MONEY FOLLOWS THE PERSON SEMI-ANNUAL PROGRESS REPORT

A. General Information

Organization Information

1. Full Name of Grantee Organization [Text Response Requested]
2. Program's Public Name [Text Response Requested]
3. Program's Website [Text Response Requested]

Project Director

4. Project Director Name [Text Response Requested]
5. Project Director Title [Text Response Requested]
6. Project Director Phone [Text Response Requested]
7. Project Director Fax [Text Response Requested]
8. Project Director Email [Text Response Requested]
9. Project Director Status
   [Checkbox Options: Full Time, Acting, Vacant, or New Since Last Report]
10. Project Director Status Date: Change date if status is different from last report.
    [Drop Down Menu: Click on the Date Box, a Calendar Will Appear, Use Mouse to Select Date from the Calendar]

Grantee Signatory

11. Grantee Signatory Name [Text Response Requested]
12. Grantee Signatory Title [Text Response Requested]
13. Grantee Signatory Phone [Text Response Requested]
14. Grantee Signatory Fax [Text Response Requested]
15. Grantee Signatory Email [Text Response Requested]
16. Has the Grantee Signatory changed since last report?
    [Checkbox Options: Yes or No]

Other State Contact

17. Other State Contact Name [Text Response Requested]
18. Other State Contact Title [Text Response Requested]
19. Other State Contact Phone [Text Response Requested]
20. Other State Contact Fax [Text Response Requested]
21. Other State Contact Email [Text Response Requested]

Independent State Evaluator

22. Independent State Evaluator Name [Text Response Requested]
23. Independent State Evaluator Title and Organization [Text Response Requested]
24. Independent State Evaluator Phone [Text Response Requested]
25. Independent State Evaluator Fax [Text Response Requested]
26. Independent State Evaluator Email [Text Response Requested]

Report Preparer

27. Report Preparer Name [Text Response Requested]
28. Report Preparer Title [Text Response Requested]
29. Report Preparer Phone [Text Response Requested]
30. Report Preparer Fax [Text Response Requested]
31. Report Preparer Email [Text Response Requested]

CMS Project Officer

32. CMS Project Officer Name [Text Response Requested]

B. Transitions

1. Please specify your MFP program's "Other" target population(s) here. Once "Other" population has been specified in this location, it need not be specified again, and the specification will carry forward throughout the report any time "Other" target population is selected as an option. [The report will update after this page is saved.]
   [Text Response Requested]

2. Please note the characteristics and/or diagnoses of your MFP program's "Other" target population(s).
   [Text Response Requested]

3. Number of people assessed for MFP enrollment. [Click on Help link for explanation]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
First Period						
Second Period						
Total for This Year						
Cumulative Number Assessed						
Transition Targets, all grant years (by population and total)						
Cumulative Number assessed as a Percent of Total Transition Target						

Please indicate what constitutes an assessment for MFP versus any other transition program.
[Text Response Requested]

4. Of the number assessed this period, number whose stay in an institution was more than 90 days but less than six months. [This question may be skipped if data is not available.]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
First Period						
Second Period						
Total						

5. Number of institutional residents who transitioned during this reporting period and enrolled in MFP. [Click on Help link for explanation]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
First Period						
Second Period						
Total						

6. Number of institutional residents who transitioned during this reporting period and enrolled in MFP whose stay in an institution was more than 90 days but less than 6 months [Specify number in each population subgroup and Total][This question may be skipped if data is not available.]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
First Period						
Second Period						
Total						

7. The reporting system automatically calculates cumulative transitions to date from new transition counts in each reporting period. If your records show different cumulative transition counts than those below, you can change them by checking 'yes' below.

   [Checkbox Options: Yes or No]

   (If Yes) Please describe why the adjustments were necessary.

   Cumulative number of MFP transitions to date. [Click on Help link for explanation]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
Adjustment value for cumulative transitions						
Total						
Transition Targets, all grant years (by population and total)						

8. Total number of current MFP participants. [Click on Help link for explanation]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
First Period						
Second Period						
Total						

9. Number of MFP participants re-institutionalized. [Click on Help link for explanation]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
For less than 30 days						
For more than 30 days						
Length of stay as yet unknown						
Total re-institutionalized for any length of time (total of above)						
Total re-institutionalized for any length of time (total of above)						
Number of MFP participants re-institutionalized as a percent of all current MFP participants						
Number of MFP participants re-institutionalized as a percent of cumulative transitions						

Please indicate any factors that contributed to re-institutionalization.
[Text Response Requested]

10. Number of MFP participants re-institutionalized for longer than 30 days, who were re-enrolled in the MFP program during the reporting period. [Click on Help link for explanation]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
First Period						
Second Period						
Total for This Year						

11. Number of MFP participants who died this reporting period. [Click on Help link for explanation]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
First Period						
Second Period						
Total for This Year						

If you wish, please provide information on the circumstances surrounding the reported deaths.

