Money Follows the Person Demonstration: Overview of State Grantee Progress, July to December 2011

June 2012

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CONTENTS

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TABLES

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FIGURES

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EXECUTIVE SUMMARY

The goal of the Money Follows the Person (MFP) Demonstration, first authorized by federal law in 2005, is to support efforts by state Medicaid programs to give people with disabilities greater choice about where they live and receive long-term services and supports (LTSS). In 2007, the Centers for Medicare & Medicaid Services (CMS) awarded MFP demonstration grants to 30 states and the District of Columbia. In 2010, Congress increased total MFP program funding to $4 billion, which allowed CMS to award additional grants to 13 more states in 2011, for a total of 44 grantees. Congress also extended the demonstration to 2016 and allowed states to use grant funds to transition individuals and enroll them in MFP until the end of federal fiscal year (FFY) 2019; grantee states have until the end of FFY 2020 to spend all grant funds. [1]

This report describes progress by 34 MFP grantees in implementing their programs during the second half of 2011 (July to December 2011). All of the data and information presented in this document are self-reported by MFP grantee states, as submitted in their 2011 end-of-the-year progress reports. The grantees include 29 states and the District of Columbia[2] that received awards in 2007 (referred to as "established grantees") and 4 (out of 13) states that received awards in 2011 and began implementation during the last half of that year ("new grantees"). The remaining 9 new grantee states are expected to be included in subsequent semiannual progress overview reports once they start transitioning individuals through MFP.

Each state MFP grant program consists of two parts: a transition program to identify Medicaid beneficiaries living in institutions who wish to live in the community and help them do so, and a rebalancing program through which states make system-wide changes that allow more people with disabilities to live and receive long-term services and supports in the community. Because grantees report on their use of rebalancing funds in the mid-year report, this report focuses on developments in state transition programs.

Cumulative MFP Transitions to Date. After four full years of implementation, from January 2008 to December 2011, 19,728 individuals were enrolled in MFP and received assistance to move from institutions to the community. Cumulative enrollment at the end of 2011 increased 65 percent from one year earlier, and was 25 percent higher than six months earlier. The number of cumulative transitions varied widely across the 34 grantee states included in this report, from fewer than 10 in Idaho and Rhode Island – 2 of the new grantee states– to 5,300 in Texas, which accounted for 27 percent of all MFP participants enrolled since the demonstration began.

Transitions During 2011 and Current MFP Participants. During the last half of 2011, 3,937 new participants were enrolled in MFP, bringing the year's total to 7,659 transitions in the 34 states. This represents a 23 percent increase over the number of new MFP enrollees in 2010,

[1] MFP grant awards are available to grantee states for the fiscal year they got the award, and 4 additional fiscal years after. Any unused grant funds awarded in 2016 can be used until 2020.

[2] One of the initial 2007 grantees did not implement its program but plans to do so in 2012. In the remainder of this report, the District of Columbia is referred to as one of the state grantees.

when 30 grantees transitioned a total of 6,251 individuals. Despite this impressive growth rate for the year, the previously seen rate of increase in new MFP enrollees every six months leveled off this reporting period, with growth at about 6 percent from mid-2011 to the end of the year compared to double-digit growth rates in previous periods. The stabilization in new enrollment growth during the second half of 2011 is also reflected in the number of current participants, counted on the last day of each reporting period.[3] The number of current participants rose under 2 percent from mid-2011 to the end of the year compared to a 17 percent increase over the first half of 2011. Growth in the number of current participants seems to have plateaued due to lower numbers of enrollees entering the program in some of the larger states. Texas, which historically has contributed the largest number of new enrollees among all grantee states in each reporting period, surpassed other states by a smaller margin than in previous reporting periods. In addition, one state suspended its MFP program in late 2010, so it had no new MFP participants in 2011. While 4 states more than doubled the number of new MFP participants in 2011 compared to 2010, and 15 states had increases of more than 20 percent, their collective numbers were not high enough to offset the effect of changes in Texas or the declines in the number of new participants in other states.

Progress toward 2011 Transition and Qualified HCBS Expenditure Goals. CMS requires state MFP programs to establish two goals, also called benchmarks. The first goal is the number of annual transitions, which most states set at the beginning of each year in supplemental budget requests submitted to CMS. As of December 31, 2011, MFP grantees exceeded the aggregate transition goal across the 34 states that reported in this period, achieving 111 percent of the annual goal (7,659 transitions of 6,912 planned), almost the same level of performance as in 2010 (109 percent).

The second goal is total Medicaid expenditures (federal and state funds combined) on home and community-based services (HCBS) for all Medicaid beneficiaries, including MFP participants, that meet the criteria for "qualified" HCBS. This includes expenditures on 1915(c) waiver services; home health, personal care, and other HCBS provided as state plan optional benefits[4]; as well as HCBS for MFP participants. Thirty-three of the 34 MFP grantee states included in this period reported qualified HCBS expenditures in 2011 totaling approximately $52 billion, achieving 106 percent of the aggregate 2011 expenditure goal; 23 of these states met or exceeded their spending targets, 7 states spent between 80 and 99 percent of their spending targets, and 3 states spent less than 80 percent of their spending targets. However, qualified HCBS spending figures for 2011 are provisional, as many grantees revise actual spending figures to reflect claims lags and other corrections in subsequent reports.

Distribution of MFP Participants by Population Subgroup. States have flexibility to target their transition programs to different population groups. During this reporting period, 41

[3] The current participant count includes individuals who transitioned, have not been reinstitutionalized for more than 30 days, have not died, have not completed the full 365-day period of MFP eligibility, and did not withdraw for other reasons.

[4] Total HCBS expenditures also include spending on HCBS by capitated managed care plans that provide long-term care services when the state can identify HCBS-related expenditures separately from total capitated payments.

percent of all individuals newly enrolled in MFP were individuals under age 65 with physical disabilities, 38 percent were adults over age 65, 15 percent were individuals with developmental disabilities, 4 percent were individuals with mental illness, and 2 percent were individuals in other categories.[5] Compared to previous reporting periods, this represents a decrease in the proportion of new enrollees with developmental disabilities and corresponding increases in the proportion of other subgroups , reflecting a trend toward enrolling greater numbers of individuals under age 65 with physical disabilities and those with serious mental illness. However, individuals with developmental disabilities still comprise 23 percent of all cumulative enrollees to date because they made up a larger share of individuals transitioned in earlier years.

MDS Section Q Referrals and ADRC/MFP Supplemental Grant Activities. This reporting period was the second time MFP state grantees were asked to report the number of individuals referred to the MFP program from MDS 3.0 Section Q assessments, and of this number, how many people subsequently transitioned to the community and enrolled in MFP.[6] Among 34 MFP grantees, 23 states reported receiving a total of 3,463 Section Q referrals. These referrals led to 295 individuals subsequently transitioning to the community and enrolling in MFP during the same six-month period, or approximately 9 percent of all such referrals, a slight increase from the prior reporting period (6 percent). Grantee states were also asked to report the types of activities supported by Aging and Disabilities Resource Center (ADRC)/MFP supplemental grants, which 28 MFP states received in late 2010 and 2011 to help expand capacities of ADRCs to assist with transition planning and referral systems. The most common activity funded by these grants, indicated by half (14) of the 28 states that reported, was education and outreach to nursing homes and community organizations about Section Q requirements and MFP transition assistance services.

Reinstitutionalizations. State MFP grantees report on key indicators of how MFP participants fare in the community. One of the most important of these indicators is the number of people who are reinstitutionalized, defined as any admission to hospital, nursing home, intermediate care facility for the mentally retarded (ICF-MR), or institution for mental disease, regardless of length of stay. During the reporting period, 14 percent (946) of current MFP participants were reinstitutionalized for any length of time, a slight rise from the previous two reporting periods (13 and 12 percent in the previous two six-month periods). However, only 31 percent of those who were re-institutionalized had stays of more than 30 days, the same share as the previous reporting period.

[5] MFP participants may have more than one condition, but are categorized by their primary condition for reporting purposes. For example, people with serious mental illness as a primary condition are counted in that group, but people in the other four groups may have co-occurring mental or behavioral health conditions.

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

Emergency Call for Back-up Assistance. Eleven states reported a total of 107 emergency calls for backup assistance during the reporting period, 47 percent (50) of which were reported by New Hampshire, where a blizzard caused residents to be without power for four or more days.

Community Residence Types. During the reporting period, apartments were the most common type of residence selected by new MFP participants. Among the 3,937 new MFP enrollees in this period, 46 percent (1,819 individuals) moved to an apartment, 34 percent (1,326) moved to a home, and 17 percent (682) moved to a small-group home. The type of residence for the remaining 3 percent, or 110 individuals, was not known at the time state grantees submitted progress reports.

Self-Direction. The number of MFP participants choosing self-direction continued to grow. Of the 18 states that provided counts of MFP participants who were self-directing (compared to 15 in the previous reporting period), 30 percent of 5,063 current participants in those states chose to self-direct HCBS, either by hiring or supervising their personal care workers or managing a budget allowance or both. This compares to 23 percent in the prior reporting period. Ohio's definition of self-direction is broader than that of any other state (all new MFP enrollees are counted as self-directing since they can decide how to spend one-time moving expense funds). Not counting that state, the share of MFP participants self-directing in the 17 other states that offer such options is 19 percent.

Implementation Accomplishments and Challenges. Overall, state MFP grantees reported more accomplishments than challenges in this period in all major program areas including: (1) recruitment, education, and marketing; (2) obtaining informed consent from participants or guardians; (3) involving stakeholders; (4) providing and assuring access to home and community-based services; (5) offering participants the option of self-directing HCBS; (6) quality management and improvement; and (7) securing affordable, accessible community housing. This dominance of achievements over challenges reflects the maturity of many programs and the fact that 30 of the 34 reporting states have operated MFP programs for four years, giving them time to devise solutions to barriers in previous periods. In contrast, new state grantees tend to report more challenges than accomplishments.

Among the most notable accomplishments in this period were increases in the number of transition coordinators available to assist individuals as they plan a move back to the community, reported by more than half of states. A majority of states also reported increased availability or accessibility of HCBS, expansions to HCBS waiver programs, and additional HCBS providers contracting with Medicaid. Eleven states reported developing coalitions with state or local housing agencies to expand the availability of affordable, accessible housing for individuals with disabilities. Twenty-five of the 34 MFP grantee states reported improvements in their quality management systems through better intra- or interdepartmental coordination and enhancements to data collection systems, quality monitoring procedures, and critical incident reporting and tracking systems.

Nonetheless, MFP grantee states faced many of the same challenges that they reported in previous periods, including state budget cuts that have made it necessary to impose stricter limits on Medicaid home and community-based service benefits. Twenty states reported an insufficient supply of affordable, accessible housing options to meet the need, and there remained shortages

of HCBS providers (9 states), direct care workers (5 states), or specific types of HCBS (7 states) to meet the need.

