Money Follows the Person Demonstration: Overview of State Grantee Progress, January to June 2011

December 2011

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Contract Number:
HHSM-500-2005-000251 (0002)

Mathematica Reference Number:
06352.400

Submitted to:
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Division of Community Services Transformation
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EXECUTIVE SUMMARY

The goal of the Money Follows the Person (MFP) Demonstration, first authorized by federal law in 2005, is to support efforts by state Medicaid programs to give people with disabilities greater choice in where to live and receive long-term services and supports. Each state MFP grant program consists of two parts: a transition program to identify Medicaid beneficiaries living in institutions who wish to live in the community and help them do so, and a rebalancing program through which states make system-wide changes that allow more Medicaid beneficiaries with disabilities to live and receive services in the community.

In 2007, the Centers for Medicare & Medicaid Services (CMS) awarded MFP demonstration grants to 30 states and the District of Columbia. In 2010, Congress increased total grant funding to $4 billion and extended the demonstration, enabling CMS to award grants to 13 more states in 2011. States now have until the end of federal fiscal year (FFY) 2019 to transition people and until the end of FFY 2020 to expend all their grant funds. This report summarizes the progress of 30 state MFP grantees that received initial awards in 2007 with a focus on developments during the first half of 2011.

Cumulative MFP Transitions and Progress Toward 2011 Transition Goals. Since the program began in 2007, 15,818 individuals were helped to move to the community by June 30, 2011, an increase of 33 percent in cumulative enrollment since December 2010, and nearly double the number ever enrolled in June 2010. The number of cumulative transitions varied widely across the 30 states, ranging from 54 in Delaware to 4,658 in Texas, which alone accounted for 29 percent of all MFP participants ever enrolled since the demonstration began. CMS requires state MFP programs to establish annual transition goals, which can be updated at the beginning of each year. In 2011, the annual MFP transition goal was 6,652 in aggregate across the 30 states. During the first six months of 2011, the 30 MFP grantees reported 3,722 new transitions, more than half (56 percent) of the annual goal and 9 percent more than the number transitioned in the previous six-month period. If states continue making progress at this rate throughout 2011, they will achieve or exceed the aggregate 2011 transition goal.

Distribution of MFP Participants by Population Subgroup. In addition to setting goals for total number of people to be transitioned, states have flexibility to target different population groups. During this reporting period, 37 percent of all individuals who ever transitioned and enrolled in MFP were individuals younger than 65 with physical disabilities, 34 percent were adults older than 65, 25 percent were individuals with developmental disabilities, 2 percent were individuals with mental illness, and about 2 percent were individuals in other categories. The distribution of cumulative transitions since the start of the program across population groups was largely similar. However, people with developmental disabilities comprised 25 percent of all MFP transitions to date because they made up a larger share of individuals transitioned in earlier years.

MDS Section Q Referrals and Aging and Disability Resource Center (ADRC)/MFP Supplemental Grant Activities. This period was the first time MFP grantees were asked to report Minimum Data Set (MDS) Section Q referrals to the MFP program for nursing home residents who expressed interest in returning to the community. Twenty MFP state grantees reported nearly 3,900 Section Q referrals in the first half of 2011, of which 229 individuals

(6 percent) transitioned to the community and enrolled in MFP during the same period. This was also the first time MFP state grantees reported on activities funded by ADRC/MFP supplemental grants. The 25 MFP states that received these grants reported using the funds to expand community options counseling and transition assistance to nursing home residents and develop Section Q referral tracking systems.

Reinstitutionalizations. State MFP grantees report on certain events that may indicate problems in the quality of care MFP participants receive in the community. This period, 13 percent of current MFP participants were reinstitutionalized for any length of time, about the same as the last six-month reporting period (12 percent); 31 percent of those who were reinstitutionalized this period had a stay of 30 days or more, slightly less than the proportion of all such readmissions in the previous reporting period (40 percent).

Self-Direction and Community Residence Types. Self-direction is becoming more common among MFP participants. Fifteen of the 26 MFP grantee states that offered self-direction options to MFP enrollees reported that 1,106 MFP participants chose to self-direct at least one type of community service, 23 percent of the 4,831 current participants in these 15 states. Among the three types of MFP-qualified community residences, the most popular among those newly enrolled this period were homes (40 percent), followed by apartments (35 percent) and small group homes (22 percent).

MFP Rebalancing Fund Spending. During this period, grantees reported on total spending to date from MFP rebalancing funds, which represent extra funds received by each state from the enhanced Federal Medical Assistance Percentage matching rate on the qualified and demonstration home and community-based services (HCBS) they provide to MFP participants. By the end of 2010, 19 of 30 MFP states reported spending $38.8 million from their rebalancing funds since the program began, nearly four times the amount reported in 2009 cumulative spending ($9.9 million). Median cumulative spending among these 19 states was about $1.5 million, ranging from $32,435 to $7.2 million. Five additional states reported that they had not spent any MFP rebalancing funds yet, but described how they planned to do so. The remaining six states did not report the amount of MFP rebalancing funds spent to date.

States are required to invest their rebalancing funds in programs or initiatives that help to shift the balance of long-term supports and services toward HCBS. Of the 30 grantees, only two (Arkansas and the District of Columbia) did not report on how it had already spent, or planned to spend, MFP rebalancing funds. Although the remaining 28 states reported a wide range of rebalancing initiatives, several themes were apparent: (1) promoting awareness, use, or access to transition services (11 states); (2) expanding or enhancing HCBS waiver programs (10 states); (3) promoting self-advocacy and consumer empowerment (6 states); (4) supporting the development or use of tools to assess consumer needs and preferences (6 states); (5) developing or improving administrative data or tracking systems (6 states); and (6) recruiting, training, or retaining direct care workers (4 states).

Implementation Accomplishments and Challenges. Every six months, state MFP grantees report on their achievements and barriers to implementing transition programs. As state MFP grantees gain experience, they have reported more accomplishments than challenges overall. However, the number and type of achievements and barriers varied by state due to differences in transition capacity, the needs of each state's target populations, and changes in community-based service delivery systems.

The most common challenges reported this period were those related to (1) state budget cuts; (2) a scarcity of affordable accessible housing units; (3) limits to the amount, scope, or duration of Medicaid HCBS benefits; and (4) shortages of community services, providers, and direct service workers. Nearly half of MFP grantee states (14) reported that the economic downturn still strained state budgets, causing adverse effects on MFP programs through cuts to Medicaid HCBS funding, staff hiring freezes and pay cuts, and reduced provider reimbursement.

On a more encouraging note, 22 states made advances in securing housing for MFP participants, either through obtaining rental vouchers from the U.S. Department of Housing and Urban Development or state housing agencies, by increasing the supply of small-group homes, or by hiring housing specialists to work at the state and local levels. Still, the majority of states (24) reported challenges finding enough affordable and accessible housing units or having too few rental vouchers to accommodate all individuals who wished to move to the community.

Almost equal numbers of states reported progress and challenges in making HCBS more accessible to participants during or after the 365-day period of MFP enrollment. The improvements occurred through (1) workforce enhancements, such as adding transition coordinators, behavioral specialists, and direct care workers, often with 100 percent federal MFP grant funds; (2) contracting with additional HCBS providers; and, (3) adding HCBS waiver capacity or services, such as nonemergency transportation and offering more options to self-direct services. Problems in trying to increase MFP participants' access to HCBS were often due to state budget cuts, as in California's proposal to eliminate adult day health services and shrink funding for personal assistance and other services covered by the In Home Supportive Services program. Almost two-thirds of the 30 MFP grantee states made improvements to quality management systems, whereas nine states had challenges in detecting quality issues for MFP participants on a timely basis. Efforts to improve coordination and enhance quality monitoring often involved upgrades to existing data collection tools or implementation of new data systems.

Looking Ahead. MFP transitions are likely to grow in the remainder of 2011 as some of the 13 states that received new grants in 2011 begin program operations and the established grantees improve and expand their programs. Despite the poor economic outlook for most state budgets, prospects for MFP enrollment growth remain strong due to support for the program from Medicaid officials and consumers alike. Both are encouraged by early MFP evaluation indicating that HCBS expenditures for MFP participants are about one-third lower than institutional care costs. However, further analyses are needed to determine whether total health care costs, including those for hospitalization, emergency room visits, and other specialty services, offset these savings.

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I. INTRODUCTION

The Money Follows the Person (MFP) Demonstration provides state Medicaid programs the opportunity to help transition Medicaid beneficiaries living in long-term care (LTC) institutions into the community. Congress established MFP through the Deficit Reduction Act of 2005 and expanded and extended it through the Patient Protection and Affordable Care Act of 2010. The Centers for Medicare & Medicaid Services (CMS) awarded MFP demonstration grants to 30 states and the District of Columbia in 2007.[1] In February 2011, CMS awarded grants to another 13 states, which are expected to begin enrolling participants into MFP in 2011 or 2012.

Each state participating in the MFP demonstration must establish a program that has two components: (1) a transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and helps them do so and (2) a rebalancing initiative designed to rebalance state Medicaid LTC systems so they rely less on costly institutional care and individuals have greater choice of where they live and receive services.[2]

This report summarizes the implementation progress of the MFP Demonstration for 30 grantee states (29 states and the District of Columbia) for the six-month period from January 1 to June 30, 2011 (referred to as this reporting period). All of the data and information are self-reported by state MFP grantees, as submitted in their 2011 mid-year progress reports. Some states were unable to provide complete data for all questions in progress reports; in such cases, missing data are noted in this report and shown as "not reported" in state tables.[3]

The remainder of this report is organized into four parts. Section II describes states' progress on key program performance indicators related to MFP transitions and program participation, including the number of people in each population group 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 III summarizes information on state grantees' use of rebalancing funds through December 2010. Section IV discusses the major accomplishments and challenges in implementing the MFP demonstration during the six-month period as reported by grantees. Section V concludes with an overall assessment of progress during this period and what to expect in the remainder of 2011. All tables can be found at the back of the report.

[1] One of the initial grantees did not implement its program, leaving 30 MFP grantees as of December 2010.

[2] For additional information about MFP Demonstration goals and eligibility rules, see CMS' MFP web page http://www.cms.gov/CommunityServices/20_MFP.asp and the 2009 and 2010 MFP annual evaluation reports produced by Mathematica at http://www.mathematica-mpr.com/health/moneyfollowsperson.asp.

[3] Mathematica does not conduct audits of state data. However, when figures are reported that are not within expected ranges, state program officials are asked to verify their accuracy and, if necessary, provide corrected data. When grantees make it evident that data are missing due to shortcomings in their reporting systems, it is shown as "not reported" (NR). Data are shown as "not applicable" (NA) when the question does not apply to the state's program.

