Money Follows the Person 2010 Annual Evaluation Report

Final Report

October 7, 2011

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EXECUTIVE SUMMARY

The Money Follows the Person (MFP) Demonstration program represents a major initiative to give people needing long-term services and supports more choice about where they live and receive care, and to increase the capacity of state long-term care systems to serve people in the community rather than in institutions. The 43 states and District of Columbia that have been awarded MFP demonstration grants (31 in 2007 and 13 in 2011) must implement: (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 that invests the enhanced federal matching funds MFP programs receive into programs and services that increase, relative to institutional care, the proportion of Medicaid long-term care expenditures flowing to community services and supports.

The first three MFP programs began transitioning participants in late 2007, and 30 programs were fully operational by the end of 2009.[1] Calendar year 2010 marked a period when the MFP demonstration grew to a total of nearly 12,000 transitions and the program was expanded by federal legislation. The 2010 Patient Protection and Affordable Care Act increased funding for the demonstration from $1.75 billion to $4 billion; relaxed the length of stay eligibility requirement from 180 days to 90 days, exclusive of Medicare-paid days; and extended the demonstration through 2016.[2]

A. Purpose of the Report

This second annual report presents three broad sets of analyses that shed light on the overall progress of the MFP program; (1) an implementation analysis of the first three years of the demonstration, (2) an assessment of the factors associated with state advancement to understand why some grantee states have made more progress than others, and (3) descriptive analyses of early outcomes. The primary data sources used for this report include grantees' semiannual progress reports; information from a series of in-depth interviews Mathematica conducted in 10 states; administrative data files designed for the evaluation of this demonstration; and quality of life survey data that grantees collect from MFP participants. To the extent possible, these data cover the program since its inception through December 2010.

B. Summary of Findings

1. Implementation Results

- **The number of transitions increased in 2010.** Nationwide, MFP programs had transitioned nearly 12,000 beneficiaries from institutional care to community living by the end of 2010.

[1] One of the initial 31 grantees elected to delay implementation of a program until 2012.

[2] Grantees will have until the end of federal fiscal year (FFY) 2020 to spend all their grant funds, which means the last time a grantee may transition someone under the authority of the demonstration will be the end of FFY 2019.

  - The cumulative number of transitions by the end of 2010 was more than double the number at the end of 2009.
  - The monthly number of MFP participants was 54 percent higher in December 2010 than in December 2009 (5,807 compared to 3,774).

- **The size of MFP programs continues to be highly variable across states.** One state, Texas, accounts for 30 percent of all transitions on a national basis, another five states account for 32 percent of all transitions. Conversely, 14 states accounted for just 11 percent of all transitions.
- **In 2010 the MFP program exceeded the aggregate annual transition goal that states set for themselves, the first year this achievement occurred.** Collectively, states projected that they would transition 5,723 individuals during 2010 while they actually transitioned 6,251, nearly 10 percent more than planned.
  - This result was driven in part by CMS' decision late in 2009 to make grant awards for subsequent years contingent on a certain level of progress toward transition goals. A key incentive for states to adjust their goals to better reflect what they thought they could actually achieve.

- **The size and performance of any state's transition program depends on several factors**.
  - States making the most progress to date – those with performance indicators above average – usually had a strong transition infrastructure to build upon at the start of the MFP program, experienced, skilled transition coordination staff complemented by housing specialists; and, strong stable program leadership and support.
  - States with below average performance frequently saw their progress slow or stall because of program management issues, rather than serious flaws in their transition program.
- **Small demographic shifts appear to have accompanied the growth in the overall size of the program.** When the MFP demonstration began, growth in the number of transitions was initially driven by beneficiaries with intellectual disabilities who transitioned from intermediate care facilities for the mentally retarded (ICFs-MR). Beginning in the fall of 2009 and throughout 2010, the growth in the number of transitions was driven by the nonelderly with physical disabilities who transitioned from nursing homes. An assessment of new transitions revealed that:
  - In the first full year of the program (2008), 29 percent of all new MFP enrollees were nonelderly with physical disabilities who transitioned from nursing homes, while 37 percent were people with intellectual disabilities who transitioned from ICFs-MR.
  - However, by the third year (2010), the distribution had nearly reversed; 38 percent of new transitions in 2010 were nonelderly with physical disabilities, while just 21 percent were people with intellectual disabilities.

- The number of people with mental illness or those with dual diagnoses increased, but remained small; their share of new MFP participants has increased from 1 percent in 2008, to 6 percent in 2010.
- The share of new transitions among the elderly has increased slightly from 32 percent in 2008 to 35 percent in 2010.

- **Despite the shift in populations targeted by MFP programs, the age and gender distributions of MFP participants did not change in 2010.** About two-thirds of participants were under age 65. Overall, almost equal numbers of women and men were MFP participants, but the elderly were disproportionately women, and people with intellectual disabilities were disproportionately men.
- **The living arrangements of MFP participants appear to have shifted somewhat in 2010.** Both the elderly and those under 65 with physical disabilities were more likely to move to apartments and less likely to move to a home in 2010 compared to 2009. At this point it is difficult to assess the significance of these trends, but they suggest that apartment living became more important during the year, at least among some of the targeted populations.
- **On average, states were spending approximately $31,000 on home and community-based services (HCBS) per MFP participant.** This per-person spending is more than one-third lower than that of average annual Medicaid spending on institutional care for elderly beneficiaries residing in nursing homes for at least three months. Conversely, it is nearly twice the per-person HCBS costs among all Medicaid beneficiaries (Irvin and Ballou 2010) and one-third greater than the HCBS costs of those in 1915(c) waiver programs (Ng, Harrington, and Howard 2011). The greater per-person expenditures for MFP participants may partly reflect the additional services these beneficiaries receive; approximately one-third of the expenditures for MFP participants are spent on MFP demonstration or supplemental services that states provide participants during the first year after they return to community living.

2. Initial MFP Participant Outcomes – Reinstitutionalization and Mortality Rates (Unadjusted)

For the 4,746 MFP participants who had returned to the community by March 2010 and for whom we had over a year of post-transition data, initial descriptive statistics were developed to assess the extent to which these early MFP participants were able to remain living in the community.[3]

[3] The results of this work are preliminary and may understate reinstitutionalization and mortality rates among MFP participants due to lags in data reporting. In addition, the MFP program cannot be credited with any observed differences in outcomes between MFP participants and the pre-MFP comparison group because the analyses did not adjust for several important characteristics—including age, health status, and length of time in an institution—that are likely to affect the outcomes of people leaving institutions. Despite this limitation, the comparisons presented here provide early descriptive evidence of how MFP participants may differ from other people who leave institutions and the extent to which they are able to remain in their communities on a long-term basis.

- **Among the earliest MFP participants, about 85 percent were able to remain living in the community for a full year after their transition.** The other 15 percent either returned to institutional care for at least 30 days (9 percent) or died (6 percent) within 12 months of transitioning to community living.
  - During the year following participants' return to the community, reinstitutionalization and mortality were far more common among the elderly leaving nursing homes (14 and 11 percent, respectively) and least common among those leaving ICFs-MR (4 and 2 percent, respectively).

- **Reinstitutionalizations are most likely to occur in the first few months after transition.** When reinstitutionalizations occurred, they tended to happen in the first half of the year and were most likely to occur within the first three months after a participant's transition. It is during this time that many states shift the responsibility of monitoring and coordinating MFP services from transition experts to community-based case managers and care coordinators.

- **When compared to beneficiaries who transitioned to the community in 2006, before the demonstration began, MFP participants were far younger and were far less likely to be reinstitutionalized or die during the year after their transition.** This analysis was restricted to MFP participants and the pre-MFP comparison group who had at least 60 consecutive days of community living.
  - The overall reinstitutionalization rate among MFP participants in this sample was about 7 percent, compared with 21 percent among those who transitioned before MFP began. Likewise, the overall death rate was 5 percent among MFP participants versus 21 percent in the pre-MFP comparison group.
  - Pre-post differences were especially apparent among the elderly—only 11 percent of elderly MFP participants were reinstitutionalized compared with 25 percent in the pre-MFP period, and only 9 percent of elderly MFP participants died compared with about 30 percent of the pre-MFP elderly. However, those who transitioned in the pre-MFP period were far older, on average, than MFP participants. About 61 percent of those who transitioned in the pre-MFP period were elderly, compared with only 28 percent of the MFP population in our sample.

3. Initial MFP Participant Outcomes – Quality of Life (Unadjusted)

To examine how the quality of life changes after an MFP participant transitions to community living, we developed a sample of 1,090 early MFP participants for whom we could link a baseline Quality of Life survey with a year-one follow-up survey and with administrative records. We used descriptive statistics to assess how the quality of life changed after a year of community living. Because the analyses did not control for other factors that may be changing during the same period and could have an impact on the quality of life (such as health status), these results are not definitive and are subject to change when more data become available and more rigorous analytical techniques are employed.

- **MFP participants' self-rated quality of life appears to improve upon transition to the community.** Eight out of 10 MFP participants were satisfied with the way they lived their lives after one year of community living, compared with 6 of 10 participants pre-transition.

- **Overall, participants reported enhanced quality of life across all measures considered.** After one year in the community, more participants were satisfied with their living arrangements, reported expanded choice and control and community integration, were treated well by their provider, and reported fewer unmet care needs compared with their experience in institutional settings.

  - Of the elements assessed, satisfaction with living arrangements exhibited the largest increase between the pre-transition and one-year surveys. A slim majority of MFP participants (52 percent) reported satisfaction with living arrangements prior to transition, whereas nearly all participants were satisfied with their post-transition living arrangements (94 percent).

  - When asked about six areas of personal choice and control in their home, MFP participants reported an average of 4.9 areas of choice and control after one year in the community, compared to an average of 3.5 areas pre-transition.

- **Although improvement was significant and broad-based, several findings raise concern and warrant monitoring.** At least one-third of participants continue to report barriers to community integration and low mood after a year in the community.

  - Prior to transitioning, nearly half of all MFP participants (48 percent) reported an inability to do things outside the institutional setting, whereas approximately one-third (34 percent) reported such barriers while living in the community. Post-transition, this barrier was most commonly reported by participants with physical disabilities (48 percent).

  - Approximately 35 percent of MFP participants reported low mood after one year, which was down from the 43 percent who reported low mood prior to the transition to community living.

- **About 15 percent of MFP participants reported working for pay and 8 percent reported volunteering.** Of those working for pay, 74 percent were participants with an intellectual disability.

  - Participants with an intellectual disability reported the highest rate of paid work, with nearly half (48 percent) working for pay. In contrast, only three percent of the nonelderly with physical disabilities who transitioned from nursing homes reported working for pay.

- **A sizeable proportion of MFP participants was not working, but expressed an interest in doing so.** Approximately 37 percent of nonelderly MFP participants with physical disabilities were not working but wished to do so. Similarly, 21 percent of elderly MFP participants who were not working expressed an interest in finding employment.

- **Employment not only suggests a high level of community integration for MFP participants, but is associated with higher rates of life satisfaction.** Of those who were working, 86 percent were satisfied with the way they were living their lives, compared to 81 percent in the overall study sample and 77 percent among those who would like to work.

C. Conclusions

Growth and expansion characterized the MFP demonstration during 2010 and we anticipate the demonstration will continue to grow in 2011. At least some of the new grantees will begin their transition programs and the established grantees (those that were awarded grants in 2007) will enhance and expand their programs. We continue to expect MFP to grow despite the poor economic outlook for most state budgets. In many states, the MFP program enjoys support from key stakeholders. The introduction in the fall of 2010 of version 3.0 of the nursing home Minimum Data Set (MDS 3.0), included new questions that require nursing home residents be asked directly about their desire to return to the community and whether they would like a referral for more information about leaving institutional care. Many states have established their MFP program as the primary recipient for these referrals. To help states increase referrals to their MFP programs and expand the referral capacity of Aging and Disability Resource Centers (ADRC), the Administration on Aging (AOA) and CMS jointly awarded 25 MFP demonstration programs with additional funding (up to $400,000). This additional funding should help to strengthen the partnership between MFP programs and ADRCs. In addition, we anticipate that the additional federal funding awarded to grantees to finance the hiring of housing, community living, and behavior health specialists will lead to further growth in 2011 and may begin to have sustaining effects on their programs. Lastly, states have begun to use their enhanced federal matching funds to make investments in community-based services and short-term results may be realized in 2011, although many of the dividends may be further in the future.

Our early assessments of outcomes suggest that MFP participants fare well, but several findings point to areas where grantees may want to focus more resources. When reinstitutionalizations occur, they frequently happen near the time when many states shift the responsibility of coordinating MFP services from transition experts to care coordinators. Some states may need to alter this shift to make sure it happens as smoothly as possible. The quality of life data also suggest that some participants may need more assistance to achieve a successful transition. With approximately one-third of MFP participants continuing to report low mood and barriers to community integration, including wanting paid employment, grantees may need to continue to work on integration issues for some time after the transition to the community is achieved.

I. INTRODUCTION AND BACKGROUND

For the national Money Follows the Person (MFP) demonstration, 2010 marked a year of growth and momentum. Compared to a year earlier, cumulative MFP enrollment had nearly doubled to slightly less than 12,000 transitions by the end of December 2010. Critical policy changes that occurred during 2010 will keep the MFP demonstration growing in 2011 and beyond. In March 2010, Congress passed the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), which increased funding for the demonstration from $1.75 billion to $4 billion and extended the demonstration. States now have until the end of 2020 to spend all their grant funds. Provisions within the Affordable Care Act also loosened the institutional length-of-stay eligibility requirements for the program from 180 days to 90 days, excluding days covered by the Medicare subacute care benefit. In addition, the Centers for Medicare & Medicaid Services (CMS) has been providing the MFP grantees with additional administrative funds to support state efforts to establish specialists in the areas of housing, transition coordination, and behavioral health. The impact of this additional funding most likely will not be fully felt until 2011 and beyond.

The additional funds provided by the Affordable Care Act will make the MFP demonstration much larger than it would have been. CMS has used the additional funding to award another round of grants and 13 additional states received new MFP grants in early 2011, bringing the total number of states with MFP demonstration grants to 43, plus the District of Columbia. However, other policy changes will affect the growth trajectory of the MFP program. Beginning on October 1, 2010, nursing homes and other institutions began assessing residents' health and functional needs with a new version of the Minimum Data Set (MDS 3.0). The new version asks residents directly if they want to speak with someone about returning to the community. It is anticipated that this change in the MDS will produce more referrals to MFP programs. To help strengthen the partnership between MFP programs and local Aging and Disability Resource Centers (ADRC), the Administration on Aging (AOA) and CMS collaborated on a new initiative that provided additional funding to 25 MFP programs. Another development that could boost MFP transitions for younger people with disabilities occurred when the U.S. Department of Housing and Urban Development (HUD) announced in April 2010 the availability of housing vouchers for people with disabilities under age 65.[4] According to MFP progress reports in mid-2010, at least 19 of the 30 state MFP grantees reported working with local public housing authorities to apply for these HUD vouchers, many of which indicated that some would be reserved for MFP participants (Lipson and Williams 2011).

This report is the second in a series of annual reports that Mathematica Policy research is producing for the national evaluation of the MFP demonstration (CMS Contract Number HHSM-500-2005-00025I TO#02). It provides basic information about the program and how it grew and changed during calendar year 2010. It also updates and summarizes analytical studies Mathematica conducted during the year.

[4] "HHS, HUD Partner to Allow Rental Assistance to Support Independent Living for Non-Elderly Persons with Disabilities." CMS and HUD joint press release, April 7, 2010.

A. Background

1. Basic Features of the MFP Program

As noted in previous reports (Irvin et al. 2010), 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 program that allows a greater proportion of Medicaid long-term care expenditures to flow to community services and supports. Like Medicaid programs in general, MFP demonstrations are subject to general federal requirements, but the design and administration of each MFP program is unique and tailored to state needs.

Transition Programs. By statute, the MFP program is for people institutionalized in nursing homes, hospitals, intermediate care facilities for the mentally retarded (ICFs-MR), or institutions for mental diseases (IMDs). Until the passage of the Affordable Care Act, people had to be institutionalized for a minimum of 180 days or six months and had to be eligible for full Medicaid benefits for at least the month before transition to the community. The Affordable Care Act reduced the minimum to only 90 days of institutional care but required programs to exclude any rehabilitative care days covered by Medicare.[5]

On the day they transition to the community, MFP participants begin receiving a package of home and community-based services (HCBS) financed by the state's MFP grant funds. MFP-financed services continue for up to one year, or 365 days, after the date of transition. After exhausting their 365 days of eligibility for MFP-financed HCBS, MFP participants become regular Medicaid beneficiaries and receive HCBS through the state plan and/or a waiver program, depending on their eligibility status.

MFP programs may provide up to three categories of services: (1) qualified HCBS, (2) demonstration HCBS, and (3) supplemental services. *Qualified HCBS* are services beneficiaries would have received regardless of their status as MFP participants, such as personal assistance services. *Demonstration HCBS* are either Medicaid services not included in the state's array of HCBS for regular Medicaid beneficiaries (such as assistive technologies) or qualified HCBS above what would be available to regular Medicaid beneficiaries (such as 24-hour personal care). States may also provide *supplemental services* to MFP participants: services that are not typically reimbursable under the Medicaid program but that make the transition to a community setting easier (such as a home computer or trial visit to the proposed community residence). States receive an enhanced federal match (known as the Federal Medical Assistance Percentage, or FMAP), which is drawn from their MFP grant funds, when they provide either qualified HCBS or demonstration HCBS.[6] They receive the regular FMAP, which is also drawn from

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[5] Initially, states had to set the minimum length of institutionalization between 6 and 24 months for MFP participants, but all selected 6 months as the minimum requirement. With the passage of the Affordable Care Act, states may now use a minimum of 90 days, but days for care covered by the Medicare program cannot be counted toward the 90-day minimum.

[6] The MFP-enhanced FMAP is set in statute (state's regular FMAP + [1 − state's regular FMAP]*.5) and cannot exceed 90 percent. Retroactive to October 1, 2008, the state's regular FMAP includes the enhancements that states received through the American Recovery and Reinvestment Act of 2009.

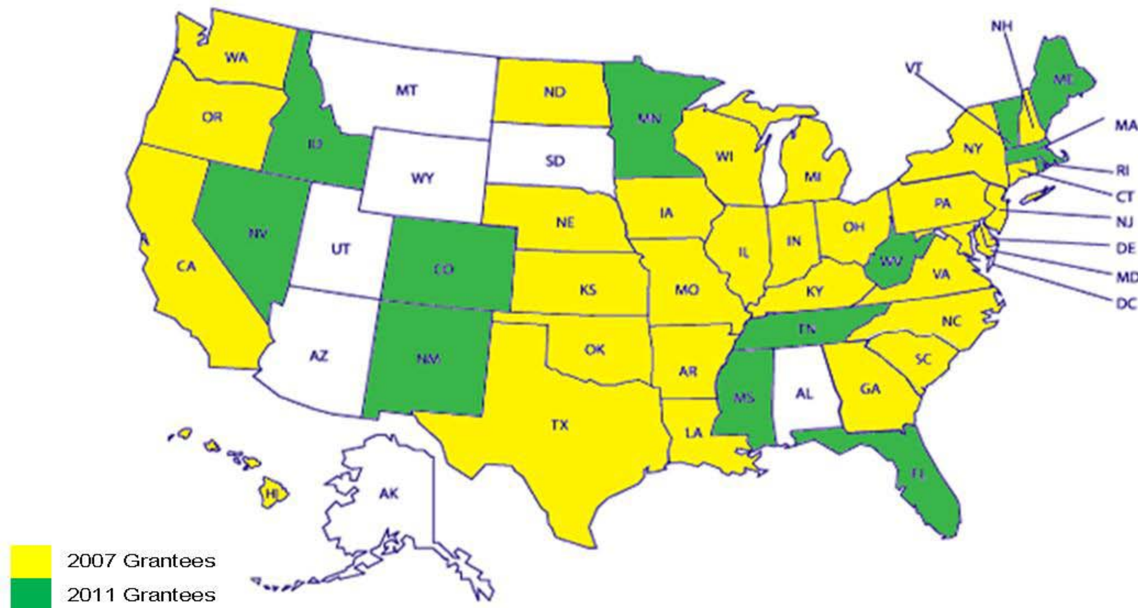
their MFP grant funds, when they provide supplemental services. In general, MFP transition programs are designed to provide a richer mix of community services for a limited time to help make the transition to the community successful.

