Money Follows the Person (MFP) Demonstration
Program Terms and Conditions

I. Preface

The following are the Program Terms and Conditions ("PTCs") for the Money Follows the Person (MFP) demonstration ("demonstration"), to enable the "Recipient" as identified on line 1 of the Notice of Award (NoA) to operate the demonstration.

The requirements contained in the Notice of Funding Opportunity (NOFO), FON# CMS-1LI-22-001, is incorporated by reference as Program Terms and Conditions attached to this NoA. In the event of any inconsistency between the provisions of these Program Terms and Conditions and the provisions of the NOFO, the provisions of these Program Terms and Conditions must prevail.

These PTCs are in effect from January 1, 2022 through the project period end date identified on line 19 of the Recipient's NoA. The demonstration period for the Recipient is the date of the period of performance issued in the Recipient's NoA.

The PTCs have been arranged into the following subject areas:

I. Preface
II. Program Authority and Objectives
III. General Program Requirements
IV. General Participant Eligibility Requirements
V. MFP Qualified Home and Community-Based Services
VI. Allowable and Required Services and Activities
VII. Quality Assurance and Quality Improvement
VIII. Operational Protocol
IX. General Reporting Requirements

Additional attachment(s) have been included to provide supplementary information and guidance for specific PTCs:

Attachment A Description of MFP Qualified Home and Community-Based Services (HCBS)

II. Program Authority and Objectives

The authority for the MFP demonstration is section 6071 of the Deficit Reduction Act of 2005 (DRA). Section 6071 of the DRA has been amended by: section 2403 of Patient Protection and Affordable Care Act; section 2 of the Medicaid Extenders Act of 2019; section 5 of the Medicaid Services Investment and Accountability Act of 2019; section 4 of the Sustaining Excellence in Medicaid Act of 2019; section 205 of the Further Consolidated Appropriations Act, 2020 (CAA); section 3811 of the Coronavirus Aid, Relief, and Economic Security Act, 2020; section 2301 of the Continuing Appropriations Act, 2021 and Other Extensions Act; section 1107 of the Further Continuing Appropriations Act, 2021, and Other Extensions Act; and section 204 of the Consolidated Appropriations Act, 2021 (CAA).

As stated in section 6071(a) of the DRA, the program purposes and objectives of MFP are:

> (1) Increase the use of HCBS, rather than institutional long-term services and supports (LTSS), in the Medicaid program;
> (2) Eliminate barriers or mechanisms, whether in 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 LTSS in the settings of their choice;
> (3) Increase the ability of state Medicaid programs to assure continued provision of HCBS to eligible individuals who choose to transition from an institution to a community setting; and
> (4) Ensure that procedures are in place (at least comparable to those required under the qualified HCBS program) to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services.

III. General Program Requirements

1. Adequacy of Infrastructure. The Recipient will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including outreach and enrollment; maintaining eligibility systems; timely access to HCBS waiver programs and state plan HCBS; effective transition coordination; and reporting on financial, quality measures, and other demonstration components. The state must assure access to an approved Medicaid HCBS program for MFP participants during the 365-day enrollment period or 366-day enrollment period in a leap year, if applicable.

2. Communication. The Recipient must have and maintain an account with GrantSolutions (GS) in order to communicate, receive, and obtain documentation from CMS. If the designated Recipient Authorized Organizational Representative (AOR) and the principal investigator/program director (PI/PD) do not already have accounts in GS, the Recipient must require the individual to contact GS immediately upon receipt of award to complete a user account form. Any change in personnel with access to GS must also be communicated to CMS and GS staff so that the key responsible individuals are current and correct within the GS system.

3. Program Guidance. The Recipient must operate their MFP program in accordance with MFP program guidance, which includes but is not limited to, MFP instructions, MFP frequently asked questions and answers, or other guidance posted on the CMS Medicaid.gov MFP webpage to support the efficient administrative and operational components of the demonstration and award.

4. Operational Protocol. The Recipient must develop and amend as necessary an Operational Protocol (OP) that details how the state will adhere to statutory and program requirements as specified in section VIII of these PTCs.

5. Public Development Process. Similar to the requirement in section 6071(c)(1) of the DRA for MFP applications, the Recipient must provide assurance that it has engaged, and will continue to engage, in a public development/stakeholder engagement process. Recipients are expected to engage a broad community of stakeholders, including but not limited to, Medicaid agency leadership, participants in HCBS programs, residents in

long-term care facilities, family members and other caregivers, HCBS providers, the aging and disability network, health plans, housing providers, and the direct care workforce, to inform the state's approach to the design of the MFP demonstration, delivery of services and activities, and the ways in which the state can leverage the MFP demonstration to expand and enhance the HCBS system. The public development/stakeholder engagement process must be documented in the OP.