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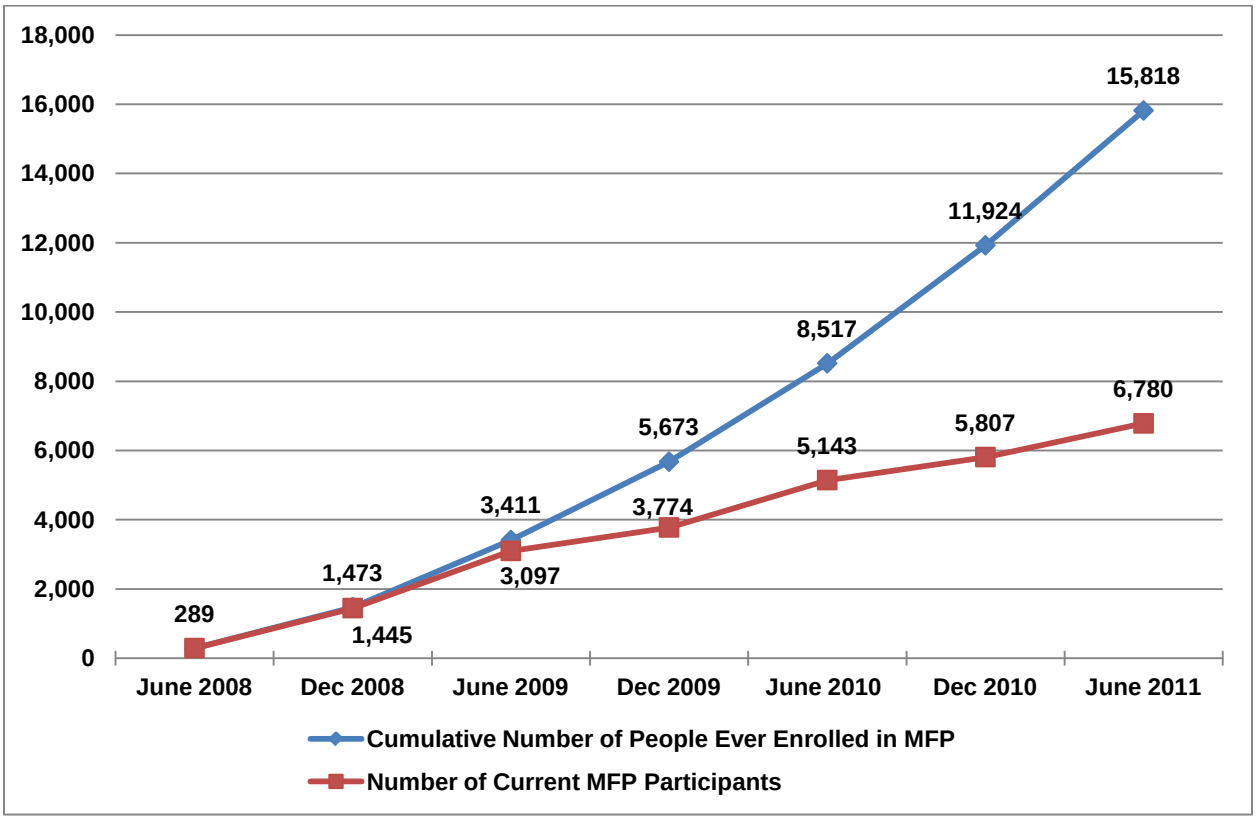
II. KEY PERFORMANCE INDICATORS—MFP TRANSITIONS AND ENROLLEES

A. New and Cumulative Transitions and Current Participants (Tables 1 and 2)

The number of new and cumulative transitions has continued to grow. From January to June 2011, state Money Follows the Person (MFP) grantees transitioned 3,722 new MFP participants, 9 percent more than the number of new participants in the second half of 2010 (3,407), and 31 percent more than the number of new participants transitioned during the first half of 2010 (2,844). The cumulative number of transitions stood at 15,818 as of June 30, 2011.

Enrollment in MFP grew steadily over the first half of 2011, continuing a trend of steady growth over the past three years. By the end of June, 15,818 individuals transitioned to the community and enrolled in MFP, a 33 percent increase from the cumulative number transitioned (11,924) as of December 31, 2010, and an 86 percent increase in cumulative enrollment (8,517) as of June 30, 2010 (see Figure 1). Overall, states reported 3,722 transitions during the six-month period from January through June 2011 and the number of current participants (those enrolled on the last day of the reporting period) stood at 6,780.

Figure 1. Cumulative MFP Enrollees and Current MFP Participants—June 2008 to June 2011



The volume of new transitions varied by state, ranging from 1,079 in Texas (nearly a third of the total) to 7 in Oregon (Table 1).[4] Among those who transitioned during this period, 39 percent were individuals younger than 65 with physical disabilities, 36 percent were adults ages 65 and older (referred to as elders in this report), 20 percent were individuals with developmental disabilities, 3 percent were individuals with mental illness, and 2 percent were "Other" individuals. Thirteen states reported 259 individuals had institutional stays between 90 and 180 days (data not shown), which represented 20 percent of the individuals enrolled in MFP in those states (259 of 1,284 individuals enrolled).[5] However, the actual number transitioned with institutional stays of this duration was likely to be higher, because many states have not established mechanisms to collect and report on the number of transitions by length of time in institutional care.

Cumulative transitions as of June 30, 2011, totaled 15,818, which represents an 86 percent increase since June 30, 2010 (8,517). The distribution of cumulative transitions across target groups is similar to that of the transitions during the past period: 37 percent were individuals with physical disabilities, 34 percent were elders, 25 percent were individuals with developmental disabilities, 2 percent were individuals with mental illness, and approximately 2 percent were Other individuals. The number of cumulative transitions across states varied considerably, ranging from 54 in Delaware to 4,658 in Texas, which alone accounted for 29 percent of all MFP participants ever enrolled since the national demonstration began. The next five states with the greatest number of cumulative transitions together comprised 31 percent of the total: Washington, Ohio, Maryland, Michigan, and Pennsylvania (listed in rank order). The remaining 24 states contributed the remaining 39 percent of total cumulative transitions to date. This variation in program size reflected, among other things, the length of program operation, the size of the eligible population in each state, and the state capacity and experience in operating transition programs of this type.

Number of Current MFP Participants. As of June 30, 2011, there were 6,780 current MFP participants (Table 2). Current MFP enrollees are defined as those who transitioned, had not been reinstitutionalized for more than 30 days nor died, had not yet completed the full 365-day period of MFP eligibility when they were receiving home and community-based services (HCBS), and did not withdraw from the program for other reasons. The number of current participants at the end of this reporting period was approximately 17 percent more than the number of MFP participants enrolled in December 2010, and 32 percent more than the number enrolled one year earlier (June 30, 2010). As shown in Table 2, the number of current participants ranged widely across states—from a low of 20 in Nebraska to 1,572 in Texas. A total of 2,309 MFP participants completed the 365-day transition period during the reporting period.

Parallel Transition Programs. To gauge the number of people that cannot enroll in MFP because they do not meet its eligibility criteria, grantees were asked to report the estimated

[4] Oregon suspended its MFP program effective October 1, 2011, when it was closed to new enrollees.

[5] In March 2010, the federal Patient Protection and Affordable Care Act changed MFP eligibility rules by reducing the minimum residency period in an institution from six months to 90 days, not counting days for Medicare-covered rehabilitation. Starting with the progress report for the January to June 2010 period, grantees were asked to report data separately on the number of MFP participants that met the new Affordable Care Act requirements.

number of individuals who transitioned from institutions to home or community-based settings through programs other than MFP, which are called parallel transition programs. Individuals who transitioned through these programs were generally ineligible for MFP because they (1) did not meet MFP's minimum residency period of 90 days; (2) chose to move to a type of community residence that does not qualify for MFP; (3) were not eligible for Medicaid or waiver services; or (4) received options counseling and transition planning services under an Aging and Disability Resource Centers (ADRCs) Nursing Home Transition and Diversion grant, as in Illinois.

Seventeen grantees reported having parallel nursing home transition programs in their states (Table 1). Sixteen states reported that almost 4,000 individuals transitioned to the community through these other programs; one state (Washington) reported nearly half (44 percent) of this number. Twelve states reported having a parallel transition program for individuals residing in intermediate care facilities for the mentally retarded (ICFs-MR), 7 of which estimated that 153 individuals with developmental disabilities transitioned to the community through these other programs during this reporting period. These totals likely underestimated the number of people that transitioned through parallel transition programs because many states did not keep accurate track of these numbers or did not report this information through the MFP progress reporting system.

B. Achievement of Annual Transition Benchmark Goals (Table 3)

As of June 30, 2011, MFP grantee states achieved 56 percent of the aggregate transition goal for 2011 (3,722 transitions of 6,652 planned across all 30 states). If progress continues at this pace, states will achieve their 2011 transition goals.

State MFP grantees' ability to meet their annual transition goals has improved in the past two years. In 2009, MFP grantees achieved only 53 percent of the aggregate annual transition goal (data not shown). In mid-2010, states achieved 50 percent of the annual transition goal (2,844 transitions of 5,723 planned for 2010). At least some of this improvement in performance can be attributed to policy guidance from the Centers for Medicare & Medicaid Services (CMS) to MFP grantees at the end of 2009 that gave states incentives to set more realistic transition goals. As a result, many states reduced their 2010 transition goals to achievable levels.

Despite progress in the aggregate, states varied in the degree to which they reached the number of planned transitions for 2011 (Table 3). Eleven states achieved 50 percent or more of their annual transition goals during the first six months of 2011, indicating that they were on track to meet or exceed their goals for the entire year. Indeed, two of these 11 states (Georgia and New Jersey) exceeded their annual goals by the middle of 2011. But 18 states achieved less than 50 percent of their 2011 transition goals by the middle of the year, indicating they need to increase their transition volume in the second half of 2011 to meet their goals.[6]

When the Affordable Care Act extended the MFP Demonstration program and CMS informed states they had until the end of federal fiscal year 2020 to expend all their grant funds, more than one-third (11) of state MFP grantees indicated that they planned to change total transition goals after 2011. Six states (Louisiana, Missouri, New Jersey, New York, Texas, and Virginia) said they expected to increase their total transition goals. Some of these six states

[6] One remaining state (Oregon) suspended its program and withdrew its 2011 transition goal.

hoped to achieve these new, higher goals by increasing staff capacity through the use of federal administrative funds. For example, New Jersey requested 100 percent federal administrative funds in June 2011 to hire 21 new MFP staff, including a statewide housing coordinator, a housing specialist, and a quality assurance specialist. Texas planned to increase MFP transition goals in response to recent or planned closures of ICFs-MR. However, three states (District of Columbia, Illinois, and Kentucky) indicated they may reduce their transition goals in the future, reflecting problems meeting previous years' goals.

Despite the aggregate progress toward achieving 2011 transition goals, nearly half (13) of MFP grantee states reported challenges in attaining them. The most common challenges (in rank order) were limited availability of affordable and accessible housing (four states); fewer Minimum Data Set (MDS) Section Q referrals than expected (three states); shortages of HCBS or qualified providers (two states); and statutory restrictions on the types of residences that qualify for MFP (two states). Other state-specific challenges to achieving transition goals included (1) complex needs of the target population; (2) waiver agencies not engaged in the MFP program; (3) delays in hiring program staff; (4) delays in implementing the change to a three-month length of institutional stay; (5) difficulty receiving timely referrals before discharge; and (6) resistance from nursing facilities that were concerned about the direct effect MFP could have on their business.

