

**THE NATIONAL EVALUATION OF THE
MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION GRANT PROGRAM**

R E P O R T S F R O M T H E F I E L D

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What Determines Progress in State MFP Transition Programs?

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The Money Follows the Person (MFP) Demonstration supports efforts by state Medicaid programs to help Medicaid beneficiaries living in long-term care institutions transition back to homes or community-based residences. MFP grant funds pay states an enhanced federal matching rate for spending on home and community-based services (HCBS) delivered to program participants during the first year of community living, and the funds also cover many program administrative costs.

This study was conducted to identify the determinants of progress in MFP programs. Specifically, relying on interviews with state officials, the study sought to identify the approaches used by MFP grantee states that have transitioned more MFP participants and have lower rates of reinstitutionalization than average. It also asked program representatives in states with varying levels of progress about factors that contribute most to progress and that present the greatest barriers. State officials interviewed for this study identified three program elements as crucial to progress in any MFP transition program: (1) effective transition coordinators, (2) ability to cover one-time moving expenses, and (3) extra support from transition coordinators or extra HCBS beyond what regular Medicaid programs typically cover. They cited the lack of affordable, accessible housing as the single greatest barrier to helping more people move out of institutions.

States that have made the most progress to date—as measured by a higher-than-average number of MFP participants, higher-than-average shares of MFP-eligible people transitioned, and lower-than-average reinstitutionalization rates relative to all MFP grantee states—more often reported using three specific strategies than did states that had made less progress. First, more successful states develop standardized processes to ensure collaboration between MFP transition coordinators and Medicaid HCBS waiver programs. Second, they make it possible for transition coordinators at the local level to spend more time helping individuals with greater needs, either by paying the coordinators more or by giving them more flexibility. Third, they employ housing specialists to work alongside transition coordinators. The report concludes with lessons that can help all state MFP programs improve their performance. These lessons may be especially useful to the 13 states that won MFP grants in 2011 and need to build a strong foundation for their MFP program to increase the chances of long-term success.

ABOUT THE MONEY FOLLOWS THE PERSON DEMONSTRATION

The MFP Demonstration, first authorized by Congress as part of the Deficit Reduction Act of 2005 and then extended by the 2010 Patient Protection and Affordable Care Act, is designed to shift Medicaid's long-term care spending from institutional care to HCBS. Congress has now authorized up to \$4 billion in federal funds to support a twofold effort by state Medicaid programs (1) to transition people living in nursing homes and other long-term care institutions to homes, apartments, or group homes of four or fewer residents and (2) to change state policies so that Medicaid funds for long-term care services and supports can "follow the person" to the setting of his or her choice. MFP is administered by CMS, which initially awarded MFP grants to 30 states and the District of Columbia and awarded grants to another 13 states in February 2011. CMS contracted with Mathematica to conduct a comprehensive evaluation of the MFP demonstration and to report the outcomes to Congress.

INTRODUCTION

Initially authorized by the Deficit Reduction Act of 2005, the MFP Demonstration helps states rebalance their long-term care systems by providing funds to assist long-term institutional residents receiving Medicaid in returning to home and community-based settings. The Affordable Care Act of 2010 increased authorized federal funding for MFP to \$4 billion and extended the program so that states now have to the end of FFY 2020 to expend their grant funds. Forty-four states have been awarded MFP grants—an initial group of 30 states and the District of Columbia received awards in 2007,¹ and another 13 states won awards in February 2011. The latter group is expected to start transitioning beneficiaries in 2011 and 2012.

The 30 grantee states that received grants in 2007 and subsequently implemented transition programs vary considerably in their progress to date as measured by three key indicators. First, the absolute number of people transitioned by the end of 2010 ranges from more than 3,000 in one grantee state to fewer than 50 in 2 states. Second, the share of people eligible for MFP who transitioned out of institutions also varies across states. Third, the rate of reinstitutionalization among MFP participants—an important indicator of the ability of state programs to help people who move out of institutions live successfully in the community—varies across states as well.

