Money Follows the Person 2012 Annual Evaluation Report

Final Report

October 15, 2013

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I. INTRODUCTION AND BACKGROUND

The national Money Follows the Person (MFP) demonstration continued to grow and mature in 2012. Cumulative MFP enrollment climbed to 30,000 transitions by the end of December 2012, a 50 percent growth over the total number at the same point in 2011. In early 2012, three more states received planning grants, bringing the total number of state grantees to 46 (45 states and the District of Columbia). Another four states (Maine, Mississippi, Nevada, and Vermont) launched their transition programs in 2012 and began serving their first MFP participants. The new grantees brought the total number of operating programs to 37. Oregon's program remains suspended as the state conducts a review of its program's overall design; New Mexico and Florida have withdrew from the program; and the other 6 states are in various stages of program planning.

This report is the fourth in a series of annual reports that Mathematica Policy Research is producing for the national evaluation of the MFP demonstration funded by the Centers for Medicare & Medicaid Services (CMS) (CMS Contract Number HHSM-500-2010-00026I/HHSM-500-T0010). It provides basic information about the program and how it grew and changed during calendar year 2012. It also updates and summarizes analytic studies Mathematica conducted during the year.

A. Background

1. Basic Features of the MFP Program

Each state in the MFP demonstration must establish a program that has two components: (1) a transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and helps them do so, and (2) a rebalancing program that allows more Medicaid long-term care expenditures to flow to community services and supports. MFP programs (like Medicaid programs in general) are subject to general federal requirements, but the design and administration of each MFP program are unique and tailored to state needs.

Transition programs. By statute, the MFP program is for people institutionalized in nursing homes, hospitals, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), or institutions for mental diseases (IMDs). Until the passage of the Affordable Care Act, MFP required participants to be institutionalized for a minimum of 180 days and they had to be eligible for full Medicaid benefits for at least a month before the transition to be eligible for the program. The Affordable Care Act reduced the length-of-stay requirement to 90 days, but states may not count any rehabilitative care days covered by Medicare.[1]

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

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

MFP programs may provide up to three categories of services: (1) qualified HCBS, (2) demonstration HCBS, and (3) supplemental services. Qualified HCBS are services that beneficiaries would have received regardless of their status as MFP participants, such as personal assistance services available through a 1915(c) waiver program or the state plan. Demonstration HCBS are either allowable Medicaid services not currently included in the state's array of HCBS (such as assistive technologies) or qualified HCBS above what would be available to non-MFP Medicaid beneficiaries (such as 24-hour personal care). MFP requires states to maintain needed services after participants leave the program as long as they maintain Medicaid eligibility, which means that demonstration HCBS tend to be short-term services that are needed to help people adjust to community living. States may also provide supplemental services to MFP participants that are not typically reimbursable outside of waiver programs but facilitate an easier transition to a community setting (such as a trial visit to the proposed community residence). States receive an enhancement to the Federal Medical Assistance Percentage (FMAP), which is drawn from their MFP grant funds, when they provide either qualified HCBS or demonstration HCBS.[2] They receive the regular FMAP, which is also drawn from their MFP grant funds, when they provide supplemental services. In general, the MFP demonstration allows states to provide a richer mix of community services for a limited time to help facilitate a successful transition to the community.

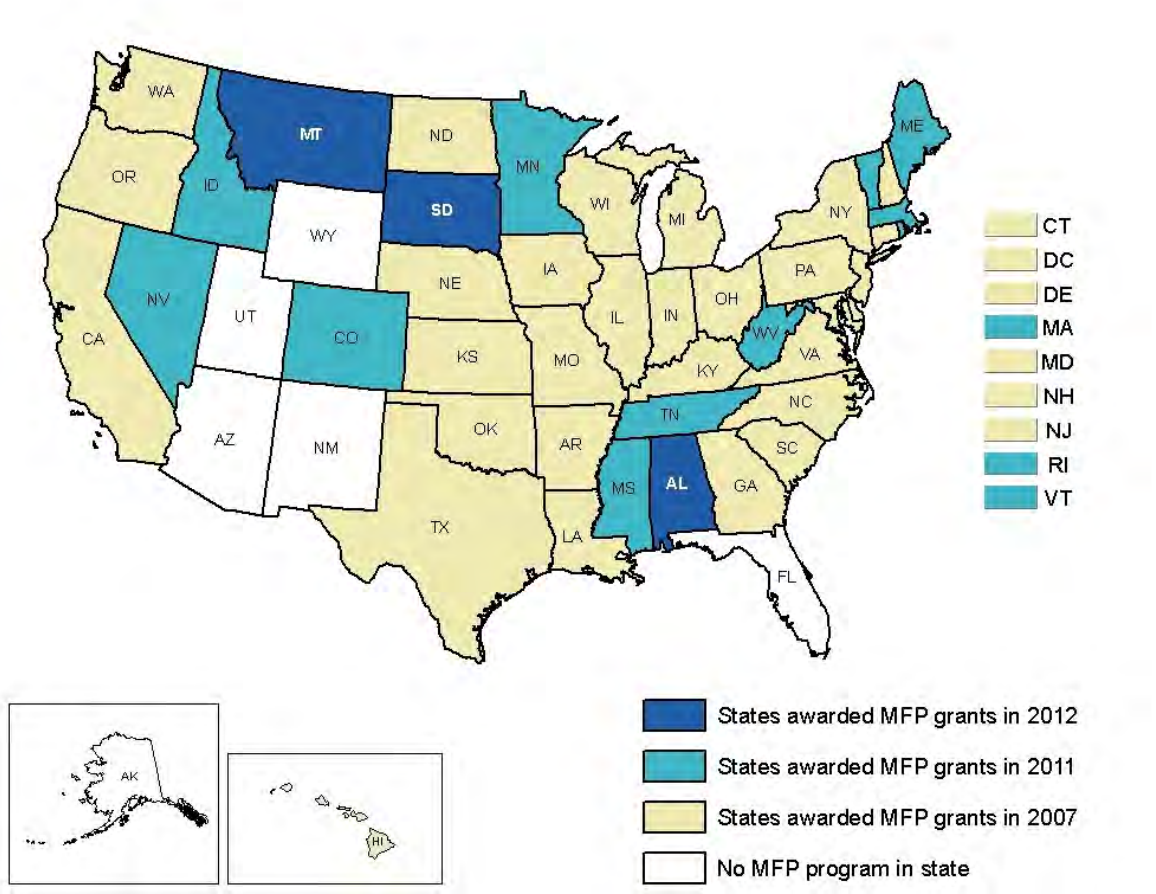
Rebalancing programs. The rebalancing program is subject to fewer basic requirements than the transition program. States must use the enhanced matching funds they receive when MFP participants use qualified HCBS or demonstration services to finance changes in their long-term care systems. No formal requirements for using or reinvesting these funds exist, except that the funds must be used for rebalancing the long-term care system. States may use the enhanced funds in a variety of ways, including (a) financing the provision of services, which includes improving housing supports; (b) expanding the availability of HCBS programs (such as increasing HCBS waiver slots); (c) improving access to HCBS, including supporting transitions of people not eligible for MFP; and (d) supporting providers with workforce initiatives, trainings, and incentives, and facility closures and right sizing. Each state sets benchmarks for measuring the success of the selected rebalancing strategy.

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

2. MFP Grant Awards

CMS began awarding MFP demonstration grants in January 2007 with 17 initial awards, followed by 14 additional awards in May 2007. In January 2011, another 13 states received MFP grants, bringing the total number of states with MFP grants to 43, plus the District of Columbia (Figure I.1). Alabama, Montana, and South Dakota received planning grants in 2012. During the year, New Mexico formally withdrew from the grant program and, as of the end of December, 45 states and the District of Columbia either had an operating MFP program or were developing their programs. Florida also formally withdrew in September 2013, just as this report was being finalized.

Figure I.1. Map of MFP Demonstration Grants



Note: New Mexico and Florida received MFP grant awards in 2011. New Mexico withdrew from the program in 2012 and Florida withdrew in 2013.

MFP programs commonly experience a delayed start-up because implementation has been more challenging than anticipated. Implementing an MFP program requires considerable effort and coordination among different agencies, particularly when the program targets multiple populations (Denny-Brown et al. 2011; Irvin et al. 2011). Some programs were delayed while key adjustments to community services were made to ensure the states could serve MFP participants. At a minimum, programs had to (a) establish processes for identifying eligible

Medicaid beneficiaries who can be adequately served in the community, (b) hire and train transition coordinators who work one-on-one with beneficiaries to set up their community living arrangements and services and supports, (c) develop strategies for locating affordable and accessible housing in areas where beneficiaries want to live, and (d) implement risk assessment and management systems that balance beneficiary choices against the risks associated with living in the community.

B. Purpose of This Report

In March 2007, CMS contracted with Mathematica to conduct a national evaluation of the MFP demonstration and the contract was renewed in 2012 (CMS Contract Number HHSM-500-2010-00026I/HHSM-500-T0010). This fourth annual report for the MFP demonstration covers the program from its inception through December 2012. The primary purpose of the report is to describe the status of the program as of December 31, 2012, including how states are progressing on their transition and HCBS expenditure goals.

The following chapters present analyses that include basic descriptive information about the program, MFP participants, and the HCBS participants receive while in the program, as well as assessments of program outcomes at the individual level. As in the previous annual reports, the work presented here adds to the foundation for the national evaluation and an assessment of program impacts. At its most fundamental level, the national evaluation of the MFP program seeks to understand whether the program met its goals to (a) increase the number and proportion of long-term institutionalized Medicaid enrollees who live successfully in the community, and (b) facilitate state rebalancing of long-term care systems. MFP programs are anticipated to have an array of effects on beneficiaries who need long-term services and supports (LTSS), including increases in the likelihood and number of transitions from institutional to community settings and the proportion of long-term care expenditures accounted for by HCBS.

C. Road Map to the Report

The next chapters are organized around three broad types of analyses: (1) an assessment of program implementation and growth; (2) descriptions of the characteristics of MFP participants and the HCBS they receive while enrolled in MFP; and (3) participant-level outcomes after the transition to community living. Chapter II describes the overall growth of the MFP demonstration and assesses whether state grantees are achieving program goals. Chapter III examines state-level implications and the larger picture of how states are using both MFP and the Balancing Incentive Program individually and together to rebalance their long-term care programs. Although it is still too early to detect the influence of these two programs, this chapter focused on determining the types of initiatives and activities states are pursuing with their MFP and Balancing Incentive Program funds. Chapter III concludes with an analysis of the overall trend in long-term care expenditures among MFP grantee states and whether that trend changed after the introduction of MFP. Chapter IV assesses state progress in four key areas of implementation: (1) the blending of MFP and managed long-term services and supports, (2) housing and strategies states are pursuing to address the challenge posed by the lack of affordable and accessible housing, (3) the direct service workforce and how states are managing when most have shortages of direct service workers, and (4) MFP activities that support employment among MFP participants. Chapter V provides descriptive statistics about the demographic makeup of MFP participants, the HCBS they receive during the year after their

transition to the community, and the level of care needs among those who transition from nursing homes. Chapter VI presents updated analyses on the implications of the transition on participants' quality of life and how participants' quality of life changes after they leave the MFP program.

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II. STATE GRANTEE PROGRESS TOWARD MFP GOALS: TRANSITIONS AND MEDICAID HCBS SPENDING

The federal statute that created MFP requires state grantees to establish two sets of annual goals: (1) the number of institutionalized individuals that programs transition back to the community, by population group; and (2) an increase in total Medicaid expenditures on home and community-based services (HCBS) for all Medicaid enrollees. Both are important indicators of progress toward MFP's overall aim: to enable more people with disabilities to receive long-term services and supports (LTSS) in home or community settings, if that is their preference.

This chapter reviews trends in MFP transitions and HCBS spending, and in meeting annual state-established targets for these two goals during the first five years of program implementation (2008 through 2012). It also explores policy and programmatic factors that have contributed to recent growth in MFP enrollment. The chapter briefly describes the transition goals of the grantees that received new MFP grants in 2011 and 2012, and projects their impact on the magnitude of MFP participants in the coming years. It concludes by discussing growth in qualified HCBS expenditures over time and differences in how state grantees achieved their 2012 HCBS spending goals.

A. Transition Trends

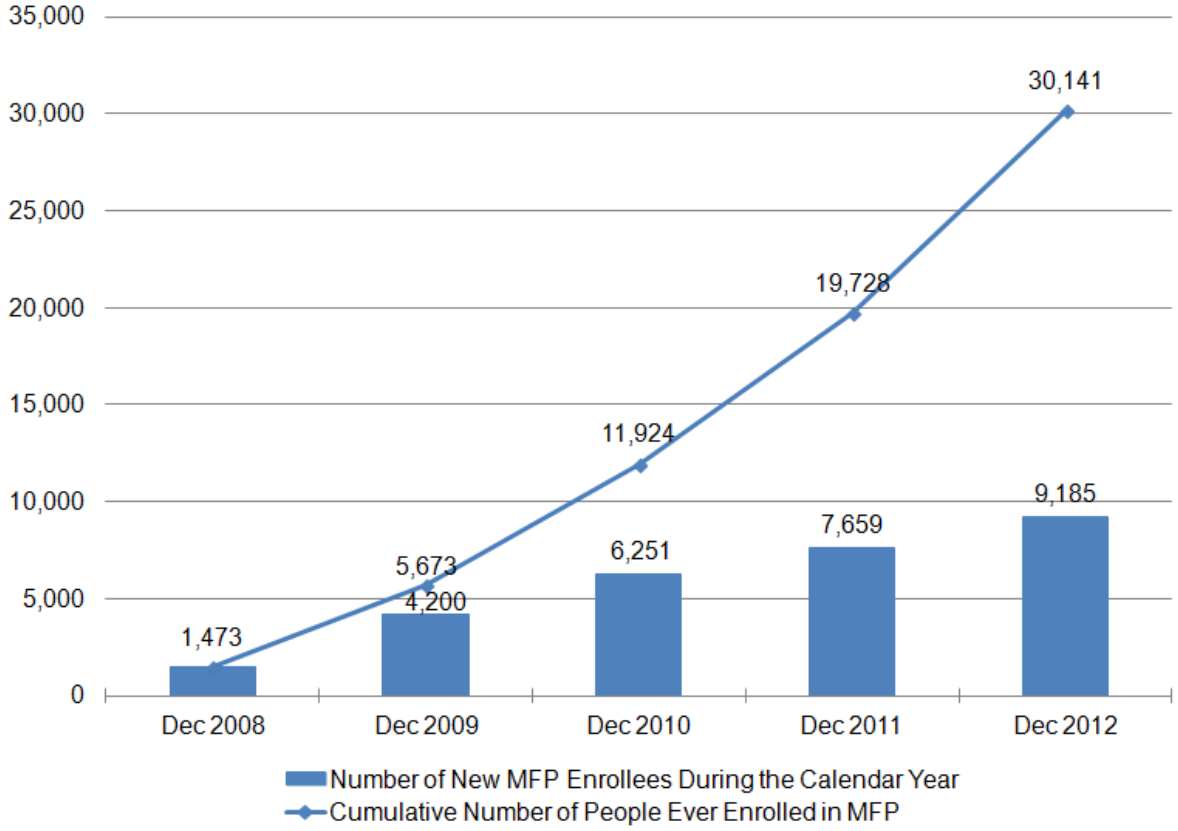
Cumulative and Annual MFP Transitions. From the start of the MFP demonstration in January 2008 through December 2012, state grantees have transitioned more than 30,000 people from institutions to the community where they received LTSS. In 2012, the fifth full year of the MFP demonstration, both the cumulative and annual number of MFP transitions increased substantially over previous years (Figure II.1). A total of 9,185 individuals enrolled in MFP and transitioned to the community in 2012, bringing the number of people ever enrolled in MFP since it began in 2008 to 30,141 individuals. This figure represents a 53 percent increase in cumulative enrollment (19,728) since the end of 2011. This growth rate sustains the strong upward trend in enrollment seen during each successive year of the program's operation.

B. Transition Activity, by State

Cumulative transitions by the end of 2012 varied widely across states, from 6,715 in Texas, to 52 in Rhode Island, not including Maine, Mississippi, Nevada, and Vermont, the four new grantees that began operations in 2012 (Figure II.2). This variation is mirrored in the cumulative number of participants enrolled at the end of 2011, from 5,300 in Texas, to 66 in Delaware (not shown). Because its program has been so much larger than other states, Texas has had a disproportionate influence on the overall national picture of the MFP program since its inception. However, that influence has been declining as MFP programs in other states have grown.

In examining annual growth rates in the number of new MFP participants among the 30 established states (disregarding the eight new grantees that began operations in 2011 or 2012), we see several patterns emerge. We distinguished four groups of states showing similar trends in the direction and degree of change over the first five years of implementation. By examining themes in the progress and challenges reported by the states in these four groups, we found some factors that may partly explain differences in rates of progress.

Figure II.1. Total MFP Enrollment, 2008—2012



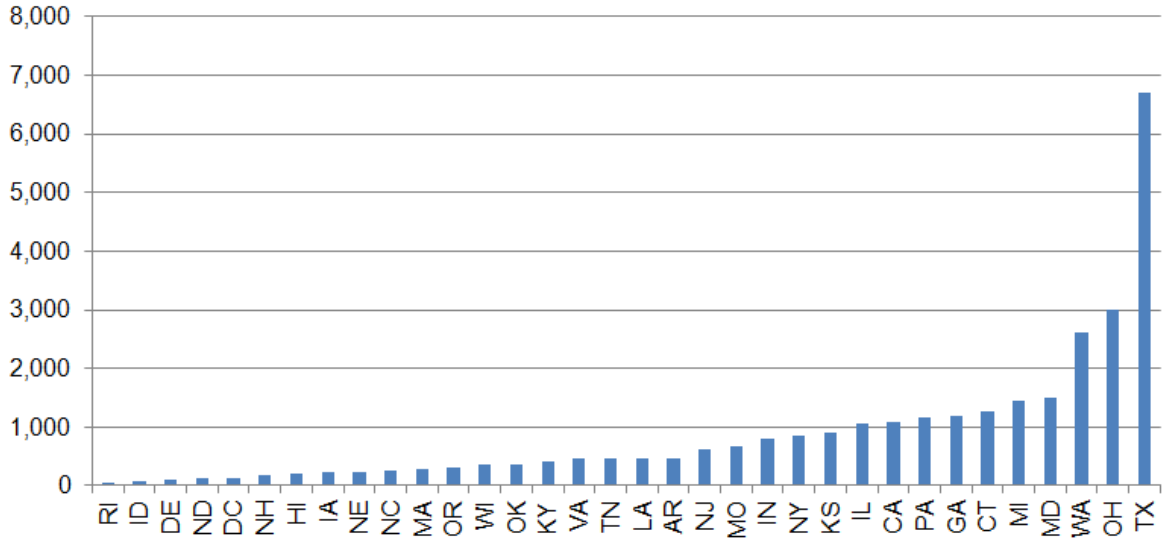
Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2008—2012.

Turnarounds. Three states substantially increased the number of new MFP participants in 2012 compared with 2011, primarily by expanding staff capacity. Nebraska increased its rate of transitions by 172 percent in 2012, representing a reversal in the trend from 2010 to 2011, when the number of new MFP participants declined 18 percent. This turnaround was largely due to expansions in transition coordination capacity in early 2012. Between 2011 and 2012, New Hampshire also experienced substantial (88 percent) growth in the number of new participants enrolled; in late 2011 and 2012, New Hampshire hired an additional transition coordinator, a housing specialist, and a programmer who uses Minimum Data Set (MDS) data to identify individuals potentially eligible for MFP.[3] Wisconsin increased its rate of transitions by 100

[3] The MDS is the nursing facility resident assessment instrument used for all nursing facility residents. MDS Section Q questions (effective October 1, 2010) require that all residents be asked directly whether 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 refer them to a state or local contact agency that will arrange for someone to speak with the resident about community living options.

percent from 2011 to 2012, which was a result of expanded staff capacity to identify, recruit, and enroll individuals in MFP.[4]

Figure II.2. Cumulative MFP Transitions by State, 2008—2012



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2008—2012.

Note: The graph excludes Maine, Mississippi, Nevada, and Vermont because they began implementing their programs in 2012. The count for Wisconsin is underreported because of delays in obtaining corrected data.

Strong, continuing growth. Eleven states had increases of 20 percent or more in the number of new MFP participants in 2012 relative to 2011. Four of these states (Georgia, North Dakota, Indiana, and Virginia) improved on growth rates from 2010/2011 to 2011/2012, and two of these states (Arkansas and Ohio) maintained their rate of enrollment since 2010. Five states experienced much higher growth rates from 2010 to 2011; the slowed growth rate in 2012 may be attributable to a combination of factors, including changes in transition coordination capacity or reductions in the number of intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) closures. Although the states in this group vary greatly in size, target groups, and other program dimensions, most had either stable leadership in 2011 and 2012; strengthened and expanded marketing efforts, transition coordination capacity, the array of HCBS, and housing assistance; or all of these advantages.