C. Number of Individuals Assessed (Table 4)

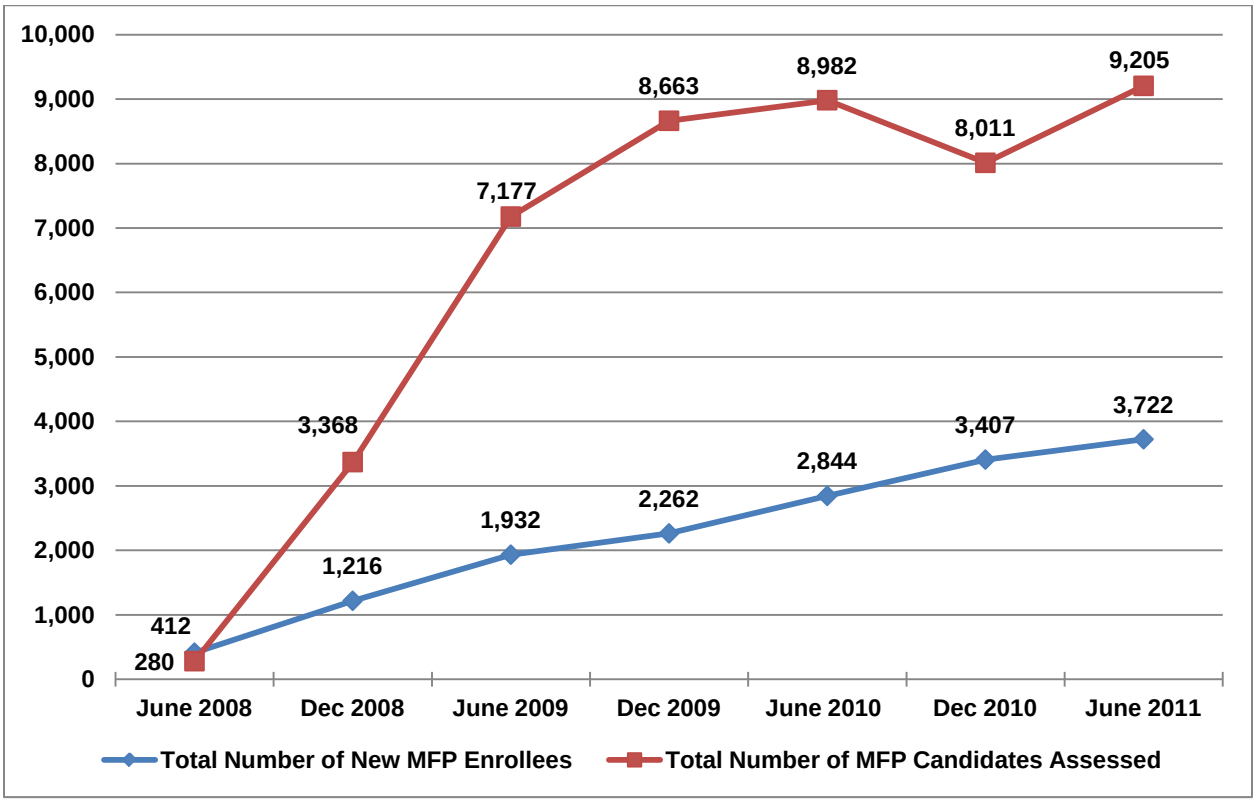
For every individual that enrolled in MFP and transitioned to the community, grantee states assessed from one-and-a-half to three times as many individuals to determine if they were eligible for MFP and what type of assistance they needed to live in the community (see Figure 2). Grantees reported a total of 9,205 individuals assessed during the reporting period, of which 68 percent were in the transition planning process, though not all of them will transition or be eligible for MFP if they do leave the institution.

The number of individuals assessed varied widely by state, ranging from 6 in Oregon to 1,684 in Michigan, which alone accounted for 18 percent of all assessments during the reporting period (Table 4).[7] Ten states that were able to provide data on the number of people assessed by length of stay in an institution reported that of the total 1,751 individuals assessed, 626 (or 36 percent) had institutional stays between 90 and 180 days (data not shown). Among all individuals assessed for potential transition to the community through MFP, about 40 percent, or 3,739 individuals, did not become MFP participants. Among those assessed but not enrolled in MFP (1) one-third (1,402) did transition to community living but did not enroll in MFP because they were ineligible or chose not to participate; (2) 19 percent had service needs that community-based providers could not meet (almost two-thirds of this group were in three states—

[7] Due to differences in how states define and track assessments, the numbers are not comparable across states. In some states, an assessment counted anyone who was initially screened and determined to meet Medicaid eligibility and who signed an MFP informed consent form, but other states used broader criteria. The reported number of assessments in Texas equaled the cumulative number of participants enrolled in the federal MFP program because the state cannot track MFP assessments separately from those assessed through a parallel transition program.

Connecticut, Delaware, and Kentucky); (3) 18 percent could not secure affordable, accessible housing; and (4) one-quarter did not enroll in MFP for other reasons.[8]

Figure 2. MFP Transitions and MFP Assessments, June 2008 to June 2011



D. MDS 3.0 Section Q Referrals to MFP and Associated MFP Transitions (Table 5)

This reporting period was the first time MFP grantees were asked to report the number of individuals referred to the MFP program from MDS 3.0 Section Q assessments and, of this number, how many people subsequently transitioned to the community and enrolled in MFP.[9] Among 30 MFP state grantees, 20 received a total of 3,889 Section Q referrals. These referrals led to 229 individuals subsequently transitioning to the community and enrolling in MFP during the same six-month period, or approximately 6 percent of all such referrals.

[8] "Other" was the largest single category of reasons for not transitioning through the MFP program. Based on grantees' notes, this group included those who were waiting for HCBS waiver approvals, did not submit documentation required for eligibility determination, withdrew their MFP application before the transition, moved out of state, refused to pay cost-share for waiver services, died in the facility before being able to transition, moved to a nonqualified residence, left the facility without leaving contact information, and did not meet the MFP institutional length-of-stay requirement due to Medicare rehabilitative covered care.

[9] The MDS is the nursing facility resident assessment instrument used for all nursing facility residents. Changes made to MDS Section Q questions (effective October 1, 2010) require that all residents be asked directly if they would like to speak with someone about moving back to a home or community residence. If the resident responds affirmatively, nursing home assessors must make a referral to a state or local contact agency, which will arrange for someone to speak to the resident about community living options.

The number of Section Q referrals across states varied widely, from just one referral (Arkansas) to more than 1,500 (Michigan). Differences in how states handled Section Q referrals can explain some of this variation. For example, in some states Section Q referrals went directly to local contact agencies, which screened individuals for MFP eligibility and did not refer ineligible individuals to the program, such as those who did not qualify for Medicaid or had not met the minimum 90-day length-of-stay requirement. In other states, Section Q referrals went to a single state entity, which then directed referrals to local contact agencies; if the MFP program was the state-designated contact agency, it could account for a large majority of all Section Q referrals.

Many MFP state grantees indicated in the previous progress report that they expected the new Section Q procedures to generate substantial increases in referrals to MFP programs. Although Section Q referrals do not automatically trigger an assessment for MFP, substantial growth in total MFP assessments between the previous reporting period (3,867 in these 20 states, data not shown) and this reporting period (6,611 in these 20 states, Table 4) suggests that Section Q referrals could have contributed, at least in part, to the sizable increase in MFP assessments.

Among the 3,889 individuals referred to MFP through Section Q, 229 subsequently transitioned to the community and enrolled in MFP during the same six-month period, or 5.9 percent of all such referrals. Several reasons could account for a low percentage of MFP transitions among Section Q referrals. First, as explained earlier, not all individuals referred to MFP through Section Q were eligible for the program. Second, some people referred to MFP might have qualified initially, but then chose to move to a type of community housing that did not meet MFP requirements. Third, there might have been a significant lag between the referral, the assessment, and the actual transition because of either staffing constraints or the difficulty of getting the housing and necessary community services in place. However, two states—Hawaii and Ohio—were notable for reporting more than 50 MDS 3.0 Section Q referrals to MFP programs and more than 30 percent of those referred were able to transition to the community and enroll in MFP during the same period. In addition, Kansas enrolled nearly two-thirds of the 19 individuals referred this period to MFP through Section Q.

Among the 10 states that reported no Section Q referrals to MFP this period, 5 indicated that they were still developing Section Q referral tracking systems (see comments in Table 5). Two MFP grantees (District of Columbia and Iowa) currently transition people from ICFs-MR, which do not use the MDS resident assessment instrument and so do not make Section Q referrals to MFP. One state (Washington) has a long-standing statewide nursing facility discharge program that makes Section Q referrals largely unnecessary. Another state (Georgia) did not provide an explanation for the lack of Section Q referrals, and Oregon's MFP program is currently in suspension.

This was also the first progress report in which MFP state grantees were asked to report on activities supported by ADRC/MFP Supplemental Funding grants, which 25 MFP grantee states received in the fall of 2010. These grants helped states expand the capabilities of ADRCs to assist with transition planning and coordination, support Section Q referral tracking systems, and develop greater capacity to follow up with nursing home residents who wish to explore community living options. Among the 25 states that indicated the types of activities these grants supported during this past period, the most common were (1) developing or expanding state capacity to provide community options counseling and transition assistance to nursing home residents (13 states); (2) developing or improving Section Q referral tracking systems (12 states);

and (3) conducting education and outreach to nursing homes and to other organizations providing long-term services and supports about Section Q and MFP transition assistance services (11 states). Of the 5 MFP state grantees that did not report any grant-related activities, 4 did not receive a grant and one said grant-supported activities had not yet begun.

E. Reinstitutionalizations (Table 6)

About 13 percent (858) of current MFP participants were reinstitutionalized for any length of time from January to June 2011, 31 percent of whom spent more than 30 days in an institution.[10] During this reporting period, 117 people who had at any point been reinstitutionalized for more than 30 days returned to community living and reenrolled in the MFP program.

Of all individuals reinstitutionalized for any length of time, 41 percent (355) were individuals younger than 65 with physical disabilities, about the same as their share (38 percent) of current participants; 40 percent (340) were elderly, slightly more than their share (34 percent) of current participants. The elderly were more likely to be reinstitutionalized for more than 30 days than individuals with physical disabilities younger than 65 (43 of such events versus 37 percent, respectively; data not shown).

Reinstitutionalization appeared to be disproportionately high among those with mental illness, and disproportionately low among those with developmental disabilities.[11] Nine percent (81) of those reinstitutionalized for any length of time were individuals with mental illness, three times their share (3 percent) of all current participants. By contrast, approximately 6 percent (49) of individuals with developmental disabilities were reinstitutionalized, about a fourth of their share (23 percent) of current participants.

Grantees reported that a decline in the individual's physical or mental health status was the most common factor contributing to reinstitutionalization, followed by participants' or families' requests to return to institutional care. Other reasons included short-term hospitalization (which might have been followed by a subsequent nursing home admission) for acute events such as exacerbation of cardiac and respiratory conditions, infections, and falls; lack of family or other informal supports in the community; inability to manage behavioral issues; and loss of housing in the community.

F. Emergency Calls for Backup Assistance (Table 7)

Seven states reported a total of 85 emergency calls for backup assistance during the reporting period; California reported 65 percent (55) of all these emergency calls. California reported that of the 55 calls, 71 percent were for critical health services and 27 percent were for transportation to medical appointments.

[10] As defined in the semiannual progress reporting system, reinstitutionalization means any admission to a hospital, nursing home, ICF-MR, or institution for mental disease, regardless of length of stay. MFP grantees were also asked to report on the number institutionalized for more than 30 days.

[11] At the time grantees were completing their progress reports, if an MFP participant was admitted for more than 30 days, CMS required that person to be disenrolled from MFP. These individuals may reenroll in MFP without meeting the minimum institutional residency requirement.

The number of emergency calls for backup assistance per 1,000 participants was slightly lower for this reporting period (12.5 calls per 1,000 participants) than the previous reporting period, July to December 2010 (13.3 calls per 1,000 participants). The calls for backup assistance were much lower than the two previous reporting periods (20.6 calls per 1,000 participants in January to June 2010 and 34.2 calls per 1,000 participants in July to December 2009) (data not shown). Of the total calls for emergency backup assistance, 51 percent (43 calls) were attributable to critical health services, 24 percent (20 calls) were in response to direct service or support workers not showing up as scheduled, and 19 percent (16 calls) were to address transportation to medical appointments. No calls were in response to life support repair/replacement. In addition, 7 percent of the total calls were attributable to theft (5 calls) or abuse (1 call).