We sought to learn from state MFP officials which transition strategies they believe contribute the most to their progress, as measured by these three indica-

¹ One of the initial 31 grantees has not yet implemented its MFP program. The original 30 grantees, including the District of Columbia, are referred to throughout as "grantee states."

tors, and which issues present the greatest barriers. We examined how differences in state approaches to core elements of transition programs—such as transition-coordination capacity, housing support, and additional HCBS provided to MFP participants—might explain variation in states' progress to date. In addition, because this demonstration program will last over 10 years, we explored whether the factors that contribute to success may change as the program evolves from the start-up phase to the expansion phase to long-term sustainability.

To determine which MFP grantee states have made more progress than others, we compared the performance of the 30 initial MFP grantee states as of June 2010² on the three indicators of progress described above: (1) cumulative number of MFP transitions; (2) cumulative MFP participants as a percentage of all institutionalized individuals in the state who would have been eligible for MFP in 2007, before the program began;³ and (3) rates of reinstitutionalization of 30 days or more for all MFP participants. Ten states were selected for inclusion in this study—5 with above-average performance and 5 with average performance. More details on the study approach can be found in the Data and Methods box at the end of this report.

² The June 2010 cutoff reflects the latest available data when the study was designed.

³ This indicator represents the proportion of MFP participants ever enrolled (as of June 2010) among all those eligible for MFP in 2007, before the program began. Until March 2010, individuals eligible for MFP were those who qualified for Medicaid and had resided in an institution for at least six months. After that date, the Affordable Care Act of 2010 reduced the minimum length of stay to 90 days, not including Medicare rehabilitation days. While this change increased the number of people eligible for MFP, data were not available when this study was designed to adjust the denominator (MFP eligibles in each state) to reflect this new eligibility rule.

We then interviewed program officials to understand what they had found most and least helpful to their progress to date. We talked to three representatives of the MFP program in each of the 10 states to learn what they considered the strengths and weaknesses of 11 major program components, and how they saw each component contributing to or holding back progress (Figure 1). We also asked respondents to assess the importance of each program component (1) to the program’s progress thus far, (2) to a successful start-up, and (3) to program expansion.

To guarantee confidentiality to program representatives, who offered candid opinions about the strengths and weaknesses of their state MFP programs, this report does not identify the states that participated. Another reason we withheld the names of the states is that progress, as defined in this study, is relative and dynamic; each state’s performance relative to the performance of other states may change over time. Consequently, this report focuses on the lessons from these states so far, rather than on their performance at one point in time.

FINDINGS

Importance of Program Components to MFP Progress

Overall, study respondents in the 10 MFP states rated three program components as most important to their progress to date: (1) transition planning and coordina-

tion, (2) coverage of one-time moving expenses, and (3) extra transition assistance or HCBS beyond what other Medicaid participants can receive (Table 1). Conversely, respondents across the 10 states rated insufficient housing strategies and resources as the single greatest barrier to progress. Two other hindrances to progress, cited by less than half of respondents, were inadequate capacity of HCBS providers to deliver specialized services and barriers created by state Medicaid long-term care policies or priorities (Table 1). When asked about the program components most important during the start-up phase, transition coordination was again cited most often; respondents also mentioned strong program leadership, effective identification and recruitment of MFP-eligible beneficiaries, and the support and involvement of key stakeholders. Respondents also said that use of effective strategies to find and locate housing was most important to progress during the program expansion phase (Table 1).

