# PATHWAYS TO INDEPENDENCE: TRANSITIONING ADULTS UNDER AGE 65 FROM NURSING HOMES TO COMMUNITY LIVING

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## EXECUTIVE SUMMARY

The Money Follows the Person (MFP) rebalancing demonstration was designed to provide Medicaid beneficiaries in long-term nursing homes and other types of facilities with more choice about where they receive long-term services and supports (LTSS). Of the 1.4 million people who spent any time in a nursing home in 2014, about 15 percent were adults under age 65 (Centers for Medicare & Medicaid Services 2016). The data suggest that nursing home residents under age 65 have disproportionately benefited from the MFP demonstration. For example, in 2014, demonstration grantees transitioned adult Medicaid beneficiaries under age 65 eligible for MFP at twice the rate of older adults. Although adults under age 65 comprise less than 20 percent of the total nursing home population, they have accounted for 40 percent of the 63,000 MFP transitions that have occurred through 2015.

To understand why adult nursing home residents under age 65 appear to disproportionately benefit from the MFP demonstration, we interviewed leading MFP demonstrations in six states: Connecticut, Maryland, New York, Oklahoma, Texas, and Washington. We learned:

- Although MFP demonstrations have few age-based procedures and processes, the study states cited several factors as contributing to their success transitioning adult nursing home residents under age 65 to independent living, including peer networks, strong transition coordination services, flexible LTSS, high levels of motivation among this population, and networks of informal supports.
- Respondents in several states noted that adults under age 65 frequently rely on peer networks to help them transition. Those who move out help friends in the nursing home make the same transition. Of the six study states, four formally offer peer support services to MFP participants to provide a first-hand perspective of the resources needed to reside independently in the community.
- Adult nursing home residents under age 65 tend to move to apartments in the community and benefit from the various initiatives MFP grantees have pursued to increase access to affordable and accessible housing. Three study states took advantage of the non-elderly disabled category II (NED 2) housing choice vouchers to improve housing options for non-elderly institutional residents who transition to the community. Four study states have received Section 811 Project Rental Assistance (PRA) funds to increase the supply of integrated, supportive housing for low-income people with disabilities.
- All study states improved the integration of mental health services with other community-based LTSS providers, which has benefitted former adult nursing home residents under age 65. Strategies include providing specialized behavioral health supports to MFP participants and modifying Medicaid waivers to better integrate mental health care for MFP participants.

### About the Money Follows the Person Demonstration

The MFP rebalancing demonstration, first authorized by Congress as part of the Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act of 2010, is designed to rebalance state Medicaid spending on long-term services and supports from institutional-based settings to community settings. Congress authorized up to $4 billion in federal funds to support a twofold effort by state Medicaid programs to (1) transition people living in long-term care institutions to homes, apartments, or group homes of four or fewer residents; and (2) 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 the Centers for Medicare & Medicaid Services (CMS), which initially awarded MFP grants to 30 states and the District of Columbia in 2007, another 13 states in February 2011, and 3 more in 2012. CMS contracted with Mathematica Policy Research to conduct a comprehensive evaluation of the MFP demonstration and report the outcomes to Congress.

## INTRODUCTION

The Money Follows the Person (MFP) rebalancing demonstration serves Medicaid beneficiaries residing long term in institutions such as nursing homes, intermediate care facilities for individuals with intellectual and developmental disabilities, psychiatric facilities, and hospitals. As of the end of 2015, the MFP demonstration was operating in 43 states and the District of Columbia and the number of cumulative transitions had grown to over 63,000 Medicaid beneficiaries (Morris et al. 2016). Of everyone transitioned by MFP, approximately 71 percent were former nursing home residents; adults under age 65 made up more than half (56 percent) of these transitions (or about 40 percent of MFP transitions overall). The data suggest that nursing home residents under age 65 have disproportionately benefited from the MFP demonstration.

Of the 1.4 million people who spent any time in a nursing home in 2014, over 15 percent were 22 to 65 years old (Centers for Medicare & Medicaid Services 2016). Compared to older adults, adults under age 65 are more likely to be long-stay residents who need ongoing assistance with routine activities (such as getting in and out of bed, walking, and eating)—the type of resident the MFP demonstration targets. Using Medicaid claims data, we find that, among Medicaid beneficiaries residing in a nursing home for 90 days or more (the length of time required to be eligible for MFP), 19 percent were adults under age 65 in 2014. Our analysis also indicates that the proportion of long-stay nursing home residents who are adults under age 65 has slowly increased from less than 17 percent in 2006 to 18 percent in 2010 and 19 percent in 2014, which is consistent with other research that indicates adults under age 65 are a growing share of nursing home residents (Miller 2011). Adults under age 65 represent a growing share of nursing home residents, in part because the size of the eligible nursing home population is decreasing each year (Miller 2011).

We estimate that, in 2014, nearly 786,000 Medicaid beneficiaries 65 and older were eligible for the MFP demonstration that year and grantees transitioned less than 1 percent (3,960 people) of this eligible group. In comparison, approximately 188,000 adult Medicaid beneficiaries under age 65 and residing in nursing homes were eligible for MFP and about 2 percent (3,966 people), actually transitioned and became MFP participants during 2014 (Morris et al. 2015). MFP demonstrations have penetrated further into the population of adults under age 65 residing long term in nursing homes, compared to older adults, and the question is why this difference has occurred. Because adults under age 65 comprise a smaller proportion of eligible nursing home residents, it takes fewer transitions to make progress moving this population. However, more than half of all nursing home transitions are adults under age 65, so other factors likely play an important role.

This report presents findings from investigations we conducted with six states that are leaders in transitioning this group from nursing homes to the community. The research questions focused on understanding why MFP grantees appear to have been more successful at transitioning adults under age 65 compared to older adults residing in nursing homes. We also wanted to understand whether (1) adult nursing home residents under age 65 had different characteristics, such as lower care needs, that made them easier to transition; and (2) state grantees had age-based transition strategies that were more successful with this population. We examined strategies state grantees used to address the lack of affordable and accessible housing, a key barrier to program growth according to grantee states (see Morris et al. [2016] for the most recent discussion of this issue). We also explored questions relating to approaches state grantees used to ensure transitions were successful long term and avoid the need to readmit participants to institutional care, as well as the strategies they used to meet the needs of participants with mental health conditions, given the high prevalence of mental health conditions detected in earlier research of MFP participants (Irvin et al. 2015).

To identify leading MFP demonstrations, we ranked states' performance on the following seven indicators:

1. **Transitions.** The cumulative number of MFP transitions through 2015 to identify grantees that transitioned greater numbers of adults under age 65 from nursing homes to the community.
2. **Reinstitutionalizations.** Readmissions to institutions lasting 30 days or more among former adult nursing home residents under age 65 participating in MFP, to identify grantees with lower reinstitutionalization rates. These rates do not take into account people who returned home to the community after experiencing a reinstitutionalization.
3. **Participants' quality of life.** Proportion of adult MFP participants under age 65 working for pay or volunteering one year after transitioning to the community, to identify grantees with higher rates of community integration among former nursing home residents.
4. **Prevalence of mental health conditions among participants.** Proportion of adults under age 65 with a co-occurring physical disability and mental health condition who were transitioned from nursing homes, to identify grantees that are serving higher shares of participants with mental health conditions through MFP.

5. **Participants with high care needs.** The proportion of participants with high care needs, to identify grantees that transitioned disproportionate numbers of participants who had high care needs in the nursing home and had stays of 90 or more days.
6. **Participants with low care needs.** The proportion of participants with low care needs, to identify grantees that transitioned disproportionate numbers of participants with low care needs, who may not need institutional-level care and could be served in a community setting.
7. **Housing or vehicular modifications.** Use of housing supports or vehicular modifications to identify grantees that had higher shares of participants who used these supports during their first year in the community.

We used the following data sources to calculate these measures: (1) program participation and service utilization data through December 2015, (2) quality of life survey data through 2015, and (3) nursing home Minimum Data Set (MDS) 3.0 assessment records through 2014. We ranked grantee states on each indicator and ranked them again by the sum of rankings across the indicators. In effect, states that rank high on multiple indicators rank high overall. Due to the methodology for constructing the indicators and weighting indicator scores, overall scores are not precise and might change if an indicator sensitive to participants' health or functional status were adjusted for risk or medical or functional acuity. Of the 44 MFP grantee states that were transitioning MFP participants in 2015, only 29 had complete data and were included in the ranking process to identify high-performing programs. Figure 1 presents information on the rankings for the six study states.

**Figure 1. Indicator rankings for the population of adults under age 65 transitioned from nursing homes, study states only**

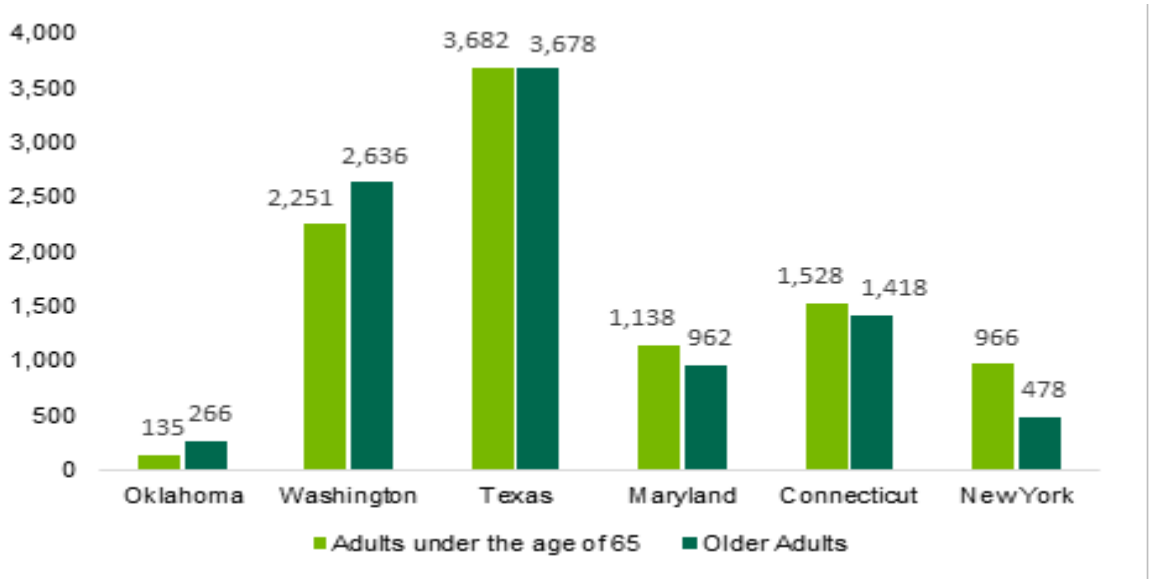
| State | INDICATOR 1 Number of transitions | INDICATOR 1 Transitioned high share of people with PD from NF | INDICATOR 2 Reinstitutional-ization rate | INDICATOR 3 Working or volunteering post-transition | INDICATOR 4 Share of participants with MI | INDICATOR 5 Percentage with high care needs while in NF | INDICATOR 5 Percentage with low care needs while in NF | INDICATOR 6 Housing modifications | Overall total ranking |
|---|---|---|---|---|---|---|---|---|---|
| New York | 16 | 12 | 12 | 12 | 1 | 2 | 1 | 16 | 72 |
| Maryland | 7 | 19 | 7 | 21 | 7 | 3 | 6 | 3 | 73 |
| Oklahoma | 18 | 1 | 2 | 13 | 4 | 19 | 3 | 24 | 84 |
| Texas | 1 | 13 | 25 | 22 | 9 | 12 | 7 | 7 | 96 |
| Connecticut | 4 | 20 | 24 | 16 | 5 | 17 | 4 | 19 | 109 |
| Washington | 3 | 17 | 17 | 20 | 17 | 14 | 17 | 6 | 111 |

Note: The states are sorted in ascending order based on their overall rank score. The overall score is the total of the scores for the individual indicators. A low score indicates better performance on the indicators. The Data and Methods appendix provides more detail about how the indicators were measured and the ranking methodology.