Looking Ahead. Despite the slowdown in the growth rate of new MFP participants this period, several developments during the last half of 2011 signal the potential for resumption of healthy growth rates in new MFP enrollment. First, although only 4 of the 13 states that received new MFP grants in 2011 began operations in the latter half of 2011, the other 9 states are expected to begin enrolling MFP participants in 2012. Second, greater availability of housing subsidies to help low-income individuals find affordable, accessible rental units are expected to become available in the first half of 2012 and may reduce barriers to securing housing in the community for those who wish to transition. Third, improvements to information systems that track individuals identified through MDS 3.0 Section Q who want to return to the community holds promise for increasing referrals to MFP.

State Medicaid agencies are planning or implementing a host of other initiatives to reduce overall spending on long-term services and supports by expanding access to home and community-based services. This may further increase opportunities for MFP-eligible individuals to return to the community and allow those living in the community to remain there. For example, about a dozen states were planning to introduce or expand managed long-term services and supports programs this year, which give contracting plans a financial incentive to serve enrollees in community settings. In addition, many states are exploring new HCBS options authorized by the Patient Protection and Affordable Care Act, such as the Balancing Incentive Program and the Community First Choice (CFC) state plan option, both of which provide an enhanced federal match rate for certain types of investments in, or expansions to, home and community-based service alternatives, although the effects of these initiatives will not be evident for some time.

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I. INTRODUCTION

The Money Follows the Person (MFP) Demonstration provides state Medicaid programs the opportunity to help transition Medicaid beneficiaries living in long-term care institutions into the community. Congress established MFP through the Deficit Reduction Act of 2005 and expanded and extended it to 2016 through the Patient Protection and Affordable Care Act of 2010.[7] To date, the Centers for Medicare & Medicaid Services (CMS) awarded 44 MFP demonstration grants, initially to 30 states and the District of Columbia in 2007, and later to another 13 states in February 2011.[8] In February 2012, CMS also released another formal call for grant applications, and 3 additional states may submit applications that, if approved, could result in program implementation by 2013 and bring the total number of grantees to 47.

Each state participating in the MFP demonstration must establish a program with two components: (1) a transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and helps them do so and (2) a rebalancing initiative designed to rebalance state Medicaid long-term services and supports (LTSS) so they rely less on costly institutional care and individuals have greater choice of where they live and receive services.[9]

This report summarizes the implementation progress of the MFP Demonstration for 34 grantee states (33 states and the District of Columbia) for the six-month period from July 1 to December 31, 2011 (referred to as "this reporting period"), the eighth semiannual reporting period since the program began in January 2008. The analysis includes the original 30 grantee states, as well as an additional 4 (out of 13) new grantee states (Idaho, Massachusetts, Rhode Island, and Tennessee) awarded demonstrations in 2011. These 4 new grantee states began enrolling participants during this reporting period, marking the first time they have submitted a semiannual progress report. The remaining 9 new grantee states are expected to start enrolling participants in 2012 after finalizing their operational protocols and modifying data systems. These other grantee states will be included in subsequent semiannual progress overview reports once they start transitioning individuals through MFP.

All of the data and information presented in this document are self-reported by MFP grantee states, as submitted in their 2011 end-of-the-year progress reports. Some grantees were unable to

[7] 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.

[8] One of the initial 2007 grantees has delayed the implementation of its program, leaving 30 MFP grantees as of December 2011. The state later re-activated its grant in 2011 and expects to begin implementing its program in 2012.

[9] For additional information about MFP Demonstration goals and eligibility rules, see CMS's MFP web page http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html and the 2009 and 2010 MFP annual evaluation reports produced by Mathematica at http://www.mathematica-mpr.com/health/moneyfollowsperson.asp.

provide complete data for all questions in the progress report template; in such cases, missing data are noted in this report and shown as "not reported" in tables.[10]

The remainder of this report is organized into three parts. Section II describes grantee states' progress on key program performance indicators related to MFP transitions and program participation, including the number of people in each population group transitioned during the six-month period, transitions relative to goals, cumulative number of transitions since the start of the program, number of individuals assessed, and reinstitutionalizations. Section III discusses the major accomplishments and challenges in implementing the MFP demonstration reported by grantee states during this six-month period. Section IV concludes with an overall assessment of progress during this period and what to expect in the upcoming year. All tables can be found at the back of the report.

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

II. KEY PERFORMANCE INDICATORS — MFP TRANSITIONS AND ENROLLEES

A. New and Cumulative Transitions and Current Participants (Tables 1, 2, and 3)

The number of new transitions during this reporting period continued a trend of increased growth, with totals at the highest levels since the start of the program. From July to December 2011, Money Follows the Person (MFP) grantee states transitioned 3,937 new MFP participants, which is 6 percent more than the number of new participants transitioned in the first half of 2011 (3,722). It is also 16 percent more than the number of new participants transitioned in the second half of 2010 (3,407). Based on data available from 13 grantee states, 28 percent of new MFP participants had institutional stays between 90 and 180 days; that proportion is up from 20 percent reported in the first half of 2011. Presumably, these individuals would have not been eligible for MFP during the reporting period had the Affordable Care Act not changed the length of stay requirement for the MFP demonstration.[11]

By the end of December 2011, 19,728 individuals had transitioned to the community and enrolled in MFP since the program began in January 2008, representing a 25 percent increase from the cumulative number transitioned (15,818) as of June 30, 2011, and a 65 percent increase from the cumulative number transitioned (11,924) as of December 31, 2010 (see Figure 1).

Number of Current MFP Participants. As of December 31, 2011, there were 6,883 current MFP participants (Table 3). Current MFP enrollees are defined as those who transitioned, had not been reinstitutionalized for more than 30 days, had not died, had not yet completed the full 365-day period of MFP eligibility when they were receiving home and community-based services (HCBS), and did not withdraw from the program for other reasons. The number of current participants at the end of this reporting period was approximately 2 percent more than the number of MFP participants enrolled as of June 30, 2011, and 19 percent more than the number enrolled one year earlier (December 31, 2010). Growth in the number of current participants seems to have plateaued due to lower numbers of enrollees entering the program in some of the larger states.

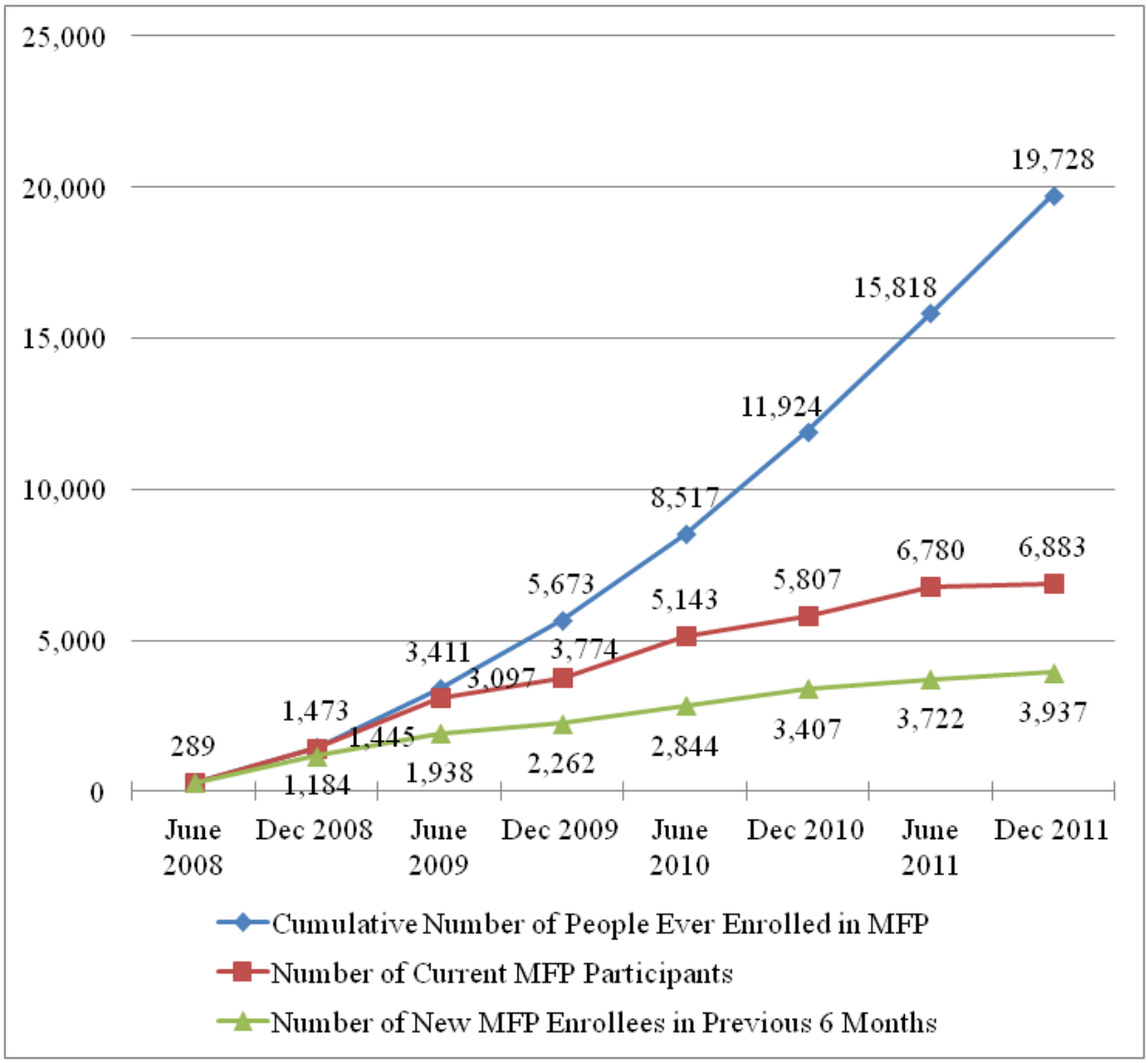
Variation Across Grantee States. The magnitude of the number of MFP transitions and enrollees varied among grantee states this reporting period. The counts of new participants ranged from more than 200 new participants reported in 5 grantee states, to less than 20 in 5 grantee states (Table 2). Three grantee states (Ohio, Texas, and Washington) accounted for nearly 40 percent of all new transitions. Oregon reported no transitions because it temporarily suspended its MFP program effective October 1, 2010, at which time it was closed to new enrollees. [12] Texas also reported the highest cumulative number of MFP transitions (5,300

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

[12] Oregon expects to resume MFP operations and re-commence transitions in 2012.

transitions) followed by Washington (1,748) and Ohio (1,533). These three states also reported the highest counts of current participants (Table 3), with Texas having 1,420 current participants, followed by 960 in Washington and 711 in Ohio.

