Money Follows the Person Demonstration Program
2019 MFP Intensive

Division of Community Systems Transformation
Disabled & Elderly Health Programs Group
Center for Medicaid & CHIP Services

August 26, 2019

Agenda

- Welcome & Opening Remarks
- Innovative Strategies: Develop and Sustain Housing Options for Community Living
- Small Group Discussions
- Lunch & Conference Plenary
- MFP Sustainability: Sustaining MFP Transition Services / How to leverage the Stories of MFP Participants into Systemic Change
- Reflections on MFP Sustainability Discussion
- MFP Grant Budget Procedures
- Open Q&A and Wrap Up

Welcome and Opening Remarks

- **Jennifer Bowdoin**, Director, Division of Community Systems Transformation (DCST)
- **Jean Close**, Deputy Director, DCST

Innovative Strategies

Developing and Sustaining Housing Options for Community Living

Moderator:

- **John Sorensen**, MFP Project Officer, DCST

Panelists:

- **Terre Lewis**, MFP Project Director, State of New Jersey
- **Matt Bohanan**, MFP Project Director, State of Colorado
- **Carol Schenck**, MFP Project Director, State of Ohio

State of New Jersey
Department of Human Services

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MONEY FOLLOWS THE PERSON HOUSING PARTNERSHIP PROGRAM

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Money Follows the Person Housing Partnership Program (MFPHPP)

- MFPHPP is a partnership between the New Jersey Housing and Mortgage Finance Agency (NJHMFA) and the New Jersey Department of Human Services (NJDHS).

- NJHMFA received $6.2 million in rebalancing dollars from NJDHS to provide capital subsidies to eligible non-profit and for-profit developers to set aside housing units for qualified individuals transitioning from nursing facilities to community settings. https://www.nj.gov/dca/hmfa/media/download/special/sn_mfphpp_guidelines.pdf.

Money Follows the Person Housing Partnership Program (MFPHPP)

Eligible Applicants:

- Nonprofit and For-Profit Developer

Target Population:

- Individuals, aged 18 and over, who are physically disabled, and currently living in nursing homes but are capable of living in community settings with the appropriate support services

Clifton Main Mews I, Clifton, Passaic County

Money Follows the Person Housing Partnership Program (MFPHPP)

Eligible Set-Aside Units:

- A maximum of five one-bedroom units per project

Eligible Projects:

- 4% and 9% Low Income Housing Tax Credits
- Multifamily Projects
- New Construction or Rehab

Subsidy Loan Amount:

- $75,000 per one-bedroom unit
- Can only be used as capital funds

Financing Term:

- Standard term of 30 years
- Must utilize NJHMFA financing

Centerton Road Family Housing Mt Laurel, Burlington County

Clifton Main Mews II Clifton, Passaic County

Money Follows the Person Housing Partnership Program (MFPHPP)

Operating Fund:

- Rental units must be affordable at 20% AMI
- Subsidies cannot be used for rental assistance
- Projects may be eligible for NJHMFA administered Sec. 811 PRA funds if available

Loan Repayment:

- Loans are structured as cash flow loans with 25% of net cash flow due to NJHMFA on an annual basis
- 0% interest during construction and permanent phases

Money Follows the Person Housing Partnership Program (MFPHPP)

Minimum Project Selection Criteria

Location in priority counties preferred:

- Bergen, Passaic, Essex, Morris, Hudson, Monmouth and Ocean
- Other locations will be considered on a case-by-case basis

Project Requirements:

- Accessible units, i.e. wider doorways, lower cabinet heights, wheel chair accessible bathrooms, etc.
- Community integration, including access to transportation, employment opportunities and other community resources
- Presence of on-site social service coordinator
- Developer must have experience with special needs housing projects
- Letter of support from NJDHS providing amount of subsidy for the project

Deed Restrictions:

- Projects are deed restricted for the term of the NJHMFA mortgage

Money Follows the Person Housing Partnership Program (MFPHPP)

Achievements:

36 units have been allocated to date (13 projects)

21 units pending HMFA approval (5 projects)

Zion Towers, Newark Essex County

Georgia King Village, Newark Essex County

Wemrock Senior Living Freehold Monmouth County

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State of Colorado
Health Care Policy and Financing

Money Follows the Person

Housing Navigation and Accessible Relationships

Matthew Bohanan

Access Unit Manager/MFP Project Director

Office of Community Living

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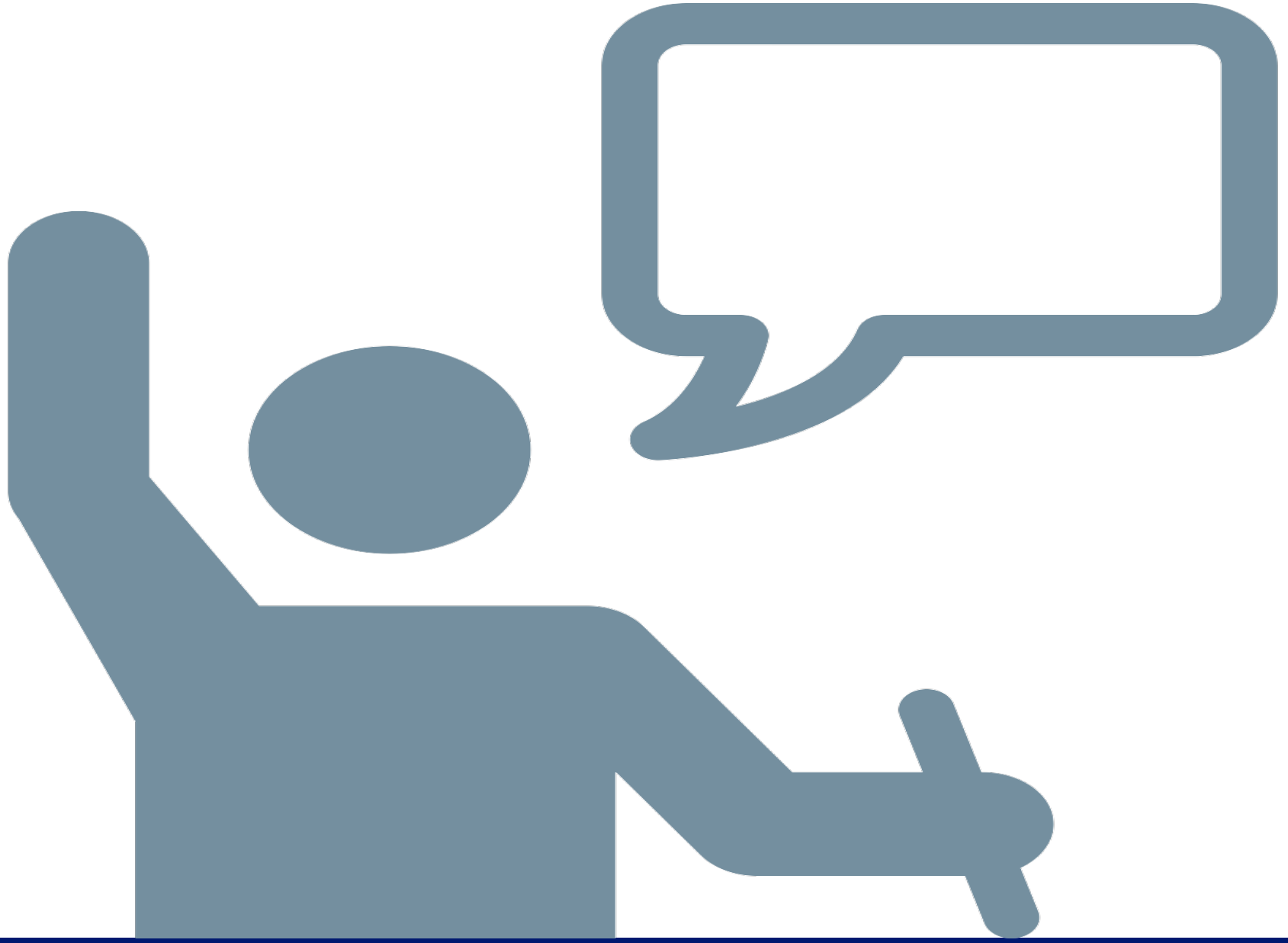
August 26, 2019

Our Mission

Improving health care access and outcomes
for the **people** we serve
while demonstrating sound stewardship of
financial **resources**

Accessible Relationships

1. *What is Housing Navigation?*
2. *Cultivating Relationships*
3. *Challenges*
4. *Outcomes*
5. *Sustainability*



Contact Information

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Thank You!

Ohio | Department of Medicaid

Collaboration: The Key to Ohio's Successful Housing Partnerships

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A brief history…

2003 Ohio begins planning with the Interagency Council on Homelessness and Affordable Housing

2008 Council and Medicaid collaborate on MFP Grant

2009 Local Housing and Service Cooperatives Established

2012 Ohio Applies for first 811 Grant

2014 Ohio receives $11.9 million grant for 811 Project Rental Assistance Program

2015 Ohio launches the Ohio Department of Medicaid Subsidy Demonstration Project

Ohio Housing Partnerships

Ohio 811 Project Rental Assistance Program

The Ohio Department of Medicaid Subsidy Demonstration Program

Non-Elderly and Disabled Category 2 (NED2) Housing Choice Voucher Partnerships

HUD Mainstream Voucher Program

Community Integration for those with Mental Illness

- Ohio led the nation in transitions for those with mental illness
- Partnerships contributed to that success
  - Long-standing relationship with the Department of Mental Illness and Addiction Services
  - SSI Ohio expedited eligibility process and SSI awards
  - Employed two housing specialists to support program
  - Funded a MHAS liaison position to the MFP program
  - Created the Home for Good program

811 Project Rental Assistance Program

811 Partners:

The Ohio Housing Finance Agency

The Ohio Department of Medicaid

The Ohio Department of Developmental Disabilities

The Ohio Department of Mental Health and Addiction Services

811 Project Rental Assistance Program

- OHFA administers the program
- Agency partners identify, recruit and train Referral Agents
- Social Serve is the program selected to manage the application, referral and wait list processes
- Cost savings utilized to support the OHFA administrative role, developer incentives, marketing and training

Ohio Department of Medicaid Subsidy Demonstration Program

- ODMSD is a smaller version of the 811 PRA program but with some distinct differences:
  - ➢No age limit
  - ➢All units are new construction
  - ➢Approximately 30 units available
  - ➢Individuals must require an accessible unit
  - ➢$3million cost savings investment in 15 year subsidies

Non-Elderly and Disabled Category 2 Housing Choice Voucher Program

- Partnership with the Metropolitan Housing Authorities in Cleveland, Cincinnati and Toledo
- Vouchers set aside for individuals transitioning in the MFP program
- Referrals provided by Transition Coordinators in the MFP program
- Referral waitlist managed by the Ohio Department of Medicaid

HUD Mainstream Voucher Program

HUD Releases NOFA for Mainstream Voucher Program

Ohio 811 Partners Secure Letters of Support for Public Housing Authorities in 2018

- State Agency Heads
- Community Partners
- MFP Program Partners and Providers

Ohio 811 Partners Support 2019 NOFA

Success by Numbers

Ohio 811 Project Rental Assistance Program
19 Currently Housed

Ohio Department of Medicaid Subsidy Demonstration Program
11 Currently Housed

NED 2
Since 2017, over 113 vouchers provided

HUD Mainstream Vouchers
Fourteen Ohio Public Housing Authorities were awarded over $2 million providing 427 vouchers

Thank you

For more information:

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Small Group Discussion - Overview

- Select your Topic for discussion from the list on each table
- Identify who will take notes
- Identify who will present during the report out
- Each person shares the topic/subtopic of interest

Small Group Discussion - Topics

- Sustainability
- Housing
- Close-out Strategies and Procedures
- Financial Management and Reporting
- Strategies for Serving Hard-to-Reach Individuals
- American Indians' and Alaska Natives' MFP Experience
- Measuring and Improving Quality
- Other

Small Group Discussion – Topic Discussion

- What is the issue / opportunity?
- How can we sustain this strategy?
- Are there other options / considerations?

Small Group Discussion – Report Outs

- Brief description of the solution / strategy

MFP Sustainability

Sustaining MFP Transition Services / How to Leverage the Stories of MFP Participants into Systemic Change

Moderator:

- **Martha Egan**, Technical Director, DCST

Panelists:

- **Cathleen Lawrence**, Division of Nursing Homes
- **Kenya Cantwell**, Division of Benefits and Coverage
- **Kathryn Poisal**, Division of Long Term Services & Supports
- **Jean Close** *on behalf of* **Sharon Brown**, Division of Reimbursement and State Financing
- **Dawn Lambert**, MFP Project Director, State of Connecticut

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Sustaining MFP Transition Services

Division of Community Systems Transformation

MFP Intensive

August 26, 2019

Agenda

- **Welcome from DCST** - Martha Egan
- **Nursing Home Discharge Planning** - Cathleen Lawrence
- **Medicaid State Plan Case Management Services** - Kenya Cantwell
- **Community Transition HCBS - 1915(c) & 1915(i)** - Kathryn Poisal
- **Community First Choice -1915(k)** - Kenya Cantwell
- **Administrative Claiming** – Jean Close on behalf of Sharon Brown
- **Wrap up** - Martha Egan

Background

Sustaining Money Follows the Person (MFP)

Community Transition Services

- Transition Coordination Prior to Discharge
- Transition Coordination in the Community
- Transition Expenses for Individuals Seeking a Return to the Community

Discharge Planning, Honoring Preferences, Communication

Cathleen Lawrence, Nurse Consultant

Division of Nursing Homes

Quality, Safety and Oversight Group

Discharge Planning

- Long-term care facility requirements were revised in 2016; first comprehensive revision since 1991.
- New regulations reflect compliance with Olmstead decision by requiring facilities to honor resident preference for discharge destination and to regularly re-evaluate residents about discharge preferences.

