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Money Follows the Person (MFP) Rebalancing Demonstration:
A Work in Progress

BACKGROUND PAPER NO. 85

CAROL V. O'SHAUGHNESSY, MA, *Principal Policy Analyst*

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OVERVIEW — *In recent years, federal and state policy efforts have expanded opportunities for people to live in home- and community-based settings rather than in nursing homes and other institutions. As part of the Deficit Reduction Act of 2005, Congress enacted the Money Follows the Person Rebalancing (MFP) program, a Medicaid demonstration to help people who need long-term services and supports (LTSS) transition from nursing homes and other institutions to their own homes or other community settings. The Patient Protection and Affordable Care Act of 2010 extended the program through September 30, 2016. Now in its eighth year of operation, MFP grants to states have helped over 35,000 people transition from institutions. The pace of transitions has increased in recent years even as programs have faced certain barriers such as lack of accessible and affordable housing and insufficient home and community-based services to assist beneficiaries with complex needs. This publication presents an overview of the MFP program, funding, and selected outcomes as described by an ongoing evaluation for the Centers for Medicare & Medicaid Services.*

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones, MA
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau, MA
Director, Publications and Online Communications

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Federal and state efforts to help people with disabilities transition from living in institutions to home and community settings have intensified in recent years. The Deficit Reduction Act of 2005 (DRA) authorized, and the Patient Protection and Affordable Care Act of 2010 (ACA) extended, the Money Follows the Person Rebalancing (MFP) program. The purpose of MFP is to provide grants to states so that they can expand opportunities for people needing long-term services and supports (LTSS) to live in their own homes or in other residential settings of their choice, rather than institutions.

BACKGROUND

The federal-state Medicaid program is the primary financing source for LTSS for people with physical, cognitive, or intellectual impairments who have limited income and assets. In fiscal year (FY) 2011, the program paid $117.3 billion for LTSS, representing almost one-third of all Medicaid spending. Although the proportion of Medicaid LTSS spending for institutional care and HCBS nationally approached a 50-50 ratio in FY 2011, institutional spending has far outweighed HCBS spending for decades. For example, in FY 1997, about three-quarters of Medicaid LTSS went to institutional care and about one-quarter to HCBS. In contrast, in FY 2011, about 52 percent of spending was for institutional spending and 48 percent was for HCBS. But still, in many states, Medicaid LTSS spending for institutional care outweighs HCBS spending.[1]

Under Medicaid law, people eligible under a state's Medicaid plan are entitled to nursing facility care; that is, if a person meets the state's income and asset requirements as well as the state's functional eligibility requirements for nursing home admission, he or she is entitled to the benefit. For many years, the entitlement to, and financing for, nursing home care has influenced state Medicaid policy and care options that are available to people with LTSS needs. Federal and state LTSS policies have encouraged greater use of HCBS over the past several decades. These policies include extensive state implementation of Medicaid section 1915(c) waiver authority[2] for HCBS options

Since its inception, MFP grants to states have helped over 35,000 people transition from institutions to homes or community residences.

enacted by Congress in 1981, state grant opportunities available under the New Freedom Initiative started by President Bush in 2001, and Medicaid state plan HCBS options enacted in the DRA and the ACA.

The MFP demonstration, in its eighth year of operation in 2014, is part of the broader strategy undertaken by the federal government and states to create more community living options for people with disabilities. Its purpose is to increase the use of HCBS for Medicaid-eligible individuals rather than institutional care; eliminate barriers in state law, budgets, or state Medicaid plans that prevent use of Medicaid funds to help people with LTSS limitations live in settings of their choice; and provide financing for supportive services in community-based settings for people who choose to transition from institutions.[3]

Since its inception, MFP grants to states have helped over 35,000 people transition from institutions to homes or community residences with appropriate supportive services.[4] In addition to transitioning individuals from institutions, the demonstration provides funding to states to make policy and administrative changes that will expand opportunities for individuals with LTSS needs to live in community settings.