Steady enrollment. Nine states experienced relatively small changes in the number of new enrollees in 2012, ranging from about -3 percent to a 19 percent increase. Four of the nine

[4] Wisconsin later corrected is 2012 transition total from 162 to 185 individuals. However, these data were not incorporated in this report because they were received after production had started.

states—Illinois, Kansas, Louisiana, and North Carolina—had much higher growth rates from 2010 to 2011 than in 2012. The slowed growth rate in North Carolina in 2012 is likely due to the temporary freezing of waiver slot allocations that occurred during the state's conversion to managed care. Kansas reported significant turnover among program leadership in 2012 that may have affected program enrollment. Enrollment in California and Michigan has gradually increased since 2010, marked by an increase in new enrollees of 15 to 19 percent between 2011 and 2012. Three of the nine states—Hawaii, Oklahoma, and Pennsylvania—did not experience growth in the number of new participants enrolled in MFP in 2012.

Declining growth. Six states experienced declines in new enrollees from 2011 to 2012, following modest gains between 2010 and 2011: the District of Columbia, Iowa, Kentucky, Maryland, Texas, and Washington. Iowa's annual rate of enrollment was constant from 2010 to 2011; the state transitioned 55 or 56 individuals with intellectual disabilities in both years. Iowa's transitions dipped slightly in 2012 to 40 transitions for the year. In Texas, which still recorded more new enrollees in 2012 than any other MFP state (1,260), program officials attributed the slowing growth rate in 2012 to difficulty in maintaining the same number of transitions from ICFs/IID as in the past. Individuals who remain in these institutions have higher needs, making it more challenging and more time-consuming to find appropriate community placement. Kentucky reports several challenges for its transition efforts, most notably turnover among program leadership in 2012, reductions in the number of referrals due to the expiration of a Section Q referral contract in mid-2012, and the lifting of a Department of Justice settlement mandate. Program officials in the other states report that a combination of factors, such as the complex needs of older adults, persistent shortages of affordable and accessible housing, and state budget restrictions, have hindered enrollment.

C. Factors that Contributed to Growth in Enrollment

Although we do not know all the reasons for differences in enrollment across MFP states, we do know of some factors that explain recent growth in enrollment. In spring 2013, we conducted semi-structured interviews with MFP program staff in Georgia, Ohio, Nebraska, and Wisconsin to learn more about how MFP grantee states leveraged MFP resources to increase transitions among MFP participants between 2011 and 2012. These four states were selected because they either had high growth in the number of overall transitions between 2011 and 2012 or they experienced recent substantial growth in underrepresented groups, such as older adults and individuals with mental illness (MI) who transitioned to the community through MFP. In most cases, increased enrollment was a direct result of expanded operating capacity, increased MDS Section Q referrals, and targeted outreach to potentially eligible individuals. Although the findings presented in this section cannot be broadly generalized across MFP grantee states, more in-depth knowledge about changes that occurred near the time of the growth suggest the types of resources and services that may need to be in place before states can realize real growth in the volume of transitions.

Georgia. Georgia's transitions grew 48 percent from 2011 to 2012, up from a 24 percent growth rate in the previous year. Georgia has been particularly successful transitioning older adults from nursing facilities to community-based settings; the number of older adults that transitioned through MFP increased 141 percent from 2011 to 2012. Several factors contributed to recent growth in the number of individuals that have transitioned to community living. First, in mid-2011, Georgia changed transition coordination vendors from a private contractor to the Department of Human Services Division of Aging Services (DAS), which oversees the Aging

Disability Resource Centers (ADRC) subcontracts. MFP transition coordinators now operate out of the ADRCs in each of the state's 12 geographic districts. MFP program officials report that the MFP program was able to better coordinate transitions under an inter-agency model because the agencies shared a philosophy. Second, the ADRCs have a statewide infrastructure in place to promote better marketing and outreach. New brochures and marketing materials were distributed to all 12 ADRCs, which increased awareness of MFP among consumers. The MFP program also began to invite more consumers to their quarterly stakeholders meeting, which has helped to spread awareness of MFP. Third, staff report that implementation of MDS Section Q in late 2010 led to options counselors targeting outreach to potential participants in nursing facilities, resulting in increased referrals in 2011 and 2012. Options counselors provide information to individuals, family members, and caregivers about community living services and supports, including the service offerings available through MFP. Finally, in 2010, Georgia entered into an Olmstead Settlement Agreement with the Department of Justice to transform the state's mental health and developmental disability service delivery system (Department of Justice 2013). Through the settlement agreement, the state plans to close all seven public institutions for mental diseases (IMDs) and ICFs/IID by 2017, although all closures may not be completed within that time frame (Jones 2011). In 2011, an ICF/IID closed in Rome, GA that contributed to increased transitions through MFP. Another ICF/IID is scheduled to close in the near future.

Ohio. Ohio has experienced substantial increases in the number of individuals that have transitioned to the community through MFP. In 2011 and again in 2012, the number of individuals transitioned increased by about 50 percent each year. Ohio attributes its recent growth in enrollment to a combination of factors, including more program experience transitioning individuals to the community; increased awareness in the community about MFP as a result of targeted outreach; increased referrals from MDS Section Q; and expanded operating capacity to identify, enroll, and transition individuals residing in long-term institutional care. In 2010, Ohio began using 100 percent administrative funding to grow its program by adding the following specialists:

- Marketing and Outreach Coordinator: focuses on marketing and outreach to nursing facilities and other referral sources.
- Community Living Administrator: manages day-to-day caseload of referrals and also conducts outreach and provides education in the community. Three staff target outreach to specific populations including children with disabilities, older adults, and individuals with physical and developmental disabilities, and individuals with behavioral health needs. The program will add another behavioral health case manager in 2013.
- HOME Choice Provider Administrator: enrolls and oversees community-based providers, including transition coordinators.
- MDS Section Q Program Manager: manages Ohio's section Q process. Additionally, reviews MDS Section Q data to identify nursing facility residents with low activity of daily living (ADL) scores to target for MFP education and outreach.
- Behavioral Health Liaison for HOME Choice: conducts community outreach to educate behavioral health boards about MFP and to recruit behavioral health providers to serve as transition coordinators. This position is shared with the Mental Health Division.

Ohio has been particularly successful in transitioning individuals with mental illness to the community. Across all states, Ohio transitioned 80 percent of all new MFP participants with mental illness (546) in 2012.[5] Between 2011 and 2012, the number of individuals with mental illness that Ohio's MFP program transitioned grew by 295 percent (110 transitioned in 2011 and 435 transitioned in 2012). Ohio reports that two factors contributed to the growth in enrollment among this population. First, in 2010 Ohio began to use behavioral health clinicians to serve as transition coordinators. Having specialized transition coordinators who are trained to work with the unique needs of individuals with behavioral health needs ensures individuals are connected to appropriate behavioral health services, provides continuity of care for MFP participants, and increases the likelihood that participants remain engaged with service providers after transitioning to the community. Second, Ohio uses its MDS Section Q data to target potential participants with behavioral health needs and the nursing facilities are the biggest source of referrals to MFP. MFP program staff report that many individuals with behavioral health needs have an acute care episode that results in a hospitalization and then transfer to a nursing facility for continuing care.

Nebraska. In 2012, the number of individuals that Nebraska transitioned to community living nearly tripled (increasing by 2.7 times), after declining between 2010 and 2011. Nebraska expanded its transition coordination capacity in 2012 to bolster enrollment in the MFP program. Through 2011, the MFP program had three transition coordinators who handled education, outreach, assessments, and transition planning statewide. In January 2012, Nebraska implemented a new model, known as Transition Planning and Support (TPS), to increase its transition coordination service capacity. Through TPS, private providers are contracted to provide coordination services for individuals transitioning from nursing facilities who need help finding appropriate housing or services in the community. Nebraska uses 100 percent administrative funds to contract with 12 TPS providers, half of which are agencies that employ multiple staff.[6] The TPS providers perform a variety of functions, including developing resources in the community where the individual will be transitioned, providing or setting up transportation during the housing search, and conducting the housing search. TPS providers also arrange for goods and services, compile the documentation required for housing and waiver applications, and administer the baseline Quality of Life survey. In addition to the TPS providers, Nebraska has two transition coordinators who act on all referrals for candidates that do not require TPS services. For example, many individuals who already have an apartment, home, or services in place in the community do not require TPS services.

In addition to expanding their transition coordination service capacity, other factors contributed to the increased number of individuals that have transitioned to the community

[5] This analysis is based on state reported data and the number of people states transitioned and classified in the targeted population with mental illness. Most likely some MFP participants in the other targeted populations.

[6] In 2010, CMS began to fund at the 100 percent claims match certain administrative costs related to activities that support MFP programs, including personnel, travel, training, and marketing and outreach.

through MFP. For example, the 2010 change in the MFP eligibility criteria allowed the MFP program to transition individuals before their institutional stay reached six months.[7] Also, increased awareness in the community about MFP has led to increased referrals.

Wisconsin. Since 2010, Wisconsin's rate of transitions has substantially increased, particularly among populations of older adults and young adults under the age of 65. Between 2010 and 2011, the total number of transitions tripled and then more than doubled between 2011 and 2012 (from 24 transitions in 2010, to 81 transitions in 2011, to 183 transitions in 2012). MFP program officials in Wisconsin report that the increased rate of transitions since 2011 is largely due to increased staff capacity. In 2000, Wisconsin began to implement a managed care program, known as Family Care, to provide individuals with more flexible and cost effective LTSS (Wisconsin DHS 2013). Over time, Family Care has expanded to 57 counties; 15 counties continue to operate under the traditional waiver program (Wisconsin DHS 2013). Between 2008 and 2011, the MFP program recruited individuals primarily from the 15 waiver counties because of limited staff capacity. In 2011, Wisconsin began to use 100 percent administrative funds to hire the following staff to expand its operating capacity:

- Data and Policy Analyst and Research Specialist: manages the MFP candidate database designed to track persons living in institutions and considering transitioning to the community including both new enrollees to managed care and managed care members who are identified as relocation candidates and tracks participant placement and follow-up Quality of Life surveys.[8]
- Disability Support Specialist: provides specialized transition planning to support transition candidates with identified behavioral support and health-related care needs that would otherwise prevent their transition. The specialist also supports non-MFP individuals with intellectual disabilities already living in the community to ensure continued community participation.
- Housing Specialist: conducts trainings and reaches out to developers, housing counselors, care managers, and public housing staff; assists individuals with searching for affordable and accessible qualified housing in the community; collaborates with Wisconsin Housing Authority to create the Housing Locater Database; conducts statewide housing needs assessments with the managed care organizations.

[7] In March 2010, the Affordable Care Act of 2010 changed MFP eligibility rules by reducing the minimum residency period in an institution from six months to 90 days, not counting days for Medicare-covered rehabilitation.

[8] The MFP candidate database was designed for the MFP demonstration and Wisconsin's systems of managed care, legacy waivers, and self-directed supports programs.

- Outreach and Education Specialist: conducts outreach to nursing facility residents in Milwaukee County to educate individuals about MFP, obtains informed consent, and administers the baseline Quality of Life survey prior to discharge to the community. Also, provides enrollment counseling to Medicaid enrollees who are living in institutions and indicate in the MDS Section Q questions or other referral a desire to transition back to the community. This position targets adults with physical or intellectual disabilities or both.

With the addition of dedicated program staff in 2011 and 2012, the MFP program began to recruit and enroll individuals in the managed care counties, substantially bolstering enrollment. A new data-tracking system was also deployed in 2012 to track program participation for all participants, including individuals served by managed care organizations. To further increase enrollment, Wisconsin plans to expand its outreach efforts in early 2013 by hiring five community-living specialists to educate candidates in person and to inform individuals in nursing facilities of their options for living in the community.

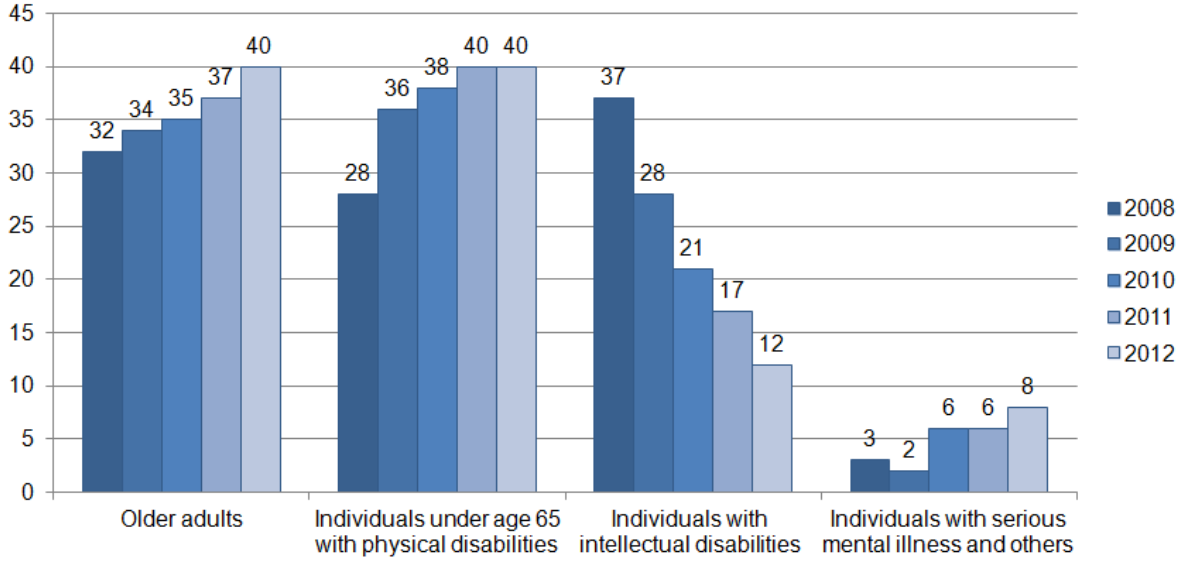
D. MFP Transitions, by Population Subgroups

During the first five years of program operations, the mix of MFP participants has changed (Figure II.3). In 2012, most participants were nursing home residents, with older adults and nonelderly residing in nursing homes each making up 40 percent of all those who enrolled in MFP in 2012. Since 2008, the populations of individuals with physical disabilities and older adults leaving nursing homes have gradually increased as a share of total MFP participants. By contrast, individuals with intellectual and developmental disabilities (ID/DD) have accounted for a smaller share of new enrollees over time, dropping from 37 percent in 2008 to 12 percent in 2012.

Several factors can explain the shift in the makeup of MFP participants since the start of the demonstration. First, at the start of the demonstration in 2008, many states were actively seeking to close or downsize ICFs/IID, either due to court orders or to address state budget shortfalls. In many cases, state MFP programs took advantage of these initiatives to work with state agencies that serve people with ID/DD to move the residents of these institutions to community residences and small group homes. Although this trend continued in subsequent years, monthly enrollment trends show that it began to slow in 2011 and 2012 (Figure II.4).

Offering transition assistance to other target populations, however, often took more time. MFP programs had to establish working relationships with the state agencies that operate HCBS waiver programs because most states enroll MFP participants into such programs after they return to the community (Lipson et al. 2011). Transitioning younger people with physical disabilities, older adults, and people with serious mental illness also became delayed if state Medicaid agencies had to first initiate new contracts with community organizations that served these populations, such as centers for independent living, aging and disability resource centers, and other local agencies. A second reason for the increase in the share of nursing home residents among MFP participants stems from the revisions to the nursing home resident assessment (MDS 3.0 Section Q) that went into effect in October 2010. The MDS 3.0 Section Q requires residents to be asked directly whether they want to speak with someone about moving back to the community. MFP program officials in most states report this new information has made MFP recruitment easier by generating a surge of referrals to MFP and facilitating identification of MFP candidates.

Figure II.3. Annual Distribution of MFP Participants by Population Group, 2008—2012

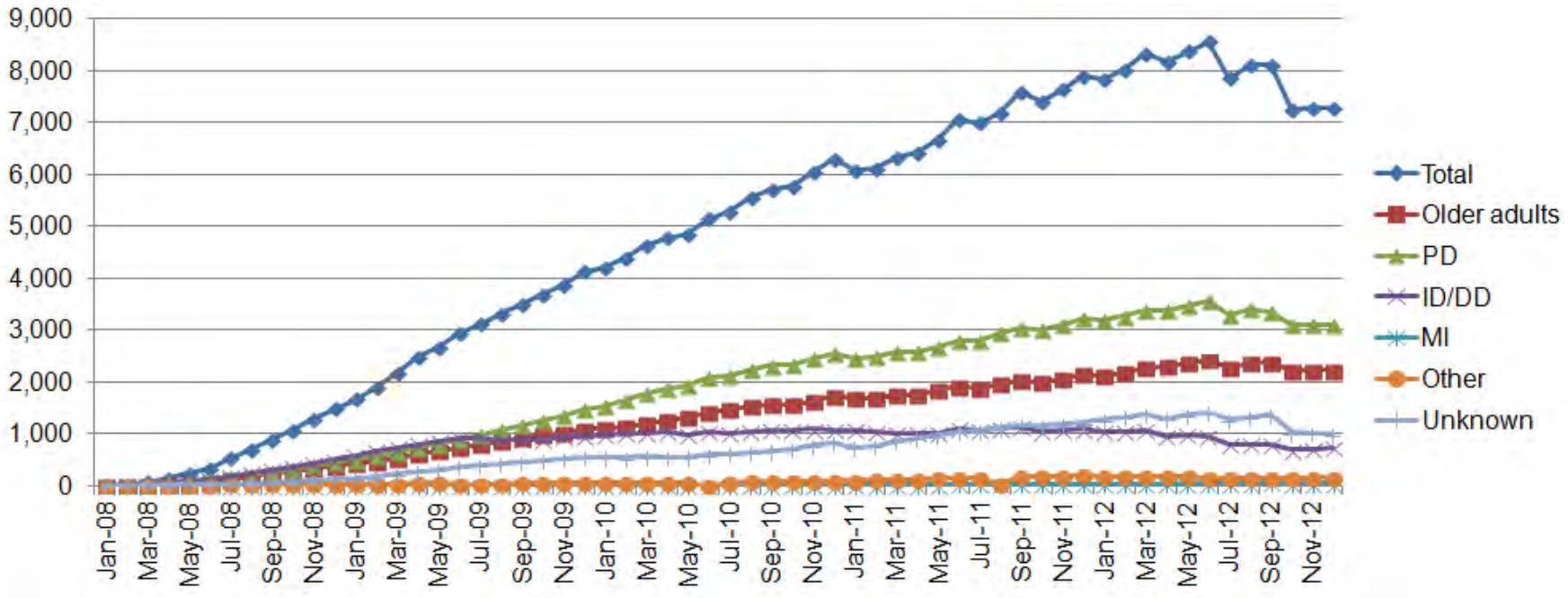


Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2008—2012.

A third reason explaining recent growth in transitions among nursing home residents may be program maturation. Calendar year 2012 marks the fifth full year of the MFP demonstration, and states that began implementing in 2008 or 2009 have over time refined their MFP transition program and expanded their operating capacity. MFP programs in the 30 established states now have formal systems in place to identify, assess, and enroll MFP candidates; arrange for long-term services and supports in the community; and find and secure affordable and accessible housing for individuals.

Finally, several MFP grantee states have also increased their transition coordination capacity which has led to increased rates of transitions in 2011 and 2012. Many MFP grantee states have used 100 percent administrative funds to hire additional staff to grow their programs and help address identified barriers to successful transition (the descriptions above illustrate how Georgia, Nebraska, Ohio, and Wisconsin used these funds to hire new staff). For example, MFP program officials have consistently reported severe shortages of affordable and physically accessible housing units for those who want to live in these types of residences. To address this barrier, many MFP grantee states have hired housing specialists to develop online registries of affordable, accessible housing for all people with disabilities, search for and secure qualified housing in the community, and assist individuals with applying for public housing or rental vouchers. The addition of housing specialists has made it somewhat easier to secure community housing for older adults and individuals with physical disabilities. Other types of staff hired with 100 percent administrative funds include deputy project directors, transition coordinators, outreach and education coordinators, behavioral health specialists, employment specialists, and intake coordinators. For these states, the addition of staff has strengthened the program's infrastructure, allowing it to target potential participants, quickly act upon new referrals, and initiate the transition planning process.

