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The Money Follows the Person Demonstration: Early Program Evaluation Analysis

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Abstract

This paper synthesizes findings from six evaluation studies focusing on the Money Follows the Person (MFP) demonstration grant program. The studies provide needs assessments of state long-term care systems and early analyses of how the MFP program has been implemented across the thirty demonstration states. The studies reveal varied levels of success and some common challenges that states have encountered in implementing their transition and rebalancing programs.

Introduction

The MFP demonstration grant program is the latest in a series of federal initiatives to rebalance state Medicaid long-term care systems. The MFP program was designed to help states reduce their reliance on institutional care and expand options for older people and persons with disabilities to receive care in the community. The MFP program was authorized by Congress under Sec. 6071 of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) and is currently being administered through the Centers for Medicare and Medicaid Services (CMS).[1]

Under the MFP program, 31 state grantees were awarded a total of $1.44 billion to implement transition and rebalancing programs between 2007 and 2011.[2] (See **Appendix 1** for a table listing the state grantees, their transition goals and funding awards.) The transition programs are designed to move Medicaid eligible enrollees in institutional care back into the community. The rebalancing programs use enhanced

[1] CMS, "Money Follows the Person Rebalancing Demonstration," Funding Opportunity No. HHS-2007-CMS-RCMFTP-0003, DHHS, July 26, 2006; available at: http://www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf.
[2] South Carolina decided not to implement a MFP demonstration program reducing the number of state grantees to thirty.

matching funds for home and community-based services and reinvest them in more consumer-directed models of care and overall service delivery changes.

This paper synthesizes six evaluation studies focusing on long-term care systems before and during early implementation of the MFP demonstration program to better understand the need for the MFP initiatives and how states have implemented their programs so far. This review provides an assessment of some early challenges and opportunities that MFP grantees have encountered. The evaluations highlight a number of common barriers and keys to success as states have worked to implement their transition and rebalancing programs. States with more advanced Medicaid programs requiring fewer system changes and with greater experience in transitioning individuals from institutions to community settings have had more initial success in implementing their MFP programs. Some of the common barriers have been difficulty in finding appropriate housing for transition candidates, the limited definition of a qualified residence under the program, and the requirement that eligible Medicaid enrollees be institutionalized for a minimum of six months.

As programs are fully implemented throughout the demonstration period additional analyses will likely uncover key factors relevant to MFP program goals. In addition, key policy changes made to the MFP program through the Patient Protection and Affordable Care Act (P.L. 111-148), should have significant bearing on the success of MFP demonstration states in the future.

Background

Despite strong evidence that people prefer home and community-based services (HCBS), Medicaid's long-term care benefit is directed toward institutional care.[3] This institutional bias forces people, who could otherwise receive services in their own homes and communities at lower cost, into institutions.[4] Increasing evidence suggests that states could achieve budget savings by rebalancing Medicaid programs and provide greater HCBS access. For example, a 2009 study by Kaye, La Plante and Harringoton, analyzed state spending data from 1995 to 2005 found that HCBS expansion "appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term care cost savings."[5]

There is also evidence to suggest that individuals in nursing homes and other long-term care facilities could live in the community—provided they had appropriate services. Prior to the MFP demonstration program, one study estimated that MFP initiatives could serve between 5% and 12% of the 1.4 million "long-stay" (defined as individuals in a nursing home for at least ninety days) residents in 2005. This would likewise hold true for similar proportions of new admissions that meet definitions of "low-care."[6]

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[3] Surveys indicate that the overwhelming majority of people fifty and older prefer to age-in-place and persons with disabilities prefer to live in their own homes, at eighty-four percent and eighty-seven percent respectively. (AARP Beyond 50.05 Survey, April 2005, and Beyond 50.03: A Report to the Nation on Independent Living and Disability, April 2003. Available at: http://www.aarp.org/research/ppi/health-care/health-qual/articles/beyond_50_hcr.html).

[4] While more than half of long-term care users receive HCBS, institutional care accounts for sixty-five percent of long-term care expenditures (Mathematica Policy Research, Inc., Medicaid Analytic Extract 2005 for 30 MFP grantee states).

[5] H.S. Kaye, M. LaPlante, and C. Harrington, "Do Non-Institutional Long-Term Care Services Reduce Medicaid Spending?," *Health Affairs* 28, no. 1 (January/February 2009).

[6] The study used two definitions for low-care, one narrowly defined and more broadly defined, based on the amount of physical assistance an individual required with activities of daily living and other factors. (Vincent Mor, et al., "Prospects for Transferring Nursing Home Residents to the Community," Health Affairs, Vol. 26, No. 6, 2007, pp. 1762-1771).

Efforts to rebalance the nation's long-term care system and make supportive services more responsive to individuals' needs have progressed in recent years through several different federal and state initiatives. A randomized trial program in Arkansas, Florida, and New Jersey, known as the Cash and Counseling demonstration, advanced the idea of consumer-directed models of service delivery. In such models, consumers are given the ability to manage their own resources and purchase goods and services that meet their long-term care needs.[7] This progress accelerated after the Supreme Court's *Olmstead v. L.C.,* 527 U.S. 581 (1999) decision[8] and through the resulting New Freedom Initiative that includes the MFP demonstration program.[9]

In 2001, the federal government started the Real Choices System Change grant program. The program was designed to support state efforts to direct more people toward community-based care and away from institutionalized settings.[10] In addition, CMS allows states to incorporate consumer-directed service options in their Medicaid Sec. 1915(c) HCBS waiver programs. States were also given added flexibility through a provision in the DRA Sec. 1915(j) that added a Medicaid state plan option for consumer-directed models like Cash and Counseling.