Discharge Planning in the Nursing Home

§483.21(c)(1) Discharge Planning Process

The facility must develop and implement an effective discharge planning process **that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.** The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.

(ii) **Include regular re-evaluation of residents to identify changes** that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.

(iv) **Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care**, as part of the identification of discharge needs.

(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

(vi) **Address the resident's goals of care and treatment preferences.**

Discharge Planning Regulations cont.

(vii) Document that a resident has been asked **about their interest in receiving information regarding returning to the community.**

(A) If the resident indicates an interest in returning to the community, **the facility must document any referrals to local contact agencies or other appropriate entities** made for this purpose.

(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, **assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available.** The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

Discharge Summary

§483.21(c)(2) Discharge Summary

When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.

(iii) **Reconciliation of all pre-discharge medications with the resident's post-discharge medications** (both prescribed and over-the-counter).

(iv) **A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services**.

F660 Discharge Planning Process

A well-executed discharge planning process, without avoidable complications, maximizes each resident's potential to improve, to the extent possible, based on his or her clinical condition. An inadequate discharge planning process may complicate the resident's recovery, lead to admission to a hospital, or even result in the resident's death.

F660 Discharge Planning Process cont.

Discharge planning must identify the discharge destination, and ensure it meets the resident's health and safety needs, as well as preferences. If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility must treat this situation similarly to refusal of care, and must:

- Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location;
- Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed;
- Document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings;
- Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.

As appropriate, facilities should follow their policies, or state law as related to discharges which are Against Medical Advice (AMA).

F661 Discharge Summary

The discharge summary may help reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident's care.

In the case of discharge to a non-institutional setting such as the resident's home, provision of a discharge summary, with the resident's consent, to the resident's community-based physicians/practitioners allows the resident to receive continuous and coordinated, person-centered care.

For residents who are being discharged from the facility to another health care facility, the discharge summary enables the receiving facility to provide appropriate and timely care.

Compliance with Discharge Planning

- Ensuring the discharge destination meets the needs of the resident.
- Addressing the psychosocial needs of residents when assisting with selection of a new location.
- Communication of necessary information to the continuing care provider.

Evaluating Discharge Planning

- Review the resident's record.
- Interview the resident/representative.
  - What was your involvement in developing your discharge plan?
  - How did the facility involve you in selecting a new location?
  - How were your goals, choices and treatment preferences taken into consideration?
- Interview staff about how they address the resident's discharge needs and involve the resident in discharge planning.

Comprehensive Care Planning

§483.21(b) Comprehensive Care Plans

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following —

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative(s)—

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

Minimum Data Set

- Minimum Data Set (MDS)—the tool used by nursing home staff to assess each resident's functional capabilities and identify health problems.
- Section Q of the MDS—This section is used by nursing home staff to assess the resident's expectations (directly or through family members/representative) of outcomes of care in the nursing home and expectations about returning to the community.
- The Section Q assessment:
  - Is resident-driven, not what the nursing home believes is the best option.
  - Engages residents in their discharge planning goals.
  - Directly asks residents if they want information about options in the community.
  - Promotes information exchange and discharge planning collaboration between nursing homes, local contact agencies, and community-based long-term care providers.

Minimum Data Set, Section Q

	1. **Yes** 9. **Resident has no guardian or legally authorized representative**
Q0300. Resident's Overall Expectation Complete only if A0310E = 1	
Enter Code	**A. Select one for resident's overall goal established during assessment process** 1. Expects to be **discharged to the community** 2. Expects to **remain in this facility** 3. Expects to be **discharged to another facility/institution** 9. **Unknown or uncertain**
Enter Code	**B. Indicate information source for Q0300A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family, or significant other, then **guardian or legally authorized representative** 9. **Unknown or uncertain**
Q0400. Discharge Plan	
Enter Code	**A. Is active discharge planning already occurring for the resident to return to the community?** 0. **No** 1. **Yes** → Skip to Q0600, Referral
Q0490. Resident's Preference to Avoid Being Asked Question Q0500B Complete only if A0310A = 02, 06, or 99	
Enter Code	**Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?** 0. **No** 1. **Yes** → Skip to Q0600, Referral
Q0500. Return to Community	
Enter Code	**B. Ask the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** 0. **No** 1. **Yes** 9. **Unknown or uncertain**
Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again	
Enter Code	**A. Does the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available**
Enter Code	**B. Indicate information source for Q0550A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family or significant other, then **guardian or legally authorized representative** 9. **None of the above**

Meeting Each Resident's Needs

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Medicaid State Plan Case Management Services - Kenya Cantwell

Case management services are services furnished to assist individuals eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Targeted Case Management (TCM)

- TCM services are defined as case management services furnished to particular defined target groups or in any defined locations without regards to requirements related to statewide provision of services or comparability.

- Section 1915(g)(1) of the Act allows the state to provide case management services on less than a statewide basis and without regard to comparability.

Service Parameters

- Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

- *For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community:*
  - Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities.

Four Components of Case Management Services

- Assessment of an eligible individual
  42 CFR 440.169 (d)(1)
- Development of a specific care plan
  42 CFR 440.169 (d)(2)
- Referral and related activities
  42 CFR 440.169 (d)(3)
- Monitoring and follow-up activities
  42 CFR 440.169 (d)(4)

Assessment

- Case Management includes the following assistance:
  - Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
    - Taking client history; and
    - Identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development of Care Plan

Development (and periodic revision) of a specific care plan that, based on the information collected through the assessment:

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and Related Activities

- Helps an eligible individual obtain needed services, including activities that help link an individual with:
  - Medical, social, educational providers; or
  - Other programs and services that are capable of providing needed services, such as
    - Making referrals to providers for needed services; and
    - Scheduling appointments for the individual.

Monitoring and Follow-up Activities

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Excluded Services

- Medicaid reimbursement is not available as Case Management services for services or activities that do not comport with the definition of Medicaid Case Management. This includes services that:
  - Are an integral component of another covered Medicaid service
  - Are integral to the administration of another non-medical program
  - Constitute direct delivery of underlying medical, educational, social or other services to which an eligible individual has been referred

Freedom of Choice

The state must assure that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services, within the specified geographic area identified in the plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice cont.

When target groups consists of eligible individuals with developmental disabilities or with chronic mental illness, providers can be limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services

The state must assure:

- Case management services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

Access to Services cont.

The state must assure:

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.
- That case management is only provided by and reimbursed to community case management providers.

Access to Services cont.

The state plan must reflect the following assurances for plans providing case management services to assist individuals who reside in medical institutions to transition to the community:

- The amount, duration, and scope of the case management activities must be documented in an individual's plan of care to facilitate a successful transition to the community.
  - This includes case management activities prior to and post-discharge

Community Transition HCBS: Transition Case Management - Kathryn Poisal

- State Medicaid Directors Letter, Olmstead Update #3, July 25, 2000
- Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community.
- There are several ways that case management services may be furnished under the Medicaid program:
  - State Plan Targeted Case Management
  - Case Management as a Medicaid Administrative Activity
  - HCBS Case Management

Community Transition HCBS: Transition Case Management cont.

- Services to assess need, arrange for, and procure needed resources
- Can be provided up to 180 consecutive days prior to discharge from an institution

Community Transition Services

- State Medicaid Directors Letter #02-008, May 9, 2002 and HCBS Waiver Technical Guide
- Allowable under Section 1915(c) HCBS waivers and Section 1915(i) State Plan HCBS benefits
- One-time non-recurring set-up expenses for individuals who make the transition from an institution to the community
- Cannot include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes
- Must be reasonable and necessary as determined through the person-centered service plan development process & clearly identified in the person-centered service plan

Community Transition Services cont.

- Allowable expenses to establish a basic household that do not constitute room & board:
  - Security deposits that are required to obtain a lease on an apartment or home;
  - Essential household furnishings and moving expenses required to occupy and use a community domicile;
  - Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating, water);
  - Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy;
  - Moving expenses; and/or
  - Necessary home accessibility adaptations.

Community Transition Services & Transition Case Management

- FFP available the date the person leaves the institution and begins receiving the 1915(c) or 1915(i) services.
- The individual must be reasonably expected to be eligible for and to enroll in the 1915(c) waiver or receive 1915(i) state plan benefit services.
- If an individual does not transition due to unforeseen circumstances (ex. death, change in eligibility status, significant change in condition), the state may be able to claim for some or all of the transition activities as administrative activity costs in accordance with an approved Medicaid cost allocation plan.
- May not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

1915(k) Community First Choice: Program Overview - Kenya Cantwell

- Purpose is to provide attendant care services and other community supports to Medicaid eligible individuals who have an institutional level of care
- CFC services are provided to individuals in their homes and communities
- CFC services are provided in a manner that highlights consumer direction, person-centered planning, and flexible service delivery options
- CFC services must be provided in settings that are home and community-based in nature

1915(k) Community First Choice: Key Features

- CFC is a state plan option, not a waiver
- CFC programs must be provided in a manner that is consistent with all state plan requirements, including freedom of choice and comparability, and be provided on a statewide basis
- The state cannot cap the number of individuals served and cannot target to certain populations, disabilities, or parts of the state
- States receive a 6 percentage point increase in FMAP for the provision of CFC services

1915(k) Community First Choice: Included Services

All CFC benefits **must** include these services:

- Assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks through hands-on assistance, supervision, and/or cueing
- Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks
- Back-up systems (such as electronic devices) or mechanisms to ensure continuity of services and supports
- Voluntary training to individuals on how to select, manage and dismiss attendants

1915(k) Community First Choice: Permissible Services

In addition to required services, States **have the option** to provide permissible services and supports that are linked to an assessed need or goal in the individual's person-centered service plan.

Permissible services and supports may include the following:

- Funding for transition costs such as security deposits for an apartment or utilities, purchasing bedding, basic kitchen supplies, and other necessities required for transition from an institution
- Expenditures relating to a need identified in an individual's person-centered plan that increases his/her independence or substitutes for human assistance to the extent that expenditures would otherwise be made for the human assistance

1915(k) Community First Choice: Developing a CFC Program

- We strongly encourage states to engage in technical assistance as early as possible.
- Think about the existing system of delivery of long term supports and services in the state and what the state hopes to achieve with CFC implementation.
- Coordination with state plan and other long term services and supports authorities, including your HCBS settings Statewide Transition Plan, is critical.
- Stakeholder engagement is a requirement.
- CMS is available to review concept papers or draft SPAs while engaging in technical assistance.

Medicaid Administrative Claiming – Jean Close on behalf of Sharon Brown

- Activities must be “found necessary by the Secretary for the proper and efficient administration of the plan.” (Section 1903(a)(7) of the Social Security Act)

- Section 1903(a) of the Act provides for variable Federal matching rates to states for administrative expenditures claimed under Medicaid; however, most administrative costs are reimbursable at 50 percent FFP.

Medicaid Administrative Activities

- 42 CFR 433.15(b) specifies rates of FFP for admin.
- Medicaid admin is generally claimed at a standard 50% FFP rate for all activities the Secretary finds necessary for the proper and efficient administration of the state plan.
- Examples of higher rates for admin:
  - 75%: SPMP, QIO, Preadmission Screening
- All admin expenditures are claimed on the Form CMS - 64.10 Base (State and Local ADM)

Examples of Administrative Activities

- Explaining Medicaid requirements
- Conducting Medicaid outreach
- Facilitating application to Medicaid
- Conducting program planning
- Providing referral assistance
- Providing Medicaid specific training
- Assisting in the securing or arranging for transportation/translation services to a Medicaid service

Medicaid Administrative Principles

The following principles reflect determinations made by CMS for administrative claiming in the 1994 SMDL:

- An allowable administrative cost must be directly related to a Medicaid State plan or waiver service.
- An allowable administrative cost cannot reflect the cost of providing a direct medical or remedial service.
- An allowable administrative cost cannot be an integral part or extension of a direct medical or remedial service, such a patient follow-up, patient education, counseling, or other physician “extender” activities.

Medicaid Administrative Principles

- An allowable administrative cost may not include funding for a portion of general public health initiatives that are made available to all persons.
- An allowable administrative cost may not include the overhead costs of operating a provider facility.
- An allowable administrative cost may not include the operating costs of an agency whose primary purpose is other than the operation of the Medicaid program.
- An allowable administrative cost must be included in a Cost Allocation Plan (CAP) that is approved by CMS and supported by a system that has the capability to isolate the costs that are directly related to the support of the Medicaid program from all other costs incurred.

Medicaid Administrative Cost Principles

- Costs must be for the “proper and efficient” administration of the Medicaid State plan.
- Costs must be allocated in accordance with the relative benefits received by all programs, not just Medicaid.
- Costs must not duplicate costs that have been, or should have been, paid through another source.
- Costs must be discounted by the Medicaid eligibility rate to ensure only those activities provided to Medicaid beneficiaries are claimed.
- Cost must be supported by an allocation methodology that appears in the State’s approved public assistance Cost Allocation Plan.

Medicaid Administrative Cost Principles cont.

- Cost must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a provider facility.
- Costs must not duplicate activities that are already being offered or should be provided by other entities, or through other programs.
- Costs must not include any cost related to the provision of a direct medical service or administrative costs incurred by the provider that are integral to the provision of the direct medical service.
- Costs must be supported by adequate source documentation.