Figure II.4. MFP Monthly Enrollment by Population Group, 2008—2012



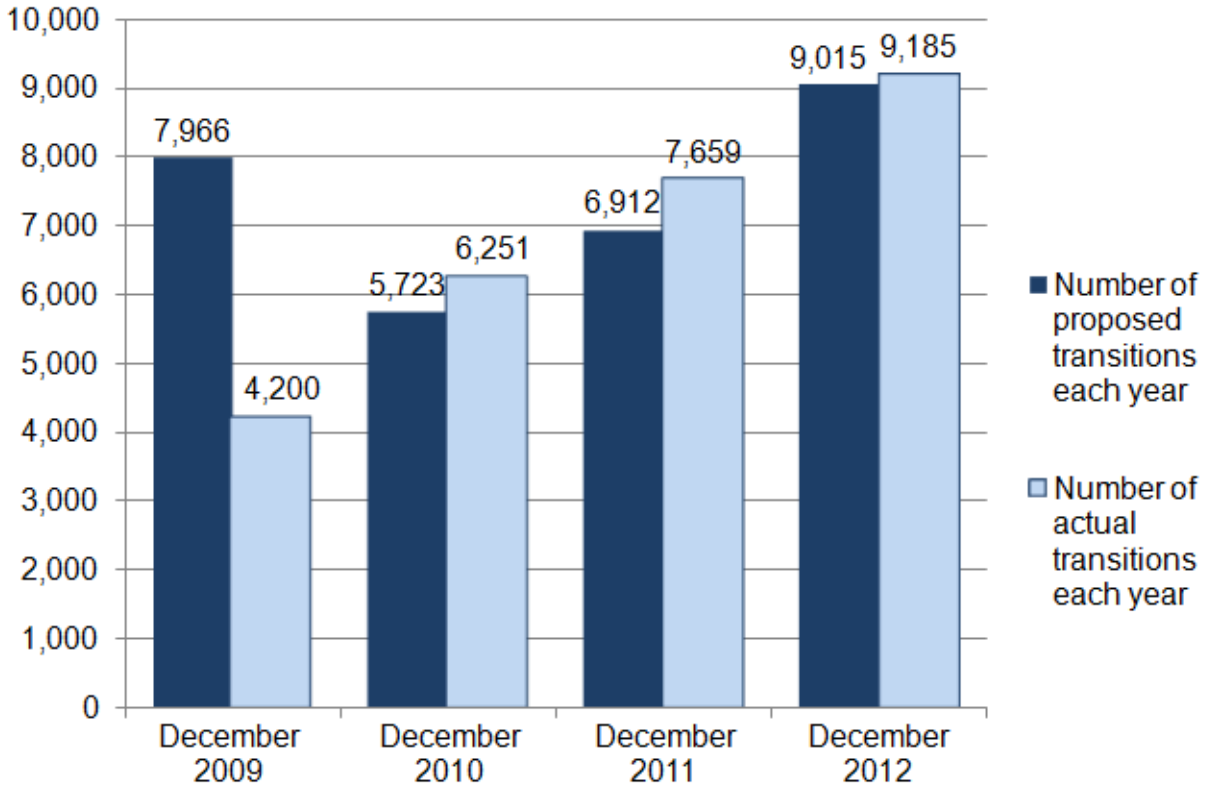
Source: State MFP Program Participation data, January 2008—Decement 2012.

Note: Analysis includes 36 grantee states with complete 2012 program participation data.

E. Progress Toward Annual Transition Goals

Overall, MFP grantees' progress toward meeting their annual transition goals improved from 2009 to 2011, but it dropped slightly in 2012 (Figure II.5). MFP grantee states exceeded their aggregate 2012 goal of 9,015 transitions by 2 percent, which is slightly lower than their performance in 2011 and 2010, when they met 111 and 109 percent of the aggregate goal, respectively. The stronger performance after 2009 is partially due to CMS guidance to states that conditioned subsequent-year grant payments on meeting certain thresholds and led most states to make more conservative annual projections starting in 2010 (CMS 2009).[9]

Figure II.5. MFP Grantees' Progress Toward Annual Transition Goals, 2009—2012



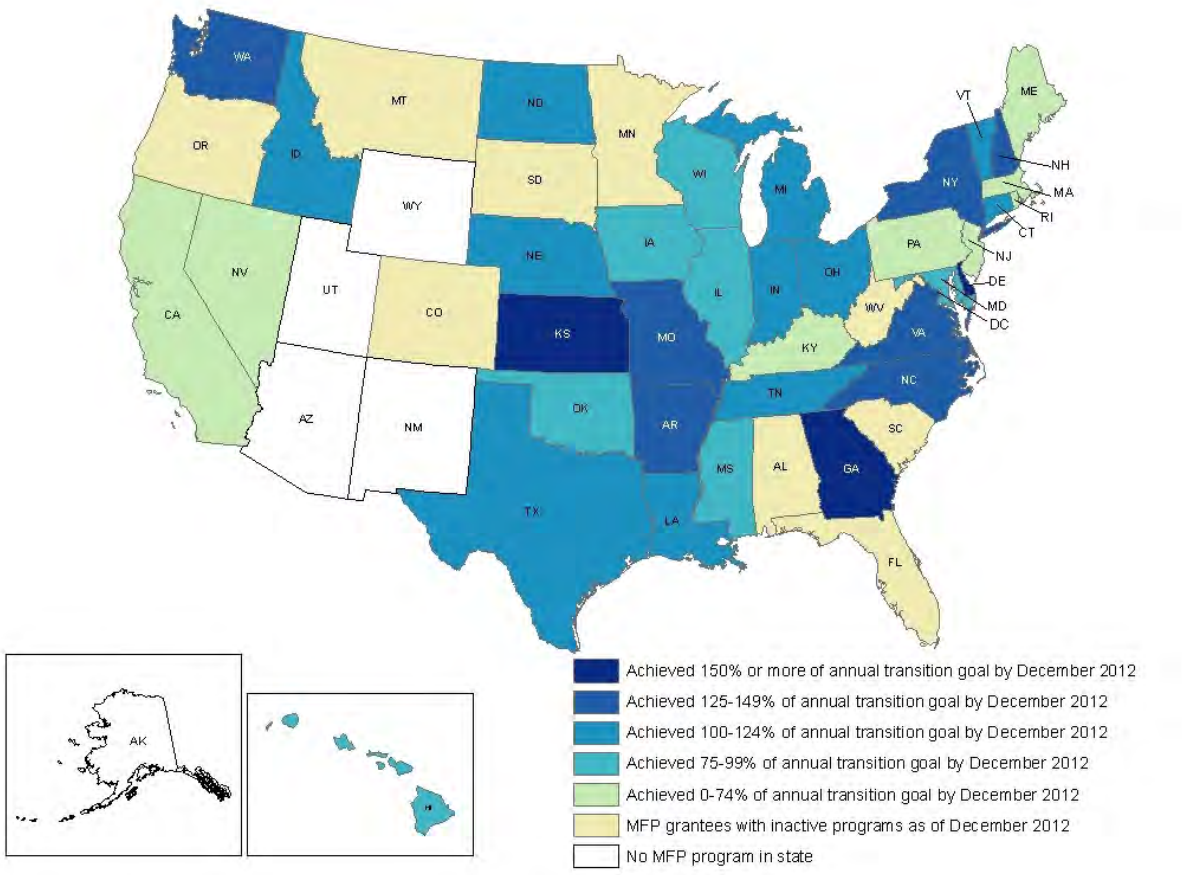
Source: Mathematica analysis of State MFP Grantee Semi-Annual Progress Reports, 2009—2012.

As in previous years, progress toward 2012 annual transition goals varied widely across states. Excluding Oregon, which temporarily suspended its program in the fall of 2010, approximately 60 percent (20) of the 33 grantees with operational MFP programs throughout 2012 achieved 100 percent or more of their annual transition goals during 2012 (Figure II.6).

[9] CMS, Money Follows the Person Demonstration Policy Guidance, "Conditional Approval of Out-year Supplemental Grant Awards for Meeting Benchmarks," December 2009.

Three of these states achieved more than 150 percent of their annual goals. Among the 13 states that did not meet their 2012 annual goal, 2 achieved at least 90 percent of their annual transition goal, the threshold established by CMS for states to receive a full supplemental award in the following year. Four states achieved between 75 and 89 percent of the goal and CMS allows these states to receive a partial supplemental award for six months. The 7 states that did not meet the 75 percent threshold were expected to submit plans to CMS describing strategies for meeting these goals in the future.[10]

Figure II.6. MFP Grantees' Achievement of 2012 Transition Goals



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2012.

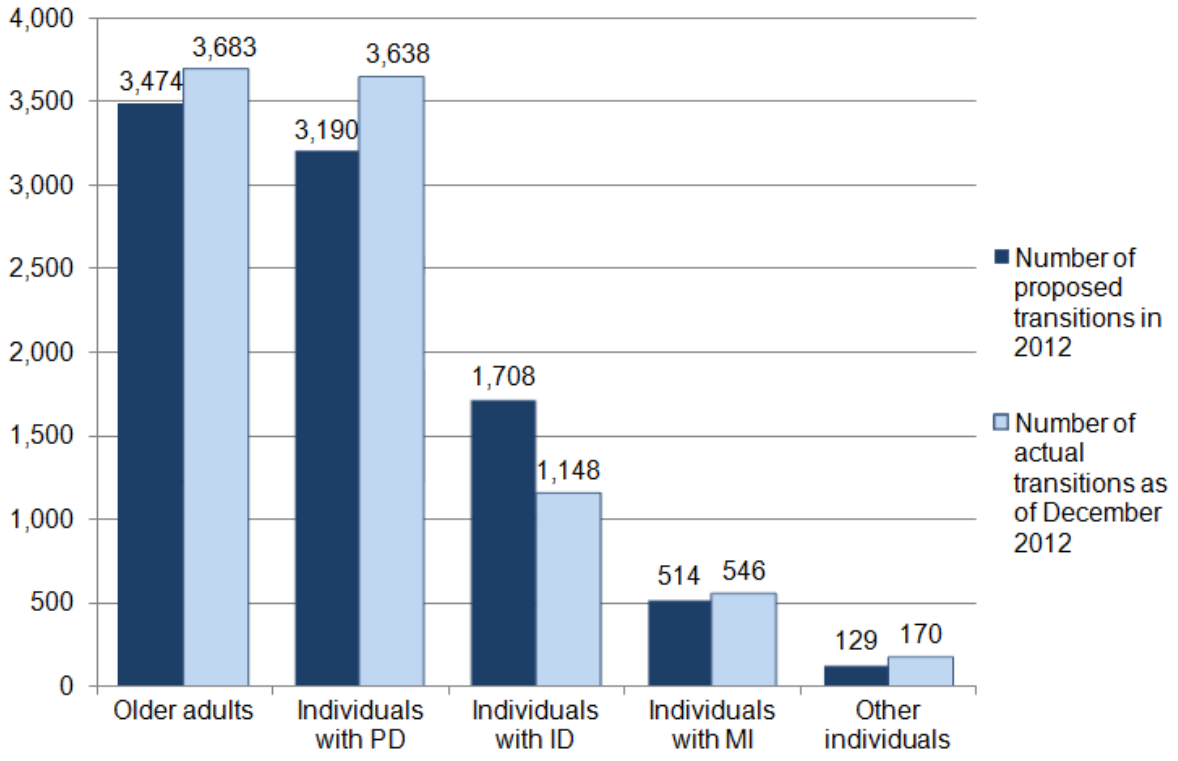
[10] According to CMS guidance, grantees that fail to meet at least 75 percent of annual transition goals are not eligible for a supplemental grant award. If they have not met their annual transition goal after another six months, grantees must submit an "action plan" describing how they will meet the goal by the end of the calendar year.

Figure II.6 (continued)

Notes: The map depicts Maine's, Nevada's, Mississippi's, and Vermont's progress toward 2012 transition goals, however these programs were not operational throughout all of 2012, because they were not awarded MFP grants until 2011. Oregon, which temporarily suspended its program during 2010, and South Carolina which received an initial grant in 2007 and had not implemented a program as of December 2012, are shown as having inactive programs in 2012. New Mexico and Florida were awarded an MFP grant in 2011, but both later rescinded its grant award; New Mexico in 2012 and Florida in 2013.

With regard to achieving transition goals by population subgroups, grantee states are, overall, achieving a higher percentage of transition goals for older adults, people with physical disabilities, people with mental illness, and people with other types of impairments compared with people with intellectual disabilities (Figure II.7). The population of individuals with an intellectual disability was the only group for which MFP grantee states did not meet their 2012 transition goal. MFP grantees states planned to transition a total of 1,708 individuals with an intellectual disability in 2012, and ultimately achieved 67 percent of their annual goal, transitioning 1,148 such individuals to the community by the end of December 2012. Why states missed this goal was unknown at the time of this report.

Figure II.7. MFP Grantees' Progress Toward 2012 Transition Goals, by Population Subgroup



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2012.

F. New State Grantees in 2011 and 2012—Transition Goals and Program Implementation to Date

In February 2011, CMS awarded MFP grants to 13 additional states: Colorado, Florida, Idaho, Maine, Massachusetts, Minnesota, Mississippi, Nevada, New Mexico, Rhode Island, Tennessee, Vermont and West Virginia. However, New Mexico later rescinded its grant award in 2012 and Florida rescinded its award in September 2012. CMS also awarded MFP grants to Alabama, Montana, and South Dakota in September 2012. One additional state, South Carolina, which received an MFP grant award in 2007 but chose not to implement its program at that time, informed CMS in 2011 that it would resume plans to implement its MFP grant in early 2013.

MFP program officials in these 16 states (excluding New Mexico) proposed to transition nearly 13,000 individuals between 2011 and 2016, which would increase the total number of MFP transitions over the entire 10-year demonstration (2007 to 2016) to about 82,000, or nearly 20 percent more than the number projected by the 30 states that received grants in 2007 and implemented programs in 2008 or 2009.

Among the 16 states, 4 (Idaho, Massachusetts, Rhode Island, and Tennessee) started operations in 2011, and 4 more (Maine, Mississippi, Nevada, and Vermont) succeeded in completing all of the requirements needed to begin operations by the end of 2012 (Appendix Table A.1). These requirements included hiring a full-time project director, developing a final operational protocol that met CMS requirements for approval, securing state funding commitments, modifying information systems to track participants and report expenditures accurately, and other start-up activities. Vermont reported exceeding its 2012 MFP transition goal (30 individuals enrolled compared with an annual target of 25). Mississippi, achieved 91 percent of its annual target, transitioning 59 of the 65 proposed transitions in 2012. Maine and Nevada collectively transitioned 6 individuals, and each met 50 percent or less of its 2012 transition goals (data not shown) due to delays in program implementation.

The new grantees that did not begin program operations in 2012 experienced various problems that delayed implementation. In some cases, grantees had to make extensive revisions to the MFP operational protocol to comply with federal program requirements. Colorado is making changes to its MMIS system and is also awaiting legislative approval to use state funds to cover the cost of the state portion of the MFP demonstration services. The fate of MFP remained uncertain in Florida throughout 2012 because the state legislature was not moving to authorize the necessary state funds. Alabama, Montana, and South Dakota received grant awards in late 2012 and are in the program-planning phase. Despite unexpected delays in program implementation, Colorado, South Carolina, and West Virginia began transitioning MFP participants to the community in early 2013 and Alabama and Minnesota expects to begin transitioning individuals to the community in summer 2013.

Among the 46 MFP grantee states that either began MFP program implementation between 2007 and 2012 or plan to do so in 2013, around 52,200 total transitions are projected from 2013 to 2016 (Appendix Table A.1). About 21 percent (11,130) of these transitions are expected to be generated by the new 2011/2012 MFP grantees. Besides the increase in total MFP participants generated by the new 2011 grantees, the MFP program overall may be especially influenced by Massachusetts, Minnesota, and Tennessee, each of which plans to transition more than 2,000 individuals and has a relatively large number of Medicaid beneficiaries enrolled in a managed

long-term services and supports (MLTSS) program. To date, Texas has been the only MFP grantee state with sizable numbers of MFP participants and enrollment in managed LTSS programs. The addition of these three states to the national MFP program provides new "testing grounds" to develop ways MFP and MLTSS can work in tandem and may benefit a growing number of states with MFP programs that also plan to expand or introduce MLTSS programs over the next several years. Chapter IV details the interconnections between MFP and MLTSS programs.

G. HCBS Spending Goals

In addition to requiring states to establish annual transition goals, states must also establish annual targets for total qualified Medicaid spending on HCBS, which includes expenditures on all types of HCBS for everyone enrolled in Medicaid. These HCBS Medicaid expenditures include all federal and state funds spent on 1915(c) waiver services, home health services, personal care, and other HCBS provided as state plan optional benefits. In addition, total qualified HCBS expenditures include all HCBS spending for MFP participants (qualified, demonstration, and supplemental services).

Most states submitted new annual benchmarks for HCBS expenditures covering 2012 to 2016, as most of the original grantees projected expenditures through only 2011 and therefore needed to extend their goals for another five years. States updated their benchmarks to reflect HCBS expenditure projections, taking into account more current trends toward managed LTSS programs or significant changes in MFP policies that affect total spending.

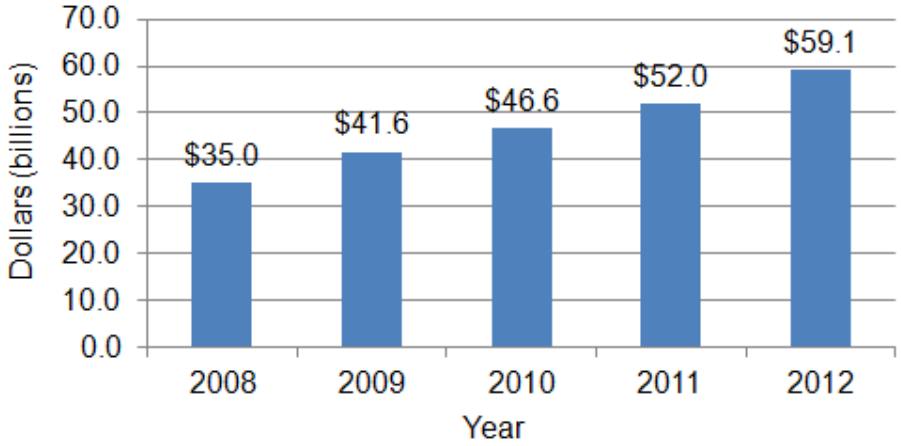
Growth in Annual HCBS Expenditures Over Time, 2008—2012. Total annual HCBS spending by states has continued to grow each year (Figure II.8). Twenty-four grantee states reported HCBS expenditures for 2008 totaling about $35 billion. Total spending has increased each year by about $5 to $6 billion, with the biggest jump occurring from 2011 to 2012 ($7.1 billion). Overall, 35 states reported HCBS expenditures for 2012 totaling approximately $59 billion. These annual increases can be attributed to the increasing number of states with MFP grants and the shift in state long-term care spending towards more HCBS. Chapter III discusses how states are shifting the balance of their long-term care expenditures.

Achievement of 2012 Qualified HCBS Spending Goals. State-by-state achievement of HCBS expenditure benchmarks has been variable, although most states met their goal. Thirty-two grantee states had expenditure benchmarks approved by the time of this report and also reported total HCBS expenditures for 2012 to allow a comparison of actual spending to projected spending (Table II.1).[11] Among these 32 states, actual spending as a percentage of their 2012 benchmark goals ranged from 65 percent (District of Columbia) to 169 percent (Mississippi). Figure II.9 shows that most are achieving at least 90 percent of their goal. States most commonly

[11] Arkansas, Maine, and Rhode Island did not report expenditures in 2012, and Hawaii, North Carolina, and Oregon did not have 2012 expenditure targets available at the time of this report.

cite lags in processing claims for the year as the reason for lower than expected spending during the year. Total HCBS spending figures for 2012 should be considered provisional. Several grantees have a history of modifying their expenditure information in subsequent years as they update projected spending with actual spending, process late billings and adjustments, and correct inaccurate reporting.

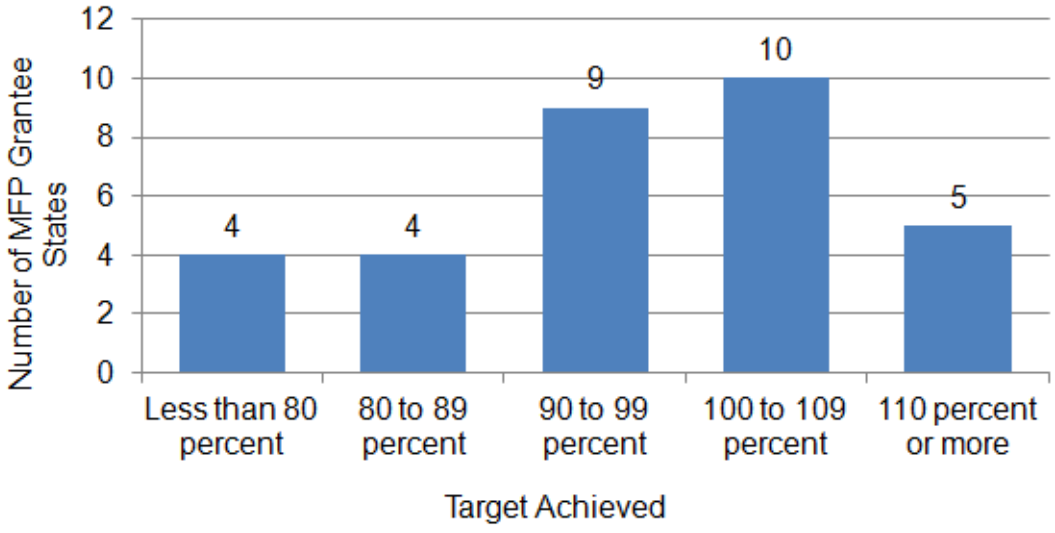
Figure II.8. Total Qualified HCBS Expenditures, 2008—2012



Source: Mathematica analysis of State MFP Grantee Semi-Annual Progress Reports, 2008—2012.

Notes: The number of states reporting total HCBS expenditures was 24 in 2008, 30 in 2009, 29 in 2010, 33 in 2011, and 35 in 2012.

Figure II.9. Number of MFP Grantee States Achieving Qualified HCBS Expenditure Goals, 2012



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2012.

Note: Total number of states in this analysis was 32.

HCBS = home- and community-based services.

