Money Follows the Person Demonstration: Overview of State Grantee Progress, January-June 2010

January 2011

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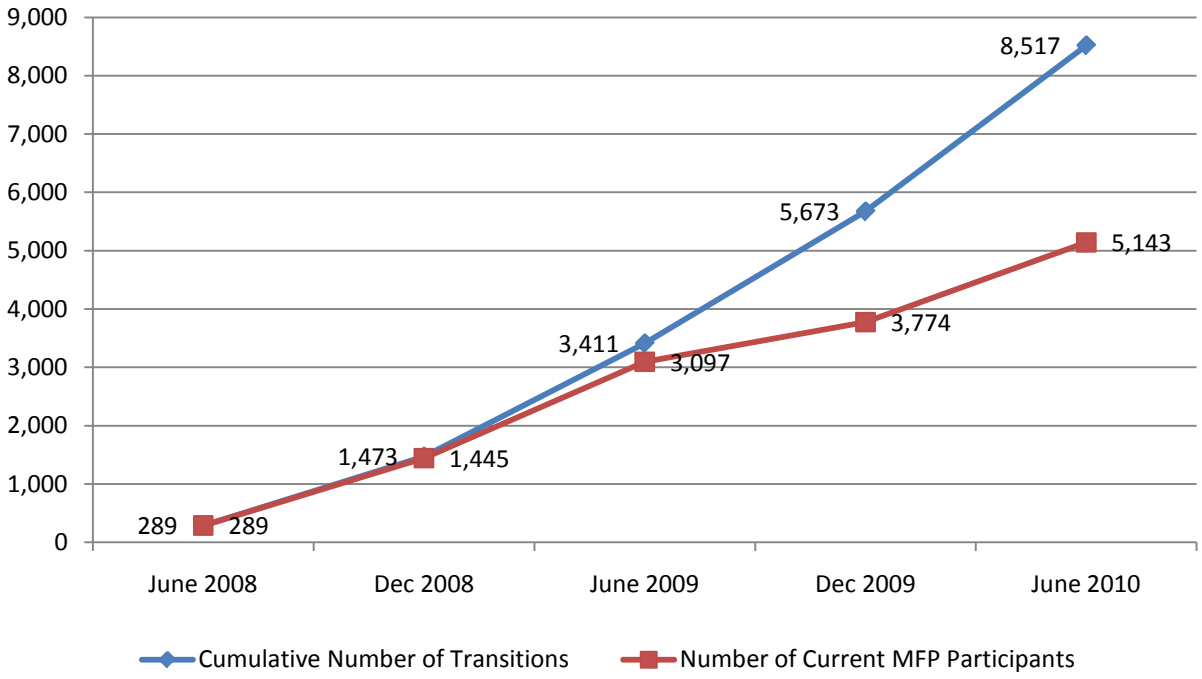
EXECUTIVE SUMMARY

This report summarizes the progress of the Money Follows the Person (MFP) demonstration in all 30 grantee states (29 states and the District of Columbia) for the six-month period from January 1 to June 30, 2010. This summary is based on data and information submitted by state grantees in their mid-year 2010 progress reports, which were due in mid-September 2010.

Enrollment in MFP grew steadily over the first half of 2010. The cumulative number of people ever enrolled in the program as of June 30, 2010 was 8,517, just over a 50 percent increase from the cumulative number enrolled as of December 31, 2009, six months before (see Figure 1 below). Overall, states reported 2,844 transitions during the six month period from January to June 2010, 25 percent more than the number transitioned in the previous six month period. However, these overall numbers mask considerable state variation; cumulative transitions to date range from 31 in Delaware and North Dakota to 2,768 in Texas. Relative to the total 2010 annual transition goal of 5,774, MFP transitions during the first half of the year represented 49.3 percent of states' overall transition goal. If states continue to make progress at the same rate for the rest of the year, the program overall is on track to meet the total transition goal for 2010.

This report has three sections. Section I describes states' progress on key program performance indicators related to MFP transitions, including number of people transitioned during the six month period, transitions relative to targets, cumulative number of transitions since the start of the program, number of individuals assessed and reinstitutionalizations. Section II summarizes initial information on state grantees' use of MFP rebalancing funds through 2009. Section III discusses the major accomplishments and challenges in implementing the MFP demonstration during the six month reporting period as reported by grantees.

Figure 1. MFP Transitions and Current MFP Participants, June 2008 to June 2010



I. KEY PERFORMANCE INDICATORS - MFP TRANSITIONS AND ENROLLEES

A. Number of New Transitions (Table 1)

From January to June 2010, states reported enrolling 2,844 new MFP participants – those who transitioned to the community for the first time—a 25.7 percent increase from the number transitioned during the last reporting period. The volume of transitions varied by state, ranging from 884 in Texas (about a third of the total) to just 3 in Wisconsin. Among those individuals who transitioned during this period, 36.2 percent were individuals with physical disabilities, 33.5 percent were elders, 25.3 percent were individuals with development disabilities, 2.9 percent were individuals with mental illness, and 2.1 percent were other eligible populations. Cumulative transitions as of June 30, 2010, totaled 8,517. With 2,768 cumulative transitions, Texas accounts for about a third of the total transitioned to date. The next five states with the greatest number of cumulative transitions comprise another third of the total: Washington, Ohio, Michigan, Maryland, and Pennsylvania. The remaining 24 states contribute the remaining third of total cumulative transitions to date.

Parallel Transition Programs. Table 1 also shows the number of people who transitioned from institutions to home or community based settings through programs *other than MFP*, which we call "parallel transition programs". Individuals who transitioned through these programs were generally ineligible for MFP for one of several reasons: (1) they were not eligible for Medicaid as in Georgia, Delaware, and Pennsylvania; (2) did not meet MFP's minimum residency period of 6 months (now 90 days[1]); or (3) chose to move to a type of community

[1] During this reporting period, the Patient Protection and Affordable Care Act changed MFP eligibility rules concerning the minimum residency period from six months to 90 days, not counting days for Medicare-covered rehabilitation. MFP grantees were asked to report on the number of individuals who enrolled in MFP during the reporting period who became eligible after a stay of 90 days (but before 6 months) as a result of the change in

residence that does not qualify for MFP. To gauge the number of people that cannot enroll in MFP because they do not meet its eligibility criteria, grantees are asked to provide an approximate number of individuals who transitioned through these programs. Nineteen grantees reported having parallel nursing home transition programs in their state, 14 of which estimated that 4,074 individuals transitioned to the community through these programs (Table 1). Of these, nearly half (48.9 percent) were from one state (Washington). Eleven states reported having parallel ICF-MR transition programs in place, and estimated that 261 individuals with developmental disabilities transitioned to the community during this period through these programs. But these totals are likely to be an underestimate of the numbers of people who transitioned through parallel transition programs because some states do not track these numbers precisely, or did not report this information through the MFP progress reporting system.