Greatest Contributors to Progress

Transition planning and coordination. According to the state officials interviewed for this study, a cadre of competent and dedicated transition coordinators is a key determinant of the program’s ability to transition more people to the community and to ensure that those who do transition receive the services they need. Program officials in nearly every state mentioned the importance of dedication and suggested

Figure 1. Major Components of MFP Transition Programs

<p>Operations</p> <ol style="list-style-type: none"> 1. Outreach to and recruitment of eligible MFP transition candidates 2. Transition planning and coordination approach and capacity 3. Coverage of one-time moving expenses 4. Enriched or extra services for MFP participants during the first 365 days in the community 5. Quality monitoring, quality assurance, and risk-mitigation procedures for MFP participants <p>Program Support</p> <ol style="list-style-type: none"> 6. Housing strategies and resources 7. Program leadership 8. State and local interagency collaboration 9. Key stakeholder support and involvement 10. Supply and capacity of home and community-based services and providers 11. State Medicaid long-term care policies and priorities

TABLE 1. MAJOR PROGRAM COMPONENTS' CONTRIBUTION TO PROGRESS, AS INDICATED BY STATE MFP PROGRAM OFFICIALS

Program Component	Biggest Benefit or Contribution to Progress to Date^a	Biggest Hindrance to Progress to Date^b	Most Important to Progress During Start-Up	Most Important to Progress During Expansion
Identifying/recruiting eligible MFP transition candidates	6	6	9	8
Transition planning and coordination	14	1	14	3
Coverage of one-time moving expenses	12	1	7	6
Extra home and community-based services provided to MFP participants and not available to other Medicaid beneficiaries	12	1	3	5
Quality monitoring, quality assurance, and risk mitigation	0	4	2	5
Housing strategies and resources	2	22	5	14
Program leadership (experience, knowledge, stability)	6	3	10	8
Interagency collaboration and relationships	6	3	6	6
Support/involvement of key stakeholders	5	3	9	5
Home and community-based service capacity	6	9	5	7
State Medicaid long-term care policies and priorities	5	8	5	6
Total number of rankings	74	61	75	73

Source: Mathematica's analysis of respondent ratings sheets.

Note: Twenty-five of 30 study participants in 10 states completed the ratings sheets, for a response rate of 83 percent. Respondents were asked to select the three most important program components in each category, resulting in a maximum of 75 responses per category (25 x 3=75). The numbers in each cell are the total number of participants who selected this component. Some respondents selected fewer than three components per category, as reflected in the differing rankings totals.

^a Responses in column 1 indicate that strengths in the program component contributed to progress.

^b Responses in column 2 indicate that shortcomings in the program component slowed progress.

that the most effective transition coordinators have the passion, commitment, and creativity to do whatever is needed to help those wishing to return to the community make a successful transition. State program officials also stressed the importance of having transition staff who are knowledgeable and skilled in developing care plans, who understand long-term care delivery in home and community-based settings, and who have experience working with the target populations and related Medicaid waiver programs. They also indicated the importance of strong client advo-

cacy and organizational skills as well as the ability to communicate with people of all types.

Having knowledgeable and experienced transition coordinators and agencies is important not only during program start-up but also during program expansion. States were able to expand MFP transition programs more quickly if their transition coordinators and agencies were experienced and if their agencies covered all or most of the state; states with few experienced agencies, or with one or two agencies

Transition Coordination: Experience Needed

“Transition coordination was a weakness in the beginning. It was difficult to get all transition coordination agencies around the state up to the same level of expertise. [In our state], Centers for Independent Living took to it naturally, but for the Area Agencies on Aging, it required them to expand their care coordination role, and some weren’t even enrolled Medicaid providers.”

—MFP project director

with limited geographic reach, were slower to expand their programs.

While the number of transition coordinators clearly influences the number of people who can be transitioned, MFP grantee states differ in how they divide the core functions of transition planning and coordination among staff of various types (Figure 2). For example, some states make transition coordinators responsible for carrying out all of the core functions needed to support MFP transitions, while other states employ state administrative staff to conduct outreach, and some hire housing specialists to find community residences. States also differ in how they divide responsibility for monitoring care plans for MFP participants once they move to the community; in some states, transition coordinators perform this function for the first several months, while other states depend on case managers of HCBS waiver programs. Consequently, more detailed studies of the division of transition functions in each state would be required to measure the relationship between the number of tran-

sition staff or the average caseload size to the number of people who can be transitioned.⁴