6. CMS Program Monitoring. CMS will assign a specific Project Officer to the Recipient to discuss ongoing demonstration operations, including but not limited to actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on program performance, transition benchmark achievements, supplemental budgetary spending, and progress on HCBS capacity building and rebalancing initiatives. This program monitoring may be conducted by phone, document review, on-site visit, or other appropriate means, such as by reviewing program progress reports. CMS will provide updates on any programmatic aspect of the demonstration, as well as federal policies and issues that may affect the demonstration. The Recipient and CMS will meet at a minimum once a month via a call, except in cases when a legal holiday or an unexpected state or federal business disruption may occur. CMS and the Recipient will jointly develop the agenda for the calls. This monitoring will serve to assess compliance with program requirements.

7. State Monitoring. The Recipient must conduct monitoring and oversight of the MFP demonstration operational activities, including, but not limited to:

a. The Recipient must monitor the services delivered under the demonstration using appropriate quantitative and qualitative measures.
b. The Recipient must monitor the quality and cost-effectiveness of program operations and the delivery of services.
c. The Recipient must implement processes for identifying issues, communicating issues to the appropriate entities, and taking corrective action.

8. Person-Centered Planning. The Recipient must use person-centered planning processes to identify MFP participants' LTSS needs, and the resources available to meet those needs, and to provide access to additional service and support options as needed. The Recipient assures that it will use person centered planning tools in compliance with the characteristics set forth in 42 C.F.R. § 441.301(c)(1)-(3).

9. MFP Service Area(s) and Target Populations. Consistent with the requirements in section 6071(c)(4) and section 6071(c)(5) of the DRA for MFP applications, the Recipient is required to specify the MFP participant target population(s) they plan to recruit and enroll in the demonstration program and to specify the geographic service area(s) of the demonstration. Individuals targeted for program participation must meet the eligibility criteria set forth in section 6071(b)(2) of the DRA, and as described in section IV of these PTCs. Additionally, the Recipient is required to specify the projected numbers of eligible individuals in each target group for each year of the demonstration program. The Recipient must also describe the target population(s). The Recipient must include all of the information stated in this paragraph in its OP.

10. Corrective Action Plan. If the Recipient does not comply with the Program Terms and Conditions of the demonstration, CMS may issue a Corrective Action Plan (CAP).

The CAP will identify the compliance concerns and summarize actions to date; detail possible enforcement actions; recommend steps, solutions, and deadlines for addressing the concern; and require the Recipient to submit a written plan to address the compliance concerns in response to the CAP. Failure to comply with these requirements may be a basis for applying a CAP in addition to the consequences defined in Standard Terms and Conditions (STC) 4 and STC 26.

IV. General Participant Eligibility Requirements

11. Individual Eligibility. An individual must meet certain MFP eligibility requirements to qualify for participation in the MFP demonstration. An individual must reside in an MFP-qualified inpatient facility as described in PTC 13 and must meet the definition of "eligible individual" in section 6071(b)(2) of the DRA.

12. Income Eligibility. Section 6071(d)(3) of the DRA expressly authorizes the waiver of the income and resource eligibility rules at section 1902(a)(10)(C)(i)(III) of the Social Security Act in order to permit a Recipient to apply institutional eligibility rules to individuals transitioning to community-based care.

13. Inpatient Facility. As defined by section 6071(b)(3) of the DRA, the term "inpatient facility" means "a hospital, nursing facility, or intermediate care facility for individuals with [intellectual or developmental disabilities]. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution."

14. Institution for Mental Diseases (IMD) Exclusion. The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services**.** The paragraph following section 1905(a)(31)(B) of the Social Security Act generally prohibits states from receiving "any [Medicaid] payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an [IMD]." Medicaid beneficiaries ages 21 through 64 residing in an IMD who are receiving services that are covered under a Substance Use Disorder or Serious Mental Illness section 1115 demonstration and who meet the MFP individual eligibility criteria may transition from an IMD to the community under the demonstration.

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

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

V. MFP Qualified Home and Community-Based Services (HCBS).

16. Qualified HCBS. Section 6071(b)(5) of the DRA defines "qualified HCB program" as follows: "The term 'qualified HCB program' means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority."

The qualified HCBS program[1] is the Medicaid service package(s) that the Recipient will make available to a demonstration participant when they move to a community-based residence. This program can be comprised of any Medicaid home and community-based state plan and waiver program services. Awardees are permitted to claim an MFP-enhanced match rate as described in PTC 22 for the first 365-day post-transition period or 366-day enrollment period in a leap year, if applicable for qualified HCBS for demonstration participants who transition from an institutional LTSS setting into the community. A list of MFP-qualified HCBS is included as Attachment A.

17. MFP Demonstration Services. MFP demonstration services are qualified HCBS that could be provided, but are not currently provided, under the Recipient's Medicaid program. See Attachment A for a list of qualified HCBS. MFP demonstration services may be helpful to recipients in states that do not have comprehensive transition services included in HCBS waiver programs or in the State Plan.