B. Achievement of Transition Benchmark Goals (Table 2)

As of June 30, 2010, states achieved 49.3 percent of their total transition goal for 2010 (2,844 transitions of 5,774 planned), and are on track to achieve their annual 2010 transition benchmark goals if they can maintain a similar level of activity. This progress is markedly improved over the last year; MFP states only achieved 52.7 percent of the annual transition goals that they set in 2009. Because CMS planned to hold states accountable for meeting transition goals starting in 2011, many states reduced their annual transition goals for 2010 and subsequent years, which partly explain the improved performance relative to goals in 2010.

(continued)

federal law. However, most states did not report this information because they have not yet developed mechanisms to collect these data.

States vary in the degree to which they are reaching their 2010 transition benchmark goals (Table 2). Seven states achieved 60 percent or more of their goals during the first half of the year, and are on track to either meet or exceed their 2010 transition benchmark. In fact, 2 of these states (Texas and Virginia) exceeded their annual goals in the first half of 2010. Eleven states achieved between 40 percent and 60 percent of their 2010 transition benchmark goals, and the remaining 12 states achieved less than 40 percent of their 2010 transition goals. Of these, 5 states (California, District of Columbia, Nebraska, North Carolina, and Wisconsin) achieved less than 20 percent of their 2010 transition target, which suggests a need for these five states to either (a) invest substantially more resources or adjust the program design to significantly increase transition volume, or (b) reduce transition goals for subsequent years through amendments to their operational protocols, so as not to jeopardize their ability to receive supplemental MFP grant funds.

Nearly two-thirds (19) of all states reported that they intend to revise their transition goals. Of these 19 states, eight (Indiana, Kansas, Louisiana, Missouri, New Hampshire, New York, North Dakota, and Texas) may *increase* their transition goals because they are receiving more referrals or plan to expand their programs by adding another target population. Two of the 19 states (Hawaii and Wisconsin) may reduce their transition goals. Five of the 19 states (Illinois, Michigan, North Carolina, Ohio, and Oklahoma) intend to spread their existing transition benchmarks over a longer period (to 2016 or beyond) because they expect it will take them longer to reach their goal, or add transitions beyond calendar year 2011. Three of the 19 states (Delaware, Maryland, and Oregon) had not yet decided how their transition goals would be changed, and Washington intends to amend one of its additional benchmarks.

Nearly two-thirds (19) of all states reported difficulty reaching their transition goals this period, due to several factors (in order of importance): (1) shortages of affordable and accessible

qualified housing; (2) statutory restrictions on housing options that can be used in MFP; (3) complex needs of the target population; (4) transition candidates not choosing to reside in an MFP-qualified residence; and (5) family opposition, particularly among candidates with development disabilities. Other state-specific challenges (discussed in Section C) included a shortage of slots in their home and community-based service (HCBS) waiver programs or lack of waivers for a particular target population; contracting delays; cuts in the state budget; transition candidates not meeting the minimum length of institutional stay requirement; inadequate service capacity; lack of caregiver supports; staff turnover; low census in facilities; decreased participation due to the state moving to a managed long-term care system; and difficulty identifying MFP-eligible transition candidates.

C. Number of Current MFP Participants (Table 3)

Current MFP enrollment as of June 30, 2010, stood at 5,143 (Table 3), which is an increase of 66.1 percent relative to the number of MFP participants enrolled at the same time last year (June 2009). Current participants are everyone eligible for MFP-financed HCBS in June 2010. This count excludes those who completed the 365-day period of eligibility, died after transitioning, were reinstitutionalized for 30 days or more, or withdrew from the program for other reasons. As shown in Table 3, the number of current MFP enrollees grew 66.1 percent between June 2009 and June 2010. But the average number of current participants masks a wide range across states – from a low of just nine participants in Wisconsin to 1,340 in Texas. A total of 1,414 MFP participants completed the 365-day transition period during the reporting period.

D. Number of Individuals Assessed (Table 4)

MFP states reported a total of 8,511 individuals assessed during the reporting period, of which 38.7 percent are in the transition planning process and expected to transition to

the community in the future. However, not all of these individuals will necessarily enroll in the MFP program if suitable HCBS and housing cannot be found. The number of individuals assessed varied widely by state, ranging from 10 in New Hampshire to 2,766 in Texas, which alone accounted for 32.5 percent of all assessments during the reporting period.

The number of assessments is a general indicator of the amount of MFP outreach, recruitment, and transition planning activity in the states. However, due to differences in how states define and track assessments, the numbers are not comparable across states. For example, in many states an assessment constitutes anyone who is initially screened and determined to meet Medicaid eligibility and who signs an MFP informed consent form. Other states use narrower criteria for what constitutes an assessment. For example, in New York, assessments are counted only when an individual and guardian (if applicable) have been accepted by a service coordination agency. In Kentucky, an MFP assessment consists of a full assessment of the individual's physical and psychosocial needs and review of clinical records; verification of Medicaid eligibility; review of community supports and available housing; and finally review of service needs and the individual's perception of his/her needs. Two states, Kansas and Pennsylvania, report providing more accurate data on the number of individuals assessed for MFP enrollment this period. The reported number of assessments in Texas (2,766) equals the cumulative number of participants enrolled in the program because the state cannot track MFP assessments and enrollment separately.

Among those assessed for MFP, 2,799 individuals were *unable* to enroll in MFP for various reasons. The most commonly cited reason (975) was that the individuals *did* transition to the community but did not enroll in MFP because they were ineligible or chose not to enroll. The second most commonly cited reason for not transitioning to the community through MFP was "Too Physically Ill," accounting for 625 individuals.

E. Reinstitutionalizations (Table 5)

Fewer than 10 percent (498) of current MFP participants were reinstitutionalized for any length of time from January to June 2010. Of those, 179 (35.9 percent of all who were admitted to an institution) were reinstitutionalized for more than 30 days, of which 82 (45.8 percent) later reenrolled in the MFP program.

As defined in the web-based progress reporting system, reinstitutionalization means any admission to a hospital, nursing home, ICF-MR, or institution for mental disease, regardless of length of stay.[2] The prevalence of reinstitutionalization is higher among elders, relative to individuals with physical disabilities and developmental disabilities. Of the total number of individuals reinstitutionalized for any length of time, 43.4 percent (216) were elders who make up only 30.8 percent of current participants and 37.1 percent (185) were individuals with physical disabilities who comprise 35.9 percent of current participants. In addition, 15.9 percent (79) of those reinstitutionalized for any length of time were individuals with developmental disabilities who make up 29.4 percent of total current participants, 2.8 percent (14) were individuals with mental illness, and 0.8 percent (4) were other individuals.

The most common factor contributing to reinstitutionalization was decline in the individual's physical or mental health status. Other reasons included short-term hospitalization (which may or may not have been followed by a subsequent nursing home admission), participants' choice to return to an institution, lack of informal supports in the community, and lack of formal paid services or supports in the community.

[2] If an MFP participant is admitted for more than 30 days, CMS requires that person to be disenrolled from MFP. These individuals may re-enroll in MFP without meeting the minimum institutional residency requirement.

