the names of the facilities for the first year, and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.

c. The minimum residency period in an institutional setting and who is responsible for assuring that the requirement has been met.

d. The process (who and when) for assuring that the MFP participant has been eligible for Medicaid a month prior to transition from the institution to the community.

e. The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that lead to re-institutionalization in order to assure a sustainable transition.

f. The State's procedures and processes to ensure that participants will have the requisite information to make choices about their care. The description shall address:

   i. How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation, including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.

   ii. Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished.

2. Informed Consent and Guardianship

a. Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.

b. Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf these participants. The policy should specify the level of interaction that is required by the State. In addition, the State must

set the requirements for, and document the number of visits, the guardian has had with the participant within the last six months. This information must be available to CMS upon request.

3. Outreach/Marketing/Education

Submit the State's outreach, marketing, education, and staff training strategy. NOTE: *All marketing materials are draft until the Operational Protocol is approved by CMS.* Please provide:

a. The information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);
b. Types of media to be used;
c. Specific geographical areas to be targeted;
d. Locations where such information will be disseminated;
e. Staff training schedules, schedules for State forums or seminars to educate the public;
f. The availability of bilingual materials/interpretation services and services for individuals with special needs; and
g. A description of how eligible individuals will be informed of cost sharing responsibilities.

4. Stakeholder Involvement

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

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

5. Benefits and Services

a. Provide a description of the service delivery system(s) used for each population that the State will serve through the Money Follows the Person Rebalancing Demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (waiver, 1115 demonstration, Medicaid State Plan, etc.). For all HCBS demonstration services and supplemental demonstration services, there is no Medicaid mechanism understanding that the services terminate with the 365 day demonstration period; however, the State must detail the providers or network used to deliver services.

b. List the service package that will be available to each population served by the Demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). Do not include acute care service or institutional services that will be paid for through the regular Medicaid program. Divide the service list(s) into Qualified Home and Community-Based Program Services, HCBS demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. If any qualified Home and Community-based Services are not currently available to Medicaid recipients in the State (and are, therefore, not included in the State's maintenance of effort calculations), provide a detailed account of when and how they will be added to the Medicaid program. For HCBS demonstration services and supplemental demonstration services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.

6. Consumer Supports

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

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

7. Self-Direction (See Appendix A)

Appendix A is considered part of the Operational Protocol and is required for States using self-direction for MFP demonstration participants. An electronic copy of the form is available at http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp or can be e-mailed directly by your CMS project officer. CMS requires that adequate and effective self-directed supports are in place.

Provide a description of the self-direction opportunities under the demonstration before the Institutional Review Board (IRB) approval.

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

a. Describe how the State accommodates a participant who voluntarily terminates self-direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method.

b. Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition.

c. Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.

8. Quality

Provide a description of the State's quality management system (QMS) for demonstration participants during the demonstration year and a description of what system they will be transitioned to after the 12-month demonstration period. Regardless of the financing and/or service delivery structure proposed under the demonstration, states must demonstrate how services during the 12-month transition period will:

- be utilized to inform the CMS evaluation of the state's MFP demonstration; and
- meet or exceed the guidance for a QMS set forth under Appendix H of the 1915(c) HCBS waiver program.

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

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

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

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

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

b. If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community. The state must provide a written narrative in this section of the OP regarding how the proposed service delivery structure (1915(b), SPA, or 1115) will address the items in section (c) below.

c. The Quality Management System under the MFP demonstration must address the waiver assurances articulated in Appendix H of the 1915(c) HCBS waiver application and include:
   i. Level of care determinations;
   ii. Service plan description;
   iii. Identification of qualified HCBS providers for those participants being transitioned;
   iv. Health and welfare;
   v. Administrative authority; and
   vi. Financial accountability.

d. If the State provides supplemental demonstration services (SDS), the State must provide:
   1. A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,
   2. A description of the remediation and improvement process.

9. Housing

a. Describe the State's process for documenting the type of residence in which each participant is living (See chart for examples in Appendix B). The process should categorize each setting in which an MFP participant resides by its type of "qualified residence" and by how the State defines the supported housing setting, such as:

   i. Owned or rented by individual,
   ii. Group home,
   iii. Adult foster care home,
   iv. Assisted living facility, etc.

If appropriate, identify how each setting is regulated.

b. Describe how the State will assure a sufficient supply of qualified residences to guarantee that each eligible individual or the individual's authorized representative can choose a qualified residence in which the individual will reside. This narrative must:

   i. Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions; and

ii. Explain how the State will address any identified housing shortages for persons transitioning under the MFP demonstration grant, including:
iii. Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet these needs; and
iv. Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants.

10. Continuity of Care Post the Demonstration.

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

a. Managed Care/Freedom of Choice (Section 1915(b)) – for participants eligible for managed care/freedom of choice services, provides evidence that:

   i. Services are ensured for the eligible participants; or
   ii. A new waiver will be created.

b. Home and Community-Based (Section 1915(c)) – for participants eligible for "qualified home and community-based program" services, provide evidence that:
   i. Slots are available under the cap;
   ii. A new waiver will be created; or
   iii. There is a mechanism to reserve a specified number of slots via an amendment to the current 1915(c) waiver.

c. Research and Demonstration (Section 1115) – for participants eligible for the research and demonstration waiver services, provide evidence that:
   i. Slots are available under the cap;
   ii. A new waiver will be created; or
   iii. There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver.

d. State Plan and Plan Amendments - for participants eligible for the State plan option services, provide evidence that there is a mechanism where there would be no disruption of care when transitioning eligible participants to and from the demonstration program

C. **Organization and Administration**

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

1. Organizational Structure: Provide an organizational chart that describes the entity that is responsible for the management of this grant and 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 this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.

