kaiser commission on medicaid and the uninsured

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Money Follows the Person: A 2012 Survey of Transitions, Services and Costs

EXECUTIVE SUMMARY

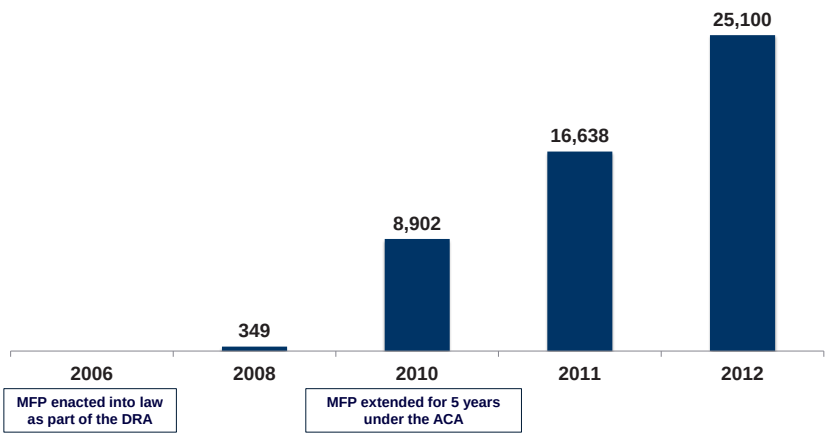
A total of 46 states, including the District of Columbia, have received federal grant money to transition Medicaid beneficiaries out of institutions and back to their homes or another qualified community-based setting through the federal Money Follows the Person (MFP) demonstration. Authorized by Congress as part of the 2005 Deficit Reduction Act (DRA) and extended under the Affordable Care Act (ACA), MFP offers states the opportunity to receive enhanced federal matching funds for 12 months for each Medicaid beneficiary who transitions back to a community-based setting as a demonstration participant. Over the past year, 16 states have applied and received funding to begin an MFP demonstration, joining the 30 states currently operating MFP demonstration programs. In August 2012, the Kaiser Commission on Medicaid and the Uninsured (KCMU) surveyed states about the current status of their MFP demonstrations inquiring about trends in enrollment, services and per capita spending. This year's annual survey highlights findings based on responses from all 46 MFP states.

Key Findings:

As of August 2012, over 25,000 individuals have transitioned back to the community as MFP participants since 2008 and another 6,400 transitions were in progress. Three states (Ohio, Texas and Washington) made up nearly half (43%) of all MFP transitions. The majority of MFP transitions to date have been individuals with physical disabilities and seniors. Individuals with mental illness or developmental disabilities are less likely to be candidates for transition due to their extensive health and long-term care service needs. Despite a slow start, MFP grantees have made significant strides in recent years averaging 8,000 transitions per year since 2010 (Figure 1). On average, MFP participants were 56 years old, took 3.5 months to transition home and most often transitioned to an apartment setting. States also reported an 8 percent reinstitutionalization rate across all populations.

Figure 1

Money Follows the Person Cumulative Transitions, 2008-2012



SOURCE: KCMU surveys of state MFP demonstration programs in 2008-2012.

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Flexible benefit design and enhanced federal funding enable MFP demonstrations to respond to beneficiary needs. States provide a comprehensive set of benefits to MFP participants to ensure successful transition back to the community. In addition to offering home and community-based waiver services that continue once a beneficiary's 365-day MFP demonstration participation period ends, 36 states reported offering demonstration-specific services to MFP participants. Demonstration services are covered under Medicaid and funded at the enhanced MFP federal medical assistance percentage (FMAP) during the individual's 12-month participation period, but after the demonstration period ends, the state is not obligated to continue these services. Twenty-two states reported offering supplemental services – services that are not necessarily long-term care in nature, e.g. coverage of one-time transition costs or services – that are only offered during the demonstration and are reimbursed at the state's regular FMAP rate. Twenty states reported offering both demonstration and supplemental services. Several states reported working with the Centers for Medicare & Medicaid Services (CMS) to re-classify supplemental services as demonstration services in order to receive the enhanced federal match.

The average monthly cost of serving an MFP participant in the community was $4,432 per person. Average MFP monthly costs were highest for individuals with developmental disabilities ($7,723) followed by individuals with physical disabilities ($4,988) and seniors ($3,286). When asked to compare the cost of serving Medicaid beneficiaries who reside in institutions to that of MFP participants, 24 states said MFP per capita costs were lower. Only one state reported that the costs were comparable, and no state said the cost of serving MFP participants was higher. When asked to compare per capita service costs for MFP participants to those for other Medicaid home and community-based services (HCBS) beneficiaries, 18 states said costs were comparable, three states reported lower costs for MFP participants, and two states reported higher costs for MFP participants.

An increasing number of states rely on housing specialists and statewide partnerships to bridge the gap between the demand for community-based housing and the availability of safe, affordable housing options. Twenty-six states employed housing coordinators who assist individuals interested in transitioning with locating and securing qualified housing; some states employ multiple housing coordinators to improve outreach and coordination efforts, help link MFP participants to housing resources, and assist in long-term services and supports (LTSS) rebalancing efforts. Looking ahead, 27 states (out of 38 state responses) reported housing to be the most significant issue facing MFP. States reported the need for additional housing resources to accommodate increasingly complex populations who wish to transition back to community living such as children with serious emotional disorders. Other states are focused on lessening the amount of time it takes to transition individuals back to the community. In the year ahead, states will continue efforts to identify additional housing subsidies or vouchers while also building capacity for more community-based providers and services.

Conclusion

By August 2012, all but 5 states were participating in MFP or had plans to implement the demonstration in the year ahead. Demand for Medicaid HCBS is increasing annually, and states are beginning to take advantage of enhanced federal funding opportunities to re-orient the delivery of LTSS through new options in the ACA. Combined with MFP, options such as the Balancing Incentive Program (BIP) could potentially blend funding to increase LTSS capacity in

the community. Meanwhile, states that participate in BIP (enhanced FMAP of 2 to 5%) and Community First Choice (enhanced FMAP of 6%) will receive an enhanced FMAP of at least 8 percent on all services that qualify under both programs. These combinations could benefit MFP participants who will transition to regular Medicaid benefits one year after community placement when their MFP participation span ends. Since the ACA extends funding for MFP through 2016, it will likely remain a key component in state LTSS rebalancing efforts going forward. The experience states have gained operating MFP demonstrations will inform overall rebalancing efforts now that states can highlight the challenges and key features of successful transitions several years into the MFP demonstration. Through a combination of flexible service design, targeted help with transition coordination, partnerships with housing authorities, and enhanced federal financing, the MFP demonstration continues to help more Medicaid beneficiaries gain independence and return to community living.