MI = Mental Illness; NF = Nursing Facility; PD = Physical Disability

Of the six selected states, four ranked high overall and two were in the middle, so they provided a range of performance. The data in Figure 2 indicate that the MFP demonstrations in Texas and Washington are among the largest programs and Oklahoma is one of the smallest.

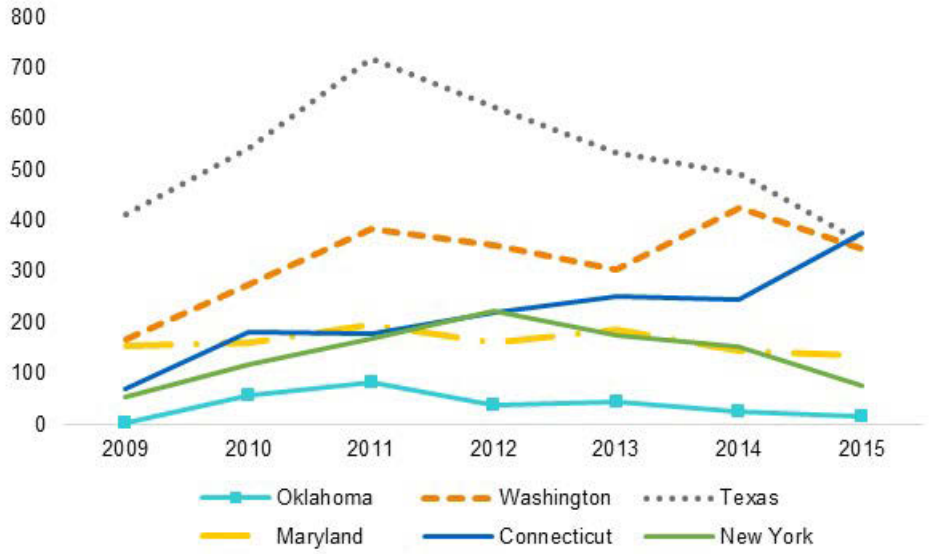
**Figure 2. Cumulative number of MFP transitions for adult nursing home residents by age group and by study state through 2015**




Source: Mathematica analysis of program participation data submitted by MFP grantees through March 2016.

In New York and Texas, the number of adults under age 65 transitioned from nursing homes has declined since 2012 and 2011, respectively (Figure 3). In Connecticut and Washington, the number of adults under age 65 transitioned from nursing homes has increased slowly over time, whereas in Maryland and Oklahoma the numbers of adults under age 65 transitioning from nursing homes have been relatively stable. Detailed information about the data and methods used for this study appear at the end of the report.

**Figure 3. Number of adults under age 65 transitioned from nursing homes by study state, 2009 to 2015**




Source: Mathematica analysis of program participation data submitted by MFP grantees through March 2016.

## Key characteristics of adults under age 65 transitioning from nursing homes

MFP grantee states had transitioned more than 24,000 Medicaid beneficiaries under age 65 from nursing homes to the community by the end of 2015, representing approximately 40 percent of all MFP transitions since the demonstration began in 2008. MFP participants under age 65 who transition from nursing homes tend to be in their pre-retirement years, and 55 percent are men (compared to 36 percent of older adults transitioning from the same type of facility [Table 1]). This is consistent with earlier work by Miller et al. (2012), who assessed adults ages 31 to 64 who entered nursing home care in 2008. Nearly one-third of the adults under age 65 who transitioned from nursing homes through MFP had low care needs, 21 percent had a cognitive impairment, and 37 percent had a serious mental illness.[1, 2] Once participants are living in the community, MFP demonstrations are relatively successful at preventing readmissions to

[1] Information about level of care needs, assistance with the activities of daily living (ADL), cognitive impairment, and prevalence of mental illness come from the nursing home minimum data set (NF-MDS). The NF-MDS is the nursing facility resident assessment instrument used for all nursing facility residents and hence, these statistics include only MFP participants who transitioned from nursing facilities. The level-of-care-need measure was defined using an approach developed by Mor et al. (2007), which relies on the resource utilization groups (RUGs) developed for the prospective payment system Medicare uses for Part A skilled nursing facility stays. The cognitive impairment measure captures nursing home residents' cognitive state, such as their orientation and ability to register and recall information. The NF-MDS also assesses nursing home residents' active diagnoses while in the facility; residents with severe mental illness include those with an active diagnosis of schizophrenia, major depression, or bipolar disorder. All information comes from the most complete MDS assessment nearest to the time of the transition to the community.

[2] Rates of mental illness appear to much higher when the diagnosis codes on medical care claims are included in the assessment. Data presented in Irvin et al. (2015) incidate that more than 60 percent of MFP participants have a diagnosis on either a Medicaid or Medicare claim during the year before the transition to the community.

institutional care lasting longer than 30 days; less than 9 percent of adults under age 65 return to a nursing home compared to 11 percent among older adults. Many of these people later transition from institutional care back to the community after they being stabilized.

### Table 1. Characteristics of adults who transitioned from nursing homes by age group

| Characteristics | Adult nursing home residents under 65 transitioned through December 2015 | Adult nursing home residents 65 and older transitioned through December 2015 |
|---|---|---|
| Mean age | 51.7 | 76.6 |
| **Age group (%)** | | |
| < 21 | 1.3 | 0.0 |
| 21–44 | 17.9 | 0.0 |
| 45–64 | 80.8 | 0.0 |
| 65–84 | 0.0 | 80.3 |
| ≥ 85 | 0.0 | 19.7 |
| **Gender (%)** | | |
| Male | 55.3 | 35.6 |
| **Medicare eligibility** | | |
| Dually eligible | 54.0 | 96.0 |
| **Level of care needs** | | |
| Low | 31.6 | 22.6 |
| Medium | 38.9 | 44.2 |
| High | 19.7 | 24.7 |
| Uncategorized | 1.6 | 1.5 |
| Mean total ADL score | 11.0 | 12.9 |
| **Cognitive impairment** | | |
| None/low | 69.4 | 52.9 |
| Mild/moderate | 15.7 | 26.9 |
| Severe/very severe | 4.8 | 11.3 |
| **Mental illness** | | |
| Serious mental illness | 36.7 | 28.5 |
| **Reinstitutionalization** | | |
| Percent reinstitutionalized >30 days | 8.6 | 10.9 |
| Total N | 24,386 | 19,012 |

Source: Mathematica's analysis of Nursing Facility Minimum Data Set (NF-MDS) and program participation data submitted to CMS through March 2016.

## States use the same processes to transition all nursing home residents through MFP, although more adults under age 65 successfully made the move to the community


The grantees included in this study could not identify a clear strategy or set of strategies that explained why they were transitioning a larger proportion of eligible adults under age 65 from nursing homes compared to older adults. Most of their strategies and procedures for the nursing home population are the same, regardless of the person's age. States universally reported that they do not target specific age groups for MFP, and adults under age 65 transitioning from nursing homes access the same system of community-based LTSS as older adults. Study states market MFP broadly to all

people who express interest in moving to a community-based setting. Specifically, these MFP programs use multiple strategies to identify and outreach to all nursing home residents, including direct marketing and outreach to nursing facilities, use of MDS Section Q referrals that capture nursing home residents' interest in transitioning to the community, and outreach by peers or the long-term care ombudsman.[3]

Although outreach strategies, service delivery, and the LTSS system in each state do not appear to be affecting states' success with transitioning adults under age 65 from nursing homes, state program staff cited several factors that have contributed to higher transition rates among this population. For example, one study state noted that some nursing home discharge planners place more referrals for younger adults, compared to older adults, because the discharge planners consider the nursing home an inappropriate setting for this population. In the remainder of this section, we present several factors that study states cited as contributing to their success transitioning nursing home residents to independent living, including peer networks, strong transition coordination, flexible LTSS, high levels of motivation among adults under age 65, and networks of informal supports.

**Peer networks.** Respondents in one study state reported that peer networks have helped some adults under age 65 transition from the nursing home to independent living. Those who move out in turn help friends who remain in the nursing home make the same transition. In Washington, many younger adults have decided to pursue transitioning through MFP after observing their peers in the nursing home move to the community and thrive in their apartments with the support of community-based LTSS. Of the six study states, four formally offer peer support services to MFP participants to provide them with first-hand experience of what it takes to reside independently in the community: Connecticut, Maryland, New York, and Texas.[4,5]

**Strong transition coordination and upfront planning.** Five study states (Connecticut, Maryland, New York, Texas, and Washington) attributed their success with the nursing home population to transition coordinators and other staff, such as housing coordinators and specialized case managers, who provide critical services prior to transition.[6] Transition coordinators assist in developing a robust person-centered plan and assemble a service package that suitably meets the participant's needs in the community, but they also serve other important

[3] 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.

[4] In Texas, peer support services are only available to MFP participants in the Behavioral Health Pilot program.

[5] In the study states, peer support services are offered to adults under age 65 in nursing homes through the MFP program, 1915(c) waiver, or the managed care organizations that serve this population.