2. Staffing Plan: Provide a staffing plan that includes:
    a. A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director's resume.
    b. The number and title of dedicated positions paid for by the grant. Please indicate the key staff assigned to the grant.
    c. Percentage of time each individual/position is dedicated to the grant.
    d. Brief description of role/responsibilities of each position.
    e. Identify any positions providing in-kind support to the grant.
    f. Number of contracted individuals supporting the grant.
    g. Provide a detailed staffing timeline.
    h. Provide in a timeline format a brief description of staff that have been hired and staff that still need to be hired.
    i. Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.

3. Billing and Reimbursement Procedures. Describe procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.

D. Evaluation

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

1. **Evaluator:** If an evaluator has been identified, name the evaluator and provide a resume of the principle investigator in an indexed appendix. Provide a description of the process that will be used to secure an evaluator if one has not yet been identified. Also provide a description of how the State will assure that the evaluator will possess the necessary expertise to conduct a high quality evaluation. Provide a brief description of the organizational and structural administration that will be in place to implement, monitor and operate the evaluation.

2. **Evaluation Design:** Provide a description of the State's evaluation design. The description should include the following:
    a. A discussion of the demonstration hypotheses that will be tested;
    b. The outcome measures that will be included to evaluate the impact of the demonstration;
    c. The data source that will be utilized;
    d. An analysis of the methods used for data collection;
    e. The control variables (independent variables) that will be used to measure the actual effects (dependent variables) of the demonstration;
    f. The method that will be utilized to isolate the effects of the demonstration from other state initiatives and state characteristics (e.g. per capita income and/or population);

g. Any other information pertinent to the State's evaluative or formative research via the demonstration operations; and
h. Any plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction.)

3. **Variables:** Describe the demographic, health care, and functional outcome variables you propose to collect in the demonstration. Provide a copy in an indexed appendix to the application. Describe the instruments and provide a rational for their use in the evaluation including reliability, validity and appropriateness for use on the study population.

4. **Process Evaluation:** Please describe how process measures will be evaluated. Include a description of how infrastructure changes will be evaluated as well as any pilot programs.

E. Final Budget

1. MFP Budget Form: Utilizing the MFP Budget Form provided in Appendix C, include an annual budget divided into the categories described below. The MFP Budget Form is set up to have the states fill in necessary information and then CMS can use the information to automatically calculate several indicators. The only cells that should be filled in by the States are those highlighted in yellow. Most of these cells represent total cost measures. This means that the number filled in should be the ***total*** costs of the service or administrative expense (not just the enhanced portion and not just the state or federal share.

a. *Enrollees*: An unduplicated count of individuals the State proposes to transition under the demonstration. Please count the person in the year that he or she will physically transition.

b. *Services*: In each service costs section, provide cost estimates for the maximum number of participants in the demonstration project and their projected annual service costs.
   i. "Qualified home and community-based program" services (eligible for enhanced FMAP);
   ii. Home and community-based demonstration services (eligible for enhanced FMAP); and
   iii. Supplemental demonstration services (those eligible for the regular FMAP).

c. *Administrative Budget*: Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.

d. *Evaluation Budget*: Please include annual estimated costs of the evaluation activities the State is proposing.

2. Budget Presentation and Narrative: Please provide a budget presentation and narrative that provides justification for items E.1.c. and E.1.d. above. Please address the following items:
   a. Personnel
   b. Fringe benefits.
   c. Contractual costs, including consultant contracts.
   d. Indirect Charges, by federal regulation.
   e. Travel
   f. Supplies
   g. Equipment
   h. Other costs

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

II. Reporting Requirements

This section of the Instruction Guide is informational. Provided for your use is the following list of reports that are required as part of your participation in the MFP initiative. All forms, that are part of this section, will be available from your project officer and reviewed in trainings conducted during the first three months of the program. Additionally, assistance will be provided by CMS to customize the forms for your particular State and the individual services that you will offer under your demonstration program.

A. **<u>Web-based Reporting</u>** – A grantee reporting system will be designed by the CMS evaluation contractor (with Grantee input) and will be used to monitor and track the status of the State's MFP program implementation and interim outputs and outcomes. The report will consist of quantitative and qualitative information of the MFP program systems changes, (e.g., legislation, flexible funding, global budgeting, SPA or waiver amendments, demonstration outputs, and services provided including:
   1. Structures – implemented program changes to rebalance resources and transition and maintain individuals in the community, i.e., systems changes, agency changes;
   2. Processes – implemented strategies and procedures of the MFP program including States' Quality Management Strategies ;
   3. Outputs – products of the MFP program, i.e., waiver and SPA amendments, State legislation, agency changes; new policies, new procedures;
   4. Outcomes—results of the MFP program, i.e., what changed, who was transitioned, what populations, community settings where transitioned individuals moved; and
   5. Impacts – Consumer outcomes, i.e., continuity of services, and appropriateness of needs and services delivered.

Reporting period: Semi-annually.

Reported to: CMS Program office. Access will also be shared with Grants office, and CMS MFP National Evaluation and Quality Contractors.