INTRODUCTION

The Money Follows the Person (MFP) demonstration grant program was authorized by Congress as part of the 2005 Deficit Reduction Act (DRA) and provides states with enhanced federal matching funds for 12 months for each Medicaid beneficiary transitioned from an institutional setting to a community-based setting. Qualified community settings include a home, apartment, or group home with less than four non-related residents. The enhanced federal support is designed to encourage state efforts to reduce reliance on institutional care for individuals needing long-term services and supports (LTSS) and expand options for individuals with disabilities and the elderly who wish to receive services in the community. The Centers for Medicare & Medicaid Services (CMS) initially awarded MFP grants to 30 states. Over the past year, 16 more states have applied and received funding to begin an MFP demonstration. Thirteen states were awarded funding in February 2011, and another three states received planning grants in March 2012.

Under the Affordable Care Act (ACA), MFP was extended by five years through 2016, and an additional $2.25 billion in federal funds were allocated for the demonstration. The ACA also changes the MFP eligibility length of stay criteria. Under the ACA, individuals who reside in an institution for more than 90 consecutive days are now eligible to participate. The previous criterion for the institutional residency period was six months to two years. However, days that an individual resides in an institution for the sole purpose of receiving short-term rehabilitation under Medicare cannot count toward the 90-day residency period required for MFP eligibility. This policy change acknowledges that earlier intervention is often critical to prevent long-term nursing home stays that make transitioning to the community more difficult. Most states anticipated this policy change would increase the number of future MFP participants.[1]

The Kaiser Commission on Medicaid and the Uninsured (KCMU) conducted a survey of state MFP project directors in 2008, 2010 and 2011 to gauge the progress states made in transitioning individuals back home. Results from the 2011 KCMU survey found 30 states had transitioned

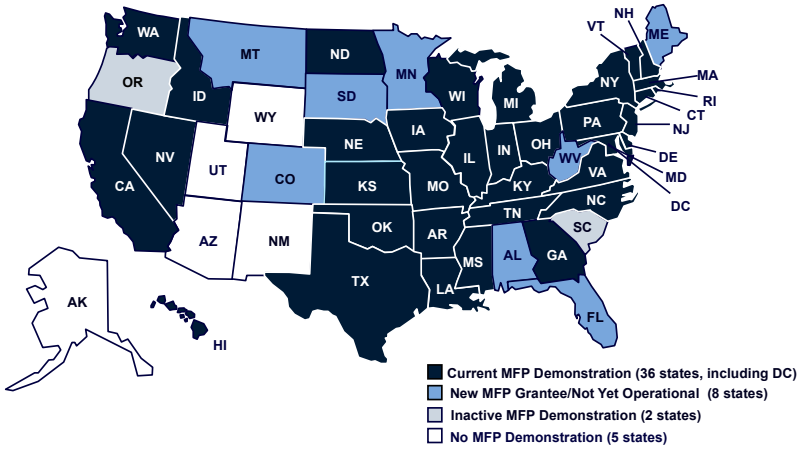
[1] M. O'Malley Watts, "Money Follows the Person: A 2011 Survey of Transitions, Services and Costs," Kaiser Commission on Medicaid and the Uninsured, December 2011, available at: http://www.kff.org/medicaid/8142.cfm.

nearly 17,000 individuals back to the community.[2] While some MFP programs became operational in 2007, the majority of transitions occurred between 2010 and 2011 because states took some time to get their programs up and running. States with existing transition programs such as Texas and Washington were almost immediately able to transition individuals once MFP funding began and their programs were implemented, but other states needed significantly more time and resources to launch their demonstration programs. Overall, MFP's progress is slowly improving; the number of participants has increased annually as solutions to barriers are identified and technical assistance is provided to help states meet transition goals.[3] Individuals benefiting from the MFP demonstration include seniors, children and adults with intellectual, developmental and/or physical disabilities, individuals with mental illness and those diagnosed with multiple chronic and disabling conditions. As more Medicaid beneficiaries are identified to transition to the community, and as the population continues to age, states reported ongoing efforts to improve workforce and housing options – two critical components of successful community placements.

Methodology – This report is based on a KCMU survey of state MFP demonstrations conducted in August 2012. The survey was designed to obtain information on MFP enrollment, services and per capita costs in each state. States also were asked to respond to questions about the role of self-direction in MFP, the adequacy of community-based providers in their state, the current economic environment and the impact of new health reform options on Medicaid home and community-based services (HCBS). At the time of the survey, a total of 36 states had operational programs, and 10 states were at varying degrees of becoming operational within the next year, including two states with suspended programs (Oregon and South Carolina) (Figure 2).[4] The data for this report was provided directly from state officials in response to a written survey. The full survey instrument can be found in Appendix A of this report. Survey responses were received from all 46 MFP

Figure 2

Money Follows the Person Demonstration Program Status, as of August 2012



SOURCE: KCMU survey of state MFP demonstration programs, as of August 2012.

[2] M. O'Malley Watts, "Money Follows the Person: A 2011 Survey of Transitions, Services and Costs," Kaiser Commission on Medicaid and the Uninsured, December 2011, available at: http://www.kff.org/medicaid/8142.cfm.
[3] S. Reinhard, "Money Follows the Person: Un-burning Bridges and Facilitating a Return to the Community," Journal of the American Society on Aging, March 2012, 36(1): 52, available at: http://www.asaging.org/blog/money-follows-person-un-burning-bridges-and-facilitating-return-community.
[4] At the time of the survey, South Carolina reported plans to be operational by the end of 2012, and Oregon reported plans to be operational again in early 2013.

grantee states. New grantee states that had yet to reach operational status responded to as many of the survey questions as possible based upon their operational protocols submitted to CMS. Several new grantee states were still in the process of hiring an MFP project director and were not able to provide significant detail on their demonstrations. One state, New Mexico, has withdrawn from the MFP demonstration and is not included in the total number of states participating in MFP.