[6] Transition coordinators conduct a person-centered assessment to identify each transition candidate's needs and preferences for community-based LTSS. However, the roles and responsibilities of transition coordinators (who may be called relocation specialists, case managers, transition specialists, or other titles) vary by state. For example, in some states, transition coordinators also conduct outreach to residents of institutions or complete surveys to monitor how participants are faring, while in other states these tasks are delegated to contracted providers. In some states, transition coordinators are responsible for finding and securing housing in MFP-qualified residences for those in need of housing, while many MFP programs hire housing specialists to handle this task.

functions. In Connecticut, transition coordinators provide strong upfront support and also complete surveys with participants in-person at a minimum of 3, 30, 60, and 90 days post-transition to monitor how they are faring in the community. In Maryland, transition coordination and case management/supports planning services are provided by providers who are engaged early in the discharge planning processes which are person-centered. In New York, transition specialists who are housed within the Centers for Independent Living (CILs), provide community preparedness education and training to MFP participants to ensure that they have essential community living skills to reside independently in the community. Washington also provides transition coordination services and, according to one respondent, the transition specialists play an especially critical role for younger adults seeking independent housing. The contracted specialists can help potential MFP participants locate housing, take them on tours to view available housing, or take photographs of the unit for viewing in the nursing home. Texas emphasized specialized services as a factor in transitioning adults under age 65, and offers MFP participants participating in its Behavioral Health Pilot Cognitive Adaptation Training (CAT) as a service beginning up to six months before the person moves to the community. According to Texas, people with behavioral health needs enter nursing homes at a younger age and this population benefits from more customized services and supports.

**Lesson Learned**

"People who have used relocation services to the fullest, [are] people who work closely with service coordinator and receive a service package that meets their needs [in the community]. Housing is very important, as is monitoring by the service coordinator to make sure things are going as needed ... It has to be a combination of these things – none in isolation would make for a successful transition."

*-State MFP program director*

**Flexible LTSS.** Connecticut, Maryland, and Washington have flexible service offerings; they allow transition coordinators to customize person-centered plans to meet the needs of MFP participants who transition to the community. The flexibility takes the form of wraparound services that supplement what is available through the Medicaid state plan, expanded access to specialized services to help people achieve stabilization in the community, or flexible funding to cover supports or environmental modifications a person needs to exit the nursing home.

The service needs of adults under age 65 exiting nursing homes differ, in some respects, from those of older adults. According to MFP staff in Texas, just over one-third of younger adults used transition assistance services (assistance with payment for utilities and rent and furniture) through 2014, compared to less than 5 percent of older adults who have transitioned through MFP. Transition assistance services are available to older adults and people under age 65 with disabilities through STAR+PLUS, which is a Medicaid managed care program. In Texas, transition coordinators report that adults under age 65 most often use personal care assistance, home modifications, nursing care, adaptive aids, and physical therapy. Furthermore, one transition coordinator in New York reported that, compared to older adults, adults under age 65 more frequently access job training and development to help them attain employment goals. Additionally, younger adults are more likely to seek paratransit or independent living skills training to assist them with learning to become independent.

The ability to customize services has allowed these programs to assemble a robust package of LTSS that meets the diverse needs of nursing home residents and enables them to transition to the community:

- In 1983, Washington established the Community Options Program Entry System (COPES) waiver program to provide personal care services in the community to individuals who meet nursing home level of care functional eligibility criteria. It included wraparound services, such as coverage for home modifications, home-delivered meals, personal emergency response systems, skilled nursing, durable medical equipment, and community transition services that provide the goods and services necessary to facilitate a move to the community. On July 1, 2015, Washington launched its Community First Choice (CFC)[7] program and transitioned several of the services originally offered under COPES to the CFC program. MFP participants in Washington also have access to additional demonstration services intended to help them adjust to community living. These services include transitional behavioral health services, community choice guides (contracted transition specialists), and consultation for challenging behaviors. The success of these services among the MFP population prompted the state to make them available to people *not* eligible for MFP through its Washington Roads program.[8] Washington initially expanded access to these demonstration services to nursing home residents who did not meet the length of stay eligibility for MFP or who opted to move to a non-qualified residence in the community. It later expanded the service to people at risk of losing their community placement in an effort to divert them from entering the nursing home and help them achieve stabilization in the community.
- In July 2015, Connecticut implemented a CFC state plan option to cover community-based personal care attendant (PCA) services (which were previously offered under the Personal Care Attendant waiver) to young adults between the ages of 18 and 64. PCAs can provide various services, including administering medication and helping the individual with employment. Under CFC, individuals receiving attendant care self-direct their own services. When CFC was launched, it provided people who self-direct and manage their own budgets with a much broader range of supports than they received previously, such as a support and planning coach, a health coach, assessments for assistive technologies, home-delivered

[7] The Community First Choice 1915(k) option, established by the Affordable Care Act in 2010, allows states to provide community-based personal attendant services and supports under their state plan to eligible Medicaid enrollees who would otherwise require institutional-level care. States implementing the CFC option receive a six percentage point increase in Federal matching payments for service expenditures related to this waiver (https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/community-first-choice-1915-k.html). Of the six study states, five (Connecticut, Maryland, New York, Texas, and Washington) have received approval of their CFC state plan amendment and have either implemented or are in the midst of implementing this new option.

[8] Individuals who require nursing home-level care, wish to receive LTSS in a community-based setting, and are not eligible for MFP can take advantage of the following MFP demonstration services through the Washington Roads program: transitional mental health, community choice guide, challenging behavior consultation, professional support services (that is, occupational therapy), informal caregiver support services, substance abuse services, respite services, service animal, adult day trial services, assistive technology and vehicle adaptations, and home modifications (Washington State Operational Protocol, Version 1.8, 2016e).

meals, and accessibility modification. The goal of the expanded self-direction option is to give MFP participants substantial control over their array of supports.

- In 2014, Maryland re-organized the delivery of LTSS by merging the Living at Home Waiver and the Waiver for Older Adults into one program, now called the Home and Community-based Options Waiver. Merging the waivers enabled the state to offer additional services to participants, standardize rates and provider qualifications, and streamline administrative processes. At the same time, Maryland also implemented a new CFC state plan option for Medicaid beneficiaries, including MFP participants. Through CFC, individuals have access to personal attendant services, environmental assessments, and accessibility adaptations; the latter benefit was enhanced to $15,000 over a three-year period, reflecting an increase above annual limits for the Older Adults and the Living at Home waiver. People transitioning to the community from institutional settings can also access transitional funds through CFC that they can use to pay for basic necessities such as rental security deposits and first month utilities.

**Highly motivated residents and strong networks of informal support.** Respondents in New York attribute their success moving young adults to the community in part to high levels of motivation among adults under age 65 who want to move from the nursing home to a residence in the community. According to one respondent, "This population tends to be extremely motivated to succeed in the community. They feel out of place in the nursing home. They don't have the same social connections in nursing homes; they are looking for the kinds of social connections that exist in the community. This level of motivation helps them overcome barriers." In Oklahoma, when a candidate is assessed for transition, the transition coordinator contacts several sources of informal support to gauge how well the person will do in the community and whether the person will have a circle of informal support after the transition.[9] Like many other states, Oklahoma does person-centered planning and incorporates informal supports into the transition plan so the participant has the best chance of thriving in the community.

**Lesson Learned**

". . .For the [adult population under age 65 with physical disabilities, informal supports are] invaluable. . .to really thrive in the community, you have to be able to do some things for yourself. That's why we do the medical assessment. We assess the [candidate's] ADLs, the IADLs and our clinical staff . . .determine whether they can really thrive in the community. And then we also look at those informal supports and what providers are available that we can put around those informal supports, as well as the person."

*-State LTSS program administrator*

[9] According to CMS guidance released on April 3, 2013, each MFP program "must have a quality management strategy consistent with the 1915(c) waiver requirements including the use of performance measures, remediation strategies, trending and analysis, and the implementation of quality improvement initiatives." MFP programs must also have three quality requirements in place that include (1) a critical incident reporting and management system, (2) a risk assessment and mitigation protocol and a process to ensure that the protocol is working as planned, and (3) a backup strategy that includes access to a 24-hour backup service to address a lapse in the provision of essential health and support services.

## Key strategies top MFP programs are using to address the housing issue for adults under age 65 residing in nursing homes

Staff in the study states indicated that they have to use multiple strategies to help younger adults locate affordable housing in the communities of their choice because no one strategy alone works consistently (Tables 2 and 3). Again, state housing strategies tend to be general and do not focus on a single target population and some strategies are not specific to the MFP population (Table 2). One state noted that subsidized housing was more readily available for older adults compared to adults under age 65 with disabilities, whereas two other states noted the opposite. Our analysis of the data indicate that adults under age 65 transitioning from nursing homes are more likely to move into apartments, a form of housing that is most likely subsidized to some extent for this population, while older adults are more likely to move into homes that either they or a family member owns (Morris et al. 2016).[10]

### Table 2. Housing opportunities for MFP participants in study states

| State | Housing choice vouchers for MFP population | Number of PHAs that changed preferences for the MFP population | Number of NED Category II HCVs utilized | Number of 811 PRA units set aside for MFP | Were changes made to the Qualified Allocation Plans or Low Income Housing Tax Credit for the MFP population? |
|---|---|---|---|---|---|
| Connecticut | 1,200[a] | 36 | 0 | 50 | Yes |
| Maryland | 84[b] | 12 | 112 | 300[b,c]. | No, but at least 5 percent of all units are for households at or below 60 percent of area median income and headed by a non-elderly person with a disability |
| New York | 500 vouchers for participants in the Nursing Home Transition and Diversion 1915(c) waiver and 1,000 vouchers for participants in the Traumatic Brain Injury 1915(c) waiver[b,d] | 0 | 0 | 0 | No |
| Oklahoma | 50 annually | 0 | 0 | 0 | No |

[10] One overarching goal of the demonstration is to give MFP participants greater choice about where to receive services in a community of their choice. Section 6071 of the Deficit Reduction Act (DRA) requires MFP participants to move into qualified housing in the community, which may include (1) a home owned or leased by the individual or a family member, (2) an apartment with an individual lease, or (3) a community-based residence in which no more than four unrelated individuals reside. In 2009, CMS released guidance clarifying that assisted living facilities may be considered a qualified residence if they meet specific conditions.

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|---|---|---|---|---|---|
| Texas | 1,100[a,e] | 0 | 35 | 192 | No |
| Washington | 215 | 6 | 215[f] | MFP applicants receive priority although none are set aside | No[g] |

Source: Descriptive information provided by MFP program staff in October 2016.

[a]State estimate.

[b]MFP program staff provided a target number or number of vouchers/units available, rather than the actual number utlized.

[c]Maryland's units are not only available to MFP participants. They are for all non-elderly adults with disabilities with iincomes at or below 30 percent area median income who are Medicaid recipients.

[d]Counts provided by New York reflect individuals enrolled in each waiver program, many of whom are MFP participants, that have received housing vouchers.

[e]Texas provided the number of households served, rather than the number of vouchers provided. Texas's vouchers are available to low-income non-elderly persons with disabilities who transition out of institutions.

[f]Washington was issued 215 NED 2 vouchers; these vouchers are not specific to the MFP population.

[g]In Washington, applicants for low-income housing tax credits get additional points for including 811 units in their proposal.