[Text Response Requested]

12. Number of MFP participants -who ever transitioned -who completed the 365-day transition period during the reporting period (leave blank for first report). [Click on Help link for explanation]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
First Period						
Second Period						
Total for This Year						

Please indicate any factors that contributed to participants not completing the 365-day transition period.

[Text Response Requested]

13. Did your program have difficulty transitioning the projected number of persons it proposed to transition in the Operational Protocol? If yes, please check the target populations that apply.

[Checkbox options: Yes or No]

(If Yes) Please select the populations affected: Elderly, MR/DD, MI, PD, "Other"

Please describe your difficulties for each target population.

[Text Response Requested]

14. Does your state have other nursing home transition programs that currently operate alongside the MFP program?

[Checkbox options: Yes or No]

(If Yes) Please approximate the number of individuals who transitioned through other transition programs during this reporting period.
[Numeric Response Requested]

Please explain how these other transition programs differ from MFP, e.g. eligibility criteria.
[Text Response Requested]

15. Does your state have an ICF-MR transition program that currently operates alongside the MFP program?

[Checkbox options: Yes or No]

(If Yes) Please approximate the number of individuals who transitioned through other transition programs during this reporting period.
[Numeric Response Requested]

Please explain how these other transition programs differ from MFP e.g. eligibility criteria.
[Text Response Requested]

16. Do you intend to seek CMS approval to amend your annual or total Demonstration period transition benchmarks in your approved OP?

[Checkbox options: Yes or No]

(If Yes) Please explain the proposed changes to your transition benchmarks.
[Text Response Requested]

C. Qualified HCBS Expenditures

Do you require modifying the Actual Level of Spending for last period?

[Checkbox options: Yes or No]

(If Yes) Please describe why the changes were necessary.
[Text Response Requested]

Qualified expenditures are total Medicaid HCBS expenditures (federal and state funds) for all Medicaid recipients (not just MFP participants), including: expenditures for all 1915c waiver programs, home health services, and personal care if provided as a State Plan optional service, as well as HCBS spending on MFP participants (qualified, demonstration and supplemental services), and HCBS capitated rate programs to the extent that HCBS spending can be separated from the total capitated rate.

Actual level of spending for each Calendar Year (CY) or State Fiscal Year (SFY) (column 4) is the sum of:

1) HCBS expenditures for all 1915c waivers and state plan HCBS services -- from CMS 64 data and

2) MFP expenditures -- from MFP Financial Reporting Forms A and B.

Grantees should enter total annual spending once each year. When making updates or corrections to actual spending amounts reported for the previous year, please check the 'yes' box at the top of this page to flag such changes.

Calendar Year	Target Level of Spending	% Annual Growth Projected	Total Spending for the Calendar Year	% Annual Change (From Previous Year)	% of Target Reached
2006					
2007					
2008					
2009					
2010					
2011					

Please explain your Year End rate of progress:
[Text Response Requested]

Do you intend to seek CMS approval to amend your annual benchmarks for Qualified HCBS Expenditures in your approved OP?

[Checkbox options: Yes or No]

(If Yes) Please explain the proposed changes to your Qualified HCBS Expenditures benchmark.
[Text Response Requested]

D.1 Additional Benchmarks

This section requests information and data on progress made towards achieving the state's additional MFP benchmarks, at least one of which reflects the state's reinvestment of savings generated under MFP to rebalance the state's long-term care system. The information below reflects your state's additional benchmarks as described in the CMS-approved Operational Protocol. If your state has not achieved the benchmark measure for this reporting period, please use the text box below to explain the barriers or challenges that have hindered progress, and plans to address them.

Sample Benchmark #X:

Sample Measure #Y (Qualitative):

Please explain your Year End rate of progress:
[Text Response Requested]

Sample Measure #Z (Quantitative):

Year	Measure Target	Measure First Period	Measure Second Period	Measure Entire Year	% Achieved First Period	% Achieved Second Period	% Achieved Entire Year
2006							
2007							
2008							
2009							
2010							
2011							

Please explain your Year End rate of progress:
[Text Response Requested]

Do you intend to seek CMS approval to amend your additional benchmarks in your approved Operational Protocol?

[Checkbox options: Yes or No]

(If Yes) [Text Response Requested]

D.2. Rebalancing Efforts

All MFP grantees are required to complete this section during this period to report on the cumulative amount spent to date and use of rebalancing funds. MFP "Rebalancing Funds" refers to the net revenue each state receives from the enhanced FMAP rate (over the state's regular FMAP) for qualified and demonstration HCBS services provided to MFP participants. MFP grantees are required to reinvest the rebalancing funds in initiatives that will help to rebalance the long-term care system. The rebalancing fund amount is calculated on your annual Worksheet for Proposed Budget --- see "Rebalancing Fund Calculation" box in the middle of the Excel Worksheet.