KEY FINDINGS

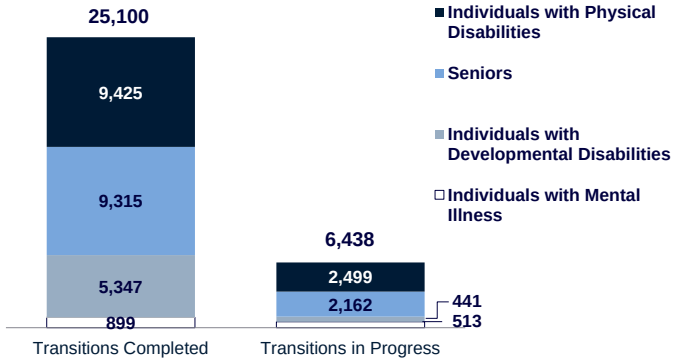
Enrollment

As of August 2012, over 25,000 individuals have transitioned back to the community since 2008 and another 6,400 transitions were in progress (Figure 3). Three states (Ohio, Texas and Washington) made up nearly half (43%) of all MFP transitions, with **Texas** accounting for the most transitions (6,072). Variation in program size reflects, among other things, the length of program operation, the size of the eligible population in each state, and state capacity and experience in operating transition programs. Among the 13 new grantee states that received funding in 2011, **Tennessee** transitioned the most MFP participants (305), while the remainder of new grantee states transitioned 100 individuals cumulatively. Similar to when the first 30 states became operational at the beginning of the demonstration, new grantees are finding that it takes time to receive approval of their operational protocol and to develop and implement the demonstration once approved. Therefore, these states have set modest transition goals for their first few years of the demonstration.

The majority of MFP transitions to date are individuals with physical disabilities (38%) and seniors (37%). One in five MFP participants (21%) is an individual with a developmental disability. Individuals with mental illness (4% of total transitions) and those with developmental disabilities are less likely to be candidates for transition due to their typically more extensive health and long-term services needs. A similar distribution of participants is projected in the year ahead with individuals with physical disabilities to represent the largest target group (45%) of transitions in progress.

Figure 3

Distribution of MFP Transitions, by Target Population, 2008-2012



NOTE: The total number of transitions completed includes 114 individuals (and 823 transitions in progress) from states that did not specify target population in their survey response.

SOURCE: KCMU survey of state MFP demonstration programs, 2012.

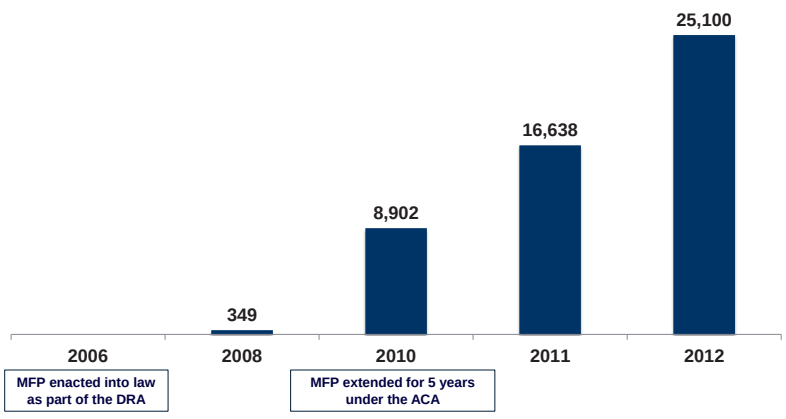
Over the past two years, states reported taking steps to increase the number of transitions among individuals with mental illness. Twenty-nine states reported efforts underway to increase transitions among this population. These efforts include: identifying children living in psychiatric residential treatment facilities who could transition to the community (6 states), adding demonstrations services targeted to meet the needs of individuals with mental illness (e.g.

Housing Access Services, a Wellness Recovery Action Plan, Family Psycho-education) (5 states), working with CMS to amend states' operational protocols to include individuals with mental illness as a target group (3 states), and developing a §1915(i) state plan amendment to cover individuals with mental illness who had not previously been eligible for Medicaid (2 states). Many states reported actively coordinating with state Behavioral Health/Mental Health Departments and collaborating with community mental health providers to ensure those with mental health needs receive the appropriate community supports after leaving the nursing home. Eleven states reported no specific plans to target this population.

Despite a slow start, MFP grantees are averaging over 8,000 transitions per year over the past three years. States are behind their original enrollment projection of 38,000 individuals by 2012, but have made significant strides in recent years. A year ago, states reported transitioning nearly 17,000 individuals back to the community up from almost 9,000 individuals in 2010 (Figure 4). As of August 2012, a total of 36 states with operational programs transitioned over 25,000 MFP participants and had another 6,400 transitions in progress. With the addition of 16 new MFP demonstrations over the past year (half of these states' demonstrations are currently operational), there will be more opportunity to serve Medicaid beneficiaries in community-based settings across the country.

Figure 4

Money Follows the Person Cumulative Transitions, 2008-2012



SOURCE: KCMU surveys of state MFP demonstration programs in 2008-2012.

We asked states to report whether they were on pace with annual transition targets, and most (25 states) reported that they were on target to meet annual goals.[5] Fifteen states reported that they were not on pace to meet their annual projections, up from 10 states in 2011. States' modest start with MFP transitions can be attributed to, for example, implementation delays and/or challenges related to transitioning populations with multiple chronic and disabling conditions. States reported a number of other challenges including: lack of affordable, accessible housing options particularly for individuals with complex medical and LTSS needs, difficulty keeping up with demand for transition services and community-based providers, and a shortage of MFP staffing.

[5] Starting in 2011, CMS revised its policy to begin holding states accountable for meeting their transition goals. CMS can withhold the disbursement of MFP grant funds for those states falling far short of their transition goals. As a result, many states reduced their annual transition goals for 2010 and subsequent years. Mathematica Policy Research, Inc., "Money Follows the Person Demonstration: Overview of State Grantee Progress, July-December 2010," May 2011, available at: http://www.mathematica-mpr.com/publications/pdfs/health/MFP_july-dec2010_progress.pdf.

This year's survey included questions related to characteristics of MFP participants. State officials were asked to report the average age of MFP participants, average time to transition out of an institutional setting, the residential housing option most often used by MFP participants, and the average rate of reinstitutionalization. Where possible, states were asked to include responses by target population. Across all MFP programs, state officials reported the following results:

- The average age of MFP participants was 56 years old;
- MFP participants averaged 3.5 months to transition back to the community;
- MFP participants most often transitioned to an apartment; and
- The average reinstitutionalization rate was 8 percent.