G. Self-Direction (Table 7)

Self-direction has become more common among MFP participants. Fifteen of the 26 MFP grantee states that offered self-direction options reported a total of 1,106 participants were self-directing at least one type of community service, 23 percent of the 4,831 current participants in those 15 states.

The share of current MFP participants self-directing HCBS has remained stable from the previous reporting period (23 percent this period compared with 24 percent in the previous period). The percentage of MFP participants that managed their own allowance or budget, however, increased from the previous reporting period. Of the 1,106 participants who self-directed services during this reporting period,[12] 67 percent (739) managed their own allowance or budget, compared with 48 percent of self-direction participants in the previous period. This increase was primarily driven by increases in a few states. For example, Pennsylvania had 107 participants managing their own budget this reporting period, more than five times the number that did so during the previous period. Additionally, 53 percent of the participants who self-directed services hired or supervised their own personal care assistants (these participants may simultaneously manage their own allowances or budgets, so the two categories are not mutually exclusive).

During this reporting period, Louisiana successfully added a self-direction option and began conducting regional training, but implementation was delayed due to lack of funding to enroll elders and individuals with physical disabilities. This problem will be remedied when Louisiana implements a new Community Choices waiver in October 2011. Illinois also planned to add a self-direction option in the fall of 2011 and Oklahoma planned to implement a self-direction option when it contracted with a fiscal intermediary and organized training for program participants and providers.

H. Type of Qualified Residence (Table 7)

During the reporting period, homes were the most common type of residence to which new MFP participants moved after leaving an institution. Among the 3,722 MFP

[12] The number of MFP participants who were self-directed was underreported because some states that offered self-direction options, such as California and North Carolina, did not track these data for MFP participants. North Carolina indicated that it was improving its ability to track this information.

participants who transitioned to the community during this period, 40 percent (1,497 individuals) moved to a home, 35 percent (1,294) moved to an apartment, and 22 percent (807) moved to a small-group home. The type of residence for the remaining 3 percent, or 124 individuals, was not known at the time of this report.[13]

These data reflect aggregate counts of the types of residence to which participants moved upon transitioning to the community. They do not indicate where MFP participants resided at the end of the reporting period. Grantees were not required to report living arrangement by population subgroup in the semiannual progress reports; however, these data were reported in MFP Program Participation Files submitted quarterly by state grantees. Mathematica's analyses of these person-level data, produced in a series of quarterly statistics reports, indicated that of the participants who transitioned to the community from program start through June 30, 2011, 30 percent transitioned to an apartment, 28 percent transitioned to a home owned by a participant or family member, 22 percent transitioned to a group home, and 9 percent transitioned to an assisted living facility. The type of qualified residence was unknown for the remaining 12 percent of participants (percentages sum to greater than 100 percent due to rounding).

[13] The number of participants residing in MFP-qualified residences do not sum to the total number of individuals who transitioned to the community this period because several states reported either more or fewer transitioned individuals than types of residences.

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III. USE OF REBALANCING FUNDS

A. Overview of Rebalancing Initiatives

The use of rebalancing funds increased tremendously in calendar year 2010 and the funds were most often used for promoting awareness, use, and/or access to transition services, and to enhance home and community-based service (HCBS) waiver programs. During this period, states reported on how they have spent, or intended to spend, Money Follows the Person (MFP) rebalancing funds. These are the net federal revenues, above the regular Federal Medical Assistance Percentage (FMAP), from an enhanced FMAP matching rate that states received for expenditures for qualified and demonstration HCBS 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 toward HCBS. Of the 30 grantees, only Arkansas and the District of Columbia did not report on how it planned to spend MFP rebalancing funds. Although the remaining 28 states reported a wide range of initiatives on which rebalancing funds have been or would be spent, several common investments were identified:

- **Eleven states reported using MFP rebalancing funds to promote awareness, use, and/or access to transition services, such as targeted case management, housing assistance, and one-time transition expenditures**. Three of these states (Illinois, Maryland, and Missouri) used MFP rebalancing funds to provide services specifically to MFP-eligible individuals and three others (California, Connecticut, and Washington) did so for non-MFP individuals. Three states had initiatives focused on housing assistance, such as hiring a dedicated housing specialist (Illinois) and developing an online housing locator (New York and Ohio); another (Washington) had hired 14 transition specialists and a program manager and was developing a supported employment collaboration. Although Oregon had suspended its program as of October 1, 2011, and was no longer enrolling new participants, the state reported on the amount and use of rebalancing funds through June 2011. Oregon covered extra benefits not available under its regular Medicaid program, such as specialized assistive technology and home modifications, so that individuals can remain in or transition to the community.
- **Ten states reported using MFP rebalancing funds to enhance HCBS waiver programs**. Oklahoma used MFP rebalancing funds to establish new waiver programs and Michigan used MFP rebalancing funds to help fund the state share of waiver program costs. Eight states used their funds to increase the number of waiver slots in existing programs. For example, Wisconsin reported spending $2.3 million on diversion funding in counties with wait lists for HCBS waiver services. The state used these funds to create new slots for individuals at high risk of a nursing home admission who would otherwise have had to wait for a waiver placement. Wisconsin reported that this initiative resulted in more than $1.5 million in accumulated savings from the cost of averted nursing home admissions.
- **Six states used MFP rebalancing funds to promote self-advocacy and consumer empowerment**. Three states (Maryland, New Jersey, and New York) funded marketing strategies to inform and educate nursing home residents directly about

available long-term services and supports (LTSS) in the community. Missouri used its funds to support advocacy specialists and Ohio continued to fund the HOME Choice Consumer Advisory Council, which helps to develop advocacy and empowerment tools and resources. Washington established a family-to-family mentoring program to support potential MFP participants.

- **Six states have used MFP rebalancing funds to support the development or use of various types of assessment tools**. Three states (Iowa, Maryland, and Missouri) used the Supports Intensity Scale, which helps to identify the support needs of a person with an intellectual or developmental disability. California continued to use the Preference Interview Tool, which assesses an individual's preferences and feasibility of transitioning. Through its Access Initiative, Ohio made enhancements to its Preadmission Screening and Resident Review. Texas used the Nursing Facility Resident Intellectual and Developmental Disabilities (IDD) Survey, which identifies unmet service needs and use of specialized services for nursing home residents with intellectual or developmental disabilities, the results of which were used to identify appropriate community placement.
- **Six states used MFP rebalancing funds to develop or improve their administrative data or tracking systems**. Two of these states (Nebraska and Washington) developed incident tracking systems and two other states (Louisiana and Ohio) enhanced their administrative and expense tracking systems. New Jersey purchased the Social Assistance Management System, which allows agencies to monitor cross-system usage and treatment patterns, and Maryland created a web-based tracking system.
- **Four states used MFP rebalancing funds to recruit, train, or retain direct care workers**. North Dakota and Texas invested in the Realistic Job Preview, which includes the development of two DVDs used for recruitment efforts. Two states targeted existing staff members by providing training (Maryland) and continuing education for direct service professionals (New Jersey).
- **Other rebalancing activities**. Several states reported unique uses for their rebalancing funds. Georgia invested in research aimed at enhancing service quality. Ohio funded research to better understand the state's workforce capacity and needs. Texas provided financial assistance to providers that voluntarily closed intermediate care facilities for the mentally retarded (ICFs-MR). New York continued to provide funding for assistive technology through equipment loans and device demonstrations.

B. Cumulative Spending through 2010 (Table 8)

Calendar year 2010 marked tremendous growth in states' spending of their rebalancing funds. That year, 24 states reported how much they had been spent so far on MFP rebalancing initiatives, compared with 12 states that did so in 2009. Of the 24 states that reported on rebalancing fund expenditures, 5 had not yet spent any MFP rebalancing funds. The remaining 19 states reported cumulative spending through December 2010, as detailed in Table 8.

Total spending through 2010 among the 19 states that reported rebalancing fund expenditures was about $38.8 million, nearly four times the amount reported in 2009 cumulative spending ($9.9 million). Among those using their rebalancing funds, state spending through 2010 ranged from a low of $32,435 in Oklahoma to a high of about $7.2 million in Washington. The

median cumulative spending among all 19 states was about $1.5 million. Several states saw significant growth in cumulative spending between 2009 and 2010. Iowa (growth from $55,000 to $3,152,014 in 2010), New Hampshire (growth from $38,000 to $1,096,047 in 2010), and Pennsylvania (growth from $549,879 to $3,464,110 in 2010) had the largest growth, almost exclusively from the purchase of waiver slots. Ohio (growth from $161,000 to $762,700 in 2010) and Washington State (growth from $2,069,960 to $7,244,482 in 2010) also showed tremendous growth in spending, both of which reported spending on a comprehensive package of targeted initiatives. Only four states (California, Illinois, New Jersey, and North Dakota) that reported initiatives in 2009 did not report an increase in spending in 2010.

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IV. CHALLENGES AND PROGRESS, BY PROGRAM COMPONENT

As in previous progress reports, Money Follows the Person (MFP) grantees continue to report more accomplishments than challenges in most dimensions of the program. The types of challenges and accomplishments vary by state due to differences in state capacity to transition individuals to the community, the needs of the target populations, and community-based service delivery systems. Despite reported progress, MFP grantee states continue to encounter persistent challenges related to state budget cuts; scarce housing options; limits imposed on Medicaid home and community-based service (HCBS) benefits; and shortages of community services, providers, and direct service workers. Key themes that emerged from their semiannual progress reports are described next.

A. State Budget Cuts

Nearly half of the Money Follows the Person (MFP) grantee states (14) reported that the effects of the economic downturn on state budgets had adversely affected their MFP programs. Although the economic climate has begun to improve in some states, many state grantees continue to feel the results of budget shortfalls, which in some states have led to across-the-board cuts to all state government programs, including Medicaid. Tightened budgets have caused staffing restrictions and pay cuts, cuts to home and community-based services (HCBS) funding, and reduced provider reimbursement rates that impaired the MFP program.

Five states (Connecticut, Delaware, Hawaii, Louisiana, and Washington) reported hiring freezes and layoffs that strained available staff resources and in some cases limited the MFP program's ability to make timely transitions. Connecticut reported that 1,000 candidates awaited assessment for MFP; however, the program lacked the capacity to review and transition these individuals due to a hiring freeze. Three states (Hawaii, Louisiana, and Washington) reported pay cuts or freezes, which led to caseload growth and strained program operations. Washington State used a portion of its rebalancing funds to finance caseload growth and offset necessary reductions in the community-based services due to budget cuts. Hawaii reported that staffing shortages caused lengthy delays in determining Medicaid eligibility, and Illinois reported that state agencies imposed utilization review processes as a way to contain growth in a number of community-based services.

Additional federal administrative funds offered some relief to offset the effects of state budget cuts. For example, Washington State reported an easing of staffing challenges due to approval to hire additional MFP-dedicated staff with 100 percent federal administrative funds. The State expects deeper budget cuts in the future and plans to target staff resources to minimize the negative impacts of the reductions.