MFP funds for one-time moving expenses. According to about a third of state program officials interviewed, one of the biggest contributors to progress is the ability to use MFP grant funds to pay for one-time expenses that occur just before or at the time of the transition. These expenses are associated with setting up a home and covering basic furnishings, security and utility deposits, groceries, and environmental modifications to ensure accessibility. Most MFP participants have no savings to cover these expenses, and people who receive disability benefits from the Supplemental Security Income (SSI) program do not begin receiving their cash benefits until after they move into the community.⁵ Generally, program officials in states that did not previously cover extensive or atypical one-time transition expenses through HCBS waiver programs found this resource to be most valuable. But even in states where waiver programs already covered such expenses, program officials

⁴ We asked respondents about transition coordinators’ caseload size and how it affected the numbers of people transitioned or coordinators’ ability to make successful transitions. But we found it difficult to make comparisons across states due to state variation in how transition functions are divided among program staff. It was beyond the scope of this study to examine these divisions of labor in detail, but this finding underscores the need to adjust for these differences when comparing caseload ratios across states.

⁵ If Medicaid pays for more than half of the cost of care in a medical facility, the individual’s SSI benefit is limited to \$30 per month. Some states supplement this benefit (<http://www.socialsecurity.gov/ssi/spotlights/spot-temp-institution.htm>). Residents of a public medical or psychiatric facility are not usually eligible to receive an SSI payment (<http://www.socialsecurity.gov/redbook/eng/ssi-only-employment-supports.htm>). Social Security Disability Insurance payments are not affected by the recipient’s living arrangement.

Figure 2. Core Functions of Transition Planning and Coordination

1. Conduct outreach to potential transition candidates
2. Perform a comprehensive assessment of individuals who wish to move back to the community
3. Confirm Medicaid eligibility
4. Secure family or guardian agreement and support
5. Obtain approval for HCBS waiver enrollment and/or specific HCBS benefit levels
6. Search for and locate suitable housing
7. Arrange for HCBS and supports for each individual
8. Develop back-up plans

On Funds for One-Time Expenses and Extra HCBS

“We would have been stopped cold if we didn’t have funding for these types of one-time expenses.”

—MFP project director

“Some of the same services are offered to people in the waiver program, but we can’t cover them while they are in a facility, so MFP makes a big difference by bringing services in early.”

—State Medicaid manager

said that MFP funding has made a difference: the grant allows them to authorize and pay for moving expenses before the participant moves out of the institution, which Medicaid rules do not typically allow. Officials noted further that the funds can be used more flexibly than Medicaid HCBS waiver funds. For example, MFP can pay for delinquent telephone and utility bills that must be settled before someone can establish new service.

Extra HCBS. About a third of the state program leaders interviewed cited the availability of extra HCBS as another important contributor to MFP transition progress. These services are typically covered as MFP demonstration or supplemental services during the first year in the community, and they go beyond what Medicaid benefits normally cover. Examples of such services include behavioral health services, overnight companions for an individual living alone who needs supervision, hours for a home health or personal care aide that are above what is typically allowed by waiver programs or the state plan, and peer support to help individuals acclimate to community living. In some states, extra

Support for Community Providers Serving People with Complex Needs

“As we transition people with more complex needs—for example, those with behavioral problems—it stretches our community providers. We have had to help community providers develop the competence to serve higher-need people. We have to be a partner, not just authorize payment, by showing that we will help in times of crisis. At a time of budget cuts, the capacity building and one-on-one work with providers and clients would be impossible without MFP funds.”

—MFP project director

HCBS is defined not by categories of service but by the ability of transition coordinators (1) to spend more time with MFP-eligible individuals than they can with non-MFP-eligible individuals (that is, those not eligible for Medicaid or living in an institution for less than 90 days) to overcome barriers to transition, (2) to make more visits in the first few months after transition, and (3) to revise care plans throughout the first year if problems arise. State officials emphasize that, in addition to paying transition-coordination agencies for the actual time and resources involved in helping people, there is a need to support those HCBS providers willing to provide care to individuals with more complex needs, through extra payment and training.