Looking at target populations across all MFP programs, MFP participants with a developmental disability were younger (on average 41 years old) than individuals with a physical disability or a mental illness diagnosis, who averaged 54 and 52 years old, respectively. The average age of senior MFP participants was 75, up from an average of 71 in 2011. MFP participants took an average of 3.5 months to transition home, less time than states reported in 2011 (4.6 months). Individuals with physical disabilities or mental illness took longer to transition home compared to seniors and people with developmental disabilities. Seniors were more likely to transition back to their own homes or a family member's home, whereas individuals with developmental disabilities more often relied on small group homes for their housing option. In both 2011 and 2012, states reported an 8 percent reinstitutionalization rate across all populations. Reinstitutionalization is defined as returning to a nursing home, hospital, or intermediate care facility for individuals with intellectual disabilities, regardless of length of stay, during the MFP participation year. Across all target populations, seniors were the group most likely to be reinstitutionalized, and individuals with developmental disabilities were the least likely to return to an institutional setting.

Forty states reported partnering with local Aging and Disability Resource Centers (ADRCs) to assist with referrals and to help coordinate transitions. Within a state, outreach and enrollment efforts are often accomplished through partnerships with the Medicaid program and other state agencies, community stakeholders and MFP staff. The ACA appropriated $10 million a year for five years (2010 to 2014) to expand ADRCs to serve as community access points for individuals seeking information and referrals for LTSS. Coordinators at ADRCs that receive funding from MFP can assist with processing referrals from the Minimum Data Set (MDS) 3.0 Section Q-Participation in Assessment and Goal Setting[6], MFP outreach and

[6] The revised federal Minimum Data Set (MDS) assessment tool for nursing home residents, MDS 3.0, went into effect on October 1, 2010. Section Q of the MDS 3.0 focuses on resident participation in assessment and goal setting, and is designed to identify the resident's goals and expectations relating to where the individual lives and receives services. If a resident indicates that he or she desires to transition out of the nursing home to a community-based setting, the nursing home must initiate care planning and may make a referral to a local contact agency, which will respond by providing information to the resident about community–based services and supports.

enrollment, MFP program eligibility verification, and waiver slot distribution to prospective MFP participants. Several states reported using MFP funds to expand ADRC activities in the year ahead. For example:

- **Illinois** used supplemental funding through CMS to hire Transition Engagement Specialists at three ADRCs throughout the state. The Specialists are tasked with outreach to potential MFP beneficiaries, building relationships with nursing homes and staff, assisting in the development of best practices related to the MDS 3.0 Section Q referral processes, and improving quality of referrals to the MFP program.

- **Massachusetts** has developed a plan to utilize ADRCs to receive and follow up on MDS 3.0 Section Q positive responses which indicate a nursing home resident's desire to return to the community. The ADRCs will complete an initial assessment and then discuss with the nursing home resident available options for returning to the community. If the resident still desires to transition to the community, a referral is made to the responsible transition entity, which then works with the resident to transition to the community.

Benefits

Flexible benefit design and enhanced federal funding enable MFP demonstrations to respond to beneficiary needs. States provide a comprehensive set of benefits to MFP participants, including those services provided under existing HCBS waivers and state plan benefits packages, as well as MFP demonstration services and supplemental services, to ensure successful transition back to the community. HCBS that qualify for the MFP enhanced federal match are those waiver and state plan services that will continue once the individual's MFP demonstration transition period has ended. Common Medicaid HCBS benefits are: case management, homemaker services, home health aide services, personal care, adult day health care, habilitation and respite care. MFP demonstration services are services that can be covered under Medicaid and funded during an individual's 12-month participation period. These are services states can provide beyond what a typical Medicaid HCBS beneficiary receives and oftentimes in an amount not

MFP is a lifesaver for a cancer survivor in an emergency situation.

One day **Debra**, 62, went to the hospital for a biopsy, and the next thing she remembers is waking up without a voice. Her doctors diagnosed her with throat cancer and immediately removed her larynx and implanted a permanent tracheostomy. Debra lived in a nursing home for almost a year until she was better able to manage her chronic lung condition and the challenges of overcoming communication barriers.

With the help of MFP, Debra moved out of the nursing home and into her own apartment. During the transition, her MFP community choice guide helped her qualify for a housing voucher, and MFP covered her security deposit and part of the first month's rent. For her cancer treatment, Debra travels 150 miles to Seattle. MFP covers her transportation and pays for her choice guide to accompany her. During one trip, there was an avalanche and all traffic was stopped. Debra's choice guide contacted local emergency services to bring oxygen and attend to Debra's medical needs during the seven-hour wait for the road to clear. Debra believes her choice guide saved her life because she would have run out of oxygen. Her quality of life has gone up "700%" since transitioning home.

"I owe my life to [MFP]." – Debra, Washington

otherwise available to a non-MFP Medicaid beneficiary. For example, a state that does not normally offer caregiver training might make such services available to caregivers of MFP participants. After the individual's transition period ends, states are not obligated to continue the MFP demonstration services, but may choose to fund them through Medicaid at the regular match rate for eligible beneficiaries. During a beneficiary's MFP participation year, HCBS and demonstration services are reimbursed at the enhanced MFP FMAP. Thirty-six states reported offering demonstration services to MFP participants in addition to HCBS waiver and state plan services.

MFP supplemental services – services that are not necessarily long-term care in nature, e.g. coverage of one-time transition costs or services – are only offered during the beneficiary's demonstration transition period and are reimbursed at the state's regular FMAP rate. Twenty-two states reported offering supplemental services to MFP beneficiaries in 2012. Twenty states reported offering both demonstration and supplemental services. States gear the benefits offered as MFP demonstration and supplemental services toward ensuring successful transition back to community living. These services include transition coordination, coverage of one-time housing expenses (such as security deposits, utility deposits and furniture and household set up costs), assistive technology, employment skills training, 24-hour back-up nursing, home delivered meals, peer community support, and ombudsman services. In this year's survey, several states reported working with CMS to re-classify supplemental services as demonstration services in order to receive the enhanced federal match.

Medicaid helps father with spinal cord injury as he waits to qualify for Medicare.