B. **Finder files and MSIS Data Extract File:** The State is required to collect and provide to CMS participant finder files (participant Social Security Number, name) and data extract files in order to enable CMS and its evaluation contractor to acquire claims information for HCBS long-term care services while participants are in their 12 months transition period.

The evaluation contractor shall provide technical assistance to MFP States in order for them to collect and provide to CMS the data that is needed for the National MFP evaluation. This includes assisting States with: 1) the process to create the participant finder files and extract files from MSIS for MFP participants; and 2) merging demonstration participants' data back to full-Medicaid status in MSIS on the 366th day of participation. This is necessary for purposes of looking at service utilization before and after participation as well as institutional and acute care services during transition period. Potentially, this data may also be used for matching data with other administrative sources (HUD, Medicare, Social Security).

The evaluation contractor shall set criteria for coding claims, review sample data to measure the output, conduct distributional reviews to make sure that demonstration participants are correctly identified, and deliver any technical assistance necessary to States to assure that participants are being coded back to full Medicaid status seamlessly. There will be a signed data use agreement (DUA) with the National MFP evaluation contractor. The contractor shall also be responsible for drafting language for participating States' IRB clearance documents.

Reporting period: Annually
Reported to: CMS Program Office

C. **Maintenance of Effort (MOE)** - Customized, project-based MOE forms will be required each year. Templates and instructions for the MOE are in Appendix D.

Reporting period: Please submit a copy of the MOE form that was submitted with your grant application, or a revised copy if so desired by the State, to be used to construct the MOE baseline. Thereafter, the report will be required annually.

Reported to: CMS Program Office

D. Financial Reporting –

1. **Official SF-269** – The CMS Office of Acquisition and Grants Management requires the submittal of financial status reports (SF-269 or SF-269A). These forms should be submitted to the CMS Grants Management Officer with a copy to the CMS Project Officer as stipulated in the special terms and conditions. This financial status report will account for all uses of grant monies during the previous period and project uses of grant money for the ensuing period. Semi-annual reports are due 30 days after the end of the reporting period.

Reporting period: Semi-annually.
Reported to: CMS Grants Office.

2. **Official SF-272** – This form is an aggregate accounting of grantee's quarterly draws from the CMS Payment Management System. The SF-272 must be submitted 90-days after the end of each quarterly reporting period. Instructions regarding the submittal of the SF-272 were included with the original award and Notice of Grant Award.

Reporting period: Quarterly.
Reported to: Payment Management System.

3. **Money Follows the Person (MFP) Financial Reporting Form** - The MFP financial Reporting form is the accounting statement which you, in accordance with special Terms & Conditions, must submit quarterly. The MFP Financial Reporting Form will illustrate the distribution of demonstration funds reported as expenditures for beneficiaries listed as participants in the Money Follows the Person demonstration program. It will include expenditures for qualified HCBS, Supplemental, and demonstration services offered under the demonstration, as well as administrative costs that will require reimbursement from demonstration funds.

   The MFP Financial Reporting Form will be used to determine if funds used for the operation of the MFP program have been accounted for properly. Your CMS Project Officer will expect the MFP Financial Reporting Form to be an auditable support document for the SF-272. The CMS Project Officer will have access to the PMS and the submitted SF-272s.

   The amounts reported on the MFP Financial Reporting Form must be actual expenditures for which all supporting documentation is readily reviewable and has been compiled within the reporting period filed. The MFP Financial Reporting Form will be used as a statement of expenditures for which you are entitled to Federal grant funds according to the terms and conditions agreed. Consequently, the amount claimed on the MFP Financial Report is a summary of expenditures derived from source documents such as invoices, cost reports and eligibility records. All summary statements or descriptions of each claim must identify the claim and source documentation. Claims developed through the use of sampling, projections, or other estimating techniques are considered estimates and are not allowable under any circumstances.

   We have created the MFP Financial Reporting Form by modifying the CMS-64 to include information relevant to the MFP program and would like to track only the demonstration expenditures for home and community-based long-term care for demonstration participants. Demonstration expenditures for beneficiaries enrolled in the MFP demonstration and included in the MFP Financial Report **SHOULD NOT** be included in the standard CMS-64 form for services. As MFP demonstration awardees, you do not have to submit a copy of the standard CMS-64 to your CMS MFP Project Officer. The State will, however, use the standard CMS-64 to claim FFP for services that are not reimbursed from demonstration funds including acute care and institutional care.

Submission of MFP Financial Report Form.--In order to stay current and properly report your expenditures, the MFP Financial Report Form will be due 90 days after the end of each Federal fiscal quarter. The first completed quarter for the MFP demonstration is March 31, 2007.

Modifications to MFP financial form.—The MFP financial form is a draft form developed with the intention of tracking expenditures in a similar fashion to the overall Medicaid program's CMS-64. If you or CMS later determine that the form needs to be modified to include or exclude information there is an approval process in which the MFP demonstration administration will make final judgment. Participants of the MFP demonstration must consult their CMS Project Officer in writing of the request to modify, and receive approval from the MFP program before submission on a modified MFP financial form is accepted as an official submission.

Copies of the MFP Financial Reporting forms as well as additional guidance regarding the forms may be found in Appendix E.

Reporting period: Quarterly
Reported to: CMS Project Officer.