On this page, enter information on expenditures and activities, whether continuing from prior reporting periods or initiated during this current reporting period, for each rebalancing initiative. If there are more than 6 rebalancing initiatives, please combine related programs and initiatives so that there are no more than 6.

If you have not spent any rebalancing funds to date, enter "$0.00" in the Total Actual Expenditures box, and in the text box, describe how your state intends to spend rebalancing funds, and indicate when the state expects to begin spending these funds.

Sample Rebalancing Initiative #X:

Name of Initiative:
[Text Response Requested]

Brief Description of the Initiative (If the grantee only has one large initiative, please list all sub-initiatives or components within this description):
[Text Response Requested]

Total Actual Expenditures for this initiative (that is, cumulative spending from start of MFP grant program through end of last calendar year)
[Numeric Response Requested]

E.1. Recruitment & Enrollment

1. Did anything change during the reporting period that made recruitment easier? Choose from the list below and check all target populations that apply. Check "None" if nothing has changed.

   [Check Box] Type or quality of data available for identification

   (If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

   Please describe by target population.
   [Text Response Requested]

   [Check Box] How data are used for identification
   (Same as previous option)

   [Check Box] Obtaining provider/agency referrals or cooperation
   (Same as previous option)

   [Check Box] Obtaining self referrals
   (Same as previous option)

   [Check Box] Obtaining family referrals
   (Same as previous option)

   [Check Box] Assessing needs
   (Same as previous option)

   [Check Box] Other, specify below
   (Same as previous option)

   [Check Box] None

2. What significant challenges did your program experience in recruiting individuals? Significant challenges are those that affect the program's ability to transition as many people as planned. Choose from the list below and check all target populations that apply.

   [Check Box] Type or quality of data available for identification

   (If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Check Box] Obtaining provider/agency referrals or cooperation

What is the current status of the issue?

[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

[Check Box] Obtaining provider/agency referrals or cooperation
(Same as previous option)

[Check Box] Obtaining self referrals
(Same as previous option)

[Check Box] Obtaining family referrals
(Same as previous option)

[Check Box] Assessing needs
(Same as previous option)

[Check Box] Lack of interest among people targeted or the families
(Same as previous option)

[Check Box] Unwilling to consent to program requirements
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

3. Did anything change during the reporting period that made enrollment into the MFP program easier? These changes may have been the result of changes in your state's Medicaid policies and procedures.

[Check Box] Determination of initial eligibility

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

[Check Box] Redetermination of eligibility after a suspension due to re-institutionalization
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

4. What significant challenges did your program experience in enrolling individuals? Significant challenges are those that affect the program's ability to transition as many people as planned.

[Check Box] Determining initial eligibility

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?

[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

[Check Box] Reestablishing eligibility after a suspension due to re-institutionalization

[Check Box] Other, specify below

[Check Box] None

5. Total number of MFP candidates assessed in this period, or a prior reporting period, who are currently in the transition planning process that is "in the pipeline," and expected to enroll in MFP.

Total [Numeric Response Requested]

6. Total number of MFP eligible individuals assessed in this period, or a prior reporting period, for whom transition planning began but were unable to transition through MFP.

   Total [Numeric Response Requested]

7. How many individuals could not be enrolled in the MFP program for each of the following reasons:

   Individual transitioned to the community, but did not enroll in MFP
   [Numeric Response Requested]

   Individual's physical health, mental health, or other service needs or estimated costs were greater than what could be accommodated in the community or through the state's current waiver programs
   [Numeric Response Requested]

   Individual could not find affordable, accessible housing, or chose a type of residence that does not meet the definition of MFP qualified residences
   [Numeric Response Requested]

   Individual changed his/her mind about transitioning, did not cooperate in the planning process, had unrealistic expectations, or preferred to remain in the institution
   [Numeric Response Requested]

   Individual's family member or guardian refused to grant permission, or would not provide back-up support
   [Numeric Response Requested]

   If necessary, please explain further why individuals could not be transitioned or enrolled in the MFP program.
   [Numeric Response Requested]

8. Number of MFP participants transitioned during this period whose length of time from assessment to actual transition took:

Less than 2 months	[Numeric Response Requested]
2 to 6 months	[Numeric Response Requested]
6 to 12 months	[Numeric Response Requested]
12 to 18 months	[Numeric Response Requested]
18 to 24 months	[Numeric Response Requested]
24 months or more	[Numeric Response Requested]

   Please indicate the average length of time required from assessment to actual transition.
   [Text Response Requested]

Percentage of MFP participants transitioned during this period whose length of time from assessment to actual transition took (denominator from total of Question #5, Transitions):

Less than 2 months	[% Provided]
2 to 6 months	[% Provided]
6 to 12 months	[% Provided]
12 to 18 months	[% Provided]
18 to 24 months	[% Provided]
24 months or more	[% Provided]

9. Total number of individuals who were referred to the MFP program through MDS 3.0 Section Q referrals during the reporting period. Please report an unduplicated count.