Figure 1. Cumulative MFP Enrollees, Current MFP Participants, and New MFP Enrollees, June 2008 to December 2011



Distribution Across Targeted Populations. Among those who transitioned during this period, 41 percent were individuals younger than 65 years with physical disabilities, 38 percent were adults ages 65 and older (referred to as "elders" in this report), 15 percent were individuals with developmental disabilities, 4 percent were individuals with mental illness, and 2 percent were "other" individuals (Table 2). Compared to the period from January to June 2011, this represents a slight increase in the proportion of individuals with physical disabilities and elders, with a corresponding decrease in the proportion of individuals with developmental disabilities. Among the counts of cumulative transitions for this reporting period, 37 percent were individuals with physical disabilities, 35 percent were elders, 23 percent were individuals with developmental disabilities, 3 percent were individuals with mental illness, and approximately 2 percent were "other" individuals. This represents a consistent distribution of cumulative transitions across target groups when compared to the first half of 2011.

Parallel Transition Programs. To gauge the number of people that cannot enroll in MFP because they do not meet its eligibility criteria, grantee states were asked to report the estimated number of individuals who transitioned from institutions to home or community-based settings through programs other than MFP, which are called parallel transition programs. Individuals who transitioned through these programs might have been ineligible for MFP because they (1) did not meet MFP's minimum residency period of 90 days; (2) chose to move to a type of community residence that does not qualify for MFP; (3) were not eligible for Medicaid or waiver services; or (4) received transition planning services under an Aging and Disability Resource Centers (ADRC) Nursing Home Transition and Diversion grant, as in Illinois.

Twenty-two grantee states reported having parallel nursing home transition programs (data not shown). The 21 grantee states able to report data for these programs estimated that 4,522 transitioned to the community through these other programs; nearly half of these individuals (45 percent) were from Washington. Ten grantee states reported having a parallel transition program for individuals residing in intermediate care facilities for the mentally retarded (ICFs-MR), 8 of which estimated that 69 individuals with developmental disabilities transitioned to the community through these other programs during this reporting period. These totals likely underestimated the number of people that transitioned through parallel transition programs because many states did not keep accurate track of these numbers or did not report this information through the MFP progress reporting system.[13]

B. Achievement of Annual Transition Goals, 2010–2011 (Table 4)

As of December 31, 2011, MFP grantee states exceeded the aggregate transition goal for 2011, achieving 110.8 percent of the total annual goal (7,659 transitions of 6,912 planned). This

[13] California, Georgia, and North Carolina reported having a type of parallel program (either for nursing home or ICF-MR transitions) in the January to June 2011 reporting period but not during July to December 2011. Delaware and District of Columbia did not report having a parallel program during January to June 2011, but started reporting enrollment in a parallel program in this reporting period. We were unable to determine whether these changes reflect a change in the availability of these types of programs in these states or reporting errors in one or more reporting time periods.

level of achievement is consistent with the rate of progress for 2010, when grantees achieved 109.2 percent of the aggregate annual transition goal.

The ability of state grantees to meet their annual transition goals has improved in the past two years. In 2009, states achieved only 53 percent of the aggregate annual transition goal for that year (data not shown). At least some of the improvement in performance during 2010 and 2011 can be attributed to policy guidance from CMS to MFP grantee states at the end of 2009 that introduced financial incentives for setting more realistic transition goals. As a result, many grantees reduced their 2010 and 2011 transition goals to achievable levels.

Despite progress in the aggregate, grantee states varied in the degree to which they reached the number of planned transitions for 2011 (Table 4). Just over half of the MFP grantee states achieved 100 percent or more of their annual transition goals during 2011. The top two performing grantees—New Jersey and Ohio—achieved 303 and 205 percent, respectively. Of the states that achieved less than 100 percent of their 2011 transition goals, 4 grantees (District of Columbia, Massachusetts, Nebraska, and Rhode Island) were 50 percent below their goals. Massachusetts and Rhode Island are new grantee states whose 2011 goals reflected earlier implementation dates than actually occurred. The District of Columbia was unable to transition as many elders and people with physical disabilities as projected; both groups were newly added to its MFP program in 2011. Nebraska fell far short of projected transitions due to unexpected challenges recruiting individuals, serving clients with high levels of need in the community, and securing available housing options. Lastly, Oregon temporarily suspended its program and withdrew its 2011 transition goal.

C. Qualified HCBS Expenditure Goals (Table 5)

CMS defines qualified HCBS expenditures as total Medicaid HCBS expenditures (federal and state funds) for all Medicaid recipients, including expenditures for all 1915(c) waiver programs, home health services, personal care, and any other HCBS provided as state plan optional benefits.[14] In addition, total qualified HCBS expenditures include all HCBS spending on MFP participants (qualified, demonstration, and supplemental services).[15]

Thirty-three grantee states reported qualified HCBS expenditures for 2011 totaling approximately $52 billion (Table 5), which was 106 percent of the aggregate spending goal for all 34 grantee states. Among the reporting states, actual 2011 spending as a percentage of 2011 benchmark goals ranged from 45 percent (Georgia) to 420 percent (Connecticut). Twenty-three grantee states met or exceeded their target spending. Of these, 7 achieved over 120 percent: they were Texas, Iowa, Ohio, Virginia, the District of Columbia, North Carolina, and Connecticut. Six of these states spent more than 123 percent but less than 150 percent of their target amounts.

[14] Total HCBS expenditures also include spending on HCBS by capitated managed care plans that provide long-term services and supports in those states that offer MFP participants the option to enroll in such plans.

[15] Grantees are instructed to report total annual qualified HCBS expenditures once each year, on a calendar-year basis; 33 grantees reported qualified HCBS expenditures in their 2011 end-of-year reports.

As previously noted, Connecticut spent 420 percent of its target.[16] Seven states spent between 80 and 99 percent of their spending targets, and 3 states spent less than 80 percent of spending targets: Georgia (45 percent),[17] Oklahoma (64 percent)[18], and Delaware (68 percent)[19].

Qualified HCBS spending figures for 2011 should be regarded as provisional, since many grantees (14) modified actual qualified HCBS expenditures that were reported in 2010. The type of modifications included replacing projected spending with actual spending; updates to reflect late billings and adjustments; and corrections to inaccurate reporting, such as removing institutional payments. In addition, 5 states indicated that the figures reported as 2011 qualified HCBS spending were provisional or incomplete, due to lags in reconciliation of claims or differences in expenditure categories used to develop forecasted targets from those captured on the CMS-64 form and the MFP Financial Reporting Forms.

All grantee states indicated that they plan to revise their annual benchmarks for qualified HCBS expenditures in subsequent years. Revisions are planned for several reasons: to more accurately reflect expenditures; to reflect the state overall redirection to managed care; to align with legislative appropriations; to account for delays in implementation; and to reflect a planned expansion of the MFP program.

D. MDS 3.0 Section Q Referrals and Related Transitions (Table 6)

This reporting period was the second time MFP grantee states were asked to report the number of individuals referred to the MFP program from MDS 3.0 Section Q assessments, and of this number, how many people subsequently transitioned to the community and enrolled in MFP.[20] Among 34 grantee states, 23 were able to report receiving a total of 3,463 Section Q referrals. These referrals led to 295 individuals subsequently transitioning to the community and enrolling in MFP during the same six-month period, or approximately 9 percent of all such referrals, a slight increase from the previous reporting period (6 percent).

[16] Connecticut has significantly exceeded its expenditures benchmark since the start of its MFP program. It is unclear the exact cause, but the state reported that there are larger initiatives underway that focus on rebalancing that have probably contributed to the high spending.

[17] Georgia's qualified HCBS expenditures for 2011 are currently being investigated since the total may not include all HCBS spending categories reported in previous years.

[18] Oklahoma reported that spending was lower than projected because the state achieved only 94.8 percent of its transition benchmark. It is unclear from the state's report whether other factors might also be influencing the state's underachievement of its spending goal.

[19] Delaware's lower than expected spending was due to a variety of factors, including a reduction in referrals to the MR waiver; policy changes, which resulted in a narrower list of eligible MR services as well as changes to how services are billed; and decreased assisted living waiver expenditures due to the state's promotion of in home community-based services.

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

The number of Section Q referrals across grantee states varied widely, from just one referral (both North Dakota and Rhode Island) to more than 1,200 (Michigan). Differences in how states handle Section Q referrals can explain some of this variation. For example, in some states Section Q referrals go directly to local contact agencies, which screen individuals for MFP eligibility and do not refer ineligible individuals to the program. (Individuals may be ineligible because they do not qualify for Medicaid or have not met the minimum 90-day length-of-stay requirement.) In other states, Section Q referrals go to a single state entity, which then directs referrals to local contact agencies; if the MFP program is the state-designated contact agency, it could account for a large majority of all Section Q referrals.

The 3,463 Section Q referrals reported in this period represents an 11 percent decrease from the previous reporting period (3,889 reported by 20 grantee states). Total MFP assessments also declined between the previous reporting period (6,958 in these 23 grantee states, data not shown) and this reporting period (6,004 in these 23 grantee states). Some states reported receiving few Section Q referrals from nursing facilities during this reporting period and cited the high turnover of nursing facility staff as a contributing factor.

Several reasons could account for the low percentage of MFP transitions among Section Q referrals (9 percent). First, as explained earlier, not all individuals referred to MFP through Section Q are eligible for the program. Second, some people referred to MFP might qualify initially but then choose to move to a type of community housing that does not meet MFP requirements. Third, either staffing constraints or the difficulty of getting the housing and necessary community services in place might lead to a significant lag between the referral, the assessment, and the actual transition. As a result, some of the referrals that occurred this reporting period may not transition until a later period. Finally, transition coordinators may initiate transition assistance for a resident before receiving an MDS referral. For example, one grantee state (Texas) attributes the low number of MDS referrals enrolling in MFP to the fact that its transition coordinators receive referrals from other sources and quickly initiate transition assistance, oftentimes before the Section Q referral is received. However, one grantee state—Ohio—was notable for reporting more than 400 MDS 3.0 Section Q referrals to its MFP program and more than 30 percent of those referred were able to transition to the community and enroll in MFP during the same period. In addition, Georgia reported a relatively high number of individuals (184) referred in this period through Section Q that ultimately enrolled in MFP (16 percent).

Among the 11 grantee states that reported no Section Q referrals to MFP during this period, 3 (Illinois, Missouri, and Wisconsin) indicated that they were still developing Section Q referral tracking systems and one state (District of Columbia) reports that data were unavailable (see comments in Table 6). One state (Iowa) exclusively transitioned people from ICFs-MR, which do not use the MDS resident assessment instrument and so do not make Section Q referrals to MFP. One state (Washington) has a long-standing statewide nursing facility discharge program that makes Section Q referrals largely unnecessary. Three new MFP grantee states (Idaho, Massachusetts, and Tennessee) began program implementation in late 2011, and did not receive any MDS Section Q referrals during the reporting period. Another state (New Jersey) did not provide an explanation for the lack of Section Q referrals, and Oregon's MFP program is currently in suspension.