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[7] Robert Wood Johnson Foundation, "Choosing Independence: An Overview of the Cash and Counseling Model of Self-Directed Personal Assistance Services," 2006. Available at: http://www.rwjf.org./files/publications/other/Choosing_Independence_final_nov22.pdf.

[8] In June 1999, the Supreme Court ruled in *Olmstead v L.C.* that states were required to provide services to persons with disabilities in community settings rather than institutions, if certain conditions are met. For Kaiser Policy Brief on the court ruling and its implications on Medicaid programs is available at: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13459. The Olmstead Supreme Court decision is available at: http://straylight.law.cornell.edu/supct/html/98-536.ZS.html.

[9] The New Freedom Initiative (NFI) was announced by President Bush on February 1, 2001 and was followed by Executive Order 13217 on June 18, 2001. The initiative is a nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses. http://www.cms.hhs.gov/NewFreedomInitiative/.

[10] Wayne, Anderson, et al., "Money Follows the Person Initiatives of the Systems Change Grantees Final Report," July 2006, http://www.hcbs.org/files/96/4769/MFP.pdf.

Grantees of the MFP program over the five-year demonstration initially projected 38,000 people would transition into the community. However, that estimate was scaled back to 34,000 people as of January 2009. Based on original data regarding the target population: 44% are elderly, 29% are adults under age sixty-five with physical disabilities, 20% are people with developmental disabilities, 6% are people with chronic mental illness, and 1% percent are people with other conditions or dual diagnoses.[11] While state grantees have considerable flexibility in how they design and implement their transition and rebalancing programs, there are several common program requirements. These include:

- The MFP programs must be managed by the state Medicaid agency;
- Program eligibility is restricted to Medicaid beneficiaries who have spent six months or more in nursing homes or other institutional care settings;
- MFP participants must transition into a "qualified" residence (i.e., home, apartment, group home of four or fewer) and states must provide participants 365 days of HCBS at an enhanced matching rate and then continuity of services through Medicaid after their MFP eligibility ends;
- The MFP statute requires state Medicaid agencies to monitor the quality of HCBS provided, guarantee participants' health and well being in the community, and develop continuous quality improvement systems for HCBS after participants' one-year of program eligibility ends; and

[11] Carol Irvin, et al., "Money Follows the Person: Opportunities for Long-Term Care Systems," Mathematica Policy Research, Inc., presentation to the Disability Policy Forum, September 2009.

- Grantees must also agree to increase the absolute amount of Medicaid HCBS spending each year of the demonstration and invest in efforts to rebalance long-term care from enhanced matching funds.

Methods and Data

The first three studies in this analysis are each part of a series of short reports under the five-year national evaluation of the MFP demonstration conducted by Mathematica Policy Research, Inc.. These efforts will culminate in a final report to Congress in 2012.[12] The interim reports focused on transition target populations, program features that could influence states' ability to meet MFP goals, and the states' early implementation experiences. The reports presented statistics on the number and characteristics of Medicaid enrollees in institutional care and descriptions of state grantees' previous experience and key program elements. These reports were based on information from state operational protocols and semi-annual progress reports submitted to CMS, as well as direct accounts from the state program directors. (See **Appendix 2** for a table that summarizes the MFP implementation analyses and data sources).

A fourth study, undertaken by the Kaiser Commission on Medicaid and the Uninsured (KCMU), provided early implementation analysis of state MFP efforts based on survey data from quantitative and qualitative research questions. The survey of lead MFP program directors was conducted by email. Responses were received from 29 out of 30 states between July and September 2008. States' program directors were asked qualitative questions that were reviewed for common responses or unusual or innovative

[12] Randall Brown, C. Irwin, D. Lipson, S. Simon, and A. Wenzlow, "Research Design Report for the Evaluation of the Money Follows the Person (MFP) Grant Program," Washington, DC: Mathematica Policy Research, Inc., October 3, 2008, http://www.mathematica-mpr.com/publications/PDFs/MFP_designrpt.pdf.

approaches. Between June 2008 and February 2009, states were asked three follow-up questions focusing on the economic downturn and its effects on MFP initiatives.

The fifth study, conducted for Delaware by The Lewin Group (Lewin), provided a needs assessment analysis of its long-term care system and made recommendations for developing a state MFP initiative. Lewin conducted both qualitative and quantitative research to develop its report. Meeting with key agency representatives, evaluators conducted focus groups with Medicaid providers, advocates, and consumers. Their analyses included state Medicaid policies and procedures including data on Delaware's past long-term care system activities, costs, and enrollment, and reviewed estimates on future enrollment and expenditures under the state Medicaid waiver program.

Similarly, a sixth study, prepared by the Public Consulting Group (PCG) for West Virginia, provided a needs assessment analysis on its long-term care system and made recommendations for implementing an MFP initiative. The evaluation team conducted interviews and public forums to gather information and stakeholder input on West Virginia's long-term care system.