   Total [Numeric Response Requested]

10. Of the MDS 3.0 Section Q referrals ever received by the MFP program, number of individuals who subsequently enrolled in MFP and transitioned to the community during this reporting period.

    Total [Numeric Response Requested]

11. What types of activities were supported by ADRC/MFP Supplemental Funding Opportunity C grant funds during this reporting period, awarded in 2010 to 25 MFP grantee states to support activities that help to expand the capacity of ADRCs to assist with MFP transition efforts, and partner in utilizing the revised Minimum Data Set (MDS) 3.0 Section Q referrals? Choose from the list below. Check "Not Applicable" if your State did not receive this grant.

    [Check Box] Develop or improve Section Q referral tracking systems–electronic or other

    [Check Box] Education and outreach to nursing facility or other LTC system staff to generate referrals to MFP or other transition programs

    [Check Box] Develop or expand options counseling or transition planning and assistance

    [Check Box] Train current or new ADRC staff to do transition planning in MFP or other transition programs

    [Check Box] Expansion of ADRC program in State

    [Check Box] Other activities – please describe in text box
    [Text Response Requested]

    [Check Box] Not applicable – state did not receive this grant

12. Please describe progress in implementing the activities identified in Question # 11 during this past reporting period, and how they have helped your state achieve MFP goals. In addition, describe the results or outcomes of these activities; if you specified numerical targets in your grant proposal, please provide counts during the reporting period.

    [Text Response Requested]

13. Please describe any barriers or challenges in implementing the activities proposed in your grant application and the steps you are taking to resolve them.

    [Text Response Requested]

E. 2. Informed Consent & Guardianship

1. What changed during the reporting period that made obtaining informed consent easier?

[Check Box] Revised inform consent documents and/or forms

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

[Check Box] Provided more or enhanced training for transition coordinators
(Same as previous option)

[Check Box] Improved how guardian consent is obtained
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] Nothing
(Same as previous option)

2. What changed during the reporting period that improved or enhanced the role of guardians?

[Check Box] The nature by which guardians are involved in transition planning

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

[Check Box] Communication or frequency of communication with guardians
(Same as previous option)

[Check Box] The nature by which guardians are involved in ongoing care planning
(Same as previous option)

[Check Box] The nature by which guardians are trained and mentored
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] Nothing

3. What significant challenges did your program experience in obtaining informed consent?

[Check Box] Ensuring informed consent

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?
[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

[Check Box] Involving guardians in transition planning
(Same as previous option)

[Check Box] Communication or frequency of communication with guardians
(Same as previous option)

[Check Box] Involving guardians in ongoing care planning
(Same as previous option)

[Check Box] Training and mentoring of guardians
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

E.3. Outreach, Marketing & Education

1. What notable achievements in outreach, marketing or education did your program accomplish during the reporting period?

[Check Box] Development of print materials

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

[Check Box] Implementation of localized/targeted media campaign
(Same as previous option)

[Check Box] Implementation of statewide media campaign
(Same as previous option)

[Check Box] Involvement of stakeholder state agencies in outreach and marketing
(Same as previous option)

[Check Box] Involvement of discharge staff at facilities
(Same as previous option)

[Check Box] Involvement of ombudsman
(Same as previous option)

[Check Box] Training of frontline workers on program requirements
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

2. What significant challenges did your program experience in conducting outreach, marketing, and education activities during the reporting period?

[Check Box] Development of print materials

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?
[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

Describe the status choice
[Text Response Requested]

[Check Box] Implementation of a localized / targeted media campaign
(Same as previous option)

[Check Box] Implementation of a statewide media campaign
(Same as previous option)

[Check Box] Involvement of stakeholder state agencies in outreach and marketing
(Same as previous option)

[Check Box] Involvement of discharge staff at facilities
(Same as previous option)

[Check Box] Involvement of ombudsman
(Same as previous option)

[Check Box] Training of frontline workers on program requirements
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

E.4. Stakeholder Involvement

1. How are consumers and families involved in MFP during this period and how did their efforts contribute to MFP goals and benchmarks, or inform MFP and LTC policies?

[Check all that apply]

	Provided input on MFP policies or procedures	Helped to promote or market MFP program	Involved in Housing Development	Involved in Quality of Care assurance	Attended MFP Advisory Meeting(s)	Other (describe)
Consumers						[text response here]
Families						[text response here]
Advocacy Organizations						[text response here]
HCBS Providers						[text response here]
Institutional Providers						[text response here]
Labor/Worker Association(s)						[text response here]
Public Housing Agency(ies)						[text response here]
Other State Agencies (except Housing)						[text response here]
Non-profit Housing Assn.						[text response here]
Other (Text Response Optional)						[text response here]

Please explain the nature of consumers' and families' involvement in MFP during this period and how it contributed to MFP goals and benchmarks, or informed MFP and LTC policies

[Text Response Requested]

Please explain the nature of others' (non-consumers) involvement in MFP during this period and how it contributed to MFP goals and benchmarks, or informed MFP and LTC policies

2. On average, how many consumers, families, and consumer advocates attended each meeting of the MFP program's advisory group (the group that advises the MFP program) during the reporting period?