Grantee states were also asked to report the types of activities that are supported by ADRC/MFP Supplemental Funding grants, which 28 MFP grantee states received in late 2010 and 2011. These grants help states expand the capabilities of ADRCs to assist with transition planning and coordination, support Section Q referral tracking systems, and develop greater capacity to follow up with nursing home residents who wish to explore community living options. Among the 28 grantee states that indicated the types of activities these grants supported during this past period, five were most common: (1) conducting education and outreach to nursing homes and to other organizations providing long-term services and supports about Section Q and MFP transition assistance services (14 states); (2) developing or expanding state capacity to provide community options counseling and transition assistance to nursing home residents (11 states); (3) developing or improving Section Q referral tracking systems (8 states); (4) training current or new ADRC staff to do transition planning in MFP or other transition programs (6 states); and (5) expanding the ADRC program in the state (6 states). Five states (Idaho, Massachusetts, Michigan, Rhode Island, and Washington) recently received ADRC/MFP Supplemental Funding grants and are either awaiting those funds or are in the early stages of implementing new initiatives. One state (Washington) encountered unforeseen delays with its procurement process and expects to begin implementing its initiatives in mid-2012.

States that received ADRC/MFP Supplemental Funding were also asked to describe results or outcomes from the activities supported by these funds. Seven states (California, Maryland, Missouri, New Hampshire, North Carolina, Pennsylvania, and Virginia) cited conducting training for nursing facilities, local contact agencies, ADRCs, and MFP organizations on options counseling. Four states (Arkansas, Delaware, District of Columbia, and North Dakota) hired staff to conduct outreach into nursing facilities, to support institutional diversion, or to provide transition coordination to nursing home residents. Four states (Arkansas, Idaho, Kentucky, and Nebraska) established or enhanced existing databases to track MDS Section Q referrals. Other states expanded outreach efforts to educate nursing facility residents and staff about options counseling.

E. Reinstitutionalizations (Table 7)

Overall, 14 percent (946) of current MFP participants were reinstitutionalized between July and December 2011 (Table 7), of whom 296 (31 percent) were reinstitutionalized for more than 30 days (data not shown).[21] Among all participants reinstitutionalized for any length of time, 43 percent were physically disabled and 41 percent were elders. During this reporting period, 222 people who had at any point been reinstitutionalized for more than 30 days were reenrolled in the MFP program.

Compared to other groups in this period, those with mental illness (23 percent) and "other" individuals (22 percent) were reinstitutionalized at much higher rates than their share of current MFP participants (data not shown). Among all individuals reinstitutionalized in the period, 6 percent (56) had mental illness, which represented twice their share of current participants (3

[21] As defined in the progress reporting system, reinstitutionalization means any admission to a hospital, nursing home, ICF-MR, or institution for mental disease, regardless of length of stay.

percent), and 4 percent (34 individuals) in the "Other" category were reinstitutionalized though they only made up 2 percent of participants.

Largely in proportion to their share of the total population (76 percent, cumulatively), individuals with physical disabilities and the elderly together made up the majority (84 percent) of those reinstitutionalized. However, the elderly made up 41 percent of reinstitutionalizations lasting more than 30 days, slightly larger than their share of total MFP participants (36 percent); those with physical disabilities made up 43 percent of reinstitutionalizations longer than 30 days, also slightly larger than their share of the population (40 percent). Individuals with intellectual disabilities were less likely to be reinstitutionalized than those in other categories.

A decline in physical or mental health status was the most commonly reported factor contributing to reinstitutionalization, with 18 grantee states mentioning this reason. In addition, 7 states reported hospitalizations and 2 reported falls as factors contributing to reinstitutionalization. Many reinstitutionalizations were due to either inadequate informal support or unsuitable living conditions, including inability of informal supports to provide the level of care required, the loss of a personal caregiver, or conflicts in the home. Other reasons for reinstitutionalization included individuals' desire to move back to an institution, a lack of community providers willing or able to provide needed supports, inability to manage behavioral issues, and loss of housing in the community.

F. Emergency Calls for Backup Assistance (Table 8)

Eleven grantee states reported a total of 107 emergency calls for backup assistance during the reporting period; 47 percent (50) of these calls were reported by New Hampshire. Many of these calls were due a blizzard that caused residents to be without power for four or more days.

The number of emergency calls for backup assistance per 1,000 participants was slightly higher for this reporting period (15.5 calls per 1,000 participants) than for January to June 2011 (12.5 calls per 1,000 participants). Of the total calls for emergency backup assistance, 49 percent (52 calls) were categorized as other, nearly all of which (50) were New Hampshire blizzard-related emergencies. Additionally, 31 percent (33 calls) were attributable to critical health services, 18 percent (19 calls) were in response to direct service or support workers not showing up as scheduled, and 3 percent (3 calls) were to address transportation to medical appointments. No calls were in response to life support repair or replacement.

G. Self-Direction (Table 9)

Self-direction continues to become more common among MFP participants. Eighteen of the 27 MFP grantee states with operational self-direction programs provided counts of the number of participants who chose to self-direct their care.[22] Among the 5,063 current participants in those 18 states as of December 2011, 30 percent (1,533) were reported to be self-directing at least one

[22] The number of states that offered a self-direction option in this period and had participants choosing to direct their own care include two states (Louisiana and New Hampshire) which reported that some participants were self-directing but which were unable to determine the actual number.

type of HCBS. Ohio counts all MFP participants as self-directing the use of their one-time moving expenses; the share of MFP participants self-directing drops to 19 percent when this grantee state is excluded from the analysis.

Late in this reporting period, Louisiana successfully added a self-direction option and rolled it out statewide but did not have any data available for this reporting period. Oklahoma is still planning to implement a self-direction option and hopes to be able to offer it in Spring 2012, once it is able to contract with a financial management service. Although the number of individuals self-directing is not comparable across states due to differences in what counts as a self-directed service option, the overall number of participants counted in self-directed programs appears to be underreported.

Sixty-four (982) percent of participants who self-directed services during this reporting period managed their own allowance or budget. This is a slight decrease from the previous reporting period, when 67 percent of self-directing participants did so. Additionally, 51 percent (780) of the participants who self-directed services hired or supervised their own personal care assistants (note that this category and the category of participants managing their own allowances or budgets are not mutually exclusive). Twenty-four MFP participants in 7 states withdrew from a self-direction program during the reporting period. Reasons for withdrawal included being reinstitutionalized, opting out of self-direction, and death.

H. Types of Qualified Residences (Table 10)

During the reporting period, apartments were the most common type of residence selected by new MFP participants. Among the 3,937 MFP participants who transitioned to the community during this period, 46 percent (1,819 individuals) moved to an apartment, 34 percent (1,326) moved to a home, and 17 percent (682) moved to a small-group home. The type of residence for the remaining 3 percent, or 110 individuals, was not known at the time states submitted progress reports.[23]

With the exception of individuals with developmental disabilities, apartments were the most common type of residence selected by all groups. Individuals with mental illness were most likely to move to an apartment; 66 percent chose this type of community residence. Those with developmental disabilities were most likely to move to a group home (67 percent). The elderly (42 percent) and working-age individuals with physical disabilities (40 percent) were more likely than other groups to move into a home (data not shown). These data reflect aggregate counts of the types of residence to which participants moved upon transitioning to the community. They do not indicate where MFP participants resided at the end of the reporting period.

[23] The total number of participants residing in MFP-qualified residences (3,827) does not sum to the total number of individuals who transitioned to the community this period (3,937) because several states reported fewer transitioned individuals by residence type than total transitions in the period.

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III. PROGRESS AND CHALLENGES BY PROGRAM COMPONENT

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

A. State Budget Cuts

A smaller proportion of states (41 percent, or 14 of 34) reported that the effects of the economic downturn on state budgets have adversely affected their MFP programs than in the previous reporting period (47 percent, or 14 of 30). In many of these states, cuts may have occurred to other Medicaid programs, but the MFP program has not been specifically affected. This may be attributable to the availability of 100 percent federal matching funds for MFP administrative positions, but states did not explicitly report this funding as a factor.

In some grantee states, worsening state budgets have led to cuts in staff, services, or payment rates; tighter eligibility criteria for entry into waiver programs; and freezes or reductions to waiver slots. Louisiana and Washington were the only 2 states to specifically report negative impacts on staffing. Washington continued to have hiring and pay freezes that have had an adverse affect on the ability of staff to conduct MFP program activities. In addition, the state consolidated its Medicaid service regions from six regions three, causing staff and business offices performing administrative functions to have to cover a larger geographic area. Budget cuts in Louisiana reduced the number of waiver slots, and North Carolina froze new enrollment in its waiver programs, which means slots for the MR/DD waiver are no longer assured for MFP participants.

Louisiana also reported reductions to services and payment rates, and New Hampshire reported cuts to funding and programs but did not provide additional details. Reduced funding in California led that state to refine waiver eligibility criteria so as to target services to individuals with the highest need. Missouri indicated that a worsening state budget makes it difficult to propose changes to existing programs or implement new programs though it did not mention the need for cuts. The other states reporting worsening state budgets indicated there were cuts or freezes to Medicaid programs or to all state agencies but did not provide details on the impacts to MFP or other LTSS.

B. Availability of and Participant Access to Home and Community-Based Services (Table 11)

A successful transition to the community requires available and accessible HCBS. States were asked to report accomplishments and challenges towards increasing access and availability of HCBS during the reporting period. Of the 34 states that reported, 25 identified progress

towards making HCBS more accessible and available to MFP participants, while the other 9 states reported no progress during the reporting period.

Accomplishments. Of the 34 states reporting, 25 reported at least one accomplishment towards increasing participants' access to HCBS. This reporting period was the first in which no grantee state reported an increase in payment rates to HCBS providers. The following are the main accomplishments reported, along with select examples:

- **Increased number of transition coordinators (17 states).** An increase in the number of staff responsible for coordinating transitions was the most frequent accomplishment reported. In Georgia, for example, an interagency agreement resulted in the funding of 14 transition coordinators and 14 MDS Section Q options counselors. Illinois used its ADRC supplemental funding to hire additional transition coordinators.
- **Increased number of HCBS providers (9 states).** Although states continued to report an insufficient supply of HCBS, some noted a steady increase in the number of Medicaid-participating providers. Efforts in Washington, for example, have resulted in new Medicaid contracts with seven adult family homes that had previously not served Medicaid clients.
- **Enhanced the Direct Service Workforce (4 states).** Three of these states (Connecticut, Iowa, New Jersey) each developed a partnership with a local college to provide training and support for DSWs. These states utilized the College of Direct Support program to offer web-based courses designed for professionals who provide direct support to individuals with disabilities. For example, after New Jersey implemented the College of Direct Support, the participating agencies showed an overall reduction in the turnover rate among direct service workers. Similarly, Iowa provided free access to College of Direct Support training to help support professionals strengthen their skills and develop a career path.
- **Improved housing options (3 states).** Like many established MFP programs, Tennessee provided a transition allowance of up to $2,500 to any participant needing financial assistance in setting up housing. Texas has used 100 percent federal administrative funding to contract with four ADRCs to hire housing navigators, and Washington has increased the capacity of its community-based Supported Living Program.
- **Added or expanded managed long-term services and support programs (2 states).** In Hawaii, staff at the nursing facility regularly met with managed care plan service coordinators to help plan and address participant needs in the community post-transition. Through an interagency partnership, North Carolina ensured that transition support needs are identified and provided for in managed care agreements.
- **Improved transportation options (2 states).** A pilot program in Washington provided trips not currently permitted under the existing scope of the non-medical emergency transportation program, such as to view potential housing options. The success of this pilot led Washington to consider statewide expansion.
- **Other improvements (6 states).** States reported a variety of other notable accomplishments. North Dakota, through a nursing facility partnership, developed an

outreach and marketing plan to ensure that all persons on Medicaid in a nursing facility were aware of grant services. Oregon used rebalancing funds to promote community nursing, and Texas increased funding to six additional ADRCs (14 total), four of which act as the states local contact agencies for MDS 3.0 Section Q.