F. Self-Direction (Table 6)

Twenty-three of the 30 MFP grantee states[3] offered self-direction options to MFP participants, but only 12.7 percent (651) of current MFP participants were reported to be self-directing HCBS. Ohio's 205 self-directing participants account for nearly a third of the total for all states. The number of individuals self-directing is not comparable across states because of differences in what counts as self-direction. For example, Ohio counts anyone managing his or her community transition services budget (an MFP supplemental service of up to $2,000 per participant), which is a one-time benefit participants use for rental deposits, home furnishings, and other expenses that arise at the time of transition to the community. Pennsylvania also reports that the actual number of MFP enrollees who self direct their own services is likely to be much higher than the number they report; the state intends to improve the accuracy of its data collection on this indicator in the future.

Of the 651 participants who were self-directing services during the reporting period, 59.6 percent hired or supervised their own personal assistants, and 43.8 percent managed their own allowance or budget (the two categories are not mutually exclusive). Seventeen MFP participants in three states withdrew from a self-direction program during the reporting period. Reasons for withdrawal included death, an end to MFP eligibility, moving to an assisted living facility, and returning to a nursing facility.

[3] In the previous six month period (July to December 2010), three additional states (District of Columbia, Illinois, and Oklahoma) reported that they planned or were considering making a consumer-directed option available to MFP participants in the future. Of these three, only Illinois reported still planning to make participant-directed services available to MFP participants.

G. Emergency Calls for Backup Assistance (Table 6)

Eleven states reported a total of 106 emergency calls for backup assistance during the reporting period; two-thirds of all these emergency calls were reported by four states (Connecticut, Indiana, Missouri, and New York). Of the total calls, 34.0 percent (36 calls) were attributable to critical health services, 34.9 percent (37 calls) were in response to direct service or support workers not showing up as scheduled, 2.8 percent (3 calls) were to address transportation to get to medical appointments, and 0.9 percent (one call) was in response to other circumstances; which the state (North Carolina) attributed to family members being unable to provide support.

H. Type of Qualified Residence (Table 6)

Among the 2,844 MFP participants who transitioned to the community this period, 40.2 percent (1,143 individuals) moved to an apartment, 30.6 percent (870) moved to a home, and 23.8 percent (677) moved to a small group home. The type of residence for the remaining 5 percent, or 154 individuals, was unavailable at the time of this report. Grantees report the type of residence to which participants moved upon transitioning to the community, rather than where they are residing at the end of the reporting period. Grantees are not required to report living arrangement by population subgroup in the semiannual progress reports, but this information can be derived from the MFP Program Participation Data files and will be presented in a forthcoming MFP Report from the Field.

II. USE OF MFP REBALANCING FUNDS

During this period, MFP grantees began to report on how they were spending MFP rebalancing funds, which are the net revenues from the enhanced Federal Medical Assistance Percentage (FMAP) that states receive on expenditures for qualified and demonstration home and community-based services provided to MFP participants during their first 365 days of community living.

States are required to invest these funds in initiatives that help to shift the balance of long-term supports and services towards home and community-based services (HCBS). Such initiatives can include efforts to expand the availability or capacity of community-based long-term care services, sustain MFP participants in the community after the 12-month eligibility period ends, or related activities. Although all states were required to report on how they spent rebalancing funds, 13 of the 30 MFP grantee states had not done so at the time of this report. Among the 17 MFP grantees that did report on their investment of rebalancing funds, there were some common themes in the types of rebalancing initiatives:

- **Increase in Waiver Slots.** Four states reported using their rebalancing funds to either increase waiver slots (Arkansas, Pennsylvania, and Wisconsin) or maintain slots that would have been otherwise been cut due to budget deficits (Oklahoma). For example, in Arkansas, 50 slots were added to the Alternatives for Adults with Physical Disabilities (AAPD) waiver and 185 slots were added to the Assisted Living for Elderly or Physically Disabled ("Living Choices") waiver, while Oklahoma reported that rebalancing savings were used to offset budget cuts to the community waiver program for persons with mental retardation. Michigan also stated that MFP

rebalancing funds were used to increase the budget for the MI Choice waiver program.

- **Preferences/Needs Assessment Tools.** Rebalancing funds were commonly directed towards the development or increased use of assessment tools intended to better facilitate community transitions. Five states (California, Iowa, Maryland, Missouri, and New Hampshire) reported this type of activity. In California, for example, funds were directed towards the expanded use of the Preference Interview Tool which assesses individuals' preferences for and feasibility of transitioning from an institutional setting. New Hampshire also reported that they developed risk assessment tools that incorporated person-centered planning principles.
- **Self-Advocacy/Consumer Empowerment.** Three states (Maryland, Missouri, and Ohio) directed rebalancing funds toward efforts to communicate information about the MFP program to potential participants. In Ohio, this was done by funding a HOME Choice Consumer Advisory Council, development of advocacy and empowerment tools (such as websites, brochures, videos), and attendance at Olmstead conferences and meetings. Maryland is funding peer outreach activities.
- **Transition Services.** Six states reported spending rebalancing funds on intensive transition services, including case management, housing assistance, and other one-time transition expenditures. Four of these states are providing intensive transition services to MFP-eligible individuals (Maryland, Missouri, Texas, and Washington), and two states (California and Washington) are providing them to individuals not eligible for MFP.
- **Other Rebalancing Activities.** Two states (New York and Texas) spent rebalancing funds in unique ways. New York is investing MFP rebalancing funds on assistive

technology (equipment loans and device demonstrations) and on promotion of affordable, accessible, and integrated housing for individuals wishing to live in the community. Texas is directing rebalancing funds towards the costs associated with the voluntary closure of ICFs-MR, and they developed a "Realistic Job Preview" video for agencies and individuals hiring direct support workers to help reduce turnover among direct support workers.

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III. PROGRESS AND CHALLENGES BY MFP PROGRAM COMPONENT

During the first half of 2010, MFP grantees reported myriad accomplishments across all dimensions of their programs, most notably related to the availability of benefits and services; increases in the number of transition coordinators and HCBS providers contracting with Medicaid; and quality management. Despite reported progress, MFP states continue to encounter systemic challenges related to state budget cuts, scarce housing options, limits imposed on Medicaid HCBS benefits, and shortages of services and providers. Key themes that emerged from their semi-annual progress reports are described below.

A. State Budget Cuts

A little over half of MFP states (16) reported that the economic downturn's impact on state budgets is adversely affecting MFP programs. Due to budget shortfalls in the billions of dollars in some states, across-the-board cuts were made to all state government programs, and Medicaid was no exception. Tightened budgets have led to staffing restrictions, cuts to HCBS funding, and reduced provider reimbursement rates that adversely affected the MFP program.

Six states reported hiring freezes, furloughs, and lay-offs that have strained available staff resources and in some cases limited the MFP program's ability to make timely transitions, conduct trainings, or perform outreach (Delaware, Hawaii, New Hampshire, Maryland, Missouri, and Washington). These restrictions do not always directly affect the staffing of the MFP program, but four states (Hawaii, Iowa, Maryland, and New Jersey) say that staffing shortages and cuts to other key agencies have hindered the implementation of MFP initiatives. Some states (Connecticut, Delaware, District of Columbia, Ohio, and Washington) reported an easing of their staffing challenges due to approval to hire additional MFP-dedicated staff with the 100 percent federal administrative matching funds from the Centers for Medicare & Medicaid Services.