Table II.1. Qualified HCBS Expenditures Through 2012, Provisional

State	2012 Target Level of Spending	Qualified HCBS Expenditures as of December 2012	Percentage of 2012 Target Achieved as of December 2012
Arkansas	$ 325,717,659	NR	NR
California[a]	$ 9,453,720,509	$9,819,315,380	103.9
Connecticut	$ 3,900,000,000	$ 4,301,824,725	110.3
Delaware	$116,964,570	$104,699,997	89.5
District of Columbia	$ 630,570,376	$407,729,935	64.7
Georgia	$1,129,869,002	$1,091,322,670	96.5
Hawaii	n.a.	$183,453,638	n.a.
Idaho	$187,576,330	$225,280,528	120.1
Illinois[a]	$1,580,353,875	$1,486,642,184	94.1
Indiana	$1,007,000,000	$841,087,179	83.5
Iowa	$601,100,000	$637,203,118	106.0
Kansas	$605,227,307	$581,625,068	96.1
Kentucky	$638,100,000	$557,621,639	87.4
Louisiana	$782,831,382	$799,438,763	102.1
Maine	$43,356,963	NR	NR
Maryland[a]	$966,129,077	$869,801,085	90.0
Massachusetts	$3,297,000,000	$3,538,657,330	107.3
Michigan	$915,628,370	$955,047,026	104.3
Mississippi	$242,461,525	$410,229,263	169.2
Missouri	$1,014,727,475	$1,164,955,196	114.8
Nebraska	$320,100,000	$308,129,544	96.3
Nevada	$165,880,999	$172,595,409	104.1
New Hampshire	$306,838,568	$265,265,236	86.5
New Jersey	$1,203,551,268	$961,231,539	79.9
New York	$13,331,710,584	$13,331,710,584	100.0
North Carolina	n.a.	$1,323,249,791	n.a.
North Dakota	$142,246,815	$169,246,963	119.0
Ohio	$3,366,000,000	$2,436,977,724	72.4
Oklahoma	$461,136,859	$457,829,646	99.3
Oregon	n.a.	$646,564,141	n.a.
Pennsylvania	$2,896,484,000	$2,896,371,697	100.0
Rhode Island	$66,500,000	NR	NR
Tennessee[b]	$959,421,425	$735,297,490	76.6
Texas	$3,378,671,461	$3,415,015,919	101.1
Vermont	$58,028,121	$61,070,402	105.2
Virginia	$1,268,832,726	$1,182,874,562	93.2
Washington[c]	$879,987,381	$859,167,918	97.6
Wisconsin[a]	$1,980,717,228	$1,964,438,418	99.2
TOTAL	$56,768,855,194	$59,162,971,707	104.2

Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2012.

Table II.1 (continued)

[a] California, Illinois, Maryland, and Wisconsin expect 2012 total spending to increase due to additional claims not yet processed.

[b] Tennessee's fiscal year runs from July 1 to June 30. The state will recalculate its target level of spending in July.

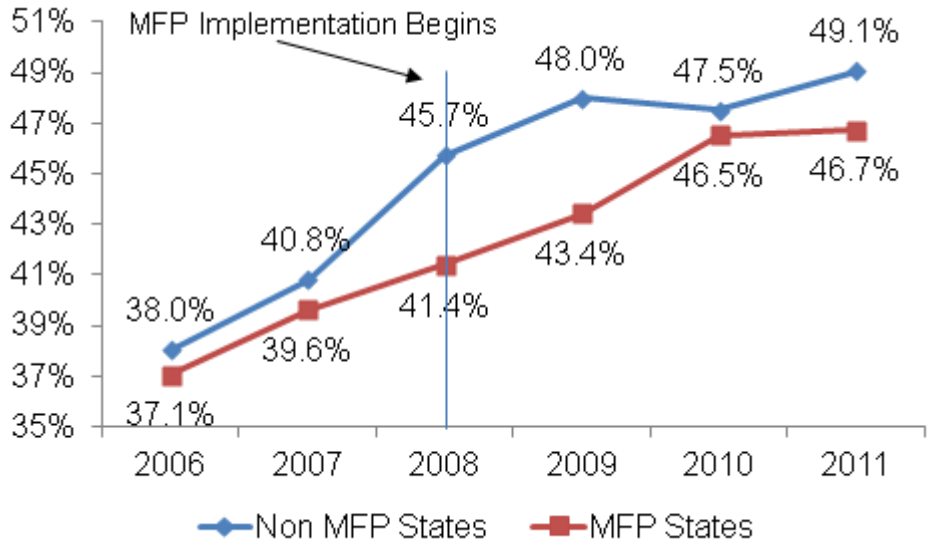
[c] Washington's HCBS expenditures are based on SFY (July–June) using month of service, and may differ slightly from those reported on the CMS-64 and MFP Financial Reporting Forms A and B due to different reporting structures.

CMS = Centers for Medicare & Medicaid Services; CY = calendar year; HCBS = home- and community-based services; SFY = state fiscal year. NR = not reported; n.a. = not applicable.

III. PROGRESS TOWARDS REBALANCING STATE LONG-TERM CARE SYSTEMS

The MFP program, together with the Balancing Incentive Program, is structured to shift more long-term care spending toward home- and community-based services (HCBS). In addition to the MFP transition program, the MFP rebalancing program and the Balancing Incentive Program both provide considerable resources to states for the improvement and enhancement of their long-term care systems so that home and community-based services are more readily available. Annual summary expenditure data published by Truven Health Analytics indicate that state long-term care systems have been slowly evolving, and expenditures for HCBS have been increasing relative to institutional expenditures (Figure III.1) (Eiken et al. 2013). States that did not receive an MFP grant award in 2007 (treated as non-MFP states in the Figure III.1) experienced an acceleration in the proportion of their long-term care spending accounted for by HCBS just before and during the early years of the MFP program. However, the MFP states caught up in 2010, partly because spending on HCBS in non-MFP states slowed relative to their spending on institutional care that year.

Figure III.1. Percentage of Long-Term Care Expenditures Accounted for by Home and Community-Based Services by MFP Status in 2007, 2005—2011



Source: Truven Health Analytics (Eiken et al. 2013).

Note: Non-MFP states included Alabama, Alaska, Arizona Colorado, Florida, Idaho, Maine, Massachusetts, Mississippi, Minnesota, Montana, Nevada, New Mexico, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wyoming. MFP states included Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Virginia, Washington, and Wisconsin.

The MFP program allows states to accumulate "rebalancing funds" from the net revenues derived from an enhanced (extra) Federal medical assistance percentage (FMAP) states receive when they provide community-based long-term services and supports (LTSS) to MFP participants. States are required to use these funds to restructure long-term care systems so that community-based LTSS are more accessible. However, states do not start accumulating these funds until their MFP transition program is up and running. In addition, accumulating funds may take time if a state starts its MFP program slowly to build infrastructure and experience.

At the time of this report, 16 MFP states had also opted to establish a Balancing Incentive Program that also provides an enhanced FMAP for all Medicaid-financed HCBS. Like the MFP program, the funds from the enhanced federal match must be invested in state long-term care systems to help make HCBS more accessible. Unlike the MFP national demonstration, a state can begin accumulating "rebalancing funds" as soon as CMS has approved its application for the Balancing Incentive Program. Once approved, a state can begin claiming for the enhanced FMAP under the Balancing Incentive Program for the HCBS provided through September 2015.

This chapter reports on the progress states are making to rebalance their long-term care systems. In summary, we find that:

- MFP rebalancing programs were still in their initial phase in 2011, the most recent period for which we had information. By the end of 2011, 30 MFP states had accumulated nearly $142.9 million in MFP rebalancing funds and had spent a little more than 44 percent of those funds in the same time period.
- States are spending their rebalancing funds on a range of initiatives. Categories of rebalancing initiatives include helping people access HCBS, financing the provision of HCBS, expanding the size of their 1915(c) waiver programs, supporting providers, strategic planning and research, and improving information systems.
- At the time of this report, 16 states were participating in both the MFP national demonstration and the Balancing Incentive Program. Based on a review of program applications and work plans, these states are using resources from the latter to bring rebalancing initiatives to the next level by building upon the infrastructure, innovations, and systems initiatives they started under MFP.
- The overall trend in the HCBS share of long-term care expenditures increased among MFP states after the implementation of the program, but not until the third year of the program (calendar year 2010). This increase was primarily driven by increased HCBS expenditures and users among those with intellectual and developmental disabilities and established long-term care users who had been using long-term care services for a year or more.

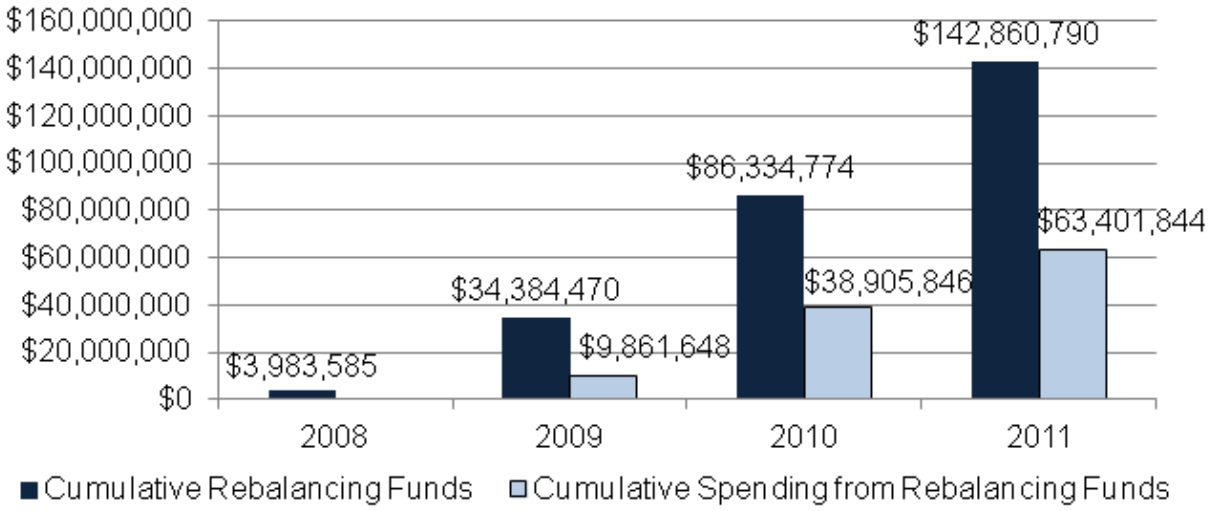
Below we describe the states accumulation of MFP rebalancing funds and how they are coordinating their MFP rebalancing initiatives with funding from the Balancing Incentive Program among the states participating in both grant programs. We also present our first analyses of whether the trend in the proportion of long-term care expenditures accounted for by HCBS shifted after the MFP national demonstration began. Future reports will assess these trends for later years of the evaluation and exploit the variation between states that were early implementers of MFP and those that implemented the program in later years.

A. State Use of MFP Rebalancing Funds

MFP states receive an enhanced FMAP rate for all qualified and demonstration HCBS provided to MFP participants. These enhanced payments make up each state's rebalancing fund and, by statute, CMS requires that the rebalancing funds be used to make HCBS more accessible.

As the data in Figure III.2 indicate, states have been slowly accumulating rebalancing funds, growing from nearly $4 million by the end of calendar year 2008 to nearly $142.9 million across 30 states by the end of calendar year 2011. States have only begun spending these funds. By the end of 2011, states had spent a little more than $63.4 million, or about 44 percent of what they had accrued by that time. However, the spending of rebalancing funds is most likely higher than these estimates suggest, because several states have not been able to report their spending of rebalancing funds (Delaware, Kansas, Louisiana, North Carolina, and North Dakota) or have inconsistently reported their rebalancing fund spending (Arkansas, California, Delaware, Hawaii, New Hampshire, and Wisconsin).

Figure III.2. Cumulative Rebalancing Funds and Expenditures of State Rebalancing Funds, December 2009—December 2011



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, June 2010—2012 and the 2012 state budget worksheets.

Relative to overall spending on long-term care services in general and HCBS in particular, the MFP rebalancing funds are small, but they can be important to shifting long-term care systems when used judiciously as the evidence presented in Section C below suggests. Total Medicaid long-term care expenditures across these 30 states grew from $95 billion in 2008 to nearly $108 billion in 2011 while their HCBS expenditures grew from approximately $39 billion to $50 billion during the same time period (Eiken et al. 2013). By 2011, the accumulated MFP rebalancing funds represented less than one percent of total Medicaid expenditures for non-institutional LTSS expenditures that the 30 MFP states incurred that year.

Types of Rebalancing Initiatives. In 2010 and 2011 grantees reported a range of rebalancing initiatives. These activities can be broadly classified as follows:

- Improving Pathways to HCBS
    - Outreach and education (7 states)
    - Assessment tools and processes (6 states)
    - Non-MFP transitions (3 states)
    - Teaching self-advocacy (1 state)
- Financing the Provision of Services
    - Transition services (6 states)
    - Full range of HCBS (14 states)
    - Housing Supports (7 states)
- Expanding and Supporting 1915(c) Waiver Programs (9 states)
- Supporting Providers
    - Workforce initiatives (4 states)
    - Trainings for state staff, providers, and communities (4 states)
    - Provider incentives and rate setting (2 states)
    - Facility closures and right sizing (3 states)
- Investing in Strategic Planning and Research (8 states)
- Improving Information Technology Systems (3 states)

Examples of these types of spending include the following:

- Improving Pathways to HCBS. Indiana, Maryland, New York, Texas, and Wisconsin are using their rebalancing funds to help educate residents of nursing homes and ICFs-ID about community living options. Maryland's initiative in this area focuses on the development of a peer-to-peer education program for people with ID. California, Connecticut, and Washington are using these funds to help others who want to transition but do not qualify for the MFP demonstration.
- Financing the Provision of Services. Several states report using their rebalancing funds to maintain the funding of HCBS as state budgets tighten during the recent economic recession. In some states, such as Indiana and the District of Columbia, these funds have been used to finance the full array of HCBS. In other states, the spending is more focused on select services. New York is using some of its rebalancing funds to finance an equipment loan program, whereas Kansas and North Dakota are providing funds (as much as $2,500 per person) to help cover some of the initial expenses associated with establishing a new home (security deposit, linens, home modifications, or adaptive equipment).

- Supporting Providers: A number of states are using their MFP rebalancing funds to support workforce initiatives, such as conducting research to better understand the state's workforce capacity for community-based long-term care (Ohio); developing trainings for state staff, providers, and communities, such as Texas' initiative to train at least 600 people in 10 communities on person-centered care for people with intellectual disabilities; examining methodologies used for nursing facility rate setting and case mix adjustments (Indiana); or covering some of the costs associated with closing a facility, as in Maryland, North Carolina, and Texas are doing.

B. Working Together: MFP and the Balancing Incentive Program

At the time of this report, 16 MFP states had also received a grant award from the Balancing Incentive Program. This program was established by the Affordable Care Act of 2010 and, like the MFP program, has a goal of rebalancing state LTSS systems toward community-based care. The Balancing Incentive Program provides a 2 percent enhanced FMAP on all HCBS the Medicaid program provides, with the exception of Mississippi which is eligible for a 5 percent enhanced FMAP, and the state begins receiving the enhanced match immediately after approval of its application. The requirements of the two programs differ in other important ways as well:

1. Although both programs require states to invest their rebalancing funds in their long-term care systems, MFP does not have a specific rebalancing goal that states need to achieve. The Balancing Incentive Program expects states to insure HCBS accounts for at least 25 or 50 percent of total long-term care expenditures depending on whether the state was below or above the 25 percent goal before it received its grant. This broad rebalancing goal must be achieved by September 30, 2015.
2. States have few specific requirements for how they spend their MFP rebalancing funds, as long as they are spending to enhance the state's long-term care system and make HCBS more accessible. The Balancing Incentive Program, on the other hand, requires that states spend the funds on new or expanded LTSS and that they implement three structural changes:
   - A core standardized assessment (CSA) process to collect a standard set of functional assessment data on all individuals applying for HCBS
   - A No Wrong Door/Single Entry Point (NWD/SEP) approach for the LTSS system that ensures statewide access to comprehensive and timely information about community living options and provides timely eligibility determination and enrollment into community-based services
   - Conflict-free case management (CFCM) procedures in the development of service plans.

As of March 2013, 13 states were participating in Balancing Incentive Program and 3 more were awarded grants in June 2013. All 16 states also participate in MFP[12] (Table III.1). Together, these states have been awarded approximately $1.2 billion in funding. This section of the report explores how states participating in both programs are layering Balancing Incentive Program initiatives upon work that began under MFP to achieve the shared goal of rebalancing.

Table III.1. States Participating in the Balancing Incentive Program as of August 2013

Arkansas	Maryland
Connecticut	Mississippi
Georgia	Missouri
Indiana	New Hampshire
Illinois	New Jersey
Iowa	New York
Louisiana	Ohio
Maine	Texas

Source: http://www.medicaid.gov/.

1. Building on MFP Services, Systems, and Innovations

The states participating in the Balancing Incentive Program are building upon infrastructure, systems, and innovations initiated by their MFP programs to support the broad goal of system rebalancing. Examples of these types of initiatives range from expansion of pilot programs started under MFP to the broader statewide population; strengthening existing MFP programs; expanding MFP to include new populations; and using the experience and knowledge of MFP staff in Balancing Incentive Program design and implementation. Below we describe examples of these types of activities.

Strengthening the Section Q Referral Process. As part of the development of the NWD/SEP system, Missouri is attempting to strengthen the link between the MDS Section Q referral process and its state MFP program. Revisions to the nursing home resident assessment (MDS 3.0 Section Q), which went into effect in October 2010, require residents to be asked directly whether they want to speak with someone about moving back to the community. Section Q was expected to lead to large increases in the number of individuals referred to MFP and

[12] As of March 27, 2013, 13 approved Balancing Incentive Program applications and six work plans had been posted on Medicaid.gov. We received an additional two work plans from CMS' contractor Mission Analytics Group.

transitioning out of facilities. Missouri's MFP program has seen fewer referrals than anticipated as a result of Section Q[13]. As part of the development of its NWD/SEP system, the Missouri MFP program is contracting with state Centers for Independent Living to provide training to nursing facilities, potential MFP participants and guardians, public administrators, and the judicial system on available community living options for individuals identified though Section Q. The state hopes that this education will lead to more referrals to the MFP program, more transitions overall, and broader awareness of the range of community living options available in the state.

Expanding Outreach Strategies Developed under MFP. To develop an effective NWD/SEP system, individuals and potential referring agencies such as nursing homes, hospitals, and community-based organizations must be aware of various entry points into to the NWD/SEP system (for example, ADRCs, toll-free numbers, and websites) where they can obtain information on community supports and services. Therefore, one required component of NWD/SEP system development is an advertising plan to raise awareness among potential referring partners and consumers. Under MFP, Georgia's State Medicaid Agency has developed an outreach plan for the MFP program; it will be expanded under the Balancing Incentive Program to persons interested in LTSS regardless of institutional status as part of the Balancing Incentive Program NWD/SEP advertising plan.

Expansion of Services and Systems Developed under MFP to Broader State Population. In New York, the Balancing Incentive Program will make a broader range of people aware of available services developed under MFP. Examples include the NY TRIAD demonstration, which lends assistive devices and durable medical equipment to transitioning individuals until the waiver in which they are participating can provide these items, and the web-based registry of accessible rental properties searchable by location, income, age and/or disability. New York's Balancing Incentive Program will also expand MFP-created peer counseling and support services that link individuals living in institutions with individuals who have successfully transitioned to community settings and will extend outreach, education, and the initiation of the MFP process of assisted HCBS waiver enrollment for people in all types of institutional settings, regardless of MFP eligibility.

Cross-Use of Program Staff to Inform Design and Implementation of the Balancing Incentive Program. Realizing the need to coordinate across the two complementary programs, many states are implementing the cross use of staff from both MFP and the Balancing Incentive Program. For example, Iowa's MFP rebalancing workgroup provided feedback on the design of the state's Balancing Incentive Program, the level-one functional and financial screen, suggested metrics for program evaluation. Texas's MFP Demonstration Advisory Committee will be the primary committee to solicit stakeholder involvement for the Texas Balancing Incentive Program and to ensure both programs are leveraged and integrated. The MFP Project Director in Connecticut plays a lead role in designing and implementing Connecticut's Balancing Incentive Program across a number of key components of the program.

[13] Information was abstracted from Missouri's semiannual progress reports for 2012.

Expanding Populations Covered under MFP. Two states plan to use funds from their Balancing Incentive Programs to expand the MFP program to include new populations. Indiana will expand MFP to include children and adolescents with serious mental illness and New York will add individuals with intellectual and developmental disabilities.

2. Braiding MFP and Balancing Incentive Program Resources

States are leveraging both MFP rebalancing and administrative dollars to finance rebalancing initiatives and to implement the structural changes required by the Balancing Incentive Program. Upon program award, states participating in Balancing Incentive Program begin receiving an increased federal medical assistance percentage (+2 percentage points for most states) on all community-based LTSS provided statewide. The increased match must be used only to provide new or expanded home and community-based LTSS. MFP rebalancing funds provide a natural source of support for the initial costs of the structural changes required under the Balancing Incentive Program, and many states participating in the Balancing Incentive Program intend to use MFP funds for this purpose.

Iowa, Arkansas, and Maryland report using MFP funds for the development of assessment tools, training on use of these tools, or implementation of tools statewide to meet the core standardized assessment requirements of the Balancing Incentive Program. In their applications to the Balancing Incentive Program, eight states made general statements about using funds to support the initial costs of implementing the three required structural changes (Connecticut, Maryland, Mississippi, Missouri, New Hampshire, Texas, Louisiana, and New York). Other planned uses of MFP funds include: expanding the MFP program to new populations (Indiana); supporting options counseling, transition coordination, and a nursing home diversion training curriculum (Missouri); and increasing housing capacity and related supports and services (New York).

3. Creative Rebalancing Efforts: Connecticut and Mississippi

Mississippi and Connecticut provide two examples of states that are implementing innovative rebalancing strategies drawing on resources from both the MFP and the Balancing Incentive Programs to achieve rebalancing.