Forms Transmittal.--Submit your MFP financial form via email. If unable to send electronic copies please use one of the following options:
Money Follows the Person Demonstration Program Office
Center for Medicaid and State Operations/DEHPG/
Mail Stop S2-14-26
7500 Security Blvd.
Baltimore, MD 21224-1850
FAX: 410-786-9004

Direct inquiries concerning the MFP financial form to your MFP Project officer.

YOU MUST SUBMIT AND KEEP AN ACTUAL SIGNED COPY OF THE MFP FINANCIAL FORM IN YOUR FILES FOR EACH REPORTING PERIOD YOU PARTICIPATE IN THE MFP DEMONSTRATION.

Money Follows the Person Rebalancing Demonstration

Operational Protocol Instruction Guide

Appendix A: Self-Direction

I. Participant Centered Service Plan Development

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

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager. *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

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

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other services to the participant.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

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

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

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

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

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

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

☐	Medicaid agency
☐	Operating agency
☐	Case manager
☐	Other (*specify):*

II. Service Plan Implementation and Monitoring

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

b. Monitoring Safeguards. *Select one:*

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

III. Overview of Self-Direction

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

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

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

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

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

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

○	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

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

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

○	The State does not provide for the direction of demonstration services by a representative.	
○	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: *(check each that applies)*:	
	☐	Demonstration services may be directed by a legal representative of the participant.
	☐	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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

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

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

○	FMS are covered as a Demonstration service	Fill out i. through iv. below:	
○	FMS are provided as an administrative activity. Fill out i. through iv. below*:*		
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the activities that they perform:	
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
		Supports furnished when the participant is the employer of direct support workers:	
		☐	Assist participant in verifying support worker citizenship status
		☐	Collect and process timesheets of support workers
		☐	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		☐	Other *(specify):*
		Supports furnished when the participant exercises budget authority:	
		☐	Maintain a separate account for each participant's self-directed budget

	☐	Track and report participant funds, disbursements and the balance–of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the self-directed budget
	☐	Other services and supports *(specify)*:
	Additional functions/activities:	
	☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Other *(specify):*
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	

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

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:*
☐	**Demonstration Service Coverage**. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled:
☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish*

	these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
○	**No.** Arrangements have not been made for independent advocacy.

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

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

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

Table E-1-n		
	Employer Authority Only	**Budget Authority Only or Budget Authority in**

		Combination with Employer Authority
Demonstration Year	**Number of Participants**	**Number of Participants**
Year 1		
Year 2		
Year 3		
Year 4		
Year 5		

Participant Employer

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

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

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

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

☐	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☐	Hire staff (common law employer)
☐	Verify staff qualifications

☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
☐	Specify additional staff qualifications based on participant needs and preferences
☐	Determine staff duties consistent with the service specifications
☐	Determine staff wages and benefits subject to applicable State limits
☐	Schedule staff
☐	Orient and instruct-staff in duties
☐	Supervise staff
☐	Evaluate staff performance
☐	Verify time worked by staff and approve time sheets
☐	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

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

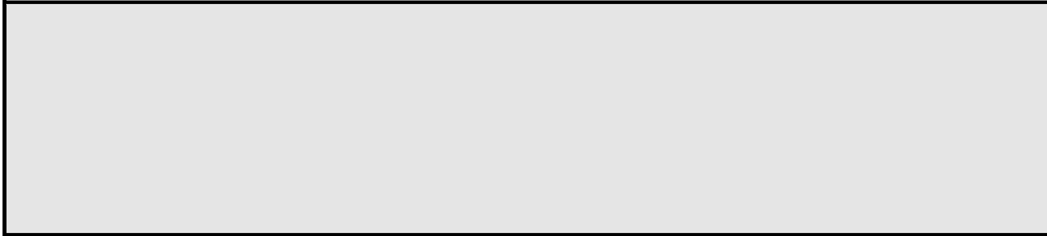
1. **Participant Decision Making Authority**. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Check all that apply:

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

2. **Participant-Directed Budget**. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method

makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

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



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

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

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

Money Follows the Person Rebalancing Demonstration

Operational Protocol Instruction Guide

Appendix B: Types of Supported Housing

Type of Qualified Residence	Number of Each Type of Qualified Residences*	State Definition of Housing Settings & Number of Each*	Number of Each Settings*	How Regulated*
Home owned or leased by individual or individual's family member	477	• Home leased by individual or family • Home owned by individual • Home owned by family	• 100 • 200 • 177	• Lease with landlord • N/A • N/A
Apartment with an individual lease, lockable access & egress, & which includes living, sleeping, bathing, & cooking areas over which the individual or the individual's family has domain & control.	477	• Apartment building • Assisted living • Public housing units	• 200 • 127 • 150	• Lease with landlord • State regulations • Public Housing Agency
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.	477	• Adult foster care • Group home	• 239 • 238	• State/agency licensing regs • Agency regs

*Numbers and terms are <u>examples</u> only.

Money Follows the Person Demonstration Program

Appendix D
Maintenance of Effort Instructions

Background

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

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

Instructions for Completing the MFP MOE Form

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

These forms will be for purposes of demonstration administration and monitoring only and will be an internal document for use by the demonstration team at the state and federal levels. As discussed in section II.D. of the Operational Protocol, reimbursement for the demonstration will actually occur through the 272 that is submitted to the payment management system by the State. The 272 form will reflect the aggregate service expenditures and the MFP Financial Reporting Forms (appendix E) will provide service specific details.