In the following section, each of the studies will be examined in greater detail, focusing on their scope, key findings, and the respective authors' conclusions. Following the reviews, this paper compares the evaluation findings and discusses overarching themes from the studies and what policy and programmatic implications they could have for the future.

Study Descriptions and Results

1) Transitioning Medicaid Enrollees from Institutions to the Community: Number of People Eligible and Number of Transitions Targeted under MFP

The first Mathmatica study, authored by Audra Wenzlow and Debra Lipson, assessed the scope of the MFP demonstration by profiling the Medicaid population in long-term institutional care facilities. The assessment was based on 2004 MFP eligibility based on population transition rates prior to the program, and transition rates that could be achieved if states meet their program goals under MFP.

The authors found that, while only about 2%t of Medicaid enrollees were institutionalized for six months or more (the MFP institutional residency requirement), these enrollees made up almost 30% of total Medicaid expenditures in the grantee states. The authors also found that 77% of enrollees in long-term institutional care were age sixty-five or older and living in nursing homes. By comparison, about 9% of populations in care facilities were people with mental retardation or developmental disability (MR/DD). This population was generally younger.

Based on 2004 data, the authors estimated that between about 2% and 6% of MFP eligible individuals (22,373 to 59,793 enrollees) moved from institutions to the community. By comparison, the authors calculated that the state grantees' transition goal of about 36,000 individuals, when compared to the MFP eligible population of more than one million individuals, represents less than 1% of individuals potentially eligible for the program. This is equivalent to only 0.9 % when calculated as an annual average (8,893 enrollees) over the transition period of 2008 to 2011. The authors also noted that the

proportion could be even lower since several states have asked CMS to approve smaller transition goals than those in their original MFP operational protocols.

The authors estimated that state grantees could also improve this transition rate by 15% to 40% annually, provided they meet transition goals. States implementing successful programs could exceed transition goals and request additional federal assistance to provide more care and/or restructure their long-term care systems. The authors conclude that this assumes grantees' MFP efforts targeted institutionalized individuals who could not be transitioned to the community—not the 2% to 6% who would have moved back into the community without assistance.

2) Implications of State Program Features for Attaining MFP Transition Goals

The second Mathmatica study, authored by Debra Lipson and Susan Williams, described MFP state transition program experiences and discussed how key program features affected implementation efforts and the likelihood of meeting transition goals. As noted previously, state grantees initially planned to transition 38,000 Medicaid eligible individuals but scaled-back their goals due to slower than anticipated progress during 2007 and 2008. The authors reported that by the end of 2008, state grantees had transitioned only 1,505 long-term-care residents into community settings, compared to the 4,250 initially projected. State grantees had varying degrees of success and experienced a number of barriers to program implementation. This included: challenges in developing systems infrastructure, affordable housing shortages, delays in making Medicaid policy changes to ensure continuity of services, and state budgetary setbacks.

Lipson and Williams reported that states with more transition experience and capacity were more likely to implement programs faster and meet transition goals more

efficiently. Based on their analysis, seven states had substantial experience operating robust transition programs alongside their MFP demonstration efforts. Thirteen states had more limited experience with transition programs focused on specific populations, or limited pilot programs that were not yet statewide. Ten states had little or no experience operating transition programs and needed to establish basic infrastructure.

The authors noted that finding and securing affordable, accessible housing was a key determinant of successful transition programs—and one of the most frequently cited barriers. They concluded that states pursuing multiple strategies to increase the supply and access to housing may have greater success over the long run than states pursuing more limited approaches. The study additionally reported that one-third of state grantees planned to make significant changes to Medicaid HCBS policies or programs to ensure that all MFP participants can remain in the community after their eligibility ends. The changes included new HCBS waiver programs, amendments to existing HCBS programs, and expanding self-directed care options. Finally, the authors concluded that states proposing more extensive Medicaid programs or amendments were likely to take longer to begin than states with more advanced HCBS programs already in place to offer essential services to MFP participants.

3) Early Implementation Experiences of State MFP Programs

The third Mathmatica study, authored by Noelle Denny-Brown and Debra Lipson, is a continuation of the second Mathematica report and focuses on state MFP efforts from October 2007 through 2008. The authors reported that states successfully transitioned 1,482 long-term care residents, or 37%, of the 3,997 individuals states had projected to move back into the community based on their approved operational protocols in June

2008. They did note, however, that transition rates in 2009 have increased substantially, but were still below stated goals.

The authors stated further that several barriers prevented states from achieving MFP goals. About half of states reported continued challenges in finding affordable and accessible housing. States reported that out of 1,039 individuals who could not be transitioned through the program in 2008, 71 individuals, or 7%, could not find appropriate housing. The authors explained that housing shortages are compounded by existing waiting lists for subsidized public housing, slow turnover rates among current residents, and a lack of accessible features and services such as transportation to maintain their independence.

States also identified the definition of a qualified residence as an obstacle to enrolling individuals in the program. Fifty-one individuals, or 5% met eligibility guidelines, but chose not to reside in a qualified residence as defined under the program. Several states reported the exclusion of assisted living facilities as a limiting factor. In addition, states reported that the six month minimum eligibility standard posed a barrier to recruitment and enrollment efforts.