FUNDING

The DRA provided $1.75 billion for the program from FY 2007 to FY 2011, and the ACA provided $2.2 billion for FY 2012 to FY 2016, totaling $4 billion. The Centers for Medicare & Medicaid Services (CMS) made the first series of grants to 29 states and the District of Columbia in FY 2007; since then, additional states have received grants, bringing the total number of active states (including the District of Columbia) to 41.[5]

The DRA stipulated that, from the amounts appropriated for each year of the program, up to $1.1 million per year be available to carry out a national evaluation of the MFP program. CMS awarded an ongoing evaluation contract to Mathematica Policy Research, which to date has produced more than 20 reports on the program. The purpose of the evaluation is to determine whether the program is meeting its goals to increase the number and proportion of institutionalized Medicaid beneficiaries to live successfully in the community,

and to increase state rebalancing efforts.[6] For information on various aspects of the evaluation results, see www.mathematica-mpr.com/health/moneyfollowsperson.asp.

MFP IN ACTION

The following discusses key components of the program along with selected findings from the national evaluation.

Eligibility and Characteristics of Participants

People eligible under the demonstration are Medicaid beneficiaries who reside in a hospital, a nursing home, an intermediate care facility for people with intellectual disabilities, or an institution for people with a mental illness; meet the state's institutional level of care requirements; and could be served in a home- or community-based setting. At the outset of the program, the law required that, in order to qualify for transition to a community-based setting through MFP, a beneficiary must have been a resident in an institution for at least six months. In 2010, the ACA eliminated the six-month residency rule and allowed people who have resided in an institution for at least 90 days to qualify. The original eligibility provision (under DRA) was found to restrict the number and types of individuals who could be eligible for transition. Mathematica has estimated that this change in law could increase the number of people eligible for the program by as much as 12 percent, or about 112,000 people per year.[7]

At the end of 2012, about 61 percent of participants were age 21 to 64 with either a physical or intellectual disability, 36 percent were elderly, and 3 percent were younger than age 21. About 65 percent were dually eligible for both Medicare and Medicaid, though these data likely understate the number enrolled in Medicare. Most elderly beneficiaries, about half of the non-elderly, and 61 percent of those with intellectual disabilities were dually eligible.[8]

Findings from the national evaluation show that a relatively high proportion of participants have mental illness. About 64 percent of those transitioned from nursing homes during the first five years of the program reported anxiety disorder, depression, manic depression, a psychotic disorder, schizophrenia or post-traumatic stress disorder (PTSD). In order to provide the necessary supports to ensure successful transitions and continuity of care, program officials

may need to arrange special community mental health services for these beneficiaries.[9]

Transition Coordinators — MFP provides a source of flexible funding for LTSS that can move with the individual to the care setting of his or her choice within the community. Enrollees receive help from transition coordinators (also called relocation specialists or case managers) to plan their move to the community, as well as a vast array of HCBS to help them reside successfully in their own homes or other community settings.

Activities of MFP transition coordinators are multi-faceted. They work with residents of an institution and its staff to identify people who might be eligible for the program and wish to transition to community settings. They also perform assessments of transition candidates and conduct pre-transition planning with the individual, secure family or guardian support for transition, conduct Medicaid eligibility determinations and obtain approval for the individual's HCBS enrollment, arrange for HCBS providers and locate suitable housing, coordinate the transition process, develop contingency plans, and provide post-transition follow-up. Participants transitioned by the end of 2010 received coordination and management services valued at $2,600 on average, including transition planning and care management services generally provided to all section 1915(c) waiver participants.[10] According to the national evaluation, key determinants of program success are the commitment, dedication, and expertise of transition coordinators.[11]