Rebalancing Programs. The rebalancing program is subject to fewer basic requirements than the transition program. States must use the enhanced matching funds they receive when MFP participants use qualified HCBS or demonstration services to finance changes in their long-term care systems. No formal requirements for using or reinvesting these funds exist, other than the funds must be used for rebalancing the long-term care system. States may use the enhanced funds in a variety of ways, including (1) reducing the use of institutional care (such as financing the costs of closing beds or facilities), (2) supporting transitions of people not eligible for MFP, (3) expanding the availability of HCBS programs (such as increasing HCBS waiver slots or adding a self-direction program), or (4) improving the infrastructure (such as expanding the availability of affordable and accessible housing). Each state sets specific benchmarks for measuring the success of the selected rebalancing strategy.

2. MFP Grant Awards

CMS began awarding MFP demonstration grants in January 2007 with 17 initial awards, and 14 additional awards in May 2007. The Affordable Care Act increased the funding available for the MFP demonstration from $1.75 billion to $4 billion. CMS used this additional funding to expand the program to more states. In January 2011, 13 additional states received MFP grants, bringing the total number of states with MFP grants to 43, plus the District of Columbia (see Figure I.1). Among the 2007 grantees, several states delayed the startup of their programs, frequently because implementation was more challenging than anticipated. As noted in previous reports (Denny-Brown et al. 2011 and Irvin et al. 2010), implementing an MFP program requires considerable effort and coordination among different agencies, particularly when the program targets multiple populations. Some programs were delayed while key adjustments to community services were made to ensure the states could serve MFP participants. At a minimum, every program had to (1) establish processes for identifying eligible Medicaid beneficiaries who can be adequately served in the community, (2) hire and train transition coordinators who work one-on-one with beneficiaries to set up their community living arrangements and services and supports, (3) develop strategies for locating affordable and accessible housing in areas where beneficiaries want to live, and (4) implement risk assessment and management systems that balance beneficiary choices against the increased risks associated with living in the community.

Figure I.1. Map of MFP Demonstration Grants



B. Purpose of this Report

In March 2007, CMS contracted with Mathematica to conduct a national evaluation of the MFP demonstration (CMS Contract Number HHSM-500-2005-00025I TO#02). This second annual report for the MFP demonstration covers the program from its inception through December 2010. The primary purpose of the report is to describe the status of the program as of December 31, 2010, including how states are progressing on their goals.

The following chapters present a mix of analyses that include basic descriptive information about the program and its progress during 2010, early assessments of program outcomes, and findings related to factors that are associated with early progress. Like the 2009 Annual Report, this report continues to set the foundation for the national evaluation and an assessment of program impacts.

At the most fundamental level, the national evaluation of the MFP program seeks to understand whether the program met its goals (1) to increase the number and proportion of long-term institutionalized Medicaid enrollees who can live successfully in the community, and (2) to facilitate state rebalancing of long-term care systems. MFP programs are anticipated to have an array of effects on beneficiaries who need long-term services and supports, including increases in the likelihood and number of transitions from institutional to community settings and greater increases in HCBS use and expenditures than in institutional care.

C. Road Map to the Report

The next chapters are organized around three broad types of analyses: (1) an assessment of program growth and focus, (2) an implementation analysis focused on the factors related to early progress, and (3) initial results on program outcomes. Chapters II and III describe the overall growth of the MFP demonstration and the basic demographic makeup of MFP participants. Chapter II reports on the status of the MFP demonstration, including the cumulative number of

Medicaid beneficiaries who transitioned to community living as a result of the MFP demonstration and the extent to which grantee states are achieving their transition goals. This chapter also provides an initial assessment of the factors related to progress at the state level. Chapter III describes MFP participants and the costs of the HCBS they receive through the MFP program.

Chapters IV and V provide preliminary descriptive assessments of program outcomes. In Chapter IV, the focus is on determining the extent to which MFP participants remain living in the community for at least a year, overall and among a select group of states. The analysis includes a comparison of the reinstitutionalization and mortality rates of MFP participants against a group of Medicaid beneficiaries who transitioned to the community without the benefit of the MFP program. Chapter V focuses on the implications of the transition on participants' quality of life including overall satisfaction with life and services received, perceptions of the quality of their care, and satisfaction with community life. The analysis also delves further into the quality of life of MFP participants who work for pay or wish to work. Because the assessment of outcomes at the participant level requires a year's worth of data, the analyses in these two chapters do not include all who had transitioned by the end of 2010. As a result, the sample sizes for the studies were relatively small and did not always support rigorous treatment to isolate the effects of the MFP program. Therefore, the results in Chapters IV and V are preliminary and subject to change as the program grows and more beneficiaries transition to community living.

Chapter VI provides an overall summary of the report and discusses some of the future work planned for the national evaluation.

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II. MFP TRANSITION TRENDS AND DETERMINANTS OF PROGRESS

A. Overview

The number of people who transition from institutions to the community is among the most important, and most closely watched, indicator of progress for the MFP demonstration. It represents the number of people who have received the full benefit of the MFP program and access to community services and supports they need to live in the community. By the end of 2010, the third full year of the program, MFP programs had transitioned nearly 12,000 people to the community and home and community-based services (HCBS). This number more than doubled since the end of 2009, indicating that 2010 was a year of strong momentum for the program. But not all MFP programs are progressing at the same pace in terms of the number of transitions and other important metrics. New insights obtained through in-depth interviews with state MFP program officials in 10 states suggest that several factors affect a state's current progress. This chapter reviews trends in MFP transitions from 2008 to 2010, overall, by population group, and by state. It also describes states' progress toward annual transition goals in 2010, which has shown a marked improvement from the year before. In addition, this chapter examines the MFP program components that may explain varying state progress on key indicators as of June 2010.

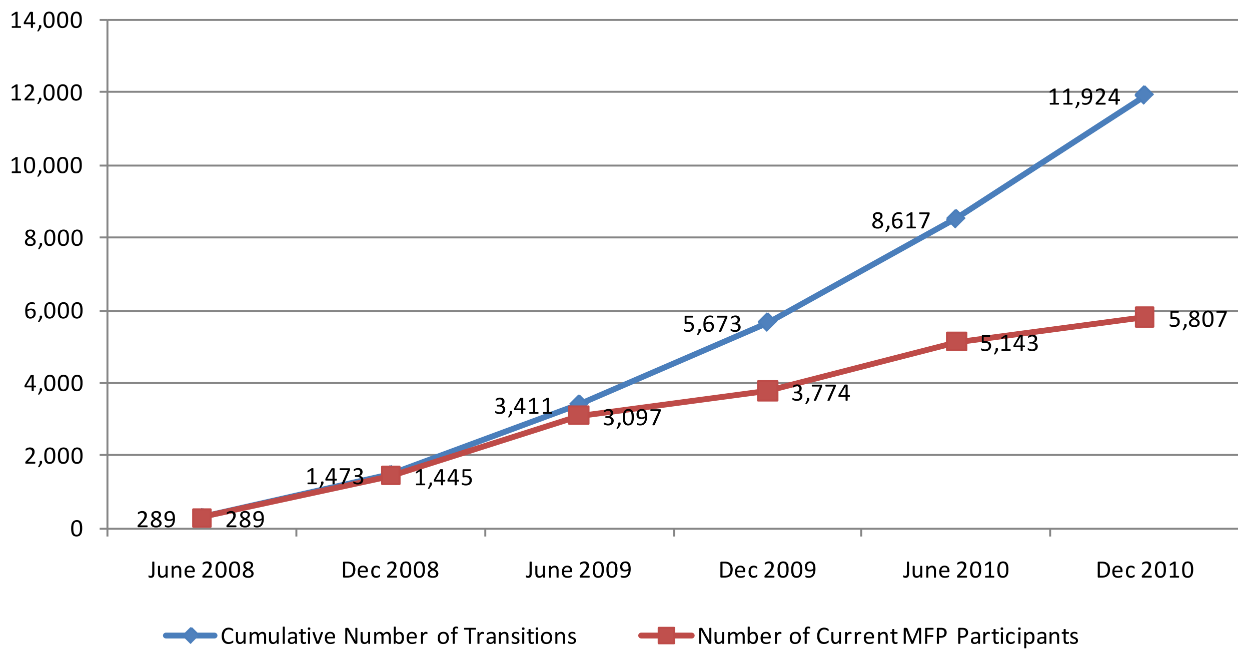
B. Transition Trends

1. Cumulative and Current Transitions

In 2010, the third full year of the MFP demonstration, annual and cumulative MFP transitions increased substantially over previous years (Figure 1). By December 2010, cumulative transitions totaled nearly 12,000, more than double the number one year earlier (5,673 transitions as of December 2009). From January to December 2010, state MFP grantees reported enrolling 6,251 new MFP participants, nearly 19 percent more than in the first two years combined (5,273).

The number of MFP participants enrolled during December 2010 stood at 5,807 (Figure II.1), 13 percent higher than the number enrolled six months earlier (5,143) during June 2010, and 54 percent more than the number enrolled one year earlier in December 2009. The number of current participants includes everyone enrolled in MFP during a given month, living in the community, and receiving HCBS financed with MFP grant funds; it excludes participants who completed 365 days in the community after their transition, died, were reinstitutionalized for 30 days or more, withdrew from the program, or became ineligible (see Chapter IV for a discussion of these outcomes).

Figure II.1. Cumulative Number of MFP Transitions and Number of Current MFP Participants, June 2008 to December 2010

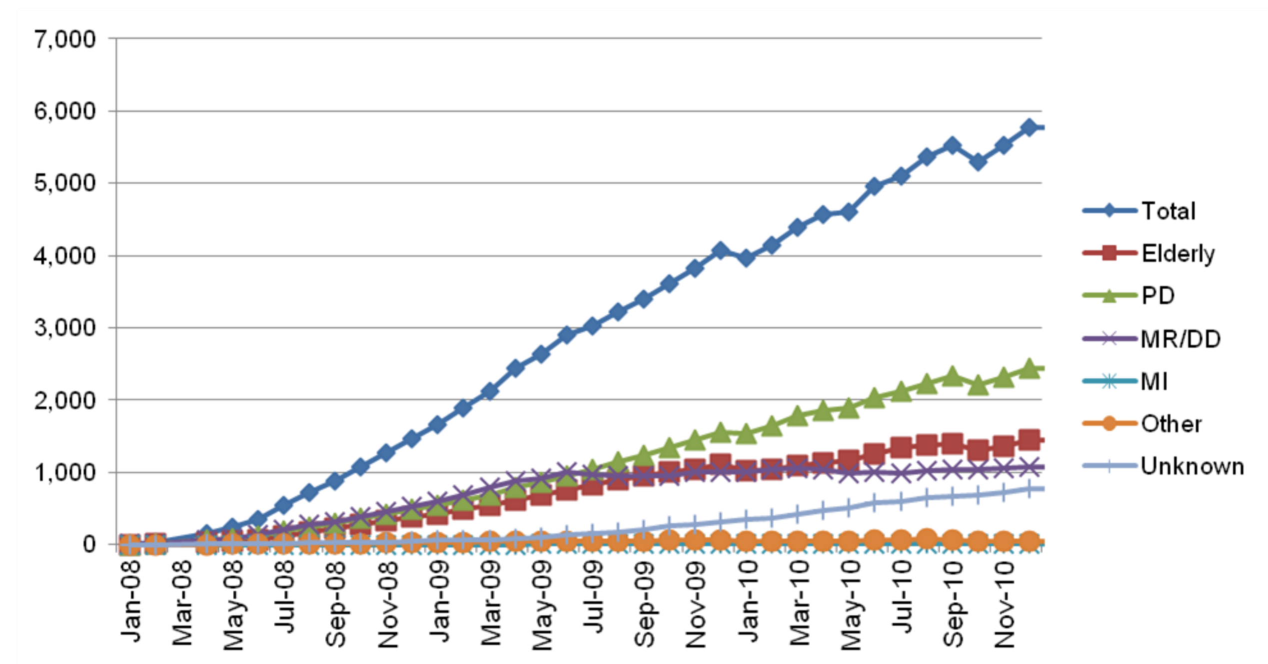


Source: Mathematica analysis of state MFP grantee web-based progress reports, June 2008 - December 2010.

2. Transitions by Population Group

Small demographic shifts appear to have accompanied the growth in transitions and the overall size of the program. At the time of this report, the evaluation had received person-level data for 11,252 people who had transitioned to community living through the MFP program (or about 94 percent of those ever transitioned by the end of December 2010). These data allow us to track MFP enrollment on a monthly basis and describe the characteristics of participants in more detail than the aggregate reports submitted by grantees. Figure II.2 indicates that, beginning in the fall of 2009, nonelderly MFP participants with physical disabilities started to drive the growth of the MFP program and they continued to do so throughout 2010. During the same period, the size of the population with intellectual disabilities remained stable.

Figure II.2. Monthly Current MFP Enrollment by Target Population, 2007-2010

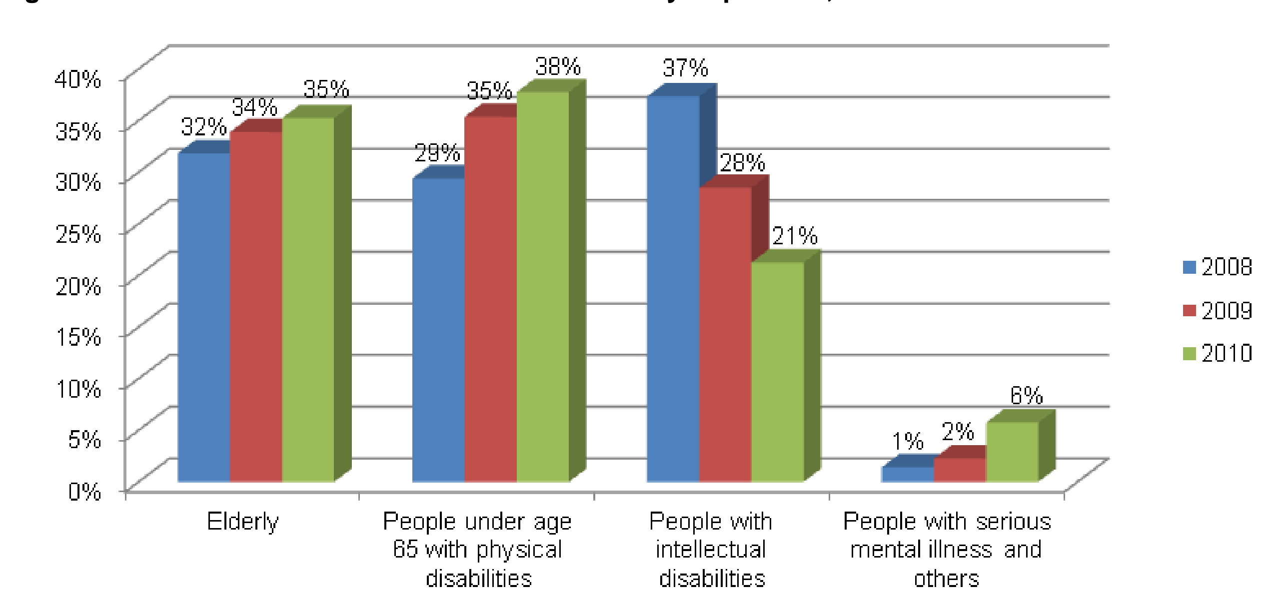


Source: Mathematica analysis of the MFP Program Participation Data Files.

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

This demographic shift becomes more apparent when we examine point-in-time distributions of current MFP participants. In the first full year of the program (2008), 29 percent of all new MFP enrollees were younger people with physical disabilities, while 37 percent were people with intellectual disabilities (Figure II.3). However, by the third year (2010), the distribution had nearly reversed; 38 percent of new transitions in 2010 were younger people with physical disabilities, while just 21 percent were people with intellectual disabilities. In addition, while the number of people with mental illness or those with dual diagnoses remains small, their share of MFP participants has increased from 1 and 2 percent in 2008 and 2009, to 6 percent of all new MFP enrollees in 2010. The share of new transitions among the elderly has increased slightly from 32 percent in 2008 to 35 percent in 2010.

Figure II.3. Annual Distribution of MFP Transitions by Population, 2008-2010



Source: Mathematica analysis of state MFP grantee web-based progress reports, June 2008 - December 2010.

All the data that were available when this report was written indicate that states continue to transition disproportionate numbers of nonelderly people with physical disabilities relative to the overall composition of the potentially eligible population. There were disproportionately more individuals under 65 with physical or intellectual disabilities among MFP participants (62 percent) by the end of 2010, compared to the share of all such individuals who would have been eligible for MFP in 2007 before the program began (24 percent). Conversely, elderly individuals who resided in nursing homes were under-represented among MFP participants (35 percent) by the end of 2010 relative to their share of those who would have been eligible for MFP in 2007 (75 percent) (Lipson and Williams 2011; Wenzlow and Lipson 2009).

Differences in the distribution of populations *eligible* for MFP and those *enrolled* in MFP is explained largely by the populations states chose to target, as reflected in their transition goals. In June 2008, when all state MFP programs received federal approval to begin implementing their transition programs, older adults comprised 47 percent of projected transitions over the course of the demonstration, substantially less than their share (75 percent) among the MFP-eligible population in 2007. There were also discrepancies between the share of MFP eligibles and projected transitions for younger individuals with physical disabilities, or with intellectual disabilities (Lipson and Williams 2011).

Over time, differences between the profile of MFP eligibles and MFP enrollees have been heightened due to two factors: (1) relationships among agencies and (2) housing options. As noted elsewhere (Denny-Brown et al. 2011), effective implementation of MFP programs requires the Medicaid agency to coordinate and collaborate with other state and local agencies that administer and operate the HCBS waivers or provide the HCBS that participants use. At the start of the demonstration, many state agencies that manage intermediate care facilities for the mentally retarded (ICFs-MR) and provide services for people with intellectual disabilities had active initiatives to downsize ICFs-MR and transition residents into community residences and small group homes. As a result, at least some MFP grantees were able to begin transitioning

people with intellectual and developmental disabilities shortly after their MFP program became operational. Starting transitions for the other targeted populations took more time when the Medicaid agency and MFP administrative staff had to establish working relationships with the institutions and community agencies that served these groups. For example, some states had to build working relationships with local centers for independent living before these centers could start transitioning nonelderly Medicaid beneficiaries with physical disabilities through the state's MFP program.

In addition to inter-agency relationships, transitions for some population groups are dependent on the availability of suitable and acceptable housing. For example, it is not uncommon for the elderly to prefer assisted living that offer congregate meals, on-call support services, and activities on site.[7] However, some states report that the restriction on assisted living as a qualified MFP residence[8] has made it difficult for them to transition older adults (Denny-Brown et al. 2011), which may contribute to the disproportionately low numbers of elders in the MFP program.

3. Transitions by State

In addition to variation across population groups, there is substantial state variation in the number and type of individuals who ever transitioned and enrolled in MFP. Cumulative transitions by the end of 2010 ranged from 3,579 in Texas to 38 in Delaware (Table II.1) The number of current participants at the end of 2010 also mirrored the wide range in enrollment (1,654 in Texas to 12 in Delaware, Table II.1).

Texas alone accounted for 30 percent of the total number who ever enrolled in MFP and transitioned by the end of 2010 (Figure II.4). Because of its size, Texas tends to influence the overall national picture of the MFP program. As the data in Table II.1 indicate, Texas has a relatively balanced program, transitioning nearly equal numbers of elders, younger people with physical disabilities, and beneficiaries with intellectual disabilities.

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[7] A review by Kane et al. (2007) of 29 surveys and studies on assisted living residents found that mean ages ranged from 71 to 86. The exclusion of assisted living facility as an MFP community residence (except in certain situations) has been attributed to advocacy by organizations representing younger persons with disabilities, who often regard apartment-style assisted living as institutional. By contrast, "judging from the market response to the availability of these settings, many older persons . . . are choosing assisted living that provides for a private apartment but also provides congregate meals, housekeeping, personal care, and access to health care" (see Kane and Kane 2001).