Steps to Claim FFP For Medicaid Administration

Step 1:	State Medicaid Agency and NWD System Engagement
Step 2:	Identify Permissible Sources of Non-Federal Funds for Match Purposes
Step 3:	Identify NWD System Activities Potentially Eligible for Federal Medicaid Administrative Funding
Step 4:	Identify Costs of Allowable and Allocable Activities
Step 5:	Establish Contractual Agreements
Step 6:	Secure CMS/CAS Review and Approval

Wrap up - Martha Egan

Questions

Submit questions to mfpdemo@cms.hhs.gov

Thank you!

Are We There Yet?
Money Follows the Person Road Trip

Baltimore Marriott Waterfront
Baltimore, Maryland
August 26, 2019

Connecticut Department of Social Services
Caring for Connecticut

A Belief in Maximizing Human Potential where ALL have the opportunity to be healthy, secure, and thriving

West Rock Nursing Home
New Haven, Connecticut

Surprise inspections by state investigators uncovered deplorable living conditions at a New Haven nursing home. The West Rock Health Care Center is closing its doors Friday, on the heels of those findings.

May 5, 2010
NBC News

Culture
Partners and Staff
Teaching and learning to see

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

25% of the people moved to the community

Believe it is possible

Complete systems assessment to determine readiness for change.

Governor's Office
Budget Office
Medicaid
Medicaid operating partners
Healthcare reform

Meet with stakeholders

Communicate ‘why’

Rebalancing – Part of a Comprehensive Healthcare Strategy

- Consumers overwhelmingly wish to have **meaningful choice** in how they receive needed long-term services and supports (LTSS).

- Average per member per month **costs are less in the community**.

- In Olmstead v. L.C., 527 U.S. 581 (1999), the Supreme Court held that title II **prohibits the unjustified segregation** of individuals with disabilities.
  - Medicaid must administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

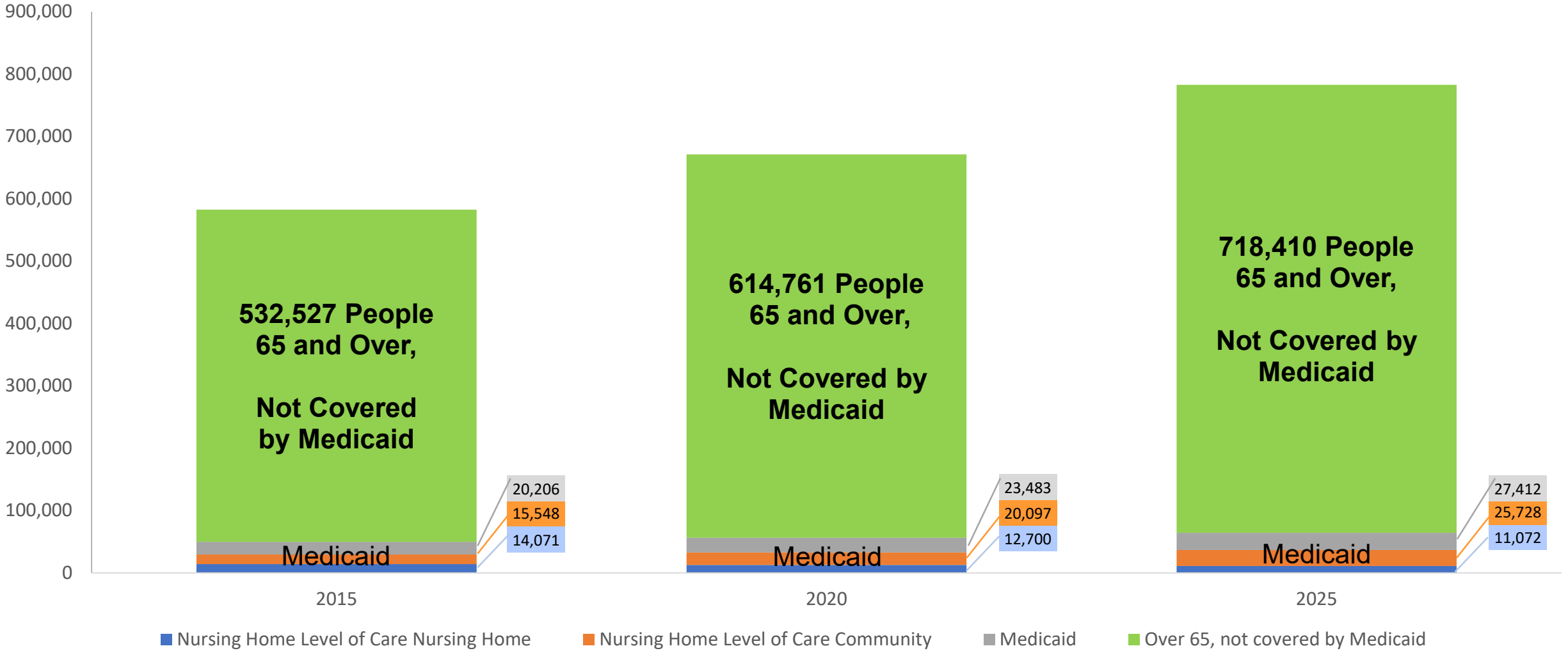
Communicate with data, stories and numbers

Data sources:
Mathematica Quality of Life
National Scorecards
University Publications
Federal Reports

99

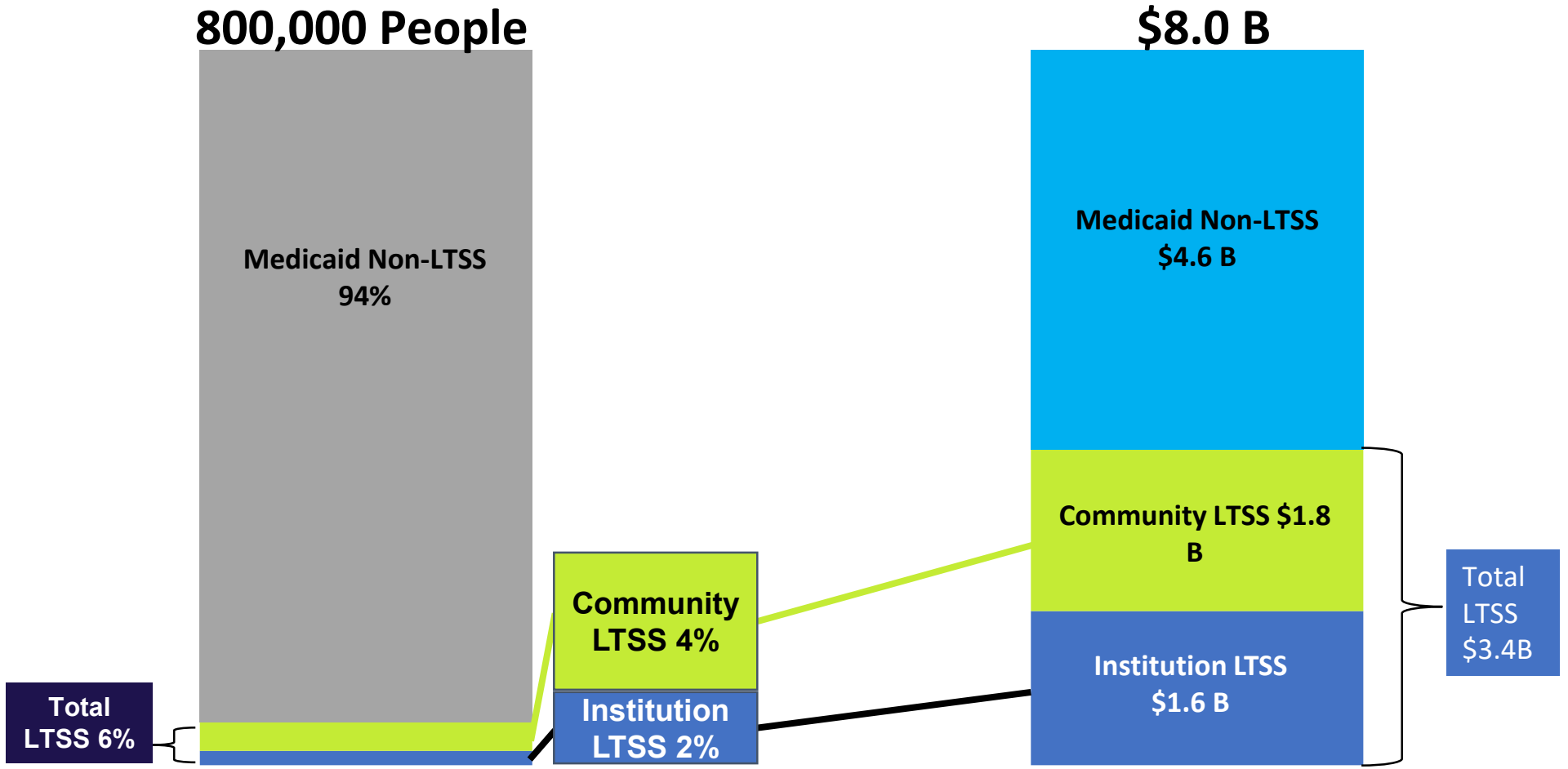
Define Problem

Growth in Connecticut Population Age 65 and Over 2015 – 2025



Connecticut State Data Center, UConn November 2012 Edition

Percentage of Medicaid LTSS Participants Compared to Overall Medicaid Expenditures (2018)



Source: Connecticut Form CMS-64 Report

Economic News Release

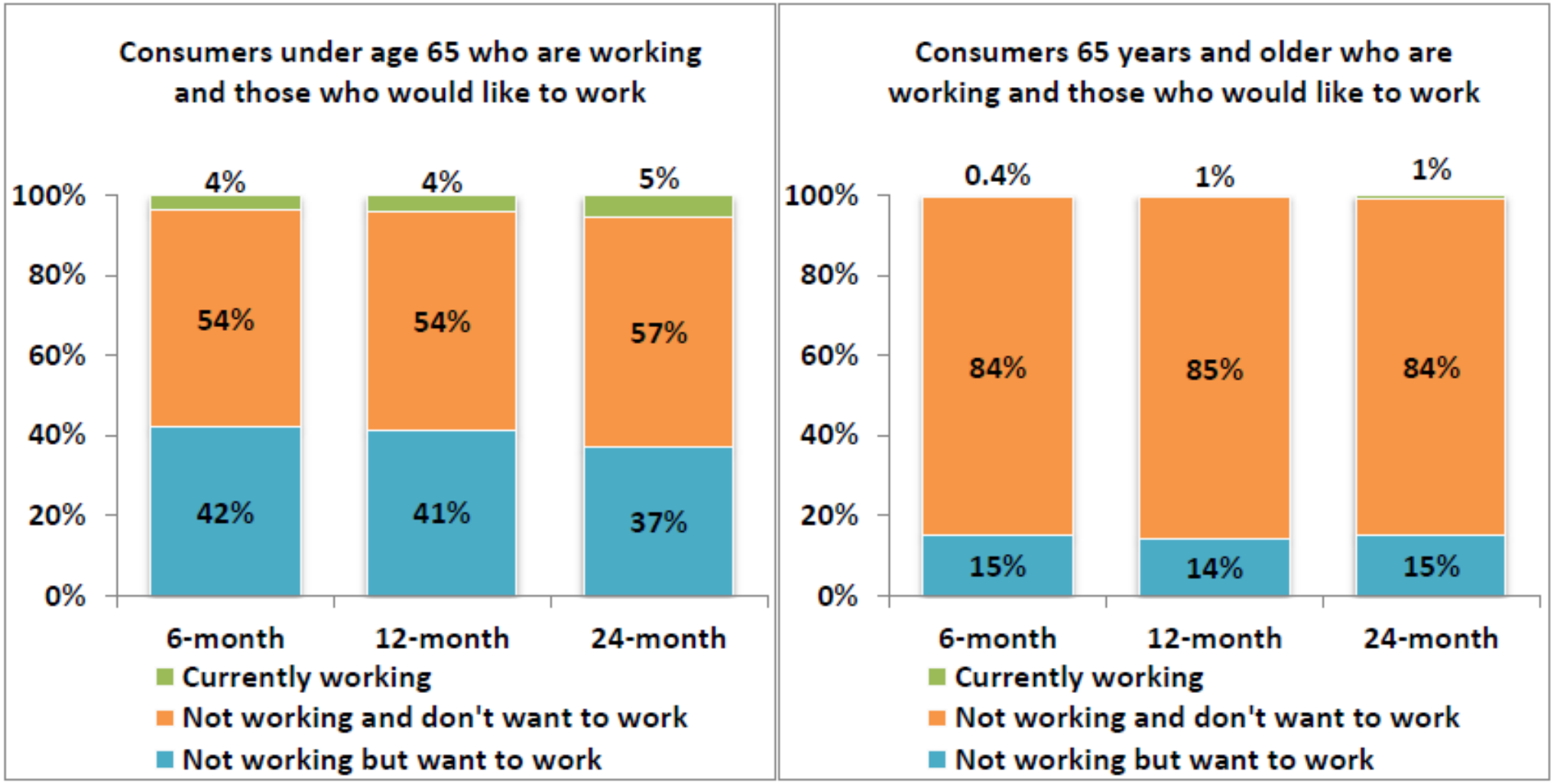
Persons with a Disability: Labor Force Characteristics Summary

For release 10:00 a.m. (EST) Tuesday, February 26, 2019 USDL-19-0326

Technical information: (202) 691-6378 * cpsinfo@bls.gov * www.bls.gov/cps
Media contact: (202) 691-5902 * PressOffice@bls.gov

PERSONS WITH A DISABILITY: LABOR FORCE CHARACTERISTICS -- 2018

In 2018, the employment-population ratio--the proportion of the population that is employed--was 19.1 percent among those with a disability, the U.S. Bureau of Labor Statistics reported today. In contrast, the employment-population ratio for those without a disability was 65.9 percent. The employment-population ratio for persons with