A number of states indicated their MFP programs have been affected by cuts to Medicaid HCBS. North Carolina reported significant cuts to case management and other community-based services that have destabilized the community support structure. Missouri had funding cuts, and staff expect more for SFY 2012, which has made it difficult to add or change HCBS programs. Provider payment reductions and service cuts have increased reluctance by some providers to participate in state Medicaid programs; California, Iowa, and Hawaii reported a loss of Medicaid-participating providers. As reported in previous periods, providers in Iowa continue to express concerns about funding for their programs and their ability to work with individuals over the long term. Other states, such as District of Columbia and Kansas, have found institutional providers are less willing to participate in the MFP program or switch the emphasis of their services from institutional to HCBS due to concerns about losing business. Arkansas had to freeze enrollment into their Alternatives for Adults with Physical Disabilities (AAPD) waiver but the cap was lifted in June 2010.

On a positive note, six states (Hawaii, Iowa, Kansas, Maryland, Michigan, Oregon, and Washington) report that services provided to MFP participants have been excluded from broader Medicaid HCBS cuts or have benefited from increased payment rates to MFP providers. Arkansas reported it was able to increase the number of slots in two HCBS waivers this year, but indicated that the waiver program will be under review over the next year in response to a severe Medicaid budget shortfall.

B. Availability of Home and Community-Based Services

Fifteen states reported improvement in the availability of HCBS to participants in the MFP program during this reporting period. Six states increased the capacity of HCBS waiver programs to serve MFP participants (California, Kansas, New York, North Dakota, North Carolina, and Pennsylvania). The District of Columbia earmarked HCBS waiver slots for MFP

participants to ensure that MFP enrollment could continue despite budget cuts in other Medicaid services, while Georgia's state legislature restored the funding for MFP capacity in the Elderly and Disabled Waiver after eliminating it the year before. Kansas also was able to ensure that MFP participants would continue to receive the same quantity and scope of services after they transferred to an HCBS waiver after 365 days despite budget cuts and limits that were placed on HCBS programs.

Several states reported offering new HCBS to MFP participants, or are planning to do so. For example, New Hampshire and Ohio added an option to self-direct services. Georgia is developing a 1915(i) state plan amendment to provide community services to people with severe mental illness, which will allow MFP to add this group as a target population. Iowa drafted administrative rules that would add mental health outreach, behavioral programming, and crisis intervention to the Intellectual Disability Waiver. Other improvements include North Dakota's success at increasing the number of meals available under the waiver from three to seven days a week, increasing the number of daily personal care hours available under the Medicaid State Plan-Personal Care program from 8 to 10 hours, and adding Programs of All-inclusive Care for the Elderly (PACE) as an MFP service. Nebraska and Pennsylvania adjusted caseload size for service coordinators and case managers to allow for more time or attention to participants.

Nine states reported challenges providing HCBS to MFP participants in this period. California, Kentucky, and North Carolina, for example, reported that they could not guarantee MFP participants would be able to secure all needed services.

C. Participant Access to Services

Half of all MFP states improved the ability of MFP participants to access services by increasing the number of transition coordinators serving MFP participants or the number of HCBS providers contracting with Medicaid. However, the majority of states reported

that MFP participants' ability to access HCBS was hindered by limits on the amount or type of HCBS covered by Medicaid or an inadequate supply of HCBS and providers.

The total number of challenges reported by states to assure access to HCBS has gradually increased from a low of 26 challenges reported in the second half of 2008 to a high of 45 challenges in the first half of 2010 (Table 7). The three most prevalent challenges among MFP states over the years have been (1) insufficient supply of HCBS providers, (2) limits on amount and scope or duration of HCBS covered benefits, and (3) insufficient supply of specific HCBS services. The latter two challenges have been reported by an increasing number of MFP states over time. Since MFP began, fewer states reported increasing payment rates for HCBS providers. Yet, since 2008, MFP states also reported a steady number of achievements in assuring access to HCBS by: (1) increasing the number of transition coordinators and (2) increasing the number of HCBS providers contracting with Medicaid.

In the first half of 2010, fourteen states reported an insufficient supply of HCBS or limits on the amount, scope or duration of HCBS covered by Medicaid. Washington reported that success in transitioning people to the community has highlighted the need for more resources to accommodate increased demand. Hawaii reported that managed long-term care plans and case managers for the Developmental Disability Waiver are authorizing a smaller service package for new HCBS participants and implementing service reductions where feasible to save money. Maryland, Missouri, and New Hampshire reported that the lack of 24-hour care for certain target populations can be a barrier to transitions for those who have resided in institutions for many years. Nine states reported an insufficient supply of HCBS providers, especially in rural areas where service options are limited. Indiana reported challenges finding providers for adult foster care homes, attendant care, and personal emergency response systems (PERS) providers. Virginia reported an insufficient supply of HCBS providers for the elderly, and people with

physical and developmental disabilities, and some parts of the state have few or no providers to serve the populations who wished to transition thus preventing their move.

On the positive side, twelve states improved the ability of participants to access HCBS by increasing the number of MFP transition coordinators (Table 7). The District of Columbia used federal funds to hire six MFP transition coordinators. Ohio planned to increase the number of transition coordination providers due to implementation of the new MDS 3.0 Section Q changes, which they expect to increase referrals to MFP. In Oklahoma, six new transition coordination agencies completed or initiated the certification process to provide transition coordination services to MFP participants.

Nine MFP states increased the number of HCBS providers contracting with Medicaid, following efforts begun in the last year or two (Table 7). Nebraska contracted with three new developmental disability providers to deliver HCBS. Also, a current provider in Nebraska has expanded capacity to serve individuals with behavioral or medical risks by opening additional residential settings. Connecticut made progress in developing strategies to assure the number of providers serving participants enrolled in the state's new Mental Illness Waiver continues to increase. Two states were able to improve transportation options (Kansas and Pennsylvania). In Kansas, the Medicaid agency moved to a managed care contract for Non-Emergency Medical Transportation (NEMT). In the past, there were no NEMT providers in certain rural parts of the state. However, the managed care organization is now required to arrange for transportation across the entire state, which has enhanced accessibility to medical appointments. This change seems to be a positive one for MFP consumers, especially in rural areas where transportation options were limited.

D. Securing Housing for MFP Participants

Most state MFP grantees (26 of 30) reported that shortages of affordable and accessible housing, rental vouchers, and small group homes prevented potential MFP participants from transitioning to the community. To address this problem, more than half the states reported applying for housing vouchers through the Notice of Funding Availability (NOFA) for Non-Elderly Persons with Disabilities through the Department of Housing and Urban Development.

Since the end of 2008, MFP states had a stable number of reported achievements in securing appropriate housing options for participants, and a rise in the number of reported challenges over the same time period. The most commonly cited accomplishments since 2008 include (1) developing local or state coalitions to identify needs and/or create housing-related initiatives (2) improving funding for home modifications, and (3) increasing the number of rental vouchers. The two most prevalent challenges reported by states since January 2008 are (1) an insufficient supply of affordable and accessible housing; and (2) the insufficient supply of rental vouchers. For more details see Table 8.