Bobby, 47, was returning home from a 12-hour work shift early one morning when he slipped on his deck and injured his spinal cord. Uninsured at the time, he sought treatment in an emergency room and was admitted to the hospital and subsequently a nursing home. Bobby qualified for Medicaid during his hospital stay, but was told he would have to wait two years before qualifying for Medicare. Bobby thought he would never go home again given his inability to walk, memory loss, and comprehension problems. Through the MFP program, Bobby moved home and is able to have all of his health care needs met regularly. He qualifies for personal care services, and has multiple personal care attendants, including his son, who helps with general hygiene tasks and household chores. Bobby takes 16 prescription drugs daily to help with nerve damage and uses a wheelchair to get around. He pays a nominal co-pay for his drugs. Without Medicaid, his drugs would be unaffordable as one drug alone costs over $900 a month. Bobby says his biggest challenges in living at home are paying the bills and getting food on the table.

"I would be living on the streets without Medicaid." – Bobby, Michigan

Many of the services offered under MFP are geared toward meeting the needs of Medicaid beneficiaries with complex health and physical limitations. For example, several states offer non-medical transportation services designed to not only help participants get to and from doctor's appointments but also to help participants run errands they would not be able to do on their own. Other notable services offered to ensure individuals not only transition home safely but also have the skills to work if they so desire are as follows: personal emergency response systems, trial overnights with staff at intermediate care facility for individuals with intellectual disabilities, roommate matching services and employment skills training.

A 2012 study by Mathematica found that more than two-thirds of all HCBS expenditures for MFP participants were for qualified HCBS, demonstration services accounted for approximately 28 percent of all HCBS expenditures for MFP participants and supplemental services accounted for less than 5 percent of all HCBS expenditures for MFP participants.[7] Looking at these service categories in further detail, two categories of services accounted for two-thirds of HCBS expenditures of MFP participants: home-based care, which includes personal assistance services to help perform activities of daily living (33%), and round-the-clock residential services, such as 24-hour attendant care provided in group homes (33%) which is especially critical for individuals with intellectual/developmental disabilities.[8] Resources devoted to coordinating and managing transitions represented the next largest service category and accounted for 6 percent of total HCBS spending for MFP participants.

Self-direction is an option in most MFP demonstrations, although the percentage of MFP participants who opt to self-direct varies widely across states. Thirty-nine states offer or have plans to offer Medicaid beneficiaries the authority to make decisions over some or all of their services. Only four states responded that self-direction was not a component of their MFP demonstrations. Self-direction is an alternative to the provider management service delivery model. Self-direction promotes personal choice and control over the delivery of services, including who provides services and how they are delivered. For example, the MFP participant may be given the opportunity to recruit, hire and supervise direct service workers. An estimated 22 percent of MFP participants self-direct at least some of their own services. Two states reported nearly 100 percent participation in self-direction (Delaware and Ohio) due to the fact that one-time home set-up funding counted as a self-directed service. Twelve states reported the percentage of MFP participants who self-direct to be less than 5 percent. Eight states reported an increase in the percentage of MFP participants who utilized self-directed options over the past year.

MFP helps woman with spinal cord injury move home and return to work.

Prior to a porch fall that severed her spinal cord, **Cathy**, 53, was living at home with her family and working full-time. Everything changed after her fall. Without Cathy's income, her family lost their home to foreclosure, and Cathy's only option was the nursing home. During a lengthy hospital stay, Cathy qualified for Medicaid and Social Security Disability Insurance (SSDI). In the nursing home, Cathy experienced repeated health problems and was anxious for the opportunity to be around people her own age. Washington State's MFP program afforded Cathy the chance to regain her independence and move to a home of her own. Medicaid provided her with a power wheelchair, a shower chair, 10 hours of personal care services a day, and emergency back-up care services. Two years after her accident, Cathy says she is back to being herself again. She works from home on the computer. She also volunteers at local hospitals educating others with spinal cord injuries about their options for community living. Her health is steady, and she enjoys being able to direct her own care.

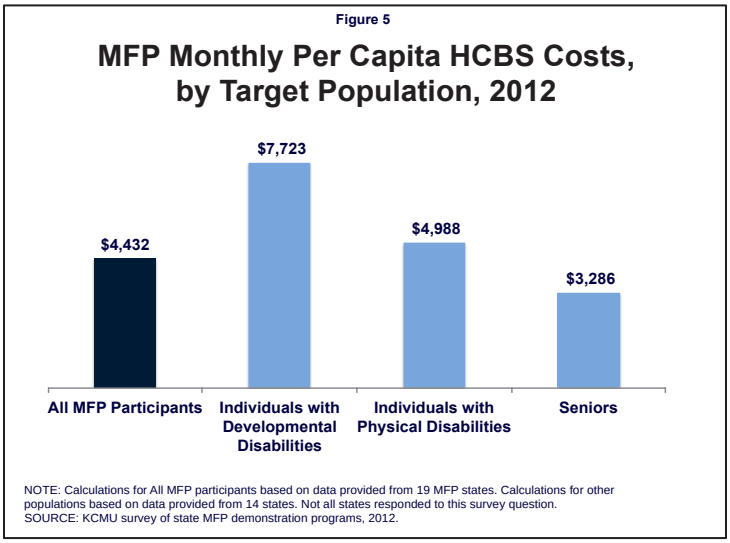
"It's [MFP] the biggest blessing and the biggest miracle I could have." – Cathy, Washington

[7] C. Irvin et al., "Money Follows the Person 2011 Evaluation Report," Mathematica Policy Research, October 2012, available at: http://www.mathematica-mpr.com/publications/pdfs/health/MFP_annual_report_2011.pdf.
[8] *Ibid*.

Financing

The average monthly per capita cost of serving an MFP participant in the community was $4,432 (Figure 5). States were asked to report average monthly per capita costs of MFP participants and amounts ranged from a high of $16,470 to a low of $1,060 per person per month, based on responses from 19 states. Differences in per capita costs may be attributable to differences in MFP covered services across states and/or a reflection of the diverse needs of the target populations. In comparison, the national average per person spending on Medicaid HCBS only, including § 1915(c) HCBS waivers, and the home health and the personal care services state plan benefits, but not other Medicaid-covered services, was $15,371 in 2009 with great variation among states and across programs.[9] As with HCBS waiver expenditures, MFP states that transitioned a greater number of individuals with developmental disabilities had higher per capita costs since these individuals have extensive health and LTSS needs. Average MFP monthly costs were highest for individuals with developmental disabilities ($7,723) followed by individuals with physical disabilities ($4,988) and seniors ($3,286). These per person per month costs are comparable yet slightly higher than the costs reported by Mathematica Policy Research.[10]

Figure 5



NOTE: Calculations for All MFP participants based on data provided from 19 MFP states. Calculations for other populations based on data provided from 14 states. Not all states responded to this survey question.
SOURCE: KCMU survey of state MFP demonstration programs, 2012.