[Check Box] Specific Amount

Please Indicate the Amount of Attendance
[Text Response Requested]

[Check Box] Advisory group did not meet during the reporting period

[Check Box] Program does not have an advisory group

3. What types of challenges has your program experienced involving consumers and families in program planning and ongoing program administration?

[Check Box] Identifying Customers

What are you doing to address the challenges?
[Text Response Requested]

[Check Box] Identifying willing families
(Same as previous option)

[Check Box] What are you doing to address the challenges?
(Same as previous option)

[Check Box] Involving them in a meaningful way
(Same as previous option)

[Check Box] Keeping them involved for extended periods of time
(Same as previous option)

[Check Box] Communicating with consumers
(Same as previous option)

[Check Box] Communicating with families
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

4. Did your program make any progress during the reporting period in building a collaborative relationship with any of the following housing agencies or organizations?

[Check Box] State agency that sets housing policies

Please describe
[Text Response Requested]

[Check Box] State housing finance agency
(Same as previous option)

[Check Box] Public housing agency(ies)
(Same as previous option)

[Check Box] Non-profit agencies involved in housing issues
(Same as previous option)

[Check Box] Other housing organizations (such as landlords, realtors, lenders and mortgage brokers)
(Same as previous option)

5. Has your program experienced significant challenges in building a collaborative relationship with any of the agencies involved in setting state housing policies, financing, or implementation of housing programs?

   [Checkbox options: Yes or No]

   (If Yes) Please Describe
   [Text Response Requested]

E.5 Benefits & Services

1. What progress was made during the reporting period regarding Medicaid programmatic and policy issues that increased the availability of home and community-based services DURING the one-year transition period?

[Check Box] Increased capacity of HCBS waiver programs to serve MFP participants

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

[Check Box] Added a self-direction option
(Same as previous option)

[Check Box] Developed State Plan Amendment to add or modify benefits needed to serve MFP participants in HCBS settings
(Same as previous option)

[Check Box] Developed or expanded managed LTC programs to serve MFP participants
(Same as previous option)

[Check Box] Obtained authority to transfer Medicaid funds from institutional to HCBS line items to serve MFP participants
(Same as previous option)

[Check Box] Legislative or executive authority for more funds or slots or both
(Same as previous option)

[Check Box] Improved state funding for pre-transition services (such as targeted case management)
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

2. What significant challenges or barriers did your program experience in guaranteeing that MFP participants can be served in Medicaid HCBS DURING the one-year transition period?

[Check Box] Efforts to increase capacity of HCBS waiver programs to serve more individuals are delayed or disapproved

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?
[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

[Check Box] Efforts to add a self-direction option are delayed or disapproved
(Same as previous option)

[Check Box] State Plan Amendment to add or modify benefits needed to serve people in HCBS settings are delayed or disapproved
(Same as previous option)

[Check Box] Plans to develop or expand managed LTC programs to serve or include people needing HCBS are delayed or disapproved
(Same as previous option)

[Check Box] Efforts to obtain authority to transfer Medicaid funds from institutional to HCBS line items to serve people transitioning out of MFP are delayed or disapproved
(Same as previous option)

[Check Box] Legislative or executive authority for more funds or slots are delayed or disapproved
(Same as previous option)

[Check Box] State funding for pre-transition services (such as targeted case management) have been delayed or disapproved
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

E. 6. Participant Access to Services

1. What steps did your program or state take during the reporting period to improve or enhance the ability of MFP participants to access home and community based services?

[Check Box] Increased the number of transition coordinators

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

[Check Box] Increased the number of home and community-based service providers contracting with Medicaid
(Same as previous option)

[Check Box] Increased access requirements for managed care LTC providers
(Same as previous option)

[Check Box] Increased payment rates to HCBS providers
(Same as previous option)

[Check Box] Increased the supply of direct service workers
(Same as previous option)

[Check Box] Improve or increased transportation options
(Same as previous option)

[Check Box] Added or expanded managed LTC programs or options
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

2. What are MFP participants' most significant challenges to accessing home and community-based services? These are challenges that either make it difficult to transition as many people as you had planned or make it difficult for MFP participants to remain living in the community.

[Check Box] Insufficient supply of HCBS providers

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?
[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

[Check Box] Insufficient supply of direct service workers
(Same as previous option)

[Check Box] Preauthorization requirements
(Same as previous option)

[Check Box] Limits on amount, scope, or duration of HCBS allowed under Medicaid state plan or waiver program
(Same as previous option)

[Check Box] Lack of appropriate transportation options or unreliable transportation options
(Same as previous option)

[Check Box] Insufficient availability of home and community-based services (provider capacity does not meet demand)
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

E.7. Self-Direction

Did your state have any self-direction programs in effect during this reporting period?