Home- and Community-Based Services — In addition to services of transition coordinators, MFP participants receive HCBS through a number of Medicaid programs, such as the section 1915(c) waiver program and other Medicaid state plan services, to help them successfully live in the community. As an incentive to state participation, states that receive MFP awards are eligible for enhanced federal financial participation (FFP), additional federal Medicaid matching funds[12] for HCBS that are necessary to help the transition to community settings. Enhanced federal matching funds are available for two types of HCBS services. The first are "qualified" HCBS services, that is, Medicaid services that beneficiaries would have received regardless of their status as MFP participants; the second are "demonstration" services, that is, services not ordinarily offered as part of a state Medicaid plan, or services in an amount that a state would not ordinarily provide, such as extra hours of personal care or behavioral health

services. Enhanced matching rates for services are available to states during the 365-day period after an MFP beneficiary has transitioned from an institution. After that period, states must continue to provide HCBS through their existing Medicaid programs for as long as the person needs them and is Medicaid-eligible.[13]

As an incentive to state participation, states that receive MFP awards are eligible for enhanced federal financial participation under Medicaid.

In addition to qualified and demonstration services, states may opt to provide a third type of services, known as "supplemental" services, that do not receive an enhanced federal match. Supplemental services are intended to be one-time services to facilitate transition, such as a security deposit on an apartment, moving expenses, furniture for an apartment, or home modifications that cost more than the state normally allows.[14] Medicaid funding may not be used to pay for room and board outside of institutions.

If a state has waiting lists[15] for section 1915(c) waiver services, it often will grant access to such programs for MFP participants when they leave the institution despite the waiting lists, an example of "money following the person." The national evaluation analyzed the HCBS provided by state MFP programs in 17 categories of services with 39 subcategories. The most frequently provided were (i) home-based services, such as home health aide, personal care, companion and homemaker services and (ii) round-the-clock services, such as care in group- or shared-living arrangements or residential settings that provide 24-hour health and social services; these two types of services accounted for one-third of expenditures each for beneficiaries who transitioned by the end of 2011. The remaining third of expenditures were for other services, such as adult day care and nursing. Of total expenditures, coordination and management accounted for about 7 percent of expenditures.[16]

Number of People Transitioned

Since the program's inception through June 2013, state MFP programs have transitioned over **35,000 people from institutions to home- and community-based settings.** Although the rate of transitions was relatively low in the first years of the demonstration, the most recent data show that there has been an upward trend. By 2012, the cumulative and annual number of people transitioned increased substantially over the prior years. Enrollment varies widely by state and the date each state began implementation. By June 2013, the cumulative number of transitions ranged from a handful in some of the

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more recent grantee states to 7,309 in Texas which has had the longest experience in implementing the program.[17]

The original 30 states that received funding in FY 2007 projected that they would transition about 38,000 individuals from institutions from October 2007 (when the first few states began implementation) to September 2012. The discrepancy between the projected and actual number of those transitioned has been attributed to a number of barriers in the HCBS system, including the complexities of initiating transition coordinator services in states that did not have them prior to the MFP program; lack of appropriate and affordable housing options for people with LTSS needs, especially for elderly individuals; and insufficient HCBS systems to meet the needs of people who wish to transition from institutions.[18] The national evaluation found that states' ability to meet transition goals may be related to the complexity of needs of the MFP target population, especially for those with have mental and behavioral health needs.[19]

Living Arrangements After Transition

The DRA defines "qualified residences" to which residents may be transitioned as a home owned or leased by the resident or a family member; a leased apartment with lockable access and egress with living, cooking, sleeping and bathing space over which the resident or family has control; or a community-based residence for up to four unrelated individuals living together. The national evaluation found that the most common types of residences used by participants were apartments (30 percent of participants), homes owned by the participants (28 percent), or group homes with four or fewer residents (15 percent). Assisted living residences and others unidentified comprised the remainder.[20]