During this reporting period, 60 percent (18) of MFP states cited a shortage of affordable and accessible housing as impeding more transitions, continuing the trend since 2008 as the most commonly reported housing-related barrier (Table 8). Over half (16) of MFP states reported an insufficient supply of rental vouchers for MFP participants, and most of these states expressed concern about the long wait time for rental assistance. Delaware, Iowa, Louisiana, Missouri, and Virginia reported that housing subsidy programs have stopped taking new applicants, and others reported significant waiting lists. Some states have been able to gain priority status for MFP applicants on these waiting lists or set aside vouchers for MFP participants, such as the District of Columbia, Georgia, and Ohio, but others such as Hawaii have been unsuccessful. Several

states reported difficulties securing public housing for participants with criminal backgrounds, and problems qualifying individuals with poor credit histories or lack of sufficient income (Michigan, Ohio, and Texas).

Another housing barrier is the shortage of small group homes and other residential options that arrange for long-term services and supports. California and Illinois reported difficulty locating community residences for people with developmental disabilities or severe mental illness. Oregon reported that some MFP transition candidates wanted to live in a setting that provides socialization opportunities and privacy but had difficulty locating places that met these conditions. Several other states (Hawaii, Maryland, North Carolina, Michigan, Illinois, and California) indicated that small group or assisted living options are available but often exceed the required four-bed limit. Some states, such as North Carolina, are engaging small group home providers to reduce their size to qualify for MFP. Others, like Maryland, have made the decision not to recruit additional small group home providers after advocates objected, saying they preferred to expand independent housing options.

States are trying to expand the availability of MFP-qualified housing options in myriad ways. Four states (Hawaii, Michigan, New Hampshire, and Oregon) reported they increased the supply of small group homes. Texas increased funding for home modifications, eight states (District of Columbia, Georgia, Maryland, New York, Ohio, Oklahoma, Pennsylvania, and Texas) increased the number of rental vouchers, and Missouri implemented a new home ownership initiative to provide support brokerage to up to 20 self-advocates and families to enable them to purchase their own home. The support brokerage includes financial counseling, assistance in exploring financial opportunities, researching available properties, and assistance through all the steps needed to close on a home purchase.

Several states explored ways to expand housing options to include assisted living facilities. Kansas received approval to use qualifying assisted living facilities as an MFP-eligible residence. California MFP participants now have the opportunity to enroll in their state's Assisted Living Waiver if they prefer to move to a community setting and receive 24-hour assistance. Arkansas made $5 million available through a rebalancing initiative to develop, implement, and administer an Assisted Living Incentive Fund that will offer incentives to develop affordable assisted living in the state, and to strengthen their financial feasibility.

MFP states also actively collaborated with stakeholders to address housing barriers. Specifically, seven states (Arkansas, Delaware, Hawaii, Indiana, New York, Ohio, and Virginia) developed or expanded inventories or statewide registries of available housing options, and five states developed coalitions to identify housing needs or to create housing-related initiatives (Texas, Georgia, Louisiana, North Carolina, and New York). Georgia convened two housing development forums as a first step toward creating a statewide coalition of housing and human services organizations to identify and address housing related needs. At least 19 MFP states also reported working with local public housing authorities to apply for the housing funds available for people under age 65 with disabilities under the Notice of Funding Availability for Non-Elderly Persons with Disabilities announced by the Department of Housing and Urban Development. Of these states, many reserved a portion of the new vouchers for MFP participants. The number of vouchers requested varied widely across the states; two of the larger requests include Louisiana which reported applying for 100 vouchers and Georgia for 925 vouchers.

E. Quality Management and Improvement

Two-thirds of states reported improvements in their quality management systems, though many continue to experience difficulty getting the necessary information to identify

needs and determine whether participants were receiving adequate services and supports. Improvements occurred in three areas: (1) interdepartmental and intradepartmental coordination, (2) new or enhanced data collection instruments, and (3) new or enhanced use of information technology. As part of these improvements, five states (Connecticut, Illinois, Michigan, Nebraska, and Pennsylvania) enhanced their critical incident reporting and tracking system. Missouri began using a reporting system to identify trends in the need for support and systems improvement for all MFP participants; the system provides individual's health scores that are used to initiate a nursing review.

Washington responded to quality concerns by implementing a new data tracking system on provider compliance with licensing requirements, created protocols for complaint investigations to promote consistency, and made visits to newly licensed adult foster homes. They also plan to require adult family homes to post their inspection/investigation reports and post enforcement letters on the state's public website. Kansas centralized the supervision of its quality assurance field staff, which has improved communication, consistency in expectation and messaging, and oversight of these staff. New Hampshire instituted a requirement that all MFP participants receive a personal alert system to enhance their emergency backup system.

Thirteen states reported a number of challenges related to remediation or discovery processes. Primary issues relate to the difficulties in identifying whether participants were receiving adequate services and supports and difficulties gathering information to identify unmet needs. A few states report delays in obtaining required documentation following a critical incident to investigate the cause and resolve the issue. Several states also reported that not all case managers or transition coordinators were documenting their contact with participants, or not communicating with central MFP staff on a timely basis after an incident occurred. One state reported that a contractor was not conducting all quality assurance activities required under its

MFP program and plans to conduct provider audits and retrospective claims reviews to remedy the situation. One state reported problems managing and implementing improvements to its quality assurance system due to increased demand from rising MFP enrollment and decreased availability of staff due to mandatory furloughs of state employees.

IV. CONCLUSION – SHIFTING CHALLENGES, NEW FEDERAL SUPPORT

As of mid-2010, all 30 MFP grantee states had been in operation at least 18 months. By that time, most state grantees were able to overcome initial start-up problems. They publicized the program and sought to allay the concerns of most institutional providers. They ironed out enrollment procedures and began to ensure smoother hand-offs for MFP participants from transition coordinators to community case managers. They worked to strengthen quality monitoring and remediation systems for MFP participants, and developed strategies to address shortages of affordable and accessible housing. Many states also expanded their capacity and infrastructure to transition significantly larger numbers of institutional residents. As a result, the number of people ever enrolled in MFP increased by nearly two and half times from June 2009 to June 2010.

While some states continue to confront challenges in implementing or expanding their transition programs, the problems they face have evolved. At a time of widespread state budget cuts, many states have found it difficult to secure sufficient state funding to cover Medicaid HCBS after an MFP participant completes 365 days in the community, expand the supply of affordable, accessible housing; and assign enough staff to ensure systematic quality oversight.

At the same time, changes to the federal MFP program, including those made by the Affordable Care Act of 2010, hold promise for helping states address these challenges. The decrease in the minimum residency period needed to qualify for MFP, from 6 months to 90 days may make it easier to transition people before they lose community housing. CMS and HUD have made available additional funds and resources, including housing vouchers for younger people with disabilities, and 100 percent federal funding for MFP administrative staff devoted to information system upgrades, housing specialists and other key activities. While it is too soon to determine how much difference the additional federal support will make, it should help alleviate

some MFP budget constraints. This will allow states to build on their momentum in increasing MFP transitions, which will in turn produce the rebalancing funds needed to support broader long-term care system balancing initiatives.