When asked to compare the cost of serving Medicaid beneficiaries who reside in institutions with MFP participants, 24 states said MFP per capita costs were lower. Only one state reported that the two costs were comparable, and no state said they were higher. When asked to compare MFP costs with costs for other Medicaid HCBS beneficiaries, 18 states said costs were comparable, three states reported lower MFP per capita costs, and two states reported higher costs. The remaining states did not answer the survey question.

Quality

States reported having specific quality management systems built into the MFP program in addition to existing Medicaid HCBS waiver quality requirements. This year's KCMU survey asked states to report on quality measures used to evaluate the MFP demonstration. Most states

[9] T. Ng et al., "Medicaid Home and Community-Based Service Programs: 2009 Data Update," Kaiser Commission on Medicaid and the Uninsured, December 2012, available at: http://www.kff.org/medicaid/7720.cfm.
[10] C. Irvin et al., "Money Follows the Person 2011 Evaluation Report," Mathematica Policy Research, October 2012, available at: http://www.mathematica-mpr.com/publications/pdfs/health/MFP_annual_report_2011.pdf. This report calculated per-person HCBS expenditures based on claims data and adjusted for length of program enrollment to control for re-admission to institutional care and mortality before completing 365 days of community living. HCBS costs of MFP participants were approximately $3,700 per person per month ($2,233 per elderly; $3,017 per person with a physical disability; $7,572 per person with an intellectual disability).

cited the CMS Quality of Life (QoL) survey as their main tool to measure quality and satisfaction among participants. MFP grantees are responsible for the survey administration, data entry, tracking, quality assurance and transmission of the data to CMS. The QoL survey is given to participants prior to leaving the institution and again at one and two years after transitioning to the community. In the survey, MFP participants are asked to report on seven measures: living situation, ability to exercise choice and control, access to personal care, treatment in terms of respect and dignity, community integration/inclusion, overall satisfaction with life, and health status.[11] National evaluation based on QoL survey responses found that most participants fare well in the community. Among early MFP participants, 85 percent were able to live in the community for at least one year,[12] and self-reported quality of life was higher, in some cases substantially so, a year after the transition.[13]

Meanwhile, there are three quality requirements under the MFP demonstration that states must ensure. They include risk assessment and mitigation processes, which are reviewed by CMS and must be approved prior to an MFP program implementation, a review of 24-hour back up service by MFP participants, and a critical incident report management system. Most states highlighted that the traditional quality standards - Medicaid Long-Term Care quality improvement and quality assurance processes that are in place through § 1915(c) waivers and through state plan assurances – are also applied to the MFP program. Several states such as **New Jersey** and **Iowa** employ a quality assurance specialist to oversee MFP quality initiatives.

ISSUES FACING MFP IN 2012 AND BEYOND

An increasing number of states rely on housing specialists and statewide partnerships to bridge the gap between the demand for community-based housing and the availability of safe, affordable housing options. All MFP states highlighted the importance of partnering with housing authorities and the federal Department of Housing and Urban Development (HUD) to improve housing options for MFP participants. These partnerships are critical to understanding statewide housing resources and funding availability. Since KCMU began surveying states in 2008, states have consistently reported challenges finding safe, affordable housing and these challenges continue for MFP officials and participants today. States are working to set aside housing subsidy vouchers for MFP clients transitioning back to the community; identifying current rental projects in operation or in the pipeline that could offer affordable housing options for MFP participants; and authorizing modifications to make existing housing units accessible. Eleven states reported applying for HUD § 811 funding for supportive housing for people with disabilities to support transitioning individuals. The newly reformed Section 811 program provides interest-free capital advances and operating subsidies to nonprofit developers of

[11] CMS and Mathematica Policy Research, "Money Follows the Person Quality of Life Survey," available at: http://www.mathematica-mpr.com/publications/pdfs/health/MFP_QoL_Survey.pdf.
[12] J. Schurrer and A.Wenzlow, "A First Look at How MFP Participants Fare After Returning to the Community," Mathematica Policy Research, Number 7, July 2011, available at: http://www.mathematica-mpr.com/publications/PDFs/health/MFPfieldrpt7.pdf.
[13] S. E. Simon and M. R. Hodges, "Money Follows the Person: Change in Participant Experience During the First Year of Community Living," Mathematica Policy Research, Number 6, May 2011, available at: http://www.mathematica-mpr.com/publications/PDFs/health/mfpfieldrpt6.pdf.

affordable housing for persons with disabilities and project rental assistance to state housing agencies.

As of August 2012, 26 states employed housing coordinators who assist individuals interested in transitioning with locating and securing housing, up from 19 states in 2011. Some states employed multiple housing coordinators. Their role is to improve outreach and coordination efforts, help link MFP participants to housing resources, and assist in LTSS rebalancing efforts. In states such as **Illinois**, housing coordinators also take lead responsibility for assuring housing referral networks operate smoothly and that referrals are made promptly to housing providers. In **New Hampshire**, housing specialists have taken on the task of providing financial literacy education so that MFP participants have knowledge of their finances and housing options. Specialists also help coordinate transportation to accommodate the needs of participants without cars since insufficient public transportation systems can impede successful community placement even after housing is secured. **Massachusetts** employed a Statewide Strategic Housing Partnership Coordinator who works in collaboration with five MFP Regional Housing Search and Network Coordinators and is responsible for identifying and securing housing for MFP participants in each region. The Coordinators work with local housing authorities, developers and landlords, and Regional Housing Search Entities. In addition:

- **Indiana's** Family and Social Services Administration Division of Aging has partnered with the Housing and Community Development Authority to enhance transitions from nursing facilities into home/community-based settings. The Home Again Project utilizes state dollars to subsidize housing for individuals transitioning from institutional care.

- **Kentucky's** MFP program contracts with the Kentucky Housing Corporation to provide two personnel who are 100% dedicated to working with MFP to identify and access appropriate housing options for MFP clients. Kentucky MFP also contracts with the University of Kentucky Human Development Institute which provides MFP with a comprehensive evaluation of housing modification needs and cost estimates for the identified modification needs from at least two building contractors. Upon approval by MFP Project Director, housing modifications proceed.

- **Iowa** utilizes a HCBS rent subsidy program administered by the Iowa Finance Authority since 2005 that acts as a bridge until Section 8 housing can be found. Eligible participants are Medicaid beneficiaries enrolled in a HCBS waiver and who are at risk of nursing facility placement. The program provides a monthly rent assistance payment to these persons to help them live in the community until they become eligible for any other local, state or federal rent assistance.