Difficulties in finding appropriate housing and services for low-income people with LTSS needs have been recognized by state and community stakeholders for many years. One of the most significant barriers faced by transition coordinators has been the limited accessibility and availability of affordable housing for MFP participants. Transition coordinators often devote a significant amount of time to working with local housing agencies to identify appropriate settings for transitioned individuals. MFP funding is intended to help states develop service options for people once they have transitioned into community settings, but the grants do not provide direct funding for

housing. In order to address the shortage of housing options for MFP participants, in 2011 the U.S. Department of Housing and Urban Development (HUD) partnered with the U.S. Department of Health and Human Services (HHS) to provide $7.5 million in rental assistance vouchers to help about 1,000 non-elderly voucher-eligible people, including MFP participants, rent private apartments.[21] Also, in 2013, HUD and HHS announced an additional $98 million in funding for 13 state housing agencies to provide rental assistance for low-income people, including those who are transitioning from institutions.[22]

Level of Care of MFP Participants Transitioned from Nursing Facilities

One of the issues in determining the success of the MFP program is the extent to which Medicaid beneficiaries transitioned to community settings are not readmitted to an institution. The likelihood of beneficiaries' ability to remain in the community is dependent on a number of factors such as the intensity of their care needs, the availability of community social supports including family caregivers to assist them, and the sustainability of affordable and accessible housing arrangements. The national evaluation reviewed one of these factors: the effect of beneficiaries' level of care needs on their ability to remain in the community. The data show that that even beneficiaries with high care needs transitioning from nursing homes can be cared for in community settings with appropriate services. There were only slight differences in the likelihood of beneficiaries with low care needs remaining in the community at least six months after transition compared with those with high care needs. For elderly beneficiaries, 87 percent of those with low care needs were able to reside in community settings for at least six months compared with 75 percent of those with high care needs. Similar patterns were found for adults under age 65.[23]

The evaluation also found that state MFP programs differed considerably in the percentage of participants with low and high care needs. For example, of those transitioned to community settings in Illinois, about 70 percent had low care needs. Of those transitioned in Oregon, almost 50 percent had high care needs with wide variation among the other states.[24] These differences may be an indicator of state targeting strategies, adequacy of support services and availability of accessible and affordable housing in communities across

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states, and state variation in the proportion of the Medicaid population living in institutions.

Costs

According to the national evaluation, state MFP programs spent about $657 million for HCBS services for people transitioned from inception through the end of 2011. On average states spent about $37,600 on HCBS per MFP enrollee from the time of his or her initial transition to the end of their enrollment in the program.[25] HCBS spending varied among the eligible populations reflecting differences in the types and intensity of services provided. Of the various population groups participating, spending averaged about $23,000 per year for the elderly; $32,000 for people with physical disabilities age 21 to 64; and $85,000 for people with intellectual disabilities. The higher per-person cost for people with intellectual disabilities is attributed to their need for 24-hour attendant care provided in small-group homes.[26]

State Rebalancing Activities

In addition to direct assistance to individuals wishing to make transitions, the MFP demonstration aims to help states make policy changes that will rebalance their LTSS programs by expanding opportunities for care in home- and community-based settings. For example, as of 2009, some states planned to develop new section 1915(c) waiver programs or to modify existing waiver programs to accommodate the needs of people transitioning from institutions. Other state rebalancing activities include developing consumer self-direction options that allow participants to choose their own providers, working with local housing providers to expand the supply of affordable and accessible housing options for participants, and developing greater capacity for transition coordination.[27]

NEXT STEPS FOR MFP

Since MFP inception, states have served as a laboratory for demonstrating how to manage, coordinate, and deliver services to people who transition from institutions. The process of transitioning from an institution has proven to be rather complex. It involves some risk-taking by residents of institutions who choose to move from settings

they know to settings where many and varied services have to be provided, coordinated, and monitored, sometimes through the efforts of multiple agencies and individuals. It also entails investment in training and supporting transition coordinators who must be expert in many aspects of LTSS, including institutional care, HCBS, and housing options for vulnerable groups. Analysts and state officials indicate that MFP is but one of a number of steps that states can take for providing more HCBS options for people with disabilities. But some states have capitalized on the opportunities offered by the MFP program rebalancing funds to enhance their HCBS platforms to expand the array of services for vulnerable populations and to plan for future policy changes.