HCV=housing choice voucher; NED=non-elderly disabled; PHA=public housing authority; PRA=project rental assistance.

MFP programs strive to locate and secure affordable and accessible qualified housing for MFP participants that is in a community of their choice, but prior studies have found that grantee states encounter myriad barriers that have hindered programs' transition efforts.[11] Adults under age 65 transitioning from nursing homes, in particular, face a unique set of housing challenges compared to the older adult population. According to one state, the younger adult population is harder to house than older adults, because the latter population usually qualifies for senior housing, which is accessible and has rent that fits within guidelines established by the U.S. Department of Housing and Urban Development. The subset of the adults under age 65 who receive Supplemental Security Income (SSI) benefits may face an especially difficult challenge in securing affordable housing, as the cost of rent often exceeds the average value of SSI payments (Cooper et al. 2015).

Three study states (Maryland, Texas, and Washington) have taken advantage of NED2 housing vouchers to improve housing options for non-elderly institutional residents who transition to the community. Four study states (Connecticut, Maryland, Texas, and Washington) were awarded Section 811 PRA funds in FY2013 and are expected to make nearly 600 units

[11] Housing barriers include, among other things, shortages of rental vouchers, small group homes, and affordable and accessible housing in safe communities; steep upfront costs associated with moving and establishing a new household; or a criminal record that makes it impossible to access publicly funded housing (Morris et al. 2015; Lipson et al. 2011).

available to persons with disabilities between FFY 2012 and 2013 (Technical Assistance Resource Center on Supportive Housing 2015).[12] Moreover, younger adults more often require home modifications before transitioning to the community. For the MFP demonstration to successfully provide adults under age 65 full access to LTSS in a community-based setting, MFP programs must implement solutions to address housing barriers. We explored with the six study states strategies they have used to address housing barriers to allow more people with disabilities to move back to their community (Tables 2 and 3).

### Table 3. Strategies MFP grantee states have used to improve housing options for MFP participants

| State | Collaboration with housing partners | Housing staff and resources | Tenancy supports and stabilization | Increasing the supply of AA housing | Transition supports |
|---|---|---|---|---|---|
| Connecticut | X | X | X | X | X |
| Maryland | X | X | X | X | X |
| New York | X | X | X | | X |
| Oklahoma | X | X | X | | X |
| Texas | X | X | X | | X |
| Washington | X | X | X | X | X |

Source: Semi-structured interviews conducted with state staff in June and July 2016.

AA = affordable and accessible.

**Established collaborations with housing partners.** Since the MFP demonstration began transitioning beneficiaries in 2008, MFP programs have established and strengthened collaborations between state health and housing partners. Several study states (Maryland, Oklahoma, and Washington) have built partnerships with property management companies, housing finance agencies, and housing authorities to obtain prioritization for MFP participants. For example, in Maryland, one property management company had income requirements above the amount that participants typically receive. Over time, the MFP program built a relationship with staff at the property management company and obtained their buy-in of the MFP program, after which the company lowered the income requirements for individuals referred through MFP, so more people secured affordable housing. Oklahoma's housing finance agency prioritizes MFP participants on its waitlist for housing vouchers, which enables the program to transition more people than otherwise. Washington has formed strong partnerships

**Lesson Learned**

"When housing authorities work with us and trust us and see that there's some value-add for them, they're more willing to set aside a percentage of vouchers."

*-State LTSS program administrator*

[12] The U.S. Department of Housing and Urban Development (HUD) Section 811 PRA program provides integrated supportive housing units for people with disabilities. Through this program, HUD seeks to increase the supply of affordable housing by promoting state housing and Medicaid agency collaborations, and requires an interagency agreement between the state housing and health agencies to be eligible for the program.

with several housing authorities and has leveraged these partnerships to create more subsidies for MFP participants.

**Hired dedicated housing staff to facilitate transitions.** Most MFP programs have used MFP funding to hire dedicated housing staff to provide participants with a range of housing-related supports and services (Irvin et al. 2016). Housing staff may include housing specialists, housing coordinators, or transition coordinators who primarily serve three key functions: (1) help participants locate and secure appropriate housing, (2) collaborate with other state agencies to shape policy and improve housing options, and (3) provide technical assistance and training to property managers and transition coordinators. All six study states have hired a combination of housing specialists to help people identify appropriate housing and relocate to the community or housing coordinators who work with outside partners, such as public housing authorities, state housing finance agencies, developers, landlords, and property management companies, to improve housing options for participants.

**Provided additional tenancy supports.** Study states employed a range of tenancy supports to help participants maintain stable housing in the community. All the study states use MFP funds to cover upfront costs, such as a security deposit or moving expenses, associated with relocating to the community. The amount of housing supports ranges from $700 in Maryland to $3,500 in Texas. All study states provide participants with tenancy training and independent living skills to educate them about tenant rights, the decision-making aspects of renting an apartment, and budgeting, as well as how to be a good tenant and neighbor. Maryland, Oklahoma, and Texas provide technical assistance and training to transition coordinators, property managers, and landlords to change their perception of challenges working with people with disabilities and educate them about fair housing rules and participants' accessibility needs.

**Offered transition supports.** Four study states (Connecticut, Maryland, New York and Washington) offer rental assistance to participants which is a critical support for many who have low incomes and rely on federal disability benefits to meet their basic needs in the community (Lipson et al. 2014). Oftentimes, participants' incomes are too low to secure affordable housing or they may experience a delay due to a waitlist for state or federally funded housing vouchers or a lag before receiving Social Security Disability Insurance or SSI benefits. Thus, short-term rental assistance enables participants to transition back to the community earlier than they otherwise could. Connecticut leverages its rebalancing funds to offer housing subsidies to MFP participants, which are then sustained with state dollars after MFP eligibility ends. Maryland and Washington have implemented bridge subsidy programs. Bridge rental subsidy programs provide temporary rental assistance until the participant can secure permanent subsidized housing. Maryland's bridge subsidy program has supported 84 MFP participants for up to three years while they were waiting for a permanent voucher. New York uses state funds to provide housing subsidies for approximately 500 participants in the Nursing Home Transition and Diversion 1915(c) waiver and approximately 1,000 participants in the Traumatic Brain Injury 1915(c) waiver, which include many MFP participants. Washington believes so strongly in the importance of supporting and maintaining existing independent housing that it uses its Washington Roads program to offer emergency rental assistance and bridge subsidies to beneficiaries who are not eligible for MFP but who require nursing home-level care and wish to receive LTSS in a community setting.

## Leading MFP programs ensure successful transitions of adult nursing home residents under age 65 by closely monitoring their well-being in the community

Although the number of MFP participants transitioned to the community represents a key measure of MFP program success, unsuccessful stays in the community may undermine program performance. Mathematica's analyses of MFP enrollment records through 2015 indicate that about 9 percent of adults under age 65 who transitioned from nursing homes left the MFP demonstration because they were readmitted to institutional care.[13] In comparison, the rate of reinstitutionalization for older adults is about 12 percent. Data provided by grantees indicate that the most common causes of reinstitutionalizations lasting 30 days or more were declines in physical or mental health and events (such as falls or accidents) that led to a hospitalization (Morris et al. 2015). According to the study states, substance abuse is another common factor that contributes to reinstitutionalizations among the younger adult population.

We asked study states about their approaches to ensuring that adults under age 65 thrive in the community. For all states, the primary method for ensuring successful transitions is to collect quality monitoring data on potential risks that could jeopardize the individual's placement in the community. However, many study states supplement this activity with quality specialists who monitor and analyze participants' well-being or independent evaluators who conduct in-depth assessments of transitions and related outcomes. The common goal for all states is to identify and mitigate potential risks before they cause the participant to return to an institutional setting.

**Monitored data on how participants are faring in the community.** The study states engage in a variety of data-driven quality monitoring activities to track how MFP participants are faring and ensure they receive adequate services and supports in the community. All six study states utilize information collected from the MFP Quality-of-Life (MFP-QoL) survey to monitor transitions, identify potential risks, and put additional supports in place to address problems before they result in a reinstitutionalization. For example, New York compares MFP-QoL data collected pre-transition, and one and two years later to identify trends and needs among MFP participants. The state also trains transition specialists to identify responses requiring follow-up with service coordinators to ensure needs, safety concerns, and gaps in service are addressed timely. All states supplement these efforts with quality management activities, such as regular reviews of case notes, analyses of reportable events, and in-person meetings with participants.

**Provided support to participants and other MFP staff to ensure successful transitions.** Three states (Connecticut, Maryland, and Washington) rely on dedicated quality specialists to monitor participants and identify barriers to continued community living. The quality specialist in Connecticut reviews all critical incidents, determines if the incident is systemic in nature and elevates systemic concerns to program leadership, and investigates incidents related to untimely deaths. In Maryland, quality and compliance specialists follow MFP participants from the time of application through the move to the community. Once participants are residing in the community, quality and compliance specialists review all critical incidents and follow up with

[13] This statistic only includes participants who return to institutional care for 30 days or more. Shorter stays were not counted.

support planners to ensure proper supports are in place for participants in danger of reinstitutionalization. Washington utilizes a quality assurance department, housed within its Department of Social and Health Services (DSHS), to monitor all of the state's LTSS waiver recipients, including MFP participants. The MFP program supplements these activities with two quality improvement specialists who conduct in-depth case reviews of participants living in the community. The specialists review data covering the first three months following a transition of a random selection of participants to confirm that supports are provided in a timely manner and transition plans are properly implemented. In all, quality specialists in Washington have reviewed over 500 cases (approximately 9 percent of all MFP transitions in the state).

**Analyzed participant outcomes and applied findings to improve service delivery.** Half of the study states (Connecticut, Maryland, and Texas) use independent evaluators to conduct ongoing assessments of participants' transitions to track how they are faring in the community. In Connecticut, the University of Connecticut follows up with MFP participants at six months and one-year post-transition to ask about several domains of interest, including health and well-being, assistive technology, unmet needs, community integration and inclusion, and satisfaction with services. According to the state's program director, independent assessments create a safe environment for respondents to talk candidly about their experiences and challenges living in the community. The MFP-QoL survey also occasionally reveals a critical incident or problem requiring immediate action to maintain a successful transition. In addition, the state identifies operational trends or concerns and tasks the University team with collecting data about the topic of interest. The state uses data gained from participants and the Unversity reports to address the issues with targeted interventions or program modifications. For example, Connecticut's MFP program staff discovered that only one-third of referrals eventually transitioned to the community. The University of Connecticut conducted an intense chart review of closed cases from the previous year and reported on the top reasons why referred individuals did not transition to the community. One common cause was the length of the process; to address this issue, the state undertook an initiative to shorten the length of time from application to assessment to transition. The Unversity continues to produce a number of reports for the state's MFP program on informal caregivers, benchmark reporting, and myriad other topics. Maryland similarly relies on the Hilltop Institute to conduct third-party analyses of its MFP program and report the findings to stakeholders looking to improve program operations.