Table 1. Overview of MFP Grant Transition Activity

State	2010 Transition Activity				Number of Participants Transitioned from January 1–June 30, 2010							
	Cumulative Number of Transitions from Program Start to June 2010	Total Number of Transitions from January to June 2010	Total 2010 Transition Goals	Percentage of 2010 Transition Target Achieved	Total Number	Elders	People with PD	People with MR/DD	People with MI	Other	Estimated Number of Individuals Transitioned Through Parallel NH Transition Programs This Period	Estimated Number of Individuals Transitioned Through Parallel ICF-MR Transition Programs This Period
Arkansas	108	35	66	53.0	35	7	12	16	0	0	—	—
California	186	58	325	17.9	58	10	25	14	2	7	100	120
Connecticut	248	119	230	51.7	119	38	61	2	18	0	50	—
Delaware	31	8	38	21.1	8	6	2	0	0	0	6	—
Dist. of Columbia	68	16	90	17.8	16	0	0	16	0	0	—	—
Georgia	300	103	200	51.5	103	27	44	32	0	0	—	89
Hawaii	45	20	96	20.8	20	10	9	1	0	0	—	—
Illinois	132	79	192	41.2	79	22	11	0	46	0	—	—
Indiana	130	70	171	40.9	70	31	39	0	0	0	—	—
Iowa	88	26	75	34.7	26	0	0	26	0	0	—	—
Kansas	214	56	80	70.0	56	27	15	11	0	3	102	—
Kentucky	83	42	201	20.9	42	11	6	18	0	7	—	—
Louisiana	68	59	280	21.1	59	14	24	21	0	0	—	20
Maryland	612	128	355	36.1	128	64	50	8	0	6	50	—
Michigan	517	142	300	47.3	142	66	76	0	0	0	509	—
Missouri	233	28	62	45.2	28	6	14	8	0	0	—	—
Nebraska	75	17	422	4.0	17	1	8	6	0	2	71	2
New Hampshire	59	14	27	51.9	14	4	2	2	0	6	—	—
New Jersey	118	33	62	53.2	33	16	2	15	0	0	200	—
New York	165	78	100	78.0	78	20	30	0	0	28	8	—
North Carolina	47	16	87	18.4	16	0	4	12	0	0	26	15
North Dakota	31	12	20	60.0	12	3	3	6	0	0	—	—
Ohio	610	208	269	77.3	208	56	124	14	14	0	29	—
Oklahoma	74	46	96	47.9	46	11	15	20	0	0	—	—
Oregon	246	83	331	25.1	83	37	39	6	0	1	—	—
Pennsylvania	419	124	243	51.0	124	80	36	8	0	0	581	—
Texas	2,768	884	819	107.9	884	238	240	406	0	0	—	—
Virginia	159	70	66	106.1	70	8	20	42	0	0	—	—
Washington	630	267	360	74.2	267	140	115	10	2	0	1,992	—
Wisconsin	53	3	111	2.7	3	0	3	0	0	0	350	15
TOTAL	**8,517**	**2,844**	**5,774**	**49.3**	**2,844**	**953**	**1,029**	**720**	**82**	**60**	**4,074**	**261**

Source: MFP semiannual web-based progress reports covering the January 1–June 30, 2010 period. Submitted September 13, 2010.

ICF-MR = intermediate care facilities for people with mental retardation; MI = mental illness; MR/DD = mental retardation/developmental disabilities; NH = nursing home; PD = physical disabilities.

Table 2. States' Progress Towards Yearly MFP Transition Goals: January 1, 2009 Through June 30, 2010

State	January – June 2010 Transition Activity			2009 Transition Activity		
	Percentage of 2010 Transition Target Achieved as of June 2010[a]	Total 2010 Transition Goals	Total Number of Transitions as of June 2010	Percentage of 2009 Transition Goal Achieved as of December 2009	Total 2009 Transition Goals	Total Number of Transitions in 2009
Wisconsin	2.7	111	3	11.4	219	25
Nebraska	4.0	422	17	9.0	434	39
Dist. of Columbia	17.8	90	16	24.7	150	37
California	17.9	325	58	22.9	551	126
North Carolina	18.4	87	16	35.6	87	31
Hawaii	20.8	96	20	21.8	110	24
Kentucky	20.9	201	42	163.6	22	36
Delaware	21.1	38	8	80.0	25	20
Louisiana	21.1	280	59	13.8	65	9
Oregon	25.1	331	83	33.2	394	131
Iowa	34.7	75	26	35.8	148	53
Maryland	36.1	355	128	114.6	288	330
Indiana	40.9	171	70	27.3	220	60
Illinois	41.2	192	79	10.3	517	53
Missouri	45.2	62	28	242.1	57	138
Michigan	47.3	300	142	95.3	300	286
Oklahoma	47.9	96	46	70.0	40	28
Pennsylvania	51.0	243	124	29.0	873	253
Georgia	51.5	200	103	55.4	350	194
Connecticut	51.7	230	119	96.3	134	129
New Hampshire	51.9	27	14	22.1	95	21
Arkansas	53.0	66	35	81.0	63	51
New Jersey	53.2	62	33	41.1	180	74
North Dakota	60.0	20	12	29.2	48	14
Kansas	70.0	80	56	21.1	417	88
Washington	74.2	360	267	110.9	293	325
Ohio	77.3	269	208	49.8	687	342
New York	78.0	100	78	79.1	110	87
Virginia	106.1	66	70	22.8	320	73
Texas	107.9	819	884	146.0	769	1,123
TOTAL	**49.3**	**5,774**	**2,844**	**52.7**	**7,966**	**4,200**

Source: MFP semiannual web-based progress reports covering the January 1–June 30, 2009 period; the July 1–December 31, 2009 period; and the January 1–June 30, 2010 period. Submitted September 10, 2009; March 1, 2010; and September 13, 2010.

[a] States shown in table are sorted by the percentage of 2010 transition target achieved as of June 30, 2010.

Table 3. Current MFP Participation: June 30, 2009 Through June 30, 2010

State	Total Number of Current Participants as of June 2009	Total Number of Current Participants as of December 2009	Total Number of Current Participants as of June 2010	Number of MFP Participants Completing the 365-Day Transition Period as of June 2009	Number of MFP Participants Completing the 365-Day Transition Period as of December 2009	Number of MFP Participants Completing the 365-Day Transition Period as of June 2010
Arkansas	21	32	35	1	17	17
California	55	118	116	0	1	43
Connecticut	30	121	204	0	0	22
Delaware	13	19	22	0	2	8
Dist. of Columbia	32	38	35	0	15	30
Georgia	122	221	175	0	22	95
Hawaii	9	22	35	0	1	5
Illinois	13	52	106	0	0	14
Indiana	1	60	132	0	0	3
Iowa	21	51	59	0	6	17
Kansas	100	88	117	0	67	24
Kentucky	10	31	62	0	0	4
Louisiana	0	9	64	0	0	0
Maryland	299	303	244	37	108	177
Michigan	151	153	188	0	57	45
Missouri	114	158	151	17	19	51
Nebraska	34	30	20	3	12	18
New Hampshire	37	28	34	10	6	6
New Jersey	37	69	52	0	13	37
New York	30	78	123	0	0	22
North Carolina	12	28	38	0	0	0
North Dakota	13	16	24	0	5	13
Ohio	231	319	646	0	67	141
Oklahoma	8	20	74	0	0	8
Oregon	63	148	199	8	15	28
Pennsylvania	132	180	202	0	49	79
Texas	1,066	1,025	1,340	190	370	405
Virginia	43	67	191	0	13	19
Washington	379	265	446	7	13	72
Wisconsin	21	25	9	10	4	11
TOTAL	**3,097**	**3,774**	**5,143**	**283**	**882**	**1,414**

Source: MFP semiannual web-based progress reports covering the January 1–June 30, 2009 period; the July 1–December 31, 2009 period; and the January 1–June 30, 2010 period. Submitted September 10, 2009; March 1, 2010; and September 13, 2010.