Challenges. Of the 34 states reporting, 24 cited at least one challenge towards increasing participants' access to HCBS. The following are the main challenges reported, along with some strategies employed to overcome them:

- **Insufficient supply or availability of HCBS providers (11 states).** Among these grantee states, a wide range of challenges were reported, which they are trying to address in various ways:
  - **Limited or no HCBS availability in certain areas (5 states).** North Carolina reported a lack of crucial services, including mobile pharmacies and fuel assistance for participants living in rural areas. To address coverage gaps, New Jersey encourages consumers to hire their own personal aides through self-directed service options. Physicians in nursing facilities in Washington were not able to authorize refills on pain medication for discharged patients from the nursing home, yet local outpatient pain clinics had significant wait lists, creating a major barrier for new participants trying to access prescription pain medications.
  - **Limited number of certain types of providers (4 states).** The District of Columbia reported a limited number of primary care physicians willing to accept MFP participants, an issue it is attempting to address through existing efforts to enhance the provision of primary care citywide. Iowa worked to expand employment opportunities for participants through the recent hiring of an employment specialist to assist in job development and provide technical assistance to providers.
  - **Staff shortages (2 states).** A staff shortage in the California Assisted Living Waiver program prevented a number of MFP participants from transitioning. The California MFP team sought to have MFP staff approved to assist people with the waiver application process.
  - **Inadequate skill set among some provider staff (2 states).** The North Carolina program supported a considerable number of individuals with dual diagnoses yet the state lacked an adequate number of providers to support this population. Program staff are developing stronger pre-transition training protocols to support provider staff.

- **Limits on amount, duration, or scope of HCBS (10 states).** Within this category, two types of challenges were most common:
  - **Lack of coverage for specific services (5 states).** A lack of 24-hour services and supports, such as personal care or attendant services, remained a major barrier for transitioning some participants in Massachusetts, Missouri, New Jersey, and North Dakota. Both Massachusetts and North Dakota were attempting to amend or create a new waiver to cover these essential services.

  - **Service and cost limitations (4 states).** Because the North Carolina Aging and Disability Waiver cannot support individuals with significant needs, the state is seeking to update the waiver's service definitions to allow additional services to be included in the definitions to better support the ability of participants to live independently in the community. The economic downturn has caused Washington to reduce funding for the Senior Citizen Service Act, which provides access to basic services aimed at preventing premature institutionalizations.

- **Lack of appropriate transportation options (6 states).** This challenge is particularly acute in rural areas where public transportation may not be an option (Louisiana, Mississippi, and Missouri). Missouri assembled a stakeholder group to address this issue. Both Washington and the District of Columbia reported a lack of coverage for nonmedical transportation. Ohio began funding the development of several local housing and service cooperatives, led by the Centers for Independent Living, which were to focus on addressing local transportation issues.
- **Insufficient supply of direct service workers (DSWs) (5 states).** To address inadequate skill sets among staff, both Iowa and Louisiana are providing training opportunities. Ohio has created a process to provide growth opportunities for direct service professionals so that positions are viewed as entry points into other careers. North Dakota, which faces a shortage of DSWs in rural counties, is in the process of implementing a DSW marketing plan utilizing the realistic job preview video project that was created to provide additional resources to direct service providers and their work with individuals in the community.
- **Lack of affordable, accessible, and integrated housing (5 states).** Both Texas and Virginia are actively working with local public housing authorities to explore ways to improve housing options. New York continued to fund several waiver programs that provide housing subsidies for eligible MFP participants.
- **Preauthorization requirements (3 states).** In California, county offices of the In-Home Support Services program have been reluctant to provide preliminary assessments and authorization of personal care services prior to MFP enrollees being discharged although these assessments are required. The MFP team worked with the department that runs the IHSS program to issue an all-county letter restating the requirement to conduct preliminary assessments in nursing facilities.

C. Securing Housing for Participants (Table 12)

Twenty-five grantee states reported achievements in securing housing for participants, with the two most frequently cited activities being the development of an inventory of affordable and accessible housing (12 states) and the development of local or state coalitions to identify needs or create housing-related initiatives (11 states). As part of the efforts to develop housing inventories, 5 grantees (District of Columbia, New Jersey, New York, Tennessee, and Washington) informed landlords about the MFP program, helped them evaluate their properties for accessibility and affordability, and determined their willingness to accept rental vouchers from MFP participants.

Eleven grantee states indicated new activities related to the development of local or state coalitions. Nine states Idaho, Hawaii, Maryland, Massachusetts, Missouri, Ohio, Tennessee, Texas, and Wisconsin) formed or strengthened partnerships in preparation for applying to the upcoming HUD Section 811 funding to provide rental assistance for non-elderly adults with disabilities in new rental housing developments. Other collaborative activities revolved around the utilization of HUD non-elderly disabled Category 2 rental vouchers awarded in January 2011; 11 grantee states (California, District of Columbia, Georgia, Illinois, Iowa, Maryland, Michigan, New Jersey, Ohio, Texas, and Wisconsin) cited partnerships to identify eligible individuals and help them apply for these vouchers. New initiatives have also been developed through MFP-housing partnerships. For example, the New Jersey Housing and Mortgage Finance Agency and the New Jersey Department of Community Affairs partnered to create the Special Needs Housing Partnership program to expand opportunities and expedite the process of placing individuals with developmental disabilities into community-based support housing. The state's short-term goal is to purchase and convert residences for 600 people by June 2013.

Other positive activities of note include the expansion of the newly developed North Dakota Housing Incentive Fund from $4 million to $15 million plus $6 million in tax incentives to encourage the development of affordable, accessible housing. Connecticut received $500,000 in bond funds to support accessibility modifications for MFP participants. Also of note are the plans of North Carolina and New York to use rebalancing funds for state initiatives to assist individuals with disabilities to identify available, accessible housing options.

Although many grantee states' reported achievements securing housing for participants, housing-related challenges continue to be a persistent challenge. As shown in Table 14, 32 states reported 56 housing-related challenges this period. The most commonly reported challenges related to insufficient supply of affordable and accessible housing (20 states) and an insufficient supply of rental vouchers (11 states). Some states indicated the shortage of available units was caused by high rent, inaccessible homes, and unsafe neighborhoods. Four states (Nebraska, Missouri, Texas, and Virginia) specifically mentioned that difficulties locating housing significantly delayed or prevented MFP transitions.

Among the 11 states reporting an insufficient number of rental vouchers, many reported that while they are working with local public housing authorities (PHAs) and are preparing to apply for future HUD notices of funding availability (NOFAs), they struggled to establish relationships with some PHAs. Texas and Wisconsin attributed this challenge to the high number of PHAs in the state, while Iowa and New Hampshire had difficulties engaging PHAs around MFP issues. Other grantee states (District of Columbia, North Dakota, Tennessee, and Texas) reported that rental vouchers did not adequately cover the cost of rent. In Louisiana, some participants were sharing supportive housing to make housing costs more affordable.

D. Quality Management and Improvement

Twenty-five of the 34 grantee states reported improvements in their quality management systems. The top four improvements reported were (1) improving intra- or interdepartmental coordination, (2) implementing or enhancing data collection instruments, (3) implementing or enhancing quality monitoring protocols, and (4) enhancing a critical incident reporting and tracking system.

Among the 10 states that reported enhanced intra- or interdepartmental coordination, the changes helped to improve timeliness of reports and strengthen quality assurance processes. In Nebraska, for example, the state implemented a quality indicator review subcommittee to review discovery and remediation results and recommend improvements. Tennessee expanded the use of its pre-admission evaluation system from TennCare to include the Department of Intellectual and Developmental Disabilities. In Georgia, the Department of Human Services and the Division of Aging Services began working together to develop a quality management system under the terms of a new interagency agreement that will shift transition coordination services from a private contractor to the state's 12 ADRCs.

Nine states reported implementing or enhancing data collection instruments. Examples include Pennsylvania's efforts to implement a new incident management system for aging waiver providers and Texas's testing of a new database of relocation contractors. Hawaii and Louisiana implemented new quality assurance monitoring tools and processes in response to renewals of a waiver.

Eight states implemented or enhanced quality monitoring protocols. Michigan implemented a new review process to improve scoring consistency across reviewers, agencies, and participants. North Dakota added nurse quality assurance reviews before and after transition. New Jersey is in the process of hiring a quality assurance specialist to develop a quality assurance process for those individuals who transition from an institution to community living. The specialist will also ensure that required services are provided, track findings over time, and analyze data to improve service delivery within the state's MFP program.

Eight states enhanced their critical incident reporting and tracking systems. For example, Missouri trained state staff in different agencies involved in the process of requesting investigations, entering data in the system to track incidents, and providing notification and alerts to investigators. Idaho had ongoing training for providers on the complaint and critical incident process and conducted periodical training for nurses and quality improvement managers. Louisiana, Nebraska, and Massachusetts updated existing critical incident systems; Pennsylvania and Washington reported progress on developing new systems.

Only 11 states reported challenges related to quality management, which were spread across the discovery, remediation, and improvement processes. Ten states reported problems with the discovery process that included being unable to identify threats to participants' health and welfare on a timely basis (Georgia, Hawaii, Louisiana, Missouri, and North Dakota) and or shortcomings in systems to determine if participants were receiving adequate services and supports (Illinois, Louisiana, Missouri, and North Carolina). Often, the problems are due to inadequate information sharing systems across agencies involved with MFP transitions. In response, Georgia, Hawaii, Louisiana, and Missouri reported that they issued reminders to other agencies of their responsibilities, and the District of Columbia, Louisiana, North Carolina, and Pennsylvania were refining or developing new incident management systems. Missouri used a number of surveys and evaluation tools to help identify if adequate supports were being provided to an individual.

Six states (District of Columbia, Illinois, Louisiana, Missouri, North Dakota, and Pennsylvania) reported challenges with the remediation process. To address these problems, states were working to improve monitoring and communication processes. In the District of

Columbia, the Medicaid rate structure gives providers little incentive to ensure full remediation, and the Medicaid agency does not have the capacity to monitor remediation action plans. In response, case managers have been hired to monitor and provide these services to MFP participants. To address its problems, Illinois is working to ensure that transition coordinators have the required level of expertise and will consult with nurse practitioners.

Seven states (Georgia, Hawaii, Illinois, Louisiana, Missouri, North Carolina, and Virginia) reported quality improvement process challenges. Most of these challenges related to difficulties in gathering information to identify trends. Georgia, Louisiana, and Virginia reported that they did not have systems in place to capture, managed, or share trend information across agencies.