## Leading programs meet the needs of adults under age 65 with mental health conditions or behavioral issues by integrating mental health care with community-based services and supports

The presence of mental health conditions creates additional challenges for transitioning people from nursing homes to the community. In response, MFP programs in the study states have developed strategies to meet the behavioral health care needs of MFP participants with mental health conditions by improving the integration of mental health services with other community-based LTSS providers. Because there are proportionately more participants with mental health problems in the younger age group compared with older adults, these strategies are more likely to be used for adults under age 65 (Leedahl et al. 2015).

Study states universally reported that the primary barrier to serving MFP participants with mental health conditions is the lack of integration between mental health and other service systems. For example, in Oklahoma and Washington, MFP participants with mental health conditions receive services from providers that operate independently from the broader LTSS support system. In some instances, these separate support systems create delays or barriers to delivering necessary mental health supports (Robinson et al. 2012). For example, MFP participants in Oklahoma are assigned to a Medicaid waiver depending on their primary diagnosis. Although participants with a secondary diagnosis of a mental health condition are provided with behavioral health services, they lack access to the specialized array of services and supports provided by the state's mental health waiver.

New York, Oklahoma, and Washington identified the challenge of providing high quality behavioral health care to MFP participants with mental health conditions as an area for future improvement. The study states are pursuing several methods to close or eliminate this gap in care and ensure the availability of behavioral health supports that MFP participants need. Below, we present three major avenues study states used to integrate mental health care with community-based LTSS and a pilot program designed to supplement LTSS with specialized behavioral health supports.

**Improve coordination between mental health providers and other LTSS.** Three states (Maryland, New York, and Washington) reported that coordination between local mental health authorities and other service systems is an essential component for providing necessary and timely services and supports to MFP participants with mental health conditions. In Washington, MFP participants primarily receive community-based LTSS for physical support needs and sometimes experience difficulty accessing the separate behavioral health system. Maryland and New York address the issue of coordination with behavioral health providers by relying on dedicated staff to liaise with mental health service systems. In Maryland, the MFP program's behavioral health specialist serves as a resource for MFP support planners by connecting the program to the state's behavioral health services system and collaborating with local mental health agencies to ensure participants receive adequate care. The New York MFP program bridges the gap between systems with transition coordinators who make referrals to behavioral health plans and mental health community-based supports when appropriate.

An alternate strategy for overcoming the disconnect between LTSS and behavioral health service systems is to embed staff in state departments of mental health to coordinate mental health services. Connecticut's MFP program pays 75 percent of the salary for six staff embedded in the state's Department of Mental Health and Addiction Services and six staff at the Department of Developmental Services. Previous studies conducted under the evaluation found that other states engage in similar efforts; for example, Ohio's MFP program funds a behavioral health liaison position to serve as a link between the state's mental health agency and the MFP demonstration (Denny-Brown et al. 2015).

**Supplement mental health waiver services with a comprehensive package of physical supports.** Connecticut expanded access to services by offering a more comprehensive package of mental health services and personal care assistance to those who need both mental health and physical supports. Previously, MFP participants in the state had to choose between its Personal Care Assistance (PCA) waiver and the Mental Health waiver. Participants who chose the PCA

waiver but required mental health supports had to coordinate with local mental health authorities to receive the mental health services they needed. As of 2015, participants with a primary diagnosis of a physical disability who also had a diagnosis for a serious mental illness may instead choose to be placed in the Mental Health waiver which delivers specialized mental health services, but then receive community-based PCA services under the CFC state plan option.

**Provide specialized behavioral health supports to MFP participants.** In Texas, a Behavioral Health Pilot program was established in 2008 that offers participants mental health and substance use treatment provided in coordination with community-based LTSS. To date, the Behavioral Health Pilot program has enrolled over 425 MFP participants, which represents about 4 percent of all MFP transitions in Texas as of the end of 2015. According to respondents from Texas, this pilot provides participants with an array of services through Medicaid managed care organizations, including CAT, community-based substance abuse treatment, transition assistance, relocation assistance, and 1915(c) waiver services. The pilot was implemented in the Austin and San Antonio service areas. To build on their initial success, the centerpiece of the pilot's services, CAT, will be expanded statewide. An additional component of the pilot is the provision of peer support, aimed at increasing participants' ability to maintain successful transitions once in the community. All pilot services begin up to six months pre-transition and continue up to one year post-transition. The state reported that individuals enrolled in the pilot displayed improved functioning and quality of life for at least one year after services ended.

## Looking to the Future

When asked about future initiatives for adult nursing home residents under age 65, program staff spoke mostly about changes they hope to make with community-based services, particularly for people with mental health conditions. Connecticut is looking into person-centered integration of behavioral health and acute care and Texas is planning to expand the CAT model statewide through managed care organizations. The study states are also actively pursuing a variety of housing initiatives. For example, New York launched its Olmstead Housing Subsidy (OHS) program, a two-year statewide pilot, in August 2016 which will make up to 400 rental subsidy vouchers available to MFP participants and other qualifying adults transitioning out of nursing homes. The OHS program will offer rental subsidy and transitional housing support services to Medicaid beneficiaries who are transitioning from nursing home settings or are at risk for nursing home placement. Texas is planning more trainings on tenancy supports to help more people achieve stable housing and Maryland recently received an additional $2 million in funding for the Affordable Rental Housing Opportunities Initiative for Persons with Disabilities. This program for Medicaid beneficiaries (ages 18 through 62) who receive federal disability benefits is jointly funded by The Harry and Jeanette Weinberg Foundation and the State of Maryland with the objective of creating more affordable and accessible housing for people with disabilities. It provides capital grants to owners of eligible rental housing developments that partner with nonprofit service organizations.

In addition, Connecticut, Maryland, Texas, and Washington, along with 24 other states and the District of Columbia, have all received grants from the U.S. Department of Housing and Urban Development to implement Section 811 PRA models that will provide additional

supportive housing units for non-elderly adults with disabilities. This new program provides five years of rental assistance to units scattered in multifamily developments. To win these awards, grantees had to develop partnerships between state health and housing agencies and in most cases, the state's MFP demonstration is the health partner and responsible for outreach and referrals to the 811 PRA program. The first people were moved into 811 PRA units in 2015 and it is too early to know whether this program will contribute to increasing transition rates among younger adults and improving housing stability for this population.

## Discussion

At approximately 40 percent of all beneficiaries transitioned by MFP grantees, former nursing home residents in their working years (ages 22 through 64) have been a prominent subgroup of MFP participants. They are primarily in their preretirement years and are more likely to be men than women. Nearly one-third have low care needs, suggesting that they can be served in the community and may not need nursing home care, and more than one-third had a mental health condition before transitioning to the community. MFP grantees have been transitioning about 2 percent of eligible people in this population, suggesting that there is ongoing demand for transition services and room to increase transitions if enough appropriate community services and housing resources are available.

Our assessment of six leading MFP grantees suggest that MFP demonstrations do not purposefully target this population. Outreach and other procedures, processes, and services for transitioning nursing home residents are not based on age, but are available to everyone in nursing home care. This uniform approach carries over to the post-transition supports the grantees provide and the monitoring they conduct to ensure the transition is as successful as possible.

The only identifiable factors that differ are the perceptions of nursing home discharge planners regarding which nursing home residents are good candidates for transition and the characteristics of this subgroup—perception that are not necessarily the result of actions grantees use to transition nursing home residents. If discharge planners are more likely to refer one subgroup over another, then it is not surprising grantees have been able to transition a larger proportion of that subgroup. Similarly, if members of one targeted group are more highly motivated to move, are better able to help themselves, and have peers and informal supports helping them, then this targeted population will have higher transition rates compared to others.

Strategies grantees use to identify and secure affordable and accessible housing also do not appear to favor younger adults over older adults, but these two populations tend to move to different types of housing in the community. Adults under age 65 are more likely to live in apartments and older adults in homes (Morris et al. 2016). Apartment living suggests that younger adults transitioned by MFP demonstrations are using available housing subsidies, either through Federal or state housing programs. These observed differences mean that the various strategies used by MFP grantees to help nursing home residents identify and secure affordable and accessible housing are more likely to benefit adults under age 65 than older nursing home residents. The grantees selected for this study are pursuing a wide range of initiatives to make it easier to identify suitable housing, such as hiring housing specialists; linking to subsidized

housing through voucher preferences for people residing in insitutions; and providing tenancy support services that improve the likelihood the community residency is stable and successful.

Although grantees have not tailored their demonstrations specifically for younger adults, the evidence suggests there are strategies they could pursue if they wanted to increase transitions among adult nursing home residents under age 65. Our discussions with program staff reinforce the important role of nursing home discharge planners and their ability to influence who is referred and the pipeline of MFP transitions. To increase transitions from nursing homes, grantees will need to continue to nurture and build their relationships with nursing home discharge planners to ensure all nursing home residents who want to live in the community and can be served in a community setting are referred and given the opportunity to benefit from from the MFP demonstration. Anecdotally, some grantees continue to report in their semiannual progress reports that nursing homes are not always receptive to outreach efforts and their unwillingness to refer people to MFP has been a barrier to transitions in some areas. Grantees facing this barrier need to continue to work at a more fundamental level to help nursing homes understand that the focus is on providing Medicaid beneficiaries with disabilities more choices about where they receive LTSS.

MFP demonstrations and Medicaid programs can also consider strategies to exploit the social networks of younger adults to help them boost transition rates within this population. The higher motivation levels and greater ability to act on their desire to move to the community, relative to older adults noted by program staff, suggest facilitating peer-to-peer supports may be one avenue to increasing transition rates. Low-cost approaches, such as providing ample access to the internet in nursing homes would help residents cultivate and maintain online social networks and nuture and stay connected to peers who have transitioned. In addition, supporting those who have transitioned to help their peers transition may be another low-cost approach to increasing transition rates.

CILs present one avenue for cultivating social networks among people with disabilities. CILs typically have a lot of experience serving and providing programs for younger adults with disabilities, although their advocacy work may create tensions with Medicaid programs and providers. In Oklahoma, these centers were involved in the early years of the MFP demonstration, but are less so today and the grantee would like to rebuild this partnership going forward. Washington continues to collaborate with CILs and Connecticut reported CILs provide housing and transition coordination and they can qualify to become specialized case managers if motivated to do so. In contrast, in New York and Texas the majority of contracted transition specialists are CILs, which program staff credit for MFP's success with younger adults. To improve transition rates among nursing home residents, grantees could continue to explore ways to strengthen their partnerships with CILs and to use this partnership to find ways of helping nursing home residents build social networks that support transitions.