Table 4. Overview of the Assessments for the MFP Program: January 1 Through June 30, 2010

State	Total Number of MFP Candidates Assessed[a]	Total Number of Candidates in the Transition Planning Process	Number Assessed Who Did Not Transition Through MFP	Individual Transitioned but Was Not Enrolled	Reasons Participants Could Not Transition Through the MFP Program									
					Too Physically Ill	Too Cognitively Impaired	Guardian Refused Participation	Could Not Locate Appropriate Housing Arrangement	Could Not Secure Affordable Housing	Individuals Did Not Choose MFP Qualified Residence	Individual Changed His or Her Mind	Individual Would Not Cooperate in Care Plan Development	Service Needs Greater than What Could Be Provided in the Community	Other
Arkansas	64	40	30	0	5	0	0	0	0	0	6	0	1	15
California	324	238	79	0	10	0	1	0	0	12	52	1	2	1
Connecticut	329	420	414	41	14	7	0	0	0	49	6	0	101	196
Delaware	34	16	12	0	0	0	2	0	9	0	0	1	0	0
Dist. of Columbia	14	15	6	3	0	0	0	0	0	1	0	0	0	0
Georgia	239	279	0	0	0	0	0	0	0	0	0	0	0	0
Hawaii	27	6	9	0	2	0	1	5	0	0	0	1	0	0
Illinois[b]	947	331	675	0	515	76	14	5	0	0	0	0	0	65
Indiana	119	60	60	0	2	0	0	0	0	0	0	0	4	0
Iowa	33	78	20	0	0	0	0	0	0	0	0	0	0	20
Kansas	129	64	27	0	3	1	1	0	0	9	4	1	1	7
Kentucky	158	18	151	1	9	2	7	0	0	5	17	1	0	7
Louisiana	96	96	6	119	5	3	3	0	0	0	1	1	9	4
Maryland	347	501	42	5	0	0	0	0	0	31	0	0	0	6
Michigan	1,172	294	668	509	34	11	11	4	0	0	43	9	7	40
Missouri	45	43	20	0	0	2	2	0	0	0	3	1	6	6
Nebraska	54	23	32	4	0	1	1	1	0	5	15	0	2	2
New Hampshire	10	8	8	0	1	0	0	0	4	0	0	0	2	1
New Jersey	33	83	1	0	0	0	0	0	0	1	0	0	0	0
New York	195	134	62	1	11	3	0	16	5	0	8	5	12	1
North Carolina	95	45	45	2	4	1	11	4	1	0	8	1	1	33
North Dakota	25	8	6	3	0	0	0	0	0	0	0	1	2	0
Ohio	346	0	26	0	7	0	0	0	0	4	5	1	9	0
Oklahoma	104	115	43	6	2	6	2	0	0	0	23	0	4	0
Oregon	88	99	270	270	0	0	0	0	0	93	0	0	0	0
Pennsylvania	201	93	77	8	1	0	0	0	0	3	0	1	1	63
Texas	2,766	0	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Virginia	62	46	0	0	0	0	0	0	0	0	0	0	0	0
Washington	441	136	7	0	0	0	0	0	0	7	0	0	0	0
Wisconsin	14	8	3	3	0	0	0	0	0	0	0	0	0	0
TOTAL	8,511	3,297	2,799	975	625	113	56	35	19	220	191	25	164	467

Source: MFP semiannual web-based progress reports covering the January 1–June 30, 2010 period. Submitted September 13, 2010.

[a] The number of assessments are not comparable across states due to differences in how states define and track assessments.

[b] Illinois included in the 'Other' category 471 individuals who could not transition through the MFP program because they indicated a preference for remaining in an institutional setting. These individuals were excluded from the reported data because the population of candidates assessed for MFP enrollment should only include those who have signed an informed consent form indicating their desire to transition to the community and enroll in the State's MFP program.

NR = Not reported.

Table 5. Number of Reinstitutionalizations: January 1 Through June 30, 2010

State	Number of MFP Participants Reinstitutionalized During the Period					
	Total Number	Elders	People with PD	People with MR/DD	People with MI	Other
Arkansas	3	2	1	0	0	0
California	9	4	5	0	0	0
Connecticut	37	23	11	0	3	0
Delaware	4	1	2	1	0	0
Dist. of Columbia	1	0	0	1	0	0
Georgia	8	7	1	0	0	0
Hawaii	9	2	6	1	0	0
Illinois	12	7	1	0	4	0
Indiana	12	5	7	0	0	0
Iowa	8	0	0	8	0	0
Kansas	7	4	2	1	0	0
Kentucky	19	5	6	6	0	2
Louisiana	2	1	0	1	0	0
Maryland	5	3	2	0	0	0
Michigan	31	16	15	0	0	0
Missouri	4	0	3	1	0	0
Nebraska	2	2	0	0	0	0
New Hampshire	1	1	0	0	0	0
New Jersey	5	0	0	5	0	0
New York	6	9	15	0	0	2
North Carolina	4	2	0	2	0	0
North Dakota	1	1	0	0	0	0
Ohio	112	52	53	0	7	0
Oklahoma	1	0	0	1	0	0
Oregon	12	4	6	2	0	0
Pennsylvania	7	6	1	0	0	0
Texas	94	49	34	11	0	0
Virginia	57	7	13	37	0	0
Washington	4	2	1	1	0	0
Wisconsin	1	1	0	0	0	0
TOTAL	**498**	**216**	**185**	**79**	**14**	**4**

Source: MFP semiannual web-based progress reports covering the January 1–June 30, 2010 period. Submitted September 13, 2010.

MI = mental illness; MR/DD = mental retardation/developmental disabilities; PD = physical disabilities.