The Recipient is expected to test and offer MFP Demonstration Services specific to the state's demonstration for MFP participants. These MFP Demonstration Services must be identified through a person-centered planning process. Demonstration Services are reimbursed at an MFP-enhanced match rate. MFP Demonstration Services are not required to continue after the conclusion of the MFP demonstration program or for the participant, at the end of the 365-day enrollment period (or 366-day enrollment period, in the case of a leap year). The Recipient must submit demonstration service descriptions in the OP. Recipients must submit an amendment to the OP when adding or removing MFP Demonstration Services.

18. Self-Directed Supports. The Recipient must provide resources to support participants or the participant's authorized representative (e.g., a surrogate, parent, or legal guardian) in directing their own care when that care is provided by an individual provider. If the Recipient elects to provide self-directed services (as defined in section 6071(b)(8) of the DRA) under the MFP demonstration, the Recipient must provide assurances that the services meet the requirements set forth in section 6071(c)(12) of the DRA in its OP.

19. Continuity of Qualified HCBS. In accordance with section 6071(c)(2) of the DRA, the MFP demonstration must operate in conjunction with a qualified HCBS program to assure continuity of services for eligible individuals. The demonstration operates in conjunction with a qualified HCBS program that is in operation in the state for such

[1] For the purposes of these PTCs, CMS will use the term "HCBS program" when referencing section 6071 of the DRA definition of an "HCB program".

individuals in a manner that assures continuity of Medicaid coverage for such individuals so long as such individuals continue to be eligible for medical assistance and meet the program requirements for the receipt of HCBS.

20. Home and Community-Based Setting Requirements. The Recipient must ensure that home and community-based settings have all the qualities required by 42 C.F.R. § 441.301(c)(4)(i), and other such qualities that the Secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by 42 C.F.R. § 441.301(c)(4)(vi) must be met. Specific to this demonstration, section 6071(b)(6)(C) of the DRA ("a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside") applies.

21. Informed Choice. Consistent with section 6071(c)(6) of the DRA, CMS will require that individuals identified as potential demonstration participants have been provided with individual choice regarding participation in the demonstration. Specific requirements must be addressed in the OP, for assurances and proposed processes that ensure:

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

22. MFP-Enhanced FMAP. Qualified HCBS and demonstration services (see PTC 16 and 17) receive MFP-enhanced reimbursement. The "MFP-enhanced FMAP" for a state, for a fiscal year (as defined in section 6071(e)(5) of the DRA), is equal to the published FMAP for the state, increased by a number of percentage points equal to 50 percent of the number of percentage points by which the FMAP for the state is less than 100 percent; but, in no case shall the MFP-enhanced FMAP for a state exceed 90 percent.

The MFP-enhanced FMAP rate may be applied to qualified HCBS and MFP demonstration services under a fee-for-service or managed care delivery system. A state may not claim the MFP-enhanced FMAP for any expenditures other than those listed in Attachment A.

The Recipient must develop and administer appropriate billing methodologies and controls for qualified HCBS and demonstration services eligible for the MFP-enhanced FMAP. The Recipient will not submit claims for demonstration expenditures through the Medicaid Budget and Expenditure System (MBES); however, the Recipient is expected to include aggregate expenditures in the MBES under the CMS 64.9i and 10i and 10Pi (as needed) forms. The Recipient must continue to submit non-demonstration expenditures for MFP participants on the regular CMS 64 form.

VI. Allowable and Required Services and Activities

23. Transition Coordination Services. Consistent with section 6071(c)(6) of the DRA, the Recipient must provide comprehensive person-centered transition coordination services that includes the provision of housing-related supports to assist an MFP participant to locate and secure MFP-qualified accessible, affordable community-based housing. Recipients have flexibility in defining the specific set of services that satisfy the following components:

- Person-centered service planning;
- Comprehensive transition services;
- Care coordination; and
- Promotion of community-integration.

The Recipient must include state-selected performance measures in the Work Plan subject to CMS review and approval to monitor and report on the performance of transition coordination services and housing-related supports, identify opportunities for service improvement, and provide a measure of progress toward achieving program goals around the provision of these services. The Recipient will report on the performance measures in the Work Plan as described in PTC 49. The Recipient agrees to participate in a CMS-sponsored housing-related services and supports learning collaborative at date(s) specified by CMS. The MFP project director and MFP programs employing MFP housing specialist(s) and/or housing coordinator(s) are expected to participate.

24. Supplemental Services. Supplemental services are short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Supplemental services are not expected to continue after the demonstration period or MFP participants' 365-day enrollment period(s) or 366-day enrollment period in a leap year, if applicable, following an inpatient facility stay of over 60 continuous days. Federal funding is available to cover 100 percent of supplemental services. The Recipient must submit supplemental service descriptions in the OP. Recipients must submit an amendment to the OP when adding or removing supplemental services. Certain supplemental services have additional requirements that the Recipient must adhere to when implementing the service. These requirements will be issued in MFP policy guidance documents. The Recipient must describe how the requirements are to be met in the OP.