✓ **MFP MOE State Plan Services**

- Lines 1 through 4 are the same figures that the State would report on the MFP MOE Form - BASE.

- For Line 2, please specify if your State provides institutions for mental disease (IMD) services for the MFP population in the MFP MOE NARRATIVE.

- Line 5 (Clinic Services) is the amount found in Line 10 of the MFP MOE Form - BASE. The State should provide an explanation of these services (e.g. the State provides Adult Day Health services and the actual expenditures for this should be provided).

- Line 6 (Targeted Case Management for Long Term Care) is the amount found in Line 24 of the MFP MOE Form - BASE.

- Line 7 (PACE) is the amount found in Line 22 of the MFP MOE Form - BASE. The State should provide the total aggregate Medicaid rate.

- Line 8 (Rehabilitation Services) is an optional Medicaid State plan service and the State should provide additional information on the MFP MOE NARRATIVE to explain the services if the State chooses to provide these services for the MFP population.

- Line 9 (Home Health Services) is the amount found in Line 12 of the MFP MOE Form - BASE.

- Line 10 (Hospice) is the amount found in Line 26 of the MFP MOE Form - BASE.

- Line 11 (Personal Care Services) is the amount found in Line 23 of the MFP MOE Form - BASE.

- Line 12 (Other) is the actual expenditures by the State on long-term care services under the State plan. An explanation of the expenditures and the long-term care services provided should be presented on the MFP MOE NARRATIVE form.

✓ **MFP MOE FORM - WAIVER**

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

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

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

- ✓ **MFP MOE NARRATIVE**

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

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

CERTIFICATION REGARDING MAINTENANCE OF EFFORT

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

____

Signature of Authorized Certifying Official

____

Title

____

Date

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MONEY FOLLOWS THE PERSON
MAINTENANCE OF EFFORT NARRATIVE FORM

STATE QUARTER ENDED

NARRATIVE

MFP MOE NARRATIVE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATE PLAN SERVICES ONLY

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION
MAINTENANCE OF EFFORT BASE FORM

MEDICAL ASSISTANCE PAYMENTS	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE
		FMAP ____%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE	
	(a)	(b)	(c)	(d)	(e)
1. INPATIENT HOSPITAL SERVICES A. Regular Payments					
B. DSH Adjustment Payments					
2. MENTAL HEALTH FACILITY SERVICES A. Regular Payments					
B. DSH Adjustment Payments					
3. NURSING FACILITY SERVICES					
4. INTERMEDIATE CARE FACILITY SERVICES - MENTALLY RETARDED: A. PUBLIC PROVIDERS					
B. PRIVATE PROVIDERS					
5. CLINIC SERVICES*					
6. TARGETED CASE MANAGEMENT FOR LONG TERM CARE*					
7. PACE* (PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY)					
8. REHABILITATION SERVICES*					
9. HOME HEALTH SERVICES					
10. HOSPICE*					
11. PERSONAL CARE SERVICES					
12. OTHER*					

NOTE: * indicates Optional Medicaid Plan Services. Please report if your State plans to provide these services for the MFP population.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

WAIVER SERVICES ONLY

CENTERS FOR MEDICARE & MEDICAID SERVICES

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION
MAINTENANCE OF EFFORT WAIVER FORM

TYPE OF WAIVER ______________________ WAIVER NUMBER ______________________	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP _____%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	{f}
1. CASE MANAGEMENT						
2. HOMEMAKER SERVICES						
3. HOME HEALTH AIDE SERVICES						
4. PERSONAL CARE						
5. ADULT DAY HEALTH						
6. HABILITATION						
a. RESIDENTIAL HABILITATION						
b. DAY HABILITATION						
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))						
a. PREVOCATIONAL SERVICES						
b. SUPPORTED EMPLOYMENT						
c. EDUCATION						
8. RESPITE CARE						
9. DAY TREATMENT						
10. PARTIAL HOSPITALIZATION						
11. PSYCHOSOCIAL REHABILITATION						
12. CLINIC SERVICES						
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))						
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES						
15. OTHER*						

NOTE: * Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.
Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.
Alternate service titles should also be noted in the MFP MOE NARRATIVE.

Money Follows the Person Rebalancing Demonstration

Operational Protocol Instruction Guide

Appendix E:

Money Follows the Person Financial Reporting Forms

Instructions

Under the MFP demonstration, states may draw quarterly amounts equal to the MFP program established FMAP of the total amount expended during such quarter as payment for eligible demonstration expenditures. It provides that CMS reimburse you at the MFP program established FMAP rate for the quarter in which the expenditure was made.

FMAP Rate Applicable to Expenditures**.**--When reporting expenditures for Federal reimbursement under the demonstration, the MFP FMAP rate in effect at the time the expenditure was recorded in your accounting system. An expenditure occurs when a cash payment is made to a provider. The term State means any agency of the State including the State Medicaid agency, its fiscal agents, a State health agency, or any other State or local organization incurring program eligible expenditures.

Reporting Form Details

1. **General**.--In order to submit the required financial information, the CMS MFP Project Officers (PO) drafted the MFP financial reporting form. The form will capture demonstration expenditures by type of service by quarter for MFP demonstration participants. The form will vary state to state by (1) the various FMAP rates which will be determined according to information in the previous table; and (2) the specific services offered by each state for its demonstration participants. The CMS MFP PO will provide an electronic version of the form for electronic submission.