Despite the accomplishments of MFP grantees and their plans for the future, there is considerable room for states to reduce the number of adults under age 65 residing in nursing homes in the same way we have seen the number of older adults in nursing homes decline (Miller 2011). MFP grantees can continue to strengthen their outreach to nursing home residents and the transition services they provide, but their ability to build communities' capacity to provide affordable and accessible housing and serve people in their homes will be key to both

transitioning beneficiaries when institutional care is unavoidable and diverting people with disabilities from institutionalization in the first instance.

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## DATA AND METHODS APPENDIX

We assessed the program performance of six MFP grantee states to better understand what it takes to successfully move adult Medicaid beneficiaries under age 65 from nursing homes to community-based LTSS. To select the six study states, we ranked grantees' performance serving adults under age 65 on the following seven indicators:

1. **Transitions.** The cumulative number of transitions through 2015 to identify grantees that transitioned higher numbers of adults under age 65 from nursing homes to the community through MFP.
2. **Reinstitutionalizations.** Readmissions to institutions lasting 30 days or more among adults under age 65 participating in MFP, to identify grantees with lower reinstitutionalization rates. These rates do not take into account people who returned home to the community after experiencing a reinstitutionalization.
3. **Participants' quality of life.** Proportion of adult MFP participants under age 65 working for pay or volunteering one year after transitioning to the community, to identify grantees with higher rates of community integration among former nursing home residents.
4. **Prevalence of mental health conditions among participants.** Proportion of adults under age 65 with a co-occurring physical disability and mental health condition who were transitioned, to identify grantees that are serving higher shares of participants with mental health conditions through MFP.
5. **Participants with high care needs.** The proportion of participants with high care needs, to identify grantees that transitioned high shares of participants who had high care needs in the nursing home and had stays of 90 or more days.
6. **Participants with low care needs.** The proportion of participants with low care needs, to identify grantees that transitioned disproportionate numbers of participants with low care needs, who may not need institutional-level care and could be served in a community setting.
7. **Housing or vehicular modifications.** Use of housing supports or vehicular modifications to identify grantees that had higher shares of participants who used these supports during their first year in the community.

The definitions, measure specifications, and data sources for these indicators are presented in Table 4.

### Exclusions

Of the 44 MFP grantee states that are participating in the demonstration, 29 were included in the ranking. Those excluded from the ranking include Oregon, which rescinded its MFP grant in 2010, and 15 additional states that were missing data for one or more indicators (Alabama, Arkansas, Colorado, Delaware, Idaho, Iowa, Kansas, Maine, Minnesota, Mississippi, Montana, South Dakota, Tennessee, Vermont, and West Virginia). Of the 29 states included in the comparison, four top ranked states (Georgia, Illinois, Missouri, and Ohio) were not selected because they were featured in an earlier study of program performance conducted in 2015 (Denny-Brown et al. 2015). California was also excluded because it has a large geographically

dispersed county-based health system dissimilar to most other health system in the MFP grantee states. Also, we opted to select Washington (ranked twelfth) over Virginia (ranked eighth) to achieve greater diversity in geographic representation.

## Ranking methodology

We assessed the performance of the six study states on the set of indicators and ranked them from highest to lowest performance on each measure. Indicators 1 and 5 are comprised of two separate measures each (Table 4). States were ranked separately on each of the measures resulting in these indicators carrying greater weight in the total overall ranking. We summed the rank scores across indicators 1 through 6 to arrive at an overall ranking for each state. We then sorted state overall rankings in ascending order, to identify grantee states with the lowest overall ranking. We considered states with lower scores to be those that appear to be serving younger adults with physical disabilities well in the community. In the case of tied values for a ranking on a particular measure, we assigned the same value to the rank scores.

### Table 4. Indicators used to compare MFP grantees' performance

| Indicator | Measure(s) | Target Population(s) Ranked on Indicator | Data Source(s) |
|---|---|---|---|
| **Effective transitions of adults under age 65 in nursing homes** | • Transitioned both older and younger adults from nursing homes<br>• Number of transitions among adults under age 65 in nursing homes<br>• Percentage of transitions accounted for by adults under age 65 residing in nursing homes | • Older and younger adults transitioning from nursing homes | • Semi-annual progress reports submitted by grantees through 2015 |
| **Reinstitutionalizations among adults under age 65** | • Annual rate of reinstitutionalization of 30 days or more among MFP participants under age 65 who transitioned from nursing homes | • Adults under age 65 transitioning from nursing homes | • MFP program participation data submitted by grantees through 2015 |
| **Participants' quality of life** | • Percent of adults under age 65 who reported working for pay or volunteering/working without pay at one-year post-transition | • Adults under age 65 transitioning from nursing homes | • Quality of life survey data submitted by grantees through May 2016 |
| **Share of older adults and younger adults with mental illness** | • Percentage of older and younger adults with mental illness | • Older and younger adults transitioning from nursing homes | • Nursing home minimum data set (MDS) 3.0 from October 2010 to December 31, 2014 |

| Indicator | Measure(s) | Target Population(s) Ranked on Indicator | Data Source(s) |
|---|---|---|---|
| **Characteristics of MFP participants transitioning from nursing homes** | • Percentage of adults under age 65 with high care needs before they transitioned from nursing homes in each state<br>• Percentage of adults under age 65 with low care needs before they transitioned from nursing homes in each state | • Adults under age 65 transitioning from nursing homes | • Nursing home minimum data set (MDS) 3.0 from October 2010 to December 31, 2014 |
| **Use of a housing or vehicular modification** | • Percentage of participants that received a housing or vehicular modification | • Adults under age 65 transitioning from nursing homes | • MFP services data submitted by grantees |

### Semi-structured interviews

We purposively selected for this study six grantee states based on their overall rankings on six indicators of LTSS system performance. The six study states were identified to have a low overall score that suggests the state is serving younger adults well in the community relative to other MFP programs. We collected information about how the study states excelled in transitioning adult nursing home residents under age 65 through semi-structured telephone interviews. The interviews covered the factors that have contributed to successful transitions among younger adults, how the MFP program identifies candidates for transition, the types of home and community-based services that are provided to this population in each study state, the strategies that each study state has used to address housing barriers faced by MFP participants, and how each state supports adults under age 65 after they have moved to the community.

### Additional contextual information

To provide some contextual background on the study states, we complied Medicaid and Medicare data and constructed three indicators of overall performance of the LTSS systems in states (Tables 5 through 10). Taken together, the six study states had a mixed performance on these three indicators.

The first indicator, which is based on data from the 2012 Medicaid Analytical eXtract data system, indicates whether beneficiaries new to the LTSS system are more or less likely to start receiving care in a community setting rather than first using institutional care. This indicator captures a sense of choice in the state's LTSS system and the ease of choosing community-based LTSS over institutional care. Of the six study states, none performed above average on this indicator. Washington had the highest performance of the study states, 56.6 percent of Medicaid beneficiaries new to LTSS in 2012 were able to use community-based LTSS before ever receiving institutional care, which is slightly below the national average of 58.0 percent. When the data are disaggregated by target population, states perform well on this measure for new LTSS users with intellectual disabilities (Table 9). Most states are able to get the majority of beneficiaries with intellectual disabilities who are new to LTSS into 1915(c) waiver programs designed for this population and avoid placement in intermediate care facilities for individuals

with intellectual disabilities. The opposite is true for people with mental illness, where states have fewer community-based LTSS options for this group and the majority have their first experience with LTSS when they enter a psychiatric facility (Table 10).

The other two indicators capture all Medicare beneficiaries who used nursing home care during calendar year 2012. Beneficiaries discharged from inpatient care to a nursing home and then remained in the nursing home for at least 100 days represent people who most likely did not intend to reside in a nursing home long term after being admitted to an inpatient setting. They represent an outcome that may not always represent what is desired by the beneficiary. Of the six study states, Connecticut, Maryland, and Washington had rates below the national average—indicating above average performance—and the other three states had rates above the national average. The last indicator considered captures Medicare beneficiaries who were in nursing home care for at least 90 days in 2012, but were able to transition back to the community. Nationally, slightly less than eight percent of Medicare beneficiaries who stayed in nursing home care for 90 days or more in 2012 were able to transition to a community setting during the year. Of the six study states, Maryland, Texas, and Washington performed above average on this indicator; Connecticut, New York, and Oklahoma were below the national average. Data for a number of states were considered unreliable when the nursing home measures were considered for Medicaid beneficiaries with either intellectual disabilities or mental illness (Tables 9 and 10). These populations do not rely on nursing home care to the same extend as adults with physical disabilities or frail older adults (Tables 6, 7, and 8).

**Table 5. Indicators of performance of state long-term services and supports systems**

| State | Percentage of new Medicaid LTSS users first receiving services in the community | Percentage of new nursing home stays lasting 100 days or more[a] | Percentage of people with 90+ day nursing home stays successfully transitioning back to the community[a] |
|---|---|---|---|
| United States | 58.0% | 18.7% | 7.7% |
| Alabama | 24.2% | 17.4% | 4.7% |
| Alaska | -- | 14.2% | 9.0% |
| Arizona | -- | 8.9% | 10.7% |
| Arkansas | 46.9% | 26.8% | 7.2% |
| California | 77.2% | 18.3% | 10.5% |
| Colorado | -- | 14.8% | 7.0% |
| Connecticut | 42.0% | 16.3% | 5.8% |
| Delaware | 41.7% | 15.5% | 7.9% |
| District of Columbia | -- | 20.6% | 9.0% |
| Florida | 63.5% | 15.7% | 10.0% |
| Georgia | 43.7% | 21.1% | 6.4% |
| Hawaii | 89.6% | 15.3% | 8.6% |
| Idaho | -- | 13.5% | 10.6% |
| Illinois | 70.5% | 18.5% | 8.6% |
| Indiana | 34.2% | 23.5% | 8.5% |
| Iowa | 62.3% | 18.4% | 4.1% |
| Kansas | -- | 18.4% | 5.8% |
| Kentucky | 42.3% | 19.9% | 6.8% |
| Louisiana | 51.7% | 35.0% | 5.6% |
| Maine | -- | 13.8% | 5.4% |
| Maryland | 55.7% | 16.5% | 8.7% |
| Massachusetts | 44.6% | 17.1% | 5.7% |
| Michigan | 55.1% | 17.6% | 9.4% |
| Minnesota | 82.0% | 14.0% | 6.0% |
| Mississippi | 44.7% | 21.7% | 6.9% |
| Missouri | 67.3% | 19.7% | 7.0% |
| Montana | 74.2% | 15.4% | 7.6% |
| Nebraska | 47.6% | 16.5% | 6.0% |
| Nevada | 44.7% | 19.2% | 9.4% |
| New Hampshire | 42.8% | 19.4% | 6.0% |
| New Jersey | -- | 15.1% | 6.4% |
| New Mexico | -- | 17.8% | 10.0% |
| New York | 43.9% | 22.9% | 7.1% |
| North Carolina | 52.1% | 18.4% | 8.5% |
| North Dakota | 56.1% | 23.1% | 4.4% |
| Ohio | 48.1% | 18.3% | 7.2% |
| Oklahoma | 45.0% | 22.3% | 7.3% |
| Oregon | 86.5% | 9.2% | 12.7% |
| Pennsylvania | 58.5% | 21.6% | 5.5% |
| Rhode Island | -- | 21.7% | 5.4% |
| South Carolina | 64.6% | 18.4% | 8.0% |
| South Dakota | 31.5% | 20.2% | 4.9% |
| Tennessee | -- | 20.8% | 8.5% |
| Texas | 47.6% | 24.7% | 8.6% |
| Utah | 39.6% | 10.5% | 14.9% |
| Vermont | 64.0% | 16.1% | 7.4% |
| Virginia | 52.6% | 16.0% | 8.1% |
| Washington | 56.5% | 15.2% | 12.4% |
| West Virginia | 36.1% | 21.5% | 6.3% |
| Wisconsin | -- | 17.1% | 8.5% |
| Wyoming | 38.6% | 20.0% | 8.0% |

Source: Mathematica analysis of 2012 data from the Medicaid Analytical eXtract system (percentage of new users) or the 2012 Chronic Condition Warehouse Timeline file (new nursing home stays and transitions).