Several states indicated that cuts to the Medicaid HCBS budget or to HCBS provider reimbursement rates had adversely affected their MFP programs. California reported significant cuts to the Medicaid budget for HCBS, resulting in reductions in the number of individuals served and elimination of the Adult Day Health Care program. In Virginia, the Medicaid program reduced provider reimbursement rates and services, which made community agencies

reluctant to serve as MFP transition coordination agencies. In Iowa, providers continue to be concerned about the availability of long-term funding for MFP participants.

Six states reported that budget cuts have resulted in service reductions that have destabilized the network of community-based services. California reported that the Adult Day Health Care program might be eliminated, which would negatively affect MFP participants. California's In Home Supportive Services (IHSS) program experienced significant cuts due to the state's fiscal difficulties and the state eliminated the Linkages Program, which prevented premature or inappropriate institutionalization of frail, at-risk elders and adults with functional impairments. Hawaii significantly reduced the Medicaid Quest benefits package. Virginia eliminated the Disability Lifeline program, which provided food stamps, medical coverage, and housing allowances for the poorest of the population. On a positive note, despite more than $200 million in cuts to the Medicaid program, Louisiana absorbed the reduction while continuing services at current levels.

B. Availability of and Participant Access to Home and Community-Based Services (Table 9)

A successful transition to the community requires available and accessible HCBS, both during and after the 365-day MFP enrollment period (counted from the first day after leaving an institution). States were asked to report on accomplishments and challenges for increasing access and availability to HCBS during the reporting period.

Accomplishments. Twenty-three of the 30 states that reported indicated progress toward making HCBS more accessible to participants. Sixteen states indicated progress increasing the availability of HCBS for MFP participants during the 365-day period in which they were enrolled, whereas 8 states reported such progress for participants after that period had ended and they shifted to regular Medicaid status. The following were the main accomplishments noted:

- **Workforce Enhancements**. Thirteen states reported an increase in the number of transition coordinators and 5 states reported an increase in the supply of direct service workers (DSWs), an increasingly common achievement among the states, as indicated in Table 9. States also increased the capacity of their workforces through training initiatives. Iowa hired a full time behavioral specialist who will provide nonviolent crisis intervention and positive behavioral support training to providers. Iowa anticipated that such targeted training will increase the number of providers serving MFP participants with behavioral problems and help to reduce the number of reinstitutionalizations.
- **Greater Number of HCBS Providers**. Ten states reported an increased number of contracted HCBS providers and four states (Connecticut, Kentucky, Louisiana, and North Dakota) increased HCBS provider payment rates. Many of the new providers Oklahoma contracted with also served individuals under the new My Life/My Choice and Sooner Seniors waiver programs. Both served MFP participants after they completed their 365 days of MFP eligibility, an effort that will ensure continuity of care for many elderly and individuals with physical disabilities.
- **Increased Capacity of HCBS Waiver Programs (data not shown)**. Six states (Georgia, Kentucky, Nebraska, New York, North Carolina, and Pennsylvania) reported increased capacity of HCBS waiver programs to support participants during

and/or after the transition period. For example, Georgia changed from using a private contractor for transition coordination services to having state employees provide these services through an interagency agreement between the Georgia Department of Human Services and Aging and Disability Resource Centers (ADRCs), an arrangement that will result in increased capacity and ability to leverage resources. Under the interagency agreement, each ADRC received funding for transition coordinator and Minimum Data Set (MDS) Section Q Options counselor personnel. Four states (Connecticut, Kentucky, Michigan, and Pennsylvania) reported legislative or executive authority to fund additional HCBS waiver slots. All four states funded additional slots for individuals with physical disabilities; three of the four (all but Pennsylvania) funded slots for the elderly and two of the four (Connecticut and Kentucky) funded slots for individuals with developmental disabilities. Notably, the additional funding in Connecticut not only affected HCBS slots for all four disability groups (including individuals with mental illness), but was available to participants both during and after their transition periods. Both Hawaii and Texas cited achievements in ensuring a seamless transition to waiver services after the 365-day transition period, thereby ensuring continuity of care.

- **Increased Transportation Options**. Five states (Louisiana, Nebraska, New Hampshire, New York, and Washington) reported improved or increased transportation options. Nebraska hired a statewide nonemergency transportation broker responsible for recruiting additional providers that supply medical transportation for HCBS waiver clients. Washington began the process of involving brokered Medicaid transportation providers for nonmedical needs, including trips to visit potential MFP qualified housing.

- **Expanded Managed Long-Term Care (LTC) Programs**. Five states (Hawaii, Kentucky, Illinois, North Carolina, and Texas) reported having developed or expanded managed LTC programs. Illinois for example, initiated an integrated care plan for Medicaid recipients who were aged, blind, or disabled that will result in an enrollment of about 40,000 individuals living in the six counties surrounding Chicago. Primary and behavioral health care services will be included in the program's first phase. Hawaii's QUEST Expanded Access (QExA) plan for seniors and people with disabilities expanded its visibility at nursing facilities. Hawaii's MFP team worked closely with QExA to identify everyone potentially eligible for MFP, and QExA employees now serve as service coordinators, providing HCBS case management statewide to MFP participants living in homes or apartments.

- Increased **State Funding for HCBS and Pretransition Services (data not shown)**. Both Pennsylvania and Illinois reported increased authority to transfer Medicaid funds previously budgeted for institutional care to HCBS. Two states (New Hampshire and North Carolina) reported improved funding for pretransition services. New Hampshire, for example, sought approval to cover transitional case management as a waiver service in the Elderly and Chronically Ill waiver program.

- **Establish Self-Direction Option (data not shown)**. Both Louisiana and North Carolina were able to expand self-direction options. Although North Carolina's option was not new, it expanded during the reporting period, gaining traction within the Community Alternatives Program for Disabled Adults (CAP/AD) waiver. The

state planned to expand self-direction options to CAP Intellectual and Developmental Disabilities (IDD) waivers for beneficiaries with developmental disabilities.

Challenges. Twenty-four states reported challenges increasing participants' access to HCBS (Table 9), the highest number of challenges reported since 2009. Ten states reported challenges toward increasing the availability of HCBS to MFP participants during the 365-day transition period, with three states reporting challenges providing services after the transition period. The following were the main challenges noted, along with strategies to overcome them:

- **Insufficient Supply of HCBS Providers and Services**. Eleven states reported an insufficient supply of HCBS providers; five states (Arkansas, Louisiana, Ohio, Virginia, and Washington) reported an insufficient supply of HCBS; and five states (Iowa, Kentucky, North Dakota, Ohio, and Virginia) noted an insufficient supply of DSWs. Scarcity of providers and DSWs was often a significant concern in rural areas. To address the provider shortage, North Dakota began to develop a Realistic Job Preview—a marketing effort to recruit qualified service providers; Kentucky hoped to overcome the DSW shortage by encouraging MFP participants to recruit and hire consumer-directed option employees. Georgia encouraged HCBS providers to embrace the concept of small-group homes with four beds or fewer, which were uncommon in the state. Six states reported a lack of transportation options, which hinder access to HCBS providers. Iowa highlighted the lack of employment training or support to MFP participants; in response, the state planned to hire an employment specialist to work closely with the MFP transition team to provide employment supports.

- **Limits on Amount, Scope, or Duration of HCBS**. This challenge was reported by 10 states, a significant jump from the 4 states that reported it in 2009 (see Table 10). Missouri, Maryland, New Hampshire, and New Jersey indicated that some participants were unable to transition during the period because their state plans do not cover 24-hour paid personal care. California and Kentucky were considering new waiver programs to fill the void, whereas Connecticut and New Hampshire sought informal supports and networks. Illinois reported that 79 percent of MFP participants needed assistance with monitoring medications, a service not covered by its HCBS waiver for the elderly; the state began collecting data to document the need for this service in the waiver.

- **Delays or Restrictions in State Funding of HCBS (data not shown)**. Two states (Missouri and New Hampshire) reported delays in efforts to obtain authority to transfer Medicaid funds from institutional to HCBS line items. For example, New Hampshire law prohibits the transfer of dedicated nursing home funds to community care. Four states (California, Hawaii, New York, and North Carolina) reported budget restrictions that led to specific program or service cuts, which reduced access to optional services and destabilized transition efforts. In response to cuts to the IHSS and Linkages programs, California's transition coordinators had to be more vigilant and proactive to decrease participants' risk of institutionalization due to loss of services.

- **Preauthorization Requirements**. Preauthorization requirements were a reported barrier in three states (Connecticut, Louisiana, and Ohio). In Louisiana, which reported difficulty in obtaining necessary home modification authorizations before a

participant leaves the nursing facility, the MFP team was working to create a "flow-through" process that will improve the timeliness of prior authorization approvals. Neither Connecticut nor Ohio indicated a strategy for overcoming this barrier.

- **Inaccessible and/or Unaffordable Housing (data not shown)**. Both New York and Texas reported a lack of affordable, accessible, and integrated housing, which restricted participants' access to HCBS. Texas continued to educate state and local public housing and finance agencies about the needs of the MFP population and New York made several housing subsidy programs available to help alleviate costs.

C. Securing Housing for Participants (Table 10)

Twenty-two state MFP grantees reported achievements in securing housing for participants, most frequently by receiving more rental vouchers, many of which were received through Category II nonelderly disabled (NED) housing vouchers from the U.S. Department of Housing and Urban Development (HUD). Still, the majority of states (24) reported challenges most often related to insufficient supply of affordable and accessible housing (18) and an insufficient supply of rental vouchers (11).

About three-quarters of states reported achievements related to housing. The most frequently cited accomplishments related to increased rental vouchers (11 states) and increased supply of small-group housing (8 states). The increase in the number of rental vouchers this period was primarily due to the January 2011 award of 948 HUD NED Category 2 rental vouchers dedicated to individuals relocating from institutions to the community. Eight MFP grantees cited the vouchers in their progress reports, although public housing authorities (PHAs) in 12 MFP states (California, Georgia, Illinois, Maryland, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, and Washington) received awards ranging from 5 vouchers in North Carolina to 215 in Washington.[14] Many states formed relationships with PHAs during the application process. In Maryland, for example, the MFP program worked closely with PHAs to identify eligible candidates and find suitable housing for voucher recipients. Other states that reported increases in rental vouchers other than those awarded by HUD NED Category II were Connecticut, Delaware, Nebraska, New York, and Texas.

Eight states (Connecticut, Hawaii, Michigan, Nebraska, New Jersey, Oregon, Washington, and Wisconsin) reported increasing the supply of small-group homes. This included a shared housing model in Connecticut and contracts with new providers in Hawaii, Michigan, and Nebraska. Eight states (Georgia, Louisiana, New Hampshire, New York, Ohio, Virginia, Texas, and Wisconsin) hired or were in the process of hiring new staff to specialize in housing issues (data not shown). Most housing specialists had responsibilities for locating or assisting with the location of housing for MFP participants; several, such as those in Georgia and New York, addressed long-term strategies for increasing supply and availability of financial assistance.

Training sessions to educate housing partners about MFP or to train transition coordinators about housing issues occurred in five states (Delaware, Michigan, New York, Virginia, and Wisconsin) (data not shown). Virginia developed a housing primer, Michigan held regular

[14] A list of awardees and the number of vouchers received can be found at http://portal.hud.gov/hudportal/documents/huddoc?id=rane2_pr2.pdf.

workshops with transition coordinators, and Delaware conducted a housing academy for potential partners. At least 15 states indicated they had formed or strengthened relationships with PHAs and other housing organizations. North Dakota passed legislation to create a tax credit to assist in financing the construction of new housing projects for people with lower incomes and support the establishment of a housing registry, location of housing, and facilitation of public–private development projects.

