

REPORT

EXECUTIVE SUMMARY

Money Follows the Person 2014 Annual Evaluation Report - Executive Summary

December 18, 2015

Carol V. Irvin
Noelle Denny-Brown
Alex Bohl
John Schurrer
Andrea Wysocki
Rebecca Coughlin
Susan R. Williams

Submitted to:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Mailstop: C2-21-15 7500 Security Blvd.
Baltimore, MD 21244-1850
Project Officer: Effie George
Contract Number: HHSM-500-2010-00026I/HHSM-500-T0010

Submitted by:

Mathematica Policy Research
955 Massachusetts Avenue
Suite 801
Cambridge, MA 02139
Telephone: (617) 491-7900
Facsimile: (617) 491-8044
Project Director: Carol Irvin
Reference Number: 40137.D6d

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The Money Follows the Person (MFP) demonstration program represents a major federal initiative to give people needing long-term services and supports (LTSS) more choice about where they live and receive care, and to increase the capacity of state long-term care systems to serve people in community settings. Calendar year 2014 marked the eighth year of the national MFP demonstration. Cumulative MFP enrollment climbed to more than 51,000 transitions by the end of December 2014, a 27 percent growth over the total number at the same point in 2013. As of December 31, 2014, 47 states had received MFP grants; Florida and New Mexico were awarded MFP grants in 2011 but later rescinded them in 2012. Oregon has also elected to rescind its grant after suspending program operations in 2010 to redesign its operations. Conversely, Montana and South Dakota began their transition programs in 2014. During 2014, 43 states and the District of Columbia (the 44 MFP grantee states) were actively transitioning participants through their MFP demonstrations.

Key Finding

By the end of calendar year 2014, MFP demonstrations had cumulatively transitioned 51,676 individuals.

A. Purpose of the Report

This is the sixth in a series of annual reports from the national evaluation of the MFP rebalancing demonstration. It presents four broad sets of analyses that report on the overall progress and effects of the MFP demonstration: (1) progress grantees are making on their statutory transition and expenditure goals, (2) the extent to which the MFP demonstration is associated with changes in transition rates from institutional care to community-based long-term services and supports (LTSS), (3) post-transition outcomes and whether the MFP demonstration is associated with these outcomes, and (4) a qualitative assessment in how the quality of life of MFP participants change after the transition to community-based services. To the extent possible, the analyses cover the program from its inception through December 2014.

B. Overview of Findings

1. Grantee Progress on Statutory Goals

The Deficit Reduction Act (DRA) of 2005, which authorized the MFP demonstration, requires state grantees to project the number of transitions their MFP demonstrations would achieve each year and by targeted population [DRA, §6071(c)(5)]. CMS allows states to modify these goals on an annual basis. The federal statute that created the MFP demonstration also requires grantee states to track and report their total qualified home- and community-based service (HCBS) expenditures each year.

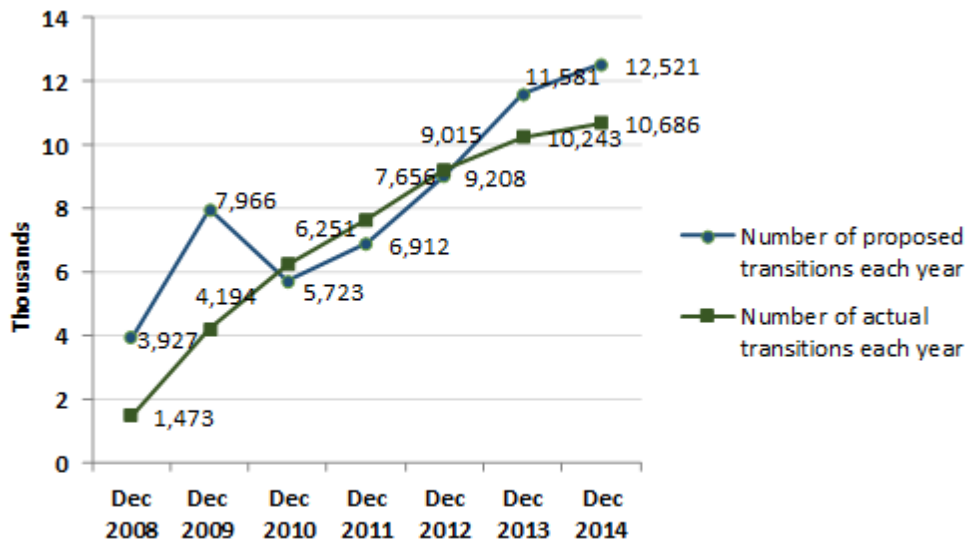
The 44 MFP grantee states actively transitioning participants in 2014 achieved 85 percent of the transition goal for 2014, transitioning 10,658 people of the 12,521 transitions projected for the year. As in the earlier years of the MFP demonstration, states may have set overly ambitious transition goals for 2014 (Figure ES.1). Several states were still in the