Mathematica evaluators further reported that state budget crises augmented negative impacts on MFP program efforts. In many states, budget shortfalls led to service cuts in services directly affected the MFP program, including cutbacks in medical, rehabilitative, home care, or other services. Eighteen state grantees experienced worsening budget circumstances that affected almost all aspects of the MFP program. The authors concluded that this contributed to reduced transition rates. Similarly, most

state MFP project directors reported uncertainty about the impact ongoing budget shortfalls would have on their programs.

4) Money Follows the Person: An Early Implementation Snapshot

Authored by Molly Watts, this study summarized findings on early implementation efforts based on survey responses from 29 out of 30 state grantees. The analysis provided a comparison with the Mathematica studies focused on implementation efforts and program features. As previously noted, due to the timing of the survey, the results reflected state experiences covering late summer and early fall 2008. According to the survey, 26 of 29 states reported that their plans had been approved by CMS. Out of 14 states that had started enrolling participants, only 10 were operational in the summer of 2008.

Eleven states reported they had completed 349 transitions and 13 states reported that they were in the process of transitioning 465 individuals. The most commonly reported services under the demonstration included: case management, a range of transition services, assistive technology, housing assistance, and assistance with home modifications. Similar to the Mathematica study, states reported finding affordable and accessible housing for MFP participants was a major challenge in transitioning individuals to the community. While this was a barrier to success, states also cited it as an opportunity to develop collaborative partnerships with some non-traditional stakeholders.

Based on follow-up questions in early 2009, states reported not having to make cuts or programmatic changes due to state budget circumstances. Although states reported no major changes related to the economic downturn, the author noted that it is likely cuts could occur in the future. The long-term effects of state and local budget

cutbacks reducing the availability of long-term services and supports in communities may impede MFP transition programs.

5) Money Follows the Person Study (Delaware)

This study,[13] authored by Lewin in February 2006, estimated that Delaware could transition 439 to 729 individuals from nursing facilities and intermediate care facilities for people with mental retardation (ICFs/MR) in the next decade. The report identified several investments the state must make in order to develop a MFP program. Over 10 years, they estimated that investments in institutional transition programs, outreach and marketing efforts, and information technology needs, would cost between $5.3 million and $9.9 million state and federal funds. If these additional investments were made, Lewin projected that the state and federal government could realize cost savings of $126 million to $207 million.

As part of its report, Lewin developed two models for implementation of a MFP initiative, a "High Model" assuming a more robust MFP program with higher transition rates and a more conservative "Low Model." These two models were compared to a baseline model after estimating enrollment and costs under the current system without a MFP initiative. The Low Model, affecting 396 individuals over10 years, calculated a transition rate of 1% percent in the first year, incrementally increasing to 3% by the fifth year and remaining at 3% for subsequent years. Comparatively, the High Model would start with a transition rate of 1.5 5 and increase up to 5% over 5 years and remain at 5% for the remaining 5 years, transitioning an estimated 657 individuals out of nursing facilities.

[13] Delaware Senate Resolution 26, passed on June 30, 2004, encouraged the Governor's Commission on Community-Based Alternatives for Individuals with Disabilities to conduct a feasibility study on implementing a MFP in Delaware. The Lewin Group was subsequently commissioned to conduct the study.

The Low Model was estimated to save Medicaid about 7% of expected expenditures compared to 12% under the High Model. Using Delaware's Federal Medical Assistance Percentage of 50.09 % federal and 49.91% state contribution (effective as of October 1, 2005), Lewin concluded that the state could save between $63 million and $104 million over the next ten years after factoring estimated implementation costs. Based on cost models, Lewin recommended that any savings be reinvested in HCBS, making the MFP program budget neutral. Delaware subsequently applied for and was awarded an MFP demonstration grant in July 2007. See **Table 1** below for a comparison of the projected implementation costs and total savings under the High and Low Models.

Table 1:
Summary Total Potential Savings to Medicaid

Low Model	**Total Savings**
Total Savings	$130,945,066
Implementation Cost	($5,270,000)
Amount Available for Reinvestment	$125,675,066
High Model	**Total Savings**
Total Savings	$217,366,098
Implementation Cost	($9,880,000)
Amount Available for Reinvestment	$207,486,098

Source: The Lewin Group, "Money Follows the Person Study," February 2006, 64.

6) Money Follows the Person and Long-Term Care System Rebalancing Study (West Virginia)

The sixth and final study, authored by PCG in August 2008, provided a detailed assessment of the West Virginia long-term care system[14] focusing on four areas: service delivery, access, financing, and quality. Based on the assessment, PCG made nineteen recommendations for expanding the availability of HCBS long-term care services. These services could be paid for by reinvesting the cost savings achieved through implementing

[14] The West Virginia Department of Health and Human Resources applied for a MFP demonstration grant in 2006, but did not receive an award from CMS.
http://www.wvdhhr.org/communications/news_releases/DHHRsubmitsMFPdemo.pdf,
http://www.wvdhhr.org/bms/sProg_Instr/Transition_Initiative_Fact_Sheet.pdf.

the study's recommendations. PCG developed projections for the 10 year period from 2008 through 2017 using "high" and "low" models for implementing a MFP program. The two models were compared to a baseline estimate of expenditures under the current system and waiver programs without a MFP initiative.