[8] Guidance issued by CMS to MFP grantees at the end of July 2009 clarified the conditions under which assisted living facilities or settings would meet the requirements of a "qualified residence" under the MFP statute. Qualifying assisted living facilities must: (1) offer apartment-style units; (2) have a legally enforceable individual lease (not a resident agreement) that does not have admission and discharge provisions that could require a person to move when their needs increase; and 3) ensure the resident has a separate eating, sleeping, bathing, and cooking area over which he or she has control.

Table II.1. Overview of MFP Grant Transition Activity

	Transitions from Program Start to December 31, 2010					
State	Cumulative Total Number	Percentage Elders	Percentage People with PD	Percentage People with MR/DD	Percentage People with MI	Percentage Other
Arkansas	150	17	36	47	0	0
California	401	20	40	27	3	10
Connecticut	405	36	45	1	18	0
Delaware	38	37	53	5	5	0
Dist. of Columbia	75	0	0	100	0	0
Georgia	442	24	33	43	0	0
Hawaii	70	47	49	4	0	0
Illinois[a]	233	28	18	0	54	0
Indiana	287	43	57	0	0	0
Iowa	118	0	0	100	0	0
Kansas	343	28	38	30	0	3
Kentucky	156	19	22	40	0	18
Louisiana	90	37	29	34	0	0
Maryland	799	40	40	17	0	3
Michigan	640	54	46	0	0	0
Missouri	285	16	37	44	0	4
Nebraska	102	22	26	43	0	9
New Hampshire	72	32	31	7	0	31
New Jersey	157	45	3	53	0	0
New York	256	32	43	0	0	25
North Carolina	60	20	10	70	0	0
North Dakota	43	21	30	49	0	0
Ohio	850	23	45	29	4	0
Oklahoma	152	21	41	38	0	0
Oregon	299	34	47	16	0	2
Pennsylvania	578	70	26	3	1	0
Texas	3,579	33	31	36	0	0
Virginia	218	17	22	61	0	0
Washington	949	47	48	5	1	0
Wisconsin	77	34	36	29	1	0
TOTAL	**11,924**	**34**	**36**	**26**	**2**	**2**

Source: MFP semiannual web-based progress reports covering the 2008-2010 period.

[a] Illinois' progress report had not been submitted as of April 6, 2011; hence, reported figures are subject to change.

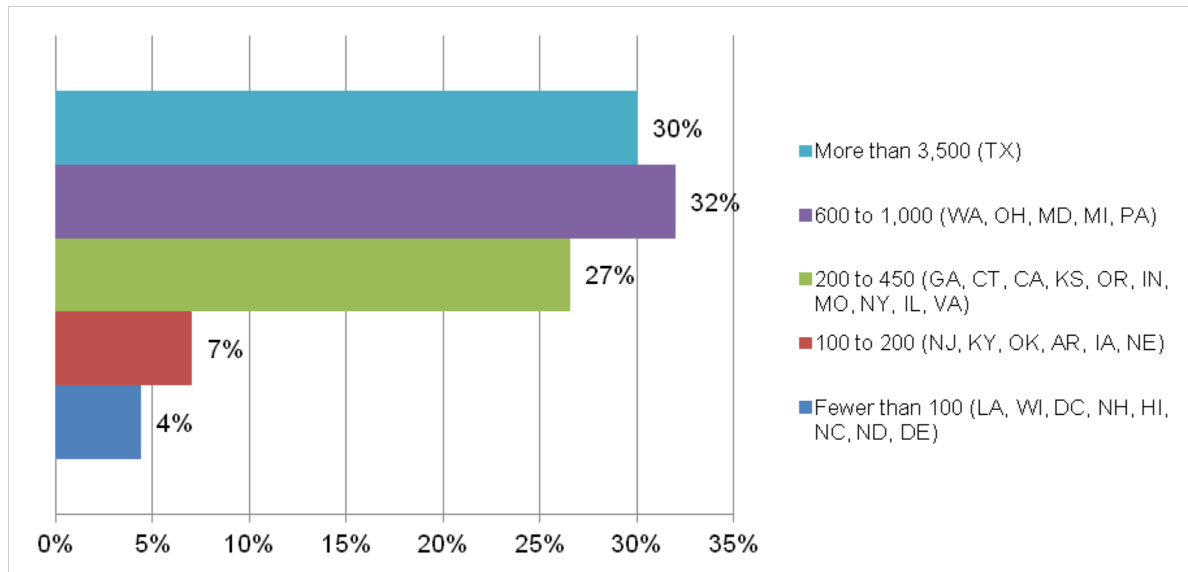
MI = mental illness; MR/DD = mental retardation/developmental disabilities; PD = physical disabilities.

The next five states together comprised 32 percent of total cumulative transitions (in rank order): Washington, Ohio, Maryland, Michigan, and Pennsylvania, each of which enrolled between 600 and 1,000 individuals so far. Within this group, Ohio is most similar to Texas in that Ohio's program is transitioning the same three target populations as Texas, but the data suggest Ohio focuses more on transitioning the nonelderly with physical disabilities from nursing homes. Washington, Maryland, and Michigan are primarily transitioning both the elderly and nonelderly from nursing home settings. In Pennsylvania, the elderly have made up 70 percent or more of the transitions.

Ten states transitioned between 200 and 450 people each, collectively accounting for 27 percent of the overall number of transitions. Within this group, six states are transitioning the elderly, nonelderly with physical disabilities, and beneficiaries with intellectual disabilities. Another three states are focused on transitioning only the elderly and nonelderly from nursing

homes. The tenth state in this group, Illinois, is notable for its focus on transitioning beneficiaries with mental illness. The remaining 14 states enrolled fewer than 200 individuals each and together contributed 11 percent of all transitions. This group includes the District of Columbia and Iowa, two grantees only transitioning beneficiaries with intellectual disabilities.

Figure II.4. Percentage of Cumulative MFP Transitions by State and Volume, 2008-2010



Source: Mathematica analysis of state MFP grantee web-based progress reports, June 2008 - December 2010.

Variation in program size reflects a combination of factors, including the size of the eligible population in each state, and the length of time the MFP program has been in operation. For example, the large number of MFP enrollees in Texas and the next five states with the most enrollees is partly explained by greater numbers of people eligible for the program in those states. But if population size were the only explanation, one would expect states like California and New York to have far more MFP transitions than they did at the end of 2010. Some states did not start MFP transition programs until 2009, which partly explains the lower numbers in Connecticut, Illinois, Indiana, Louisiana, New York, North Carolina, and Oklahoma. However, transitions in some of these states grew rapidly once they began implementing their programs; indeed, annual rates of growth in transitions from 2009 to 2010 were more than double (greater than 100 percent) in eight states (see Table II.2).

In addition, program enrollment during 2008 and 2009 is likely to reflect state capacity and experience in operating transition programs like MFP before it began. Texas, for example, which operated an MFP program for several years before the federal MFP demonstration, benefited from established systems and agencies that had knowledge and skill in helping individuals transition from institutions back to the community. California, on the other hand, had much less transition capacity and fewer systems to build on, and had to contend with a decentralized, county-administered Medicaid program that created challenges to statewide implementation. See Section C. below for a discussion of other reasons that accounted for state grantees' ability to transition the eligible population.

Table II.2. MFP Transitions by State and Year, and 2009 to 2010 Annual Percentage Growth Rate*

State	2008	2009	2010	2009-2010 Growth Rate
TOTAL	1,473	4,204	6,247	49%
Louisiana	0	9	81	800%
Oklahoma	0	28	124	343%
Indiana	0	60	227	278%
Illinois	0	53	180	240%
Kentucky	5	36	115	219%
California	2	126	273	117%
Connecticut	0	129	276	114%
Kansas	70	88	185	110%
New York	0	87	169	94%
Hawaii	1	24	45	88%
Washington	38	325	586	80%
Virginia	16	73	129	77%
North Dakota	5	14	24	71%
Arkansas	22	51	77	51%
Texas	761	1,123	1,695	51%
Ohio	60	342	448	31%
New Hampshire	24	21	27	29%
Georgia	3	194	245	26%
Nebraska	19	39	44	13%
Pennsylvania	42	253	283	12%
Iowa	9	53	56	6%
Oregon	32	131	136	4%
New Jersey	11	74	72	-3%
Maryland	154	330	315	-5%
North Carolina	0	31	29	-6%
Michigan	89	286	265	-7%
Wisconsin	25	28	24	-14%
Delaware	3	20	15	-25%
Missouri	67	138	80	-42%
Dist. of Columbia	15	38	22	-42%

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

* Note: States shown in order of annual percentage growth rate, 2009-2010.

C. State MFP Grantees' Progress in Achieving Transition Goals

The Deficit Reduction Act of 2005, which authorized the MFP program, requires state grant applications to specify the projected numbers of eligible individuals in each target group to be transitioned to the community during each year of the MFP demonstration [DRA, §6071(c)(5)]. The DRA statute also required CMS to condition the release of grant funds in subsequent fiscal years on grantees' progress in meeting their transition goals, also called benchmarks.

In aggregate, the total number of transitions proposed in the initial grant applications submitted by the 31 states receiving awards in 2007 was 37,731 over a five-year period.[9] However, CMS allows states to modify their goals on an annual basis when they submit requests for supplemental budget funds. For this reason, overall transition goals in many states, and the aggregate transition goal for all states, have changed over time. In June 2008, when CMS approved all states' MFP operational protocols, the aggregate transition goal stood at 35,380. In February 2010, after states submitted supplemental budget funding requests for calendar year 2010, the aggregate goal declined to 23,352. This sharp decrease was driven in part by CMS' communication to states in December 2009 (CMS 2009) that, starting in 2011, it would make grant awards for subsequent years contingent on a certain level of progress toward transition goals. As a result, states had an incentive to make their 2010 projections as realistic as possible.

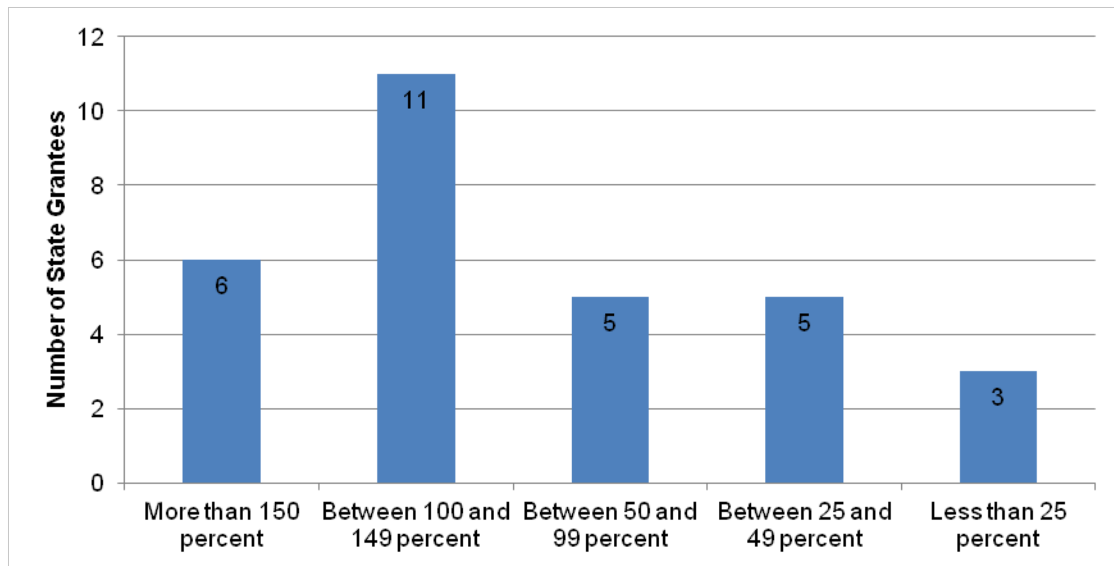
Calendar year 2010 marked the first year the MFP program exceeded the aggregate annual transition goal. Collectively, states projected that they would transition 5,723 individuals during 2010 while they actually transitioned 6,251, which is nearly 10 percent more than projected. This result is quite different from 2009, when MFP grantees achieved just 53 percent of the annual aggregate transition goal (4,194 transitions of 7,966 planned). (In 2008, not all grantees had yet implemented programs, so an aggregate rate of transition goal achievement was not calculated.)

States varied, however, in the degree to which they reached their 2010 transition goals (see Figure II.5 and Denny-Brown et al. [2011] for details). Seventeen states met or exceeded their total transition goals for 2010; Texas alone transitioned 876 more individuals during 2010 than its yearly goal. Five states (California, Illinois, Iowa, Kentucky, and Michigan) achieved between 50 and 99 percent of their 2010 goals. Five states (Delaware, Hawaii, Louisiana, North Carolina, and Oregon[10]) achieved between 25 and 50 percent of their 2010 transition goals, and three (District of Columbia, Nebraska, and Wisconsin) achieved less than 25 percent of their 2010 goals.

[9] One of the 31 initial state grantees has not yet implemented its MFP program; after subtracting that state's transition goals, the total among the 30 MFP grantees was 37,539.

[10] Oregon achieved 41 percent of its 2010 goal due to the suspension of the MFP program in the fall of 2010 after key management staff resigned; the state is conducting a comprehensive reassessment of the program and has not yet indicated when it will resume operations.

Figure II.5. Number of States Achieving 2010 Transition Goal Thresholds



Source: MFP semiannual web-based progress reports covering the January 1–June 30, 2010 and July 1–December 31, 2010 periods.

Despite overall success in achieving the aggregate transition goal in 2010, some states continued to report difficulties reaching their transition goals because of (1) the complex needs of the target population, (2) shortages of affordable and accessible qualified housing, (3) statutory restrictions on the types of residences that qualify for MFP, and (4) shortages of qualified community-based providers. Because the Affordable Care Act extended the MFP demonstration program and states have until the end of 2020 to expend their grant funds, more than two-thirds of current state MFP grantees indicated in early 2011 that they will revise annual transition goals in the future. Most are expected to increase the total number of planned transitions over the life of the MFP demonstration, since they have more time to achieve them.

D. Determinants of State Progress and Performance

To understand what accounts for differences in the progress of MFP programs, we sorted the 30 states into three groups—those making above-average, average, and below-average progress on three indicators of performance: (1) cumulative number of transitions to date, (2) percentage of long-term institutional residents eligible for MFP that were transitioned, and (3) rates of reinstitutionalization of 30 days or more among MFP participants. Table II.3 shows differences in the means of each indicator for each group of states (the 10 states in each of the top, middle, and bottom thirds) in December 2010.[11] We conducted interviews between March and May 2011 with representatives from 10 states, 5 with indicators frequently above average and 5 with indicators usually near the average, to understand and compare the program features and strategies that contributed to their progress to date.[12] We did not interview program

[11] States were selected based on their performance relative to other states as of June 2010, when selections were made. Some states moved into different groups at the end of 2010 because their performance improved or worsened relative to other states.

[12] This report conceals the identity of the 10 states included in this special study. We consulted with and obtained CMS' agreement on which states to include, but we assured state MFP representatives who participated in

representatives in states whose performance on the progress indicators was usually below average because the reasons for their lower performance were evident from information reported by state program officials in their semi-annual progress reports and were typically related to delays in start-up or gaps in program leadership.

Table II.3. MFP Performance Indicators as of December 2010, Averages for All States and by Quartile

Indicator	Cumulative MFP Transitions	MFP Transitions as a Share of MFP Eligibles in 2007*	Rate of Reinstitutionalizations (more than 30 days)
Average, All MFP States	397	1.62%	7.34%
Average Among States in:			
Top Third	960	3.33%	12.9%
Middle Third	219	1.06%	6.3%
Bottom Third	75	0.46%	2.8%

Source: Mathematica analysis of State MFP Grantee Semi-Annual Progress Reports, June 2008 to December 2010.

Note: For each indicator, a state may be in a different group. The ordering of states by average rate of reinstitutionalization has a different connotation (worst to best) than the other two indicators (best to worst).

* Not adjusted for states that are only targeting certain population groups, such as Iowa and Washington, DC, which target only participants with mental retardation/developmental disabilities; and New York, Indiana, and Michigan, which target only the aged and disabled in nursing facilities.

1. Findings

Several factors have contributed to differences in the pace of progress across MFP grantee states. States making greater progress up to this point in the demonstration generally had the following characteristics: (1) experience running transition programs prior to the start of MFP; (2) greater numbers of experienced transition coordinators; (3) strategic use of MFP demonstration funds to cover one-time moving costs and HCBS not included in the state's regular HCBS programs; (4) recruitment through direct contact with potential MFP participants; (5) strong and stable program leadership; (6) deployment of housing specialists to provide one-on-one assistance to MFP candidates in housing searches; and (7) supportive Medicaid HCBS policies.

Prior transition experience and capacity. As discussed in previous reports (Lipson and Williams 2009), states that had prior experience with transition programs before MFP began generally have been able to transition more people (or a greater percentage of those who were eligible for MFP in 2007) than those without as much experience. This experience gave states an advantage, by ensuring there were community agencies and staff who knew how to conduct transition planning and coordination, and providing a foundation to expand transition capacity throughout the state. Experienced transition coordinators can also train those with less experience and work with individuals living in institutions whose situation makes the transition to the community particularly challenging. States that began the MFP program with relatively

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(continued)

interviews that their identity and state would be kept confidential to encourage them to offer candid opinions about strengths and weaknesses of their MFP programs.

little experience and capacity needed more time to find qualified community organizations, train staff, and ensure they understood Medicaid and MFP rules as well as community resources. Once this capacity and skill was developed, transition numbers often rose quickly, as indicated by high rates of growth (over 100 percent or more than double) in the number of transitions from 2009 to 2010 for several states (see Table II.2). States in this group include California, Connecticut, Illinois, Indiana, Kentucky, Louisiana, New York, and Oklahoma.

Skilled, dedicated transition coordinators. Both the volume of transitions and the ability to live successfully in the community after the transition depend on the number, skills and knowledge, and the dedication of transition coordinators. State officials say that the number of transition staff needed in each state depends on the size of the state, MFP transition goals, expectations regarding caseload size, and the level of need of the targeted populations, which can change over time. The number of transition staff can also be affected by how the state manages the core functions of transition planning and coordination (see Table II.4). States use different ways of allocating these core functions across program staff. Some expect transition coordinators to perform all of the core functions, while others divide the functions across different positions. For example, some states expect transition coordinators to do outreach to potential MFP participants and find housing, while other states employ state administrative staff to carry out these functions.

Table II.4. Core Functions of Transition Planning and Coordination

1. Reach out to potential transition candidates
2. Conduct a comprehensive assessment of individuals who wish to move back to the community
3. Confirm Medicaid eligibility
4. Secure family or guardian agreement and support
5. Obtain approval for enrollment into HCBS waiver and eligibility for specific HCBS benefits
6. Search for and locate suitable housing
7. Arrange for home and community-based services and supports needed by each individual
8. Develop back-up plans

State program officials emphasized the importance of hiring transition staff with demonstrated knowledge and skill in developing care plans, understanding long-term care issues in both home and community-based services (HCBS) and institutional settings, and working with the target population. Besides experience, program officials at all levels in nearly every state cited dedication as one of the most important attributes of highly effective transition coordinators. They defined this trait as having the passion, commitment, and creativity to do whatever is needed to help anyone who wishes to return to the community. Other important attributes included strong client advocacy skills, the ability to communicate with people of all types, and being highly organized.

MFP Demonstration grant funds for one-time moving expenses and extra HCBS. When long-time residents of institutions move to the community, they often have one-time expenses associated with setting up a home, such as expenses for basic furnishings, security and utility deposits, groceries, moving, and environmental modifications to ensure accessibility. Many (though not all) MFP programs cover these one-time expenses as MFP demonstration services that receive an enhanced match or as supplemental HCBS that receive the state's regular federal match. About a third of state program officials interviewed cited the ability to fund demonstration and supplemental services as one of the biggest contributors to their progress. Because most MFP participants are unable to save funds while residing in an institution and

those eligible for Supplemental Security Income (SSI) benefits do not receive their cash benefits until after they move into the community, many states that did not cover one-time transition services under waivers found this resource extremely valuable. State program officials say it is not just the ability to provide demonstration and supplemental services that facilitates transitions to the community, but also the ability to authorize and pay for one-time expenses before someone moves out of the institution (which Medicaid rules do not typically allow). In addition, these services provide more flexibility for one-time expenses than Medicaid HCBS waiver funds. For example, program officials say the funds have been used to pay for medication boxes and delinquent telephone and utility bills that must be settled before someone can establish new service. Program officials in some states will allow MFP funds to be used for a second move, if the first community residence does not work well.