25. **Administrative Activities—Program Operations.** The Recipient shall use demonstration administrative funding to cover expenses required to execute the planning and operation of the program. This includes making investments in technology, tools, stakeholder engagement, marketing, and human resources that will allow the state program to build capacity to serve MFP target populations and pursue program goals in accordance with state priorities and the objectives of the MFP demonstration. MFP funding is available to cover up to 100 percent of the cost of administrative activities directly attributable to the operation of the state's MFP demonstration. Examples of reimbursable activities include MFP travel expenses, training, outreach and marketing, IT

infrastructure to accommodate MFP financial and evaluation reporting requirements, and key personnel.[2]

26. Administrative Activities—Required Personnel. The Recipient must fund two full-time equivalent (FTE) positions to operate and administer the program: (1) MFP project director; and (2) MFP data and quality analyst. MFP grant funding is available to cover up to 100 percent of the cost of these two FTE personnel positions.

a. MFP Project Director: The Recipient shall ensure the continuous employment of a dedicated full-time equivalent MFP project director through the end of the Recipient's period of performance. CMS expects the Recipient to hire an MFP project director with sufficient Medicaid and long-term services and supports experience to develop, monitor, and operationalize the administrative and financial obligations of the demonstration as well as having the necessary skills to implement MFP and HCBS infrastructure activities and state system relationship building. A full-time equivalent MFP project director may include one of the following position types:

- A full-time (1.0 full-time equivalent (FTE)) state employee;
- A full-time (1.0 FTE) contracted personnel position with an employee/employer relationship with the state grant administering department; or
- A full-time (1.0 FTE) university position within a university organization that is recognized as a state entity with a memorandum of agreement with the Recipient or state administering department.

The Recipient must submit a prior approval request, specifically a principal investigator/program director (PI/PD) amendment in GrantSolutions to include the MFP project director resume or Curriculum Vitae. The resume must include a description of relevant work experience demonstrating program management experience pertaining to Medicaid LTSS; a description of budget, finance, communication, and technology skills; and a description of leadership and partnership building experience.

Should the named MFP project director discontinue full-time employment, the Recipient must submit an interim plan prior to the position vacancy to CMS on how the Recipient will assure the continuation of demonstration administration and operations while the state pursues, within a reasonable time-frame, the hiring of a new MFP project director. The Recipient must submit a prior approval for any new MFP project director applicant subject to the same terms as described above. This would include an interim or temporary PI/PD.

b. MFP Data and Quality Analyst: The Recipient shall ensure the continuous employment of a dedicated full-time equivalent MFP data and quality analyst through the end of the period of performance. CMS expects the Recipient to hire an MFP data and quality analyst with sufficient data quality skills to perform data quality measurement and metric generation, data aggregation into quality performance indicators, and data interpretation,

[2]Key personnel (wt): individuals, in addition to the principal investigator/program director (PI/PD) and the authorized organizational representative (AOR), identified by the OPDIV in the Notice of Award (NoA) that are considered critical to the project, i.e., their removal or absence from the project would have a significant impact on the approved project. The AOR who has the delegated authority to execute decisions on behalf of the recipient and the PI/PD are always considered both a "key person" and a "principal", as defined below. Other key personnel generally are not considered "principals" for purposes of suspension and debarment.

as well as the ability to develop various data reporting structures and formats. A full-time equivalent MFP data and quality analyst may include one of the following position types:

- A full-time (1.0 FTE) state employee;
- A full-time (1.0 FTE) contracted personnel position with an employee/employer relationship with the state grant administering department; or
- A full-time (1.0 FTE) university position within a university organization that is recognized as a state entity with a memorandum of agreement with the state grant administering department.

27. Administrative Activities—Additional Uses of Funds to Expand and Enhance the State's HCBS System. The Recipient may use award funding for administrative activities to expand and enhance the state's HCBS system under the Medicaid program. The Recipient must describe administrative activities to expand and enhance the state's HCBS system in the OP and must follow applicable reporting requirements as described in PTC 41. MFP funding is available to cover up to 100 percent of the cost of administrative activities to implement the state's MFP project and to expand and enhance the state's HCBS system.

28. National Evaluation. The Recipient must cooperate with CMS and the CMS-directed national program evaluation's contractor tasked with the evaluation of the MFP demonstration. As required under section 6071(g)(2) of the DRA, the Secretary must submit a final report to the President and Congress not later than September 30, 2026, and section 6071(i)(1) of the DRA requires the Secretary to submit a Best Practices Report not later than September 30, 2022, providing the findings and conclusions on the conduct and effectiveness of the MFP demonstration and best practices from MFP state demonstration projects. The Recipient will be required to provide information and data to inform the CMS Evaluation Reports in a form and manner and by a deadline specified by CMS.