PCG considered five parameters in estimating the fiscal impact of the low model: how many persons can be transitioned, where beneficiaries are transitioned to in the community, what additional costs to Medicaid are incurred as a result of the additional services needed, the impact of provider taxes, and other administrative and transition costs. Based on these parameters, PCG assumed the low model would transition a total of 75 people per year evenly distributed by month, 10% of whom would return to a nursing facility after one year. The low model also assumes that an additional $1,500 in acute care costs per participant would be incurred and that 10% of the participants would not use any Medicaid services after transition. Finally, PCG made a 5.5% adjustment to savings to account for provider taxes. Based on its analysis, PCG estimated that the low model would result in a net savings to the state of more than $57 million over the 10 year period.

Under the high model, PCG assumed the state would transition two times the number of people as the low model and that to do so the state would have to adopt policy changes that provided more residential options and expanded Medicaid waiver and state plan services. After analyzing cost data for the range of services needed to transition these individuals (including assisted living, traumatic brain injury services, telemedicine, personal care, MR/DD waiver, and adult and disability waiver services), PCG determined a blended annual rate for services. In determining this blended rate, PCG made

assumptions regarding the number of people being transitioned to different institutional settings (nursing facilities, intermediate care facilities for persons with mental retardation (ICF/MR), and state long-term care facilities) and what services they would receive in the community.

Assuming that 100 people would transition from nursing facilities, 100 from ICF/MR, and 80 from state long-term care settings, PCG calculated the blended rate for individuals transitioning from each type of institutional setting and multiplied the annual cost of each service by the total number of individuals that would receive the services. They then computed the total transition cost for each institutional setting by service type. Using different assumptions for each type of transition situation, PCG estimated the cost savings for each of the three transition program areas in the high model. They estimated that the average SFY 2007 cost of a blended package of services would be approximately $28,066 for individuals transitioning from nursing facilities. See **Table 2** below showing the transition cost per person/per year for each of the three transition programs.

Table 2:
Cost of Transition by Program (high model)

Transition Service Type	**Per Year**	**NF (100 Residents)**	**ICF/MR (100 Residents)**	**State LTC (80 Residents)**
Assisted Living	$ 30,000	$ 1,650,000	$ -	$ 1,350,000
A&D Waiver (other)	$ 12,634	$ 379,020	$ -	$ 315,850
Traumatic Brain Injury Services	$ 20,256	$ 101,280	$ -	$ 202,560
Home with No Services	$ -	$ -	$ -	$ -
Personal Care	$ 6,000	$ 180,000	$ 120,000	$ 180,000
Adult Day Care	$ 18,250	$ 456,250	$ -	$ 456,250
Home Health	$ 1,500	$ 30,000	$ -	$ 30,000
Telemedicine	$ 1,000	$ 10,000	$ -	$ 10,000
MR/DD Comprehensive	$ 48,687	$ -	$ 3,408,090	$ -
MR/DD Supports	$ 34,420	$ -	$ 1,032,600	$ -
Total Cost		**$ 2,806,550**	**$ 4,560,690**	**$ 2,544,660**
Per Person/Per Year Transition Cost		**$ 28,065.50**	**$ 45,606.90**	**$ 31,808.25**

Source: Public Consulting Group, "Money Follows the Person" and Rebalancing Study, August 2008, 25.

Over ten years, PCG projected the high model would save over $62 million from transitioning individuals out of nursing facilities back to the community. Under the ICF/MR transition program, they projected net savings in excess of $50 million over the 10 year timeframe, reaching $10 million a year by the end of the period. Finally, utilizing the average per diem cost for each state's five long-term care facilities in SFY 2004 and an inflation adjustment of 4.4%, they projected 10 individuals transitioned each year would result in an estimated net savings of $6.6 million annually by SFY 2017 and over $32 million over the 10 year period.

Policy and Program Implications

While it is still too early in the MFP demonstration to draw many conclusions on the pros and cons of transition programs and rebalancing efforts, the studies discussed above highlight emerging themes that should help inform current programmatic efforts as well as future policymaking. It is clear that the MFP program has served as a driver for program innovation and policy development. However, the changes have not been easy and states continue working to transform their Medicaid long-term care systems.

Based on the Mathematica analyses, states that were more successful in implementing their programs typically had the benefit of more-established HCBS systems. As a result, they avoided many significant Medicaid policy changes and development of supportive infrastructure for transitioning MPF participants into the community. Further, states that developed interagency collaborations and strong partnerships between with local program managers and transition staff, saw better implementation results. Targeting decisions have also been a key predictor of success: states focused on individuals with less complex conditions and fewer intensive needs

achieved greater initial success. However, states must balance the ease of transition with maximizing assistance to individuals most in need of transition.

As shown in the Mathematica and KCMU studies, many states encountered similar challenges in implementing their MFP programs. In particular, difficulty in locating affordable and accessible housing was a significant barrier to states' ability to transition individuals back into the community. Aspects of this included both developing new partnerships and techniques to identify appropriate housing, and addressing the broader issue of housing shortages for the elderly and persons with disabilities. Based on the analyses, the current definition of qualified housing made it more difficult to find housing options for individuals due to restriction on residences housing five or more individuals. The institutional residency requirement (minimum of six months) has also been identified as a barrier to success based on the Mathematica and KCMU analysis.