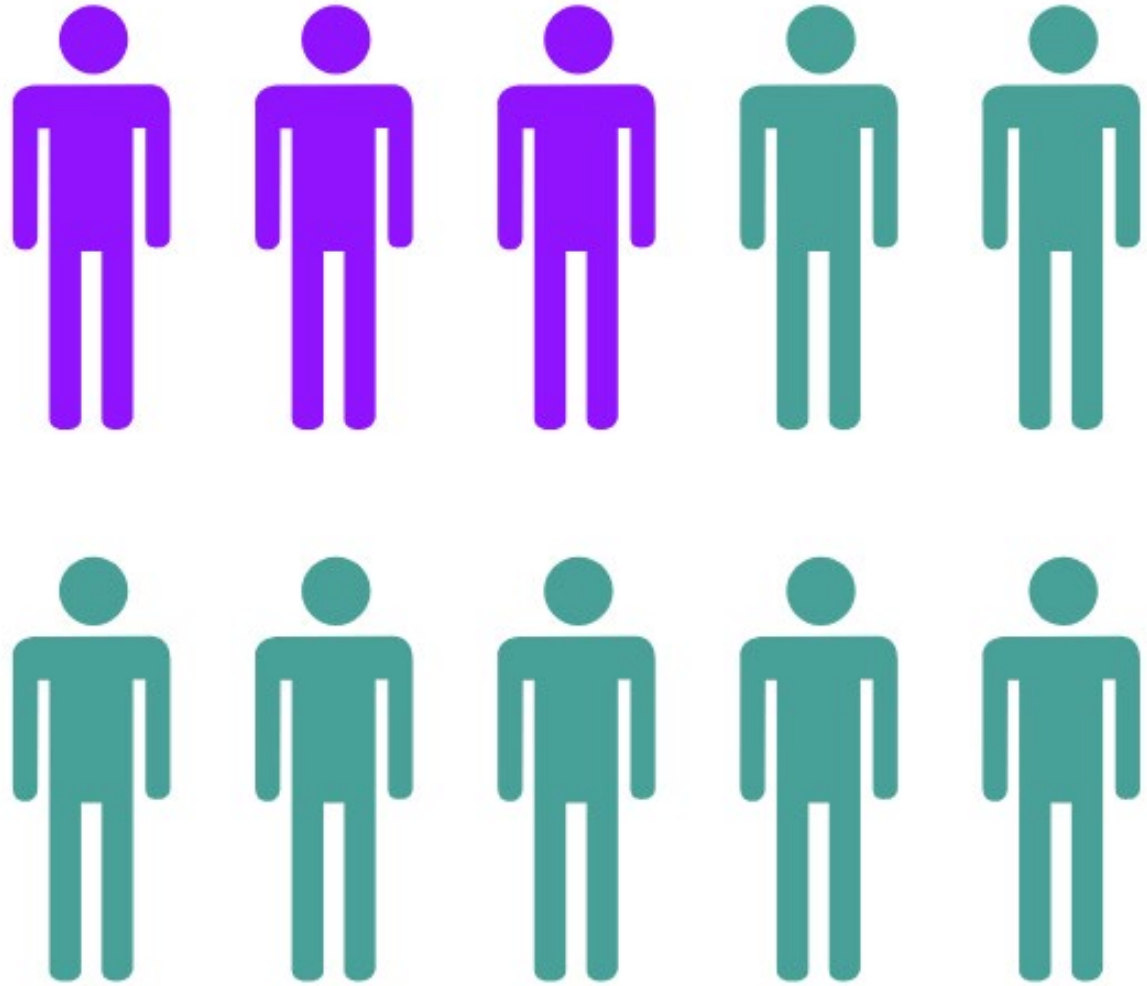
UConn Health, Center on Aging

Operating Agency: *CT Department of Social Services* **Funder:** *Centers for Medicare and Medicaid Services*

Based on latest data available at the end of the quarter

Connecticut Home Health Patients with a Hospital Admission (2017)

3 out of 10 people discharged to hospital is highest rate in the United States



Key:

- Hospital Admission
- No Hospital Admission

Source: AARP: PICKING UP THE PACE OF CHANGE: 2017 LONG-TERM SERVICES AND SUPPORTS

Medicare Service Use of Nursing Facility Stay per 1000 Connecticut Enrollees (2016)

Number of people with nursing home stay higher than any other state

Key:

- Nursing Home Stay
- No Nursing Home Stay

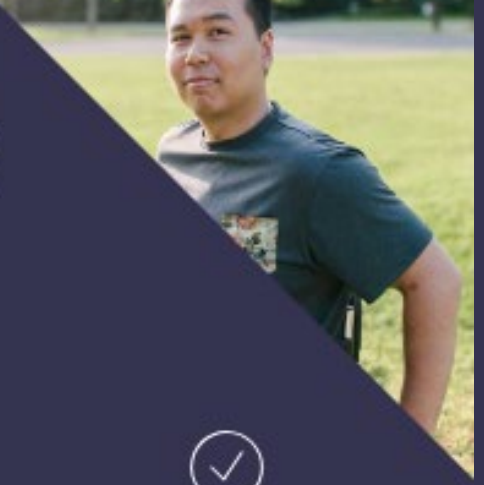
Notes
Analysis excludes beneficiaries in Medicare Advantage and beneficiaries with zero months of Medicare Part A coverage.

Data are as of July 1 of the year indicated in each timeframe.

Sources
Kaiser Family Foundation analysis of a five percent sample of Medicare claims from the CMS Chronic Condition Data Warehouse, 2000-2014.

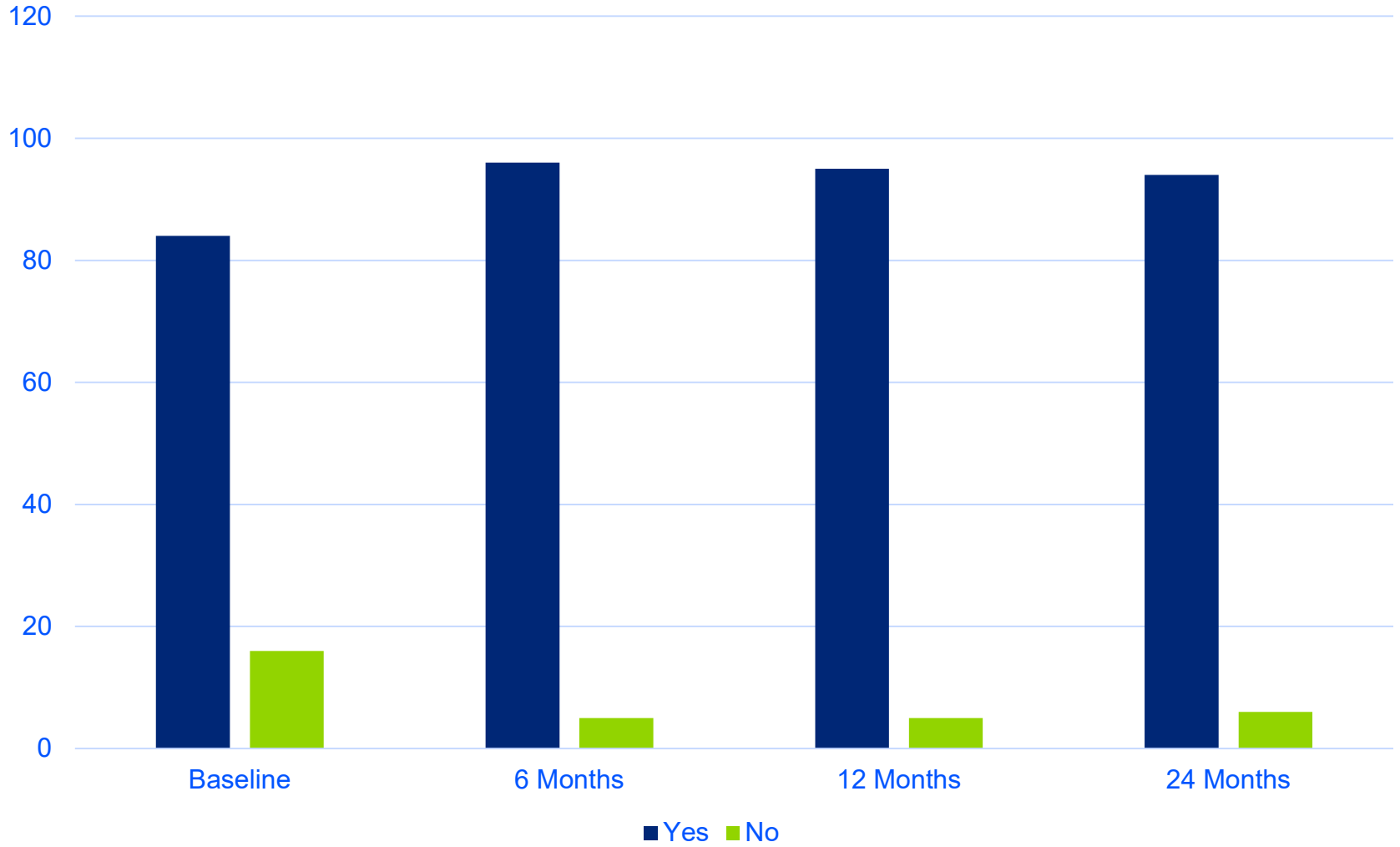
Analyze and publish success

01 BENCHMARKS



	2007	2018	✓
TRANSITION PEOPLE FROM INSTITUTIONS	0	5286	✓
INCREASE % FUNDING TO COMMUNITY	33%	49%	✓
INCREASE % OF LTSS MEMBERS IN COMMUNITY	52%	61%	✓
INCREASE % OF HOSPITAL DISCHARGES TO COMMUNITY	47%	57%	✓
INCREASE PROBABILITY OF DISCHARGE WITHIN 6 MONTHS	27%	41%	✓

Do the people who help you treat you the way you want them to?



UConn Health, Center on Aging

Operating Agency: *CT Department of Social Services* **Funder:** *Centers for Medicare and Medicaid Services*

Based on latest data available at the end of the quarter

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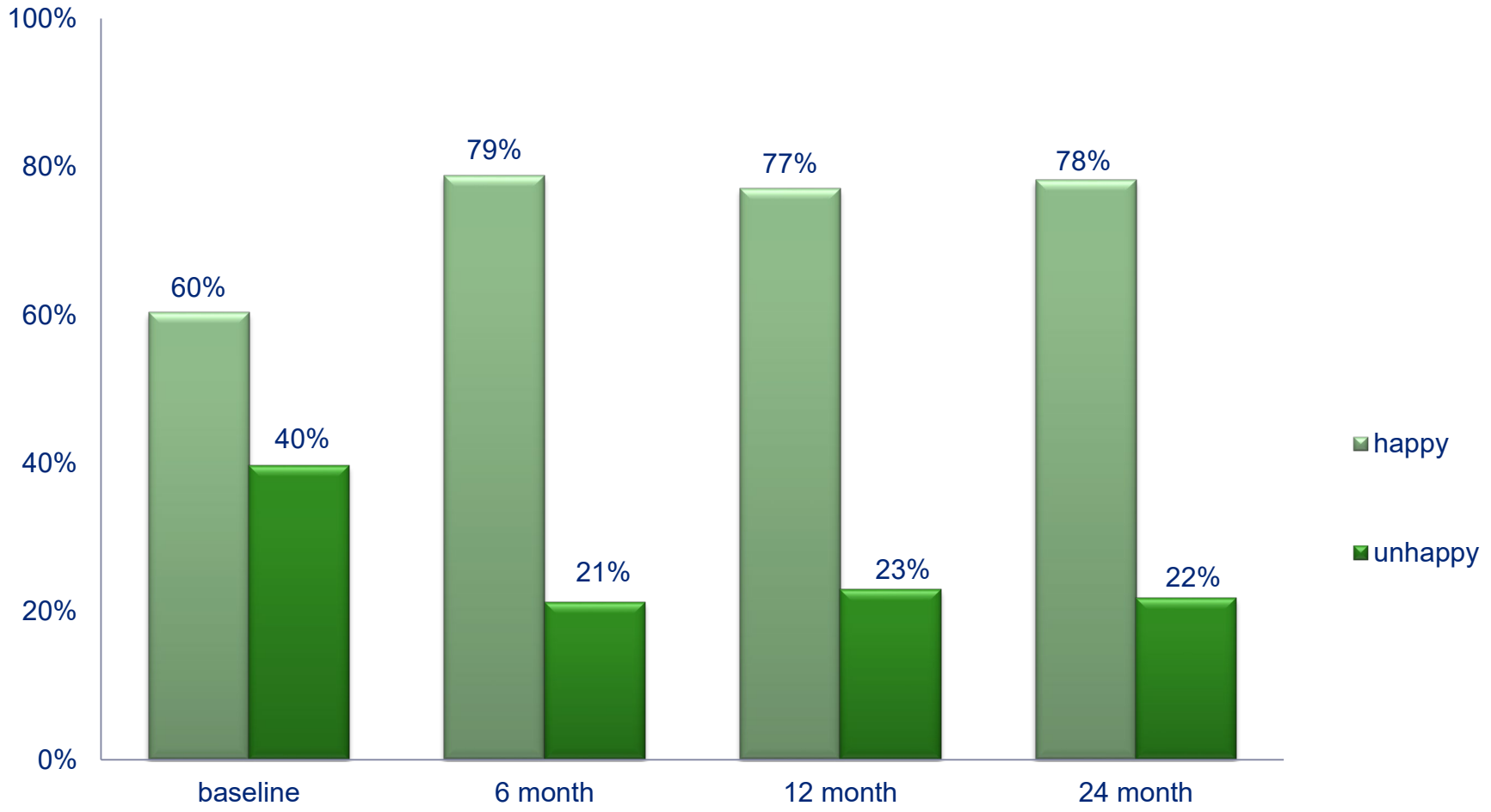
Happy or unhappy with the way you live your life*