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IV. CONCLUSION

The fourth full year of the MFP Demonstration program was characterized by strong growth in enrollment and improvements to transition coordination capacity and quality management systems. The cumulative number of participants ever enrolled in MFP reached 19,728 individuals by December 2011, 65 percent more than in December 2010. In the last half of 2011, 4 of 13 new grantee states began implementation, heralding a new era of growth in the program. During the second half of the year, 34 states reported 3,937 new enrollees into MFP, bringing the 2011 annual total to 7,659 people transitioned and enrolled in MFP, 23 percent more than the total number of new enrollees in 2010 (6,251 individuals).

Despite this impressive growth rate, the rise in new MFP transitions slowed in the second half of the year, dropping to 6 percent from the first half of the year, compared to double-digit growth rates in each six-month period during the program's first three years. In addition, the number of current participants, counted on the last day of each reporting period, rose by 1.5 percent during the last half of the year, compared to at least 12 percent or more in each of the six-month periods preceding this last one.

Several factors may account for this apparent stabilization of new enrollment. First, Texas, which continues to dominate MFP enrollment by accounting for a quarter to a third of all new and cumulative transitions, had a slowdown in the growth of its new enrollments. During the last half of 2011, Texas reported 642 new MFP transitions, compared to more than 1,000 in the first half of 2011 and 811 in the last half of 2010. Texas officials attributed the decline in new enrollees to the difficulty in transitioning as many residents of ICFs-MR to the community as they had done earlier because the residents of these institutions who did not transition previously have higher needs, making it more difficult, and more time consuming, to find an appropriate community placement. Second, Oregon suspended new enrollment in October 2010 and thus reported no new MFP enrollees in 2011. Third, although 4 states more than doubled the number of new MFP participants from 2010 to 2011, and 15 states had modest increases over previous years, the number of new enrollees in these 19 states was not sufficient to offset declines in the number of new participants from 2010 to 2011 in 5 other states.

Another factor that could account for the slowdown in the growth rate in new MFP enrollees in the second half of last year may have been budget shortfalls, which led some states to make cuts in provider payment rates and place stricter limits on the amount, scope, or duration of HCBS.[24] These restrictions may have led MFP program staff to be more cautious about enrolling new participants if they were uncertain about the availability of state funding and of HCBS to ensure MFP participants can continue living in the community after their first year of program

[24] For example, 7 states in both FY 2011 and FY 2012 restricted HCBS programs or services, and 4 states in FY 2011 and 6 states in FY 2012 made reductions to personal care services as a state plan option. See V.K. Smith et al., "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012," Kaiser Commission on Medicaid and the Uninsured, October 2011.

participation. Such caution may abate as the outlook for state revenue growth begins to improve in 2012.[25]

Looking Ahead. Despite the slowdown in new MFP enrollment growth, several developments suggest the potential for resumption in healthy growth rates in new MFP enrollment in 2012. A boost in the number of new enrollees is expected from the 13 states that received new grants in 2011, as they begin operations and start enrolling MFP participants in 2012. In addition, 16 of the established grantee states reported hiring new transition coordinators during the last half of 2011, which may result in higher numbers of new enrollees in 2012. Almost a dozen states reported greater availability of housing subsidies to help low-income individuals find affordable, accessible rental units, and many others are making progress towards expanded housing options through collaborations with state and local housing agencies. States have also made improvements to information systems to track whether individuals identified through MDS 3.0 Section Q referrals wishing to return to the community may be eligible for MFP.

In addition, state Medicaid agencies are planning other initiatives to expand access to home and community-based services, which may increase opportunities for individuals with disabilities who are admitted to institutions to return to the community and allow those living in the community to remain there. For example, at least a dozen states were planning to introduce or expand managed long-term services and supports programs in FY 2011 or FY 2012 (Smith et al. 2011; see footnote 22), which use capitated payment and other methods to give health plans strong incentives to serve as many individuals as possible, which is often less costly. For example, one new MFP grantee state, Tennessee, introduced a new managed LTSS program in 2010 which set capitation rates at a level that assumed managed care organizations would be able to reduce institutional care by 4 to 6 percent over two years. According to state officials, before 2010 about 17 percent of the long-term care population was using HCBS, but a year after statewide implementation of the managed LTSS program, the share of HCBS users was over 30 percent of all people receiving LTSS.[26]

Furthermore, many states are exploring new HCBS options made available under the Affordable Care Act, including the Balancing Incentive Payments program, which provides an enhanced federal match rate for qualifying states, and the Community First Choice (CFC) state plan option, which also provides an increased federal match rate for home and community-based attendant services and supports. At this time, it is unclear how many states will elect these options, and it will take many years before their effects are known.

[25] National Association of State Budget Officers, "Summary: Fall 2011 Fiscal Survey of States," November 28, 2011. http://www.nasbo.org/sites/default/files/Fall%202011%20Fiscal%20Survey%20-%20Summary.pdf

[26] Patti Killingsworth, Chief, Long-Term Care, TennCare Bureau, Tennessee, Presentation to the Medicaid and CHIP Payment and Access Commission (MACPAC), November 2011. Meeting information available at http://www.macpac.gov/home/meetings

Table 1. Cumulative Number of MFP Grant Transitions Through December 31, 2011

State	Cumulative Number of Transitions from Program Start to December 31, 2011					
	Cumulative Total	Elders	People with Physical Disabilities	People with Developmental Disabilities	People with Mental Illness	Other
Arkansas	272	34	74	163	1	0
California	630	139	212	193	20	66
Connecticut	796	319	350	21	106	0
Delaware	66	22	33	5	6	0
District of Columbia	110	2	16	92	0	0
Georgia	746	168	218	360	0	0
Hawaii	139	69	64	6	0	0
Idaho[a]	4	0	2	2	0	0
Illinois	482	142	117	0	223	0
Indiana	460	295	165	0	0	0
Iowa	173	0	0	173	0	0
Kansas	595	150	273	152	0	20
Kentucky	314	76	68	124	0	46
Louisiana	257	71	80	106	0	0
Maryland	1,167	497	470	167	0	33
Massachusetts[a]	52	30	13	8	1	0
Michigan	1,056	538	518	0	0	0
Missouri	454	84	178	171	0	21
Nebraska	136	32	43	53	0	8
New Hampshire	107	37	32	8	0	30
New Jersey	347	115	82	150	0	0
New York	506	160	208	0	0	138
North Carolina	157	41	37	79	0	0
North Dakota	75	13	22	40	0	0
Ohio	1,533	341	775	276	141	0
Oklahoma	262	64	122	76	0	0
Oregon[b]	306	105	144	50	0	7
Pennsylvania	821	585	193	33	10	0
Rhode Island[a]	6	3	3	0	0	0

Table 1 (continued)

State	Cumulative Number of Transitions from Program Start to December 31, 2011					
	Cumulative Total	Elders	People with Physical Disabilities	People with Developmental Disabilities	People with Mental Illness	Other
Tennessee[a]	62	35	25	2	0	0
Texas	5,300	1,818	1,853	1,627	2	0
Virginia	388	76	99	213	0	0
Washington	1,748	854	798	93	3	0
Wisconsin	201	71	82	47	1	0
TOTAL	19,728	6,986	7,369	4,490	514	369

Source: MFP semiannual web-based progress reports covering the July 1 to December 31, 2011, period. Submitted March 1, 2012.

[a] Idaho, Massachusetts, Rhode Island, and Tennessee implemented new MFP programs during the July 1, 2011, to December 31, 2011, reporting period.

[b] Oregon temporarily suspended its MFP program effective October 1, 2010, and stopped enrolling new participants.

ICF-MR = intermediate care facility for people with mental retardation; MFP = Money Follows the Person.

Table 2. Number of Institutional Residents Who Transitioned Under MFP during This Reporting Period: July 1 to December 31, 2011

State	Number of New MFP Participants that Transitioned During the Reporting Period					
	Total Number	Elders	People with Physical Disabilities	People with Developmental Disabilities	People with Mental Illness	Other
Arkansas	60	8	8	44	0	0
California	142	45	68	1	2	26
Connecticut	228	114	86	9	19	0
Delaware	12	4	6	1	1	0
District of Columbia	22	2	14	6	0	0
Georgia	95	25	17	53	0	0
Hawaii	32	16	16	0	0	0
Idaho[a]	4	0	2	2	0	0
Illinois	131	34	49	0	48	0
Indiana	137	79	58	0	0	0
Iowa	37	0	0	37	0	0
Kansas	114	18	65	26	0	5
Kentucky	84	21	22	32	0	9
Louisiana	93	19	28	46	0	0
Maryland	211	100	83	21	0	7
Massachusetts[a]	52	30	13	8	1	0
Michigan	178	92	86	0	0	0
Missouri	77	21	29	22	0	5
Nebraska	18	4	8	6	0	0
New Hampshire	18	9	5	1	0	3
New Jersey	99	41	35	23	0	0
New York	136	46	50	0	0	40
North Carolina	49	12	19	18	0	0
North Dakota	19	2	6	11	0	0
Ohio	394	86	215	14	79	0
Oklahoma	52	15	24	13	0	0
Oregon[b]	0	0	0	0	0	0
Pennsylvania	102	78	21	1	2	0
Rhode Island[a]	6	3	3	0	0	0
Tennessee[a]	62	35	25	2	0	0
Texas	642	237	315	90	0	0
Virginia	69	15	18	36	0	0
Washington	506	258	201	47	0	0
Wisconsin	56	19	24	13	0	0
TOTAL	3,937	1,488	1,619	583	152	95

Source: MFP semiannual web-based progress reports covering the July 1 to December 31, 2011, period. Submitted March 1, 2012.

[a] Idaho, Massachusetts, Rhode Island, and Tennessee implemented new MFP programs during the July 1 to December 31, 2011, reporting period.

[b] Oregon temporarily suspended its MFP program effective October 1, 2010, and stopped enrolling new participants.

ICF-MR = intermediate care facility for people with mental retardation; MFP = Money Follows the Person;

Table 3. Current MFP Participation: December 31, 2010, through December 31, 2011

State	Total Number of Current Participants			Number of MFP Participants Completing the 365-Day Transition Period		
	As of December 2011	As of June 2011	As of December 2010	July to December 2011	January to June 2011	July to December 2010
Arkansas	59	101	63	35	21	16
California	244	268	168	127	62	63
Connecticut	402	305	264	314	192	104
Delaware	29	26	12	9	0	14
District of Columbia	35	21	22	7	13	15
Georgia	134	220	235	0	104	79
Hawaii	55	55	40	21	13	16
Idaho[a]	4	NA	NA	0	NA	NA
Illinois	187	174	144	85	62	33
Indiana	254	274	157	34	42	16
Iowa	51	65	56	29	24	26
Kansas	224	233	212	92	38	32
Kentucky	123	135	103	50	41	18
Louisiana	155	133	81	29	32	7
Maryland	343	292	283	136	108	115
Massachusetts[a]	52	NA	NA	0	NA	NA
Michigan	218	230	191	75	72	69
Missouri	96	148	122	40	35	49
Nebraska	21	20	51	12	9	13
New Hampshire	33	27	38	13	13	11
New Jersey	174	157	74	34	110	35
New York	221	190	156	72	62	43
North Carolina	47	108	68	39	0	35
North Dakota	29	29	25	9	10	0
Ohio	711	521	425	220	167	138
Oklahoma	52	108	75	56	0	15
Oregon	0	42	191	28	51	55
Pennsylvania	219	243	241	113	84	74
Rhode Island[a]	6	NA	NA	0	NA	NA
Tennessee[a]	60	NA	NA	0	NA	NA
Texas	1,420	1,572	1,654	587	677	470
Virginia	209	280	198	36	52	27
Washington	960	760	394	72	173	75
Wisconsin	56	43	64	21	42	7
TOTAL	6,883	6,780	5,807	2,395	2,309	1,670

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

[a] Idaho, Massachusetts, Rhode Island, and Tennessee implemented new MFP programs during the July 1 to December 31, 2011, reporting period.