Key Finding

In 2014, MFP grantees transitioned 10,658 people which represents a 4 percent increase in the number of transitions from the previous year.

early phases of their programs in 2014 and most MFP demonstrations have fewer than expected transitions during the start-up phase when procedures and systems are not fully implemented. Nevertheless, the number of transitions that occurred during 2014 were the largest number recorded by the states indicating that the program continued to grow in size.

Figure ES.1. MFP grantees' progress toward annual transition goals, 2008–2013



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2008–2014.

Note: N = 30 grantee states in 2009 and 2010; 34 states in 2011; 37 states in 2012; 42 states in 2013; and 44 states in 2014.

The grantee states track and report their total qualified community-based LTSS expenditures each year. These total expenditures include not just all spending on community services for MFP participants, but all federal and state Medicaid spending on 1915(c) waiver services and home health, personal care, and other optional state-plan community-based LTSS provided for all Medicaid beneficiaries.¹ By statute, states in the MFP demonstration are required to set annual expenditure goals for their community-based LTSS which, as with their transition goals, they can alter over time as the context in states change.

The 43 MFP grantee states that reported data spent a total of \$70.3 billion on community-based LTSS, achieving 98 percent of the aggregate expenditure goal for the year (\$71.9

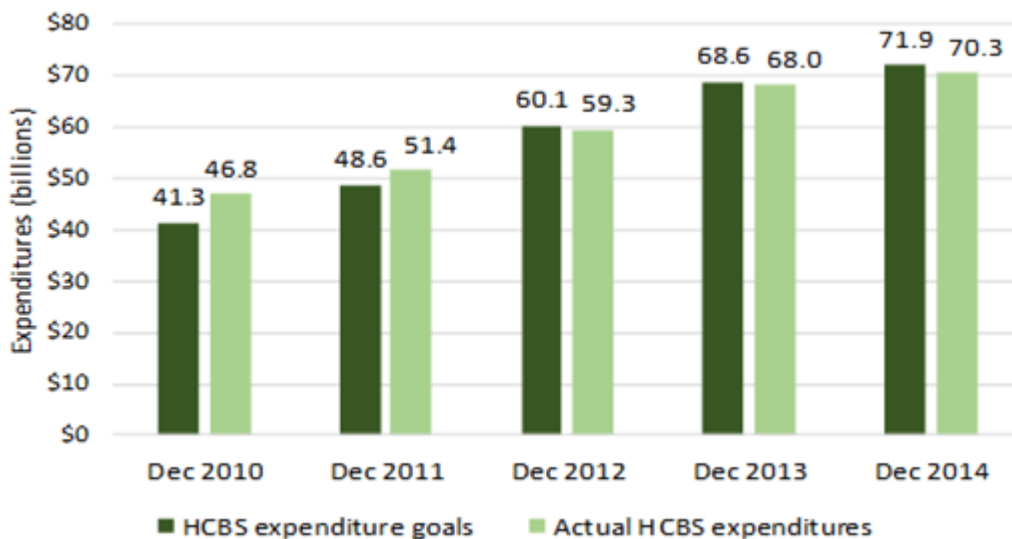
Key Finding

During calendar year 2014, MFP demonstrations incurred at least \$70.3 billion in qualified community-based LTSS expenditures. This figure will increase when several states with incomplete data update their expenditure amounts for the year.

¹ Other optional state-plan community-based LTSS include services such as adult day care, private duty nursing, and residential care.

billion) (Figure ES.2). However, the total reported spending for 2014 is likely underestimated because the reported data for some states were incomplete. One state did not report expenditures for 2014 and two other states reported incomplete expenditure data. In addition, some states experienced lags in their claims processing systems. Given what we have seen in past years, we anticipate expenditures for 2014 will increase by 8 to 10 percent once state reporting is complete.

Figure ES.2. Projected and actual qualified community-based LTSS expenditures, December 2010 to December 2014



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2010 to 2014.

Note: N = 29 grantee states in 2010; 33 states in 2011; 35 states in 2012; 41 states in 2013; and 43 states in 2014.