UConn Health, Center on Aging

Operating Agency: *CT Department of Social Services* **Funder:** *Centers for Medicare and Medicaid Services*

Based on latest data available at the end of the quarter

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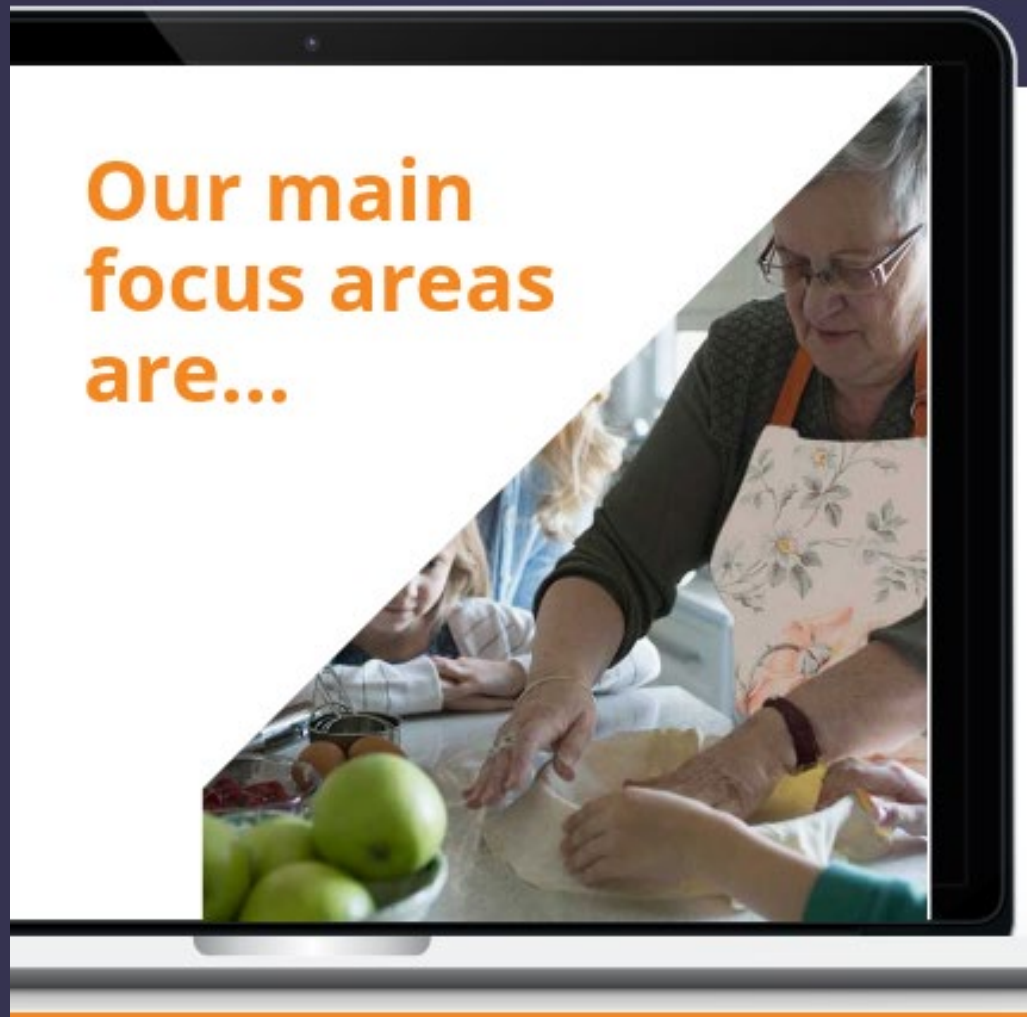
Develop a plan

02 STRATEGIES



01 Transitions to Community

02 Home and Community

03 Housing

04 Diversion

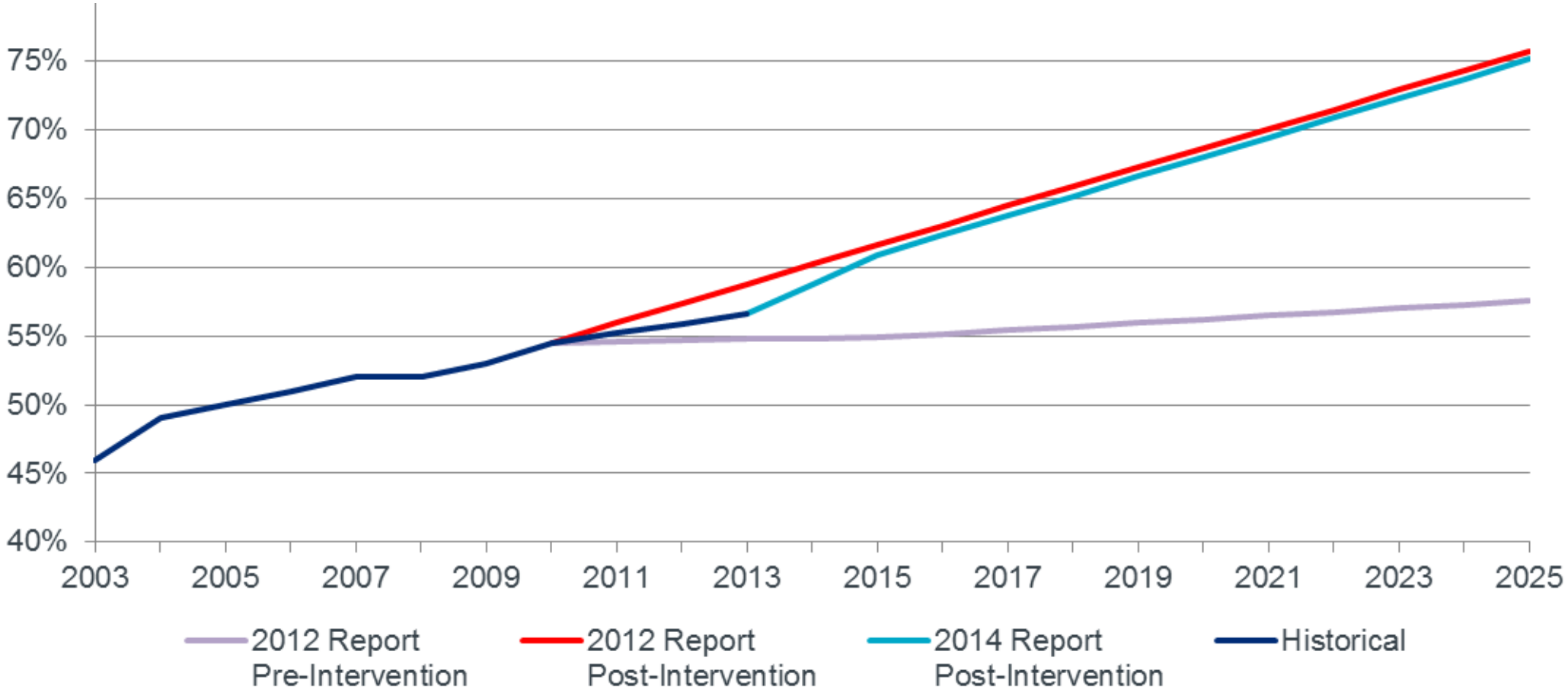
05 Workforce

06 Community Integration

07 Business Diversification

Communicate impact of plan on existing system

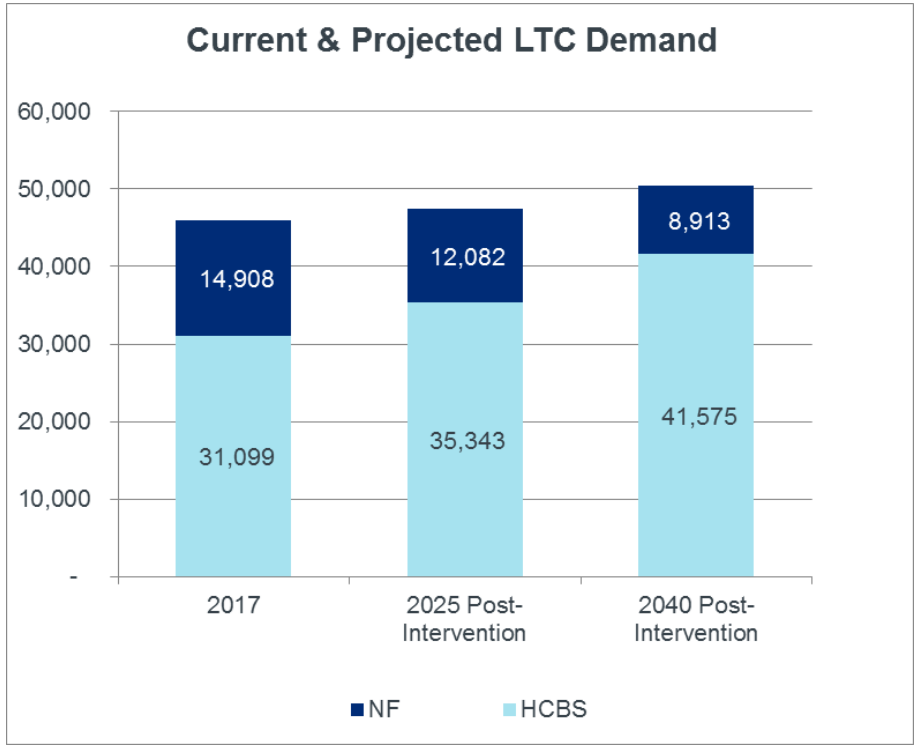
Projected use of nursing home compared to community long-term services and supports

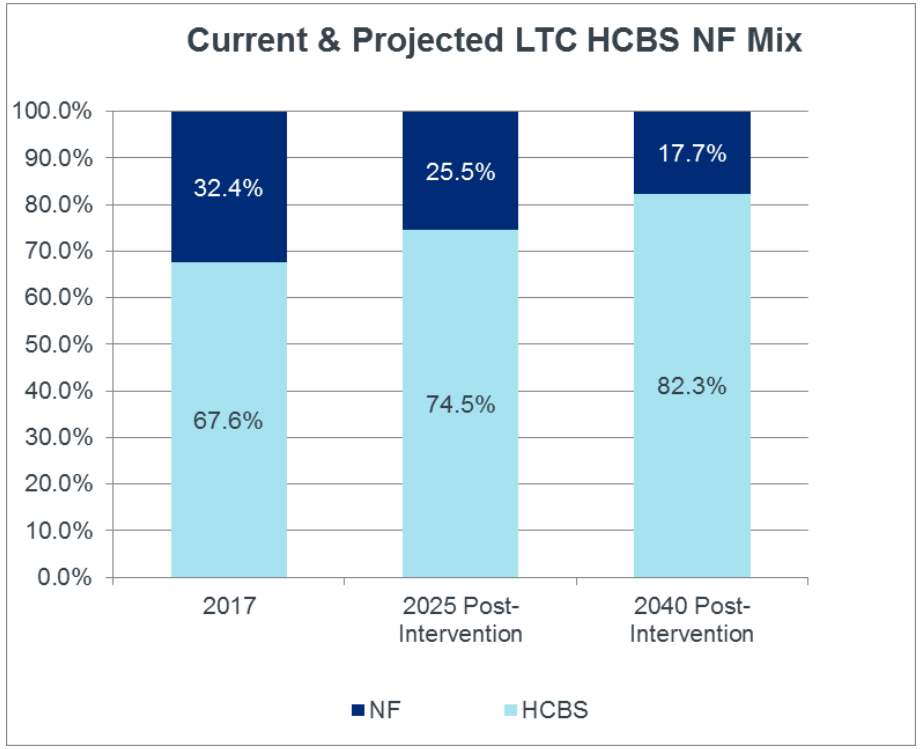


Strategic LTSS rebalancing initiatives have changed the historical trend of where LTSS participants will receive services by 2025. Current projections indicate that 75% of all LTSS participants will receive services in the community rather than in a nursing home by 2025

Analysis
Home and Community Based Services as a Proportion of State Population at Nursing Home Level of Care

Projections of future HCBS/NF levels presume the State will continue to use current initiatives and will utilize additional initiatives in future years in order to achieve the projected 2040 HCBS levels.





Source: Connecticut Long-Term Care Demand Report, July 2019, Mercer Consulting, Government, Human Services

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Translate plan into budget language

Average Return on Investment
Per Member Per Day
Institution Cost compared to Community Cost

Net Medicaid savings: $50
Cost of community housing: $26
State savings: $24

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Connecticut General Assembly
Office of Fiscal Analysis Budget Book
Agency Budget Draft Sheets
SFY 20 - 21

Human Services — Department of Social Services

Account	Governor Recommended		Legislative		Difference from Governor	
	FY 20	FY 21	FY 20	FY 21	FY 20	FY 21

Legislative

Same as Governor

Strengthen Rebalancing Efforts under Money Follows the Person

Personal Services	726,400	726,400	726,400	726,400	-	-
Other Expenses	800,000	500,000	800,000	500,000	-	-
Medicaid	(480,000)	(4,740,000)	(480,000)	(4,740,000)	-	-
Total - General Fund	**1,046,400**	**(3,513,600)**	**1,046,400**	**(3,513,600)**	**-**	**-**
Positions - General Fund	**7**	**7**	**7**	**7**	**-**	**-**

Background

The Money Follows the Person (MFP) rebalancing demonstration is a federal initiative that encourages states to reduce their reliance on institutional care for Medicaid recipients by transitioning individuals out of institutional settings and into community settings with appropriate supports.