Almost two-thirds of MFP states reported an adequate supply of direct care workers in the community. While most states reported adequate numbers of workers, many were actively improving and expanding the direct service workforce to address challenges such as high turnover rates, varied skill sets among workers, and shortages of direct service workers in rural settings. At the same time, they were preparing for the aging population and increased number of individuals who will need assistance and support to remain in their home. Most efforts are intended to strengthen the capacities of direct support professionals and elevate their standing as professionals (i.e. compensation, benefits and authority). Examples of workforce development

strategies adopted by states include: a direct care service registry website, encouragement of Medicaid beneficiaries to hire family caregivers through the self-directed option, online training programs that provide education and competency-based training curricula. The following are some state-specific examples of workforce initiatives:

- **New Hampshire** utilized the federally-funded Direct Connect Program in the state Department of Labor to assist with engaging and training direct service workers in a way that provides steps towards a career lattice.

- **New Jersey** completed the statewide implementation of the College of Direct Support (CDS) in June 2011. Service providers for individuals with developmental disabilities across the state are now providing continuing education and online training opportunities to their staff. These enhanced training opportunities are aimed at improving the quality of services provided and the professionalism of the direct support workforce. Funding for the CDS is provided by the state's rebalancing fund. Currently 92 agencies are utilizing the CDS curriculum, with future plans being developed to include working with the elderly in addition to populations with intellectual/developmental disabilities.

- **Connecticut** has created a strategic workforce development plan that includes a communication/marketing campaign to attract direct services workers. The campaign includes the use of billboards and radio and will launch in February 2013.

Although cost containment remains a focus in Medicaid, MFP demonstrations were largely spared from cuts related to the economic downturn. Thirty-one states reported that cuts to MFP did not occur over the previous year or were not likely to occur at the time of the survey. Only six states reported experiencing or anticipating cutbacks due to the current fiscal environment that would affect their MFP demonstrations. Some states described budget limitations that made it difficult to expand transition coordination services, and other states mentioned the negative impact waiting lists for services have on current and future MFP participants.

States are utilizing enhanced federal funding opportunities to re-orient the delivery of LTSS through MFP and other new options in the ACA. Over the past year, 16 additional states applied and received funding to implement MFP demonstrations. Meanwhile, the ACA includes a number of new LTSS options that are now in effect. Twenty-six states reported plans to implement a health homes initiative, a new approach to manage care for the chronically ill that provides states with a 90% federal match rate for health home services during the first two years that a health home State Plan Amendment (SPA) is in effect;[14] twenty-three state reported plans to take up the § 1915(i) option (or already have the option in place) which allows states to provide HCBS as an optional benefit under their state Medicaid plan; twenty states are pursuing the Balancing Incentive Payment (BIP) program that provides financial incentives (2 to 5 % FMAP increase) to states that undertake structural reforms to increase access to community

[14] M. Nardone and J. Paradise, "Medicaid Home Health for Beneficiaries with Chronic Conditions," Kaiser Commission on Medicaid and the Uninsured, May 2012, available at: http://www.kff.org/kaiserpolls/8304.cfm.
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LTSS as an alternative to institutional care; and 14 states reported interest in taking up the Community First Choice option, which provides a 6 percent FMAP increase for community-based attendant supports and services to individuals who require an institutional level of care through a state plan amendment.

Housing remains the biggest challenge facing states in the year ahead. States have repeatedly cited the lack of safe, affordable and accessible housing as the biggest barrier to MFP transitions since the demonstration program began in 2008. In this year's survey, 27 states (out of 38 state responses) reported housing to be the most significant issue facing MFP in the year ahead. Some states reported the need for additional housing resources to accommodate increasingly complex populations who wish to transition back to community living such as children with serious emotional disorders. Other states are focused on lessening the amount of time it takes to transition individuals back to the community. This is especially critical for individuals with disabilities who tend to experience lengthy waiting periods for access to subsidized housing vouchers. In the year ahead, states will continue efforts to identify additional housing subsidies or vouchers while also building capacity for more community-based providers and services.

Several states noted that ongoing delivery system reforms could make competition for community-based resources a challenge. Changes such as the move to managed LTSS in states such as **Delaware** and **New Jersey**, will mean that managed care organizations may provide access to transition services for MFP participants. Over the next two years, significant managed care initiatives will occur in over two-thirds of states, increasing the prevalence of managed care in Medicaid.[15] These initiatives include enrollment of new eligibility groups into managed care and new or expanded use of managed LTSS. Since most managed care organizations lack experience in serving populations with complex needs, important consideration should be given to ensure adequate access to services. **Tennessee** has been operating its managed LTSS programs (CHOICES) since 2010 and simultaneously enrolls beneficiaries into MFP and CHOICES. In Tennessee, care coordination is provided by the managed care organization, and care coordinators are responsible for assessing member interest in transition (at least annually), MFP eligibility, and transition assessment/planning facilitation.[16]

CONCLUSION

By August 2012, all but 5 states were participating in MFP or had plans to implement the demonstration in the year ahead. Demand for Medicaid HCBS is increasing annually, and states are actively working to take advantage of enhanced funding options, included in the ACA, to improve access and delivery of community-based LTSS available under Medicaid. The federal MFP demonstration is just one mechanism that states have to improve their LTSS systems. Seventeen MFP grantee states also operate parallel transition programs for individuals who wish

[15] V. Smith et al., "Medicaid Today Preparing for Tomorrow: A Look At State Medicaid Program Spending, Enrollment, and Policy Trends," Kaiser Commission on Medicaid and the Uninsured, October 2012, available at: http://www.kff.org/medicaid/8380.cfm.

[16] Presentation by C. Lemaire Lozier, Bureau of TennCare, "Money Follows the Person and MLTSS: Overview for MFP Participating States," November 14, 2012, available at: http://www.mfp-tac.com/2012_sesdesc/day1_230_e.html.

to return to community living but who are not eligible for MFP.[17] These could include individuals who reside in a nursing home for less than 90 days or individuals who transition to an assisted living facility (not a qualified residence under the MFP option). States also operate diversion programs that seek to prevent institutionalization in the first place.