Greatest Barriers to Progress

Housing shortages. MFP program officials cited the shortage of affordable, accessible housing that qualifies for MFP (homes, apartments, group homes of four or fewer individuals, and in some circumstances assisted-living facilities) as by far the biggest obstacle to greater progress in transitioning more people to community living. The majority (22) of the 25 respondents who rated barriers to progress cited housing as the biggest hindrance to more progress (Table 1). Nearly all MFP grantee states are using similar strategies to address this problem, such as creating or improving registries to match potential MFP participants with available housing units, working with public housing agencies to increase housing vouchers for people with disabilities or to give priority to people living in institutions, and working to create special tax incentives for developers. While no state representatives think they have solved the problem, they believe that one of the most promising strategies has been to hire housing specialists to work alongside transition coordinators (see further discussion below). These specialists provide one-on-one assistance to MFP candidates in locating suitable housing options. Because they have experience with and knowledge of public housing programs or the private real estate market, housing specialists are better equipped to overcome housing barriers than are transition coordinators and can often expedite housing searches by using established relationships with public housing authorities and landlords.

Inadequate HCBS capacity. Over one-third of state respondents cited as a barrier to progress inadequate capacity of HCBS providers to deliver the specialized care needed by some individuals who want to return

to the community. For example, several state officials mentioned not having enough providers to serve people with behavioral health issues, mental illness, or traumatic brain injury. Others said they did not have enough adult family care homes to serve people with special needs, such as individuals with dementia or those who are obese. They also highlighted challenges in arranging for basic HCBS and in finding enough direct-care workers to serve individuals, especially those who live in rural areas, because many providers are unwilling to drive long distances to deliver in-home care at the current payment rates.

State Medicaid policies. A third program component considered a barrier by about one-third of respondents is a lack of supportive Medicaid programs and policies in their states. In the current fiscal environment, many states have had to cut Medicaid benefits or provider rates to balance their budgets, which has led to reductions in funds for HCBS waiver programs or in HCBS covered by state plan benefits. State officials noted that because institutional services are an entitlement in Medicaid, while HCBS are not, legislatures are more likely to make cuts to the latter. Several state respondents said that rate reductions for HCBS providers are leading some providers to turn down high-need clients. When state MFP programs cannot assure individuals and their families that HCBS will continue after the first year (after the MFP enrollment period ends) because they are uncertain about future funding, people living in institutions are more reluctant to move to the community.

Differences Between High- and Average-Performing States

An important goal of the study was to determine if there were notable differences in the experiences of respondents from states that performed above average on the three progress indicators versus those from states that had average progress indicators. To answer this question, we compared how respondents rated various MFP program components in terms of their contribution to or hindrance of progress. There were no large differences in how the program representatives in the high-performing states rated specific program components compared to how respondents in average-performing states rated them. Independent of these ratings, we analyzed respondents' comments about their MFP implementation experiences and approaches to each program component and compared the strate-

gies used by the two sets of states. The results reveal patterns that may help to explain the differences in progress made by the two groups.

- **Transition coordination and planning.** Officials from states with higher-than-average performance indicators more frequently cited using four specific approaches to transition coordination than did states with average performance. These approaches include (1) developing standardized processes to ensure collaboration between transition coordinators and Medicaid HCBS waiver programs, which makes it easier to enroll MFP participants into waivers the day they move to the community; (2) clarifying the roles and responsibilities of transition coordinators and waiver case managers, which helps to prevent MFP participants from getting lost in the system; (3) adjusting payment rates for transition coordination, which gives transition coordinators the flexibility to devote more time to individuals with greater needs; and (4) allowing transition coordinators to make frequent home visits and calls to MFP participants following the transition. Officials from average-performing states more frequently mentioned being stymied by their lack of experienced transition coordinators. They also reported contracting with organizations that lacked transition experience or that had not previously been Medicaid-certified providers. They further cited the need for transition-coordination agencies to build new relationships or to strengthen existing relationships with HCBS providers and public housing agencies.
- **Housing strategies.** States with higher-than-average performance indicators more often employed housing specialists to work alongside transition coordinators. As discussed above, housing specialists typically provide one-on-one help to MFP participants and build relationships with local public housing authorities, thereby relieving transition coordinators of the need to become experts in complex housing regulations and programs. Using federal MFP administrative funding, many grantee states have recently hired or plan to hire housing specialists, so they are likely to see greater progress in the future if their experience is similar to that of states that hired housing specialists early on. In one state with higher-than-average performance, housing specialists also organized seminars on how to start small adult family homes in areas with shortages.