2. Lessons learned to improve transitions and LTSS system performance

State staff managing MFP demonstrations on the front lines have acquired valuable knowledge about what it takes to execute a successful transition and what is needed to effectively serve populations with complex needs in the community. Through a qualitative assessment of six states, we learned how several state grantees have translated several lessons learned from program development to improve service delivery for populations with complex medical and support needs (Denny-Brown et al. 2015).

- Early identification of an individual’s needs and preferences is essential to facilitate timely linkages to services in the community and avoid reinstitutionalization.** The study states have learned that assessment instruments need to consider each person’s holistic needs and preferences and the assessment process needs to be completed together by the transition candidate and the transition coordinator. Both Missouri and Ohio strengthened its assessment processes and instruments by improving the early identification of behavioral health issues, such as active use of alcohol or other drugs.

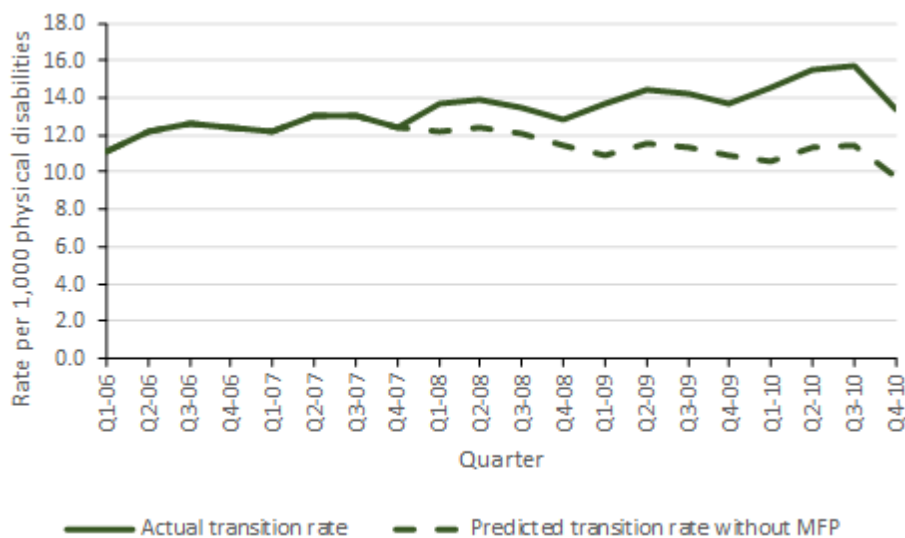
- **The flexible funding of the MFP demonstration offers states the ability to test service innovations that stabilize participants soon after transitioning to the community.** New Jersey established an Olmstead resource team that provides intensive supports for participants in the areas of physical, nutritional, and/or behavioral management during their first 90 days in the community. Illinois relies on highly trained designated transition coordinators to provide a single point of coordination for participants who often have complex behavioral health needs. After learning that participants with behavioral health needs tend to be at greater risk of reinstitutionalization during their first 90 days in the community, Ohio extended its transition coordinator services to support participants during the first 90 days post-transition.
- **Quality monitoring systems are key to tracking participants' outcomes in the community.** All of the states included in this study described having strong quality systems in place to monitor how participants fare in the community. Three states, Louisiana, New Jersey, and Ohio, have dedicated quality assurance staff who collect and analyze service use and quality data for the MFP population and investigate potential issues that arise.
- **Strong partnerships with stakeholders are important to coordinate efforts related to service delivery and propel system transformation efforts forward.** In many grantee states, the MFP demonstration has been a collaborative effort among multiple state and local agencies. For example, Ohio created a behavioral health liaison position, which was jointly funded with the Department of Mental Health and Addiction Services, to recruit behavioral health providers to serve as transition coordinators. Missouri worked with its public housing authorities to obtain housing preferences for MFP participants in counties where participants transitioning from an institution have the greatest housing needs.

3. Trends in transition rates and post-transition outcomes

The 2014 annual report for the MFP demonstration provides evidence of the effect of the MFP demonstration on rates of transitions to the community and on post-transition outcomes. It builds on previous research, but the analysis continues to be hampered by the data.

The results imply that for most targeted populations, the number of transitions occurring across states did not increase after MFP was launched, suggesting that the MFP demonstration was not large enough to affect transition rates, either directly or indirectly through spillover effects. The one exception was younger adults with physical disabilities residing in nursing homes, for whom the number of transitions increased from 2008 through 2010 (Figure ES.3). We estimate that, by 2010, about 95 percent of MFP participants in this targeted population represented new transitions or transitions that would not have occurred if this demonstration had not been implemented.

Figure ES.3. Regression-adjusted trends in transition rates: Younger adults with physical disabilities in nursing homes



Source: Mathematica’s analysis of 2006–2011 MAX data.