About a third of the state program leaders interviewed cite the availability of extra HCBS, provided as MFP demonstration or supplemental services, beyond what Medicaid would normally cover as one of the biggest contributors to their progress in helping people return to, and remain in, home and community settings. Both categories of services can be provided to MFP participants during the first 365 days of community living. Examples of such services include: intensive transition planning and coordination (beyond what can be covered under waivers); behavioral health services; overnight companions for individuals who need supervision and live alone; home health or personal care aide hours beyond the amount that waiver programs or state plans typically allow; and peer support to help acclimate to community living.

Recruitment through direct contact with potential MFP participants. While state MFP programs use different strategies to publicize the MFP program and its services, states making more progress stress two things: (1) continuous outreach is critical due to staff turnover and (2) direct contact with individuals in institutions is a more effective way to identify MFP candidates. For example, states that regularly send transition coordinators, outreach staff, and peer counselors (disabled individuals who moved out of facilities in the past) to institutions to meet with residents report greater success identifying people who want to move and who qualify for MFP. By contrast, sending letters to facility administrators, social work staff, or residents and presenting at state professional conferences are less effective strategies because such communications are easier to ignore or forget. In cases in which nursing home administrators are unwilling to allow staff into their facility to meet with residents, MFP program officials turn to ombudsmen, Medicaid officials, or state licensing officials to gain access. Revisions to the nursing home resident assessment (MDS 3.0 Section Q), which went into effect in October 2010, require residents to be asked directly if they want to speak with someone about moving back to the community. As a result, MFP program officials in most states say this new information has made MFP recruitment easier by opening doors that had previously been closed to transition staff and has already generated a surge of referrals to MFP.

MFP program leadership. Any new program needs strong leadership to get started, grow, and become established. The need for strong leadership is heightened by (1) the programs' dependence on cooperation from Medicaid HCBS waiver programs and operational staff, (2) extensive federal reporting requirements, and (3) the program's potential to disrupt or challenge entrenched interests. States that had made more progress by mid-2010 usually had project directors and supervisors who: (1) were with the program since it began; (2) had extensive knowledge of state Medicaid rules and systems; and (3) spent considerable time establishing relationships or building partnerships with other state agencies, local organizations, and consumer and provider stakeholders. By contrast, states in which there was turnover in the MFP

project director, or where MFP program leaders did not have prior Medicaid experience, were more likely to encounter resistance that slowed progress.

Housing Specialists. By far, the biggest obstacle to greater progress in helping more people living in institutions move to the community is the shortage of affordable, accessible housing that meets the criteria for qualified MFP residences (homes, apartments, group homes of four or fewer individuals, and in some circumstances, assisted living facilities). Over half of the MFP program officials in the 10 states we interviewed cited housing as the biggest hindrance to more progress. States that are making more progress attribute their success, in part, to housing specialists who have been assigned to work with local transition coordinators in providing one-on-one help to MFP participants and building relationships with local public housing authorities. Housing specialists relieve transition coordinators of the need to become experts in complex housing regulations and programs. Many MFP states recently hired, or plan to hire, housing specialists with 100 percent federal MFP funding, so the experience of states that began using federal funds for this purpose earlier in the program indicates that states starting to do so can expect to see greater progress in the future.

State Medicaid long-term care policies. A variety of state long-term care policies appear to have had a beneficial effect on the number of MFP transitions in some states. These include: (1) court orders and settlement agreements resulting from legal cases that require ICFs-MR to close or downsize, which caused states to ask MFP programs to help transition people living in the affected institutions; (2) state Medicaid rules that allow people transitioning from institutions to bypass waiting lists to enroll in Medicaid HCBS waiver programs; and (3) multiple transition programs so that the state can offer help to anyone regardless of whether they qualify for MFP. According to one state Medicaid official, this policy "casts a wide net," thereby increasing the opportunity for states to find those who *do* qualify for MFP. It also signals a strong commitment by the state to ensure everyone has a choice about where they wish to live and receive long-term services and supports.

2. Conclusions

At the time of this study, there do not appear to be striking differences in the features or strategies used by states making more or less progress. Yet, some patterns emerged that suggest factors that (1) might distinguish the two sets of states and (2) seem important to progress at different stages in the program's evolution. The factors mentioned here merit further study in all MFP grantee states:[13]

- **States with above-average performance.** These states usually had a strong foundation at the start of the MFP program—previous transition program experience for residents of ICFs-MR and nursing homes; existing transition coordination capacity in all or most regions within the state; experienced, skilled transition coordination staff, complemented by housing specialists; and strong stable program leadership and support. To maintain their status as the strongest performers relative to other state MFP programs depends on the continuation of these factors, as well as

[13] A forthcoming Report from the Field will provide more detail on how state respondents in the 10 states rated the importance of program components during start-up and scaling-up.

the ability to keep MFP a priority in a changing policy or political environment, protect it from detrimental budget cuts, and increase affordable housing options to accommodate people with complex needs.

- **States with average performance.** These states often had little previous experience with transitions for nursing facility residents (though most had programs to transition residents of ICFs-MR), or their experience with nursing facility transitions was limited to a few regions within the state. This meant that, for most of these states, it took longer to put a foundation in place for transition coordination. In addition, their approach to publicizing MFP was more "scattershot," involving letters or brochures, and less likely to involve direct outreach to residents. In the future, however, the implementation of MDS 3.0 Section Q is likely to increase direct contact with residents in all states. In two of the states in this group, there was a change in MFP director, or an acting project director without authority, and in another two states, the MFP program did not have strong or consistent support from Medicaid agency leaders. The good news is that these disadvantages can be overcome. For example, in one state, when a new project director came on board with more experience and understanding of state Medicaid HCBS programs, progress accelerated.[14]
- **States with below-average performance.** Progress in nine states had slowed or stalled in mid-2010 because of program management issues, rather than serious flaws in their transition programs. All of the states in this group began program operations later than those in the first two groups for various reasons. For example, some of these states needed to contract with local transition agencies or with vendors to conduct Quality of Life surveys but encountered delays in state procurement processes. Other states in this group faced roadblocks in trying to make changes to the state Medicaid Management Information System to fulfill MFP financial reporting requirements. Three states did not have a full-time MFP project director for long periods of time. Several did not have HCBS waiver programs (or slots in existing waiver programs) to serve MFP participants in particular target groups, so these programs began transitioning the populations they could serve right away while they worked on establishing the necessary waiver programs for the other targeted populations they wanted to serve. While three of the nine states are still struggling to address some of these problems, the remaining six were able to make up lost ground and were showing signs of accelerating progress at the time of the study.[15]

Sustained progress in MFP transition programs may depend on states' ability to continually expand and strengthen these core elements: experienced, skilled, and dedicated transition coordinators; flexibility in the use of one-time moving expenses; supplemental HCBS; stable, knowledgeable program leaders; and strong links to the housing sector.

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[14] In an indication of accelerating progress, two of the states in the "average performance" group had annual transition growth rates from 2009 to 2010 that more than doubled (see Table II.2).

[15] Six of the states in the "below average" group were in the top 10 states in terms of their annual transition growth rate from 2009 to 2010. But most of them began their programs in 2009, so in many cases, 2009 numbers do not reflect the entire year, which artificially inflates the annual rate of increase in 2010.

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III. PARTICIPANT CHARACTERISTICS AND HCBS EXPENDITURES

A. Overview

To better understand who is benefiting from the MFP program during its initial years, this chapter provides some information on the small demographic shifts that are occurring in the program and explores the demographic characteristics of MFP participants. The first section of this chapter profiles MFP participants who transitioned through December 2010. It describes their demographic characteristics, the types of institutions in which they resided before their transition, and community living arrangements. Although the subgroups targeted by MFP programs shifted somewhat during 2010, as shown in Chapter II, the age and gender distributions have not changed during the first three years of the demonstration. However, a slightly higher proportion of the elderly and younger beneficiaries with physical disabilities transitioned to apartment living compared to what was observed in 2009 and earlier. The second section of this chapter reports MFP program expenditures on HCBS through the end of calendar year 2010. This section provides overall and per-participant expenditures by state, the proportion of expenditures in each category of HCBS (qualified HCBS, demonstration HCBS, and supplemental services), and the cumulative growth in expenditures. Preliminary data suggest HCBS spending for MFP participants is about 21 percent lower than the average per resident spending among elderly in nursing homes. While the majority of HCBS spending for MFP participants is on qualified HCBS, most states are providing additional services that are not otherwise available to Medicaid beneficiaries who are not in the MFP program.

B. MFP Participant Characteristics

The analyses presented in this section are based on individual enrollment records MFP programs submit to CMS on a quarterly basis. At the time this report was written, we had records for 11,252 of the 11,924 participants (94 percent). While individual records provide the flexibility needed to evaluate the program, the records do not always contain all the detailed information desired. For example, the available data for these analyses do not identify participants with mental illness, unless they were transitioned from an institution for mental diseases (IMD). As a result, the results in this section underreport the number of participants with mental illness. In addition, some records lack information about the institution from which the participant transitioned, which results in a distribution of MFP participants across the targeted populations that differs somewhat from the distribution reported in Chapter II.

1. Demographic Characteristics

During 2010, the age and gender composition of MFP participants did not change significantly; the majority of MFP participants (64 percent) continue to be beneficiaries under age 65 (Table III.1). In general, the MFP program is transitioning few beneficiaries who are age 21 or younger; this is to be expected, since less than 1 percent of persons eligible to enroll in MFP belong to this age group (Wenzlow and Lipson 2009). The few young adults, adolescents, and children who have been MFP participants are clustered among beneficiaries with intellectual disabilities and those in the other targeted populations, which includes individuals with mental illness or those with long hospital stays. At the other end of the age distribution, more than 850 individuals older than 85 years of age transitioned to the community through the MFP program (the oldest person to transition was 105 years old), with a third of those transitions occurring in Texas (state-level data not shown). Those with missing information about the institution from

which they transitioned appear to be somewhat older than the overall population of MFP participants; approximately 41 percent are age 65 or older compared to 36 percent of all MFP participants.

On the whole, MFP participants are evenly split between males and females (Table III.1). Within each target population, the gender distribution varies. Of the elderly MFP participants, about 63 percent are female; three-quarters of the persons age 85 and older who made a transition were female. Among those with intellectual disabilities, the gender distribution is reversed, with a majority being male. The gender distribution is more balanced among the nonelderly with physical disabilities.

Table III.1. Demographic Characteristics of MFP Participants from 2008 to 2010[a] (Percentages Unless Otherwise Indicated)

Characteristic	All MFP Participants	Elderly	PD	MR/DD	Other[b]	Unknown
Total	**11,262**	**3,288**	**4,213**	**2,532**	**191**	**1,038**
Age						
<21	2.6	0.0	0.8	7.4	16.2	4.3
21-44	18.1	0.0	19.1	41.2	20.4	14.2
45-64	43.5	0.0	79.9	41.2	35.1	40.5
65-84	28.0	77.9	0.0	9.0	19.4	31.9
85+	7.5	22.1	0.0	0.3	8.4	9.2
Unknown	0.3	0.0	0.1	0.9	0.5	0.0
Gender						
Female	49.0	63.4	45.2	35.6	48.2	51.5
Male	51.0	36.6	54.7	64.4	51.8	48.6
Unknown	0.0	0.1	0.0	0.0	0.0	0.0

Source: Mathematica analysis of MFP Program Participation Data files.

Note: Virginia was not included in the analysis because its data were not available at the time of this report. Data were only available through the end of 2009 for the District of Columbia and Michigan; through the end of March 2010 for New Hampshire; through the end of June 2010 for Arkansas; and through the end of September 2010 for Indiana, Maryland, and North Carolina.

[a]Includes everyone who was an MFP participant in calendar year 2010 regardless of when the initial transition occurred.

[b]The Other category includes nine individuals in the population with mental illness.

PD=nonelderly participants who transitioned from nursing homes; MR/DD=participants with intellectual disabilities.

2. Community Living Arrangements

MFP participants have been fairly evenly distributed across homes, apartments, and group homes (Table III.2). The distribution of community living arrangements, however, varied across target populations. The majority of the elderly and younger beneficiaries with physical disabilities transitioned to homes owned by themselves or a family member or to apartments, while those with intellectual disabilities primarily transitioned to group homes.

Based on the available data, it appears that few participants lived with family members after they transitioned to community living. However, grantees have been struggling to track this information, and nearly half of the enrollment records lack detailed information on living arrangements. MFP participants in the youngest and oldest age groups are most likely to live at home (data not shown); for example, roughly 40 percent of participants older than age 85 live

with family members whereas less than 20 percent of persons ages 21 to 64 do so (data not shown).

Table III.2. Living Arrangements of MFP Participants from 2008 to 2010[a] (Percentages Unless Otherwise Indicated)

Characteristic	All MFP Participants	Elderly	PD	MR/DD	Other[b]	Unknown
Total Number	**11,262**	**3,288**	**4,213**	**2,532**	**191**	**1,038**
Type of Qualified Residence						
Home[c]	26.9	46.2	30.0	3.0	17.8	13.3
Apartment	27.6	22.5	42.1	13.4	13.1	22.5
Assisted Living	9.0	14.3	9.9	3.0	3.7	4.2
Group Home[d]	23.9	7.4	7.9	75.6	10.0	18.0
Unknown	12.6	9.7	10.2	5.0	55.5	41.9
Lives with a Family Member						
Yes	10.1	15.0	11.7	1.4	18.3	7.2
No	45.3	36.7	53.2	46.5	25.7	40.9
Unknown	44.7	48.3	35.1	52.1	56.0	51.9

Source: Mathematica analysis of MFP Program Participation Data files.

Note: Virginia was not included in the analysis because its data were not available at the time of this report. Data were only available through the end of 2009 for the District of Columbia and Michigan; through the end of March 2010 for New Hampshire; through the end of June 2010 for Arkansas; and through the end of September 2010 for Indiana, Maryland, and North Carolina.

[a]Includes everyone who was an MFP participant in calendar year 2010 regardless of when the initial transition occurred.

[b]The Other category includes nine individuals in population with mental illness.

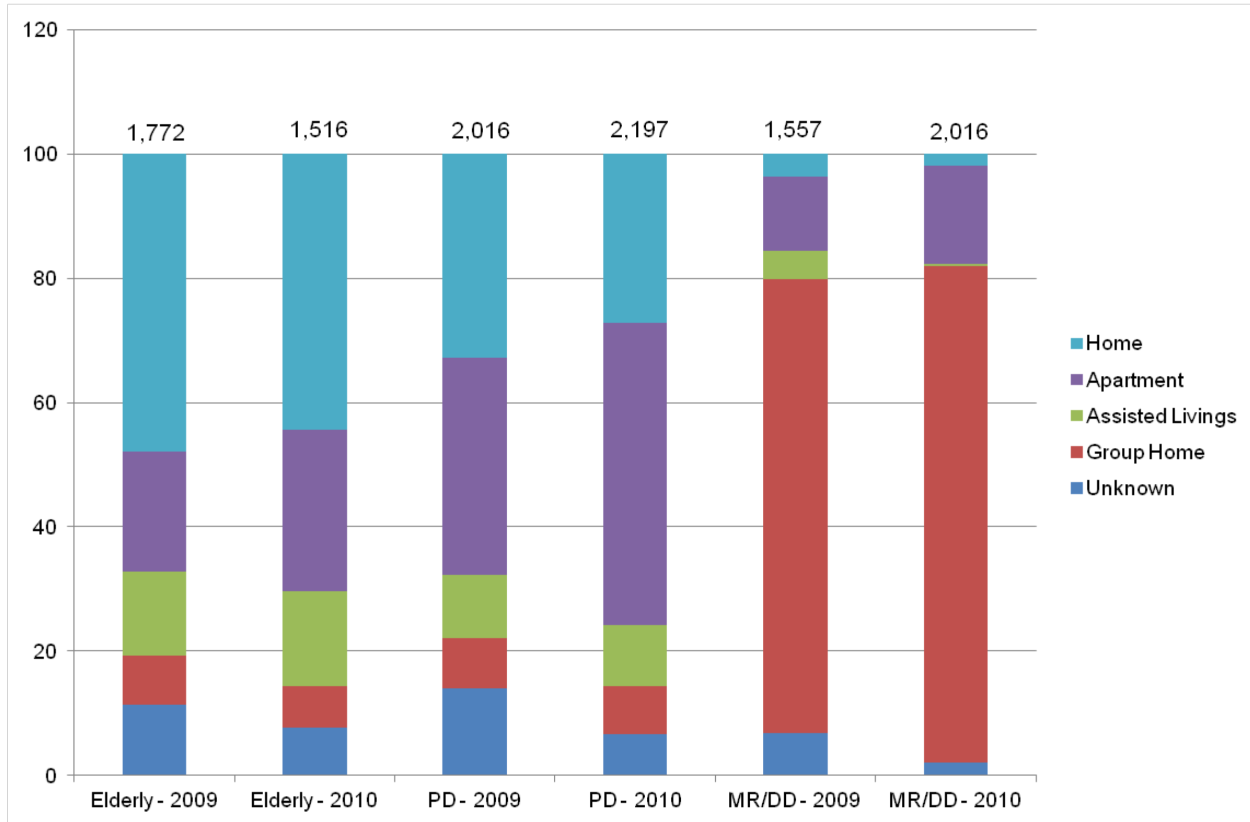
[c]Home owned by the participant or by a family member.

[d]Group home of no more than four people.

PD=nonelderly participants who transitioned from nursing homes; MR/DD=participants with intellectual disabilities.

The living arrangements of MFP participants appear to have shifted somewhat in 2010 (see Figure III.1). Both the elderly and those under 65 with physical disabilities were more likely to move to apartments and less likely to move to a home in 2010 compared to 2009. Those with intellectual disabilities continue to move to group homes in large proportions. At this point it is difficult to assess the significance of these trends, but they suggest that fewer participants had homes to which they could transition in 2010 and that apartment living became more important during the year, at least among some of the targeted populations. It is possible that, when programs were first starting, their outreach and marketing efforts were able to quickly identify those beneficiaries who either still owned a home or had family members willing and able to provide a home for them. In addition, programs are building capacity regarding housing and how to identify and obtain affordable and accessible housing for those who do not have the option of transitioning to a home that either they or a family member owns.

Figure III.1. Change in the Distribution of Community Living Arrangements by Target Group, 2009 to 2010[a]



Source: Mathematica analysis of the MFP Program Participation Data files.

Note: Virginia was not included in the analysis because its data were not available at the time of this report. Data were only available through the end of 2009 for the District of Columbia and Michigan; through the end of March 2010 for New Hampshire; through the end of June 2010 for Arkansas; and through the end of September 2010 for Indiana, Maryland, and North Carolina.

[a]Includes everyone who was an MFP participant in calendar year 2010 regardless of when the initial transition occurred.

PD=nonelderly participants who transitioned from nursing homes; MR/DD=participants with intellectual disabilities

C. MFP Services Expenditures

1. State-by-State MFP Expenditures

The MFP demonstration presents an important opportunity to determine whether it is cost-effective to serve Medicaid beneficiaries who currently reside in institutions in community settings. Using aggregate data from state budget worksheets, HCBS expenditures for MFP participants reveal large variation across the states. On average, total HCBS expenditures have been approximately $30,813 per MFP participant transitioned by the end of December 2010 (Table III.3). This amount is 3 percent higher than the average as of the end of 2009, which was $29,898 (see Irvin et al. 2010).

Table III.3. MFP Expenditures, 2007-2010

State	Number of Transitions	Average HCBS Spending (in dollars) per MFP Participant
Total	11,849	30,813
Arkansas	150	17,793
California	401	22,000
Connecticut	405	22,875
Delaware	38	34,579
District of Columbia	--	--
Georgia	442	39,239
Hawaii	70	15,953
Illinois	233	10,347
Indiana	287	11,277
Iowa	118	61,264
Kansas	343	29,425
Kentucky	156	38,439
Louisiana	90	27,390
Maryland	799	49,403
Michigan	640	16,973
Missouri	285	46,581
Nebraska	102	41,557
New Hampshire	72	37,220
New Jersey	157	28,496
New York	256	52,611
North Carolina	60	23,352
North Dakota	43	43,600
Ohio	850	53,773
Oklahoma	152	33,042
Oregon	299	53,898
Pennsylvania	578	15,544
Texas	3,579	24,700
Virginia	218	67,136
Washington	949	19,033
Wisconsin	77	58,505

Source: Mathematica analysis of MFP 2011 Budget Worksheets for HCBS expenditures. Enrollment data from the MFP semiannual web-based progress report cover the July1-December 31, 2010 period. Submitted February 28, 2011.