Twenty-seven states reported 56 challenges in securing housing for MFP participants (Table 10), and shortages of affordable and accessible housing continued to be the most frequently cited barrier to transition efforts (18 grantees). Some states indicated this shortage was caused by high rent, inaccessible homes, and unsafe neighborhoods. Georgia reported competition with PHAs' multiyear wait lists for the short supply of affordable, accessible homes; low vacancy rates of existing affordable, accessible homes; and high general demand for affordable apartments. Michigan reported problems finding homes that can accommodate people who are 60 or younger and the morbidly obese.

Despite the reports of increases in the supply of rental vouchers, 11 grantees reported that the number of rental vouchers continued to be insufficient. For example, Texas reported it had only 20 vouchers available for people ages 62 and older. Many states reported long wait lists, some of which were closed to new applicants. Michigan worked with local housing groups to increase access to vouchers by designating nursing facility residents as homeless. Other challenges identified by grantees included (1) difficulties establishing relationships with PHAs (Arkansas, Georgia, Iowa, Louisiana, Texas, and Wisconsin); (2) difficult and time-consuming processes for finding and securing housing (Connecticut); and (3) inadequate financial incentives for providers to supply four-bed group homes (Illinois, Maryland, and Virginia).

D. Quality Management and Improvement

Sixty-three percent of MFP grantee states (19) reported improvements in their quality management systems. Only 9 states reported challenges related to quality management, all of which identified problems related to the discovery process.

The top three improvements to quality management systems this period were (1) improving intra- or interdepartmental coordination, (2) implementing or enhancing quality monitoring protocols, and (3) enhancing or establishing new data collection instruments. As part of these improvements, 10 states reported enhanced intra- or interdepartmental coordination, which improved timeliness of reports and strengthened quality assurance processes. Some of these activities included regular meetings between agency staff or a quality assurance team, such as in Louisiana, Missouri, and Washington. Other efforts included work done in Kentucky and New Hampshire between the MFP programs and sister agencies to streamline reports and communication processes to improve information sharing and smooth transitions. In Illinois, transition coordinators worked with staff from the Division of Rehabilitation Services to identify beneficiaries with severe mental illness through chart reviews and to affect earlier referrals to the Division of Mental Health. Nine states reported implementing or enhancing quality monitoring protocols. North Dakota implemented a nurse quality program in June to track health-related issues and critical incidents; Washington State was implementing a new quality improvement initiative that includes surveys to improve client safety and well-being and to identify areas in need of system improvements. In Illinois, the University of Illinois-Chicago College of Nursing developed a root cause analysis approach for reviewing a subset of MFP participants to better

understand differences between transitioned candidates with and without critical incidents and as a basis for more thorough reviews of deaths.

As part of efforts to improve coordination and enhance quality monitoring, eight states implemented or enhanced new data collection instruments. These tools included Georgia's new MFP Sentinel Events Log that was used for tracking and analysis. Early findings revealed a need for providing health education on secondary conditions related to disability. Louisiana developed a Support Coordination Monitoring Tool as part of its 1915(c) waiver application, which regional office staff will use to monitor service delivery activities and outcomes of the support coordination agencies. Missouri also implemented a standardized tool for reviewing monthly and quarterly event data to help identify themes and trends for overall quality improvement strategies. Other states that developed new data collection tools included Hawaii, Kentucky, Nebraska, Pennsylvania, and Washington. In other quality assurance efforts, California, Missouri, and New Jersey hired or planned to hire additional MFP staff to provide quality monitoring and improvement functions.

Nine states reported challenges with identifying risks to participants' health and welfare on a timely basis, called the discovery process. Three states (Georgia, Hawaii, and Kentucky) tried to remedy the problem by improving communication and sharing of information. For example, Kentucky increased on-site monitoring of providers by MFP management staff after it received delayed critical incident reports from residential providers for beneficiaries with developmental disabilities. Georgia forged an interagency agreement to facilitate more communication between Medicaid and operating agencies. North Dakota reported that its quality assurance process did not review care plans for every waiver participant, so some issues were not detected in a timely manner; similarly, Wisconsin's MFP staff did not have direct access to critical incident data. Both states worked with partner agencies to solve these problems. Four states (Illinois, Louisiana, North Dakota, and Pennsylvania) reported challenges in the remediation process, and four (Hawaii, Illinois, Louisiana, and North Dakota) reported quality improvement process challenges. Of note, North Dakota adjusted its remediation process to be more consumer-oriented and added performance measures to identify areas for improvement.

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V. CONCLUSION

The first half of the Money Follows the Person (MFP) program's fourth year of operations saw continued growth and evolution. The cumulative number of participants ever enrolled in MFP reached more than 15,800 individuals by the end of June 2011, 33 percent more than in December 2010. This was the first reporting period, however, in which the rate of increase in new MFP enrollees was relatively modest compared with the previous period. The number of people who transitioned with the help of MFP programs in the first half of 2011 (3,722) was about 9 percent more than the number of new MFP enrollees in the second half of 2010. By contrast, the number of new enrollees increased at rates above 20 percent in previous reporting periods.

Although it is not clear if this trend will continue, there are several possible explanations for a slowing growth rate in new MFP enrollees. For instance, it could signal that many of the 30 established grantees (those that were awarded MFP grants in 2007) have reached full operating capacity. Alternatively, state budget cuts and shortages of home and community-based services (HCBS) or providers might make program staff more cautious about enrolling new participants. Such caution could be due to uncertainty about the long-term availability of state funding and providers to ensure that MFP participants receive all services needed to live in the community successfully. On the other hand, the lower growth rate in new MFP enrollees could be a short-term lull as states prepare to expand MFP programs to transition additional target groups and strengthen the capacity of state HCBS systems to accommodate more people and those with special needs.

MFP grantee states varied in their pace of progress toward meeting MFP transition goals and expanding MFP enrollment. As in the past, the largest share of total MFP participants came from six states—Maryland, Michigan, Ohio, Pennsylvania, Texas, and Washington. However, some states saw growth rates in new enrollees this period that were higher than the overall average, such as Louisiana, New Jersey, and North Carolina, whereas others had notable declines in the number of new enrollees this period compared with the previous period, such as California, Iowa, Nebraska, and Oklahoma.

Variation in states' rates of progress was attributable to many factors, including their ability to effectively identify MFP-eligible transition candidates, expand transition coordination capacity, and overcome community housing barriers. For example, although most states received more referrals to the MFP program from nursing homes using the new Minimum Data Set (MDS) Section Q assessment tool, some states were more effective than others in identifying MFP-eligible individuals among those referred and in using Aging and Disability Resource Center (ADRC)/MFP supplemental grant funds to forge stronger links between ADRC education and outreach efforts and MFP programs. In addition, some states were able to expand MFP transition and HCBS capacity with 100 percent federal administrative funds to a greater extent than others. And although most states continued to report insufficient housing or lack of housing vouchers, 13 MFP grantee states received U.S. Department of Housing and Urban Development (HUD) vouchers for MFP-eligible individuals and, among them, some forged partnerships between MFP and public housing authorities (PHAs) sooner than others to award those vouchers quickly.

As the number of MFP participants has grown, more states have stepped up investment of MFP rebalancing funds in activities designed to expand and strengthen the HCBS system. These funds represent net revenue to states from the enhanced Federal Medicaid Assistance Percentage (FMAP) for HCBS provided to MFP participants during the first year after transition. Cumulative MFP rebalancing fund spending of about $38.8 million was almost four times the amount spent one year earlier. This amount remained just a fraction of total Medicaid long-term care (LTC) spending, but MFP grantee reports suggested that many states used the funds to make strategic investments to fill critical gaps in the HCBS system in the short term, while building the infrastructure needed to improve the availability of HCBS in the long term.

Looking ahead, MFP transitions are likely to grow in the next reporting period as some of 13 states that received new grants in 2011 begin program operations this year and the established grantees enhance and expand their programs. Prospects for growth remain strong despite the poor economic outlook for most state budgets. In many states, the MFP program benefits from strong support by senior Medicaid officials and from beneficiaries' advocates. In addition, initial results of analyses conducted for the MFP evaluation indicated that Medicaid HCBS expenditures for MFP participants were as much as one-third lower than what institutional care costs for the average elderly nursing home resident.[15] However, Medicaid does not cover housing costs for individuals living in the community, whereas it does cover room and board costs in institutional care payments, so the costs are not directly comparable. In addition, further analyses are needed to determine whether total health care costs, including those for hospitalizations, emergency room visits, and other specialty services, offset any savings.

[15] Irvin, C. D. Lipson, A. Wenzlow, S. Simon, A. Bohl, M. Hodges, and J. Schurrer. "Money Follows the Person 2010 Annual Evaluation Report." Final report submitted to the Centers for Medicare & Medicaid Services. Cambridge, MA: Mathematica Policy Research, October 2011.

Table 1. Overview of MFP Grant Transition Activity

State	Cumulative Number of Transitions from Program Start to June 30, 2011						Number of Participants Transitioned from January 1 to June 30, 2011						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
	Cumulative Total	Elders	People with PD	People with MR/DD	People with MI	Other	Total Number	Elders	People with PD	People with MR/DD	People with MI	Other		
Arkansas	212	26	66	119	1	0	62	1	12	48	1	0	NA	NA
California	537	113	202	149	22	51	136	34	41	40	10	11	23	23
Connecticut[a]	561	203	259	10	86	0	156	59	78	4	12	0	82	NA
Delaware	54	18	27	4	5	0	16	4	7	2	3	0	NA	NA
District of Columbia	88	0	2	86	0	0	13	0	2	11	0	0	NA	NA
Georgia	651	143	201	307	0	0	209	39	55	115	0	0	NA	96
Hawaii	107	53	48	6	0	0	34	19	13	2	0	0	NA	NA
Illinois	348	105	68	0	175	0	107	38	21	0	48	0	39	NA
Indiana	305	137	168	0	0	0	109	64	45	0	0	0	NA	NA
Iowa	136	0	0	136	0	0	18	0	0	18	0	0	1	NA
Kansas	481	132	208	126	0	15	138	36	76	23	0	3	17	NA
Kentucky	304	80	59	120	0	45	74	25	13	28	0	8	NA	NA
Louisiana	164	52	52	60	0	0	74	19	26	29	0	0	NA	0
Maryland	947	399	380	142	0	26	148	76	60	6	0	6	91	NA
Michigan	863	434	429	0	0	0	135	68	67	0	0	0	740	NA
Missouri	359	60	139	144	0	16	63	12	25	20	0	6	NR	NR
Nebraska	120	28	35	48	0	9	18	6	8	4	0	0	127	6
New Hampshire	87	28	27	7	0	25	15	5	5	2	0	3	NR	NR
New Jersey	243	98	18	127	0	0	86	28	14	44	0	0	64	16
New York	370	114	158	0	0	98	114	32	49	0	0	33	14	NA
North Carolina	99	28	16	55	0	0	39	16	10	13	0	0	10	10
North Dakota	56	11	16	29	0	0	13	2	3	8	0	0	NA	NA
Ohio	1,139	255	560	262	62	0	289	60	179	19	31	0	1	NA
Oklahoma	208	48	97	63	0	0	56	16	35	5	0	0	NA	1
Oregon	306	105	144	50	0	7	7	5	2	0	0	0	490	NA

Table 1 (*cont'd*)

State	Cumulative Number of Transitions from Program Start to June 30, 2011						Number of Participants Transitioned from January 1 to June 30, 2011						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
	Cumulative Total	Elders	People with PD	People with MR/DD	People with MI	Other	Total Number	Elders	People with PD	People with MR/DD	People with MI	Other		
Pennsylvania	719	507	172	32	8	0	128	97	19	12	0	0	464	NA
Texas	4,658	1,581	1,538	1,537	2	0	1,079	400	417	262	0	0	0	0
Virginia	269	43	64	162	0	0	51	7	16	28	0	0	NA	NA
Washington	1,282	604	600	62	16	0	310	156	139	4	11	0	1,768	1
Wisconsin	145	52	58	34	1	0	25	7	10	8	0	0	44	0
TOTAL	15,818	5,457	5,811	3,877	378	292	3,722	1,331	1,447	755	116	70	3,975	153

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2011, period. Submitted September 2, 2011.