Connecticut. Connecticut has a well-established and strong MFP program. The state was one of the original 30 MFP grantees. In 2012, Connecticut began implementing a long-planned expansion of the MFP program, under which annual transitions increased from 384 in 2011 to 988 in 2012. The state is involved in a multifaceted rebalancing initiative, of which MFP has been a key component. Connecticut used MFP dollars to fund a strategic rebalancing plan that provided town-level supply and demand projections for community and institutional LTSS over the coming years. It also identified service gaps to meet projected demand at the town level. Connecticut has used this report to initiate conversations with the nursing home industry leaders and engage them in “right sizing” efforts that include reducing facility beds and transitioning beds to assisted living environments, as well as training facility staff to become community providers. Right sizing work will contribute to the required rebalancing of the LTSS system and Medicaid expenditures as required under the Balancing Incentive Program. The state is about to begin the second edition of this rebalancing plan, which will incorporate supply and demand projections for transportation and housing and will thus assist the state in identifying and planning to address service gaps in these areas as well.

Under MFP Connecticut has implemented a number of innovations that support both MFP and Balancing Incentive Program goals. The state developed an expedited system for eligibility and enrollment into MFP. Under the Balancing Incentive Program, Connecticut plans to build on the enhanced communication model used by this system, expanding it statewide so that all individuals benefit from the expedited process. Connecticut also used MFP funds to develop a core data set, which comprises of a core set of questions assessing functional status of everyone potentially eligible for LTSS, regardless of their entry point into the system. As part of this process, the state also developed a short self-assessment pre-screening assessment for functional and financial eligibility. Individuals will be able to complete this assessment online, submit it, and receive an automated referral to the appropriate waivers for which they may be eligible. This system provides one of the key "doors" into the state's NWD/SEP system. The state is using MFP participants and staff to pilot test the system before statewide rollout.[14] The prescreening assessment is part of the broader ConneCT system, a web-based platform that will facilitate enrollment into both the state health insurance exchange, and referrals and enrollment into the LTSS system. Connecticut developed the system using the enhanced 90 percent FMAP available for improvements to MMIS enrollment and eligibility systems.

Mississippi. Mississippi is a newer MFP state that began transitioning individuals as recently as March of 2012. By the end of 2012, the state had transitioned only 66 individuals. Although Mississippi is still developing its MFP program, the state is finding creative ways to use both Balancing Incentive Program and MFP rebalancing funds to make great strides with its long-term care system.

In its Balancing Incentive Program application, Mississippi cited its plans for a more "holistic" approach to rebalancing, diversion, and transitions, combining MFP's transition efforts with policies and procedures that prevent unnecessary institutionalization in the first place. One way the state is achieving its goals is by using funds generated by the enhanced FMAP received on all HCBS through the Balancing Incentive Program to fund new waiver slots.[15] MFP participants have guaranteed waiver slots, but the waiver programs in Mississippi have had a history of long waiting lists for individuals residing in the community. The state had begun to worry that people would enter facilities just to get transitioned out and get into services through MFP. Now, using Balancing Incentive Program funds, Mississippi plans to transition 300 community-dwelling individuals currently on a waiting list for HCBS into services in the quarter between March and June 2013.

Under the Balancing Incentive Program, Mississippi will develop a common Pre-Admission and Screening Resident Review (PASRR) tool. The new tool will be used to assess all individuals interested in LTSS regardless of who is administering the tool. Staff will be trained

[14] Data based on the state's Balancing Incentive Program application, as well as an interview with the MFP project director.

[15] Data based on the state's Balancing Incentive Program application, as well as an interview with the MFP project director.

on all available LTSS options, both community and institutional. The new procedure should lead more individuals to find out about community LTSS options and thus lower nursing home admissions in the first place.

Also using Balancing Incentive Program funds, the state recently implemented a new data system that allows access to real-time assessment data on individuals with ID/DD who have recently entered facilities. Using this system, the state can target recently admitted individuals with minimal care needs who might be good community-living candidates. The state then contacts these individuals in an attempt to transition them back to the community before they lose important community supports and connections, or sell their homes.

Currently, the main barrier to transitions under MFP is a shortage of affordable and accessible housing. The state is considering using MFP rebalancing funds to address this shortage. MFP funds may be used to pay for housing-related expenditures, but Balancing Incentive Program funds may not.

C. Trends in the Balance of State Long-Term Care Spending and Utilization—A State-Level Claims Analysis from 2005—2010

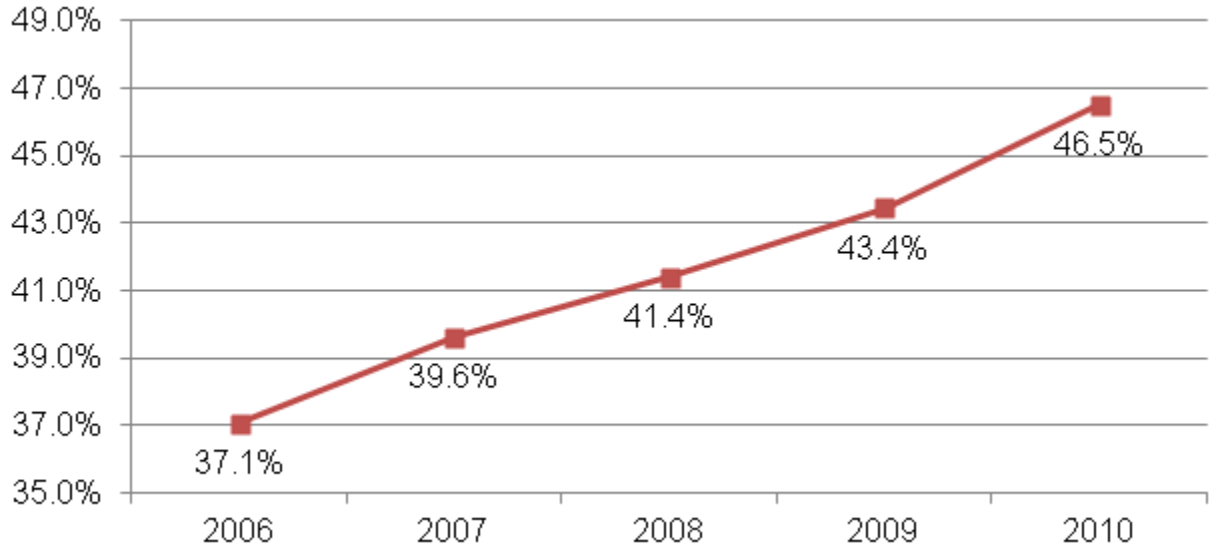
It is important to consider whether all the efforts described above have resulted in measurable shifts in the balance of LTSS systems during the first few years of MFP. However, assessing program effects at the state level is not straightforward, because the contributions of MFP and the Balancing Incentive Program could be confounded by other efforts states may have made to balance their systems before the national MFP demonstration began or other secular trends related to the economy or by simple aging of the population. As Figure III.1 indicates, states were already in the process of rebalancing their systems before MFP was implemented in 2008—although MFP and then the Balancing Incentive program would be expected to aid these efforts.

1. The Balance of Long-Term Care Expenditures After MFP

From 2006 through 2010, the HCBS share of LTC expenditures in these 30 states rose from about 37 percent to 47 percent (Figure III.3). As noted before, the HCBS share was increasing even prior to MFP, reflective of states' earlier efforts at rebalancing their systems. Thus, any changes in the balance of state systems after 2008 cannot be fully attributed to MFP.

The unadjusted trend in the proportion of long-term care expenditures accounted for by HCBS shows a marked increase as early as 2010. This shift may indicate a delayed effect of MFP on LTC expenditures, which reflects the delays inherent in how MFP programs accumulate their rebalancing funds. MFP programs must first transition people before they can accumulate and spend funds.

Figure III.3. Trend in HCBS Share of LTC Expenditures Among MFP Grantees, 2006—2010 (unadjusted)



Source: Truven Health Analytics (Eiken et al. 2013).

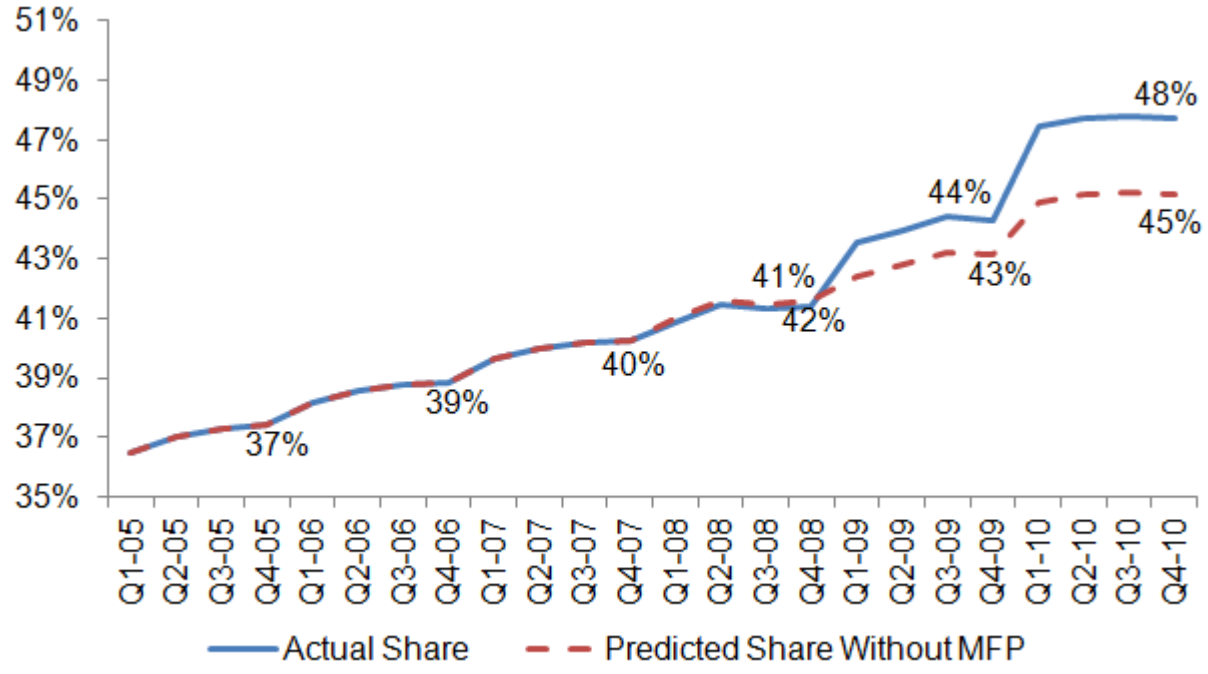
Note: Analysis includes the 30 states that received MFP grants in 2007.

2. MFP's Association with the HCBS Share of LTC Expenditures and Users

Although the unadjusted data may suggest that the trend in the HCBS share of long-term care expenditures may have shifted as early as 2010, the results are somewhat different when we adjust and control for other factors that affect long-term care expenditures. When we controlled for population demographics (such as age and gender), the pre-MFP trend in long-term care expenditures, and fixed state characteristics in a regression framework, we find that the post-MFP trend (calendar year 2008 and later) in HCBS expenditures was not statistically significantly different from the pre-MFP trend (before 2008) until 2010 (Figure III.4).[16] Starting in 2010, MFP is associated with a statistically significant 2.5 percentage point increase in the HCBS share of expenditures. In other words, the 2010 HCBS share of total LTSS spending in the 30 grantee states was 2.5 percentage points higher than what it would have been without MFP.

[16] All figures and analyses in this section are based on data from the Medicaid Analytic eXtract (MAX) data system. The use of individual records enabled us to analyze effects at the user level as well as at a finer time frequency than data abstracted from state aggregate reports, such as reports by Truven Health Analytics (Eiken et al. 2013). As a result, data in this section may differ from other published statistics. Notably, MAX data do not capture services billed in bulk because they cannot be linked to specific beneficiaries, and our statistics do not include services provided by managed care organizations.

Figure III.4. Trends in the HCBS Share of LTC Expenditures With and Without MFP, 2005—2010 (regression adjusted)



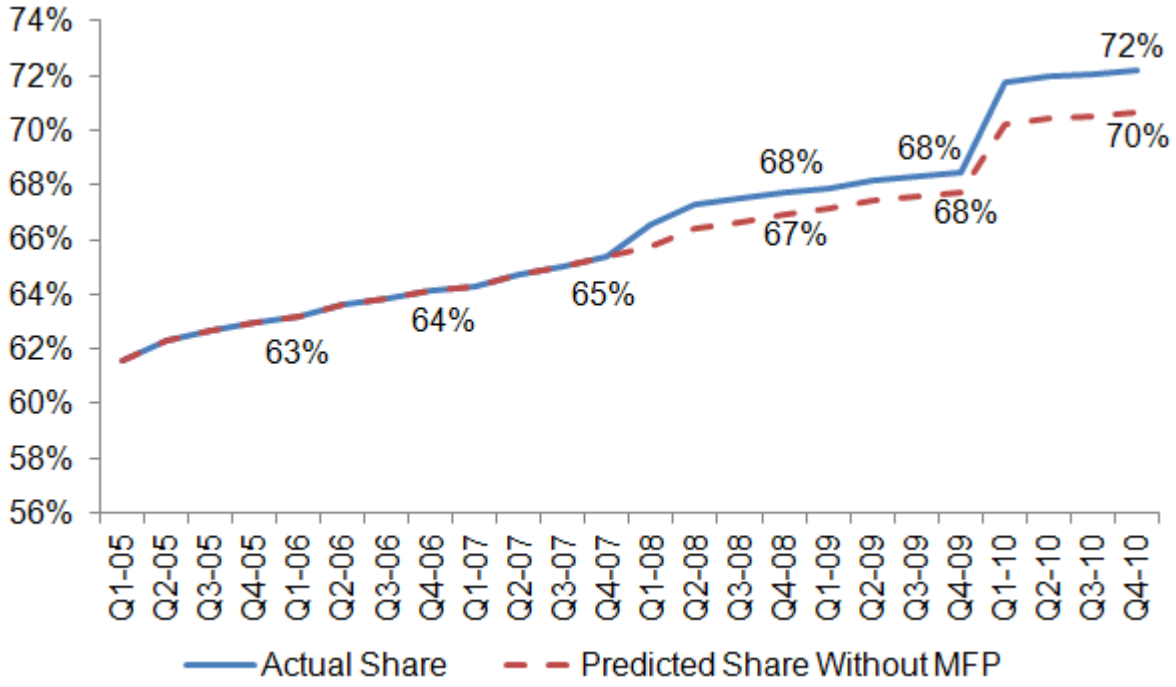
Source: Mathematica Analysis of 2005—2010 MAX data for 30 states.

Note: The analysis is based on 2,004 state-month observations of the HCBS share of long-term care expenditures.

These results suggest that MFP's influence on the balance of state long-term care systems was not immediate, but its influence increased over time as states developed or expanded their MFP programs. They are also consistent with our expectation of a lagged effect of the rebalancing funds on the overall trend in long-term care expenditures, given that states were still in the initial stages of accumulating MFP rebalancing funds in 2008 and 2009, and had not spent them to a large extent until 2010.

We also analyzed the trend in the proportion of long-term care users who received HCBS, to investigate how this measure of long-term care systems changed after states began implementing their MFP programs. We found similar results and beginning in 2010 we detected a statistically significant but weaker increase in the trend of HCBS users as a proportion of all long-term care users (Figure III.5). In this case the association was weaker because the absolute increase was smaller at 1.5 percentage points. These results highlight an important point: because institutional services are more expensive, a change in the percentage of HCBS users is likely to lead to a disproportionately larger change in HCBS expenditures. The estimates suggest that for a 1.5 percentage point increase in the proportion of long-term care users receiving HCBS, the states spending on HCBS relative to overall long-term care expenditures increased by 2.5 percentage points.

Figure III.5. Trends in the HCBS Share of LTC Users With and Without MFP, 2005—2010 (regression adjusted)



Source: Mathematica Analysis of 2005—2010 MAX data for 30 states.

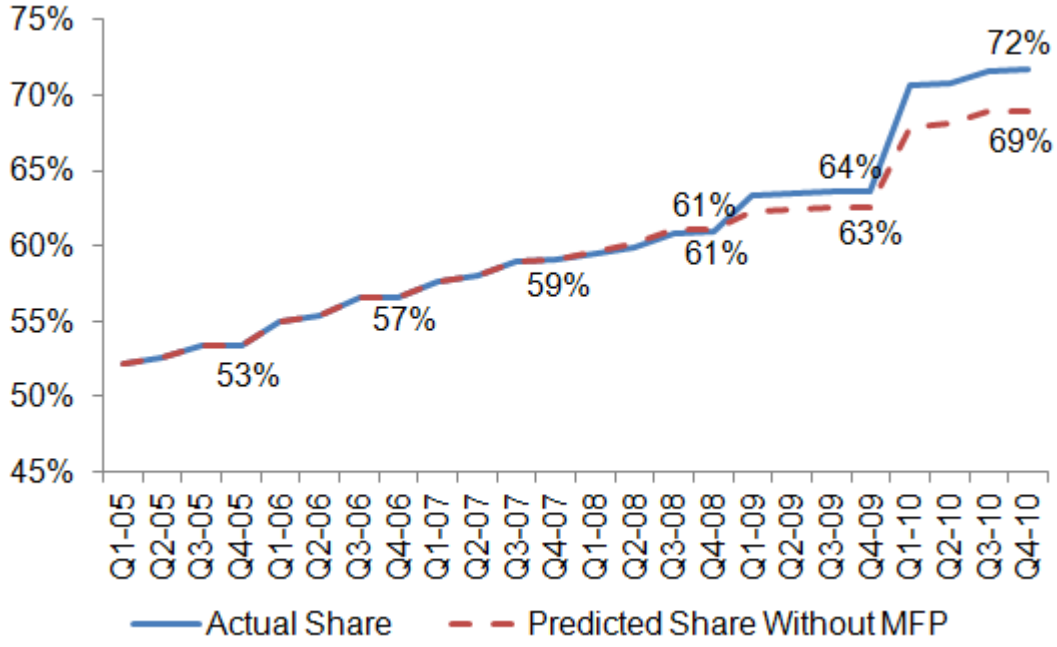
Note: The analysis is based on 2,004 state-month observations of the HCBS share of long-term care expenditures.

3. Subgroup Analyses

a. Target Population

We estimated MFP's association with the balance of HCBS expenditures separately for different population subgroups—elderly, nonelderly with physical disabilities, individuals with intellectual and developmental disabilities, and individuals with mental illness. The increase in the trend of HCBS expenditures as a proportion of total LTC expenditures was most pronounced among individuals with intellectual and developmental disabilities. Specifically, by 2010, the HCBS share of LTC expenditures among this population was 2.7 percentage points higher than it would have been if MFP had not been implemented. This result is consistent with Irvin et al. (2012) who found that MFP was associated with increased transitions among this population beginning with the first year of implementation (2008). Similar but far weaker and statistically insignificant evidence exists among the elderly and individuals with mental illness. Among the nonelderly with physical disabilities, we found no evidence of an association between MFP and the trend of HCBS expenditures as a proportion of total LTC expenditures.

Figure III.6. Trends in HCBS Share of LTC Expenditures for Individuals with Intellectual and Developmental Disabilities With and Without MFP, 2005—2010 (regression adjusted)



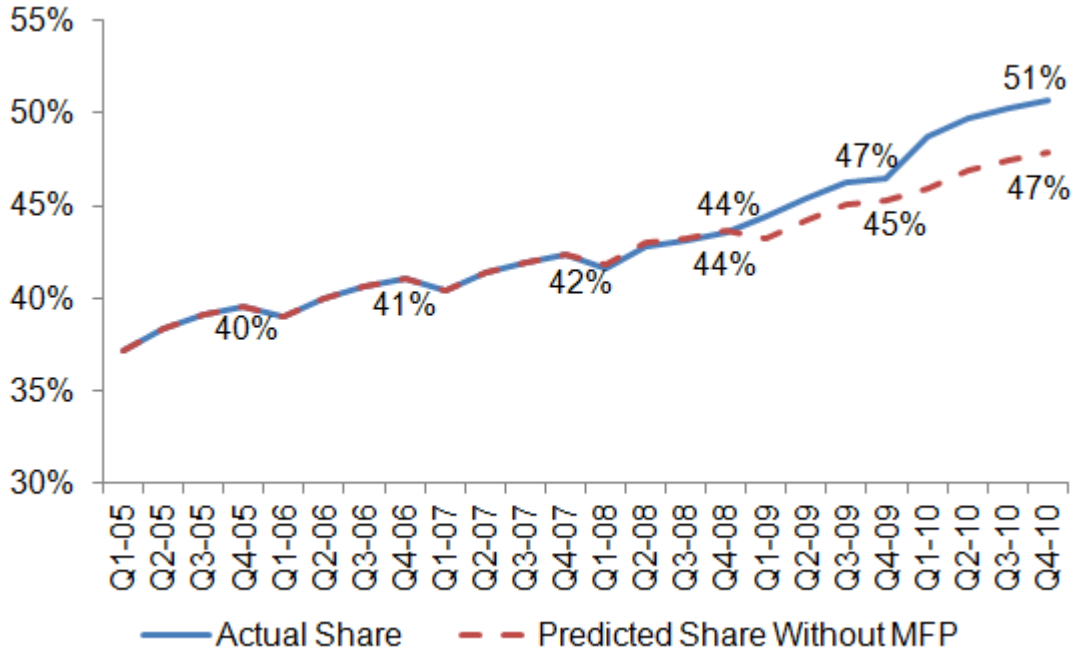
Source: Mathematica Analysis of 2005—2010 MAX data for 30 states.