[Checkbox options: Yes or No]

1. How many MFP participants were in a self-direction program during the reporting period?

Populations Affected					
Elderly	MR/DD	MI	PD	Other	Total

2. Of those MFP participants in a self-direction program how many:

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
Hired or supervised their own personal assistants						
Managed their allowance or budget						

3. How many MFP participants in a self-direction program during the reporting period reported abuse or experienced an accident?

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
Reported being abused by an assistant, job coach, or day program staff						
Experienced an accident (such as a fall, burn, medication error						
Other						

4. How many MFP participants in a self-direction program disenrolled from the self-direction program during the reporting period?

Populations Affected					
Elderly	MR/DD	MI	PD	Other	Total

5. Of the MFP participants who were disenrolled from a self-direction program, how many were disenrolled for each reason below?

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
Opted-out						
Inappropriate spending						
Unable to self-direct						
Abused their worker						
Other						

Are there any other comments you would like to make related to self-direction for MFP participants, or the numbers reported, during this reporting period?
[Text Response Requested]

E. 8. Quality Management & Improvement

[Check Box] Do you want the information on critical incidents in questions #8 and #9 on this page to appear in print version of the report?

1. What notable improvements did your program make to your HCBS quality management systems that affect MFP participants? These improvements may include improvements to quality management systems for your state's waiver programs.

[Check Box] Improved intra/inter departmental coordination

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

[Check Box] Implemented/Enhanced data collection instruments
(Same as previous option)

[Check Box] Implemented/Enhanced information technology applications
(Same as previous option)

[Check Box] Implemented/Enhanced consumer complaint processes
(Same as previous option)

[Check Box] Implemented/Enhanced quality monitoring protocols DURING the one-year transition period (that is, methods to track quality-related outcomes using identified benchmarks or identifying participants at risk of poor outcomes and triggering further review at a later point in time)
(Same as previous option)

[Check Box] Enhanced a critical incident reporting and tracking system. A critical incident (e.g., abuse, neglect and exploitation) is an event that could bring harm, or create potential harm, to a waiver participant.
(Same as previous option)

[Check Box] Enhanced a risk management process
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

2. How many calls did your program receive from MFP participants for emergency back-up assistance during the reporting period by type of assistance needed? Emergency refers to situations that could endanger the health or well-being of a participant and may lead to a critical incident if not addressed. (Please note this question only captures calls that were considered to be emergencies and not those that are informational or complaints.)

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
Transportation to get to medical appointments						
Life-support equipment repair/replacement						
Critical health services						
Direct service/support workers not showing up						
Other						
Total						

3. For what number of the calls received were you able to provide the assistance that was needed when it was needed?

Populations Affected					
Elderly	MR/DD	MI	PD	Other	Total

4. Did your program have to change back-up services or quality management systems due to an identified problem or challenge in the operation of your back-up systems?

   [Checkbox Options: Yes or No]

   (If Yes) Please describe the changes you have made, as well as the effectiveness of these changes

   [Text Response Requested]

5. What significant challenges did your program experience with Discovery processes? Significant challenges include difficulty identifying, in a timely fashion, incidents that place a participant at risk/danger to themselves or others.

   [Check Box] Identifying whether participants are receiving adequate supports/services

   (If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?
[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested

[Check Box] Identifying whether services/supports are delivered as intended
(Same as previous option)

[Check Box] Identifying in a timely manner when participants' health and welfare is not achieved
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None
(Same as previous option)

6. What significant challenges did your program experience with Remediation processes? Significant challenges include difficulty acting promptly to address an identified risk/danger at the individual level.

[Check Box] Addressing an identified risk/danger in a timely manner

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?
[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

[Check Box] Providing additional services when needed
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

7. What significant challenges did your program experience with Improvement processes? Significant challenges include difficulty gathering or analyzing information from Discovery activities to identify trends that affect an entire population of individuals/participants, or difficulty designing system improvements to prevent or reduce the occurrences of quality issues.

[Check Box] Gathering information to identify trends

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe the challenges

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?
[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

[Check Box] Designing system improvements
(Same as previous option)

[Check Box] Implementing system improvements
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

8. How many critical incidents occurred during the reporting period?
[Numeric Response Requested]

9. Please describe (in the text box below). Further detail regarding the nature of each critical incident may be provided with question Number 10 (below, on this page).
   [Text Response Requested]

10. Please describe the nature of each critical incident that occurred. Choose from the list below.

    [Check Box] Abuse

    Please specify the number of times this type of critical incident occurred.
    [Numeric Response Requested]

    Did the state make changes, either for the consumer(s) or its system, as a result of the analysis of critical incidents?
    [Text Response Requested]

    What is the current status of the issue?