[a]In Connecticut, the distribution of transitions by population does not sum to the total number of transitions or cumulative number of transitions.

ICF-MR = intermediate care facility for people with mental retardation; MFP = Money Follows the Person; MI = mental illness; MR/DD = mental retardation/developmental disability; NH = nursing home; PD = physical disability.

NA = not applicable, the state does not have a parallel program.

NR = not reported, the state has a program but did not report numbers.

Table 2. Current MFP Participation: June 30, 2010, through June 30, 2011

State	Total Number of Current Participants as of June 2011	Total Number of Current Participants as of December 2010	Total Number of Current Participants as of June 2010	Number of MFP Participants Completing the 365-Day Transition Period from January to June 2011	Number of MFP Participants Completing the 365-Day Transition Period from July to December 2010	Number of MFP Participants Completing the 365-Day Transition Period from January to June 2010
Arkansas	101	63	35	21	16	17
California	268	168	116	62	63	43
Connecticut	305	264	204	192	104	22
Delaware	26	12	22	0	14	8
District of Columbia	21	22	35	13	15	30
Georgia	220	235	175	104	79	95
Hawaii	55	40	35	13	16	5
Illinois	174	144	106	62	33	14
Indiana	274	157	132	42	16	3
Iowa	65	56	59	24	26	17
Kansas	233	212	117	38	32	24
Kentucky	135	103	62	41	18	4
Louisiana	133	81	64	32	7	0
Maryland	292	283	244	108	115	177
Michigan	230	191	188	72	69	45
Missouri	148	122	151	35	49	51
Nebraska	20	51	20	9	13	18
New Hampshire	27	38	34	13	11	6
New Jersey	157	74	52	110	35	37
New York	190	156	123	62	43	22
North Carolina	108	68	38	0	35	0
North Dakota	29	25	24	10	0	13
Ohio	521	425	646	167	138	141
Oklahoma	108	75	74	0	15	8
Oregon	42	191	199	51	55	28
Pennsylvania	243	241	202	84	74	79
Texas	1,572	1,654	1,340	677	470	405
Virginia	280	198	191	52	27	19
Washington	760	394	446	173	75	72
Wisconsin	43	64	9	42	7	11
TOTAL	6,780	5,807	5,143	2,309	1,670	1,414

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2010, period; the July 1 to December 31, 2010, period; and the January 1 to June 30, 2011, period.

Table 3. MFP States' Progress Toward Yearly Transition Goals: 2011 and 2010

State	January to June 2011 MFP Transition Activity			2010 MFP Transition Activity		
	Percentage of 2011 Transition Target Achieved as of June 2011[a]	Total 2011 Transition Goals	Total Number of Transitions in 2011	Percentage of 2010 Transition Goal Achieved as of December 2010	Total 2010 Transition Goals	Total Number of Transitions in 2010
New Jersey	141.0	61	86	116.1	62	72
Georgia	104.5	200	209	122.5	200	245
Kansas	93.9	147	138	231.3	80	185
Ohio	87.1	332	289	166.5	269	448
Arkansas	79.5	78	62	116.7	66	77
Texas	79.2	1,362	1,079	207.0	819	1,695
California	66.3	205	136	84.0	325	273
New York	59.1	193	114	169.0	100	169
Kentucky	57.8	128	74	57.2	201	115
Washington	55.7	557	310	162.8	360	586
New Hampshire	50.0	30	15	100.0	27	27
North Carolina	48.8	80	39	33.3	87	29
Oklahoma	48.7	115	56	129.2	96	124
Louisiana	47.7	155	74	28.9	280	81
Hawaii	47.2	72	34	46.9	96	45
Illinois	45.9	233	107	93.8	192	180
Michigan	45.0	300	135	88.3	300	265
Indiana	43.4	251	109	132.8	171	227
Maryland	42.2	351	148	103.6	304	315
Pennsylvania	41.3	310	128	116.5	243	283
Delaware	40.0	40	16	39.5	38	15
Virginia	37.8	135	51	195.5	66	129
North Dakota	33.3	39	13	120.0	20	24
Missouri	27.6	228	63	129.0	62	80
Connecticut	25.6	609	156	120.0	230	276
Iowa	24.0	75	18	74.7	75	56
Wisconsin	20.8	120	25	24.3	111	27
Nebraska	17.0	106	18	10.4	422	44
District of Columbia	9.3	140	13	24.4	90	23
Oregon[b]	NA	0	7	41.1	331	136
TOTAL	56.0	6,652	3,722	109.2	5,723	6,251

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2011, period; the January 1 to June 30, 2010, period; and the July 1 to December 31, 2010, period.

[a]States are sorted by the percentage of 2011 transition targets achieved as of June 30, 2011.

[b]Oregon suspended its MFP program effective October 1, 2011, withdrawing its 2011 transition goal.

NA = not applicable.

Table 4. Overview of the Assessments for the MFP Program: January 1 through June 30, 2011

State	Total Number of MFP Candidates Assessed[a]	Total Number of Candidates in the Transition Planning Process	Number Assessed That Did Not Transition through MFP	Reasons Participants Did Not Transition through the MFP Program					
				Individual Transitioned but Was Not Enrolled	Too Physically Ill, Cognitively Impaired, or Service Needs Greater than What Could Be Provided in the Community	Family Member or Guardian Refused Participation or Would Not Provide Back-Up Support	Could Not Secure Affordable, Accessible Housing or Did Not Choose MFP-Qualified Residence	Individual Changed His or Her Mind, Would Not Cooperate in Care Plan Development, Had Unrealistic Expectations, or Preferred to Remain in the Institution	Other
Arkansas	79	28	9	3	2	1	1	1	0
California	372	392	23	390	19	18	332	11	0
Connecticut	422	679	573	87	87	12	0	99	288
Delaware	291	67	110	16	137	7	24	9	0
District of Columbia	22	32	14	1	2	2	2	2	0
Georgia	215	466	69	NR	NR	NR	NR	NR	NR
Hawaii	52	6	11	7	0	1	1	1	1
Illinois	1,319	542	61	0	19	1	6	14	21
Indiana	165	45	82	0	30	32	13	0	7
Iowa	55	85	85	0	0	0	0	0	85
Kansas	225	111	53	10	11	3	7	11	11
Kentucky	261	254	637	20	207	55	72	119	164
Louisiana	201	169	38	3	5	0	1	31	0
Maryland	412	780	55	0	0	1	37	0	17
Michigan	1,684	433	1,059	740	68	17	25	107	102
Missouri	102	30	51	0	8	2	0	4	23
Nebraska	36	14	127	62	30	18	63	83	2
New Hampshire	15	22	7	2	12	0	9	0	0
New Jersey	166	18	29	0	0	0	12	0	17
New York	182	241	132	14	50	3	29	10	26
North Carolina	80	138	60	2	0	0	0	0	58
North Dakota	22	16	8	3	2	1	0	2	0
Ohio	761	886	46	0	0	3	4	16	31
Oklahoma	150	150	97	2	3	1	0	9	4
Oregon	6	NA	NA	NA	NA	NA	NA	NA	NA
Pennsylvania	173	106	12	7	0	0	0	0	5
Texas	1,079	NR	NR	NR	NR	NR	NR	NR	NR
Virginia	81	61	NR	NR	NR	NR	NR	NR	NR
Washington	488	510	258	0	0	0	21	6	112
Wisconsin	89	15	33	33	0	0	0	0	0
TOTAL	9,205	6,296	3,739	1,402	692	178	659	535	974

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2011, period. Submitted September 2, 2011.

Note: The reasons participants did not transition to the community do not sum to the total number assessed that did not transition through MFP because several states cited multiple reasons for the same individuals.

[a]The number of assessments is not comparable across states due to differences in how states defined and tracked assessments.

NA = not applicable (Oregon's program was suspended effective October 1, 2011, so it was no longer conducting MFP assessments); NR = not reported.

Table 5. Overview of Minimum Data Set (MDS) 3.0, Section Q Referrals: January 1 through June 30, 2011

State	Number of Individuals Referred to MFP through MDS Section Q Referrals	Number of Individuals Referred through MDS Section Q Referrals that Enrolled in MFP	MDS 3.0 MFP Enrollees as a Percentage of MDS 3.0 Referrals	State Comments on Status of MDS 3.0 Referral Tracking Systems
Arkansas	1	0	0	
California	NR	NR	--	Just beginning to track MDS.3.0 referrals; will have data next reporting period.
Connecticut	35	12	34	
Delaware	47	3	6	
District of Columbia	NA	NA	--	The District of Columbia's MFP program currently serves individuals residing in ICFs-MR, which are not required to perform MDS assessments.
Georgia	NR	NR	--	
Hawaii	56	34	61	
Illinois	36	0	0	
Indiana	644	5	1	
Iowa	NA	NA	--	Iowa's MFP program currently serves individuals residing in ICFs-MR, which are not required to perform MDS assessments.
Kansas	19	12	63	
Kentucky	116	2	2	
Louisiana	110	9	8	
Maryland	313	7	2	The state is trying to obtain Sec Q referral data electronically from CMS, based on nursing facilities' MDS data sent to CMS, expected to occur in the next six months.
Michigan	1,567	17	1	
Missouri	NR	NR	--	The state reports receiving more referrals to MFP as a result of Section Q, but did not provide any data.
Nebraska	113	3	3	The state developed an electronic referral system for MDS Section Q referrals, which can be adapted by partner agencies in the state's ADRC networks.
New Hampshire	3	0	0	
New Jersey	NR	NR	--	
New York	76	3	4	
North Carolina	2	2	100	
North Dakota	4	1	25	
Ohio	287	102	36	Ohio's MFP information manager worked with an MDS 3.0 manager on data integrity.
Oklahoma	2	2	100	
Oregon	NA	NA	--	Oregon suspended its MFP program effective October 1, 2011.

Table 5 (*cont'd*)

State	Number of Individuals Referred to MFP through MDS Section Q Referrals	Number of Individuals Referred through MDS Section Q Referrals that Enrolled in MFP	MDS 3.0 MFP Enrollees as a Percentage of MDS 3.0 Referrals	State Comments on Status of MDS 3.0 Referral Tracking Systems
Pennsylvania	343	15	4	
Texas	NR	NR	--	The state recently developed the MDS 3.0 tracking database and entered into contracts with ADRCs to act as local contact agencies (LCAs) for MDS 3.0 Section Q (relocation contractors were already acting as LCAs). As these LCAs recently became operational, no MDS 3.0 Section Q referrals were reported this period.
Virginia	115	0	0	
Washington	0	0	--	Enhance the ADRC statewide infrastructure and support care transition activities through the procurement and configuration of an application service provider (ASP) database equipped with four functions: client management, reporting, a public-facing resource directory, and an online self-service portal. Also developed three videos for display on the self-service portal to educate and inform consumers.
Wisconsin	NR	NR	--	Design of the electronic referral system occurred in the first half of 2011; the system will go live in the second half of 2011.
TOTAL	3,889	229		

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2011, period. Submitted September 2, 2011.