   The complete set of forms to be submitted are
   a. MFP Demonstration Financial Form a;
   b. MFP Demonstration Financial Form b; and
   c. MFP Narrative.

2. **The MFP Demonstration Financial Form.--**The columns separate demonstration expenditures into total computable payments being claimed for funding in the MFP demonstration, the amount expended by the state and the amount being claimed as Federal expenditures. The Federal expenditures reported will be itemized at the various FMAP rates.

   Report all current quarter expenditures on the *MFP Demonstration Financial Form a*, to show demonstration expenditures by type of service. For services not captured use the *MFP Demonstration Financial Form b*, to capture other types of service breakouts on line 12 “Optional Medicaid Plan Services” and line 15 “Other”. The Form CMS-64 Narrative is provided to detail descriptions of services listed on *MFP Demonstration Financial Form b*.

a. **State Plan and Waiver Services**.—The MFP financial form is a draft form developed with the intention of tracking expenditures in a similar fashion to the overall Medicaid program's CMS-64. The services listed are a subset of the services listed on the Form CMS-64. For definitions of the services please see Service Definitions in Appendix E-2.
b. **Column (a) - TOTAL COMPUTABLE** -Displays the total computable amount of MAP for the MFP Program.
c. **Column (b) – TOTAL STATE SHARE** - Displays the State share of MAP for the MFP Demonstration Services.
d. **Column (c) – Qualified HCBS Services (Enhanced)** -Displays the Statutory waiver services or state plan services that will continue once the MFP demonstration ends. Under the demonstration these services will receive enhanced FMAP.
e. **Column (d) – Demonstration Services (Enhanced)** -Displays the Statutory waiver services or state plan services that will only be offered during the up to 12 month transition period, as defined by the demonstration. Under the demonstration these services will receive enhanced FMAP.
f. **Column (e) – Supplemental Services** -Displays the service expenditures not normally covered by Medicaid but will be made available during the MFP demonstration. These services will not be billed for FMAP once the demonstration ends. All Supplemental services should be itemized under "Waiver Services, 15 Other". Please list a detailed itemization on MFP Demonstration Financial Form b and a narrative on the Form CMS-64 Narrative.
g. **Column (f) – TOTAL FEDERAL SHARE**.-Displays the Federal share of costs for the MFP Demonstration Services. This amount should be a cumulative amount equal to columns (b), (c) and (d).

MFP DEMONSTRATION FINANCIAL FORM a

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

DEMONSTRATION EXPENDITURES BY TYPE OF SERVICE
FOR THE MONEY FOLLOWS THE PERSON DEMONSTRATION PROGRAM
EXPENDITURES IN QUARTER ________________(ex. Q1-2007 = 1st Quarter of 2007)

	TOTAL COMPUTABLE	TOTAL STATE SHARE	ENHANCED FMAP		Reg. FMAP	TOTAL FEDERAL SHARE
			*Qualified HCBS _____%	**Demonstration Services _____%	***Supplemental Services _____%	
I. State Plan Services	(a)	(b)	(c)'	(d)	(e)	(f)
5. CLINIC SERVICES*						
6. TARGETED CASE MANAGEMENT FOR LONG TERM CARE*						
7. PACE* (PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY)						
8. REHABILITATION SERVICES*						
9. HOME HEALTH SERVICES						
10. HOSPICE*						
11. PERSONAL CARE SERVICES						
12. OPTIONAL MEDICAID PLAN SERVICES* (List on page 2)						
II. Waiver Services	(a)	(b)	(c)'	(d)	(e)	(f)
1. CASE MANAGEMENT						
2. HOMEMAKER SERVICES						
3. HOME HEALTH AIDE SERVICES						
4. PERSONAL CARE						
5. ADULT DAY HEALTH						
6. HABILITATION						
a. RESIDENTIAL HABILITATION						
b. DAY HABILITATION						
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))						
a. PREVOCATIONAL SERVICES						
b. SUPPORTED EMPLOYMENT						
c. EDUCATION						
8. RESPITE CARE						
9. DAY TREATMENT						
10. PARTIAL HOSPITALIZATION						
11. PSYCHOSOCIAL REHABILITATION						
12. CLINIC SERVICES						
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))						
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES						
15. OTHER* (List on page 2)						

* Qualified HCBS Services are statutory HCBS waiver services that will continue once the MFP demonstration has ended
** Demonstration Services are statutory HCBS waiver services that will only be billed during an individual's 12 month transition period.
*** Supplemental services are non-statutory HCBS waiver services that will only be available for the MFP Demonstration period.

MFP DEMONSTRATION FINANCIAL FORM b

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

DEMONSTRATION EXPENDITURES BY TYPE OF SERVICE
FOR THE MONEY FOLLOWS THE PERSON DEMONSTRATION PROGRAM
EXPENDITURES IN QUARTER ________________(ex. Q1-2007 = 1st Quarter of 2007)

	TOTAL COMPUTABLE	TOTAL STATE SHARE	ENHANCED FMAP		Reg. FMAP	TOTAL FEDERAL SHARE
			*Qualified HCBS ____%	**Demonstration Services ____%	***Supplemental Services ____%	
I. State Plan Services	(a)	(b)	(c)'	(d)	(e)	(f)
12. OPTIONAL MEDICAID PLAN SERVICES* (List from page 1)						
a.						
b.						
c.						
d.						
e.						
f.						
g.						
h.						
II. Waiver Services (List from page 1)	(a)	(b)	(c)	(d)	(e)	(f)
15. OTHER*						
a.						
b.						
c.						
d.						
e.						
f.						
g.						