Complementary Medicaid Policies: Multiple Transition Programs

“A person can be eligible [for MFP] the day you find them and not the day they move. For example, someone who chooses to move into an adult family home with more than four adults cannot be enrolled in MFP. But because [our state] has other programs for such people, it’s not a wasted effort. States need more than one transition program “box” because individual needs change over time.”

—State Medicaid official

- **Other characteristics that distinguish high- and average-performing MFP grantee states.** Several other factors also seemed to benefit grantee states with higher-than-average performance indicators. These states usually had a strong foundation at the start of the MFP program: they had experience with transition programs for nursing home residents and for residents of intermediate care facilities for the mentally retarded (ICFs-MR); they had existing transition-coordination capacity in all or most regions within the state; and they had strong, stable program leadership and support. As state officials noted, grantee states with higher performance indicators also benefited from two state Medicaid policies: (1) court orders and settlement agreements requiring ICFs-MR to close or downsize, which led facility staff to involve the MFP program in meeting such requirements and subsequently led to a spike in MFP transitions, and (2) the operation of multiple transition programs designed to help anyone transition, regardless of whether they qualify for MFP. According to one state Medicaid official, this second policy “casts a wide net,” thereby increasing the opportunity for grantee states to find those who do qualify for MFP. Offering transition services to all institutional residents seems to increase overall MFP transitions.

Multiple transition programs are not exclusive to grantee states in the higher-performing group; for example, all 10 grantee states included in this study had a parallel transition program that helped non-MFP-eligible individuals return to the community. However, in 4 of the 5 states with average performance indicators, such programs existed only for people in ICFs-MR, not those in nursing homes. Where average states

did have experience with nursing-facility transitions, it was limited to a few regions in the state. Consequently, it took longer to put a statewide foundation in place for transition coordination. In addition, average states were more likely to take a “low-touch” approach to publicizing MFP (using mass mailings and brochures) and less likely to use “high-touch” outreach to residents. Program leadership was also less stable in these states: 2 of them had one or more changes in MFP directors in the first two years of the program, and in another 2 states, the MFP program lacked strong or consistent support from Medicaid agency leaders.

Study respondents rated strong program leadership as especially important during the start-up period, when it is critical to gain support and commitment from key stakeholders, including the state and local agencies that will be involved in program implementation. For example, because many grantee states enroll MFP participants in HCBS waiver programs, knowledge of these programs, and relationships with the agencies that run them, can be essential. Respondents also suggested that it is important for program leaders to organize and implement initial outreach and marketing efforts, and to establish management information and budget systems to accurately report on enrollment and spending to federal and state managers.

Weaknesses in program leadership, transition capacity, or outreach strategies during program start-up do not mean that MFP programs will be permanently impaired. In one grantee state, progress accelerated quickly when a new project director came on board with more experience and understanding of state Medicaid HCBS programs. Recent increases in transition volume in several grantee states that had less experience in

The Importance of Direct Contact with Residents

“We recently began working with Area Agencies on Aging on Minimum Data Set (MDS) Section Q to identify potential MFP participants. [The new] Section Q question made it a blanket approach, so everyone is asked if they want to talk to someone about leaving the institution. Since the new procedures went into effect, we received over 1,000 referrals. MFP didn’t get numbers like that before.”