Translate plan into changing lives.

Doug Lagasse's Story

"I now have a path to success instead of a path to failure. [MFP] helped me in ways that allow me to focus on my health and get better. "

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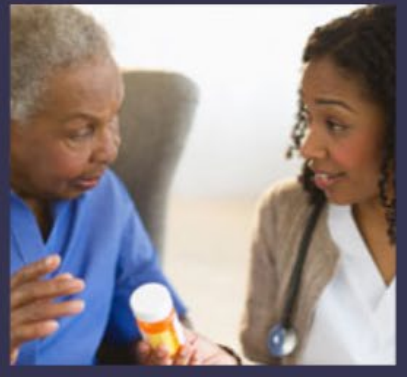
LESSONS LEARNED



Engagement

Investment in ongoing education

HOUSING

ROI

Targeted housing saves Medicaid money

Culture

Belief in human potential

STAFF

Direct Care

Who do we hire and who are our partners?

Reflections MFP Sustainability

- Highlights from session
- What are states currently doing?
- What action might MFP program directors/staff take?

MFP Grant Budget Procedures

Moderator:

- **Todd Wilson**, MFP Team Lead, DCST

Panelists:

- **Geoffrey Ntosi**, Grants Management Officer, Office of Acquisition and Grants Management (OAGM)
- **Monica Anderson**, Grants Management Specialist, OAGM

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Annual MFP Fiscal Management

Money Follows the Person
National HCBS Conference Workshop
August 26, 2019

Presented by: Geoffrey Ntosi, MBA

Monica Anderson, MS

Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management (OAGM)

Agenda

- OAGM Budget Workbook Overview: Budget Summary and Categories
- OAGM Budget Workbook File
- Overview of MFP Budget Submission and Required Documents
- Application Expectations and Requirements
- Lessons Learned
- Overview of the Closeout Process
- Questions and Answers

Budget Workbook Overview

Excel Budget Workbook submission

- Consolidated Budget – Light Green tab
- Budget Summary – Blue tab

Each budget category can be found on the labeled worksheet (Red tabs).

- A. Personnel
- B. Fringe Benefits
- C. Travel
- D. Equipment
- E. Supplies
- F. Subrecipients
- H. Other
- J. Indirect Costs

Note: The totals from each tab (A-J) are tallied on the Budget Summary (blue tab) worksheet. Supporting documentation should be embedded in the budget workbook on the appropriate cost category tab.

Budget Workbook

- ✓ Consolidated Budget Tab
- ✓ Budget Summary tab – DO NOT ENTER INFORMATION ON THIS TAB!
- ✓ Each tab reflected in the image above represents a worksheet in the workbook.
- ✓ Each worksheet is completed with the cost itemization in the table and a brief instructional narrative highlighted in gray.
- ✓ The Green tabs provide an area for details of each Sub-recipient in the request.
- ✓ Sub-recipient budgets should reflect an itemization of each individual subaward submitted with the request.
- ✓ 2nd Tier Sub-recipient Budgets should only be completed, if applicable.
- ✓ The SF-424A should directly reflect the totals listed on the Budget Summary page.

Narrative Cost Justifications

- Your submission must include a detailed narrative justification for EACH cost line item in each category table. Narratives can be provided in a text box, an excel, word or pdf.doc that is inserted next to the cost table in the Budget Workbook.
- Each tab contains requirements for each cost category

Your submission must:

- Explain how each cost was determined
- Show all calculations (Excel formula, add a table, or narrative)
- Explain how the cost furthers the objectives of the program

Consolidated Budget

Grantee Name: **Award Number:**

6. Object Class Categories	CY 2018 (Budgeted)	CY 2018 (Actuals)	CY 2018 Unobligated Balance	CY 2019	CY 2020	Total
a. Personnel						$0.00
b. Fringe Benefits						$0.00
c. Travel						$0.00
d. Equipment						$0.00
e. Supplies						$0.00
f. Contractual						$0.00
g. Construction						$0.00
h. Services (OTHER)						$0.00
i. Total Direct Charges (sum of 6a-6h)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
j. Indirect Charges						
k. Total Federal Budget (sum of 6	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

2019 - 2020 Estimated Federal Budget

Enter unobligated balance of federal funds as of 12/31/2018 - FFR Line 10H

$0.00 Difference should be zero

$0.00 Restricted for 2020

Additional Details

Please enter the values for each object class category as specified by the Columns listed. The Budgeted column should reflect the approved budget from the previous fiscal year. The Actuals column should reflect the actual costs for the project as of the end of the previous calendar year. The MFP project is based on a January 1 - December 31 calendar year schedule.

Rows C14 - H14 and C16 - H16 contain a formula to calculate the totals. Please do not enter any figures in these cells. Column H6 - H14, and H16 also contain formulas to calculate the totals. No figures should be entered into these cells.

Budget Summary

Budget Summary 2019 Only

Grant #:

Agency Name:

Category	CY 2019 Federal Cost	Unobligated Balances from CY	Supplement	Non-Federal Match	Total
Personnel	0.00	0.00	0.00		0.00
Fringe Benefits	0.00	0.00	0.00		0.00
Travel	0.00	0.00	0.00		0.00
Equipment	0.00	0.00	0.00		0.00
Supplies	0.00	0.00	0.00		0.00
Contractual	0.00	0.00	0.00		0.00
Services-Other	0.00	0.00	0.00	0.00	0.00
Total Direct Costs	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Indirect Costs	0.00	0.00	0.00		0.00
Total Project Costs	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Additional Detail

Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management (OAGM)

Personnel

A. Personnel	**0.00**	To Section B-SF-424A	
Unobligated Balance:	0.00		
Supplement	0.00		

Effective Jan 2019 - the Executive Level II salary cap will continue at $189,600.

				Level of Effort		Costs		
Position Title	**Name**	**Position Status**	**Annual Salary/Rate NTE $187,000**	**Federal**	**Non-Federal Match**	**Federal**	**Non-Federal Match**	**Role & Responsibilities**
			$ -	100%	0%	$ -	-	
			$ -	100%	0%	$ -	-	
			$ -	100%	0%	$ -	-	
			$ -	100%	0%	$ -	-	
			$ -	100%	0%	$ -	-	
			$ -	100%	0%	$ -	-	
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			$ -	100%	0%	$ -	-	
			$ -	100%	0%	$ -	-	
			$ -	100%	0%	$ -	-	
			$ -	100%	0%	$ -	-	
			$ -	100%	0%	$ -	-	
Total			**$ -**			**$ -**		

ADDITIONAL DETAIL

Fringe Benefits

B. Fringe Benefits	$ -		To Section B-SF-424A	
Unobligated Balance:	0			
Supplement	0			

Component	Benefit Rate	Salaries/Wages	Federal	Non-Federal Match	Narrative/Comment
Retirement		-	$ -	$ -	
Social Security & Medicare		-	$ -	$ -	
Group Life		-	$ -	$ -	
Health Insurance		-	$ -	$ -	
Retiree Health Credit		-	$ -	$ -	
Disability		-	$ -	$ -	
			$ -	-	

ADDITIONAL DETAIL

Apply the appropriate fringe benefit rate to each salary amount determined in the personnel section. Fringe benefits may include contributions for social security, employee insurance, pension plans, etc. Only those benefits not included in an organization's indirect cost pool may be shown as direct costs.

Please submit a narrative justification for EACH line item for this cost category table that itemizes all components of the fringe benefit rate. Enter a description of the fringe funds requested and how the benefits were calculated.

Narrative can be provided in an excel spreadsheet or pdf document pertaining to this cost table.

Travel

C. Travel	0.00	-	Section B- SF-424A
Unobligateed Balance:	0.00	0	
Supplement	0.00	-	

The GSA POV mileage reimbursement rate is $0.58 per mile, effective January 1, 2019.

Purpose of Travel	Location	Item	Estimated Staff Eligible for	Number of Days	Rate	Federal Cost	Non-Federal
MFP P/D Conference		Airfare				$ -	$ -
		Hotel				$ -	$ -
		Per Diem (Meals)				$ -	$ -
		Cab				$ -	
Housing Conference		Airfare				$ -	
		Hotel				$ -	
		Per Diem (Meals)				$ -	
State Travel		Airfare				$ -	
		Hotel				$ -	
		Per Diem (Meals)				$ -	
Local Travel		Mileage				$ -	
Grand Total						-	-

Equipment

D. Equipment		$0.00		To Section B-SF-424A	
Unobligated Balance:		0			
Supplement		$0.00			

Item	Rate	Total Cost	Federal Cost	Non-Federal Cost	Description
			$0.00		
Equipment Total			$0.00		

Supplies

D. SUPPLIES	0.00			To Section B - SF-424A	
Unobligated Balance:	0.00				
Supplement	0.00				
Item(s)	Rate	Cost	**Federal**	**Non-Federal Match**	Explanation
	0.00	$ -	$ -	$ -	
	0.00	$ -	$ -	$ -	
	0.00	$ -	$ -	$ -	
	0.00	$ -	$ -	$ -	
	0.00	$ -	$ -	$ -	
	0.00	$ -	$ -	$ -	
Supplies Total		$ -	$0	$0	

SUBRECIPIENT

F. Subrecipient Cost	$ -	To Section B -SF-424A
Unobligated Balance	$0.00	
Supplement	$ -	

Item #	Subrecipient (Enter the name of the Subrecipient)	Statement of Work	Cost	Federal	Non-Federal Match
1	.	See example in guidance section			
2		See example in guidance section			
3					
4		See example in guidance section			
5		Mandatory CMS Survey ($100 per survey * 300= 30,000)			
6		Attach separate categorical Budget			
7		Attach contract or separate categorical Budget			
8					
9					
10					
	Total		$ -	$ -	$ -

ADDITIONAL DETAIL

For the subrecipients that have not been arranged, please provide the expected Statement of Work, Period of Performance and how the proposed costs were estimated. Where there are contracts that cover more than one department or project, describe the agreement and be prepared to provide either the interagency agreement (IAAs) that clearly shows the cost to your project or a budget that clearly explains and itemizes the cost to your project.

Subrecipient budgets

Provide narrative justification for each Subrecipient and show calculations for each line item: how the Subrecipient was selected, vendor quotes, period of performance, description of the scope of the work, personnel/salary, fringe, travel costs, level of effort (LOE) and how the cost rates were determined. Itemize budget with calculations and describe how each Subrecipient relates to furthering the objectives of the program. Add rows and additional tables as necessary to accurately reflect proposed budget.

If applicable, show the indirect cost rate (ICR) and calculated modified total direct costs (MTDC) in narrative. MTDC consists of total direct costs minus the following exclusions: equipment over $5,000, capital expenditures, charges for patient care, tuition remission, rental costs of offsite facilities, scholarships, fellowships, and the portion of each subSubrecipient in excess of $25,00.
2nd Tier Subrecipients – Provide same detailed information, as provided for "Subrecipients", on the 2nd Tier SubSubrecipientor Budgets tab. Include vendor quotes/itemized cost build-ups, period of performance, description of the scope of the work, personnel, salary (level of effort), fringe, supplies, travel costs, how base cost rates and user rates were determined. Show calculations and describe how each subSubrecipient relates to furthering the objectives of the program.

#1 Subrecipient or Consultant:

Budget Category	Cost	Narrative Descriptions
Personnel		
Fringe Benefit		
Travel		
Equipment		
Supplies		
2nd Tier Subrecipient		
Other		
Indirect		
Totals	$0.00	

Narrative Justification Subrecipient #1:

Other-service dollars

H. Other				
Total Federal HCBS Cost		$0.00		
Unobligated Balance		$0.00		
Supplement		$0.00		
Services	Cost	**Federal**	**Non-Federal Match**	Cost Methodology
Qualified HCBS Services			$ -	Clearly explain how your Qualified HCBS Sevices Cost was derived. See example
Demonstration HCBS Services			$ -	Clearly explain how your Demonstration HCBS Sevices Cost was derived
Supplemental Services		$ -	$ -	Clearly explain how your Supplemental Sevices Cost was derived
Total	$ -	$ -	$ -	

Services Detail Worksheet Example

Monthly Average Per Client 2013	
Qualified Services	**Demonstration Services**
$2,100.00	$950.00

Month	**Estimated Enrollment Qualified Sservices**	**Estimated Enrollment Demonstration Services**	**Qualified Services Cost**	**Demonstration Services Cost**
January	6	7	12600	6650
February	12	9	25200	8550
March	12	16	25200	15200
April	28	20	58800	19000
May	39	14	81900	13300
June	40	24	84000	22800
July	50	32	105000	30400
August	63	35	132300	33250
September	70	40	147000	38000
October	79	45	165900	42750
November	86	50	180600	47500
December	99	53	207900	50350
		Totals	1226400	327750
		Federal Match Rate	75%	75%
		Federal Request	919800	245812.5
State General Fund		306600.00	81937.50	
Total				

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Office of Acquisition and Grants Management (OAGM)

Indirect Charges

J. Indirect Charges		0.00		
Unobligated		0.00		
Supplement		0.00		

BUDGET NARRATIVE: Object Class Category by Line	Total Costs	Federal Share	State Share	BUDGET NARRATIVE: Justification
DCA/CMS-Approved Cost Allocation	$ -	$ -	$ -	Please attach approved IDC rate or Cost allocation plan and explain calculation
DACS & OOIE/CMS-Approved Cost Allocation	-	$ -	$ -	
Total	-	$ -	$ -	

Additional Detail

Enter your ICR and provide a copy or link to your agency's approved (current) Negotiated Indirect Cost Rate Agreement (NICRA).