Table 6. Other Key Indicators: January 1 Through June 30, 2010

State	Number of MFP Participants Self-Directing	Number of MFP Participants Who Hired/Supervised Personal Assistants	Number of MFP Participants Who Managed Their Allowance/Budget	Number of Emergency Calls for Backup Assistance	Number of MFP Participants Who Transitioned to Home	Number of MFP Participants Who Transitioned to Apartment	Number of MFP Participants Who Transitioned to Group Home
Arkansas	8	7	7	1	8	17	10
California	0	0	0	0	11	33	11
Connecticut	101	101	2	17	26	90	3
Delaware	20	20	20	0	2	5	0
Dist. of Columbia	NA	NA	NA	0	0	18	6
Georgia	0	0	0	7	24	43	35
Hawaii	7	7	0	0	5	0	15
Illinois	NA	NA	NA	0	7	71	1
Indiana	1	1	1	20	42	15	13
Iowa	2	2	2	0	1	26	0
Kansas	46	46	0	0	16	29	11
Kentucky	5	5	5	0	8	10	24
Louisiana	NA	NA	NA	2	23	39	0
Maryland	0	0	0	0	50	56	20
Michigan	43	43	43	2	52	87	3
Missouri	53	53	0	15	2	19	7
Nebraska	NA	NA	NA	0	5	7	5
New Hampshire	0	0	0	11	7	5	4
New Jersey	0	0	0	0	11	8	12
New York	NA	NA	NA	20	17	61	0
North Carolina	0	0	0	2	0	0	0
North Dakota	0	0	0	0	1	12	0
Ohio	205	0	205	0	23	173	12
Oklahoma	NA	NA	NA	9	7	20	19
Oregon	NA	NA	NA	0	14	13	56
Pennsylvania[a]	90	39	0	0	63	53	8
Texas	7	1	0	0	347	89	317
Virginia	28	28	0	0	13	21	23
Washington	35	35	0	0	84	121	62
Wisconsin	0	0	0	0	1	2	0
TOTAL	**651**	**388**	**285**	**106**	**870**	**1,143**	**677**

Source: MFP semiannual web-based progress reports covering the January 1– June 30, 2010 period. Submitted September 13, 2010.

[a] Pennsylvania reports that the number of MFP enrolled individuals self-directing their services is higher than reported. Pennsylvania expects the number of participants self-directing their services will increase once more accurate data become available.

NA = Indicates that state does not have self-direction option in place.

Table 7. MFP Grantees' Progress and Challenges in Assuring Participants' Access to Home- and Community-Based Services, by Reporting Period, 2008-2010

Response Option	Jan-June 2008[a]	July-Dec 2008[b]	Jan-June 2009[b]	July-Dec 2009[b]	Jan-June 2010[b]
Number of Grantees Self-Reporting Challenges [c]					
Insufficient supply of HCBS providers	2	7	6	7	9
Insufficient supply of direct service workers	0	5	3	4	4
Preauthorization requirements	2	1	2	3	2
Limits on amount and scope or duration of home and community-based services	1	3	4	4	10
Lack of appropriate transportation options	0	1	3	3	4
Insufficient supply of HCBS services	1	2	5	9	8
Other	4	7	11	7	8
SUBTOTAL	10	26	34	37	45
Number of Grantees Self-Reporting Progress [d]					
Increased the number of transition coordinators	3	9	12	8	12
Increased the number of HCBS providers contracting with Medicaid	2	7	10	10	9
Increased access requirements for managed long-term care providers	0	0	0	0	1
Increased payment rates to HCBS providers	1	8	6	5	3
Increased the supply of direct service workers	1	0	2	1	2
Improved or increased transportation options	1	1	1	1	2
Added or expanded managed LTC programs	0	1	1	1	2
Other	2	6	2	4	6
SUBTOTAL	10	32	34	30	37

Source: MFP semiannual web-based progress reports covering the January 1–June 30, 2008 period; the July 1–December 31, 2008 period; the January 1–June 30, 2009 period; the July 1–December 31, 2009 period; and the January 1–June 30, 2010 period. Submitted September 5, 2008; March 2, 2009; September 10, 2009; March 1, 2010; and September 13, 2010.

Note: The progress reports are designed to capture information on states' progress and challenges encountered in all dimensions of the program. Information presented is based on self-reported information and reflects the challenges encountered during the reporting period.

[a] Only 10 states completed a progress report for the January-June 2008 reporting period.

[b] 30 states completed a progress report for this reporting period.

[c] Report question asks, "What are MFP participants' most significant challenges to accessing home and community-based services? These are challenges that either make it difficult to transition as many people as you had planned or make it difficult for MFP participants to remain living in the community."

[d] Report question asks, "What steps did your program take during the reporting period to improve or enhance the ability of MFP participants to access home and community-based services?"

Table 8. MFP Grantees' Progress and Challenges Securing Appropriate Housing Options for Participants, by Reporting Period, 2008-2010

Response Option	Jan-June 2008[a]	July-Dec 2008[b]	Jan-June 2009[b]	July-Dec 2009[b]	Jan-June 2010[b]
Number of Grantees Self-Reporting Challenges [c]					
Lack of information about affordable and accessible housing	1	3	1	2	2
Insufficient supply of affordable and accessible housing	5	13	19	14	18
Lack of affordable and accessible housing that is safe	0	0	2	3	5
Insufficient supply of rental vouchers	4	8	15	14	16
Lack of new home ownership programs	0	0	0	0	2
Lack of small group homes	0	6	5	6	6
Lack of residences that provide or arrange for long term services and/or supports	0	1	2	2	2
Insufficient funding for home modifications	0	1	1	1	1
Unsuccessful efforts in developing local or state coalitions of housing and human services organizations to identify needs and/or create housing related initiatives	0	0	0	2	0
Unsuccessful efforts in developing sufficient funding or resources to develop assistive technology related to housing	0	0	0	0	0
SUBTOTAL	11	35	53	51	56
Number of Grantees Self-Reporting Progress [d]					
Developed inventory of affordable and accessible housing	1	6	7	2	3
Developed local or state coalitions to identify needs and/or create housing-related initiatives	1	4	8	9	5
Developed statewide housing registry	1	5	4	1	3
Implemented new home ownership initiative	1	0	1	0	1
Improved funding for developing assistive technology related to housing	1	2	2	1	1
Improved information systems about affordable and accessible housing	0	2	2	2	2
Increased number of rental vouchers	1	5	5	5	8
Increased supply of affordable and accessible housing	2	2	3	2	1
Increased supply of residences that provide or arrange for long term services and/or supports	0	1	4	1	0
Increased supply of small group homes	0	2	3	3	4
Increased/improved funding for home modifications	2	3	5	6	1
Other	2	6	6	6	9
SUBTOTAL	12	38	50	38	38

Source: MFP semiannual web-based progress reports covering the January 1–June 30, 2008 period; the July 1–December 31, 2008 period; the January 1–June 30, 2009 period; the July 1–December 31, 2009 period; and the January 1 – June 30, 2010 period. Submitted September 5, 2008; March 2, 2009; September 10, 2009; March 1, 2010; and September 13, 2010.

Note: The progress reports are designed to capture information on states' progress and challenges encountered in all dimensions of the program. Information presented is based on self-reported information and reflects the challenges encountered during the reporting period.

[a] Only 10 states completed a progress report for the January-June 2008 reporting period.

[b] 30 states completed a progress report for this reporting period.

[c] Report question asks, "What significant challenges did your program experience in securing appropriate housing options for MFP participants? Significant challenges are those that affect the program's ability to transition as many people as planned or to keep MFP participants in the community."

[d] Report question asks, "What achievements in improving housing options for MFP participants did your program accomplish during the reporting period?"

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