Note: The 2011 Budget Worksheet for the District of Columbia contained inaccuracies and was excluded from the analysis.

Comparing the average MFP expenditures to national estimates for HCBS and institutional long-term care provides a context for these estimates. According to the latest available data, mean HCBS spending for beneficiaries in 1915(c) waiver programs was $23,155 per person in 2007 (Ng, Harrington, and Howard 2011). Only nine (approximately one-third of grantees) MFP programs have per-person service expenditures less than this national average: Arkansas, California, Connecticut, Hawaii, Illinois, Indiana, Michigan, Pennsylvania, and Washington. Compared to average annual Medicaid spending on institutional care for elderly individuals

residing in nursing homes for three months, average annual spending on HCBS for MFP participants is 35 percent lower, $30,813 compared to $47,231[16] per person in 2006 (Mathematica calculation, inflated to 2010 US dollars). In addition, 22 of 29 states had average annual spending on HCBS at or below the national average for nursing home care.[17]

Differences in average state HCBS spending on MFP participants may be attributable to several factors. States can choose the services they want to offer and have discretion on how to classify them into the categories of qualified HCBS, demonstration, or supplemental services. The services offered most likely reflect the needs of the population that an MFP program targets and the types of additional HCBS required to serve these needs and are not already part of a state's array of HCBS for regular Medicaid beneficiaries. In addition, state grantees are transitioning different types of populations, and those that have higher proportions of enrollees with intellectual disabilities, who typically use a more costly array of services than older adults and younger individuals with physical disabilities, would be expected to have higher per participant costs. This observed state variation underscores the need to control for variation in participants' health and functional levels whenever program costs are analyzed and future analyses will address this deficiency. In addition to differences in the populations served, variation in state MFP spending on HCBS may also be due to differences in the mix of services covered, the volume of services provided, and provider payment rates.

2. MFP Expenditures by Federal Medical Assistance Percentage (FMAP) Group

One reason for the variation in average MFP expenditures by state is the type of services provided to program participants. MFP demonstration programs can offer a variety of services grouped into three FMAP categories: (1) qualified HCBS, (2) HCBS demonstration services, and (3) one-time supplemental services that support transitions to the community. Qualified HCBS are services that the state provides to all Medicaid beneficiaries who need these services either through their state plan or through HCBS waivers, regardless of their participation in the MFP program. States also have the option to offer MFP-specific HCBS benefits to MFP participants that are not otherwise available to regular Medicaid beneficiaries. Examples may include extra hours of personal care assistance beyond what is allowed or a specific type of behavioral health service. Lastly, states may provide supplemental services as one-time benefits to support the transition back into the community that are typically not allowable Medicaid-covered services (such as payment of overdue electrical bills). States are not required to provide HCBS demonstration or supplemental services. All qualified HCBS and demonstration services provided to MFP participants are reimbursed at an enhanced Federal Medical Assistance Percentage, making it appealing for states to offer either or both categories of services. States receive their regular FMAP for the supplemental services they provide.

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[16] Inflated to 2010 U.S. dollars using the Medical Care consumer price index from the U.S. Bureau of Labor Statistics website [http://www.bls.gov/cpi/cpi_dr.htm].

[17] The reported information is based on Mathematica analyses of MAX 2006 data. The 2006 spending amount is provided to illustrate the difference in spending between institutional and HCBS care; Medicaid spending per long-term institutional resident would be higher if it included Medicaid costs for long-term residents of ICFs-MR. Future analyses in this evaluation will compare Medicaid spending per user for all long-term institutional long-term care users to HCBS spending per MFP enrollee.

Approximately two of every three dollars spent on MFP are for qualified HCBS, but the proportion spent on each category varies by state (Table III.4). Nine states offer qualified HCBS exclusively, and Texas only provides HCBS demonstration services. Connecticut, Delaware, and Indiana spend a disproportionately large share of their expenditures on supplemental services to aid the transition to the community. Despite a disproportionately large share of expenditures going to qualified HCBS, states are using MFP funds to provide additional services. Twenty-one states offer some type of additional services, 19 states offer HCBS demonstration services, 15 states offer supplemental services, and 13 offer both demonstration and supplemental services.

Table III.4. Total MFP Expenditures and Proportion in Each FMAP Category, 2007-2010

State	Total MFP Expenditures 2007-2010 (dollars)	Percentage of Expenditures for Qualified HCBS	Percentage of Expenditures for Demonstration HCBS	Percentage of Expenditures for Supplemental Services
Total	**365,106,711**	**66.8**	**28.7**	**4.4**
Arkansas	2,669,000	79.6	20.4	0.0
California	8,822,090	93.6	6.4	0.0
Connecticut	9,264,507	64.6	2.6	32.8
Delaware	1,314,020	26.7	38.7	34.5
District of Columbia	--	--	--	--
Georgia	17,343,691	94.4	4.6	1.0
Hawaii	1,117,590	97.5	2.5	0.0
Illinois	2,410,840	86.1	3.5	10.3
Indiana	3,236,561	58.9	1.1	40.1
Iowa	7,229,108	94.1	4.0	1.9
Kansas	10,092,712	92.0	7.8	0.2
Kentucky	5,996,439	97.0	0.0	3.0
Louisiana	2,465,118	100.0	0.0	0.0
Maryland	39,472,971	100.0	0.0	0.0
Michigan	10,862,601	100.0	0.0	0.0
Missouri	13,275,711	99.4	0.3	0.3
Nebraska	4,238,779	100.0	0.0	0.0
New Hampshire	2,679,832	98.1	1.4	0.6
New Jersey	4,473,874	100.0	0.0	0.0
New York	13,468,291	100.0	0.0	0.0
North Carolina	1,401,143	98.6	1.4	0.0
North Dakota	1,874,821	90.2	4.4	5.5
Ohio	45,706,950	68.3	14.9	16.8
Oklahoma	5,022,455	100.0	0.0	0.0
Oregon	16,115,538	88.2	0.0	11.8
Pennsylvania	8,984,149	100.0	0.0	0.0
Texas	88,400,062	0.0	100.0	0.0
Virginia	14,635,585	75.7	17.6	6.7
Washington	18,062,411	83.7	15.7	0.6
Wisconsin	4,469,862	100.0	0.0	0.0

Source: Mathematica analysis of MFP Budget Worksheets for 2011.

Note: The 2011 Budget Worksheet for the District of Columbia contained inaccuracies and was excluded from the analysis.

FMAP = Federal Medical Assistance Percentage; HCBS = home and community-based services.

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IV. POST-TRANSITION OUTCOMES OF MFP PARTICIPANTS

By the end of 2010, a large enough number of people had been transitioned by MFP programs to make analyses of post-transition outcomes feasible for the first time. This chapter presents a descriptive assessment of two outcomes: (1) reinstitutionalization and (2) mortality. We estimate rates of these outcomes for the overall population of MFP participants and, to assess state-level variation, for 10 grantee states. To provide context for these estimates, we also compare outcomes of MFP participants to those of Medicaid beneficiaries transitioning from institutions to home and community-based services (HCBS) prior to the demonstration. In general, we find lower rates of reinstitutionalization and death among MFP participants than among Medicaid beneficiaries who transitioned during the baseline period before MFP was established. However, until the evaluation obtains data needed to control for differences in key characteristics between MFP participants and the comparison groups, our results cannot be interpreted as evidence that MFP programs are improving post-transition outcomes.

A. Rates of Reinstitutionalization and Death

By the end of 2010, almost 12,000 people had transitioned from institutions to the community through MFP, and for about half of these MFP participants, over a year had passed since their initial transitions (Denny-Brown et al. 2011). This subgroup of MFP participants—those who had at least a year of experience since their initial transition to the community—is the focus of our analysis. We examined how this subgroup of participants fared in the year after their transition to the community in terms of three mutually exclusive outcomes:

- **Reinstitutionalization**. Participant returned to a nursing home, hospital, or intermediate care facility for the mentally retarded (ICF-MR) during the year and stayed for at least 30 days.[18]
- **Death**. Participant was not readmitted to an institution for at least 30 days but died during the year.[19]
- **Remaining in the community.** Participant remained in the community for the full year after transition and is not included in the two other groups.

Although the characteristics of the initial group of MFP participants may not reflect those of all MFP participants served to date, their post-transition experiences provide insight into what happens to participants during their first year of MFP participation.

1. Transition Outcomes by Subgroup

Across 25 grantee states, there were 4,746 MFP participants who had reentered the community by March 2010 and for whom we had sufficient post-transition data.[20] Our sample

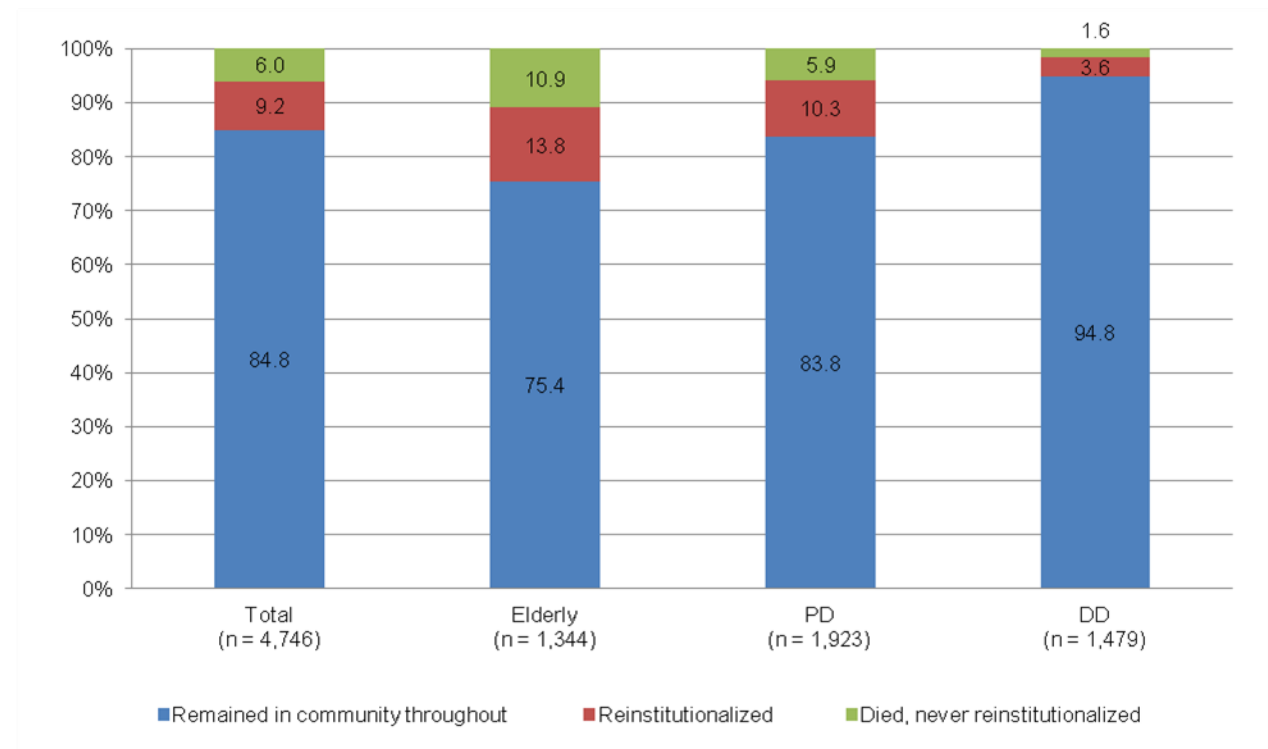
[18] CMS specified the 30-day institutional stay requirement for grantee reporting purposes to differentiate short-term nursing home, hospital, or ICF-MR stays from long-term readmissions. In future work, the national evaluation will also assess the degree to which MFP participants returned to institutions for less than 30 days.

[19] Death should not be strictly considered a poor outcome. Some participants may wish to spend their final days in a community setting, which they may see as preferable to dying in an institution.

only includes the elderly who were 65 or older, people under 65 with physical disabilities, and people with intellectual disabilities, because up to this time almost all (98 percent) of the MFP participants came from these three MFP subgroups (Lipson and Williams 2011). (People with mental illness made up the remaining 2 percent.)

Within a year of their transition, about 9 percent of MFP participants had been reinstitutionalized with stays of 30 days or more, 6 percent had died, and 85 percent had successfully remained in the community for a full year after their transition (Figure IV.1). As would be expected, reinstitutionalization and death were most common among the elderly. About 14 percent of the elderly returned to an institution, compared to 10 percent of people with physical disabilities and only 4 percent of those with intellectual disabilities. Mortality rates were lower; about 11 percent of the elderly died within the year, compared to only 6 percent of people with physical disabilities and 2 percent of people with intellectual disabilities.

Figure IV.1. Outcomes of MFP Participants in the Year After Transitioning to the Community, Overall and by Subgroup



Sources: Mathematica's analysis of 2008–2010 MFP Program Participation Data Files for 25 MFP grantee states (excludes Arkansas, Delaware, Louisiana, Pennsylvania, and Virginia due to insufficient data).

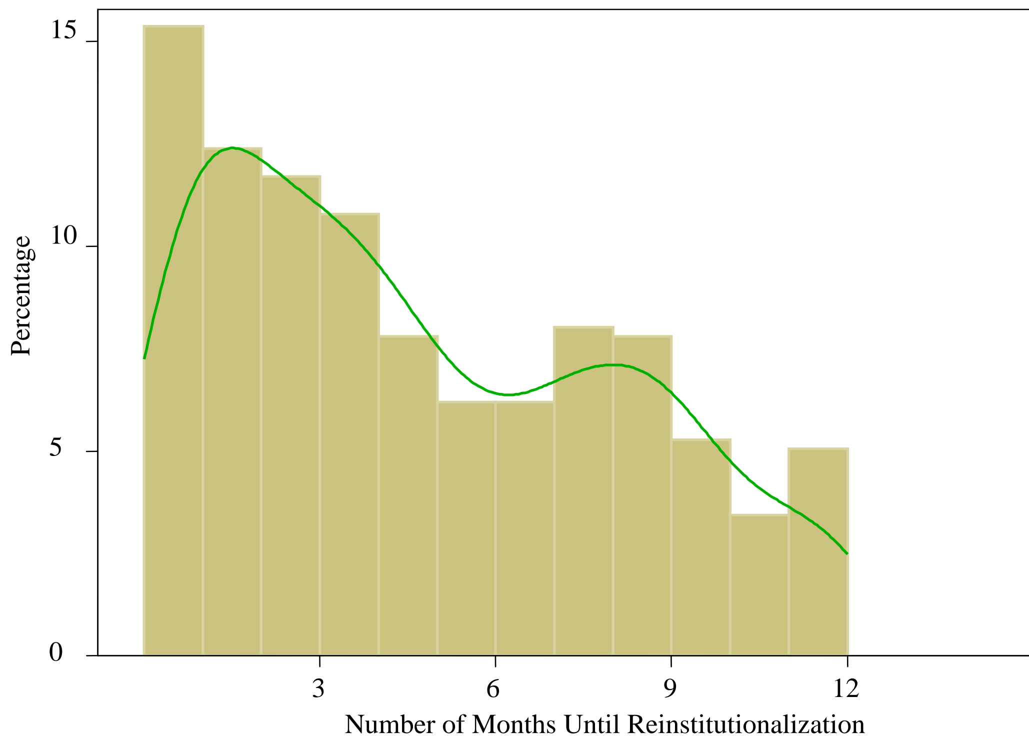
DD = developmental disability (people who transitioned from an ICF-MR); elderly = people age 65 or older who transitioned from a nursing home; PD = physical disability (people under age 65 who transitioned from a nursing home).

(continued)

[20] To present one-year outcomes, we only included in our analysis people for whom we had 13 months of data because grantees identify reinstitutionalized participants only if they remain in an institution for at least 30 days. The 25 grantee states included in this study are California, Connecticut, the District of Columbia, Georgia, Hawaii, Iowa, Illinois, Indiana, Kansas, Kentucky, Maryland, Michigan, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Texas, Washington, and Wisconsin. Five grantee states—Arkansas, Delaware, Louisiana, Pennsylvania, and Virginia—were excluded due to insufficient data.

Most MFP participants remained in the community for a full year, but when reinstitutionalizations occurred, they tended to happen during the first six months after transition, and were most likely to occur within the first three months (Figure IV.2). Of those reinstitutionalized, about 39 percent returned to a nursing home, hospital, or ICF-MR within the first three months of their transition and another 25 percent returned during the second three months. We found no discernable pattern in the amount of time an MFP participant remained in the community before death.

Figure IV.2. Distribution of Months Spent in the Community Before Reinstitutionalization Among MFP Participants



Source: Mathematica's analysis of 2008–2010 MFP Program Participation Data Files for 25 MFP grantee states (excludes Arkansas, Delaware, Louisiana, Pennsylvania, and Virginia due to insufficient data).

Note: The figure presents the frequency distribution and the kernel density curve (a smoothed probability density function estimate) for the number of months until reinstitutionalization.

2. Transition Outcomes by State

Grantee states vary substantially in the number and type of people they transition under MFP (see discussion in Section A.3 of Chapter II). Some were only beginning to implement their programs in 2009 and, at the time of this analysis, only a small number of MFP participants had completed a year of participation in these states. However, 10 grantee states, accounting for 4,246 (89 percent) of the 4,746 participants in our sample, had more than 100 MFP participants with post-transition outcome information for a full year. For these grantees, we examined cross-state variation in reinstitutionalizations and deaths.

We expect transition outcomes to vary across the MFP subgroups—aged in nursing homes, people under 65 in nursing homes, or those in ICFs-MR—and thus across states. In our sample,

a higher than average percentage of participants were elderly people who left nursing homes in Connecticut, New York, Oregon, Texas, and Washington, whereas more than half of the participants in Georgia and Kansas transitioned from ICFs-MR (Table IV.1). The distribution of participants in the remaining states—Maryland, Missouri, Ohio, and 15 states combined (each with fewer than 100 participants)—fell between these two extremes.