Notes: The percentage of new LTSS users whose first LTSS service is community-based is based on all Medicaid beneficiaries who used LTSS services at any point during calendar year 2012. The percentage of new nursing home stays lasting 100 days or more and the percentage of people with 90 or more days of nursing home care who transition back to the community are based on all Medicare beneficiaries who used nursing home care during 2012, regardless of their eligibility for Medicaid.

[a] Includes all Medicare beneficiaries, including those only eligible for Medicare as well as those dually eligible for Medicare and Medicaid.

-- = The Medicaid data were either missing, incomplete, or considered unreliable.

**Table 6. Indicators of performance of state long-term services and supports systems, adults 21 and older**

| State | Percentage of new Medicaid LTSS users first receiving services in the community | Percentage of new nursing home stays lasting 100 days or more[a] | Percentage of people with 90+ day nursing home stays successfully transitioning back to the community[a] |
|---|---|---|---|
| United States | 58.3% | 36.7% | 5.2% |
| Alabama | 28.8% | 34.1% | 3.0% |
| Alaska | -- | -- | -- |
| Arizona | -- | -- | -- |
| Arkansas | 64.8% | 41.8% | 6.4% |
| California | 74.6% | 31.7% | 8.0% |
| Colorado | -- | -- | -- |
| Connecticut | 40.5% | 29.1% | 3.8% |
| Delaware | 43.9% | 32.2% | 4.3% |
| District of Columbia | -- | -- | -- |
| Florida | 62.7% | 34.7% | 6.8% |
| Georgia | 40.7% | 41.4% | 3.9% |
| Hawaii | 83.1% | 30.6% | 3.9% |
| Idaho | -- | -- | -- |
| Illinois | 77.0% | 35.8% | 5.0% |
| Indiana | 28.0% | 44.9% | 4.3% |
| Iowa | 72.8% | 31.4% | 2.5% |
| Kansas | -- | -- | -- |
| Kentucky | 30.8% | 37.6% | 4.3% |
| Louisiana | 58.2% | 50.8% | 4.3% |
| Maine | -- | -- | -- |
| Maryland | 58.3% | 39.7% | 5.2% |
| Massachusetts | 46.5% | 36.4% | 4.2% |
| Michigan | 54.9% | 39.7% | 5.4% |
| Minnesota | 83.6% | 25.8% | 6.4% |
| Mississippi | 55.4% | 36.2% | 4.3% |
| Missouri | 65.2% | 38.2% | 4.8% |
| Montana | 67.7% | 32.5% | 4.8% |
| Nebraska | 49.5% | 33.9% | 3.8% |
| Nevada | 56.4% | 36.7% | 5.1% |
| New Hampshire | 34.7% | 40.6% | 2.5% |
| New Jersey | -- | -- | -- |
| New Mexico | -- | -- | -- |
| New York | 37.3% | 41.6% | 5.4% |
| North Carolina | 56.8% | 36.5% | 5.4% |
| North Dakota | 35.4% | 42.1% | 2.6% |
| Ohio | 46.6% | 36.5% | 4.3% |
| Oklahoma | 60.3% | 36.7% | 5.2% |
| Oregon | 73.4% | 20.3% | 8.8% |
| Pennsylvania | 59.3% | 43.9% | 3.4% |
| Rhode Island | -- | -- | -- |
| South Carolina | 59.9% | 39.1% | 3.7% |
| South Dakota | 32.9% | 39.7% | 3.0% |
| Tennessee | -- | -- | -- |
| Texas | 49.1% | 42.7% | 6.1% |
| Utah | 39.2% | 33.7% | 10.7% |
| Vermont | 67.2% | 24.3% | 5.5% |
| Virginia | 53.1% | 35.8% | 4.4% |
| Washington | 67.0% | 32.4% | 8.3% |
| West Virginia | 43.0% | 41.0% | 3.3% |
| Wisconsin | -- | -- | -- |
| Wyoming | 37.2% | 40.1% | 4.0% |

Source: Mathematica analysis of 2012 data from the Medicaid Analytical eXtract system (percentage of new users) or the 2012 Chronic Condition Warehouse Timeline file (new nursing home stays and transitions).

Notes: The percentage of new LTSS users whose first LTSS service is community-based is based on all Medicaid beneficiaries who used LTSS services at any point during calendar year 2012. The percentage of new nursing home stays lasting 100 days or more and the percentage of people with 90 or more days of nursing home care who transition back to the community are based on all Medicare beneficiaries who used nursing home care during 2012, regardless of their eligibility for Medicaid.

[a] Includes only Medicare beneficiaries dually eligible for Medicare and Medicaid.

-- = The Medicaid data were either missing, incomplete, or considered unreliable.

**Table 7. Indicators of performance of state long-term services and supports systems, older adults ages 65 and older**

| State | Percentage of new Medicaid LTSS users first receiving services in the community | Percentage of new nursing home stays lasting 100 days or more[a] | Percentage of people with 90+ day nursing home stays successfully transitioning back to the community[a] |
|---|---|---|---|
| United States | 46.3% | 39.8% | 4.5% |
| Alabama | 18.6% | 36.5% | 2.6% |
| Alaska | -- | -- | -- |
| Arizona | -- | -- | -- |
| Arkansas | 53.0% | 45.0% | 6.3% |
| California | 59.1% | 33.8% | 7.0% |
| Colorado | -- | -- | -- |
| Connecticut | 31.5% | 31.1% | 3.3% |
| Delaware | 29.2% | 37.3% | 3.8% |
| District of Columbia | -- | -- | -- |
| Florida | 63.9% | 37.8% | 6.2% |
| Georgia | 28.8% | 45.1% | 3.4% |
| Hawaii | 0.0% | 31.7% | 3.8% |
| Idaho | -- | -- | -- |
| Illinois | 72.2% | 38.9% | 4.0% |
| Indiana | 19.6% | 51.6% | 3.6% |
| Iowa | 43.9% | 35.0% | 2.0% |
| Kansas | -- | -- | -- |
| Kentucky | 22.5% | 41.2% | 3.7% |
| Louisiana | 27.5% | 53.7% | 3.7% |
| Maine | -- | -- | -- |
| Maryland | 22.2% | 44.1% | 4.4% |
| Massachusetts | 32.4% | 41.5% | 3.5% |
| Michigan | 29.6% | 45.2% | 4.5% |
| Minnesota | 83.0% | 26.7% | 5.6% |
| Mississippi | 47.2% | 38.1% | 3.7% |
| Missouri | 47.7% | 41.9% | 4.0% |
| Montana | 30.9% | 36.9% | 4.1% |
| Nebraska | 39.4% | 36.9% | 3.0% |
| Nevada | 58.3% | 40.4% | 4.5% |
| New Hampshire | 26.0% | 45.9% | 1.9% |
| New Jersey | -- | -- | -- |
| New Mexico | -- | -- | -- |
| New York | 27.3% | 43.3% | 4.8% |
| North Carolina | 41.8% | 39.8% | 4.8% |
| North Dakota | 28.7% | 45.1% | 2.4% |
| Ohio | 43.2% | 41.6% | 3.6% |
| Oklahoma | 48.3% | 39.1% | 4.6% |
| Oregon | 68.1% | 21.7% | 7.5% |
| Pennsylvania | 36.0% | 48.4% | 2.9% |
| Rhode Island | -- | -- | -- |
| South Carolina | 43.1% | 43.0% | 3.3% |
| South Dakota | 24.7% | 42.7% | 2.5% |
| Tennessee | -- | -- | -- |
| Texas | 36.2% | 45.4% | 5.6% |
| Utah | 35.0% | 38.8% | 9.6% |
| Vermont | 49.3% | 25.2% | 5.0% |
| Virginia | 46.5% | 40.0% | 4.0% |
| Washington | 63.1% | 34.3% | 7.0% |
| West Virginia | 25.4% | 46.2% | 3.0% |
| Wisconsin | -- | -- | -- |
| Wyoming | 22.2% | 46.3% | 3.3% |

Source: Mathematica analysis of 2012 data from the Medicaid Analytical eXtract system (percentage of new users) or the 2012 Chronic Condition Warehouse Timeline file (new nursing home stays and transitions).

Notes: The percentage of new LTSS users whose first LTSS service is community-based is based on all Medicaid beneficiaries who used LTSS services at any point during calendar year 2012. The percentage of new nursing home stays lasting 100 days or more and the percentage of people with 90 or more days of nursing home care who transition back to the community are based on all Medicare beneficiaries who used nursing home care during 2012, regardless of their eligibility for Medicaid.

[a] Includes only Medicare beneficiaries dually eligible for Medicare and Medicaid.

-- = The Medicaid data were either missing, incomplete, or considered unreliable.