    Check Box Options: [Resolved, In Progress, Abandoned]
    (If Resolved or Abandoned) Explain status choice

    [Check Box] Neglect
    (Same as previous option)

    [Check Box] Exploitation
    (Same as previous option)

    [Check Box] Hospitalizations

    Please specify the number of times this type of critical incident occurred.
    [Numeric Response Requested]

    Of these hospitalizations, approximately how many occurred within 30 days of discharge from a hospital or other institutional setting?
    [Text Response Requested]

    [Check Box] Emergency Room visits

    Please specify the number of times this type of critical incident occurred.
    [Numeric Response Requested]

    Of these emergency room visits, approximately how many occurred within 30 days of discharge from a hospital or other institutional setting?
    [Text Response Requested]

    [Check Box] Deaths (preventable, questionable, or unexpected)

    Please specify the number of times this type of critical incident occurred.
    [Numeric Response Requested]

Did the state make changes, either for the consumer(s) or its system, as a result of the analysis of critical incidents?
[Text Response Requested]

What is the current status of the issue?

Check Box Options: [Resolved, In Progress, Abandoned]
(If Resolved or Abandoned) Explain status choice

[Check Box] Involvement with the criminal justice system
(Same as previous option)

[Check Box] Medication administration errors
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

Are there any other comments you would like to make related to quality management for MFP participants, or the numbers reported, during this reporting period?
[Text Response Requested]

E. 9. Housing for Participants

1. What notable achievements in improving housing options for MFP participants did your program accomplish during the reporting period?

[Check Box] Developed inventory of affordable and accessible housing

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe the achievements
[Text Response Requested]

[Check Box] Developed local or state coalitions of housing and human service organizations to identify needs and/or create housing-related initiatives
(Same as previous option)

[Check Box] Developed statewide housing registry
(Same as previous option)

[Check Box] Implemented new home ownership initiatives
(Same as previous option)

[Check Box] Improved funding or resources for developing assistive technology related to housing
(Same as previous option)

[Check Box] Improved information systems about affordable and accessible housing
(Same as previous option)

[Check Box] Increased number of rental vouchers
(Same as previous option)

[Check Box] Increased supply of affordable and accessible housing
(Same as previous option)

[Check Box] Increased supply of residences that provide or arrange for long term services and/or supports
(Same as previous option)

[Check Box] Increased supply of small group homes
(Same as previous option)

[Check Box] Increased/Improved funding for home modifications
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

2. What significant challenges did your program experience in securing appropriate housing options for MFP participants? Significant challenges are those that affect the program's ability to transition as many people as planned or to keep MFP participants in the community.

   [Check Box] Lack of information about affordable and accessible housing

   (If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

Please describe the challenges

Please describe by target population
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?
[Check Box Options: Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

[Check Box] Insufficient supply of affordable and accessible housing
(Same as previous option)

[Check Box] Lack of affordable and accessible housing that is safe
(Same as previous option)

[Check Box] Insufficient supply of rental vouchers
(Same as previous option)

[Check Box] Lack of new home ownership programs
(Same as previous option)

[Check Box] Lack of small group homes
(Same as previous option)

[Check Box] Lack of residences that provide or arrange for long term services and/or supports

(Same as previous option)

[Check Box] Insufficient funding for home modifications

(Same as previous option)

[Check Box] Unsuccessful efforts in developing local or state coalitions of housing and human services organizations to identify needs and/or create housing related initiatives

(Same as previous option)

[Check Box] Unsuccessful efforts in developing sufficient funding or resources to develop assistive technology related to housing

(Same as previous option)

[Check Box] Other, specify below

(Same as previous option)

[Check Box] None

3. How many current MFP participants are living in each type of qualified residence as of the end of the reporting period? [This question is optional.]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
Home (owned or leased by individual or family)						
Apartment (individual lease, lockable access, etc)						
Group home or other residence in which 4 or fewer unrelated individuals live						

4. How many MFP participants who transitioned to the community during the reporting period moved to each type of qualified residence? [This question is required.]

	Populations Affected					
	Elderly	MR/DD	MI	PD	Other	Total
Home (owned or leased by individual or family)						
Apartment (individual lease, lockable access, etc)						
Group home or other residence in which 4 or fewer unrelated individuals live						

5. Have any MFP participants received a housing supplement during the reporting period? Choose from the list of sources below and check all target populations that apply.

[Check Box] 202 funds

(If checkbox above is selected)

Populations Affected				
Elderly	MR/DD	MI	PD	Other

[Check Box] CDBG funds
(Same as previous option)

[Check Box] Funds for assistive technology as it relates to housing
(Same as previous option)

[Check Box] Funds for home modifications
(Same as previous option)

[Check Box] HOME dollars
(Same as previous option)

[Check Box] Housing choice vouchers (such as tenant based, project based, mainstream, or homeownership vouchers)
(Same as previous option)

[Check Box] Housing trust funds
(Same as previous option)

[Check Box] Low income housing tax credits
(Same as previous option)

[Check Box] Section 811
(Same as previous option)

[Check Box] USDA rural housing funds
(Same as previous option)

[Check Box] Veterans Affairs housing funds
(Same as previous option)

[Check Box] Text Response
(Same as previous option)

[Check Box] None

Are there any other comments you would like to make related to housing for MFP participants, or the numbers reported, during this reporting period?
[Text Response Requested]

F. Organization & Administration

1. Were there any changes in the organization or administration of the MFP program during this reporting period? For example, did Medicaid agency undergo a reorganization that altered the reporting relationship of the MFP Project Director?