MFP = Money Follows the Person.

NA = not applicable.

Table 4. MFP States' Progress Toward Yearly Transition Goals: 2011 and 2010

State	2011 MFP Transition Activity			2010 MFP Transition Activity		
	Percentage of 2011 Transition Target Achieved as of December 2011[a]	Total 2011 Transition Goals	Total Number of Transitions in 2011	Percentage of 2010 Transition Goal Achieved as of December 2010	Total 2010 Transition Goals	Total Number of Transitions in 2010
New Jersey	303.3	61	185	103.6	304	315
Ohio	205.7	332	683	120.0	20	24
Kansas	171.4	147	252	100.0	27	27
Arkansas	156.4	78	122	116.1	62	72
Georgia	152.0	200	304	207.0	819	1,695
Washington	146.5	557	816	24.4	90	23
California	135.6	205	278	122.5	200	245
New York	129.5	193	250	116.5	243	283
Texas	126.4	1,362	1,721	24.3	111	27
Kentucky	123.4	128	158	33.3	87	29
Tennessee[b]	112.7	55	62	NA	NA	NA
New Hampshire	110.0	30	33	132.8	171	227
North Carolina	110.0	80	88	39.5	38	15
Louisiana	107.7	155	167	129.2	96	124
Michigan	104.3	300	313	46.9	96	45
Illinois	102.2	233	238	169.0	100	169
Maryland	102.3	351	359	28.9	280	81
Indiana	98.0	251	246	57.2	201	115
Oklahoma	93.3	115	108	129.0	62	80
Hawaii	91.7	72	66	84.0	325	273
Virginia	88.9	135	120	195.5	66	129
North Dakota	82.1	39	32	195.5	66	129
Pennsylvania	74.2	310	230	74.7	75	56
Iowa	73.3	75	55	162.8	360	586
Delaware	70.0	40	28	166.5	269	448
Wisconsin	67.5	120	81	41.1	331	136
Connecticut	63.1	609	384	231.3	80	185
Missouri	61.4	228	140	93.8	192	180
Idaho[b]	50.0	8	4	NA	NA	NA
Nebraska	34.0	106	36	88.3	300	265
Massachusetts[b]	33.1	157	52	NA	NA	NA
District of Columbia	25.0	140	35	116.7	66	77

Table 4 (continued)

State	2011 MFP Transition Activity			2010 MFP Transition Activity		
	Percentage of 2011 Transition Target Achieved as of December 2011[a]	Total 2011 Transition Goals	Total Number of Transitions in 2011	Percentage of 2010 Transition Goal Achieved as of December 2010	Total 2010 Transition Goals	Total Number of Transitions in 2010
Rhode Island[b]	15.0	40	6	NA	NA	NA
Oregon[c]	0.0	0	7	120.0	230	276
TOTAL	110.8	6,912	7,659	109.2	5,723	6,251

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

[a] States are sorted by the percentage of 2011 transition targets achieved as of December 31, 2011.

[b] Idaho, Massachusetts, Rhode Island, and Tennessee implemented new MFP programs during the July 1 to December 31, 2011, reporting period.

[c] Oregon temporarily suspended its MFP program effective October 1, 2010, withdrawing its 2011 transition goal.

MFP = Money Follows the Person.

NA = not applicable.

Table 5. 2011 Qualified HCBS Expenditures

State	2011 Target Level of Spending	Qualified HCBS Expenditures as of December 2011	Percentage of 2011 Spending Target Achieved as of December 2011	Notes
Arkansas	$310,207,295	$273,630,663	88.2	Arkansas is recalculating expenditures and expects the total to change.
California	$7,331,511,878	$7,384,175,951	100.7	California expects 2011 total spending to increase due to a lag in reporting transitions and MFP-eligible costs.
Connecticut	$947,221,439	$3,982,424,577	420.4	
Delaware	$173,847,870	$117,713,429	67.7	
District of Columbia	$362,694,697	$488,413,049	134.7	
Georgia	$995,862,771	$452,536,000	45.4	
Hawaii	$191,425,457	$179,994,236	94.0	
Idaho	$173,681,787	$190,543,631	109.7	
Illinois	$1,090,008,725	$1,194,034,807	109.5	Illinois expects 2011 total spending to increase in the next reporting period due to additional claims not yet processed.
Indiana	$818,936,660	$828,657,319	101.2	
Iowa	$447,193,837	$568,180,676	127.1	
Kansas	$567,047,471	$595,878,030	105.1	
Kentucky	$394,268,812	NR	NR	Kentucky did not report HCBS expenditures.
Louisiana	$760,688,415	$768,248,101	101.0	
Maryland	$1,030,502,887	$884,326,679	85.8	Maryland expects 2011 total spending to increase in the next reporting period due to additional claims not yet processed.
Massachusetts	$2,971,000,000	$3,057,232,175	102.9	
Michigan	$882,556,572	$922,033,036	104.5	
Missouri	$975,701,618	$1,032,114,154	105.8	
Nebraska	$298,000,000	$297,556,094	100	
New Hampshire	$263,636,743	$251,356,942	95.3	
New Jersey	$1,128,119,524	$1,147,639,370	101.7	
New York	$12,320,606,000	$11,141,127,094	90.4	
North Carolina	$1,363,116,342	$1,915,779,480	140.5	
North Dakota	$126,985,273	$129,241,252	101.8	
Ohio	$1,793,686,395	$2,281,235,082	127.2	
Oklahoma	$725,985,693	$465,198,882	64.1	
Oregon	$809,434,719	$648,019,061	80.1	
Pennsylvania	$2,405,204,000	$2,490,896,723	103.6	

Table 5 (continued)

State	2011 Target Level of Spending	Qualified HCBS Expenditures as of December 2011	Percentage of 2011 Spending Target Achieved as of December 2011	Notes
Rhode Island	$63,300,000	$68,577,722	108.3	
Tennessee	$914,790,702	$1,064,909,793	116.4	Tennessee's fiscal year runs from July 1 to June 30. The state will recalculate its progress toward the target level of spending in July.
Texas	$2,735,440,000	$3,378,681,461	123.5	
Virginia	$845,412,400	$1,107,374,113	131.0	
Washington	$794,769,660	$859,571,858	108.2	Washington's HCBS expenditures are based on SFY (July–June) using month of service, and might not exactly equal those reported on the CMS-64 and MFP Financial Reporting Forms A and B due to different reporting structure.
Wisconsin	$1,939,677,771	$1,800,000,000	92.8	Wisconsin's CY 2011 number is an estimate based on data available at this time. It might change as a result of claims lag and reconciliation of costs.
TOTAL	$48,952,523,413	$51,967,301,440	106.2	

Source: MFP semiannual web-based progress reports covering the July 1 to December 31, 2011, period. Submitted March 1, 2012.

CMS = Centers for Medicare & Medicaid Services; CY = calendar year; HCBS = home and community-based services; MFP = Money Follows the Person; SFY = state fiscal year.

NR = not reported.

Table 6. Overview of Minimum Data Set 3.0, Section Q Referrals: July 1 to December 31, 2011

State	Number of Individuals Referred to MFP Through MDS Section Q Referrals	Number of Individuals Referred Through MDS Section Q Referrals that Enrolled in MFP	MDS 3.0 MFP Enrollees as a Percentage of MDS 3.0 Referrals	State Comments on Status of MDS 3.0 Referral Tracking Systems
Arkansas	16	11	69	
California	54	7	13	
Connecticut	43	12	28	
Delaware	14	9	64	
District of Columbia	NR	NR	—	The District reports it had no new MDS Section Q data available in 2011 and is working with its reporting agency to obtain these data to identify potential MFP candidates.
Georgia	184	29	16	
Hawaii	32	16	50	Hawaii receives an MDS report approximately every quarter and plans to use these data to target potential candidates for transition.
Idaho	0	0	0	
Illinois	NR	NR	—	Illinois plans to improve its system to track Section Q referrals and transitions through MFP next reporting period.
Indiana	5	1	20	
Iowa	NA	NA	—	Iowa's MFP program currently serves individuals residing in ICFs-MR, which are not required to perform MDS assessments.
Kansas	26	10	38	Kansas has improved its referral tracking systems although this has not had a significant impact on referrals to date.
Kentucky	31	11	35	
Louisiana	34	6	18	
Maryland	582	5	1	
Massachusetts	0	0	0	Massachusetts began program implementation in July 2011.
Michigan	1,200	17	1	
Missouri	NR	NR	—	Missouri implemented a web-based system to track Section Q referrals, and expects to provide complete data beginning next reporting period.
Nebraska	28	1	4	Nebraska developed a web-based referral system to track MDS Section Q referrals across partner agencies.
New Hampshire	8	0	0	New Hampshire implemented a referral tracking system in late 2011. Beginning next reporting period, the tracking system will fully capture MDS section Q referrals as a referral source in the MFP data base.
New Jersey	NR	NR	—	
New York	98	16	16	New York developed referral and tracking tools to track the types of patients referred to the MFP program as well as outcome data.

Table 6 (continued)

State	Number of Individuals Referred to MFP Through MDS Section Q Referrals	Number of Individuals Referred Through MDS Section Q Referrals that Enrolled in MFP	MDS 3.0 MFP Enrollees as a Percentage of MDS 3.0 Referrals	State Comments on Status of MDS 3.0 Referral Tracking Systems
North Carolina	8	2	25	
North Dakota	1	1	100	
Ohio	419	129	31	
Oklahoma	69	1	1	
Oregon	NA	NA	—	Oregon suspended its MFP program effective October 1, 2011.
Pennsylvania	210	8	4	Pennsylvania's ADRC/Opportunity C grant proposal included funding for IT solutions to improve the communication between data reporting systems, but it has not yet implemented the IT system.
Rhode Island	1	1	100	Rhode Island began program implementation in November 2011.
Tennessee	0	0	0	Tennessee began program implementation in October 2011.
Texas	214	2	1	
Virginia	186	0	0	
Washington	0	0	0	Washington encountered procurement delays securing a vendor to configure an application service provider (ASP) database equipped with four functions: client management, reporting, public-facing resource directory, and an online self-service portal.
Wisconsin	NR	NR	—	Wisconsin tested its system for MDS Section Q reporting and made modifications to address identified issues, but did not implement the system during the reporting period. Wisconsin tracks the number of MDS Section Q referrals by ADRC but does not currently have individual-level data available statewide.
TOTAL	3,463	295		

Source: MFP semiannual web-based progress reports covering the July 1 to December 31, 2011, period. Submitted March 1, 2012.