Note: The actual transition rate reflects both MFP and non-MFP transitions to community-based LTSS. The estimated change in transition rates was statistically significant in 2008 (p-value = 0.010), 2009 (p-value = 0.009), and 2010 (p-value = 0.012).

LTSS = long-term services and supports; MAX = Medicaid Analytical eXtract.

We also assessed post-transition outcomes from 2008 to 2010, including rates of reinstitutionalization, mortality, and successful transitions during the first 12 months after the transition. We only found effects among older adults who transitioned from nursing homes. We found an increase in the number of successful transitions in the post-MFP period within this target population, which was driven by declines in reinstitutionalization rates.

Because of the significant lag times in the Medicaid data available to the national evaluation of the MFP demonstration, these results should not be considered definitive. They are based on transitions that occurred during the initial years of the demonstration while the first grantees were still in the early stages of implementation. We have also determined that the results are sensitive to the states and years included in the analysis, as well as to the specifications of the model. Nevertheless, we will continue to assess the association between MFP and state transition rates and post-transition outcomes and anticipate that as more years of data become available, our estimates of demonstration effects will become more robust.

4. The relationship between MFP participation and health service expenditures and utilization

Determining whether MFP demonstrations influence individual’s Medicaid and Medicare costs and service utilization patterns in the post-transition period has been a focus of the national evaluation. In our analyses of expenditures and utilization during the first 12 months after the

transition, we continue to find notable declines in total Medicaid and Medicare expenditures after the transition from long-term institutional care for all target populations. In some cases, the decline is as much as 30 percent. The analysis suggests that the decline in total expenditures is primarily due to the shift in LTSS spending from institutional- to community-based services. In addition, across all target populations, MFP participants have higher total expenditures post-transition than those transitioning outside of the program. This difference is primarily due to the greater expenditures incurred by MFP participants for community-based LTSS, which is by program design.

When we disaggregated the analysis and assess expenditures and use across different categories of services, the results were more nuanced and mixed.

- MFP participants appear to use more inpatient, emergency department (ED), and physician services after the transition, and often use more of these services for ambulatory care sensitive conditions (ACSCs) such as falls, delirium, dehydration, and pressure ulcers.
- MFP participants receive more of their LTSS and post-acute care in community settings than others who transition, as shown by their greater expenditures for community-based LTSS and Medicare home health care. Conversely, MFP participants frequently have fewer expenditures for Medicare skilled nursing facility (SNF) services and facility-based subacute care than others who transition to community living, although the difference is not always statistical significant.
- The presence of a mental health condition does not appear to change the relationship between MFP participation and expenditure and utilization patterns. However, for some target populations, MFP participants with mental health conditions were more likely to use outpatient mental health services and less likely to use inpatient mental health services than other transitioners with mental health conditions, conforming to other outcomes that suggest MFP participants are more likely to receive community-based care than institutional-based care.

We also assessed the expenditures and service utilization patterns among people who survive two years after the transition to assess what happens to these types of outcomes after participants leave the MFP demonstration. This component of the analyses was more exploratory and preliminary because of the small samples available for the analyses. We found that MFP participants have similar or lower expenditures than other transitioners two years after the initial transition and the service category driving these findings varies by target population.

5. Changes in MFP participants' quality of life

For the MFP demonstration to be successful, participants' life satisfaction must be maintained or improved after they transition from a long-term care institution to community living. We examine how reported quality of life across several domains changes one and two years after the transition to community living. We also conducted more in-depth analyses of unmet need for personal care assistance and the association between this type of unmet need and use of health care services.

- Consistent with past research, our analyses show that participants experience increases across all seven domains of their quality of life after transitioning to the community, and the

improvements are largely sustained two years post-transition. Among all seven domains of participants' quality of life, participants experienced the highest levels of satisfaction with their living arrangements; nearly all participants (92 percent) reported liking where they lived one year after community living, which represents a 32 percentage point increase compared to when they were in institutional care.

- Contrary to concerns that transitioning to the community could lead to unintended declines in meeting personal care needs, our analyses indicate that, after one year in the community, the care needs of most participants in our sample were met at similar or higher levels than what was reported while in institutional care. Six percent of participants in our sample reported any unmet care need after one year in the community; assistance with bathing was the most frequently reported unmet need (4 percent), followed by toileting (2 percent).
- When people experienced an unmet need for personal care, they were also slightly more likely to experience a fall or trauma during their first year in the community. They also were more likely to have an ED visit (not resulting in a hospitalization), inpatient admission, and nursing home or subacute care facility stay one year post-transition.

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