   [Checkbox options: Yes or No]

   (If Yes) Please describe the changes.
   [Text Response Requested]

2. What interagency issues were addressed during this reporting period?

   [Check Box] Common screening/assessment tools or criteria

   Which agencies were involved?
   [Text Response Requested]

   [Check Box] Common system to track MFP enrollment across agencies
   (Same as previous option)

   [Check Box] Timely collection and reporting of MFP service or financial data
   (Same as previous option)

   [Check Box] Common service definitions
   (Same as previous option)

   [Check Box] Common provider qualification requirements
   (Same as previous option)

   [Check Box] Financial management issues
   (Same as previous option)

   [Check Box] Quality assurance
   (Same as previous option)

   [Check Box] Other, specify below
   (Same as previous option)

   [Check Box] None

3. Did your program have any notable achievements in interagency communication and coordination during the reporting period?

   [Checkbox options: Yes or No]

   (If Yes) What were the achievements in?
   [Text Response Requested]

4. What significant challenges did your program experience in interagency communication and coordination during the reporting period?

[Check Box] Interagency relations

Please describe the challenges. What agencies were involved?
[Text Response Requested]

What are you doing to address the challenges?
[Text Response Requested]

What is the current status of the issue?

Check Box Options: [Resolved, In Progress, Abandoned]

(If Resolved or Abandoned) Explain status choice
[Text Response Requested]

[Check Box] Privacy requirements that prevent the sharing of data
(Same as previous option)

[Check Box] Technology issues that prevent the sharing of data
(Same as previous option)

[Check Box] Transitions in key Medicaid staff
(Same as previous option)

[Check Box] Transitions in key staff in other agency
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

G. Challenges & Developments

1. What types of overall challenges have affected almost all aspects of the program?

[Check Box] Downturn in the state economy

Please Describe
[Text Response Requested]

[Check Box] Worsening state budget
(Same as previous option)

[Check Box] Transition of key position(s) in Medicaid agency
(Same as previous option)

[Check Box] Transition of key position(s) in other state agencies
(Same as previous option)

[Check Box] Executive shift in policy
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

2. What other new developments, policies, or programs (in your state's long-term care system) have occurred that are not MFP initiatives, but have affected the MFP demonstration program's transition efforts?

[Check Box] Institutional closure/downsizing initiative

Please Describe
[Text Response Requested]

[Check Box] New/revised CON policies for LTC institutions
(Same as previous option)

[Check Box] New or expanded nursing home diversion program
(Same as previous option)

[Check Box] Expanded single point-of-entry/ADRC system
(Same as previous option)

[Check Box] New or expanded HCBS waiver capacity
(Same as previous option)

[Check Box] New Medicaid State Plan options (DRA or other)
(Same as previous option)

[Check Box] New managed LTC options (PACE, SNP, other), or mandatory enrollment in managed LTC
(Same as previous option)

[Check Box] Other, specify below
(Same as previous option)

[Check Box] None

H. Independent Evaluation

1. Is your state conducting an independent evaluation of the MFP program, separate from the national evaluation by Mathematica Policy Research?

   [Checkbox options: Yes or No]

   (If Yes) Please explain the proposed changes to your Qualified HCBS Expenditures benchmark.
   [Text Response Requested]

2. Were there any outputs/products produced from the independent state evaluation (if applicable) during this period?

   [Checkbox options: Yes or No]

   (If Yes) Please explain the proposed changes to your Qualified HCBS Expenditures benchmark.
   [Text Response Requested]

I. State-Specific Technical Assistance

What type of state-specific programmatic TA did you receive during the reporting period? This could include TA provided to a group of states. Do not use this section to report on all-grantee meetings or events. Add an event for each type of issue (quality, housing, self-direction, other programmatic issues, evaluation, and data management/submission; any others) and indicate how the TA was delivered (group by teleconference, group in person, individual by telephone, individual in person, or peer-to-peer). You may add more than one event of the same type to indicate different delivery methods.

Sample TA Event #X:

List of Technical Assistance Events for this Reporting Period

Date	[Text Response Requested]
Type	[Text Response Requested]
Delivery Method	[Text Response Requested]
Describe the focus of the TA you received	[Text Response Requested]
Usefulness	[Text Response Requested]
If useful, describe what changed as a result. – if not useful, explain why.	[Text Response Requested]

J. Overall Lessons & MFP-related LTC System Change

Are there any other comments you would like to make regarding this report or your program during this reporting period?

[Text Response Requested]