As provided by the ACA, the demonstration is projected to end in 2016; the law stipulated that states may use any MFP funds remaining after 2016 until 2020. Before the program was extended by the ACA, the national evaluator posed the question to grantees whether state officials would have continued the program in the absence of federal funding. Their reactions were mixed. The majority of state MFP officials told the national evaluators that if the MPF program "can demonstrate state budget savings, or if it costs Medicaid no more than the cost of care in an institution" then it would become a permanent part of the state's Medicaid program.[28]

ENDNOTES

1. Steve Eiken *et al.*, "Medicaid Expenditures for Long Term Services and Supports in 2011," revised October 2013, Mathematica Policy Research, Inc. and Truven Analytics, for the Centers for Medicare & Medicaid Services, www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Downloads/LTSS-Expenditure-Narr-2011.pdf; and Steve Eiken *et al.*, "Medicaid Long-Term Care Expenditures in FY 2009," figure 1, Thompson Reuters, August 17, 2010, www.hcbs.org/files/193/9639/2009LTCExpenditures.pdf. The 2011 calculation includes, for HCBS, expenditure data for section 1915(c) waivers; personal care; home health; HCBS under sections 1115, 1915(a), 1915(i), and 1915(j) of the Social Security Act; PACE; private duty nursing, personal care under section 1915(j) of the SSA; and Money Follows the Person for HCBS; and for institutional care, nursing facility care, and intermediate care facilities for people with intellectual disabilities.

2. Under section 1915(c) of the Social Security Act, known as the Medicaid home- and community-based waiver authority, states may provide a wide range of home- and community-based services, including case management, personal care, adult day care, assistive technologies, personal emergency response systems, home modifications and accessibility adaptations, homemaker/home

health aide services, adult day health services, habilitation services, psychosocial rehabilitation services, clinic services for individuals with chronic mental illness, home-delivered meals, and other services developed by the state and approved by CMS that are required to keep a person from being institutionalized. States may limit the number of people to be served, the types of services to be offered, and the geographic area where services are to be provided. To be eligible for section 1915(c) services, people must meet the state's level of care criteria for institutional care, in addition to income and assets requirements.

3. Section 6071 of the Deficit Reduction Act of 2005, "Money Follows the Person Rebalancing Demonstration," available at www.gpo.gov/fdsys/pkg/BILLS-109s1932enr/pdf/BILLS-109s1932enr.pdf.

4. Bailey G. Orshan *et al*., "Money Follows the Person Demonstration: Overview of State Grantee Progress, January to June 2013, Final Report," December 31, 2013, www.mathematica-mpr.com/publications/PDFs/health/mfp_jan-jun2013_progress.pdf.

5. Orshan *et al*., "Money Follows the Person Demonstration: Overview of State Grantee Progress, January to June 2013," A few state grantees have withdrawn from the program or have suspended operations and do not have active programs.

6. Carol V. Irvin *et al*. "Money Follows the Person 2012 Annual Evaluation Report, Final Report," October 15, 2013, www.mathematica-mpr.com/publications/pdfs/health/MFP_2012_Annual.pdf.

7. Debra J. Lipson and Susan R. Williams, "Money Follows the Person Demonstration Program: A Profile of Participants," Mathematica Policy Research, Number 5, January 2011, www.mathematica-mpr.com/publications/PDFs/health/mfpfieldrpt5.pdf.