29. Cooperation with the Contractor for Quality Assurance and Improvement, and Technical Assistance and Oversight. The Recipient must fully cooperate with the CMS-designated contractor to support quality assurance and improvement, oversight, and technical assistance activities. The Recipient must participate in certain technical assistance activities and venues as directed by CMS throughout the Recipient's period of program performance.

30. Annual MFP Intensive Meeting. The Recipient agrees to attend an annual meeting of MFP demonstration projects for the duration of the Recipient's period of program performance. The location, date, and time of the meeting is to be determined. Grant award funds may be used to cover expenses associated with attending an annual meeting of MFP demonstration projects. The MFP project director and the MFP data and quality analyst are expected to attend.

VII. Quality Assurance and Quality Improvement

31. Quality Management Strategy and Plan. In accordance with section 6071(c)(11)(A) of the DRA, Recipients are required to develop and implement a

comprehensive and integrated quality management strategy and plan, subject to CMS review and prior approval. The plan will focus on quality assurance and quality improvement for HCBS under the state Medicaid program, including a plan to assure the health and welfare of individuals participating in the MFP demonstration. Such a strategy enhances the state's capacity to assure that the LTSS system operates as designed and that the critical processes of discovery, remediation, and systems improvement occur in a structured and routine manner.

The plan must include targeted system performance requirements to which the critical processes apply, aligning with assurances defined within the section 1915(c) HCBS waiver program, including that 1) the state conducts level of care need determinations consistent with the need for institutionalization; 2) plans of care are responsive to participants' needs; 3) qualified providers serve participants; 4) health and welfare of participants is protected; (5) State Medicaid Agency retains administrative authority over the program; and (6) the state provides financial accountability of the program.

32. 24-Hour Back-Up System. The quality management plan must include a 24-hour back-up system for critical services. The plan should address, at a minimum, the back-up systems related to (1) critical services, (2) transportation, (3) direct care workers, (4) repair and replacement for durable medical equipment (DME) and other equipment (including provision of loaning equipment while repairs are being made), and (5) access to medical care (including how participants are assisted with initial appointments, how to make appointments, and how to resolve appointment or care issues). The Recipient must describe how the requirement will be met in the OP.

33. **Continuous Quality Improvement.** To ensure that procedures are in place and comparable to those required under Medicaid's qualified HCBS program, the Recipient will be required to implement a CMS-defined set of nationally standardized HCBS quality measures to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services. See PTC 43 for reporting requirements on the HCBS quality measures.

34. Continuous Quality Improvement Technical Assistance. In accordance with section 6071(f) of the DRA, technical assistance will be available under MFP to support the Recipient in developing a comprehensive quality management strategy to include use of data collection tools and resources, reporting, data quality monitoring, and program evaluation methods. The MFP Quality and Data Analyst must participate in quality improvement technical assistance activities.

VIII. Operational Protocol

35. Operational Protocol Components. The Operational Protocol (OP) is the operational guide that outlines the Recipient's demonstration and addresses how the Recipient will meet the objectives of the MFP program. The Recipient must leverage input from stakeholders, including HCBS participants and providers, to design the program and operational elements of the MFP demonstration and prepare the OP. The OP shall describe the operational approach and project implementation plan, including program benchmarks and program content where applicable, for the following program components:

- Target population and service area
- Reporting
- Project Administration
- Recruitment and Enrollment
- Outreach/Marketing/Education
- Stakeholder Engagement
- Benefits and Services
- Transition and Housing Services
- Self-Direction and Informal Caregiving
- Quality Measurement, Assurance, and Monitoring
- Continuity of Care Post-Transition
- Equity
- Public Health Emergencies
- Tribal Initiative (if applicable)

CMS reserves the right to amend or add new OP elements during the demonstration period. The Recipient must submit the OP to CMS for review and approval. Only after CMS approval of the OP may the Recipient enroll participants in MFP and request reimbursement for MFP-funded services and claim the MFP-enhanced FMAP. The MFP-enhanced match will be available prospectively upon the date of CMS's approval of the OP, not retrospectively.

36. Operational Protocol – Amendment Process. The Recipient must amend its MFP OP in response to changes in federal or state law, regulation, or policy impacting MFP eligibility, enrollment, or program operations and when responding to new needs that affect MFP operations, inclusive of changes to any of the required MFP OP elements. Recipient requests to amend the OP must be submitted to CMS for approval no later than 30 days prior to the planned date of implementation of the change and may not be implemented until approved. OP amendment requests must include the following:

(a) An explanation of the stakeholder process used by the Recipient consistent with the Recipient requirements described in the OP to reach a decision regarding the requested amendment;

(b) A detailed description of the amendment, including impact on MFP program participants which isolates, by MFP program target populations, the impact, and includes Medicaid beneficiaries eligible for LTSS;

(c) An implementation date for the amendment provisions;

(d) A data analysis which identifies the impact of the proposed amendment on the current CY budget and for the demonstration period of performance. If applicable, a revised budget must be submitted through the GrantSolutions Grants Management Module; and

(e) A description of how the MFP program sustainability plan will be modified to incorporate the amendment provisions.