States have a number of options to utilize federal funds to expand Medicaid HCBS, and many have already begun to implement these options. Combined with MFP, options such BIP and CFC could potentially blend funding to increase LTSS capacity in the community.[18,19] MFP could help fund the structural reform requirements for states participating in BIP, such as a no wrong door/single entry point system for all LTSS and/or a core, standardized assessment instrument for determining eligibility for Medicaid services. States that participate in BIP (enhanced FMAP of 2 5%) and CFC (enhanced FMAP of 6%) would receive an enhanced FMAP of at least 8 percent on all services that qualify under both programs. These combinations could benefit MFP states with sustained enhanced funding after the 12-month MFP enhanced match ends.

The ACA extends funding for MFP through 2016, and MFP will remain a key component in state LTSS rebalancing efforts going forward. The experience states have gained operating MFP programs will add to overall rebalancing efforts now that states can highlight the challenges and key features of successful transitions several years into the demonstration. A reoccurring theme over the past three KCMU surveys has been the ongoing challenge of locating safe, accessible and affordable housing options for MFP participants. States increasingly look to hire housing coordinators within MFP to increase awareness of state and federal funding opportunities, to help forge partnerships with state Medicaid agencies and housing authorities and/or local developers, and to assist Medicaid beneficiaries with housing registries and home modifications. Flexibility in service design is another major strength of the MFP demonstration. MFP transition coordinators design care plans that include help with one-time moving expenses such as utility deposits or home modifications or overnight trials with staff – extra services beyond what Medicaid typically covers, designed to ease the transition back to community living. Through a combination of flexible service design, targeted help with transition coordination, partnerships with housing authorities, and enhanced federal financing, the MFP demonstration continues to help more Medicaid beneficiaries gain independence and return to community living.

This brief was prepared by Molly O'Malley Watts, Principal of Watts Health Policy Consulting, for the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. Special thanks to Rebecca Sheplock for her research assistance and to MaryBeth Musumeci and Erica Reaves for their comments and review of the brief.

[17] N. Denny-Brown et al. "Money Follows the Person Demonstration: Overview of State Grantee Progress, January to June 2011," Mathematica Policy Research, December 2011, available at: http://www.mathematica-mpr.com/publications/PDFs/health/mfp_jan-jun2011_progress.pdf.

[18] Center for Health Care Strategies, "Balancing Incentive Program: Strengthening Medicaid Community-Based Long-Term Services and Supports," September 2012, available at: http://www.chcs.org/usr_doc/LTSS_Balancing_Incentive_Program3.pdf

[19] C. Irvin et al., "Money Follows the Person 2011 Evaluation Report," Mathematica Policy Research, October 2012, available at: http://www.mathematica-mpr.com/publications/pdfs/health/MFP_annual_report_2011.pdf.

Appendix A

THE KAISER COMMISSION ON
Medicaid and the Uninsured

MONEY FOLLOWS THE PERSON DEMONSTRATION: A 2012 SNAPSHOT

The Kaiser Commission on Medicaid and the Uninsured (KCMU) is conducting a short survey of state MFP demonstrations. This is the fourth KCMU survey conducted since 2008 that seeks to highlight recent state experiences and trends in Medicaid home and community-based services. Once again, we are requesting your assistance in completing the following survey. Questions regarding the survey can be directed to Molly O'Malley Watts (703) 371-8596 or MaryBeth Musumeci at (202) 347-5270.

Please return completed surveys by SEPTEMBER 12th to: momalley8@gmail.com

1. Money Follows the Person Program Status

a. Is your program operational? ☐ Yes ☐ No
b. If no, why not and when do you intend to be operational? _____

2. Money Follows the Person Demonstration Services

MFP participants in your state receive the following services (*check all that apply*):

☐ HCBS waiver services ☐ State Plan services ☐ Demonstration services ☐ Supplemental services

3. Money Follows the Person Transitions by Population

	Total	Seniors	Physical Disability	Developmental Disability	Mental Illness	Dual Eligible
Cumulative Transitions Completed						
Transitions in Progress						
Rate of Reinstitutionalization						
Average age of MFP participants						
Average length of time to transition to community						
Housing option most likely to transition to						

a. Is your program on pace with annual transition targets? ☐ Yes ☐ No

b. If no, please describe reasons for delay in meeting transition goals.

_____

c. Is your state trying to increase transitions for people with mental illness? ☐ Yes ☐ No ☐ Don't Know

If yes, please describe efforts to increase services and outreach to this population.

_____

4. Money Follows the Person and Self-Direction

a. Does your program offer self-directed options to MFP participants? ☐ Yes ☐ No

b. Estimate the percentage of current MFP participants who self-direct some or all of their services:

____%

c. Has this percentage changed over the past year? ☐ Increased ☐ Decreased ☐ No Change

5. Money Follows the Person Community Housing Options

a. Describe the *key steps* your state has taken to provide safe, affordable and accessible housing for MFP participants:

_____

b. Do you employ a housing coordinator within MFP to help with transitions? ☐ Yes ☐ No

6. MFP Participant Per Capita Costs

	Total	Seniors	Physical Disability	Developmental Disability	Mental Illness	Dual Eligibles
Average Monthly Cost						

a. Compared to costs for institutional beneficiaries is this cost ☐ higher ☐ comparable ☐ lower?

b. Compared to costs for other HCBS beneficiaries is this cost ☐ higher ☐ comparable ☐ lower?

7. MFP Quality Measures

a. Describe measures your state is currently using to assess quality after MFP community placement:

_____

8. Community Workforce

a. Does your state have an adequate supply of direct service workers? ☐ Yes ☐ No

b. Please describe strategies to address workforce issues: _____

9. Health Reform Opportunities

a. Is your state actively exploring any of the following ACA options? (*Check all that apply*):

LTSS State Option	Yes/No
Community First Choice	
State Balancing Incentive Program	
HCBS state plan option (1915i)	
Health Home option	

Comments on how your MFP demonstration works in conjunction with other long-term services and supports rebalancing efforts: _____

b. Is your state partnering with Aging and Disability Resource Centers (ADRCs) to help identify participants? ☐ Yes ☐ No **Comments**: _____

10. Impact of the Economic Downturn

Has your MFP demonstration had to make any changes or cutbacks due to fiscal concerns (i.e., limiting enrollment, reducing services, etc.)? If so, please describe: _____

☐ Yes ☐ Possibly Yes ☐ Not Likely ☐ No ☐ Don't know

11. Future Outlook

What are the most significant issues or challenges facing MFP in the coming year or two?

Thank you for your participation in this survey.

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THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.