8. Irvin *et al*., "Money Follows the Person 2012 Annual Evaluation Report, Final Report."

9. Irvin *et al*., "Money Follows the Person 2012 Annual Evaluation Report, Final Report."

10. Carol V. Irvin *et al*. "Post-Institutional Services of MFP Participants: Use and Costs of Community Services and Supports," Mathematica Policy Research, Number 9, February 2012, www.mathematica-mpr.com/publications/pdfs/health/mfpfieldrpt9.pdf.

11. Debra J. Lipson, Christal Stone Valenzano, and Susan R. Williams, "What Determines Progress in State MFP Transition Programs?" Mathematica Policy Research, Number 8, October 2011, www.mathematica-mpr.com/publications/pdfs/health/MFPfieldrpt8.pdf.

12. The MFP Demonstration Program provides an enhanced FMAP rate for qualified services, which include HCBS services and demonstration services. This rate is equal to taking the published FMAP for a state, subtracting it from 100 percent, dividing the total by half, and then adding that amount to the published FMAP. As an example, a state that normally has a 50 percent FMAP will have a 75 percent FMAP under MFP. The enhanced FMAP for MFP cannot exceed 90 percent. The enhanced rate is available for qualified services provided to an MFP participant for 365 days after transition from an institution.

13. Irvin *et al*. "Post-Institutional Services of MFP Participants."

14. Irvin *et al*. "Post-Institutional Services of MFP Participants."

15. Many states have waiting lists for waiver programs. In 2012, 524,000 individuals were reported to be on waiting lists for waiver programs in all but nine states, with an average wait time for services across LTSS populations of 27 months. Pamela Doty, presenting on behalf of Terence Ng, "HCBS Waiver Wait Lists: National Estimates 2012," slides from presentation at the NAUSAD HCBS Waiver Conference, September 10, 2013, www.nasuad.org/documentation/HCBS_2013/Presentations/9.11%2010.00-11.15%20Roosevelt.pdf.

16. Irvin *et al*., "Money Follows the Person 2012 Annual Evaluation Report, Final Report."

17. Orshan *et al*., "Money Follows the Person Demonstration: Overview of State Grantee Progress, January to June 2013."

18. Lipson and Williams, "Money Follows the Person Demonstration Program: A Profile of Participants."

19. Debra J. Lipson and Susan R. Williams, "Implications of State Program Features for Attaining MFP Transition Goals," Mathematica Policy Research, June 2009, www.mathematica-mpr.com/publications/pdfs/Health/MFPfieldrpt2.pdf.

20. Irvin *et al*., "Money Follows the Person 2012 Annual Evaluation Report, Final Report."

21. U.S. Department of Housing and Urban Development (HUD), "HUD, HHS Announce Joint Effort to Assist Nearly 1,000 non-Elderly Persons with Disabilities to Move from Institutions to Independence," press release, January 6, 2011, http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2011/HUDNo.11-003.

22. HUD, "HUD and HHS Partner to Provide Permanent Housing and Services to Low-Income People with Disabilities," press release, February 12, 2013, available at http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2013/HUDNo.13-024.

23. William Kim and Carol V. Irvin, "Disparities in Post-Transition Outcomes by Level of Care Needs Among Former Nursing Home Residents," Mathematica Policy Research, Number 12, September 2013, www.mathematica-mpr.com/publications/pdfs/health/MFPfieldrpt12.pdf.

24. Irvin *et al*., "Money Follows the Person 2012, Annual Evaluation Report."

25. Enrollment period refers to the 365-day period from the day the individual moves from an institution to a home or community residence. This period may be longer than a year because the 365-day period can be stopped if the participant is admitted to a hospital or institution but returns to his or her home or community residence within 30 days when the 365 period resumes.

26. Irvin *et al*., "Money Follows the Person 2012, Annual Evaluation Report."

27. Lipson and Williams, "Implications of State Program Features for Attaining MFP Transition Goals."

28. Lipson, Valenzano, and Williams, "What Determines Progress in State MFP Transition Program?" p. 9.