IX. General Reporting Requirements.

37. Reporting. Consistent with section 6071(c)(13) of the DRA, the Recipient must collect, and report to CMS and/or its contractors data related to MFP Demonstration Project progress and goal achievement. The Recipient is required to report projected and actual financial information on demonstration expenditures. Additionally, the Recipient must comply with reporting requirements for grant accountability as stated in the Standard Terms and Conditions of Award.

38. Qualified HCBS Expenditures Reporting Requirements. The Recipient must report on qualified HCBS expenditures in the MFP demonstration financial reporting forms A, B, C, and D ("ABCD") as further described in PTC 48. The Recipient must report quarterly on MFP qualified HCBS expenditures for state plan services and HCBS waiver programs for each calendar year.

39. Demonstration Services Reporting Requirements. The Recipient must report on each discrete demonstration service in the MFP demonstration financial reporting forms ABCD and in the Semi-Annual Progress report as specified in PTC 42. The Recipient must report demonstration expenditures on a calendar year quarterly basis in the financial reporting forms ABCD and on a calendar year semi-annual basis in the semi-annual report. Additionally, the Recipient shall participate in discussions with CMS and MFP evaluators on implementation of the demonstration service(s), including progress toward the goals, and key challenges, achievements and lessons learned.

40. Supplemental Services Reporting Requirements. The Recipient must report on each discrete supplemental service in the MFP demonstration financial reporting forms ABCD and in the Semi-Annual Progress report as described in PTC 42. The Recipient must report supplemental expenditures on a calendar year quarterly basis in the financial reporting forms ABCD and on a calendar year semi-annual basis in the Semi-Annual Progress report. CMS reserves the right to require additional reporting on supplemental services as part of a supplemental services housing plan.

41. Administrative Activities Reporting Requirements. The Recipient must report on expenditures for administrative activities in the MFP demonstration financial reporting forms ABCD, in the Semi-Annual Progress report as further described in PTC 42, and in the Work Plan as described in PTC 49. The Recipient must report on expenditures for each discrete administrative activity.

42. Semi-Annual Progress Report. The Semi-Annual Progress report is to present the Recipient's analysis and the status of the various operational areas in reaching the objectives of the demonstration. Through the Semi-Annual Progress reports, the Recipient will further enumerate how it has, or intends to, meet or align with the Recipient's MFP operational procedures and processes; transition benchmarks; program goals for expanding and enhancing HCBS; and sustainability plans. The Recipient must submit the Semi-Annual Progress report in the form and manner specified by CMS, no later than 30 calendar days following the end of each second and fourth calendar year quarter. The Recipient must submit the progress report through the final reporting period of the Recipient's program period of performance, even if the Recipient has not operated for a complete reporting period.

43. HCBS Quality Measures. The Recipient must report on the HCBS Quality Measure Set, as described in State Medicaid Director Letter # 22-003, to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services, as discussed in PTC 33. The HCBS Quality Measure Set is a set of nationally standardized quality measures for Medicaid-funded HCBS that is intended to promote more common and consistent use within and across states of such nationally standardized quality measures in HCBS programs, create opportunities for CMS and states to have comparative quality data on HCBS programs, and drive improvement in quality of care and outcomes for people receiving HCBS. See https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf for more information.

The Recipient must also report annually on a minimum of three MFP performance indicators that are connected to the achievement of the objectives identified in section 6071(a) of the DRA and to satisfy the objective in section 6071(d)(4)(A)(i) in a form and manner specified by CMS. These measures will inform progress on MFP demonstration project outcomes and HCBS system reform efforts and must be approved by CMS.

44. Transformed Medicaid Statistical Information System (T-MSIS) Reporting. The Recipient must submit production data monthly to T-MSIS that is specific to MFP enrollees as specified by CMS. The Recipient must coordinate with the state staff responsible for the state's T-MSIS files to remedy issues related to data accuracy and completeness, data submission timeliness, and other issues identified in the state's monthly production data submissions related to MFP enrollees.

45. Critical Incident Reporting. The Recipient must have a system as well as policies and procedures in place through which providers must identify, report, and investigate critical incidents that occur within the delivery of services under this demonstration. The Recipient must ensure that provider contracts reflect these requirements. The Recipient must also have a system as well as policies and procedures in place through which to detect, report, investigate, and remediate abuse, neglect, and exploitation. The Recipient must educate providers and participants about this system. The Recipient must require providers to take specific action steps in the event of known or suspected abuse, neglect, or exploitation. The Recipient is required to report on critical incidents related to MFP participants in each Semi-Annual Progress Report.