Note: The analysis is based on 2,004 state-month observations of the HCBS share of long-term care expenditures.

b. New versus Established Users

We also looked separately at users who were new to long-term care and had not used these types of services in the previous calendar year (new users), and users who had been using long-term care services for at least a year or more (established users). This break down of the long-term care population is useful, because MFP may have differential effects on these two groups. MFP should have fewer direct effects on new users, given the eligibility requirement that beneficiaries reside in an institution for a minimum period of time (six months, prior to the Affordable Care Act; 90 days, following its passage) to be eligible for the MFP transition program. Thus, the primary effect on new users is likely to reflect MFP's overall influence on states' LTSS systems and general improvements in access to HCBS. For established users, particularly those in institutional care, MFP may have a more direct and immediate effect on their care relative to new users. MFP's association with the increasing HCBS share of total LTC expenditures was driven primarily by established users. This finding indicates that the influence of MFP during its early years was primarily through the MFP transition program and points to how the rebalancing program affected access to HCBS for those who had been in long-term care for a year or more. MFP's lack of effects on people new to long-term care services, at least in the first years of the program, suggest that it may take time for states to change their systems so that HCBS is more accessible to those entering long-term care for the first time.

Figure III.7. Trends in HCBS Share of LTC Expenditures for Established LTC Users With and Without MFP, 2005—2010 (regression adjusted)



Source: Mathematica Analysis of 2005—2010 MAX data for 30 states.

Note: The analysis is based on 2,004 state-month observations of the HCBS share of long-term care expenditures.

4. Robustness of Results

Trend analyses present important challenges because of other events that may be occurring at the same time as MFP, such as the downturn in the economy or an aging population. Although we attempted to control for such factors, we could not capture every factor that might contribute to increasing HCBS expenditures and users relative to institutional care. We verified the robustness of these results in several ways.

Robustness to the Sample of States. We determined the sensitivity of our results to the inclusion and exclusion of particular states. One such state was Texas, which had a state MFP program before the national program was implemented. Our main findings are robust to the sample of states, which means that we could not identify a state or group of states driving the results. When we conducted a separate assessment of Texas, we found a substantial positive association between MFP and HCBS expenditures as a proportion of LTC expenditures in that state as early as 2008. This finding is consistent with Texas' history of having an MFP program before the national demonstration began. Texas was well prepared to expend its program in 2008.

Robustness to Timing of Implementation. As noted elsewhere, the MFP program was relatively small in 2008, and some states awarded an MFP grant in 2007 did not begin transitioning people until 2009. However, when we reclassified 2008 as a pre-MFP year, the results for 2009 and 2010 changed little from the main results.

Robustness to the Measurement of MFP Intensity. As a proxy for MFP intensity, we measured the number of MFP participants per user of long-term care services for each state and each year. We used this variable instead of the indicators for the post MFP years. We found that each additional MFP participant per thousand LTC users is associated with a statistically significant 0.9 percentage point increase in the HCBS share of LTC expenditures (for reference, the average 2010 value for this variable across grantee states was 1.2 MFP participants per thousand LTC users). Essentially, states where MFP participants accounted for a larger share of the population of long-term care users tended to have higher HCBS shares of LTC expenditures.

Robustness to Using Nongrantee States as a Control Group. An alternative methodology is to use nongrantee states as a control group. This methodology has the benefit of allowing us to control for systematic factors other than MFP that might have influenced the balance of grantee's LTC systems, particularly post-MFP. The underlying assumption behind this approach is that trends in differences between grantee and nongrantee states would be unchanged if MFP had never been implemented. When using this approach we again found no change in the trend of expenditures during 2008 and 2009, but a statistically significant increase in the trend in 2010. Specifically, by 2010, the HCBS percentage in grantee states was estimated to be 3.9 percentage points higher than what it would have been in the absence of MFP. Moreover, there is a positive but slightly lower and statistically insignificant change in the proportion of long-term care users receiving HCBS.

Although the differences-in-differences approach was appealing because of the potential to control for more factors, the methodology is sensitive to the nongrantee trend in HCBS share. Because we found inconsistencies in the nongrantee trend between the Medicaid data we used in these analyses and the data reported by Truven Health (Eiken et al. 2013), we ultimately decided to move forward with the trend analysis over the differences-in-differences approach. Nevertheless, the robustness of the findings across the two methodologies and the other robustness checks suggest that the expenditure changes that we attribute to MFP were not spurious.

5. Discussion

Several limitations of this study merit discussion. The most serious methodological consideration is the lack of a credible comparison group. This analysis developed inferences about the effects of MFP by comparing projected pre-MFP trends to actual experience during the MFP period. It is evident that other changes could have occurred between the pre- and post-MFP years that would have shifted in the balance of state LTC systems even in the absence of MFP (such as court cases that required states to downsize or close facilities for people with intellectual disabilities). Notably, the differences-in-differences analysis, which used nongrantee states as a control group to account for these confounding factors, produced consistent findings and lends credibility to the results from the trend analysis.

Our analysis was limited to the first three years after the implementation of the national MFP demonstration, but for the third year we had data available for only 17 of the 30 states that received MFP grants in 2007. Thus, we were unable to evaluate the long- or even medium-term effects of MFP on state LTC expenditure patterns. This limitation is particularly important as many states have needed time to develop mature programs and to transition targeted populations. More generally, the influence of MFP may be enhanced or attenuated (or varied) as states fain

experience and improve upon their interventions or as demographic or state priorities evolve over time.

The analysis focused on high-level effects of MFP on the balance of state LTC systems and did not address which specific interventions, such as the various rebalancing initiatives described earlier, may have been more effective at shifting the balance toward HCBS. The difficulty of identifying the subgroups most likely to be affected by specific interventions makes this type of approach extremely difficult and time consuming. Related is the exclusion of beneficiaries in managed LTSS programs. Additional research exploring these mechanisms, including managed LTSS, will be important for improving the effectiveness and financial sustainability of the program, for both established and new MFP states.

These limitations suggest the importance of assessing our main findings in conjunction with the robustness checks. We find that MFP has had a delayed influence on the balance of long-term care expenditures. By the third year of implementation, HCBS was accounting for a larger share of LTC expenditures than would have been the case in the absence of MFP. To find an increasing trend in expenditures flowing to community-based services this early most likely reflects some effect of the MFP program, as well as other changes that were happening at the state level, because the analysis could not completely control for secular trends (such as an aging population) that put upward pressure on HCBS spending. In the third year of the demonstration, the program experienced considerable growth when the total number of transitions more than doubled, but spending from rebalancing funds had just begun in most states (Denny-Brown et al. 2011; Irvin et al. 2011). The gain detected in 2010 should be sustained in the ensuing years as the investment from MFP, and now the Balancing Incentive Program, become larger and extend their reach. HCBS expenditures should further accelerate as states expand their MFP rebalancing initiatives and fully implement their Balancing Incentive Program work plans.

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IV. SELECT TOPICS IN IMPLEMENTATION

How a grantee implements its MFP program has important implications for its ultimate success. In this chapter, we explore four selected implementation topics that have been the focus of considerable technical assistance to the grantees and recent policy development: (1) the interplay between MFP and managed long-term services and supports (MLTSS), (2) how states are addressing the challenge presented by the lack of affordable and accessible housing, (3) how states are improving the supply, stability, and skills of direct service workers, and (4) the extent to which MFP programs are providing employment supports.

A. MFP and Managed Long-Term Services and Supports

A small number of states have had both MFP and MLTSS since the inception of MFP, but a few have introduced MLTSS programs after the implementation of MFP. To ensure that MFP and MLTSS programs support and complement each other to achieve system rebalancing, state Medicaid programs need to:

- Ensure MFP and MLTSS program managers work closely together to develop policies, plans, and procedures for transitioning MLTSS members between service settings
- Specify the roles of the MFP and MLTSS programs for providing transition assistance to overlapping target groups and clear lines of responsibility to ensure service transitions are as smooth as possible
- Design payment methods that promote transitions and MFP goals
- Modify the reporting requirements of health plans to meet federal MFP quality monitoring and reporting needs
- Take advantage of MFP program resources to improve monitoring of care quality, provide bonuses for MFP transitions, and train health plan staff on how to deal with more challenging transitions

1. Introduction

Over the past decade, a growing number of states have expanded their Medicaid managed care programs to include long-term services and supports (LTSS). As of April 2013, 20 states had Medicaid MLTSS arrangements, more than double the number in 2004 (NASUAD 2013; Saucier et al. 2012). The increase can be attributed to several factors. In the search for cost savings, states have begun to require managed care enrollment among high-cost populations—including older adults and people with disabilities who were often excluded from these programs in the past. Because complex populations are more likely to use LTSS, states generally believe that holding plans at risk for the entire continuum of care—acute, primary, behavioral, and LTSS—will promote more coordinated, and less costly care. In addition, states participating in the Demonstration to Integrate Care for Medicare-Medicaid Enrollees are adding LTSS to the

benefit package managed by plans to encourage them to coordinate the full array of services required by beneficiaries eligible for both Medicare and Medicaid, under a capitated or a managed fee-for-service payment model. As of this report, seven states had approved Medicare-Medicaid demonstrations and about a dozen more were pursuing demonstrations.[17]

As more Medicaid programs operate both MLTSS and MFP programs, it is important to examine how they work together to achieve the goal of shifting the balance of LTSS from institutional care to home and community-based service (HCBS) settings. The two programs use different strategies to achieve this goal. As in traditional HCBS waiver programs paid on a fee-for-service basis, MLTSS programs are designed to maintain people in the community and prevent or shorten institutionalization stays. In states with HCBS waiver programs, MFP programs focus on transitioning people currently residing in institutions back into the community. But in states with MLTSS, responsibility for helping enrollees transition from institutions to the community may fall to MCOs, creating opportunities for MFP and MLTSS programs to interact as individuals move from institutional to community settings.

In recognition of the potential for the two programs to work in concert, CMS recently provided official guidance that sets clear expectations for states to take into account MFP and similar transition programs in the design of MLTSS programs (CMS 2013). The guidance noted that MFP can help states meet CMS' requirement that MLTSS programs develop policies, plans, and procedures to assist beneficiaries in making successful transitions between service settings. The guidance also explained that CMS expects states to integrate into their comprehensive quality strategy for managed care all relevant quality initiatives, including those related to MFP.

Several issues determine whether and how the two programs can complement each other, including the populations covered by each one, how contracted managed care organizations (MCOs) participating in MLTSS programs are paid to promote transitions from institutional care to HCBS; how MFP and MCO staff divide responsibility for transition planning; and how states track quality of care and MFP performance indicators for MFP participants enrolled in MLTSS plans. To understand how state MFP programs are addressing these issues, Mathematica studied how seven states have structured the MFP-MLTSS interface to offer lessons that can help other states design programs that maximize cooperation and minimize conflicts. Six of the seven states (Hawaii, Kansas, Massachusetts, Tennessee, Texas, and Wisconsin) allow MFP participants to enroll in MLTSS, and the seventh state (Michigan) is planning to convert an HCBS program that manages MFP transitions into a capitated payment model.[18]

[17] Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office, Financial Alignment Initiative, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

[18] Five of these states were reviewed in a previous study by Lipson and Stone Valenzano (2013).

2. Populations Covered by MFP and MLTSS

The eligibility rules and enrollment policies of MFP and MLTSS affect the extent to which Medicaid LTSS users may be served by one or both programs. When there eligible populations overlap, MFP and MLTSS programs must clearly define their roles and responsibilities in assessing the ability of people in institutions to return to the community, planning transitions, and monitoring post-transition progress. For example, State MFP programs often serve older adults, adults under age 65 with physical disabilities, and individuals with intellectual or developmental disabilities (ID/DD). MFP programs sometimes serve other populations as well, such as people with serious mental illness (SMI), children with disabilities, and people with traumatic brain injury (TBI). In contrast, MLTSS programs typically serve older adults and adults under 65 with physical disabilities; they less frequently serve people with ID/DD and SMI. Among the seven states examined for this study, the Massachusetts' MFP and MLTSS programs had only one of these populations in common; Kansas, Tennessee, and Texas had two populations in common; and Hawaii and Wisconsin had three populations in common across the MFP and MLTSS programs. Even so, some states may exclude coverage of HCBS for certain populations under the MLTSS program, potentially complicating coordination of care for people who transition. For instance, in Hawaii and Kansas, people with ID/DD are in comprehensive managed plans for their primary and acute care services, but their HCBS is a separate program provided on a fee-for-service basis. The state waiver agencies that provide their HCBS also oversee care coordination for people with ID/DD.

MLTSS enrollment policies can also determine whether someone living in an institution is eligible for transition assistance from MFP or MLTSS. In Hawaii, Kansas, and Tennessee, all Medicaid-eligible institutional residents must be enrolled in a MLTSS plan, so the MCO is responsible for identifying people who are candidates for transition, as well as MFP enrollment, and providing transition assistance. In Wisconsin, enrollment into MLTSS while residing in an institution is voluntary. However, in Wisconsin counties in which the MLTSS program Family Care operates, individuals residing in institutions who wish to return to the community must first enroll in Family Care, because transition assistance is available only through the state's MLTSS program. In Texas, people residing in institutions cannot be enrolled in an MLTSS plan until they return to the community. Therefore, MFP relocation agencies, under contract with the state take the lead role in identifying potential MFP participants ready to transition and providing the bulk of transition planning. Other factors that determine whether an individual living in an institution receives transition assistance from the MFP program or an MCO include service carve-outs, dual enrollment in Medicare and Medicaid, level-of-care requirements, and statewide versus regional coverage of both programs (see Lipson and Stone Valenzano [2013] for more detail).

3. Financial Incentives

Payment procedures for MLTSS plans can affect the extent to which MCOs transition people from institutions, enroll people in MFP, and use HCBS to keep people in community settings. Hawaii, Kansas, Tennessee, and Wisconsin set the LTSS portion of their capitation rate to represent a blend of average institutional care and HCBS costs, and assume a specified mix or ratio between the two. Because institutional care is more costly than HCBS, this blended rate gives MCOs a strong financial incentive to serve people in the community and help those who are admitted to institutions return to the community as quickly as possible. Other states, such as

Massachusetts, pay the MCO at a community HCBS rate for the first 90 days of an enrollee's institutional stay, after which, the MCO receives a higher institutional rate. To promote a speedy return to the community, Massachusetts then pays the MCO the higher institutional rate for the first 90 days after someone returns to the community. Though Texas has carved out institutional care from its MLTSS plans, which reduces the incentive for MCOs to avoid institutionalizations or promote transitions, MCOs are subject to financial penalties if they do not maintain or reduce nursing home occupancy rates from year to year.

These types of financial incentives can lead to shorter stays in institutions and longer time spent living in the community, although they do not necessarily lead to increased MFP enrollment and transition rates. To the extent that MCOs transition eligible members as soon as possible, there will be fewer people who meet MFP's minimum-stay eligibility requirement, which is 90 days not counting Medicare-financed rehabilitation days. Alternatively, if MCOs do not get increased payments for members who enroll in MFP, they may be less inclined to invest time in finding and enrolling members in the MFP program, especially if there are additional MFP-specific reporting and quality assurance requirements associated with MFP participants. For example, in Wisconsin, officials say MCOs that participate in the state's MLTSS program, Family Care, do not see the benefit of MFP because it creates more work for them, such as conducting MFP quality-of-life surveys, submitting extra reports, and tracking members' change in living situation, but offers no additional benefits to the MCO or its members. To counter this disincentive, Tennessee uses MFP grant funds to provide bonuses to MCOs for MFP enrollment, to help meet the state's MFP transition benchmarks, and for maintaining MFP participants in the community for a year after a transition. Kansas and Massachusetts take a different tack by offering MCO members that enroll in MFP access to additional funds for certain moving costs. Other states believe that the MLTSS capitation rate includes adequate compensation for transition services and therefore additional bonuses or services are not warranted.

4. Roles of MFP Transition Coordinators and MLTSS Care Managers

Each MFP and managed MLTSS program has to clearly define the roles and responsibilities of staff involved in identifying potential transitions, transition planning, and post-transition monitoring. Many of these decisions are influenced by the design of the MLTSS program and the overlap between populations. In Hawaii, Kansas, Tennessee, and Wisconsin, MLTSS care managers handle the entire transition planning process, establish care plans, arrange for all HCBS, and continue monitoring MFP participants' care after they have moved to the community. In some cases, states report that MLTSS care managers begin the transition planning process while enrollment of new members is pending even though they are not yet eligible for capitated payment, because the individual's care is likely to cost less if he or she is living in the community. In Texas, however, because the MLTSS program is not responsible for institutional care, nor are the MCOs paid to provide transition services as part of their capitated rate, transition responsibilities are divided between the MFP and MLTSS programs. MFP transition coordinators are responsible for identifying living and household needs, locating housing, arranging transportation services, and setting-up households. The MLTSS care managers are responsible for developing care plans, arranging HCBS, and post-transition monitoring. Texas requires the two parties to establish procedures to ensure they communicate with each other, have clearly defined areas of responsibility, and have a smooth hand-off after a transition occurs.

Regardless of how they divide responsibility for planning transitions, state MFP program managers communicate regularly with the MCOs about referring eligible participants to the MFP

program, extra MFP quality monitoring requirements, and reporting data on MFP participants. The MFP programs also communicate regularly with the MCOs about specific challenges encountered by the plans in conducting transitions or serving certain population groups. These challenges have included behavioral health needs, guardianship problems, shortages of affordable housing, and risks of reinstitutionalization, among others. Some MFP programs, such as Wisconsin, have designated a liaison to ensure ongoing communication between the state and MLTSS plans. MFP programs in some states also provide training to MCO staff to strengthen their capacity to provide HCBS to individuals with special needs. These trainings have covered a variety of subjects, such as financial assistance, foster homes, housing resources, and behavioral health needs. Federal MFP grant funds are available to cover the cost of these types of administrative activities, which states might otherwise be unable to afford.

5. Monitoring Care Quality and Service Usage for MFP Participants Enrolled in MCOs

Federal regulations [42 C.F.R. S438.202(a)] require states to establish quality assessment and improvement strategies with contracted MCOs. In the states studied, the MCOs are responsible for meeting the quality standards specified in their contract for all members participating in MFP, such as ensuring access to and the quality of all covered services, including HCBS. MFP has three specific quality assurance requirements that should be included in the contracts with MCOs, including an (1) incident report management system that provides timely reports on certain events, (2) risk assessment and mitigation, and (3) 24-hour emergency back-up. In most states, MCOs already provided these quality assurance services, or states amended MCO contracts to require that they start providing these services to MFP participants. Nonetheless, some states report challenges in receiving critical incident reports in a timely manner and systematically tracking outcomes for MFP participants enrolled in MLTSS. Kansas implemented a new online critical incident reporting system that will include data entered by MCOs. MFP program staff or Medicaid quality assurance reviewers located throughout Kansas will monitor and follow up on reports from this system.

MFP programs must also report data to CMS on MFP participants' service use, reinstitutionalization, quality-of-life survey results, consumer direction, and choices in qualified residences, among others. Some MFP grantees have experienced challenges reporting some of these elements for participants who are members of MLTSS programs. For example, Texas and Massachusetts indicated that they do not receive encounter data from MCOs that allow them to report on MFP participants' service use. Texas officials used MFP rebalancing funds to set up a "data mart" that will improve its analytical capabilities, for instance, by tracking reinstitutionalizations among MFP participants, including those enrolled in MCOs. Tennessee tried to address this issue by modifying the contracts with MCOs to include these MFP reporting requirements for all its members. MLTSS programs in Kansas are required to submit monthly reports on MFP participants to track MFP-specific data elements such as current living setting.

Though all six states made, or are still pursuing, changes to MLTSS reporting requirements to meet MFP quality and reporting requirements, Michigan decided that the MFP requirements were too difficult to incorporate into its MLTSS program. Consequently, the state's integrated

care demonstration program for Medicare-Medicaid enrollees will include capitated MLTSS, but MFP participants will not be allowed to enroll. The state plans to revisit this policy once it has more information about MCOs' data system capabilities.[19]

B. How Grantees are Tackling the Housing Challenge

In 2012, as in every year since the program began, MFP programs cited the lack of affordable and accessible housing as the most important barrier to MFP transitions. States are using federal and state resources to address this barrier in four ways.