* Qualified HCBS Services are statutory HCBS waiver services that will continue once the MFP demonstration has ended

** Demonstration Services are statutory HCBS waiver services that will only be billed during an individual's 12 month transition period.

*** Supplemental services are non-statutory HCBS waiver services that will only be available for the MFP Demonstration period.

MFP DEMONSTRATION FINANCIAL FORM c

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

DEMONSTRATION EXPENDITURES BY TYPE OF SERVICE
FOR THE MONEY FOLLOWS THE PERSON DEMONSTRATION PROGRAM
EXPENDITURES IN QUARTER ________________(ex. Q1-2007 = 1st Quarter of 2007)

	TOTAL COMPUTABLE	TOTAL STATE SHARE	ADMINISTRATIVE FMAP			TOTAL FEDERAL SHARE
			* Normal Rate 50%	** SPMP 75%	*** Enhanced 90%	
III. Administrative	(a)	(b)	(c)'	(d)	(e)	(f)
a.						
b.						
c.						
d.						
e.						
f.						
g.						
h.						
i.						
j.						
k.						
l.						
m.						
n.						
o.						
p.						
q.						
TOTALS						

* Administration - Normal should include all costs that adhere to CFR Title 42, Section 433(b)(7)

** Administrative Skilled Professional Medical Personnel (SPMP) - 75% should include all costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10)

*** Administrative Enhanced - 90% should include all costs that adhere to CFR Title 42 Section 433(b)(3)

Money Follows the Person Rebalancing Demonstration

Operational Protocol Instruction Guide

Appendix E-1:

Federal Medical Assistance Percentages (FMAP)

The Federal Medical Assistance Percentages (FMAP) for Fiscal Year 2007 have been calculated pursuant to the Social Security Act (the Act). These percentages will be effective from October 1, 2006 through September 30, 2007. The percentages below establish the current FMAP rate and will be used to determine the amount of Federal matching for the enhanced MFP Demonstration rates. The percentages in this chart apply to State expenditures for most medical services and medical insurance services, and assistance payments for certain social services. The statute provides separately for Federal matching of administrative costs.

STATE	FMAP (2007)	MFP Enhanced
Alabama	68.85	90
Alaska	51.07	76.6
American Samoa*	50.00	75
Arizona	66.47	90
Arkansas	73.37	90
California	50.00	75
Colorado	50.00	75
Connecticut	50.00	75
Delaware	50.00	75
District of Columbia**	70.00	90
Florida	58.76	88.1
Georgia	61.97	90
Guam*	50.00	75
Hawaii	57.55	86.3
Idaho	70.36	90
Illinois	50.00	75
Indiana	62.61	90
Iowa	61.98	90
Kansas	60.25	90
Kentucky	69.58	90
Louisiana	69.69	90
Maine	63.27	90
Maryland	50.00	75
Massachusetts	50.00	75

Michigan	56.38	84.6
Minnesota	50.00	75
Mississippi	75.89	90
Missouri	61.60	90
Montana	69.11	90
Nebraska	57.93	86.9
Nevada	53.93	80.9
New Hampshire	50.00	75
New Jersey	50.00	75
New Mexico	71.93	90
New York	50.00	75
North Carolina	64.52	90
North Dakota	64.72	90
Northern Mariana Islands*	50.00	75
Ohio	59.66	89.5
Oklahoma	68.14	90
Oregon	61.07	90
Pennsylvania	54.39	81.6
Puerto Rico*	50.00	75
Rhode Island	52.35	78.5
South Carolina	69.54	90
South Dakota	62.92	90
Tennessee	63.65	90
Texas	60.78	90
Utah	70.14	90
Vermont	58.93	88.4
Virgin Islands*	50.00	75
Virginia	50.00	75
Washington	50.12	75.2
West Virginia	72.82	90
Wisconsin	57.47	86.2
Wyoming	52.91	79.4

Money Follows the Person Rebalancing Demonstration

Operational Protocol Instruction Guide

Appendix E-2:

Service Definitions

Service Definitions

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

1. HCBS STATE PLAN SERVICE DEFINITIONS

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

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

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

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

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

Home health services. (42 CFR § 440.70)
(a) ``Home health services'' means the services in paragraph (b) of this section that are provided to a recipient--
(1) At his place of residence, as specified in paragraph (c) of this section; and
(2) On his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except as specified in paragraph (b)(3) of this section.

(b) Home health services include the following services and items. Those listed in paragraphs (b) (1), (2) and (3) of this section are required services; those in paragraph (b)(4) of this section are optional.
(1) Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency as defined in paragraph (d) of this section, or if there is no agency in the area, a registered nurse who--

(i) Is currently licensed to practice in the State;
(ii) Receives written orders from the patient's physician;
(iii) Documents the care and services provided; and
(iv) Has had orientation to acceptable clinical and administrative recordkeeping from a health department nurse.

(2) Home health aide service provided by a home health agency,
(3) Medical supplies, equipment, and appliances suitable for use in the home.
(i) A recipient's need for medical supplies, equipment, and appliances must be reviewed by a physician annually.
(ii) Frequency of further physician review of a recipient's continuing need for the items is determined on a case-by-case basis, based on the nature of the item prescribed;
(4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services. (See Sec. 441.15 of this subchapter.)