States were likewise hampered by the economic recession and accompanying state budget cutbacks to community service programs integral to MFP programs. It is apparent that these budget cuts have had an adverse impact on states efforts to meet their initial goals. They also created a sense of uncertainty as MFP programs try to scale up their efforts to meet projected transition rates during the remaining demonstration year. Over the last year, these pressures have increased further, as evidenced by the survey response in the KCMU study and the data reported in Mathematica's most recent monthly report.

Analyses conducted for Delaware and West Virginia underscore that MFP initiatives aimed at rebalancing state long-term institutional care systems with HCBS can produce both federal and state cost savings. While these endeavors take considerable time

and resources during launch, they are more cost-efficient to states and more in alignment with the needs and desires of their residents.

Through 2010's health care reform law (P.L. 111-148), Congress enhanced incentives for states' Medicaid rebalancing program efforts. In particular, the law includes several provisions that make improvements to the availability of long-term services and supports. These provisions include: new financial incentives to states that are spending less than 50% of their Medicaid long-term care dollars on; a new Medicaid benefit called the "Community First Choice Option" for individuals with an institutional level of need who want to receive home and community-based attendant services; improvements to the HCBS state plan option that remove some of the barriers to providing HCBS created under DRA Sec. 1915(j); and a new national voluntary insurance program for purchasing services and supports in the community, known as the Community Living Assistance Services and Supports, or CLASS program.[15]

Of particular relevance, the law amended Sec. 6071(h) of the DRA, extending the MFP rebalancing demonstration and evaluation from 2011 to 2016. It also reduced the current institutional residency requirement from "not less than 6 months…" to "for a period not less than 90 consecutive days" and eliminated states' ability to authorize a longer minimum period previously available to them. The provision also specifies that time spent in an institution "solely for purposes of receiving short-term rehabilitative services" will "not be taken in account for purposes of determining the 90-day period."

[15] These are only some of the long-term services and supports (LTSS) provisions included in the health care reform law (P.L.111-48). For more in depth analysis of the LTSS provisions, refer to issue briefs by the National Senior Citizens Law Center and the National Academy for State Health Policy at: www.nsclc.org and http://www.thescanfoundation.org/.

These changes to the current MFP statute reflect early evaluation findings on how the current residency requirement created obstacles to state grantees' transition efforts.

Further, such actions will increase the number of Medicaid enrollees who meet the MFP demonstration's eligibility standards, leading to additional Medicaid matching funds for community-based services and supports. This added financial incentive, including a $2.25 billion appropriation under the health care reform law through FY 2016, will increase demonstration states' efforts to meet MFP transition goals and rebalance their Medicaid systems. While it remains to be seen how exactly states will adjust their transition efforts, it is clear that some the initial challenges in recruiting qualified candidates should decrease considerably. Additional federal assistance comes at a critical time as states trying to close budget gaps by reducing optional services under their HCBS waiver programs.

Finally, in addition, as part of President Obama's *Year of Community Living*, the Departments of Health and Human Services (HHS) and Housing and Urban Development (HUD) recently announced a new collaboration to provide $40 million to public housing authorities to fund 5,300 housing vouchers for persons with disabilities. The program will specifically target non-elderly persons with disabilities who are currently living in institutions, but could move back into the community with assistance, or who are at risk of institutionalization without housing assistance. The new initiative is intended to augment current efforts under the MFP program.

As states continue to fully implement their MFP programs, future studies assessing participant impacts and program outcomes should highlight effective program performance and areas needing policy improvement. As baby boomers age and

individuals with disabilities of any age seek greater independence in their communities, such analyses will be critical as federal, state, and local policymakers consider the growing demand for HCBS.

Appendix 1:

Source: Mathematica Policy Research, Inc., "Research Design Report for the Evaluation of the Money Follows the Person (MFP) Grant Program," October 2008. (Table I.1)

MFP DEMONSTRATION GRANTS:
PROPOSED NUMBER OF TRANSITIONS AND FEDERAL GRANT AMOUNTS, BY STATE

State	Number of Transitions Proposed	Elderly	PD	MR/DD	MI	Other	Five-Year Federal Commitment	Per-Participant Federal Spending
Arkansas	305	92	146	60	7	0	$20,923,775	$68,603
California	2,000	419	897	316	183	185	$117,805,229	$58,903
Connecticut	700	267	175	68	141	49	$30,651,724	$43,788
Delaware	100	32	28	20	20	0	$5,298,282	$52,983
District of Columbia	400	0	0	400	0	0	$37,498,726	$93,747
Georgia	1,312	375	375	562	0	0	$44,034,960	$33,563
Hawaii	415	175	190	50	0	0	$10,531,860	$25,378
Illinois	3,457	1,517	1,000	255	685	0	$69,727,420	$20,170
Indiana	1,039	793	246	0	0	0	$21,047,402	$20,257
Iowa	528	0	0	475	0	53	$51,383,613	$97,317
Kansas	963	242	356	315	0	50	$41,655,861	$43,256
Kentucky	546	215	90	197	0	44	$49,174,209	$90,063
Louisiana	355	259	76	20	0	0	$13,742,646	$38,712
Maryland	1,994	1,361	371	250	0	12	$71,043,160	$35,628
Michigan	3,100	2,325	775	0	0	0	$54,375,943	$17,541
Missouri	250	48	52	125	0	25	$5,125,352	$20,501
Nebraska	900	400	200	200	0	100	$27,686,808	$30,763
New Hampshire	354	87	200	5	0	62	$15,829,191	$44,715
New Jersey	587	173	89	325	0	0	$36,277,687	$61,802
New York	2,000	850	850	0	0	300	$61,498,857	$30,749
North Carolina	304	22	202	80	0	0	$3,360,352	$11,054
North Dakota	110	42	34	30	0	4	$8,434,036	$76,673
Ohio	2,231	1,428	345	373	85	0	$105,645,125	$47,353
Oklahoma	2,007	1,575	282	150	0	0	$39,189,885	$19,527
Oregon	1,000	260	500	200	0	40	$77,163,797	$77,164
Pennsylvania	2,667	1,878	537	87	165	0	$73,329,961	$27,495
South Carolina	192	160	32	0	0	0	$5,814,422	$30,283
Texas	2,999	800	600	1,599	0	0	$88,112,393	$29,381
Virginia	1,041	325	358	358	0	0	$18,835,906	$18,094
Washington	660	348	172	80	60	0	$21,109,770	$31,985
Wisconsin	1,056	448	189	247	0	172	$37,125,825	$35,157
Totals	35,572	16,916	9,367	6,847	1,346	1,096	$1,263,434,176	$35,518
Percent of Total	100	47.6	26.3	19.2	3.8	3.1	n.a.	n.a.