—MFP project director

transition coordination at the start of the MFP program also indicate that progress can speed up once capacity is developed. And national implementation of Section Q in MDS 3.0 (the universal assessment tool for nursing homes), which requires all nursing home residents to be asked directly if they wish to speak with someone about returning to the community, ensures direct contact with residents in all states, not just in those that invested MFP resources in this activity early on.

LESSONS FOR STATE MFP PROGRAMS

Findings from this study offer lessons that can help MFP programs achieve their transition goals, whether they are new grantee states developing programs or established grantees seeking to increase the number of people they can successfully return to the community. Experience from states that have made the most progress by mid-2010 shows other states what they can do to make more progress.

1. Hire skilled, knowledgeable, and dedicated transition coordinators, and clarify their roles and responsibilities. State officials say that progress toward meeting MFP transition goals depends first and foremost on hiring or contracting with agencies that have skilled transition coordinators. The most effective transition coordinators, officials say, are passionate in their belief that anyone can live successfully in the community and are dedicated to marshalling all necessary resources to meet each individual's needs and preferences. To be effective, coordinators must have a thorough understanding of Medicaid HCBS waiver program requirements and services, knowledge of community resources, good communication skills (so they can interact with people with different types of disability and from a range of cultural backgrounds, as well as with family members and providers). While some program officials believe transition coordinators must have clinical nursing and social-work training, others

WILL MFP CONTINUE AFTER FEDERAL FUNDING ENDS?

Before the passage of the Affordable Care Act of 2010, the MFP Demonstration was originally scheduled to end in 2011. If MFP had ended this year, would states have continued MFP programs? We asked state MFP officials whether, after federal grant funds end, their state would likely continue the MFP program or a similar transition service to help Medicaid beneficiaries residing in institutions for a long time return to the community. Their answers provide an early indication about the long-term sustainability of MFP.

The majority of state MFP officials (17 of 27 respondents) said MFP would become a permanent part of state Medicaid programs if it can demonstrate state budget savings, or if it costs Medicaid no more than the cost of care in an institution. Although several respondents indicated that support from advocates would also be needed to continue the program, none thought advocacy by itself would be enough without evidence of cost savings and available funds to cover the state's share of costs. The following are examples of officials' responses:

- "If [funding for] MFP ended today, [my] state would be hard-pressed to continue it."
- "All states are going through hard times, and funding is a real issue, so even popular programs have to make the case that they are cost effective."
- "We don't foresee stopping the movement out of institutions, but lack of [state] funds definitely could slow it down by cutting administrative staff positions."

Some state program officials said the extension gives them more time to demonstrate the program's potential to rebalance the long-term care system. Among their comments:

- "It helped that MFP was extended . . . so people stop thinking about it as a short-term project and instead think about how it could contribute to system rebalancing over the long term."
- "MFP should be a building block for long-term care system reform, not a stand-alone project, or else it becomes vulnerable; the legislature will [just] wait for it to go away."

believe organizational and communication skills are more important. Finding people with these traits, providing them with training in MFP program rules and procedures, clarifying their roles and responsibilities, and giving them the flexibility they need to do these demanding jobs are essential ingredients of successful MFP transition programs.

2. Take advantage of MFP’s flexibility to tailor one-time moving expenses, transition-coordination resources, and extra HCBS to each person, especially for those with greater needs.

All people seeking long-term services and supports can benefit from individual attention to their situation and needs. But a person-centered, individualized care planning and service mix can be essential to people seeking to transition to the community after spending months or years in an institution. State program officials should take advantage of available federal funds to hire specialists, and they should use the flexibility afforded by the MFP Demonstration to depart from federal or state Medicaid rules and benefit policies to give those wishing to leave an institution the opportunity to do so. Because of MFP’s status as a demonstration, MFP programs can be modified by states in ways not possible under regular Medicaid HCBS waiver programs. For example, states can choose to cover unusual one-time moving expenses, allow transition coordinators to spend more time with those who need help in removing barriers, or authorize specialized behavioral health services or extra hours of personal care services that Medicaid would otherwise not allow.