ADRC = Aging and Disability Resource Center; ICFs-MR = intermediate care facilities for the mentally retarded.

NA = not applicable; NR = not reported; "--" = percentage is not available because data were not available or reported.

Table 6. Number of Reinstitutionalizations: January 1 through June 30, 2011

	Number of MFP Participants Reinstitutionalized During the Period					
	Total Number	Elders	People with PD	People with MR/DD	People with MI	Other
Arkansas	5	1	1	3	0	0
California	10	5	2	0	0	3
Connecticut	36	17	11	2	6	0
Delaware	1	1	0	0	0	0
District of Columbia	0	0	0	0	0	0
Georgia	0	0	0	0	0	0
Hawaii	12	5	5	2	0	0
Illinois	96	27	8	0	61	0
Indiana	13	8	5	0	0	0
Iowa	1	0	0	1	0	0
Kansas	22	12	9	1	0	0
Kentucky	46	7	15	15	0	9
Louisiana	3	2	1	0	0	0
Maryland	16	14	2	0	0	0
Michigan	165	78	87	0	0	0
Missouri	1	0	1	0	0	0
Nebraska	1	1	0	0	0	0
New Hampshire	0	0	0	0	0	0
New Jersey	0	NR	NR	0	0	0
New York	94	33	40	0	0	21
North Carolina	7	1	2	4	0	0
North Dakota	3	1	2	0	0	0
Ohio	146	39	92	1	14	0
Oklahoma	11	0	9	2	0	0
Oregon	5	2	3	0	0	0
Pennsylvania	18	11	7	0	0	0
Texas	99	52	35	12	0	0
Virginia	17	6	6	5	0	0
Washington	23	15	7	1	0	0
Wisconsin	7	2	5	0	0	0
TOTAL	858	340	355	49	81	33

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2011, period. Submitted September 2, 2011.

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

NR = not reported.

Table 7. Other Key Indicators: January 1 through June 30, 2011

State	Number of Emergency Calls for Backup Assistance	Self-Direction			Community Residence Type		
		Number of MFP Participants Self-Directing	Number of MFP Participants that Hired/Supervised Personal Assistants	Number of MFP Participants that Managed Their Allowance/Budget	Number of MFP Participants that Transitioned to Homes	Number of MFP Participants that Transitioned to Apartments	Number of MFP Participants that Transitioned to Group Homes
Arkansas	0	5	5	4	18	31	13
California	55	NR	NR	NR	23	77	37
Connecticut	6	136	136	0	23	122	11
Delaware	1	22	22	22	4	10	2
District of Columbia	0	NA	NA	NA	0	7	6
Georgia	0	NR	NA	NA	29	66	127
Hawaii	0	4	4	0	7	3	24
Illinois	0	NA	NA	NA	NR	NR	NR
Indiana	9	0	0	0	27	73	9
Iowa	0	1	1	1	2	16	0
Kansas	3	115	113	0	42	52	44
Kentucky	0	60	40	40	12	30	32
Louisiana	0	NR	NA	NA	29	34	12
Maryland	0	0	0	0	78	57	12
Michigan	8	41	41	41	48	82	5
Missouri	0	30	30	30	4	33	26
Nebraska	0	NA	NA	NA	6	9	3
New Hampshire	0	0	0	0	7	8	0
New Jersey	0	2	2	1	24	18	44
New York	3	NA	NA	NA	30	83	1
North Carolina	0	NR	NR	NR	29	3	4
North Dakota	0	0	0	0	0	13	0
Ohio	0	492	0	492	231	27	15
Oklahoma	0	0	0	0	2	49	5
Oregon	0	0	0	0	0	0	7
Pennsylvania	0	107	107	107	45	50	13
Texas	0	11	1	1	677	158	244
Virginia	0	12	12	0	8	16	35
Washington	0	68	68	0	87	156	67
Wisconsin	0	0	0	0	5	11	9
TOTAL	85	1,106	582	739	1,497	1,294	807

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2011, period. Submitted September 2, 2011.

NA (not applicable) indicates that state does not have self-direction option in place; NR (not reported) indicates that the state has a self-direction program but was unable to report data.

Table 8. Use of Rebalancing Funds through December 31, 2010

State	Cumulative Rebalancing Expenditures as of December 2010	Cumulative Rebalancing Expenditures as of December 2009	Name or Type of Activities
Arkansas	NR	121,583	NR
California	150,000	150,000	(1) Preference Interview Tool; (2) Transition services
Connecticut	1,508,000	NR	(1) Transition services
Delaware	NR	NR	(1) Reduce overall program costs
District of Columbia	NR	NR	NR
Georgia	0	NR	(1) Research to improve program quality
Hawaii	253,344	NR	(1) Waivers
Illinois	NR	0	(1) Waivers
Indiana	888,884	NR	(1) Reallocation of dollars for nursing care to HCBS
Iowa	3,152,014	55,000	(1) Waiver; (2) Supports Intensity Scale (SIS)
Kansas	NR	NR	(1) State costs for start-up moving-related expenses
Kentucky	1,468,575	NR	(1) Waivers
Louisiana	NR	NR	(1) Data system improvements
Maryland	3,459,409	2,083,024	(1) Waivers; (2) SIS; (3) self-advocacy; (4) transition services; (5) staff training; (6) data system improvements
Michigan[a]	2,610,815	NR	(1) Enhance HCBS for MFP participants
Missouri	2,343,544	1,653,227	(1) SIS; (2) self-advocacy; (3) transition services; (4) hiring third-party for assessments
Nebraska	0	NR	(1) Data and tracking system development
New Hampshire	1,096,047	38,000	(1) Waivers; (2) transition services
New Jersey	0	0	(1) Self-advocacy; (2) staff training; (3) quality management system
New York	1,416,335	645,431	(1) Self-advocacy; (2) transition services
North Carolina	0	NR	(1) Develop rebalancing strategy
North Dakota	0	0	(1) Realistic Job Preview
Ohio	762,700	161,000	(1) Assessment tool; (2) self-advocacy; (3) housing initiative; (4) performance tool; (5) workforce support
Oklahoma	32,435	NR	(1) Waivers
Oregon[b]	4,378,520	0	(1) Waivers; (2) transition services
Pennsylvania	3,464,110	549,879	(1) Waivers
Texas	1,975,100	1,009,994	(1) Nursing Facility Resident Survey; (2) Realistic Job Preview; (3) ICF/MR closures; (4) ADRC Support
Virginia	245,668	0	(1) Transition services
Washington	7,244,482	2,069,960	(1) Family mentoring (2) employment initiative; (3) staff hiring; (4) incident tracking; (5) budget reduction offsets
Wisconsin	2,334,281	1,324,550	(1) Waivers
TOTAL	$38,784,263	$9,861,648	

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2011, period. Submitted September 2, 2011.

[a]Michigan does not currently track the amount of money spent on rebalancing funds specifically within the MFP program. The reported figure is an estimate through December 2010.

[b]Oregon reported cumulative rebalancing expenditures through June 2011.

ADRC = Aging and Disability Resource Center; HCBS = home and community-based service; ICF/MR = intermediate care facility for people with mental retardation.

NR = not reported.

Table 9. MFP Grantees' Progress and Challenges in Ensuring Participants' Access to Home and Community-Based Services, by Reporting Period, 2009-2011—Number of States Reporting Each Type of Progress or Challenge

Response Option	Jan to June 2009	July to Dec 2009	Jan to June 2010	July to Dec 2010[c]	Jan to June 2011
Number of Grantees Self-Reporting Progress[a]					
Increased the number of transition coordinators	12	8	12	13	13
Increased the number of HCBS providers contracting with Medicaid	10	10	9	5	10
Increased access requirements for managed long-term care providers	0	0	1	1	1
Increased payment rates to HCBS providers	6	5	3	1	4
Increased the supply of direct service workers	2	1	2	1	5
Improved or increased transportation options	1	1	2	3	5
Added or expanded managed long-term care programs	1	1	2	2	1
Other	2	4	6	7	4
SUBTOTAL	34	30	37	33	43
Number of Grantees Self-Reporting Challenges[b]					
Insufficient supply of HCBS providers	6	7	9	9	11
Insufficient supply of direct service workers	3	4	4	6	5
Preauthorization requirements	2	3	2	3	3
Limits on amount and scope or duration of HCBS	4	4	10	7	10
Lack of appropriate transportation options	3	3	4	3	7
Insufficient supply of specific types of HCBS	5	9	8	4	5
Other	11	7	8	10	9
SUBTOTAL	34	37	45	42	50

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2009, period; the July 1 to December 31, 2009, period; the January 1 to June 30, 2010, period; the July 1 to December 31, 2010, period; and the January 1 to June 30, 2011, period.

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

[a]Report question asked, "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?"

[b]Report question asked, "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."

[c]Illinois did not report data on participants' access to HCBSs.

HCBS = home and community-based services.

Table 10. MFP Grantees' Progress and Challenges Securing Appropriate Housing Options for Participants, by Reporting Period, 2009-2011—Number of States Reporting Each Type of Progress or Challenge

Response Option	Jan to June 2009	July to Dec 2009	Jan to June 2010	July to Dec 2010[c]	Jan to June 2011
Number of Grantees Self-Reporting Progress[a]					
Developed inventory of affordable and accessible housing	7	2	3	3	5
Developed local or state coalitions to identify needs and/or create housing-related initiatives	8	9	5	6	3
Developed statewide housing registry	4	1	3	1	3
Implemented new home ownership initiative	1	0	1	0	0
Improved funding for developing assistive technology related to housing	2	1	1	2	2
Improved information systems about affordable and accessible housing	2	2	2	3	4
Increased number of rental vouchers	5	5	8	9	11
Increased supply of affordable and accessible housing	3	2	1	2	1
Increased supply of residences that provide or arrange for long-term services and/or supports	4	1	0	1	1
Increased supply of small-group homes	3	3	4	3	8
Increased or improved funding for home modifications	5	6	1	1	5
Other	6	6	9	8	9
SUBTOTAL	50	38	38	39	52
Number of Grantees Self-Reporting Challenges[b]					
Lack of information about affordable and accessible housing	1	2	2	0	2
Insufficient supply of affordable and accessible housing	19	14	18	17	18
Lack of affordable and accessible housing that is safe	2	3	5	3	3
Insufficient supply of rental vouchers	15	14	16	14	11
Lack of new home ownership programs	0	0	2	0	0
Lack of small-group homes	5	6	6	4	6
Lack of residences that provide or arrange for long-term services and/or supports	2	2	2	3	3
Insufficient funding for home modifications	1	1	1	2	3
Unsuccessful efforts in developing local or state coalitions of housing and human services organizations to identify needs and/or create housing-related initiatives	0	2	0	3	1
Unsuccessful efforts in developing sufficient funding or resources to develop assistive technology related to housing	0	0	0	0	0
Other	8	7	4	5	9
SUBTOTAL	53	51	56	51	56

Source: MFP semiannual web-based progress reports covering the January 1 to June 30, 2009, period; the July 1 to December 31, 2009, period; the January 1 to June 30, 2010, period; the July 1 to December 31, 2010, period; and the January 1 to June 30, 2011, period.

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

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

[b]Report question asked, "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."

[c]Illinois did not report data on housing for participants.

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