Source: State MFP operational protocols.
Note: This information is from the MFP operational protocols approved between September 2007 and July 1, 2008. States may revise the transition numbers as they implement their programs.

MI = people with mental illness; MR/DD = people with mental retardation/developmental disabilities; n.a. = not available; PD = people with physical disabilities.

Appendix 2:

Source: Mathematica Policy Research, Inc., "Research Design Report for the Evaluation of the Money Follows the Person (MFP) Grant Program," October 2008. (Table ES.1)

SUMMARY OF IMPLEMENTATION ANALYSES TO BE CONDUCTED

Research Question	Outcome Measure	Data Source		
		Web Report	MSIS/Medicare Claims	Other Data[a]
What were the MFP programs. Goals and Interventions				
What were the programs' transition goals?	- Program transition goals			✓
Which populations did grantees target for transition? What was their level of care? How did the size of the targeted population compare to total number of Medicaid beneficiaries institutionalized?	- Basis of eligibility - Distribution of MFP participants by level of care - Ratio of projected number of transitions to number eligible		✓	✓
How did grantees identify individuals to target for transition? How was the program promoted to beneficiaries?	- Categories of recruitment and outreach activities - State agencies that conducted these activities - Types of challenges to recruitment and outreach and descriptions of how states addressed the challenges	✓		✓
What services not covered normally by the Medicaid program did grantees make available to MFP participants? What types of demonstration and supplemental services were offered?	- Types of services provided by grant - Whether program offered an enriched service package or filled gaps in service - Use of managed long-term care	✓		✓
To what extent did grantees involve consumers, family members, providers, and other stakeholders when designing and implementing the MFP program? How successful were they in these efforts?	- Assessment of consumer and family involvement in MFP program design - Assessment of consumer and family involvement in ongoing program operations	✓		✓
How did MFP programs ensure or promote consumer choice of residential setting? To what extent did MFP participants choose to self-direct services?	- Approach to housing (active versus passive strategies) - Percent enrolled in self-direction programs	✓		✓
What other changes in state Medicaid policies or programs did grantees make to (1) transition MFP participants and (2) help them remain in the community?	- Assessment of categories of changes (e.g., amendments to existing HCBS 1915(c) waivers, establishment of new waivers, modification of budget policies)	✓		✓

Research Question	Outcome Measure	Data Source		
		Web Report	MSIS/Medicare Claims	Other Data[a]
Did the MFP programs accomplish their transitioning and rebalancing goals? - Program Performance Indicators				
What benchmarks did the grantees set? To what extent did the grantees achieve their benchmarks? Which states were more effective in achieving their benchmarks? How ambitious were the benchmarks?	- Ratio of actual results to benchmark - Ratio of benchmark to pre-MFP values - Year-to-year trend in ratio of HCBS spending to total long-term care spending - Year-to-year trend in institutional spending - Year-to-year trend in HCBS spending	✓	✓	
What factors were associated with greater success in achieving benchmarks?	- Correlation of program characteristics with success indicators, controlling for pre-MFP levels	✓	✓	
What were the most common challenges to achieving the targeted number of transitions? What challenges did grantees encounter in trying to achieve their benchmarks? How did they try to overcome these challenges?	- Grantee-reported challenges	✓		
What processes and system changes were implemented to rebalance Medicaid long-term care spending? – Systems Change				
How much did states get in enhanced FMAP grant funds to rebalance their LTC systems? How were these enhanced funds used to rebalance LTC systems?	- Total enhanced funding received overall and as a percent of total HCBS spending and as a percent of total spending on long-term care services - Types of rebalancing benchmarks ratio of benchmarks to pre-MFP levels or transition services and infrastructure, institutional capacity reduction, or investments in HCBS systems) or by type of targeted group (MFP participants only or all users of long-term care services)	✓		✓
Are the changes made by grantees sustainable? Will they have lasting impact on state LTC systems beyond the MFP demonstration period?	- Assessment of changes made by grantees	✓		
Has collaboration among state agencies increased or improved as a result of MFP rebalancing and system change efforts?	- New collaborations - Enhancement of ongoing collaborations	✓		

[a]Other data include documents such as the MFP application and operational protocol, state financial reports, administrative files that have information on qualified residences, the MFP Quality of Life file, NF-MDS, OSCAR, and OASIS.