Show calculated modified total direct costs (MTDC). MTDC consists of total direct costs minus the following exclusions: equipment over $5,000, capital expenditures, charges for patient care, tuition remission, rental costs of offsite facilities, scholarships, fellowships, and the portion of each subgrant/subcontract in excess of $25,000.

Personnel Information Guidance

Enter Personnel that are absolutely necessary for the MFP project. At minimum, the PI/PD must be included. Identify each individual separately and provide: the title; time commitment to the project in months; time commitment to the project as a percentage of full-time equivalent; annual salary; wage rates; etc. Be sure to explain how requested personnel funds will support the purpose and goals of this project. And where necessary, please describe the role, responsibilities and unique qualifications of each position.

Note: In accordance with the Consolidated Appropriations Act, no cooperative agreement funds may be used to pay an individual working on a DHHS funded project at a rate in excess of the Federal Executive Level II Pay Scale. The Federal Executive Pay scale is updated in January of each calendar year. The rates are set by Congress as part of the annual federal budget appropriations process. The “direct salary and institutional base salary" are limited to the Executive Level II of the Federal Executive Pay scale. The salary limitation applies to grants/cooperative agreements/contracts including subawards/subcontracts.

Budget Workbook Changes

- **Personnel** – The salary cap information is included in the budget workbook.
- **Fringe Benefits** – NICRA Language is included in "Additional Information."
- **Travel** – The language for CFR citation **45 CFR 75.473-75.474 Travel Costs** are included on this tab.
- **Supplies** – The language for CFR citation **45 CFR §75.2, Definitions, Supplies** is included for clarity.

Budget Workbook Changes (continued)

- **Subrecipients** - Renamed the tab (formerly Contracts), enter the Sub-recipient name, include a Statement of Work.
- **Sub-recipient Budgets** - Renamed the tab (formerly Contract Budgets), Requires added for recipient:
  - "Please submit a detailed budget narrative justification for EACH line item, in paragraph format, for each cost category table; budget narratives can be provided in a text box or an excel, word or pdf.doc that can be inserted next to the cost table in the Budget Workbook."
- **2nd Tier Sub-recipient Budgets** - Renamed the tab (formerly Contract Budgets), Individual tables do not feed into the "Sub-recipient Budgets" sheet.

Budget Workbook Changes (continued)

- **Other** - Inserted language directing Recipients to include contracts (goods and services) and supporting documentation
  - The HCBS Costs (Qualified, Demonstration and Supplemental Costs) listed on the "Other" tab of the Excel Budget Workbook correlates to the Worksheet For Proposed Budget (WFPB).
  - The total services costs and the total administrative costs on the WFPB should agree with the total services costs and total administrative costs in the Excel Budget Workbook.

- **Indirect Costs** - Inserted a table to help Recipients calculate their MTDC

Overview of Budget Submission

- Submission must include the following items:
  - Cover Letter on Institutional letterhead, signed by the Authorized Organizational Representative (AOR)
  - Budget & Narrative Justification Current Year only
  - WFPB form
  - MOE form
  - SF-LLL Assurance-Non-Construction
  - Conference / Travel Request form
  - Travel Expense Log(s) – use travel log form provided by OAGM
- Submitted via GrantSolutions as an amendment

Application Expectations

- Annual budget review
- Flexibility to re-allocate funds
  - Must remain within the approved cumulative budget ceiling.
  - FFR (SF-425) must be submitted before request will be processed.
  - Semi-annual progress report
- Online Forms:
  - SF-424B Assurances-Non-Construction
  - SF-LLL Disclosure of Lobbying Activities

Application Expectations (continued)

Additional Information to be Submitted

- Cover Letter on Institutional letterhead, signed by the Authorized Organizational Representative (AOR)
- Budget narrative and justification
- Worksheet for Proposed Budget (WFPB) revised 2/5/2019
- Maintenance of Effort (MOE) revised 10/01/2018
- SF-LLL Disclosure of Lobbying Activities
- Most Recent Approved Indirect Cost Agreement
- Other supporting documents (contracts, travel log and conference request and approval form, etc.)

Lessons Learned:
Avoiding delays and pitfalls

- Justification! Justification!! Justifications!!!
- New initiative justification (This may signal a change of scope which requires prior approval).
- Categorical breakdown of unobligated balance
- Travel (travel log, food, etc.)
- Supplies (marketing & promotional Items, etc.)
- Contracts and Sub-awards
- Review last NOA for remarks and outstanding information.

Pre-Closeout

- All recipients will receive a Pre-Closeout Letter at least 60 days prior to the closeout date of the project.
- It is recommended that the project director/principal investigator review the closeout letter with Authorized Organization Representative (AOR) and Finance Officer, and/or Sponsored Projects staff.

Pre-Closeout Letter
(Draft)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop B3-30-03
Baltimore, Maryland 21244-1850

DATE

DRAFT COPY

Dear MFP Awardee:

Our records indicate that the <<**ENTER PROGRAM NAME**>> MFP award issued to the <<**ENTER RECIPIENT/AWARDEE**>> (Recipient) is scheduled to end September 30, 2020. In accordance with the terms and conditions of Recipient's award, final reports are due no later than December 31, 2020. The final reports include:

- **A final Federal Financial Report (SF-425, FFR)**. Lines 10d-10h must be completed (and lines 10i through 10o as applicable and/or allowable). Recipient must include information on program income and indirect costs, if approved as part of grant award.
- **A final performance/progress report (PPR)**. The format for this report will be provided by the CMS Program Office.
- **A Tangible Personal Property Report, Final Report, SF-428-B.** A Supplemental Sheet, SF-428-S, must be included as instructed below (see subsection below titled *Disposition of Federally Owned Property, Equipment, and Residual Unused Supplies*). If there is no tangible personal property to report, select "d." in section 1 and indicate "none of the above."
- **A Final Invention Statement and Certification, HHS-568.** If no inventions have been made under this award, insert the word "None" under "Title of Invention" in Section B, Inventions.

In addition to these standard final reports, additional forms may be required which include:

- A final Worksheet for Proposed Budget (WFPB)
- A final Maintenance of Effort (MOE) form

This letter further details these requirements and other relevant information to ensure proper closeout of this award.

Submission of Closeout Materials to CMS

To initiate the closeout process, Recipient must create a **Closeout** amendment through the Amendment Module in GrantSolutions. This amendment, and upload of all required documents, must be completed no later than 90 days following the project period end date noted on Recipient's Notice of Award (NoA). Submission of these closeout documents, other than as noted in this letter, will result in Recipient's reports being considered delinquent.

Final Federal Financial Report (SF-425, FFR)

The final FFR must be completed in the GrantSolutions FFR Module (if available for Recipient's program) and a copy of this FFR uploaded to the Closeout Amendment in GrantSolutions. Otherwise, Recipient must complete the fillable PDF version of the FFR and upload it to the **Closeout** amendment. The final FFR must show cumulative expenditures under the award and any unobligated balance of federal funds. As appropriate, all parts of the form (lines 1-9 and 10d-13) must be completed except for line items 10.a through 10.c. The final expenditure report must show $0 for unliquidated obligations (line 10f) or the report will not be accepted and will be returned. Please note that final, cumulative federal cash transactions information (lines 10.a through 10.c) must still be reported to the Payment Management System (PMS) based upon the quarterly schedule established for submission of these reports (see *Quarterly Financial Reporting* section within the terms and conditions of Recipient's Notice of Award). It is the Recipient's responsibility to reconcile any financial reports submitted to PMS and to CMS. Reconciliation consists of ensuring that disbursements equal obligations and drawdowns, to include making any necessary adjustments, e.g. for an overpayment. Block 10.h of the Final SF-425 must match the award balance (if there is one) in PMS.

Recipient is reminded that it is responsible for the timely closeout of any subgrant(s) and or contract(s) under the grant, and the financial settlement of any claims so that it can meet CMS closeout requirements. Recipient should establish a receipt date for its subrecipients/contractors to submit closeout data, final reports, and final claims that allows Recipient to meet the requirements for submission of final reports.

In accordance with HHS regulation, a non-Federal entity must liquidate all obligations incurred under the award not later than 90 days after the end of the funding period to coincide with the submission of the final FFR. This deadline may be extended with prior written approval from the CMS Grants Management Specialist. Allowable costs must be incurred during the period of performance (except as described in 45 CFR §75.461 for award funds issued on or after December 26, 2014). Costs incurred beyond the project period end date **will not** be reimbursable.

Final Performance/Progress Report

Recipient must upload the final performance/progress report to GrantSolutions as part of closeout process unless alternative guidance is provided by Recipient's Grants Management Specialist.

Disposition of Federally Owned Property, Equipment, and Residual Unused Supplies

Upon completion (or early termination) of a project, Recipient must take appropriate disposition actions. Recipients of funding from CMS should proceed in accordance with the guidance provided within this letter and applicable term and condition.

Recipient must complete and submit the **SF-428-B Tangible Personal Property Report Final Report** (also see the specific Standard Term and Condition entitled Reporting Requirements). The Tangible Personal Property Report (SF-428-B) is a standard form to be used by awarding agencies to collect information related to tangible personal property when required by a Federal financial assistance award. This form allows recipients to request specific disposition of Federally-owned property and acquired equipment. This form also provides a means for calculating and transmitting appropriate compensation to CMS for residual unused supplies. As noted in 1.b of this report, if Recipient agency is in possession of federally-owned property or

acquired equipment (defined as nonexpendable personal property with an acquisition cost of $5,000 or more under the award), Recipient must also submit a **SF-428-S, Supplemental Sheet**, that lists and reports on all federally-owned or acquired equipment under the specific grant or cooperative agreement award. If there is no tangible personal property to report, select "d." in section 1 of the SF-428-B and indicate "none of the above." Recipient must request specific disposition instructions from CMS if the Recipient has federally-owned Property or if the following guidance is insufficient for the Recipient to properly complete disposition.

- Items of equipment with a current per unit fair market value of $5,000 or less may be retained, sold, or otherwise disposed of with no further obligation to the HHS awarding agency.
- Except as provided in 45 CFR §75.319(b) for award funds issued on or after December 26, 2014, items of equipment with a current per-unit fair market value in excess of $5,000 may be retained by the non-Federal entity or sold. If there is no longer a use for the equipment under the original project or program or for other activities currently or previously supported by CMS or other HHS awarding agencies, except as otherwise provided in Federal statutes and regulations, CMS is entitled to an amount calculated by multiplying the current market value or proceeds from sale by CMS's percentage of participation in the cost of the original purchase. If the equipment is sold, CMS may permit the non-Federal entity to deduct and retain from the Federal share $500 or ten percent of the proceeds, whichever is less, for its selling and handling expenses.
- Reportable residual unused supplies, which in the aggregate exceed $5,000 in fair market value, which cannot be used by the original project or program nor are needed for other activities currently or previously supported by CMS, other HHS awarding agencies, or another Federal agency, must be retained by the Recipient for use on other activities or sold, but the Recipient must, in either case, compensate the Federal government for its share. CMS is entitled to an amount calculated by multiplying the current fair market value or proceeds from sale by CMS's percentage of participation in the cost of the original purchase.

In certain instances, the non-Federal entity may transfer title to the property to the Federal government or to an eligible third party subject to prior approval by CMS. In such cases, the non-Federal entity must be entitled to compensation for its attributable percentage of the current fair market value of the property.

Inventions

A Final Invention Statement and Certification (Form HHS 568) must be completed and submitted within 90 days following the expiration or termination of a grant or award. The Statement must include all inventions which were conceived or first actually reduced to practice during the course of work under the grant or award, from the original effective date of support through the date of completion or termination. The Statement shall include any inventions reported previously for the grant or award as part of a non-competing continuation application. Recipients must also provide details about all inventions that have been licensed but not patented, and include details on income resulting from HHS-funded inventions and patents. Unpatented research products or resources—research tools—may be made available through licensing to vendors or other investigators. Income earned from any resulting fees must be treated as program income. This reporting requirement is applicable to grants and awards issued

by the U.S. Department of Health and Human Services in support of research and research-related activities. If no inventions have been made under this award, insert the word "None" under "Title of Invention" in Section B, Inventions.

Audit Requirements

Recipient is reminded that it is still required to comply with the audit requirements as outlined in Federal grant regulations. If, after the closeout has been completed, a subsequent audit report identifies unallowable costs, CMS has the right to disallow costs and recover an appropriate amount based on sustained audit findings.

Corrections to Closeout Documents to Include Refunds or Debts to Federal Government

The closeout of a grant does not affect Recipient's obligation to return any amounts due as a result of later audit disallowances, refunds, corrections, or other actions. All funds due that are not returned constitute a debt to the federal government. It is not necessary to submit revised closeout documents with each repayment; however, it is necessary that each payment be accompanied by the following information: the grant number, the source or nature of the payment, and any other pertinent information relating to the amount that assists us in properly accounting for the funds.

Records Retention Requirements

Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained by the grantee for a period of 3 years from the date of submission of the final SF-425 (FFR) except if any litigation, claim, financial management review, or audit is started before the expiration of the 3-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

If Recipient anticipates not being able to meet the above time frames or requirements, it must immediately notify the Grants Management Specialist in writing via a grant note in GrantSolutions with a follow-up notification via email.

Please note that the information in this letter is consistent with HHS regulation 45 CFR Parts 74 and 92 for award funds issued prior to December 26, 2014 and with HHS regulation 45 CFR Part 75 for award funds issued on or after December 26, 2014. Any pertinent differences, for the purposes of closeout, are noted.