46. Maintenance of Effort. In accordance with section 6071(c)(9) of the DRA, the Recipient must provide information and assurances that total expenditures under the state Medicaid program for HCBS will not be less for any fiscal year during the MFP demonstration project period for any succeeding fiscal year before the first year of the MFP demonstration project. Maintenance of effort (MOE) will be monitored by comparing spending in the baseline year (federal fiscal year prior to the Program Implementation Phase and HCBS Transitions Phase) to each subsequent year of MFP demonstration project operation. The spending will be in aggregate and will include spending on all state plan HCBS and HCBS waiver programs (see Attachment A for descriptions of HCBS covered under this demonstration project). During the Program

Implementation and HCBS Transitions Phase, the Recipient will report these expenditures for all populations. In other words, the HCBS expenditures will not be limited to demonstration service areas or to demonstration populations. These expenditures will be reported annually to CMS on a CMS-provided MOE template form.

47. MFP Capacity Building Supplemental Funding Opportunity. Recipients in receipt of an HCBS Capacity Building supplemental funding award must report on the activities and milestones funded through this opportunity in the Semi-Annual Progress report and Work Plan and must report on expenditures on a quarterly basis in the financial reporting forms ABCD. The Recipient must report, as part of the annual supplemental budget process, on the projected and actual expenditures related to the MFP Capacity Building supplemental award.

48. General Financial Reporting Requirements. The Recipient will comply with all general financial reporting requirements as stated in the "FINANCIAL REPORTING" section of the Standard Program Terms and Conditions of Award. In addition to the Federal Financial Report (SF-425) (see **a**.), the Recipient will be required to submit the following programmatic financial reports:

a. Federal Financial Report (SF-425) – Semi-annual submission. This report describes the extent to which the MFP demonstration project contributes to accomplishing MFP objectives.

b. CMS 64.9i, 9Pi and 64.10i, 10Pi – Quarterly submission. These forms allow the state and CMS to track expenditures associated with the demonstration participants.

c. MFP Financial Reporting Forms (ABCD) – Quarterly submission. The MFP financial reporting forms are modified from the CMS Form-64. The forms provide a mechanism for tracking expenditures under the demonstration.

d. Maintenance of Effort (MOE) Form – Annual submission. This form captures all LTSS expenditures (both HCBS and institutional) annually to ensure that the Recipient has maintained its financial effort, taking into account all service costs, administrative costs, and rebalancing investments.

e. MFP Worksheet for Proposed Budget (WFPB) – Annual submission. This form provides CMS with a standardized report of each Recipient's high-level budget information, as well as projected transition benchmark information. The WFPB is included as a section in the annual budget workbook submission required in the annual supplemental funding request.

49. Work Plan on State Initiatives to Expand and Enhance HCBS. CMS expects the Recipient to use grant funds for the purposes of providing new or expanded HCBS and for initiatives to strengthen HCBS system infrastructure. The Recipient must submit a standardized (CMS-provided template) Work Plan as required by section 6071(c)(7)(B)(iii) of the DRA to document progress on the use of initiatives designed to accomplish the objective in section 6071(a)(1) of the DRA to increase the use of HCBS, rather than institutional LTSS.

If the Recipient fails to make progress under the approved Work Plan as described in section 6071(c)(13)(C), the Recipient shall implement a corrective action plan reviewed and approved by CMS in accordance with CMS Standard Terms and Conditions.

Attachment A: MFP Qualified Home and Community-Based Services

The following are qualified HCBS eligible for the MFP-enhanced FMAP with corresponding descriptions:

State Plan Services

Home Health Services: Home health services are mandatory services authorized at section 1905(a)(7) of the Social Security Act (the Act) and codified in regulations at 42 C.F.R. § 440.70. Home health services include nursing services, home health aide services, medical supplies, equipment, and appliances, and may include therapy services (physical therapy, occupational therapy, speech pathology, and audiology).

Personal Care Services: Personal care services are optional services authorized at section 1905(a)(24) of the Act and codified in regulations at 42 C.F.R. § 440.167. Personal care services can include a range of human assistance provided to persons who need assistance with daily activities.

Self-Directed Personal Care Services: Section 1915(j) of the Act allows self-direction of state plan personal care services. Requirements are set forth in 42 CFR Part 441 Subpart J.

Case Management: Case management services, as defined under sections 1905(a)(19) and 1915(g) of the Act and codified in regulations at 42 C.F.R. § 440.169 and 42 C.F.R. § 441.18, assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services.

Rehabilitative Services: The rehabilitative services benefit is an optional Medicaid state plan benefit authorized at section 1905(a)(13) of the Act and codified in regulation at 42 C.F.R. § 440.130(d) as "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 beneficiary to his best possible functional level." Many mental health and substance use disorder services are authorized under this benefit. For MFP, rehabilitative services furnished in IMDs are not considered as qualified HCBS.