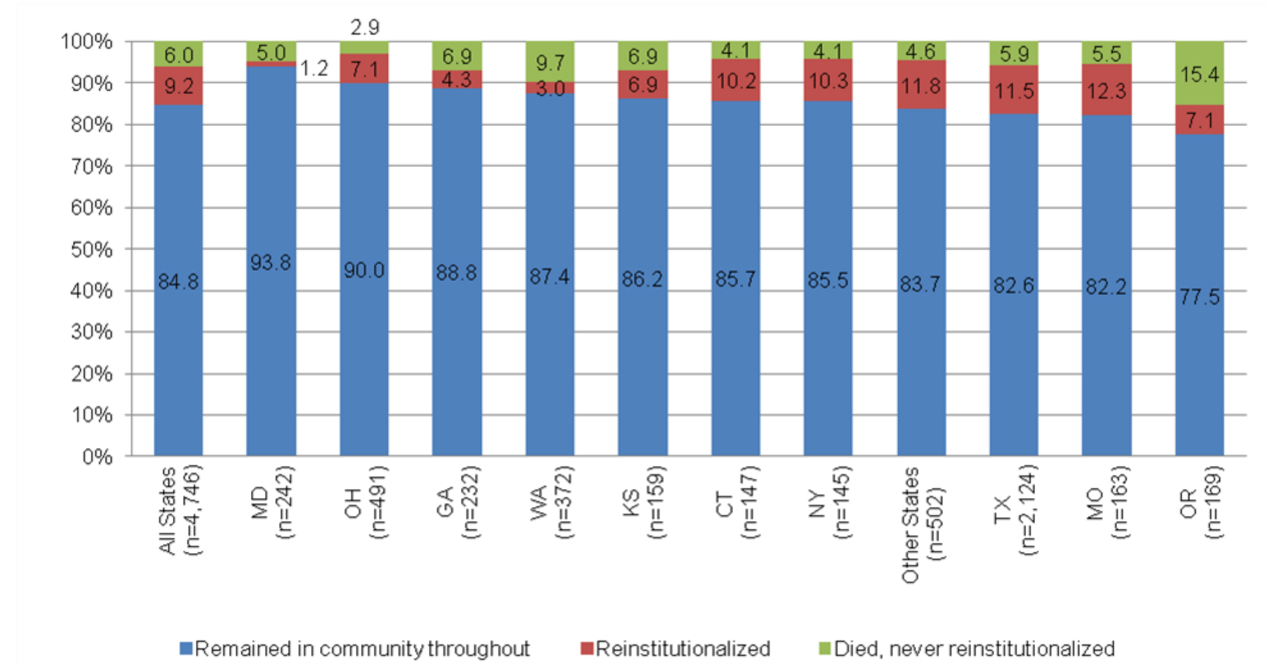
Table IV.1. Number and Characteristics of MFP Participants with More Than One Year of Post-Transition Outcome Data, Overall and by State

State	Number of MFP Participants	Percentage Leaving Nursing Homes, 65+	Percentage Leaving Nursing Homes, <65	Percentage Leaving ICFs-MR
Total	**4,746**	**28.3**	**40.5**	**31.2**
Connecticut	147	40.8	58.5	0.7
Georgia	232	15.1	28.9	56.0
Kansas	159	17.0	27.7	55.3
Maryland	242	20.2	55.8	24.0
Missouri	163	11.7	46.0	42.3
New York	145	31.7	68.3	0.0
Ohio	491	10.4	49.7	39.9
Oregon	169	30.2	49.7	20.1
Texas	2,124	34.4	32.8	32.8
Washington	372	39.5	53.5	7.0
15 Other States	502	25.7	38.4	35.9

Source: Mathematica's analysis of 2008–2010 MFP Program Participation Data Files for 25 MFP grantee states (excludes Arkansas, Delaware, Louisiana, Pennsylvania, and Virginia due to insufficient data).

Across the 10 study states, reported reinstitutionalizations ranged from only 1 percent of participants in Maryland to 12 percent in Missouri (Figure IV.3). Only 3 percent of enrollees in Ohio died during the year after beginning their participation in MFP, compared with 15 percent in Oregon. Generally, grantee states with older participants tended to have higher rates of reinstitutionalization, and those primarily serving people leaving ICFs-MR had lower rates of reinstitutionalization. Overall, however, the percentage of participants remaining in the community for a full year was above the national MFP average (85 percent) in 7 of the 10 states. This suggests that, in states with more established MFP programs (as measured by larger sample sizes), participants were more likely to remain in the community throughout the year. In the other 15 grantee states with smaller numbers of enrollees, about 12 percent of participants were reinstitutionalized, 5 percent died, and 84 percent remained in the community.

Figure IV.3. Outcomes of MFP Participants During the Year After Transition, Overall and by State, Ordered by the Percentage Remaining in the Community



Source: Mathematica's analysis of 2008–2010 MFP Program Participation Data Files for 25 MFP grantee states (excludes Arkansas, Delaware, Louisiana, Pennsylvania, and Virginia due to insufficient data).

Texas, which accounted for 2,124 (45 percent) of our sample MFP participants, had a higher than average rate of reinstitutionalization. Despite the large percentage of elderly among its participants, we hypothesized that reinstitutionalization rates would instead be lower in Texas than in other states due to Texas' experience running two transition programs prior to the MFP demonstration (Texas Health and Human Services Commission et al. 2009). Two reasons could potentially explain the unexpected pattern: (1) Texas may have already transitioned less difficult cases under its earlier program and, unlike other states, had to focus on elderly and disabled populations with higher care needs under MFP; and (2) reinstitutionalizations and deaths may be underreported in other states. In future work, we will use information from Medicaid and Medicare eligibility and claims records to better control for differences in observed characteristics of people enrolled in MFP and the comparison group, and to confirm reinstitutionalizations and deaths to more consistently measure outcomes across states.

Small sample sizes precluded us from estimating reinstitutionalization and death rates by MFP subgroup by state.

B. MFP Participants' Experiences Transitioning to Community Living Compared to Those of Other Enrollees

To shed light on whether MFP might be helping Medicaid beneficiaries remain in the community longer, we compared the characteristics and post-transition outcomes of MFP participants to those of Medicaid beneficiaries who transitioned to the community and used HCBS before MFP began. To make these comparisons more meaningful, we selected

beneficiaries who were enrolled in Medicaid in 2006 and (1) lived in the 25 grantee states included in our sample, (2) would have been eligible for MFP had the program existed in 2006 (that is, they had been institutionalized for six months or more),[21] and (3) used Section 1915(c) waiver services or state plan HCBS (including personal care, home health for at least three months, home-based private duty nursing, residential care, or adult day care, but not hospice).[22]

We obtained information on the comparison group from the 2006 Medicaid Analytic eXtract (MAX) data system. We occasionally found that institutional claims were missing for a given month and state in MAX. To account for these missing claims, we limited both groups to people who lived in the community for at least 60 days following discharge from an institution. The analysis below is based on 4,562 MFP participants and 12,849 MFP-eligible beneficiaries who transitioned to community care in 2006 across the 25 grantee states.

We caution that we cannot necessarily credit MFP with any observed differences in outcomes between MFP participants and the pre-MFP comparison group because we were unable to adjust for several important characteristics—including age, health status, and length of time in an institution—that are likely to affect the outcomes of people leaving institutions. Despite this limitation, the comparisons presented here provide early descriptive evidence of how MFP participants may differ from other people who leave institutions and the degree to which they are able to remain in their communities.

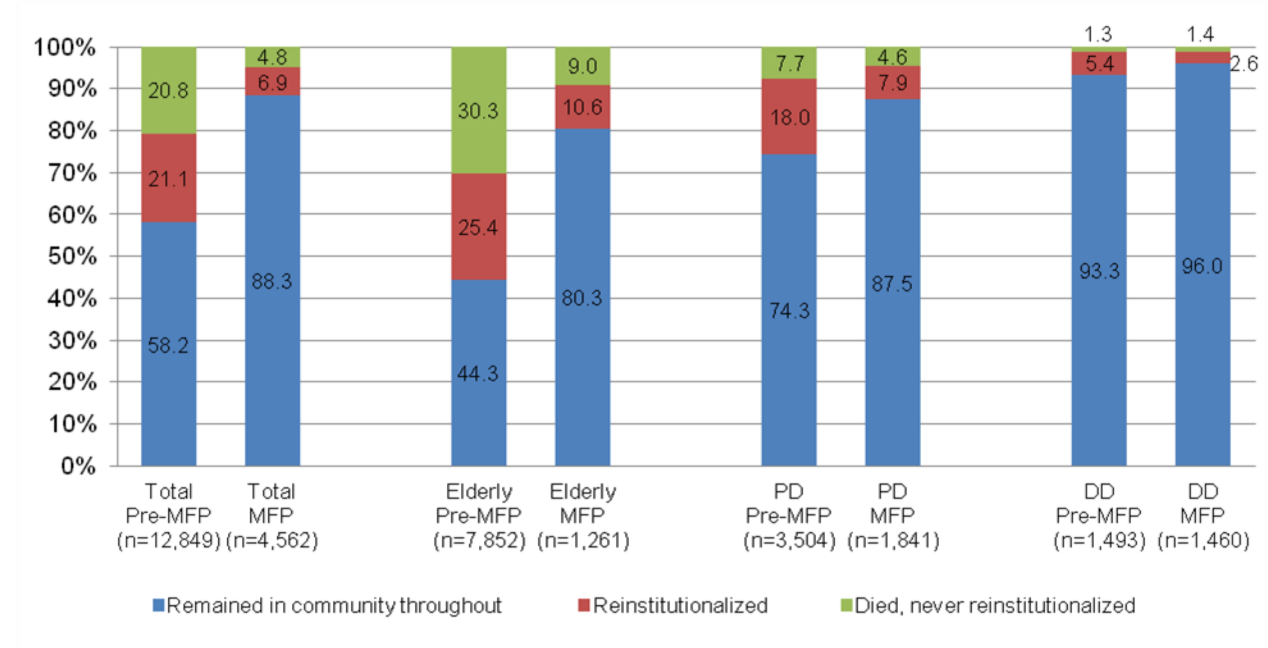
1. Pre-Post Comparisons by Subgroup

Overall and within each subgroup, reinstitutionalization and death rates were far lower among MFP participants than among their pre-MFP counterparts (Figure IV.4). The overall reinstitutionalization rate among MFP participants (with 60-day stays) was about 7 percent, compared with 21 percent among those who transitioned before MFP began. Likewise, the overall death rate was 5 percent among MFP participants versus 21 percent in the pre-MFP comparison group. These pre-post differences were especially apparent among the elderly—only 11 percent of elderly MFP participants were reinstitutionalized compared with 25 percent in the pre-MFP period, and only 9 percent of elderly MFP participants died compared with about 30 percent of the pre-MFP elderly. However, pre-MFP transitioners were far older, on average, than MFP participants. About 61 percent of those who transitioned in the pre-MFP period were elderly, compared with only 28 percent of the MFP population in our sample (Figure IV.5).

[21] Prior to the passage of the Patient Protection and Affordability Care Act (ACA) in March 2010, Medicaid beneficiaries were required to have 180 days of institutional care to be eligible for MFP. The ACA reduced the requirement to at least 90 days, not counting any days covered by Medicare's skilled nursing home benefit. We used the 180 day (six-month) eligibility requirement when selecting individuals for the comparison group because all MFP participants in our analysis transitioned prior to the enactment of the ACA.

[22] Although hospice is a covered MFP service, at the time of this report we did not have evidence that states targeted individuals for community-based end-of-life care under MFP. Excluding hospice users from the comparison group helps to ensure we do not overstate death rates in the pre-MFP period.

Figure IV.4. Post-Transition Outcomes for Pre-MFP Eligibles Who Transitioned to the Community and MFP Participants, Overall and by Subgroup



Sources: Mathematica's analysis of the 2006–2007 Medicaid Analytic Extract files and the 2008–2010 MFP Program Participation Data Files for 25 MFP grantee states (excludes Arkansas, Delaware, Louisiana, Pennsylvania, and Virginia due to insufficient data).

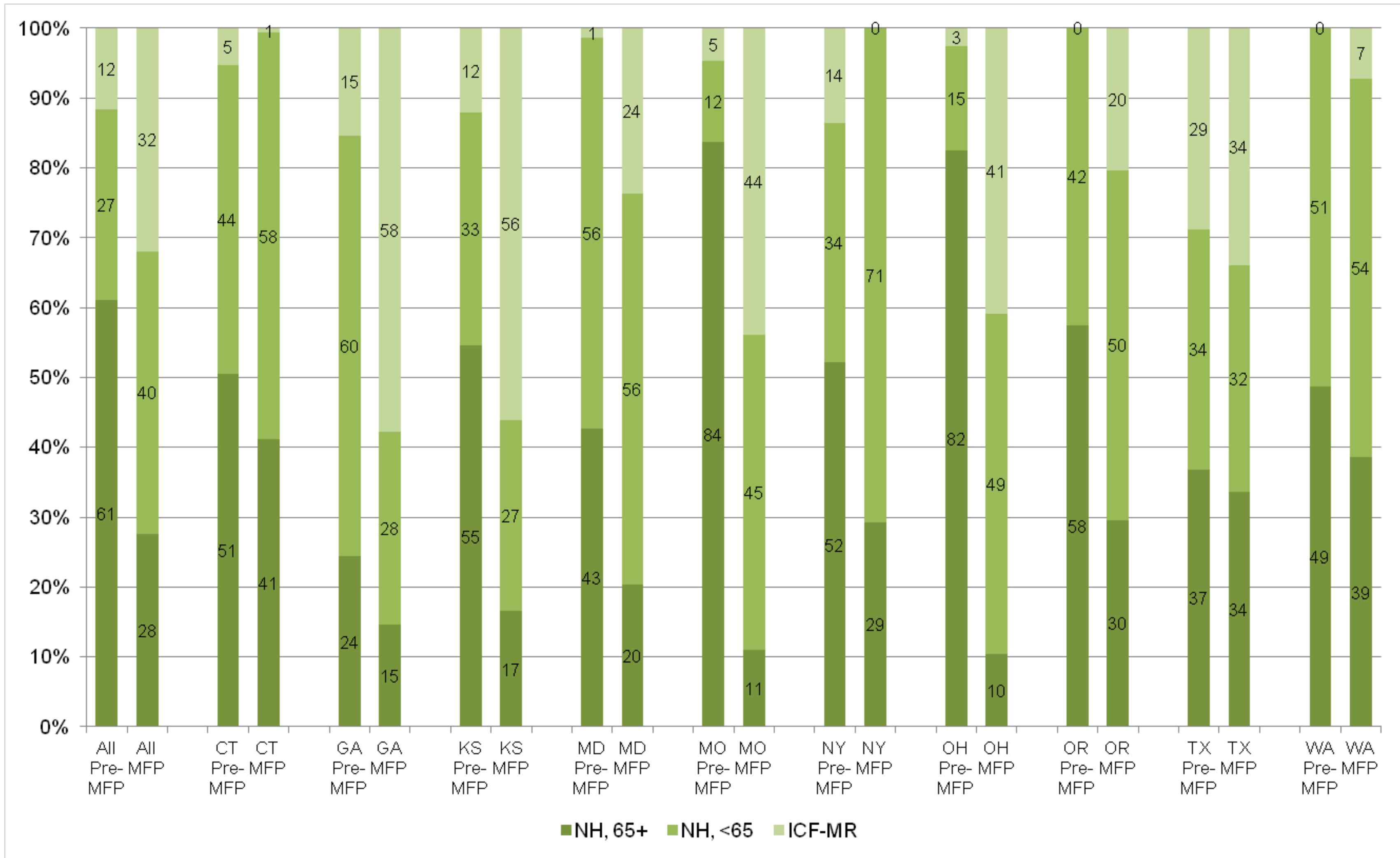
DD = developmental disability (people who transitioned from an ICF-MR); elderly = people age 65 or older who transitioned from a nursing home; PD = physical disability (people under age 65 who transitioned from a nursing home).

2. Pre-Post MFP Comparisons by State

We observed a similar pattern—fewer elderly and lower reinstitutionalization rates among MFP participants than in the comparison group—in each of the 10 grantee states, although to varying degrees. At one extreme were Missouri and Ohio, where over 80 percent of pre-MFP transitioners were elderly, compared with only 11 and 10 percent, respectively, of MFP participants (Figure IV.4). It is, therefore, not surprising that reinstitutionalization and death rates among MFP participants were just a fraction of the rates among pre-MFP transitioners in these states (Figure IV.5). In Missouri, about 86 percent of MFP participants but only 40 percent of the pre-MFP group remained in the community for a full year. In Ohio, 92 percent of MFP participants but only 34 percent of the pre-MFP group remained in the community. The results for these two states skewed the national average.[23]

[23] After excluding Missouri and Ohio, the percentage who died in the pre-MFP period declined from 21 to 14, the reinstitutionalization rate declined from 21 to 20, and the percentage remaining in the community increased from 58 to 67 across states (data not shown). In contrast, the rates for MFP participants were unchanged once we excluded the two states.

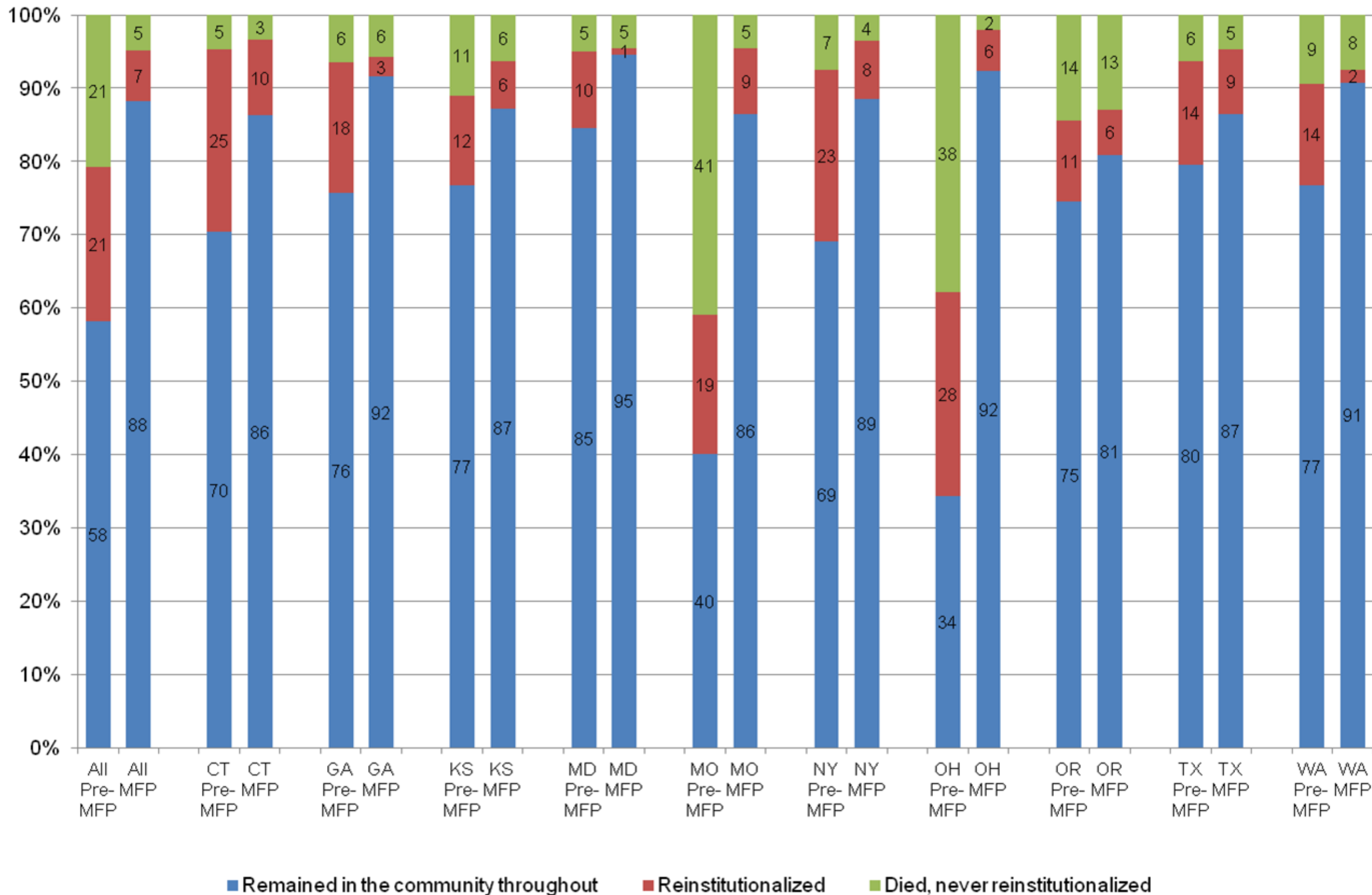
Figure IV.5. Distribution of (1) Pre-MFP Eligibles Who Transitioned to the Community and (2) MFP Participants with More Than One Year of Post-Transition Outcome Data, Overall and by State



Sources: Mathematica's analysis of the 2006–2007 Medicaid Analytic Extract files and the 2008–2010 MFP Program Participation Data Files for 25 MFP grantee states (excludes Arkansas, Delaware, Louisiana, Pennsylvania, and Virginia due to insufficient data).

ICF-MR = intermediate care facility for the mentally retarded; NH = nursing home.

Figure IV.6. Outcomes for (1) Pre-MFP Eligibles Who Transitioned to the Community and (2) MFP Participants with More Than One Year of Post-Transition Outcome Data, Overall and by State



Sources: Mathematica's analysis of the 2006–2007 Medicaid Analytic Extract files and the 2008–2010 MFP Program Participation Data Files for 25 MFP grantee states (excludes Arkansas, Delaware, Louisiana, Pennsylvania, and Virginia due to insufficient data).