1. Increasing the supply of housing options and resources. MFP programs are actively (a) promoting the development of permanent supportive housing through state investment and federal funding such as the Department of Housing and Urban Development's Section 811 program; (b) financing the modification of existing housing units and obtaining additional funds for rental and bridge subsidies to help MFP participants while they wait for permanent rental assistance; and (c) addressing the shortages of small group homes for four or fewer residents by promoting financial incentives for potential developments, such as tax benefits, and by promoting roommate arrangements. Some states are hiring housing specialists tasked with working on these issues at the state level.
2. Employing more housing resources to facilitate transitions. MFP programs are making housing information more readably accessible by using specially trained housing specialists to educate stakeholders and by developing information tools such as public web-based housing locators. Housing specialists also establish relationships with the state housing finance agency, public housing authorities (PHAs), and other state and local agencies, as well as with landlords, developers, and other stakeholders; identify and coordinate efforts to pursue funding opportunities; train MFP staff, particularly transition coordinators, on housing related issues, and on available subsidy and voucher programs; educate PHA staff on the complex needs of the MFP population; track statewide housing needs and housing inventory; and provide one-on-one assistance to MFP participants.
3. Providing tenant assistance and support. To assist MFP candidates in overcoming personal barriers to securing housing, such as a criminal background, poor credit, or missing identification (for example, Social Security cards), MFP programs are strengthening relationships with their counterparts at PHAs, who have experience in this area. Some states have hired housing coordinators who are working

[19] Michigan is also planning a separate MLTSS program, which would convert the MI Choice waiver, a 1915(c) HCBS waiver for people with physical disabilities and older adults, to a capitated payment arrangement in October 2013. Currently, waiver agency case managers provide most MFP transition services and arrange HCBS for MI Choice waiver beneficiaries. Under current plans, these waiver agencies will become prepaid ambulatory health plans, a form of managed care that absolves them of responsibility for any institutional services.

with landlords and public housing authorities, explaining to them the advantages of renting to these individuals who have support services and care management. Other states have developed programs specifically for formerly incarcerated people and some transition and housing coordinators have developed expertise in serving this population.

4. Promoting long-term collaboration between health and housing. In 2012, 21 state MFP programs reported stronger collaboration with state housing finance agencies and local PHAs, particularly in states that received federal grants to develop formal partnerships between Medicaid and the state housing agency.

1. Introduction

Central to making community-based independent living possible for individuals with disabilities is the availability of affordable accessible housing. For many individuals living in an institution, the home they once lived in may no longer be available. For others, that home may no longer be affordable. According to the Department of Housing and Urban Development (HUD), more than one million very low income non-elderly individuals with disabilities were paying more than half of their income for housing in 2011, a number that has increased by 32 percent since 2009 (HUD 2013). In 2012, the average one-bedroom apartment cost more in rent annually than the entire annual income of an individual receiving Supplemental Security Income (SSI), and "there was not one state or community in the nation where a person with a disability receiving SSI could afford to rent modest rental housing without a permanent rental subsidy" (Cooper et al. 2011).

In addition to finding housing that is affordable, individuals with disabilities must also find housing that meets their individual accessibility needs. Previous homes, if they are still available, may not have the necessary modifications and accessibility features to accommodate the individual's disability, or they may not be located in a community with access to the services and supports required for independent living. For example, the elderly and individuals with physical impairments may require housing with specific modifications or features, such as wheelchair accessibility, grab bars, a seated shower, and low counters. Individuals with severe mental illness or with an intellectual or developmental disability may prefer to transition into a small group home, perhaps with access to public transportation or close proximity to a day support program. Finally, individuals with disabilities may encounter landlords who have concerns about financial and long-term stability in renting to this population. Combined, these barriers s slow the rate of transitions, and challenge state MFP program goals of reducing the number of individuals living in institutions.

More than a decade after the 1999 U.S. Supreme Court decision in Olmstead v. L.C. (527 U.S. 581), which ruled that people with disabilities are entitled to receive services in "the most integrated setting appropriate," and five years after implementation of the first MFP program in 2007, transitions continue to be hindered by the lack of appropriate housing. A nation-wide recession, reduced federal funding for housing assistance, and shrinking state budgets have exacerbated the shortage of affordable housing. Despite these difficult conditions, states have employed a variety of strategies to overcome housing-related challenges, often taking advantage of a range of tools and resources made available by the federal government.

In recent years, federal legislation has encouraged the collaboration between CMS and HUD in helping low-income individuals with disabilities live independently in housing linked to community-based services and supports. The 2009 Community Living Initiative (CLI), launched on the 10th anniversary of the Olmstead decision, has played a prominent role in promoting the CMS-HUD partnership.[20] In 2010, Congress passed the Frank Melville Supportive Housing Investment Act, which reformed and revitalized the Section 811 program to link affordable housing with services and supports for those with the lowest incomes and the most significant disabilities.[21] More recently, CMS and HUD have collaborated on several initiatives relevant to MFP participants, including the Non-Elderly Disabled Category 2 (NED2) Housing Choice Voucher program, which allocated a total of 948 vouchers for individuals transitioning out of an institution (923 of the 948 vouchers went to states with an MFP program);[22] the 2012 Real Choice Systems Change (RCSC) grant, awarded by CMS to six MFP states to support the development of a sustainable Medicaid-housing partnership;[23] and the HUD Section 811 Project Rental Assistance (PRA) program, which provides funding for the development and subsidization of rental housing with supportive services awarded to 13 MFP states.[24] Table IV.1 shows which states have received these awards.

[20] The CLI was created to promote federal partnerships that advance the directive of the Olmstead decision. The goal of the CLI is to ensure that LTSS are person-driven, inclusive, sustainable, efficient, coordinated, and transparent.

[21] The Melville Act revised the Section 811 program to emphasize the importance of integrating people with significant disabilities into communities that facilitate the provision of community-based services and supports, including access to transportation and other public facilities. The Melville Act also requires that about 56,000 housing choice vouchers be permanently reserved for non-elderly people with disabilities.

[22] NED2 vouchers were allocated to 27 Public Housing Authorities (PHA) in 14 MFP states. Arizona was the one non-MFP state that received vouchers; 25 of the 948 vouchers released. The PHAs were required to partner with the state MFP program or the Health and Human Services (HHS) agency that would be responsible for coordinating the services of potential voucher users.

[23] The RCSC grant was awarded Indiana, Maryland, Mississippi, Oregon, Texas, and Wisconsin, which were required to use the funds to strengthen the partnership between the state's Medicaid program and its housing finance agency. All six grantees intended to leverage the partnership to pursue the HUD Section 811 Project Rental Assistance (PRA) funding opportunity.

[24] On February 12, 2013, HUD announced that $98 million in Section 811 PRA funding would be awarded to housing agencies in 13 states (all of which maintain an MFP program). This funding is expected to produce 3,530 integrated supportive housing units for individuals with significant disabilities.

Table IV.1. MFP Programs and Housing-Related Funds Awarded by State

State	MFP Program	NED2 Vouchers	RCSC Grant	Section 811 PRA
Alabama	X	-	-	-
Alaska	-	-	-	-
Arizona	-	X	-	-
Arkansas	X	-	-	-
California	X	X	-	X
Colorado	X	-	-	-
Connecticut	X	-	-	-
Delaware	X	-	-	X
District of Columbia	X	-	-	-
Florida	X	X	-	-
Georgia	X	X	-	X
Hawaii	X	-	-	-
Idaho	X	-	-	-
Illinois	X	X	-	X
Indiana	X	-	X	-
Iowa	X	-	-	-
Kansas	X	-	-	-
Kentucky	X	-	-	-
Louisiana	X	-	-	X
Maine	X	-	-	-
Maryland	X	X	X	X
Massachusetts	X	X	-	X
Michigan	X	X	-	-
Minnesota	X	-	-	X
Mississippi	X	-	X	-
Missouri	X	-	-	-
Montana	X	-	-	X
Nebraska	X	-	-	-
Nevada	X	-	-	-
New Hampshire	X	-	-	-
New Jersey	X	X	-	-
New Mexico	-	-	-	-
New York	X	X	-	-
North Carolina	X	X	-	X
North Dakota	X	-	-	-
Ohio	X	X	-	-
Oklahoma	X	-	-	-
Oregon	X	-	X	-
Pennsylvania	X	X	-	X
Rhode Island	X	-	-	-
South Carolina	X	-	-	-
South Dakota	X	-	-	-
Tennessee	X	-	-	-
Texas	X	X	X	X
Utah	-	-	-	-

Table IV.1 (continued)

State	MFP Program	NED2 Vouchers	RCSC Grant	Section 811 PRA
Vermont	X	-	-	-
Virginia	X	-	-	-
Washington	X	X	-	X
West Virginia	X	-	-	-
Wisconsin	X	-	X	-
Wyoming	-	-	-	-
Total	46	15	6	13

This rest of this section summarizes progress made by MFP programs in overcoming housing-related challenges, and it identifies the strategies as well as the federal resources that are contributing to this effort. Progress reported by the states, and summarized in this section, falls into three broad categories: (1) activities aimed at increasing the supply of housing options and resources, (2) housing-focused efforts designed to facilitate transitions, and (3) the provision of tenant assistance and support to ensure long-term housing stability. Information presented in this section is based on feedback received through two 2012 semi-annual MFP progress reports, as well as on lessons learned through Mathematica's evaluation efforts related to the RCSC grant and the NED2 programs.[25]

2. Increasing the Supply of Housing Options and Resources

The most commonly cited housing-related challenge, reported by 26 MFP states in 2012, is an insufficient supply of housing that is both affordable and accessible for MFP participants, a problem that is often worse in rural areas. The income level of many MFP participants, particularly those relying on SSI benefits, which are set at 18.7 percent of Area Median Income (AMI), is often too low to afford what state and federal housing programs typically define as "affordable." (The federal standard for low-income housing projects is 30 percent of AMI.) In addition to being affordable, housing options must be accessible, and ideally, located in a safe neighborhood and within a community to which the individual wants to relocate. Because of the lack of housing options, however, individuals transitioning may have to choose a residence that is outside of their preferred community or away from social supports, or remain in the institution until better options become available. Although the demand for affordable accessible housing continues to outpace supply, states are reporting a range of long-term strategies that promote the development of new housing.

[25] Mathematica was tasked with assessing the use of the RCSC grant as part of our MFP evaluation contract with CMS. Our evaluation of the NED2 program, which included a qualitative implementation evaluation of the processes used, as well as an impact analysis of the effect of NED2 vouchers on local rates of transitioning, stems from a contract with the HHS Office of the Assistant Secretary for Planning and Evaluation. As of this writing, public reports are forthcoming.

Strategies to Increase the Supply of Affordable Accessible Housing. State MFP programs are actively engaging governor's offices, legislatures, and relevant state housing finance agencies to promote the development of permanent supportive housing (PSH) through state investment and use of federal funding opportunities. For example, in 2012, the Illinois Housing Development Authority received $40 million through capital budget funds for the development of PSH, and the New Jersey MFP program, in collaboration with the state Housing and Mortgage Finance Agency, used a Special Needs Housing Partnership Loan Program to provide financing for the creation of PSH. In 2012, many MFP state programs collaborated with their state Housing Finance Agencies in applying for HUD's Section 811 PRA funding opportunity to develop rental housing with supportive services. To do this work, MFP programs are using administrative funds to hire a housing specialist tasked with working on statewide policy development. All 13 states awarded PRA funding in early 2013 have an MFP program, thus ensuring continued collaboration and partnership between Medicaid and housing agencies in these states.

In addition to new development opportunities, states have increased the housing supply by modifying existing housing units to make them accessible to MFP participants. Nebraska's MFP program, for example, collaborates with the Assistive Technology Partnership, a program that modifies homes to meet the needs of MFP participants. The Ohio MFP program, in collaboration with state Centers for Independent Living, has received a grant from the state's housing finance agency to purchase and install modular ramps in participants' homes. In some states, existing Medicaid 1915(c) waiver programs do not adequately cover home modifications. For example, in Virginia, waivers cover home modifications only after an individual has transitioned and is enrolled in the waiver, even though such modifications are usually needed prior to the transition and are allowable services. For participants in waivers that do not cover modifications, Louisiana is using MFP administrative funding to make one-time modifications. In contrast, New Jersey reports that all HCBS waivers serving MFP participants include provisions for home modifications.

As new housing units become available, several states, such as Connecticut and Hawaii, are systematically recording and tracking this growing inventory, and updating databases and related-resources. Several states, such as New Jersey, are transmitting the updates to field staff.

Strategies to Increase the Supply of Available Housing Rental Vouchers. In 2012, 19 state MFP programs reported an insufficient supply of housing vouchers as a major challenge towards transitioning more individuals out of institutions, with nearly all states reporting lengthy or even closed waiting lists for existing vouchers. This issue creates a particular challenge for participants who want to move into an apartment, or into a community with high rents and low vacancy rates. Some states report having made additional funding available for rental subsidies. In Illinois, for example, legislation signed in 2012 made $10 million in subsidies available for people with disabilities, and additional vouchers were allocated by the Texas Department of Housing and Community Affairs, although demand continues to exceed supply.

States and disability advocates have long lobbied for set-aside vouchers for the institutionalized population. In 2011, HUD, in collaboration with CMS, allocated 923 of 948

NED2 vouchers to 27 PHAs in 14 states with an MFP program for this purpose.[26] PHAs that were awarded NED2 vouchers partnered with their state MFP program or HHS agency, which was then responsible for coordinating services for voucher recipients. Although HUD stipulated that these NED2 vouchers were not to be restricted to MFP participants, most were used by MFP participants in 2012. These vouchers have been used to transition into the community individuals who would otherwise have remained in an institution, and the vouchers will remain a dedicated subsidy for this population going forward (Lipson et al. 2013).

Several states are using state or MFP rebalancing funds to support bridge subsidies, which provide temporary support to MFP participants to reside in the community while they wait for permanent rental assistance to become available. Finally, some MFP teams have begun working with PHAs to give priority status to MFP participants on waiting lists.

Promoting the Development of Qualified Small Group Homes. In 2012, 10 state MFP programs reported an insufficient supply of qualified small group homes as a housing-related barrier for MFP participants. The problem is acute for participants with ID/DD, who are more likely than other MFP populations to transition to a small group home, as well as for states that have a large number of individuals with ID/DD needing to transition due to closures of state institutions resulting from Department of Justice or Olmstead-related lawsuits. Because the legislation that established the MFP demonstration defines a qualified group home as one with no more than four beds, people who move to a larger group home are not eligible for the MFP program. To address the shortage, Illinois and other states are promoting the development of smaller qualified group homes through a range of financial incentives, such as tax benefits for potential developers. Connecticut notes that its transition coordinators are attempting to promote roommate arrangements, such as three-bedroom apartments, among those leaving ICFs/IID as a more immediate solution to the shortage of small group homes.

3. Employing More Housing Resources to Facilitate Transitions

Conducting Outreach to Improve Awareness of Housing Options. In 2012, states reported a range of efforts to improve knowledge of, and access to, information regarding affordable accessible housing options. Because not all case managers and transition coordinators have a background or training in housing issues, several states have taken steps to educate staff about housing options. Hawaii, for example, has initiated an education series for transition coordinators, in collaboration with PHA staff, to provide information about rental voucher application processes and resources. Many states are relying on newly established MFP housing specialists to help improve staff knowledge of housing issues.

[26] To be eligible for a NED2 voucher, applicants must be between 18 and 62; meet HUD's definition of disability, as well as HUD's income eligibility requirements; and reside in an institution at the time of voucher receipt. MFP transition coordinators are responsible for identifying a potential NED2 voucher recipient, helping them complete the voucher application, and once approved, helping the individual identify housing. In some states, the MFP transition coordinators may also receive support for this work from housing specialists.

States have made significant progress in improving access to housing-related information among the broader public. Nine states reported progress in 2012 in developing a statewide housing registry, and nine states reported improvements in housing-related information systems. Many states continue to maintain and improve a public website that includes a housing locator, allowing potential participants to identify housing options in communities of their choice. Several states have regarded being without a housing locator as a barrier, and hope to develop one in the near future. Many states, like Tennessee, are conducting outreach efforts to encourage landlords to use the website as a tool for listing properties, and to social service agencies to use it as a resource for individuals seeking housing options.

Establishing Housing Specialists. More and more MFP programs have taken steps to fund a housing focused position, such as a housing specialist or housing coordinator, within their team, as has been strongly encouraged by CMS project staff. Placement of the housing specialist within the program structure varies by state. Many states, like Ohio, rely on a single statewide housing coordinator; others employ regional housing specialists, as in Washington; and still others may encourage the staffing of housing specialists within local MFP agencies or to collaborate with local housing-focused organizations, as in Maryland. Housing specialists' responsibilities vary by program, but often include: establishing relationships with the state housing finance agency, PHAs, and other state agencies, as well as with landlords, developers, and other stakeholders; identifying and coordinating efforts to pursue other potential housing funding opportunities; training other MFP staff, particularly transition coordinators, on housing related issues, and on available subsidy and voucher programs; educating PHA staff on the complex needs of the MFP population; tracking statewide housing needs and housing inventory; and providing one-on-one assistance to MFP participants for applying for housing subsidies or finding suitable units. Mathematica's NED2 evaluation highlighted the importance of an MFP-funded housing specialist; PHAs that had the most trouble issuing NED2 vouchers were all in states that, at the time, lacked an MFP-funded housing specialist (Lipson et al. 2013).

4. Providing Tenant Assistance and Support

Challenges unique to individual participants, such as having a criminal background, poor credit, or missing documentation, such as Social Security cards and birth certificates, can prevent applicants from being approved to lease a rental unit, or can significantly slow the process of being issued and using a rental voucher. These barriers were noted most frequently by MFP staff in states with PHAs that received NED2 vouchers, and other states in which the MFP team has a developed relationship with their housing counterparts. In states with NED2 vouchers, MFP transition coordinators are tasked with assisting potential voucher recipients navigate the voucher application process, and as a result, have become increasingly familiar with these kinds of participant-level challenges; the ones PHA staff have long dealt with. A recent evaluation of the NED2 program found that, MFP staff members who developed a strong relationship with their PHA counterparts developed a better understanding of a PHA's voucher issuing process, thus

allowing them, over time, to be more efficient and effective in helping MFP participants prepare voucher applications (Lipson et al. 2013).[27]

A criminal background is often regarded as the most difficult barrier to housing. The Ohio MFP program has targeted this obstacle through its partnership with the Exit Program, which assists formerly incarcerated individuals with finding housing and supportive services. Additionally, Ohio's MFP program is working with the Corporation for Supportive Housing to develop housing subsidies specifically for individuals with criminal backgrounds. The MFP program also links participants with criminal backgrounds to transition coordinators who have relevant training and experience with this population.

Landlords and property managers sometimes express concern about the long-term stability of an MFP participant or the need to make costly home modifications. In areas with low vacancy rates, landlords may be unwilling to hold a rental unit while a participant's service plan is being implemented, a process that can often take months. Several MFP teams have noted that an experienced transition coordinator can appropriately time a transition with a lease start date. MFP programs that conduct outreach to engage and educate landlords and property developers note an increasing willingness to work with the MFP program, and thus more broadly increasing housing opportunities for individuals with disabilities.

5. Promoting Long-Term Collaboration Between Health and Housing: Setting the Foundation for Future Housing Initiatives

In 2012, 21 state MFP programs reported stronger collaboration around housing issues as an achievement, with many programs noting an improved partnership with their state Housing Finance Agency or with local PHAs. Stronger collaborations were particularly evident in states that had received NED2 vouchers, which required a working relationship between MFP and local PHA staff; in states that were awarded an RCSC grant, which was used to promote a formal partnership between Medicaid and the state housing agency; and in states that pursued Section 811 PRA funding, which required a formal Medicaid-housing partnership agreement. These recent CMS-HUD collaborative efforts have had a positive impact on the relationship between MFP and state housing agencies, which may ultimately lead to smoother transitions for MFP participants.

Much can be learned about the impact of cross-agency collaboration through the NED2 HCV program, which in many states resulted in the first time MFP staff had the opportunity to work with local housing staff. Because MFP Transition Coordinators had to work directly with staff at local PHAs, states invested in a significant amount of cross-agency training, which resulted in increased knowledge among MFP staff about housing issues and processes. The NED2 evaluation concluded that regular and frequent communication between MFP and housing

[27] Our process evaluation of the NED2 program relied on in-depth discussions with those MFP and PHA staff involved in implementing the NED2 program.

staff was associated with faster use of vouchers, and faster transitions. Additionally, every state that received NED2 vouchers indicated an intent to leverage the collaborative experience in pursuit of Section 811 PRA funding, which required a formal Medicaid-housing partnership. In fact, 9 of the 13 states that received PRA funding also received NED2 vouchers.

The 2011 RCSC grant also helped promote a stronger Medicaid-housing partnership. The six RCSC grantees, all of which have an MFP program, and two of which have experience with the NED2 vouchers, used the grant to fund activities that would strengthen the state's Medicaid-housing partnership, with the ultimate purpose of using that partnership as leverage in pursuit of Section 811 PRA funding. The solicitation for both the RCSC grant and the PRA funding emphasized the engagement of consumer and disability advocate organizations, and several MFP states have indicated the inclusion of such groups in housing workgroups.

Finally, interagency collaboration has been strengthened by Department of Justice or Olmstead-related lawsuits that have resulted in the closing of state-run institutions and in consent decrees that require cities or states to transition a set number of individuals out of institutions. Several MFP programs are now working closely with governor's offices, Olmstead task forces, divisions for the individuals with intellectual and developmental disabilities, as well as with consumer and disability advocacy groups in preparation for assisting with the necessary transitions. This activity has increased collaboration among various state agencies and community partners, creating synergies that will produce additional strategies for enhancing housing opportunities for all individuals who may choose to transition out of an institution.