FMAP = Federal Medical Assistance Percentage; HCBS = home- and community-based services; LTC = long-term care; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum dataset; OASIS = Outcomes and Assessment Information Set; OSCAR = Online Survey, Certification, and Reporting database

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Bibliography

Anderson, W., J. Wiener, and J. O'Keeffe, Money Follows the Person Initiatives of the Systems Change Grantees Final Report, Prepared for the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services, July 2006. http://www.hcbs.org/files/96/4769/MFP.pdf.

Brown, R., C. Irwin, D. Lipson, S. Simon, and A. Wenzlow, "Research Design Report for the Evaluation of the Money Follows the Person (MFP) Grant Program," Washington, DC: Mathematica Policy Research, Inc., October 3, 2008. http://www.mathematica-mpr.com/publications/PDFs/MFP_designrpt.pdf.

Centers for Medicare and Medicaid Services, Money Follows the Person Grants web site http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp.

Denny-Brown, Noelle, and Debra J. Lipson, "Early Implementation Experiences of State MFP Programs," Cambridge, MA: Mathematica Policy Research, Inc., Number 3, November 2009. http://www.mathematica-mpr.com/publications/PDFs/health/MFPfieldrpt3.pdf.

Kaye, H.S., M. LaPlante, and C. Harrington, "Do Non-Institutional Long-Term Care Services Reduce Medicaid Spending?," *Health Affairs* 28, no. 1, January/February 2009.

Lipson, Debra J. and Susan R. Williams, "Implications of State Program Features for Attaining MFP Transition Goals," Washington, DC: Mathematica Policy Research, Inc., Number 2, June 2009. http://www.mathematica-mpr.com/publications/pdfs/health/MFPfieldrpt2.pdf.

Mathematica Policy Research, Inc. Center for Studying Disability Policy. http://www.disabilitypolicyresearch.org/latestwork.asp.

--------- "Money Follows the Person Evaluation Issues First Report from the Field Transitioning Medicaid Enrollees from Institutions to the Community," news release, February 26, 2009.
http://www.mathematica-mpr.com/newsroom/releases/2009/MFPreport2_09.asp.

--------- "New Mathematica Report Profiles State "Money Follows the Person" Efforts Initiative Aims to Help Transition Institutionalized Individuals Back Into the Community," news release, July 13, 2009.
http://www.mathematica-mpr.com/newsroom/releases/2009/MFPBrief0709.asp.

--------- "Early Implementation of "Money Follows the Person" Initiative More Challenging than Expected According to New Report from Mathematica, From Institutions to the Community: Expanding Options for Long-Term Care Residents," news release, November 18, 2009. http://www.mathematica-mpr.com/newsroom/releases/2009/MFP_report_11_09.asp

Mor, Vincent, P. Gonzalo, et al., "Prospects for Transferring Nursing Home Residents to the Community," *Health Affairs*, Vol. 26, No. 6, 2007, pp. 1762-1771.

Public Consulting Group, "Money Follows the Person" and Long Term Care System Rebalancing Study Executive Summary, Prepared for the State of West Virginia Department of Health

and Human Resources Office of the Ombudsman for Behavioral Health Olmstead Office, August 8, 2008. http://www.hcbs.org/files/158/7867/WVMFPRebalancing.pdf.

Rossi, P., M. Lipsey, and H. Freeman, *Evaluation: A Systematic Approach*, 7th edition, Thousand Oaks, CA: Sage Publications, 2004.

Rutgers Center for State Health Policy and the National Academy for State Health Policy Money Follows the Person Toolbox, August 2006. http://www.nashp.org/Files/MFP_toolbox.pdf.

Rutgers Center for State Health Policy Discussion Paper, "Money Follows the Person: State Approaches to Calculating Cost Effectiveness," September 2006.
http://www.hcbs.org/files/97/4838/MFPCostEffectivenessFinal090506.pdf.

The Lewin Group, "Money Follows the Person Study," Prepared for the State of Delaware Governor's Commission on Community-Based Alternatives for Individuals with Disabilities, February 2006. http://ddc.delaware.gov/$$$finalmfpreport21306.pdf.

Watts O'Malley, Molly, "Money Follows the Person: An Early Implementation Snapshot," Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2009. http://kff.org/medicaid/upload/7928.pdf.

Weiner, J., H. Sanderson, M. Gold, and M. Hollowell, "Long-Term Services and Supports: Consumers in Charge─Consumer Direction and the Money Follows the Person Program," Washington, DC: National Health Policy Forum, George Washington University, November 7, 2008. http://www.nhpf.org/library/forum-sessions/FS_11-07-08_Consumer_Direction.pdf.

Wenzlow, Audra T. and Debra J. Lipson, "Transitioning Medicaid Enrollees from Institutions to the Community: Number of People Eligible and Number of Transitions Targeted Under MFP," Ann Arbor, MI: Mathematica Policy Research, Inc., Number 1, January 2009. http://www.mathematica-mpr.com/publications/pdfs/health/MFPfieldrpt1.pdf.