At the other extreme, the distribution of MFP participants in Texas across subgroups was very similar to that of its pre-MFP comparison group. Differences in outcomes were also less pronounced. About 9 percent of Texas' MFP participants were reinstitutionalized, 5 percent died, and 87 percent remained in the community, compared with 14 percent, 6 percent, and 80 percent, respectively, in the pre-MFP period. Given Texas' experience implementing transition programs before the MFP demonstration, we hypothesize that the pre-post MFP differences in Texas reflect, at least in part, effects associated with new dedicated staff or other transition or coordination supports enabled by the demonstration.

Overall, however, this state-level analysis highlights differences between MFP program characteristics and outcomes across states and the challenges that the national MFP evaluation will face in measuring outcomes, identifying comparison groups, and adequately assessing impacts of the demonstration as it progresses. Since each state provides a unique set of services for its beneficiaries, and some states are targeting populations that infrequently transitioned in the past in their state, identifying appropriate comparison groups to assess impacts within each state will be a major challenge for the evaluation.

C. Limitations

Although our analysis sheds some light on the post-transition outcomes of the first group of beneficiaries to transition under MFP, four limitations prevent us from drawing firm conclusions about the role of reinstitutionalization and mortality in MFP. First, the reinstitutionalization and death rates reported here differ substantially from those in grantee web-based reports for different time periods. If the MFP program data used for our analysis underreport reinstitutionalizations and deaths, differences between states may be distorted, and differences between MFP participants and the comparison group may be overstated.

Second, the death and reinstitutionalization rates reported in our comparative analysis may differ somewhat from the true rates for both MFP participants and pre-MFP eligibles. To account for missing claims, we could only compare reinstitutionalization and death rates for people who successfully remained in the community for at least 60 days. If these rates differed between the MFP and pre-MFP groups before the 60-day mark, our results will not accurately reflect the overall differences in post-transition outcomes. Also, MFP participants may include some people receiving hospice care, whereas we excluded pre-MFP eligibles receiving state-plan hospice at the time of their transition. Finally, we derived our outcomes data from different sources, using claims data for the pre-MFP transitioners and program data for the MFP participants. These two data sets may differ in completeness or accuracy.

Third, as described above, our comparison group—the pre-MFP eligibles who transitioned to HCBS—may differ from MFP participants in ways that we could not account for due to data limitations. These differences may include health status, length of time spent in an institution before transitioning, and level of care needed. Our analysis was also constrained by the information common to both MFP participant files and MAX data files—state, gender, institutional facility, and age. Due to the small sample of people who had completed their MFP participation at the time of this study, we were unable to refine the analysis by restricting the comparison group to those who statistically matched to MFP participants.

The fourth limitation is one shared by all pre-post analyses: other changes may be occurring during the "pre" and "post" periods that affect the outcomes. In this study, such changes may

include nursing home or ICF-MR closures, changes in state policy affecting Medicaid HCBS benefits, and changes in the availability of other support services (including subsidized housing). These changes could affect the number of transitions and the types of people able to transition. More robust methods (for example, difference-in-difference methods) could be used to ameliorate this problem, but they would require data on people who transitioned after MFP's implementation but did not participate in the program. In future reports, when more Medicaid data are available, we will be able to use such methods to better assess the effects of MFP on the people who transition and their post-transition outcomes.

D. Conclusion

This preliminary investigation of first-year outcomes of the MFP demonstration provides a baseline for expected post-transition outcomes as the demonstration progresses, as well as some guidance for states seeking to improve their programs, as follows:

- **Rates of Reinstitutionalization and Death Vary by Subgroup.** During the year following participants' return to the community, reinstitutionalizations and deaths were far more common among the elderly leaving nursing homes (14 and 11 percent, respectively) and least common among those leaving ICFs-MR (4 and 2 percent, respectively). States targeting the elderly should, therefore, expect higher post-transition reinstitutionalization and death rates. Also, as the populations targeted by grantees change, we will expect post-transition outcomes to change.
- **Reinstitutionalizations Are Most Likely to Occur in the First Few Months After Transition.** When reinstitutionalizations occurred, they tended to happen in the first half of the year and were most likely to occur within the first three months after a participant's transition. It is during this time that many states also shift the responsibility of coordinating MFP services from transition experts to care coordinators. States should consider how to make this process as smooth as possible to ensure continuity of care, especially during participants' first, most vulnerable months in the community.
- **States with More Experience Transitioning People Under MFP Are More Likely to Have a Higher Percentage of Participants Remain in the Community for a Full Year.** Most states with more than 100 MFP participants meeting the one-year mark post transition had a higher than average percentage of participants remaining in the community throughout the year. Grantees just beginning their programs should expect improved outcomes as their program develops and matures.
- **Populations Transitioning From Institutions Vary Substantially Across States and Over Time.** This analysis shows that states vary substantially in the populations they reach with demonstration services. The outreach, staffing, and coordination challenges associated with implementing a transition program—or alternatively, the way in which a state targeted its program to certain types of candidates—may manifest themselves in the types of people the states were able to help transition (and thus their outcomes) during the initial stages of the demonstration. Furthermore, compared to beneficiaries who transitioned to the community in 2006, before the demonstration began, MFP participants were far younger and, therefore, were far less likely to be reinstitutionalized or die during the year after their transition. Great care

should be taken when comparing outcomes of one state or one time period with those of another.

Our findings for Texas—a state with extensive experience running transition programs and where MFP participants and pre-MFP eligibles are similar in age, sex, and type of disability—suggest the potential for small but positive effects of MFP on reinstitutionalizations. It is possible that these differences reflect program effects associated with MFP administrative supports, such as additional funding for dedicated program staff. (It is unlikely that the differences were caused by MFP supplementary services, as Texas provides relatively few of these services compared to other grantee states.) Further analyses will be needed to assess the true impacts of MFP on the nature and success of transitions, and how they vary across states with new versus established programs.

We caution that the outcomes reported in this chapter are preliminary and may understate reinstitutionalizations and deaths among MFP participants. As more data become available, we will be able to better estimate reinstitutionalizations and deaths, identify appropriate comparison groups for people enrolled in MFP, and assess the impact of the demonstration on Medicaid beneficiaries' ability to return to the community and successfully stay in the setting of their choice.

V. MFP PARTICIPANTS' QUALITY OF LIFE AFTER TRANSITIONING TO COMMUNITY LIVING

While institutional-based care can provide the intensive, ongoing assistance and supervision that some people require, long-term residence in a facility can come at a cost for the residents in terms of control over their lives and their ability to live as they choose. A key goal of the MFP national evaluation is examining evidence that the MFP demonstration at least maintained, if not improved, the quality of life for individuals who transitioned from institutional to community-based settings. While community-based care is often viewed as desirable and providing a better quality of life than institutional living, little empirical evidence exists to support this contention. In light of the Community Living Initiative, a program designed and implemented in 2009 to coordinate the efforts of several federal agencies to facilitate community living for individuals with disabilities and older Americans, policymakers and other stakeholders need information on how the transition to community living affects quality of life.

This chapter examines how the quality of life of MFP participants changes after they transition to community living.[24] It also highlights the link between employment and quality of life. We briefly describe the approaches to survey administration and the data used for this report, and then describe MFP participants' change in quality of life in three areas: (1) overall satisfaction, (2) quality of care, and (3) community life. Next, we examine the prevalence of and barriers to work. We report findings for all participants and examine results by target population: those who transitioned from intermediate care facilities for the mentally retarded (ICFs-MR), aged participants (defined as age 65 or older) who transitioned from a nursing facility, and participants younger than age 65 who transitioned from a nursing facility. We refer to these target populations in the report as participants with intellectual disabilities (ID), aged participants, and participants with physical disabilities (PD), respectively.

Key Findings. Our findings related to quality of life include the following:

- The expectation that participants' self-rated quality of life would improve upon transition to the community was supported, albeit provisionally. Eight out of 10 participants were satisfied with the way they lived their lives after one year of community living, compared with 6 of 10 participants pre-transition.
- Overall, participants reported enhanced quality of life across all quality of life measures. After one year in the community, more participants were satisfied with their living arrangements, reported expanded choice and control and community integration, were treated well by their provider, and reported fewer unmet care needs compared with their experience in institutional settings. Satisfaction with care in the community did not change but remained high across all participants.
- Although improvement was significant and broad-based, several findings raise concern and warrant monitoring. At least one-third of participants continue to report barriers to community integration and low mood after a year in the community.

[24] *Quality of life* refers here to participants' direct reports of satisfaction with the way they live their life, satisfaction with the care they receive and their living situation, access to personal care, help with activities of daily living, feelings of respect and dignity, adequacy of community integration, and mood.

- About one in seven participants reported working for pay, while nearly one in five were not working but were interested in doing so. Rates of employment and interest in work varied widely across target populations. Overall, individuals who were working were more likely to indicate satisfaction with life than individuals who were not working but wanted to do so.

A. Background

While the primary aim of this chapter is to assess quality of life after MFP participants transitioned to the community, other key research questions addressed include:

- *To what extent are MFP participants engaged in work after one year of community living?* Working in the community is one proxy for successful community integration, particularly given that working-age adults comprise the plurality of MFP participants (Lipson and Williams 2011). We examine the percentage of participants working for pay and the percentage not working but interested in doing so.
- *What factors differentiate those who are working and those who are not working but are interested in doing so?* Examination of these post-transition relationships will help guide future analyses of how quality of life changes after the transition to community living. In addition, the information may help grantees understand barriers to work and participants' rating of overall quality of life.

1. The Survey

Quality of life is measured using the MFP-Quality of Life (MFP-QoL) survey administered by grantees. The instrument is based largely on the Participant Experience Survey, though a few items are drawn from other instruments (Sloan and Irvin 2007).[25] The MFP-QoL instrument captures three areas of participants' quality of life around which the findings in this chapter are organized: (1) life satisfaction, (2) quality of care, and (3) community life. Life satisfaction assesses participants' reported global satisfaction with life and serves as a bellwether indicator of their quality of life. Satisfaction with care assesses participants' unmet needs for personal care and treatment by providers. Community life is assessed by measures addressing satisfaction with one's living arrangements, choice and control in one's home, and community integration and inclusion.

2. Survey Administration

Grantees are responsible for survey administration, data entry, tracking, and transmission of the data to CMS. They are required to administer the MFP-QoL instrument at three points in time: at baseline, defined as immediately prior to transition from an institution, and at one and two years post-transition.[26] The survey is administered by grantees during in-person interviews

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[25] These include ASK ME!, Cash and Counseling, National Core Indicator Survey, Quality of Life Enjoyment and Satisfaction Questionnaire–Short Form, and Nursing Home Consumer Assessment of Health Plans Survey.

[26] Grantees are instructed to administer the baseline MFP-QoL survey immediately prior to transition and no later than two weeks post-transition. Participants who return to institutions are still interviewed in those settings at one and two years post-transition, regardless of whether they have any further involvement in the MFP program.

with participants or their proxies. It takes about 20 minutes to administer and consists of 41 questions.[27] Methods and staff used to administer the survey vary by state, with most grantees using transition coordinators or case managers to collect quality of life data (Irvin et al. 2010).

Administration of the survey via a proxy respondent is permitted. Among all respondents in our sample, proxy respondents were used for 20 percent of all baseline surveys and 13 percent of one-year follow-up surveys. The use of a proxy respondent varied widely by target population; rates of proxy use were significantly higher among respondents with an intellectual disability, with 50 percent of all baseline and 29 percent of follow-up interviews completed by a proxy respondent. Proxy use was less common among participants who transitioned out of nursing homes.

3. Data

The analytic sample for this report included data from 1,090 participants with matched baseline surveys (conducted prior to the transition to community living) and one-year follow-up surveys that could also be matched with administrative data.[28,29] Data in this report use baseline surveys conducted with MFP participants between January 2008 and March 2010 paired with one-year follow-up assessments, and represent data from 23 of the 30 grantees.[30] To ensure follow-up assessments capture experience at one year, we include those conducted between 8 and 16 months after baseline surveys were conducted.

Table V.1 shows the analytic sample construction and the number of cases excluded because of lack of (1) participant identifiers in survey data, or (2) matching identifiers in administrative data. Overall, the analysis sample represents approximately 16 percent of participants who were transitioned as of March 2010 (Lipson and Williams 2011; Irvin et al. 2010).[31] Several factors contribute to the low proportion of transitions represented in this sample. First, at program startup, the survey was not administered to many of the first MFP participants, as grantees were not always prepared for the speed with which some participants transitioned; this problem was compounded by the simultaneous lag in establishing formal procedures for identifying and gaining access to participants prior to transitions. For example, some participants transitioned before the person conducting the interview could reach them for the baseline survey. Second, some states had trouble submitting their data according to the schedule established for the

[27] Of the 41 questions in the survey, 6 are not relevant to an institutional setting and are not collected during the baseline interview. Three other questions assess abuse and neglect and are optional.

[28] Enrollment records from the MFP Program Participation Data files were used to identify program participation and membership in specific target population groups.

[29] Because the sample available for analysis is not necessarily representative of the full MFP population, results must be interpreted cautiously and are subject to change.

[30] Six grantees (Delaware, Indiana, Louisiana, Michigan, North Carolina, and North Dakota) submitted baseline and follow-up quality of life data. However, either their baseline and follow-up surveys could not be paired, or their paired baseline/follow-up surveys could not be matched with program participation data. Virginia has not submitted readable program participation data.

[31] The number of cumulative participants through March 2010 was extrapolated by taking the midpoint of the total number of transitions reported through December 2009 (Irvin et al. 2010) and the number reported through June 2010 (Lipson and Williams 2011).

evaluation, and such difficulties can affect the availability of either the quality of life data or the administrative data. Third, Medicaid identifiers in the quality of life data are not always recorded properly, and without accurate identifiers, the quality of life data cannot be linked to administrative data.[32] Mathematica continues to work with grantees to improve the timeliness of data collection and submission and the quality of the Medicaid identifiers.

Table V.1. Analytic Sample Construction

Number of Records	Description
1,411	Participants with baseline and one-year follow-up surveys submitted to CMS
1,256	Participants with baseline and one-year follow-up surveys who could be linked to program participation records
1,090	Participants with matched baseline and one-year follow-up surveys who could be linked to program participation records and had a follow-up assessment completed between 8 and 16 months after the baseline survey

Source: Mathematica analysis of linked MFP-QoL surveys and MFP Program Participation data submitted through March 2011, representing pre-transition surveys conducted between January 2008 and March 2010.

Nearly one of three participants in the analytic sample (32 percent) were nonelderly and had a physical disability, 24 percent had an intellectual disability, and 20 percent were aged (Table V.2).[33,34] Compared to the population that successfully transitioned through MFP as of December 2010 (as reported in Chapter II), the quality of life analytic sample under-represents the elderly and nonelderly who transitioned from nursing homes. The sample was diverse in terms of age; the largest age group consisted of participants between ages 45 and 64 (41 percent). The sample comprises participants from 23 of the original 30 grantees, although participants from five states constituted 56 percent of the sample: Ohio (13 percent), Oregon (13 percent), Missouri (12 percent), Connecticut (9 percent), and Pennsylvania (9 percent).

[32] For security, identifiable data are kept to a minimum on the MFP-QoL instrument; Medicaid identifiers are the only method used to track participants.

[33] Data on participant race were not available for analysis but will be examined in subsequent reports.

[34] A large percentage (22 percent) of the sample did not have information available on site of institutionalization. This variable is missing on grantee-submitted MFP Program Participation Data files; however, the data will be available through follow-up with the grantees and linking these data to Medicaid eligibility records, which will be conducted later.

Table V.2. Sample Demographics

	Number	Percentage
Total	**1,090**	**100.0**
Target Population		
Aged	219	20.1
PD	347	31.8
ID	265	24.3
Other	15	1.4
Missing	244	22.4
Age Group		
<21	23	2.1
21-44	196	18.0
45-64	454	41.7
65-74	142	13.0
75-84	79	7.2
≥85	52	4.8
Missing	144	22.2
Sex		
Female	553	50.7
Male	537	49.3

Source: Mathematica analysis of linked MFP-QoL surveys and MFP Program Participation data submitted through March 2011, representing pre-transition surveys conducted between January 2008 and March 2010.

Note: Excludes data from Delaware, Indiana, Louisiana, Michigan, North Carolina, North Dakota, and Virginia.

ID = participants who transition from ICFs-MR; PD = participants under age 65 who transition from nursing homes.

B. Change in Quality of Life After Transition to Community Living

This section describes the differences in reported quality of life between the pre-transition period and the first year post-transition. Results for each area of quality of life are presented for all respondents and by target population. Table V.3 summarizes the magnitude of the percentage point change for each measure of quality of life with the exception of reported choice and control, which is a count of elements over which the respondent has choice.[35] Appendix Table QOL-A displays the pre-transition and one-year post-transition results for all participants and by target population. All findings reported as significant were significant at $p<.01$. Results presented in this chapter are consistent with previous findings based on an earlier, smaller sample of participants (Simon and Hodges 2011).

[35] Reported choice and control accounts for up to six areas of autonomy: being able to go to bed when one desires, the ability to be alone when one chooses, the ability to eat food of one's choice and when one chooses, and the ability to use the telephone or watch television when one chooses. Findings related to this outcome are reported in Table QOL-A.

Table V.3. Percentage Point Change: Quality of Life Measures by Target Population

	All Participants	Aged	PD	ID
Life Satisfaction	+++	+++	+++	++
Satisfaction with Care	+	-	-	+
Access to Personal Care	++	++	++	+
Respect and Dignity	+++	+++	+++	++
Satisfaction with Living Arrangements	+++++	+++++	+++++	+++
Community Integration	++	+++	++	++
Mood Status	+	++	+	+
Number of Observations	1,090	219	347	265

Source: Mathematica analysis of linked MFP-QoL surveys and MFP Program Participation data submitted through March 2011, representing pre-transition surveys conducted between January 2008 and March 2010.

Note: Excludes data from Delaware, Indiana, Louisiana, Michigan, North Carolina, North Dakota, and Virginia.

ID = participants who transition from ICFs-MR; PD = participants under age 65 who transition from nursing homes.

- indicates decline of fewer than 5 percentage points.
+indicates improvement up to 10 percentage points.
++ indicates improvement of 11 - 20 percentage points.
+++ indicates improvement of 21 -30 percentage points.
++++ indicates improvement of 31-40 percentage points.
+++++ indicates improvement of more than 40 percentage points.

1. Life Satisfaction

Participants' satisfaction with the way they are living their lives (that is, global satisfaction with life) is a key indicator of quality of life and a fundamental concern of MFP stakeholders.[36] After one year of community living, global satisfaction increased significantly overall and for each target population. Prior to transitioning to community living, nearly three-fifths of participants (59 percent) expressed satisfaction with the way they lived their lives, compared to four-fifths of participants (81 percent) one year post-transition.

In addition to measuring satisfaction with life, the MFP-QoL survey also assesses participants' mood status.[37] Although significant, the magnitude of improvement participants experienced for mood status was small relative to other domains assessed. Fewer MFP participants reported feeling sad or blue after transitioning to community living (35 percent, compared to 43 percent who reported feeling this way while living in an institutional setting). Participants with physical disabilities were most likely to report feeling sad or blue post-transition (43 percent).

[36] This question reads, "Taking everything into consideration, during the past week have you been happy or unhappy with the way you live your life?"

[37] This question reads, "During the past week have you felt sad or blue?"