ADRC = Aging and Disability Resource Center; ICFs-MR = intermediate care facilities for the mentally retarded; IT = information technology; MDS = Minimum Data Set; MFP = Money Follows the Person.

NA = not applicable.

NR = not recorded.

Table 7. Number of Reinstitutionalizations: July 1 to December 31, 2011

State	Number of MFP Participants Reinstitutionalized During the Reporting Period					
	Total Number	Elders	People with Physical Disabilities	People with Developmental Disabilities	People with Mental Illness	Other
Arkansas	6	0	5	1	0	0
California	33	16	8	0	1	8
Connecticut	30	20	7	0	3	0
Delaware	2	0	1	0	1	0
District of Columbia	2	2	0	0	0	0
Georgia	7	3	4	0	0	0
Hawaii	5	2	3	0	0	0
Idaho	0	0	0	0	0	0
Illinois	51	22	5	0	24	0
Indiana	9	9	0	0	0	0
Iowa	5	0	0	5	0	0
Kansas	10	8	2	0	0	0
Kentucky	58	23	15	8	0	12
Louisiana	20	8	3	9	0	0
Maryland	18	9	8	0	0	1
Massachusetts	1	0	1	0	0	0
Michigan	187	87	100	0	0	0
Missouri	16	5	6	5	0	0
Nebraska	4	3	1	0	0	0
New Hampshire	1	1	0	0	0	0
New Jersey	6	3	3	0	0	0
New York	84	36	35	0	0	13
North Carolina	20	6	7	7	0	0
North Dakota	2	1	1	0	0	0
Ohio	179	43	108	1	27	0
Oklahoma	24	11	11	2	0	0
Oregon	0	0	0	0	0	0
Pennsylvania	0	0	0	0	0	0
Rhode Island	1	0	1	0	0	0
Tennessee	8	4	4	0	0	0
Texas	90	41	39	10	0	0
Virginia	30	6	11	13	0	0
Washington	28	15	11	2	0	0
Wisconsin	9	1	7	1	0	0
TOTAL	946	385	407	64	56	34

Source: MFP semiannual web-based progress reports covering the July 1 to December 31, 2011, period. Submitted March 1, 2012.

MFP = Money Follows the Person

Table 8. Reported Number of Emergency Calls for Backup Assistance: July 1 through December 31, 2011

State	Number of Emergency Calls for Backup Assistance
Arkansas	1
California	0
Connecticut	10
Delaware	0
District of Columbia	4
Georgia	0
Hawaii	0
Idaho	0
Illinois	0
Indiana	14
Iowa	0
Kansas	7
Kentucky	2
Louisiana	0
Maryland	0
Massachusetts	0
Michigan	2
Missouri	0
Nebraska	0
New Hampshire	50
New Jersey	11
New York	5
North Carolina	0
North Dakota	0
Ohio	0
Oklahoma	0
Oregon	0
Pennsylvania	0
Rhode Island	0
Tennessee	0
Texas	0
Virginia	1
Washington	0
Wisconsin	0
TOTAL	107

Source: MFP semiannual web-based progress reports covering the July 1 to December 31, 2011, period. Submitted March 1, 2012.

NR = not reported.

Table 9. Total Number of Current MFP Participants in a Self-Direction Program: July 1 through December 31, 2011

State	Total Number of Current MFP Participants That		
	Chose to Participate in a Self-Direction Program	Hired/Supervised Their Own Personal Assistants	Managed Their Own Allowance/Budget
Arkansas	5	5	5
California	NA	NA	NA
Connecticut	226	217	9
Delaware	29	28	28
District of Columbia	NA	NA	NA
Georgia	N A	NA	NA
Hawaii	4	4	0
Idaho	0	0	0
Illinois	0	0	0
Indiana	NA	NA	NA
Iowa	2	2	2
Kansas	95	95	0
Kentucky	64	46	0
Louisiana	NR	NR	NR
Maryland	0	0	0
Massachusetts	1	1	0
Michigan	45	45	45
Missouri	61	61	61
Nebraska	NA	NA	NA
New Hampshire	NR	NR	NR
New Jersey	0	0	0
New York	NA	NA	NA
North Carolina	5	5	5
North Dakota	0	0	0
Ohio	711	0	711
Oklahoma	0	0	0
Oregon	0	0	0
Pennsylvania	115	115	115
Rhode Island	0	0	0
Tennessee	0	0	0
Texas	9	1	1
Virginia	9	3	0
Washington	152	152	0
Wisconsin	0	0	0
TOTAL	1,533	780	982

Source: MFP semiannual web-based progress reports covering the July 1 to December 31, 2011, period. Submitted March 1, 2012.

MFP = Money Follows the Person.

NA = not applicable (state does not have self-direction option in place).

NR = not reported (state has a self-direction program but was unable to report data).

Table 10. Number of MFP Transitions During the Reporting Period by Type of Qualified Community Residence the Participant Transitioned to: July 1 through December 31, 2011

State	Number of New MFP Participants That Transitioned During the Reporting Period to[a]		
	Homes	Apartments	Group Homes
Arkansas	14	31	7
California	26	114	2
Connecticut	39	187	2
Delaware	3	8	1
District of Columbia	0	36	2
Georgia	16	27	71
Hawaii	12	1	19
Idaho	0	2	2
Illinois	0	0	0
Indiana	36	113	8
Iowa	2	35	0
Kansas	28	47	32
Kentucky	25	20	39
Louisiana	27	50	13
Maryland	83	100	27
Massachusetts	20	13	19
Michigan	91	80	7
Missouri	11	38	28
Nebraska	9	3	6
New Hampshire	5	6	7
New Jersey	35	43	21
New York	39	97	0
North Carolina	42	4	3
North Dakota	0	0	0
Ohio	89	309	28
Oklahoma	3	37	13
Oregon	0	0	0
Pennsylvania	22	48	2
Rhode Island	3	3	0
Tennessee	45	15	2
Texas	419	122	101
Virginia	26	6	38
Washington	143	202	161
Wisconsin	13	22	21
TOTAL	1,326	1,819	682

Source: MFP semiannual web-based progress reports covering the July 1 to December 31, 2011, period. Submitted March 1, 2012.

MFP = Money Follows the Person.

[a] The number of participants residing in MFP-qualified residences does not sum to the total number of new individuals who transitioned to the community this period for each state because some states reported either more or fewer transitioned individuals than types of residences.

Table 11. Progress and Challenges in Ensuring Participants' Access to Home and Community-Based Services, by Reporting Period, 2009–2011—Number of Grantee States Reporting Each Type of Progress or Challenge

Response Option	July to Dec 2009	Jan to June 2010	July to Dec 2010	Jan to June 2011	July to Dec 2011
Number of Grantee States Reporting Progress[a]	20	22	23	23	25
Increased the number of transition coordinators	8	12	13	13	17
Increased the number of HCBS providers contracting with Medicaid	10	9	5	10	9
Increased access requirements for managed long-term care providers	0	1	1	1	1
Increased payment rates to HCBS providers	5	3	1	4	0
Increased the supply of direct service workers	1	2	1	5	4
Improved or increased transportation options	1	2	3	5	2
Added or expanded managed long-term care programs	1	2	2	1	2
Other	4	6	7	4	6
Number of Grantee States Reporting Challenges[b]	23	25	22	23	24
Insufficient supply of HCBS providers	7	9	9	11	9
Insufficient supply of direct service workers	4	4	6	5	5
Preauthorization requirements	3	2	3	3	3
Limits on amount and scope or duration of HCBS	4	10	7	10	10
Lack of appropriate transportation options	3	4	3	7	6
Insufficient availability of specific types of HCBS	9	8	4	5	7
Other	7	8	10	9	11

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

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

[a] Report question asked, "What steps did your program take during the reporting period to improve or enhance the ability of MFP participants to access home and community-based services?" Grantees could respond to more than one category.

[b] Report question asked, "What are MFP participants' most significant challenges to accessing home and community-based services? These are challenges that either make it difficult to transition as many people as you had planned or make it difficult for MFP participants to remain living in the community." Grantees could respond to more than one category.

HCBS = home and community-based services; MFP = Money Follows the Person

Table 12. Progress and Challenges Securing Appropriate Housing Options for Participants, by Reporting Period, 2009–2011—Number of Grantee States Reporting Each Type of Progress or Challenge

Response Option	July to Dec 2009	Jan to June 2010	July to Dec 2010	Jan to June 2011	July to Dec 2011
Number of Grantees Reporting Progress[a]	18[b]	22	18[c]	23	25[c]
Developed inventory of affordable and accessible housing	2	3	3	5	12
Developed local or state coalitions to identify needs or create housing-related initiatives	9	5	6	3	11
Developed statewide housing registry	1	3	1	3	4
Implemented new home ownership initiative	0	1	0	0	0
Improved funding for developing assistive technology related to housing	1	1	2	2	4
Improved information systems about affordable and accessible housing	2	2	3	4	4
Increased number of rental vouchers	5	8	9	11	8
Increased supply of affordable and accessible housing	2	1	2	1	6
Increased supply of residences that provide or arrange for long-term services or supports	1	0	1	1	0
Increased supply of small-group homes	3	4	3	8	5
Increased or improved funding for home modifications	6	1	1	5	4
Other	6	9	8	9	11
Number of Grantees Reporting Challenges[d]	24[e]	24	23[f]	26	32
Lack of information about affordable and accessible housing	2	2	0	2	2
Insufficient supply of affordable and accessible housing	14	18	17	18	20
Lack of affordable and accessible housing that is safe	3	5	3	3	9
Insufficient supply of rental vouchers	14	16	14	11	11
Lack of new home ownership programs	0	2	0	0	0
Lack of small-group homes	6	6	4	6	3
Lack of residences that provide or arrange for long-term services or supports	2	2	3	3	1
Insufficient funding for home modifications	1	1	2	3	2
Unsuccessful efforts in developing local or state coalitions of housing and human services organizations to identify needs or create housing-related initiatives	2	0	3	1	0
Unsuccessful efforts in developing sufficient funding or resources to develop assistive technology related to housing	0	0	0	0	0
Other	7	4	5	9	8

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

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

Table 12 (continued)

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

[b] Arkansas, Illinois, and Missouri did not report data on housing progress for participants for this reporting period.

[c] Illinois did not report data on housing progress for participants for this reporting period.

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

[e] Arkansas, Illinois, Kansas, and Missouri did not report data on housing challenges for participants for this reporting period.

[f] Connecticut, Illinois, and Indiana did not report data on housing challenges for participants for this reporting period.

MFP = Money Follows the Person.

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