OBRA '89 Grandfathered Day Habilitation Programs (Adult Day Services) as Covered under Section 1905(a)(13) Rehabilitative and 1905(a)(9) Clinic Services: In states with Omnibus Budget Reconciliation Act of 1989 (OBRA '89) grandfathered status, day habilitation programs are covered under the clinic services (codified in regulation at 42 C.F.R. § 440.90) and/or the rehabilitative services state plan benefit (codified in regulation at 42 C.F.R. § 440.130(d)). OBRA '89 prohibits CMS from withholding FFP for day habilitation and related services offered under the state plan clinic or rehabilitative services benefit on behalf of persons with [intellectual or developmental disabilities] if the day habilitation program was approved in the state plan on or before June 30, 1989. Absent OBRA '89 status, a state may not cover day habilitation services under state plan 1905(a) services. Day habilitation programs (also known as adult day services) can be covered under HCBS state plan and waiver programs, and section 1115 demonstrations.

Private Duty Nursing (in-home only): Private duty nursing is an optional Medicaid state plan benefit authorized at section 1905(a)(8) of the Act and codified in regulation at 42 C.F.R. § 440.80 as "nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided: (a) by a registered nurse or a licensed practical nurse; (b) under the direction of the recipient's physician ; and (c) to a recipient in one or more of the following locations at the option of the State: **(1) his or her own home;** (2) a hospital; or (3) a skilled nursing facility."

The MFP-enhanced FMAP is only applicable when the service is provided in a recipient's **own home.**

Hospice Services: Hospice care is an optional benefit authorized at section 1905(a)(18) of the Act, that provides an array of services to individuals who are determined to be terminally ill due to a medical prognosis that his or her life expectancy is six months or less. Hospice services include, nursing, medical social services, physicians' services and counseling services. A full list of hospice services are defined in section 1861(dd)(1) of the Act. The hospice state plan benefit follows this provision.

Coverage of Services to Children with Autism Spectrum Disorder (ASD): Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services.

Other Licensed Practitioner Services: Other Licensed Practitioner services (OLP) services, authorized as an optional state plan benefit at section 1905(a)(6) of the Act and defined at 42 C.F.R. § 440.60(a), are "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law."

Preventive Services: Preventive Services, authorized as an optional state plan benefit at section 1905(a)(13) of the Act and defined at 42 C.F.R. § 440.130(c), are "services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to— (1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency."

Therapy Services: Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 C.F.R. § 440.110. These services are authorized as optional state plan benefits at section 1905(a)(11) of the Act.

HCBS under Sections 1915(c), 1915(i), 1915(j) and 1915(k)

Section 1915(c): Waiver authority found at section 1915(c) of the Act gives states the option to offer LTSS in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act.

Section 1915(i): Section 1915(i) is an optional state plan benefit that allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target group criteria) as set forth in 42 CFR Part 441 Subpart M.

Section 1915(j)-Self-directed 1915(c) services: Section 1915(j) of the Act allows self-direction of HCBS otherwise available under a section 1915(c) waiver program that are provided to an individual who has been determined eligible for the self-directed option. Requirements are set forth in 42 CFR Part 441 Subpart J.

Section 1915(k): The section 1915(k) Community First Choice (CFC) state plan benefit provides certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. States receive an extra six percentage points of federal match for CFC service expenditures.

Other HCBS Options

Program of All-Inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. An interdisciplinary team of health professionals provides PACE participants with coordinated care.

Managed Long-Term Services and Supports (MLTSS): Managed LTSS (MLTSS) refers to the delivery of LTSS through capitated Medicaid managed care programs. Recipients can implement MLTSS using an array of managed care authorities, including a section 1915(a) voluntary program, a section 1932(a) state plan amendment, a section 1915(b) waiver, or a section 1115 demonstration. Any of those managed care authorities can be "paired" with state plan HCBS benefits offered under section 1905(a), 1915(i), 1915(j), or 1915(k) or an HCBS waiver program under section 1915(c).

Section 1945 Health Homes: The optional health home state plan benefit authorized under section 1945 of the Act includes various services that help to ensure the coordination of all primary services, acute care services, behavioral health (including mental health and substance use) services, and LTSS for individuals with chronic conditions, and thus help to ensure treatment of the "whole person." Section 1945 defines health home services as comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; individual and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

Section 1115 Demonstrations: States can utilize section 1115(a) demonstration authority to test new strategies to promote the objectives of the Medicaid program. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, including but not limited to statewideness and comparability, to the extent and for the period necessary to carry out the demonstration. In addition, section 1115(a)(2) of the Act allows the Secretary to provide FFP for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary. Any of the qualified HCBS described above are eligible for the MFP-enhanced match when authorized under an approved 1115 demonstration.