2. Quality of Care

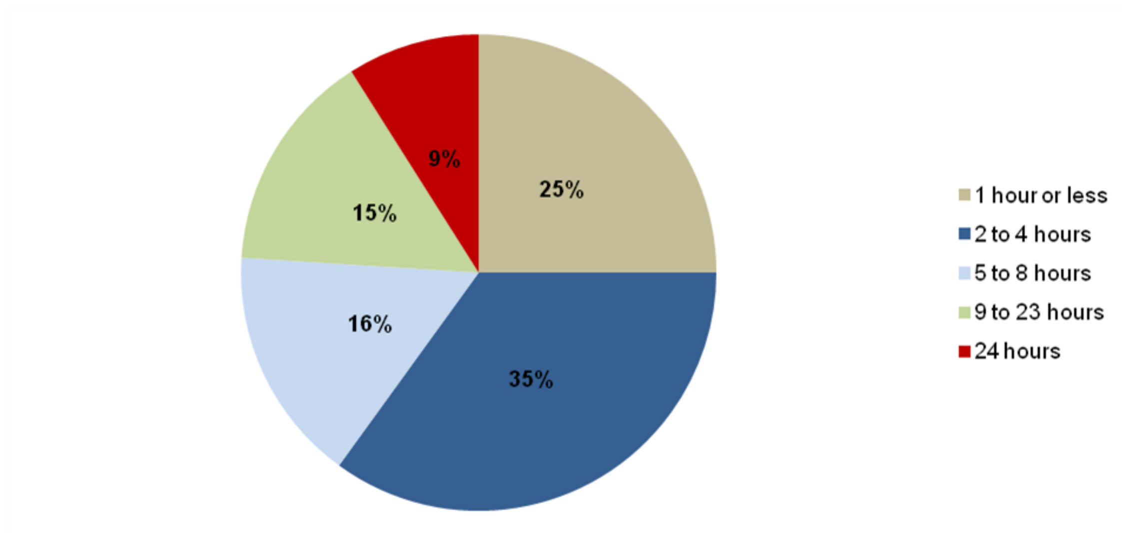
One concern about transitioning individuals from institutional to community-based living is the potential for participants to experience reduced quality of care. Home and community-based settings require a wider range of care providers and may involve informal supports, resulting in diffused accountability, particularly compared with care in institutional settings. In spite of these concerns, two of the three measures used to assess the quality of care—having one or more unmet needs for personal care assistance and being treated by providers with respect and dignity—improved post-transition. The third measure—satisfaction with care—did not change after a year of community living.

The percentage of participants who reported one or more unmet care needs (such as bathing, meal preparation, medication management, and toileting) decreased significantly between the pre- and post-transition periods (from 14 to 3 percent). This finding was consistent across target populations. Similarly, treatment with respect and dignity by providers showed significant improvement between the pre- and post-transition periods. More than two-thirds of participants (68 percent) reported being treated with respect and dignity while living in an institutional setting; post-transition this rate increased to 92 percent, a trend that was consistent for all of the target populations.

Satisfaction with care was nearly universal for MFP participants pre-transition, as it was reported by 89 percent of participants. After a year of community living, a similar percentage of participants (92 percent) continued to report being satisfied with their care. Participants with physical disabilities and aged participants were slightly less satisfied with the care they received in the community, but the changes were not significant.

Informal support can play an important role in meeting participants' care needs in the community. Over one-third of participants were receiving some form of informal support after one year in the community (36 percent). Aged individuals and younger individuals with a physical disability were the most likely to report receiving some informal support (53 and 48 percent, respectively), while about one in eight participants with an intellectual disability (14 percent) reported receiving this type of support. Figure V.1 shows the distribution among those receiving informal support of daily hours of such support. The distribution of hours was similar for aged and younger individuals with a physical disability. Participants with an intellectual disability who received informal support typically received one or two hours of assistance (47 and 28 percent, respectively). Receipt of informal support in the community was not associated with higher satisfaction with care.

Figure V.1. Daily Hours of Informal Support Provided, All Participants



Source: Mathematica analysis of linked MFP-QoL surveys and MFP Program Participation data submitted through March 2011, representing pre-transition surveys conducted between January 2008 and March 2010.

Note: Excludes data from Delaware, Indiana, Louisiana, Michigan, North Carolina, North Dakota, and Virginia.

3. Community Life

Participants' ability to do things of their choosing in their community is one indicator of a successful transition to community living. Other aspects relevant to individuals' community life are satisfaction with one's living arrangements and autonomy in basic activities around the home. Most participants reported post-transition enhancements in all three areas.

Of the elements assessed, satisfaction with living arrangements exhibited the largest increase between the pre-transition and one-year surveys. A slim majority of MFP participants (52 percent) reported satisfaction with living arrangements prior to transition, whereas nearly all participants were satisfied with their post-transition living arrangements (94 percent).

When asked about six areas of personal choice and control in their home, participants reported an average of 4.9 areas of choice and control after one year in the community, compared to an average of 3.5 areas pre-transition. Each target population experienced a similar increase.

Prior to transitioning, nearly half of all MFP participants (48 percent) reported an inability to do things outside the institutional setting, whereas approximately one-third (34 percent) reported such barriers while living in the community. Post-transition, this barrier was most commonly reported by participants with physical disabilities (48 percent).

C. Work Status and Its Association with Quality of Life After Transition to Community Living

Volunteer and paid work were assessed as part of the one-year follow-up QoL survey. Overall, 15 percent of MFP participants reported doing paid work and 8 percent reported

volunteering. Participants with an intellectual disability comprised the majority of working MFP participants (74 percent).

The percentage of participants who were working for pay or had an interest in paid work varied by target population (see Table V.4). Participants with an intellectual disability reported the highest rate of paid work, with nearly half reporting working for pay. However, a sizeable proportion of participants was not working and expressed an interest in doing so. For example, while 3 percent of participants with a physical disability were working for pay, another 37 percent were not working but wished to do so. Similarly, while no aged participants were working for pay, 21 percent expressed an interest in work.

Table V.4. Work Status at Follow-Up by Target Population (Percentages Unless Noted Otherwise)

Target Population	Working for Pay (N=166)	Not Working for Pay, Want to Work for Pay (N=198)	Not Working for Pay, Not Interested (N=726)
Total	15	18	67
Aged	0	21	79
PD	3	37	60
ID	48	9	43
Other	8	31	61
Unknown	19	12	69

Source: Mathematica analysis of linked MFP-QoL surveys and MFP Program Participation data submitted through March 2011, representing pre-transition surveys conducted between January 2008 and March 2010.

Note: Excludes data from Delaware, Indiana, Louisiana, Michigan, North Carolina, North Dakota, and Virginia.

ID = participants with intellectual disabilities who transitioned from an ICF-MR; PD = participants with physical disabilities who transitioned from nursing homes.

Employment not only suggests a high level of community integration for MFP participants, but is associated with high rates of life satisfaction. As the information in Table V.5 indicates, 86 percent of those who are working are satisfied with the way they are living their lives, compared to 81 percent in the overall study sample and 77 percent among those who would like to work. To explore whether the data suggest that those who would like to work face significantly more barriers to work than those who were working at the time of the follow-up survey, we assessed components of participant experience among those who reported working and those who were not working but expressed an interest in doing so (Table V.5).[38]

[38] Given the low rates reported for volunteering, we do not explore relationships between volunteer work status and characteristics of participant experience.

Table V.5. Paid Work Status and Association with Participant Experience at Follow-Up (Percentages Unless Noted Otherwise)

Characteristic[a]	Working for Pay (N=166)	Not Working, Want to Work for Pay (N=198)	Significance of Difference
Global satisfaction	86	77	**
Receives ADL assistance	80	69	**
Any unmet ADL need	2	6	*
Does not receive informal support	84	58	***
Want to do things outside home but cannot	31	48	***
Cannot get places	1	4	**

Source: Mathematica analysis of linked MFP-QoL surveys and MFP Program Participation data submitted through March 2011, representing pre-transition surveys conducted between January 2008 and March 2010.

Note: Excludes data from Delaware, Indiana, Louisiana, Michigan, North Carolina, North Dakota, and Virginia.

[a]Measured after one year in the community.

ADL = activities of daily living.

* Significantly different from zero at the .10 level, two-tailed test

** Significantly different from zero at the .05 level, two-tailed test.

*** Significantly different from zero at the .01 level, two-tailed test.

Overall, compared with participants who did not work for pay but wished to do so, participants who were working received more assistance with activities of daily living (ADLs). This suggests that needing assistance with ADLs is not necessarily a hindrance for most MFP participants who work and ostensible barriers presented by the need for assistance are surmountable, at least for some MFP participants. Similarly, participants who would like to work were more likely to report unmet ADL needs, not being able to do everything they wanted to outside their home, and facing barriers to getting to places they needed to go. The latter two findings raise the possibility that transportation needs are a key impediment to work for some MFP participants. Finally, receipt of informal support was more prevalent among participants who were not working. Interpretation of this finding is difficult; however, it may suggest a higher level of need among these nonworking participants. Future analyses, which will be aided by larger numbers of respondents, will explore these issues in more depth.

D. Conclusions

Our findings confirm previously reported evidence that transition to the community under MFP is associated with improved overall satisfaction with life and that participants are satisfied with their community-based living arrangements (Simon and Hodges 2011). Further, improvement or maintenance of quality of life is pervasive across all domains of participant experience and target populations.

A small segment of MFP participants reported working for pay, with a slightly larger percentage not working but expressing interest. Compared with participants who wanted to work but were not doing so, MFP participants who worked for pay were more likely to report

satisfaction with the way they lived their lives. Receipt of ADL assistance was common among working participants, indicating that ADL limitations need not be an impediment to work.

Although data from the quality of life survey indicate participants are generally happy with the way they are living their lives in the community, particularly when compared with life in institutional settings, several findings temper the generally positive associations with these transitions. First, a significant portion of participants (34 percent) reported barriers to community integration after a year of community living.[39] This is a particularly salient issue among participants with a physical disability, as nearly one-half (48 percent) reported such a barrier. Second, one-third of participants reported feeling sad or blue in the past seven days (35 percent) while living in the community. Although both of these findings represent an improvement from pre-transition levels, they reveal the potential for grantees to use MFP-QoL data to proactively monitor participants' well-being and to screen for unmet participant needs. For example, participants who report feeling sad and blue during the past seven days on the MFP-QoL survey may warrant further assessment by mental health professionals or primary care physicians.

Not surprisingly, MFP participants, like many other users of home and community-based services, rely on informal support systems to supplement formal care arrangements. More than one-third of participants reported use of informal care and their caregivers provided a mean of 6.6 hours of support (median of 4 hours) per day. Informal support had no association with care satisfaction.

1. Limitations

Several important limitations apply to the work presented in this chapter. First, the findings should not be viewed as representative of the entire MFP program, particularly because the sample under-represents the experience of aged and younger participants with physical disabilities across many states. Replication of these findings with larger, more representative samples will have enhanced external validity and, therefore, will be more generalizable to the experience of MFP participants.

Second, the method of survey administration varies by grantee. However, many use providers to administer either the pre-transition or post-transition survey (or both). In cases in which providers administer the survey, it is possible participants may feel compelled to emphasize reports of satisfaction or to conflate feelings of satisfaction with their living arrangement with feelings about the provider. If sample sizes allow, future analyses may examine the relationship between mode of administration and quality of life change. For example, we will restrict analyses to grantees that contract out survey administration to examine whether quality of life change trends vary by survey administration method.

Third, our ability to describe differences among target populations is limited by a substantial amount of missing data regarding the type of institution from which participants transition (this data element is missing on about 22 percent of the records in the Program Participation files

[39] This question asks respondents, "Is there anything you want to do outside your home that you can't do now?"

states submit). At the time this report was written, we were in the process of obtaining more complete information from states and should be able to capture more participants in later stages of our analyses.

We acknowledge we have not controlled for a range of unmeasured program and individual-level factors that are likely to affect participants' experience in the community. Later analyses will explore the role of program-level variables such as model of caregiver employment, use of transition services, or assistive technology. We will also examine the role of participant-level characteristics such as baseline clinical and functional characteristics on improvement in global satisfaction.

Finally, proxy respondents provided information about community-based quality of life for 13 percent of all participants, and nearly 3 of every 10 participants with an intellectual disability. Although proxy respondents and participants provided equivalent ratings of satisfaction for both administrations of the survey, some question the validity of proxy responses for subjective questions, such as quality of life (Elliott et al. 2008). Future analyses will continue to explore the impact of proxy respondents on assessment of participants' quality of life.

VI. CONCLUSIONS

Growth and expansion characterized the Money Follows the Person (MFP) demonstration during 2010. States awarded MFP grants in 2007 gained momentum as they increased the number of Medicaid beneficiaries they transitioned during the year by more than 50 percent over the year before. New federal legislation, the 2010 Patient Protection and Affordable Care Act, extended the demonstration and increased the amount of authorized funding for the program.[40] CMS used this new funding to award 13 new grants in February 2011. CMS also increased funding for program administrative costs such as the hiring of specialists in the areas of housing, community living, and behavioral health.

The overall success of MFP and whether it can improve long-term care systems to enable more people who need long-term services and supports to live in the most integrated settings possible will hinge on whether states can supply the housing and community-based services that beneficiaries need. Success will also be determined by the ability of MFP programs to serve beneficiaries in the community on a long-term basis, beyond the 365-day MFP eligibility period, and do so at less cost than if participants had remained in institutional care. To realize these outcomes, MFP programs will have to balance the enhanced choice and control that community living offers beneficiaries with sound management of the inherent risks of community living.

A. Review of Results Through 2010

During 2010, the MFP demonstration increased the number of Medicaid beneficiaries transitioned by more than 50 percent over the previous year and expanded into 13 additional states. By the end of calendar year 2010, nearly 12,000 beneficiaries had been transitioned by MFP programs. As it has grown, the distribution of MFP participants across the major targeted populations has shifted slightly and the states are transitioning more nonelderly nursing home residents with physical disabilities (38 percent of new MFP participants in 2010) than the elderly (35 percent) or beneficiaries with intellectual disabilities residing in intermediate care facilities for the mentally retarded (ICFs-MR) (21 percent). While small, the number of MFP participants with mental illness has grown from 2 percent of all transitions to 6 percent.

While the achievement of approximately 12,000 transitions may be modest by some standards, the size and performance of any state's transition program depends on many factors. Other reports have discussed the challenges states face implementing a transition program for beneficiaries who need long-term services and supports (Denny-Brown et al. 2011; Denny-Brown and Lipson 2009), but Mathematica's recent primary data collection effort in 10 states revealed that states with above-average performance through 2010 on transitions and reinstitutionalizations had a strong foundation at the start of the MFP program. They had previous experience transitioning not only residents of ICFs-MR, but also residents of nursing homes. They had existing transition coordination capacity in all or most regions of the state, which meant they did not have to expend a lot of time and resources developing skilled transition coordination staff. In addition, they had strong, stable program leadership and support. The other states that have had either average or below-average performance are likely to improve once they have gained experience with transitions and built the capacity to coordinate transitions,

[40] States now have until the end of 2020 to expend all their MFP grant funds.

including having skilled transition coordinators in most regions of their states. Perhaps the most important factor for these states is an emphasis on developing strong and stable program leadership. Several states in the average and below-average performance groups have addressed some of the critical issues that have been holding them back and we anticipate that these states will show stronger performance in 2011.

The first analyses of participant outcomes, while descriptive and not conclusive, suggest that MFP participants are generally faring well. Approximately 85 percent of MFP participants who transitioned by March 2010, and for whom we had sufficient post-transition data, were able to remain living in the community a full year. The other 15 percent either were reinstitutionalized for at least 30 days (9 percent) or died (6 percent) before the one-year anniversary of their transition to community living. Younger, nonelderly participants had lower reinstitutionalization and mortality rates than elderly MFP participants. When reinstitutionalizations occurred, they tended to happen in the first three to six months after leaving the institution. When MFP participants were compared to Medicaid beneficiaries who transitioned from institutional care to home and community-based services (HCBS) before the implementation of the MFP program, MFP participants were found to be younger and to experience lower reinstitutionalization and mortality rates. More study of reinstitutionalizations and mortality is needed before concluding that MFP and the services MFP programs provide improve the likelihood that a transition to community living will be long term or until the end of life.

The early evidence also suggests that the quality of life for MFP participants improves after their return to the community. Using a sample of 1,090 participants with matched baseline and follow-up surveys, the quality-of-life data indicate that 8 out of 10 MFP participants were satisfied with the way they lived their lives after one year of community living, up from the 6 of 10 participants pre-transition. Of all the elements assessed, satisfaction with living arrangements exhibited the largest increase, from 52 percent reporting satisfaction with their living arrangements before the transition to 94 percent post-transition. The level of community integration also improved by 14 percentage points after one year. Employment is a form of integration and 15 percent of MFP participants reported working for pay (of whom 74 percent were participants with intellectual disabilities) while 8 percent reported volunteering. Working for pay was associated with a higher rate of overall satisfaction with life. Overall, 81 percent of participants in the sample reported being satisfied with the way they lived after a year in the community, compared to 86 percent among those who worked for pay and 77 percent who were not working but wanted to do so.

B. Looking Toward 2011 and Beyond

We anticipate that the MFP demonstration will continue to grow in 2011, as the new grantee states begin their transition programs and as the established grantees (those that were awarded grants in 2007) enhance and expand their programs. The introduction of version 3.0 of the nursing home Minimum Data Set (MDS 3.0) and new questions that ask nursing home residents directly about their desire to return to the community and whether they would like a referral for more information about leaving institutional care are expected to increase referrals to MFP programs. Many states have established their MFP program as the primary recipient for these referrals. MFP programs are also receiving technical assistance to help them coordinate with Aging and Disability Resource Centers (ADRCs) and 25 grantees received additional funding to enhance and improve their collaboration with ADRCs. In addition, we anticipate that some of the additional funding awarded to established grantees in 2010 and 2011 to finance the hiring of

housing, community living, and behavioral health specialists will lead to further growth. We also anticipate that the investments grantees are making in their long-term care systems with the enhanced federal matching funds they receive may begin to influence overall state long-term care systems.

We believe the MFP program will continue to grow despite the poor economic outlook for most state budgets. In many states, the MFP program enjoys support from top Medicaid officials and the advocacy community continues its strong support for the program. The initial descriptive analyses showing that the HCBS expenditures for MFP participants are lower than their institutional care costs suggest the program may be a good investment for states, but only if these beneficiaries would not have transitioned to community living otherwise and their acute care costs do not offset any savings in their long-term care. On average, states are spending approximately $31,000 on HCBS per MFP participant. This per-person spending is 35 percent lower than average annual Medicaid spending on institutional care for elderly beneficiaries residing in nursing homes for at least three months. However, the HCBS expenditures of MFP participants are nearly twice the per-person costs for HCBS among all Medicaid beneficiaries (Irvin and Ballou 2010) and a third higher than per person HCBS expenditures for those in 1915(c) waiver programs (Ng, Harrington, and Howard 2011). The greater per-person expenditures for MFP participants may partly reflect the additional services these beneficiaries receive; approximately one-third of the expenditures for MFP participants are spent on MFP demonstration or supplemental services that states provide participants during the first year after they return to community living. They may also have a greater need for care than the average HCBS user. Nevertheless, before the cost-effectiveness of the MFP program can be determined, the analyses of expenditures must be expanded to include costs for all medical care including hospitalizations, physician visits, and emergency room use.

As more data become available for a greater number of MFP participants who have a year or more of post-transition experience, the evaluation will expand its scope and the rigor of its analyses. In the near term, data will be obtained from Medicaid eligibility records and the MDS to describe the level of care needs of MFP participants before they left the nursing home (comparable information is not available for former residents of ICFs-MR). We will also analyze Medicaid and Medicare claims for hospitalizations, physician visits, and emergency room use. The goal will be to make case-mix adjustments which take into account factors that may explain outcomes and to better isolate the effects of the MFP program.

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APPENDIX A

QUALITY OF LIFE MEASURES BY TARGET POPULATIONS, PRE-AND POST TRANSITION

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Table A.1. Quality of Life Measures by Target Populations, Pre- and Post-Transition[a]

	All Participants (N=1,090)		Aged (N=219)		PD (N=347)		ID (N=265)	
Measure	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Global life satisfaction	59	81	53	78	54	77	75	87
Satisfaction with care	89	92	92	89	90	87	91	95
Unmet personal care needs	14	3	18	3	21	7	4	0
Respect and dignity	68	92	68	93	63	90	74	90
Satisfaction with living arrangements	52	94	47	96	39	92	75	95
Community integration	48	34	53	32	60	48	30	22
Choice and control[a]	3.5	4.9	3.7	4.8	3.7	5.0	3.2	4.4
Sad mood	43	35	53	34	49	43	31	26

Source: Mathematica analysis of linked MFP-QoL surveys and MFP Program Participation data submitted through March 2011, representing pre-transition surveys conducted between January 2008 and March 2010.

Note: Excludes data from Delaware, Indiana, Louisiana, Michigan, North Carolina, North Dakota, and Virginia.

[a]All measures are expressed in percentages except for reported choice and control, which accounts for up to six areas of autonomy: being able to go to bed when one desires, the ability to be alone when one chooses, the ability to eat food of one's choice and when one chooses, and the ability to use the telephone or watch television when one chooses.

PD = Participants with physical disabilities who transitioned from nursing homes.

ID = Participants with intellectual disabilities who transitioned from an ICF-MR.

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