3. Provide expert one-on-one help with housing.

Although shortages of affordable, accessible housing options afflict nearly every state and community, MFP programs making the most progress appear to be those that, from the very beginning, have assigned housing specialists to help find suitable residential options for those wishing to transition. Expecting

transition coordinators to become housing experts may be asking too much of them, given the number and complexity of housing policies and programs. MFP programs should make use of people with knowledge and experience in the housing arena to reduce the time required to find housing in the short term, while also working on system-level changes to expand the supply of housing in the long term.

While these lessons highlight the fundamentals of a sound transition program, the experiences of grantee states that have made the most progress so far suggest that adequate funding for Medicaid HCBS may also play an important role in ensuring progress, and that strong backing by senior Medicaid managers can be very helpful. The better-performing MFP programs tend to be those that are bolstered by state programs offering transition assistance to anyone wishing to relocate to the community, whether qualified for MFP or not. Program leaders in some of the best-performing states also stressed that (1) MFP should be seen as one option in a larger menu that gives all individuals a real choice about where to receive long-term services and supports, and (2) support for MFP should not detract from concurrent efforts to divert people from institutional care and to keep them at home.

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DATA AND METHODS

To compare the performance of state MFP programs, we analyzed the latest semiannual data (from June 2010) reported by state MFP grantees in the web-based progress reporting system. We focused on three indicators: (1) cumulative number of transitions to date, (2) percentage of ever-enrolled MFP participants among long-term institutional residents who would have been eligible for MFP in 2007 had the program been in effect, and (3) rates of reinstitutionalization of 30 days or more among MFP participants. We observed wide ranges on each of these indicators. The cumulative number of transitions at that time ranged from 31 to about 2,700. The proportion of MFP-eligible individuals transitioned varied from 0.13 percent to nearly 5.0 percent; the eligible population was defined by the original MFP length-of-stay eligibility criterion of six months because those were the most recent data available when the study was designed. Rates of reinstitutionalization (for 30 or more days) among MFP participants, unadjusted for age or type and severity of medical conditions, varied from 0 to nearly 30 percent across the 30 grantee states. Although unadjusted rates of reinstitutionalization do not account for differences across states in the age, severity of medical conditions, and other important characteristics of MFP participants, they provide an early indicator of each state's ability to ensure that MFP participants receive all long-term services and supports needed to remain in the community.

After calculating averages for the indicators across all 30 state MFP grantees, we sorted states into three groups: those with indicators (1) above the average, (2) near the average, and (3) below the average. From the 7 states with indicators usually above the average, we selected 5. From the 14 states whose indicators were usually near the average, we selected 5 representing a mix of characteristics, including population size, geographic location, and level of experience with transition programs. Because the cumulative number of transitions is affected by the length of program operations, we excluded 9 grantee states whose below-average performance could be attributed either to (1) a later starting date than the other states and hence less time to carry out transitions or (2) administrative problems, unrelated to program strategies, that were assumed to affect progress toward successful transitions.

We collected information from the 10 states through two avenues. First, we conducted semistructured telephone interviews with 3 MFP program staff in each state: (1) the state MFP project director, (2) a senior state official responsible for Medicaid long-term care policy, and (3) a staff person or agency director responsible for MFP transition coordination at the local level. The interviews covered several topics, including the state or local agency's experience and capacity for conducting transition programs before MFP began, the strengths and weaknesses in each of 11 program components (see Table 1), and the evolution over time of factors that determine progress as the program itself evolves. In total, we conducted interviews with 27 of 30 program representatives in 10 grantee states; we were unable to complete interviews with one representative in each of 3 states. Second, we asked respondents to pick 3 program components among 11 listed that most contributed to, and most hindered, their progress so far and at two stages of program evolution, start-up and expansion. We received 29 ratings sheets from the 30 individuals contacted, but in some cases ratings were missing for some components, so these components received fewer than 29 responses.

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