**Table 8. Indicators of performance of state long-term services and supports systems, adults ages 21 to 65**

| State | Percentage of new Medicaid LTSS users first receiving services in the community | Percentage of new nursing home stays lasting 100 days or more[a] | Percentage of people with 90+ day nursing home stays successfully transitioning back to the community[a] |
|---|---|---|---|
| United States | 67.3% | 24.6% | 11.1% |
| Alabama | 46.8% | 24.4% | 6.0% |
| Alaska | -- | -- | -- |
| Arizona | -- | -- | -- |
| Arkansas | 84.6% | 26.2% | 7.6% |
| California | 82.4% | 24.2% | 15.2% |
| Colorado | -- | -- | -- |
| Connecticut | 46.4% | 19.0% | 9.2% |
| Delaware | 71.3% | 15.5% | 9.1% |
| District of Columbia | -- | -- | -- |
| Florida | 49.1% | 22.1% | 12.9% |
| Georgia | 56.3% | 27.8% | 7.9% |
| Hawaii | 7.5% | 25.9% | 6.8% |
| Idaho | -- | -- | -- |
| Illinois | 62.3% | 25.5% | 10.3% |
| Indiana | 43.5% | 23.6% | 10.8% |
| Iowa | 72.8% | 19.6% | 6.7% |
| Kansas | -- | -- | -- |
| Kentucky | 42.1% | 23.6% | 11.0% |
| Louisiana | 72.2% | 37.5% | 8.9% |
| Maine | -- | -- | -- |
| Maryland | 70.4% | 26.0% | 11.5% |
| Massachusetts | 63.0% | 19.0% | 14.2% |
| Michigan | 75.7% | 21.8% | 16.2% |
| Minnesota | 80.2% | 19.6% | 17.3% |
| Mississippi | 71.6% | 27.7% | 8.4% |
| Missouri | 81.3% | 28.7% | 9.4% |
| Montana | 80.2% | 16.7% | 11.1% |
| Nebraska | 59.5% | 23.9% | 10.1% |
| Nevada | 53.2% | 27.2% | 8.8% |
| New Hampshire | 51.6% | 21.3% | 11.4% |
| New Jersey | -- | -- | -- |
| New Mexico | -- | -- | -- |
| New York | 53.9% | 31.4% | 12.4% |
| North Carolina | 74.4% | 23.8% | 10.9% |
| North Dakota | 56.6% | 29.6% | 4.3% |
| Ohio | 47.3% | 23.7% | 10.1% |
| Oklahoma | 76.9% | 28.4% | 8.7% |
| Oregon | 78.8% | 15.9% | 18.8% |
| Pennsylvania | 66.6% | 25.6% | 9.5% |
| Rhode Island | -- | -- | -- |
| South Carolina | 79.6% | 23.9% | 7.9% |
| South Dakota | 46.1% | 26.8% | 8.6% |
| Tennessee | -- | -- | -- |
| Texas | 54.5% | 31.5% | 10.3% |
| Utah | 41.7% | 24.5% | 15.6% |
| Vermont | 69.8% | 19.6% | 13.1% |
| Virginia | 54.5% | 20.3% | 8.2% |
| Washington | 70.0% | 26.8% | 18.0% |
| West Virginia | 64.6% | 20.3% | 7.4% |
| Wisconsin | -- | -- | -- |
| Wyoming | 67.8% | 21.3% | 11.9% |

Source: Mathematica analysis of 2012 data from the Medicaid Analytical eXtract system (percentage of new users) or the 2012 Chronic Condition Warehouse Timeline file (new nursing home stays and transitions).

Notes: The percentage of new LTSS users whose first LTSS service is community-based is based on all Medicaid beneficiaries who used LTSS services at any point during calendar year 2012. The percentage of new nursing home stays lasting 100 days or more and the percentage of people with 90 or more days of nursing home care who transition back to the community are based on all Medicare beneficiaries who used nursing home care during 2012, regardless of their eligibility for Medicaid.

[a] Includes only Medicare beneficiaries dually eligible for Medicare and Medicaid.

-- = The Medicaid data were either missing, incomplete, or considered unreliable.

**Table 9. Indicators of performance of state long-term services and supports systems, individuals with intellectual disabilities**

| State | Percentage of new Medicaid LTSS users first receiving services in the community | Percentage of new nursing home stays lasting 100 days or more[a] | Percentage of people with 90+ day nursing home stays successfully transitioning back to the community[a] |
|---|---|---|---|
| United States | 96.8% | 27.9% | 30.2% |
| Alabama | 95.7% | 38.2% | 12.5% |
| Alaska | -- | -- | -- |
| Arizona | -- | -- | -- |
| Arkansas | 58.9% | nr | nr |
| California | 98.8% | 27.0% | 32.4% |
| Colorado | -- | -- | -- |
| Connecticut | 99.9% | 26.2% | 19.0% |
| Delaware | 92.8% | nr | nr |
| District of Columbia | -- | -- | -- |
| Florida | 96.0% | 21.7% | 26.6% |
| Georgia | 98.6% | 48.1% | 18.8% |
| Hawaii | 100.0% | nr | nr |
| Idaho | -- | -- | -- |
| Illinois | 86.5% | 30.9% | 37.0% |
| Indiana | 90.2% | 30.7% | 46.0% |
| Iowa | 98.4% | 28.4% | 15.9% |
| Kansas | -- | -- | -- |
| Kentucky | 99.6% | 33.9% | nr |
| Louisiana | 84.0% | 32.4% | nr |
| Maine | -- | -- | -- |
| Maryland | 99.3% | 20.8% | nr |
| Massachusetts | nr | nr | 0[b] |
| Michigan | 100.0% | 0[b] | 0[b] |
| Minnesota | 44.8% | nr | nr |
| Mississippi | 45.2% | nr | nr |
| Missouri | 99.2% | 22.4% | 28.4% |
| Montana | 99.4% | nr | nr |
| Nebraska | 89.1% | nr | nr |
| Nevada | 97.8% | nr | nr |
| New Hampshire | 99.3% | nr | nr |
| New Jersey | -- | -- | -- |
| New Mexico | -- | -- | -- |
| New York | 99.0% | 30.7% | 28.1% |
| North Carolina | 62.5% | 48.6% | 28.2% |
| North Dakota | 99.1% | nr | nr |
| Ohio | 95.9% | 22.6% | 48.7% |
| Oklahoma | 65.1% | nr | nr |
| Oregon | 100.0% | nr | nr |
| Pennsylvania | 99.1% | 36.4% | 27.1% |
| Rhode Island | -- | -- | -- |
| South Carolina | 99.5% | 31.0% | nr |
| South Dakota | 94.3% | nr | nr |
| Tennessee | -- | -- | -- |
| Texas | 79.2% | 32.3% | 22.4% |
| Utah | 75.6% | nr | nr |
| Vermont | 0[b] | 0[b] | 0[b] |
| Virginia | 92.3% | 28.0% | 31.0% |
| Washington | 0[b] | nr | 0[b] |
| West Virginia | 95.6% | nr | nr |
| Wisconsin | -- | -- | -- |
| Wyoming | 100.0% | nr | nr |

Source: Mathematica analysis of 2012 data from the Medicaid Analytical eXtract system (percentage of new users) or the 2012 Chronic Condition Warehouse Timeline file (new nursing home stays and transitions).

Notes: The percentage of new LTSS users whose first LTSS service is community-based is based on all Medicaid beneficiaries who used LTSS services at any point during calendar year 2012. The percentage of new nursing home stays lasting 100 days or more and the percentage of people with 90 or more days of nursing home care who transition back to the community are based on all Medicare beneficiaries who used nursing home care during 2012, regardless of their eligibility for Medicaid.

[a] Includes only Medicare beneficiaries dually eligible for Medicare and Medicaid.

[b] No beneficiaries dually eligible for Medicare and Medicaid were in this population.

-- = The Medicaid data were either missing, incomplete, or considered unreliable.

nr = We are not reporting because there are fewer than 11 beneficiaries in this group.

**Table 10. Indicators of performance of state long-term services and supports systems, individuals with mental illness**

| State | Percentage of new Medicaid LTSS users first receiving services in the community | Percentage of new nursing home stays lasting 100 days or more[a] | Percentage of people with 90+ day nursing home stays successfully transitioning back to the community[a] |
|---|---|---|---|
| United States | 5.7% | 61.2% | 8.6% |
| Alabama | nr | nr | nr |
| Alaska | -- | -- | -- |
| Arizona | -- | -- | -- |
| Arkansas | 0.3% | 73.1% | nr |
| California | 0[b] | 0[b] | 0[b] |
| Colorado | -- | -- | -- |
| Connecticut | 5.3% | nr | 58.3% |
| Delaware | nr | nr | 0.0% |
| District of Columbia | -- | -- | -- |
| Florida | nr | nr | nr |
| Georgia | 0[b] | 0[b] | 0[b] |
| Hawaii | 0[b] | 0[b] | 0[b] |
| Idaho | -- | -- | -- |
| Illinois | 0.4% | 51.1% | 11.4% |
| Indiana | 39.8% | nr | nr |
| Iowa | nr | nr | nr |
| Kansas | -- | -- | -- |
| Kentucky | 1.4% | nr | nr |
| Louisiana | 0.7% | 68.5% | 5.5% |
| Maine | -- | -- | -- |
| Maryland | 4.8% | nr | nr |
| Massachusetts | 2.0% | nr | nr |
| Michigan | 100.0% | 0[b] | 0[b] |
| Minnesota | 3.6% | nr | 0.0% |
| Mississippi | nr | nr | 0.0% |
| Missouri | nr | 0[b] | 0[b] |
| Montana | 6.9% | nr | nr |
| Nebraska | nr | nr | 0[b] |
| Nevada | nr | nr | nr |
| New Hampshire | 1.7% | nr | nr |
| New Jersey | -- | -- | -- |
| New Mexico | -- | -- | -- |
| New York | 18.6% | 63.8% | 10.5% |
| North Carolina | 0.2% | nr | nr |
| North Dakota | nr | 0[b] | nr |
| Ohio | 0.6% | nr | nr |
| Oklahoma | 0.1% | 66.7% | nr |
| Oregon | 4.4% | 0[b] | nr |
| Pennsylvania | 0.5% | 71.4% | nr |
| Rhode Island | -- | -- | -- |
| South Carolina | 0.5% | nr | nr |
| South Dakota | nr | nr | nr |
| Tennessee | -- | -- | -- |
| Texas | 1.4% | nr | nr |
| Utah | 0.0% | 0[b] | nr |
| Vermont | nr | nr | nr |
| Virginia | 1.2% | nr | nr |
| Washington | 1.0% | 54.1% | nr |
| West Virginia | 0.7% | nr | nr |
| Wisconsin | -- | -- | -- |
| Wyoming | 8.6% | 0[b] | 0[b] |

Source: Mathematica analysis of 2012 data from the Medicaid Analytical eXtract system (percentage of new users) or the 2012 Chronic Condition Warehouse Timeline file (new nursing home stays and transitions).

Notes: The percentage of new LTSS users whose first LTSS service is community-based is based on all Medicaid beneficiaries who used LTSS services at any point during calendar year 2012. The percentage of new nursing home stays lasting 100 days or more and the percentage of people with 90 or more days of nursing home care who transition back to the community are based on all Medicare beneficiaries who used nursing home care during 2012, regardless of their eligibility for Medicaid.

[a] Includes only Medicare beneficiaries dually eligible for Medicare and Medicaid.

[b] No beneficiaries dually eligible for Medicare and Medicaid were in this population.

-- = The Medicaid data were either missing, incomplete, or considered unreliable.

nr = We are not reporting because there are fewer than 11 beneficiaries in this group.