Sincerely,

<<**ENTER NAME OF GMS**>>
Grants Management Specialist
Division of Grants Management
Office of Acquisition and Grants Management

cc: Project Officer

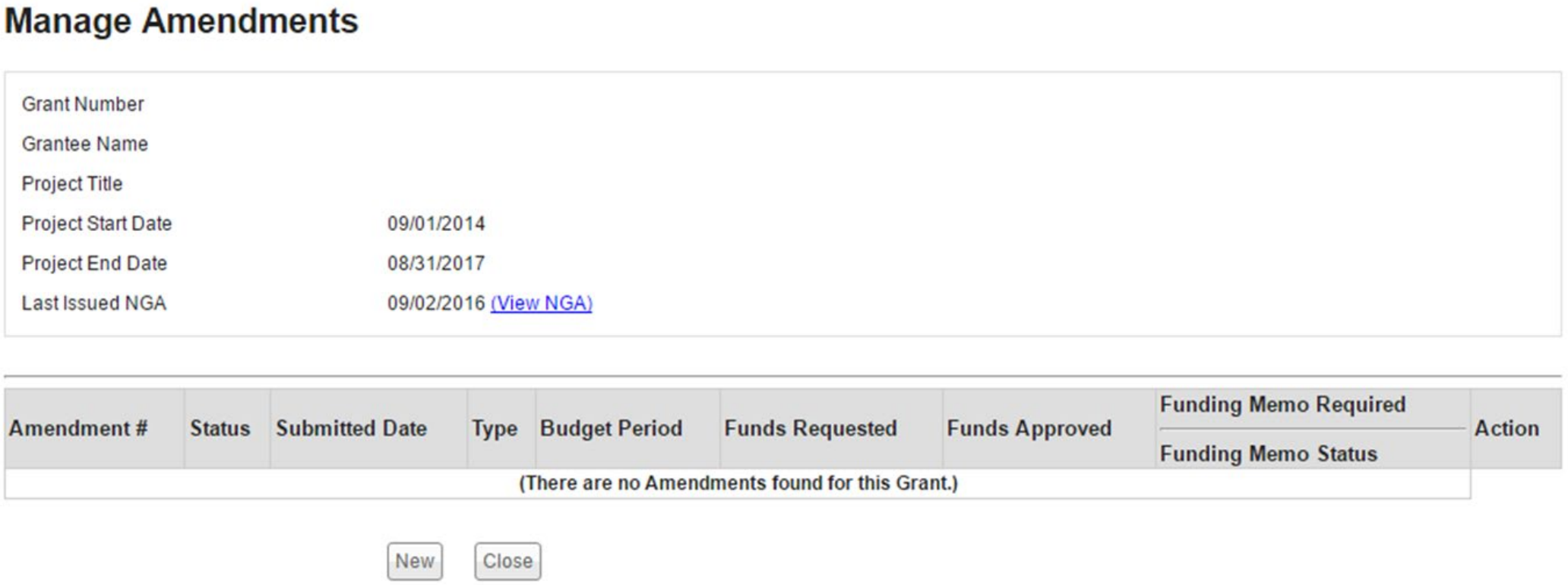
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management (OAGM)

Close-out Application Process

- To begin the submission of the Closeout application, please select the MFP award

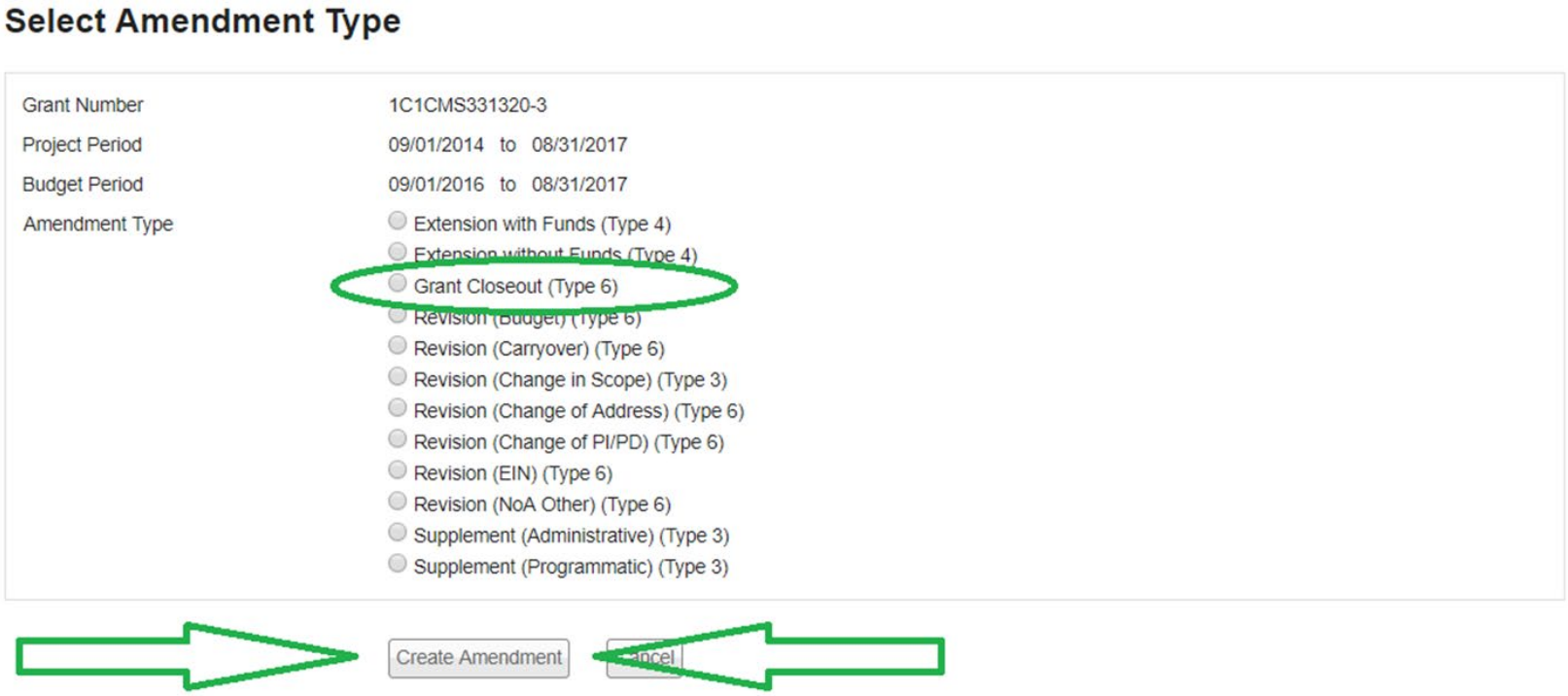
Close-out Application Process II

- Create A New Amendment



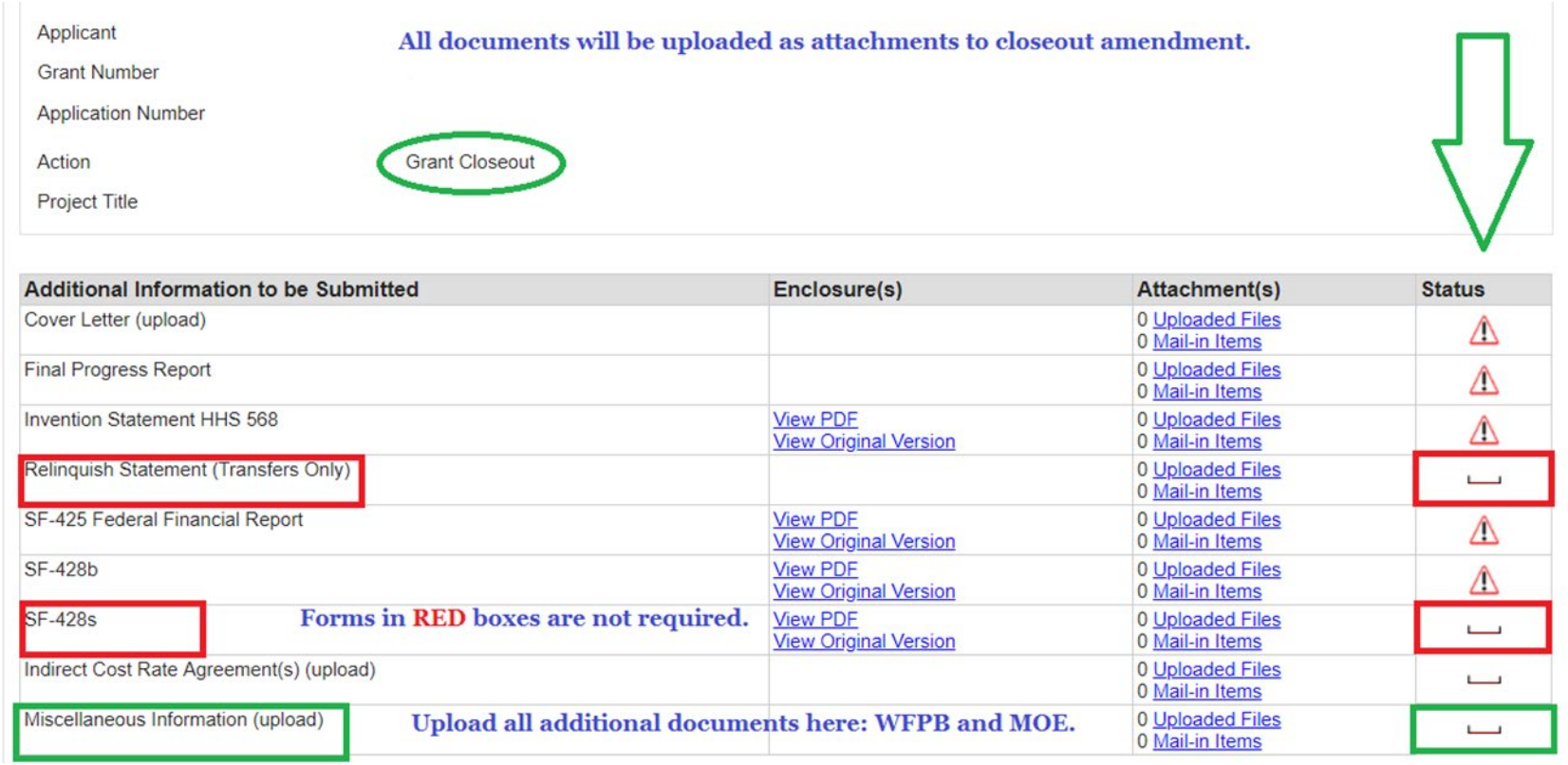
Close-Out Application Process III

- Select the Amendment Type and create the amendment
- For the Closeout application, select Grant Closeout (Type 6)



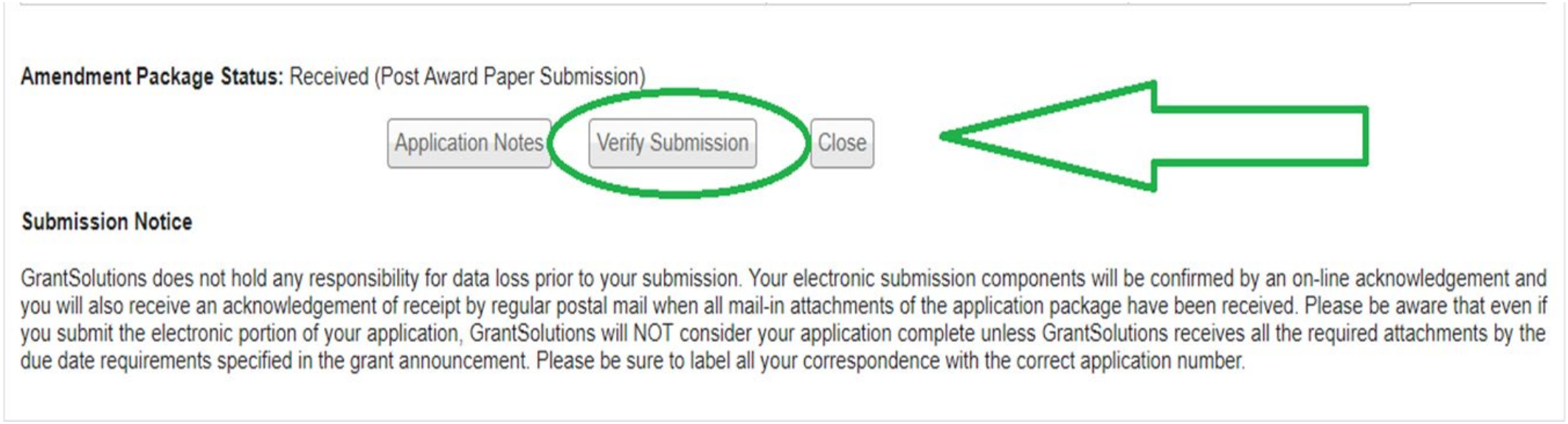
Close-out Application Process IV

- Complete the Amendment for submission



Close-out Application Process V

- You may save the amendment until all documents are uploaded.
- Submit the Amendment.



Questions & Answers

Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management (OAGM)

Thank You

- Office of Acquisitions & Grants Management
- Center for Medicare & Medicaid Services
- 7500 Security Blvd, Mail Stop B3-30-03
- Baltimore, MD 21244

- **Geoffrey Ntosi**
- 410-786-6070
- Geoffrey.Ntosi@cms.hhs.gov

- **Monica Briggs Anderson**
- 410-786-2988
- Monica.Anderson@cms.hhs.gov

Open Discussion

Q&A

Wrap Up

- Highlights
- Action Items
- Complete Evaluation