(c) A recipient's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded, except for home health services in an intermediate care facility for the mentally retarded that are not required to be provided by the facility under subpart I of part 483. For example, a registered nurse may provide short-term care for a recipient in an intermediate care facility for the mentally retarded during an acute illness to avoid the recipient's transfer to a nursing facility.

(d) ``Home health agency'' means a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in Medicare, including the capitalization requirements under Sec. 489.28 of this chapter.

(e) A ``facility licensed by the State to provide medical rehabilitation services'' means a facility that--
(1) Provides therapy services for the primary purpose of assisting in the rehabilitation of disabled individuals through an integrated program of--
(i) Medical evaluation and services; and
(ii) Psychological, social, or vocational evaluation and services; and
(2) Is operated under competent medical supervision either--
(i) In connection with a hospital; or
(ii) As a facility in which all medical and related health services are prescribed by or under the direction of individuals licensed to practice medicine or surgery in the State.

Hospice

Personal care services. (42 CFR § 440.167)

Unless defined differently by a State agency for purposes of a waiver granted under part 441, subpart G of this chapter—

(a) Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are--

(1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;

(2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and

(3) Furnished in a home, and at the State's option, in another location.

(b) For purposes of this section, family member means a legally responsible relative.

Optional Medicaid Plan services.

HCBS WAIVER SERVICE DEFINITIONS

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

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

1. *Basic homemaker services* means general household activities (meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home; or

2. *Chore Services* needed to maintain a clean, sanitary and safe environment in the home, provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

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

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

a	Assistance with eating, bathing, dressing, personal hygiene, activities of daily living and health related services. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. Personal care services may also include such housekeeping chores as bed making, dusting and vacuuming, that are essential to the health and welfare of the individual, and health-related services to the extent permitted by State law

b	A range of human assistance to enable program participants to accomplish tasks that they would normally perform for themselves if they did not have a disability. This may take the form of hands-on assistance, performing a task on behalf of the person, shadowing, or cueing to prompt the person to perform a task. Personal care services may be episodic, or provided on a continuing basis. Assistance most often relates to the performance of activities of daily living (bathing, dressing, toileting, transferring, eating, maintaining continence) and instrumental activities of daily living (more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation, transportation, grocery sopping, using the telephone, medication and money management).

c	Attendant services that include supportive and health-related services, specific to the needs of an individual with disabilities. Supportive services are those that reinforce the individual's strengths, while substituting or compensating for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant services incorporate and respond to the individual's preferences and priorities, and may include health-related services to the extent permitted by State law.

d	Adult Companion Services means non-medical care, supervision and socialization, and health-related services provided to an adult with functional disabilities. Health-related services incidental to the provision of adult companion services may be included to the extent permitted by State law. Providers may also perform light housekeeping tasks incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care.

e	Personal Emergency Response Systems (PERS) consist of an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to a telephone and programmed to signal a response center, staffed by trained individuals, once the "help" button is activated.

f	Assistive technology means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

g	Assisted living services means personal care and supportive services (homemaker, chore, attendant services, meal preparation), including 24 hour on-site response capability to meet scheduled or unscheduled needs and to provide supervision, safety and security, for individuals residing in a homelike, non-institutional setting. Services also include social and recreational activities, and medication assistance, to the extent permitted under state law. Assisted living services do not include any component of the cost of room and board. Assisted living services must be provided pursuant to a written residency agreement or contract that specifies –

i. the rights and responsibilities of the individual, including the following:

- the right to privacy;
- consistent with state regulations, the right to assume risk as specified in the contract with the provider, consistent with the ability and willingness to understand and assume responsibility for the consequences of that risk;
- the right to receive services in a way that promotes maximum respect, dignity, independence, and respects the individual;
- the rights of the provider.
- the type and services, including the degree of nursing and/or medical oversight to be furnished, and
- the terms or arrangements under which services are to be provided.

Assisted living services provided by third parties must be coordinated with the assisted living provider.

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

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

Habilitation services means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Supports should be consistent in all settings (including the place where the individual lives) and encourage and reinforce incidental learning and appropriate behavior. For individuals with degenerative conditions, habilitation may include training and supports designed to maintain skills and functioning and to prevent or slow regression to the extent possible. These services may also include any or all of the following components:
1. Home-based *(Residential) habilitation* means individually tailored adaptive skill development, assistance with activities of daily living, community inclusion, transportation, social and leisure skill development, that assist an individual to reside in the most integrated

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

2. *Day habilitation* services are a set of activities, formally identified and incorporated in an individual's plan of care, designed to promote the ability of individuals with disabilities to live more independently in the community, close to families and friends; and participate in community life. Services are furnished in an environment designed to facilitate acquisition of skills, appropriate behavior, greater independence and personal choice.

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

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

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

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

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

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

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

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

1. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

2. occupational therapy, requiring the skills of a qualified occupational therapist,

3. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

4. drugs and biologicals, not otherwise available to the individual through Medicare, furnished for therapeutic purposes,

5. individual activity therapies that are not primarily recreational or diversionary,

6. family counseling (the primary purpose of which is treatment of the individual's condition),

7. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

8. diagnostic services.

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

1. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

2. social skills training in appropriate use of community services;

3. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

4. telephone monitoring and counseling services

Clinic Services (whether or not furnished in a facility) for individuals with chronic mental illness means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that

are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(a) Services furnished at the clinic by or under the direction of a physician or dentist.

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

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