C. How States are Leveraging MFP to Enhance their Direct Service Workforce

For some time, states have reported widespread shortages of skilled direct service workers and high staff turnover because of very low wages; poor benefits, such as a lack of health insurance; little opportunity for professional growth; the stigma associated with direct service work; and low public awareness of the field and its contributions. States have been attempting to address these problems by using funds from federal and private grant programs, their MFP rebalancing funds, and tapping an intensive technical assistance program through the CMS National Direct Service Workforce Resource Center. States are implementing promising initiatives that include:

- Improving wages and benefits to attract qualified workers and to reduce turnover
- Creating tools, such as videos, that present a realistic view of the rewards and challenges to attract the right workers
- Enhancing the work environment and organizational culture to improve recruitment, retention, and job satisfaction
- Offering education and training options to increase job commitment
- Developing registries that link available jobs to individuals in need of in-home personal assistance
- Strengthening their workforce data collection and reporting systems to inform policymaking and funding decisions

- Leveraging MFP funds to implement web-based training portals for providers, provide more behavioral support for MFP participants who have difficult behaviors, and marketing and recruitment of workers that include bonuses for completion of specified training milestones

1. Introduction

Over the next few decades, the aging of the U.S. population will increase the number of individuals who are over 65, raising demand for LTSS. Individuals under the age of 65 with disabilities are also becoming increasingly reliant on access to HCBS. To meet these challenges, the federal government is offering states incentives to expand Medicaid beneficiaries a larger role in choosing their own personal care assistants and deciding which services they would receive and how they would receive them.

The supply of trained direct service workers (DSWs) is critical to meeting the growing demand for HCBS and to ensuring community support for MFP participants. DSWs provide hands-on support to the elderly and to people with disabilities by performing daily activities that make independent living possible, such as assistance with personal care and hygiene, medication management, transportation assistance, employment supports, and behavior support and crisis intervention. The direct service workforce covers several occupational titles, including direct support professionals, who typically provide community-based services and supports to individuals with developmental disabilities; personal and home care aides, who often provide services and supports to the elderly and individuals with physical disabilities; home health aides, who typically deliver clinical services in the home; and nursing facility aides. Altogether, there were approximately four million DSWs nationwide in 2011.[28]

Widespread shortages among state DSWs exist for a variety of reasons. DSW work typically pays very low wages and mostly lacks benefits, such as health insurance. Few do not see opportunities for professional growth in this line of work and some believe the work is stigmatizing. As a result, the field is characterized by high turnover rates, which disrupts continuity of care.

Because most HCBS is funded through Medicaid, federal and state governments have an interest in addressing these problems. This section reviews recent state initiatives aimed at increasing the supply of trained DSWs and discusses how MFP resources are being leveraged to address the challenge of doing so.

2. Recent Initiatives to Help States Overcome the DSW Challenge

Over the past decade, CMS has made available several funding opportunities and resources to help states cope with the challenges associated with the recruitment, retention, and training of DSWs. The Real Choice Systems Change (RCSC) grant program awarded at least 20 grants to

[28] http://phinational.org/policy/states/united-states/.

states to help promote innovation in long-term care systems, including initiatives targeting the recruitment and retention of DSWs (Table IV.2). Initiatives were quite diverse, and included the development of public awareness and recruitment campaigns, increases in wage and health benefits, the development of new training courses that might allow for job advancement, improvement in organizational culture and work environment, and the development of resources to aid system administration and planning.

Table IV.2. Use of DSW-Related Grants and Technical Assistance by State

State	RCSC Grants[a]	CMS DSW Grants[b]	BJBC Initiative[c]	DSW RC TA[d]	MFP Enhancing DSW[e]	PHCAST Demonstration[f]
Alabama	-	-	-	-	-	-
Alaska	X	-	-	-	-	-
Arizona	-	-	-	X	-	-
Arkansas	X	X	-	-	-	-
California	-	-	-	-	-	X
Colorado	-	-	-	-	-	-
Connecticut	-	-	-	-	X	-
District of Columbia	-	-	-	-	X	-
Delaware	-	X	-	X	-	-
Florida	X	-	-		-	-
Georgia	X	-	-	X	-	-
Guam	X	-	-	-	-	-
Hawaii	-	-	-	-	X	-
Idaho	-	-	-	-	-	-
Illinois	-	-	-	-	-	-
Indiana	-	X	-	X	-	-
Iowa	-	-	X	-	X	X
Kansas	-	-	-	-	-	-
Kentucky	X	X	-	-	-	-
Louisiana	-	X	-	X	X	-
Maine	X	X	-	-	-	X
Maryland	X	-	-	-	-	-
Massachusetts	-	-	-	-	-	X
Michigan	-	-	-	X	-	X
Minnesota	X	-	-	-	-	-
Mississippi	-	-	-	-	-	-
Missouri	-	-	-	-	-	-
Montana	X	-	-	-	-	-
Nebraska	-	-	-	-	-	-
Nevada	X	-	-	-	-	-
New Hampshire	X	-	-	-	X	-
New Jersey	X	-	-	X	X	-
New Mexico	-	X	-	-	-	-

Table IV.2 (continued)

State	RCSC Grants[a]	CMS DSW Grants[b]	BJBC Initiative[c]	DSW RC TA[d]	MFP Enhancing DSW[e]	PHCAST Demonstration[f]
New York	-	-	-	X	-	-
North Carolina	X	X	X	X	X	X
North Dakota	-	-	-	-	X	-
Ohio	-	-	-	X	X	-
Oklahoma	-	-	-	-	-	-
Oregon	X	-	X	-	-	-
Pennsylvania	-	-	X	-	-	-
Rhode Island	-	-	-	-	-	-
South Carolina	-	-	-	X	-	-
South Dakota	-	-	-	-	-	-
Tennessee	-	-	-	-	-	-
Texas	-	-	-	X	X	-
Utah	-	-	-	X	-	-
Vermont	X	-	X	-	-	-
Virginia	-	X	-	-	-	-
Washington	-	X	-	-	-	-
West Virginia	-	-	-	-	-	-
Wisconsin	X	-	-	X	-	-
Wyoming	-	-	-	-	-	-

Source: [a]Anderson et al. 2004. [b] According to a Lewin Group assessment of the 2003—2004 DS workforce grants. [c] Yallowitz and Hofland, 2008. [d] States that requested and received intensive TA from the DSW RC between 2006—2008. [e]According to a 2011 survey of MFP states conducted by the Lewin Group. [f]U.S. Department of Health and Human Services, 2012.

To further foster the development of innovative ideas for addressing the DSW challenge, CMS initiated the Demonstration to Improve the Direct Service Community Workforce, awarding grants to 10 states in 2003—2004 to test the effectiveness of various workforce interventions focused on the retention and recruitment of DSWs.[29] In 2005, CMS commissioned

[29] This demonstration stemmed from President Bush's New Freedom Initiative, which was designed to help states improve the quality of their long-term care system. CMS awarded five grants in October 2003 to Delaware, Louisiana, Maine, New Mexico, and North Carolina, and another five in May 2004 to Arkansas, Indiana, Kentucky, Virginia, and Washington. For details and updates on these state's activities, see http://www.dswresourcecenter.org/tiki-index.php?page=Demonstration+to+Improve+the+Direct+Service+Community+Workforce%3A+An+Update.

the National Direct Service Workforce Resource Center (DSW RC) to help support state efforts in this area and to promote innovative strategies for strengthening the DSW (such as, developing a competent and trained workforce). The DSW RC acts as a portal for family caregiver supports and workforce development initiatives.[30] It also disseminates information to increase awareness of the workforce crisis and provides DSW stakeholders with easy access to relevant materials, resources, and best practices. In addition to its on-line presence, staff at the DSW RC, which comprises a collaboration of experts from various stakeholder organizations, provide in-depth individualized technical assistance (TA) to states. In 2008, the DSW RC began providing intensive DSW-related TA to MFP grantees.

Further motivating CMS' focus on DSW issues is the lack of a single national set of competency standards for the training and development of DSWs. In September 2010, CMS convened a leadership summit called "Building Capacity and Coordinating Support for Family Caregivers and the Direct Service Workforce" to identify common goals and policy recommendations for supporting and strengthening the DSW. Among other things, participants at the summit agreed that training and credential requirements for DSWs should be expanded beyond the current minimum standards to reflect the basic skills needed for providing high-quality service, such as communication, advocacy, and problem solving. As a result, in 2011 CMS began funding the Road Map of Core Competencies for the Direct Service Workforce project through the DSW RC. Through this project, a core set of competencies will be identified based on existing sets, synthesized and reviewed by various stakeholders, and tested and evaluated for widespread promotion and use.[31]

One of the more notable private DSW initiatives was the Better Jobs Better Care (BJBC) initiative sponsored by the Robert Wood Johnson Foundation (RWJF) and the Atlantic Philanthropies, who jointly developed and funded this $15.5 million five-year demonstration between July 2002 and August 2008. The BJBC awarded grantee teams led by nonprofit organizations in five states for the ultimate purpose of identifying and testing new approaches that lead to improved recruitment and retention of high-quality DSWs in both institutional and home and community-based settings[32] (Yallowitz and Hofland, 2008; RWJF, 2011).

The Affordable Care Act established the Personal and Home Care Aide State Training (PHCAST) Program. Grants were awarded $15 million to six states: California, Iowa, Maine,

[30] For more information, see http://www.dswresourcecenter.org.

[31] For more information on the Road Map of Core Competencies project, see http://dswresourcecenter.org/tiki-index.php?page=Training.

[32] The five grantees of BJBC funding were (1) the Iowa CareGivers Association (Des Moines, IA), (2) the North Carolina Foundation for Advanced Health Programs (Raleigh, NC), (3) the Oregon Works Coalition (Salem, OR), (4) the Center for Advocacy for the Rights and Interests of the Elderly (Philadelphia, PA), and (5) the Community of Vermont Elders (Montpelier, VT). For more details about these grantee's individual initiatives, and the broader BJBC program, please see Yallowitz and Hofland (2008).

Massachusetts, Michigan, and North Carolina. These states are working to develop, implement, and evaluate competency-based curricula and certification programs to train qualified personal and home care aides. By statute, these states must develop written materials and protocols for delivery core training competencies 10 areas: (1) the role of the personal or home care aide; (2) consumer rights, ethics, and confidentiality; (3) communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills; (4) personal care skills; (5) health care support; (6) nutritional support; (7) infection control; (8) safety and emergency training; (9) training specific to an individual consumer's needs; and (10) self care (U.S. Department of Health and Human Services 2012). This grant program was scheduled to conclude in 2013 and a final report detailing the results of the program was not available at the time of this report.

Appendix C, Table C.1 details the types of initiatives each state has implemented through the resources discussed above.

3. Promising Initiatives to Enhance the DSW

Evaluations of recent grant activities, publications by experts in the field, and experiences by TA providers have identified the following promising initiatives that states are being encouraged to consider.

Better wages and better benefits, particularly access to health insurance, can attract qualified workers and reduce turnover. PHI (formerly the Paraprofessional Healthcare Institute) estimates that nearly half of all DSWs live in households earning below 200 percent of the federal poverty level and are dependent on public assistance, such as food stamps, Medicaid, or housing assistance. Improving wages and benefits for DSWs is not only key to stabilizing employment, it can also provide greater economic security for many low-income families (PHI 2011; RWJF 2011). PHI also reports that less than half of DSWs had employer-sponsored health care coverage in 2009. In its evaluation of the RCSC funded activities, RTI identified the provision of employer-based health insurance as one of the most promising initiatives for retaining high-quality workers (Anderson et al. 2004).[33] In its synthesis of results from DSW initiatives funded by CMS grant programs, Irvin and Lester (2012) emphasized that DS provider organizations should be careful to ensure that benefit programs are tailored to fit the needs of staff. Access to health insurance for example, is not a benefit to a DSW who is working part-time. A study funded by ASPE found that the strongest predictor of job retention was work hours; the more hours aides worked per week, the more likely they were to remain in the workforce (Feldman 2007).

Presenting a realistic view of the rewards and challenges of a position can attract the right workers. The synthesis conducted by Irvin and Lester (2012) also found that initiatives

[33] The RCSC grants were conceived as experiments for developing new ideas to improve state long-term care systems. Evaluations were not required in grantee proposals. Furthermore, RTI did not perform a rigorous evaluation of the effectiveness of the funded activities.

such as realistic job preview videos were associated with lower staff turnover. It is recommended that when implementing a job preview initiative, ideally, the content should match the job the person is applying for; that the video should be combined with job shadowing to ensure realistic expectations; and the process should include post-hire activities, such as peer mentoring and coaching. These efforts go a long way toward ensuring the right workers are hired and remain committed to the job. RTI assessments highlighted as a particularly promising initiatives job fairs that target and recruit DSWs and provide training and background checks all at one venue (Anderson et al. 2004).

An enhanced work environment and organizational culture can improve recruitment, retention, and job satisfaction. Irvin and Lester (2012) report that CMS grantees have found that the most effective strategies to improve recruitment, retention, and job satisfaction were those that focused on improving worker recognition and value. These efforts can include public initiatives, such as a marketing campaign that seeks to raise awareness about the contributions of DSWs, as well as employee programs that recognize high-performing workers. Both the Lewin Group and an evaluation of the BJBC initiative found that job satisfaction and culture changes in an organization can lead to increased job commitment, particularly a better relationship with supervisors, better career ladders, and increased involvement in decision making (RWJF 2011; Wright 2009).

Education and training options for DSWs can increase job commitment. According to the DSW RC, current training for DSWs is often inadequate, and contributes to poor quality care and high turnover among staff (Wright 2009). Initiatives such as competency-based training, realistic orientation programs, peer mentoring, and continuing education are ways to engage staff and reduce turnover. Also, providing transportation and compensation to participate in training can foster a feeling of value—that the employer believes in the worker enough to cover these additional expenses. RTI recommends distance learning as a potential option (Anderson et al. 2004). PHI argues that a significant investment in training standards and curricula is necessary to reduce staff turnover and prepare for the greater number of qualified DSWs that are needed.[34]

A registry can be used to link available workers with individuals in need of in-home services. One initiative, strongly promoted by CMS, is the use of a "matching service registry" (MSR) to connect the supply of qualified home care workers with individuals who are self-directing their in-home services. Aging and Disability Resource Centers (ADRCs) may be particularly suited to manage an MSR, considering their role as an entry point for LTSS, but this initiative will require adequate funding. RTI, when evaluating the RCSC grants, also identified this type of program as particularly promising for workers who are on-call and looking for additional hours (Anderson et al. 2004). A recent estimate identifies 15 publically funded state-based MSRs (DSW RC 2012).

State policymakers should promote the development or enhancement of workforce data collection and reporting systems. Better data can help states identify gaps in the system,

[34] For more information on these issues, see http://www.phinational.org/policy/issues.

as well as develop the best tools to address such gaps and to assess their effectiveness. States need to assess how the DSW is changing or improving over time; however, government information management systems are rarely set up to gather and report basic information, such as number of workers employed by program and compensation levels.

4. States are Leveraging MFP to Promote a Stronger DSW

CMS has encouraged MFP grantees to address the DSW challenge by using MFP technical assistance (TA) resources and administrative funds. MFP TA organizations have provided support and encouragement to MFP grantees to take the lead in developing partnerships and to use MFP as a resource to support the most promising training and credentialing systems, develop DSW registries, conduct public education campaigns, and test other innovative policies (Robbins and Flanagan 2011). A survey of 30 MFP programs in March 2011 indicated that 11 states were using MFP as a catalyst to support DSW initiatives, 8 states were using 100 percent federal MFP administrative funds, and 4 were using MFP rebalancing funds to support DSW-related initiatives.[35, 36]

The most common initiatives are those focused on training workers and developing curriculum. For example, both Iowa and New Jersey fund the College of Direct Support, a web-based training portal available to provider staff statewide. A pilot program in New Jersey found that use of the college was associated with a decrease in staff turnover, and use of certain training modules can lead to college credit, thus further encouraging staff to commit to the profession. Both the District of Columbia and Louisiana have developed a DSW curriculum; in Louisiana, it has been approved for use towards licensing requirements. Connecticut has developed comprehensive training options that focus on assisting institutional-based DSWs who wish to transition to community-based work. Ohio, which has a state-funded DSW initiative, is developing a training curriculum and structure that will ultimately be used to support a statewide credentialing system.

Grantees are also taking steps to provide support to DSWs in the field. Iowa, North Dakota, and Texas have all used MFP administrative funds to hire staff to provide support to DSWs in the field. For example, Iowa has hired a full-time Behavioral Support Specialist who assists

[35] The 11 states are: Connecticut, the District of Columbia, Hawaii, Iowa, Louisiana, North Carolina, North Dakota, New Hampshire, New Jersey, Ohio, and Texas.

[36] CMS provides states with the opportunity to use 100 percent administrative funding (not to exceed 20 percent of the grant) for personnel, travel, training, outreach/marketing, and innovative ideas as approved by CMS. Connecticut, the District of Columbia, Hawaii, Iowa, Louisiana, New Hampshire, North Dakota, and Texas report using this opportunity to fund DSW initiatives. States also earn enhanced federal matching funds on both qualified and demonstration services they provide to MFP participants. States are required to use the enhanced portion of the federal match to expand community-based LTSS capacity, including DSW initiatives. States meeting this requirement include Ohio, New Jersey, North Dakota, and Texas.

transition specialists in developing behavioral plans for their participants, provides training to DSWs on how to implement these plans, and provides crisis prevention training. Iowa also funds services and training provided by the Iowa Program Assistance Response Team (I-PART), which assists providers and DSWs in managing serious and challenging behaviors. North Dakota has hired a DSW Development Coordinator, who is responsible for developing and implementing initiatives that aim to strengthen and train the state's DSW. Similarly, Texas hired a Workforce Development Program Specialist to take the lead on promoting workforce-related initiatives and to help improve the quality of the state's DSW. Through its partnership with the DSW RC, Louisiana is offering behavioral and physical support training to field staff and plans to place trainers within provider organizations to facilitate ongoing training.

Finally, grantees report funding initiatives that focus on marketing and recruitment of high-quality DSWs. Both North Dakota and Texas have developed realistic job preview videos to educate applicants about the rewards and challenges of direct service work, and ultimately to improve recruitment and retention. North Dakota has also developed data collection tools to assist in tracking staff turnover, which has also been used to provide data to the state legislature in support of DSW initiatives. Louisiana is funding a "sustainability award," which is a one-time payment of $500 to any DSW who participates in training, passes the related assessments, and then works in a participant's home for 365 consecutive days.

Despite the reported progress, states continue to face challenges in strengthening their DSW. In 2012, eight states reported an insufficient supply of DSWs in the MFP semiannual progress reports that are submitted to CMS.[37] Another survey by the DSW Resource Center (DSW RC) asked state MFP programs about their TA needs related to DSW issues. Nearly one-third (14 states) of the 44 responding states reported having no partnerships with DSW-type entities, such as a state workforce agency, community colleges, training providers, or direct service employers. Nearly half of the states (19 of 40 responding states) reported that the supply of workers was inadequate. States reported a range of workforce-related challenges, most notably a lack of care coordination (23 percent), lack of provider training (23 percent), and managing change with limited fiscal resources (21 percent).[38] States have reported several challenges through the semiannual reports, including high turnover among DSWs, difficulty recruiting workers in rural areas, and insufficient skills and training. In response to these challenges, the DSW RC began providing intensive TA to MFP grantees upon request. The most common areas of training requested thus far have been workforce preparation (14 states), stakeholder coordination (8 states), worker recruitment and retention (6 states), and issues related to DSWs in rural areas (5 states). In 2011, the DSW RC coordinated the formation of the MFP DSW Workgroup. In addition to quarterly conference calls, the workgroup maintains an online discussion forum that promotes peer-to-peer sharing and the exchange of ideas.

[37] Twice annually, states are required to submit a web-based progress report to CMS. Mathematica is contracted to review and summarize these submitted reports for CMS. States report on a range of topics and issues, much of which is referenced throughout this report.

[38] Information on how to interpret some of this information, such as how the lack of care coordination affects this workforce, was not available.

D. Promoting Employment Among MFP Participants

MFP grantees are offering a variety of employment services and supports to participants through the MFP service package. Data from grantees also provide insight on the types and costs of HCBS employment supports delivered to participants during their first year of community residence. Our assessment of MFP programs indicates that:

- Most grantee states (30 of 38 states in our analysis) offer supported employment to MFP participants, which CMS defines to be "assistance in obtaining and keeping competitive employment in an integrated work setting" (CMS Employment Initiatives 2013). Many grantee states also offer non-emergency transportation to participants to help them travel to and from supported employment services or a day program; nearly two-thirds provide some form of assistive technology.
- An analysis of claims records found that 15 out of 25 MFP grantees provided employment supports and services to MFP participants. Most of these services were pre-vocational and supported employment services. Depending on the state, between 1 and 4 percent of current participants used these services. Expenditures for these services accounted for less than 1 percent of total HCBS spending by MFP programs by the end of 2012.
- Some MFP programs received CMS approval to use 100 percent federally funded administrative dollars to hire specialized personnel or to implement initiatives to enhance their employment supports. Several MFP grantee states have opted to use these funds to hire employment specialists to assist participants with identifying employment goals and finding and maintaining competitive work. Others have opted to use MFP grant funds to finance or expand vocational services; one state plans to add an MFP demonstration service to fund the cost of assistive technology to enable individuals who were previously employed to return to work.

1. Introduction

Employment, particularly meaningful and competitive work, is intrinsically tied to individuals' social identity, self-esteem, livelihood, and social connectedness. Not only does working increase individuals' financial independence and self-sufficiency, but the social interaction that comes from being employed can enhance individuals' well-being and integration into the community. Life satisfaction and community integration are particularly important to individuals with disabilities who have transitioned to community living from long-term institutional settings. Younger adults under the age of 65 with a mental illness or physical or intellectual/developmental disability (ID/DD), which comprises 60 percent of MFP participants, can especially benefit from working in integrated employment alongside people without disabilities (Williams et al 2013).

Employment rates are consistently low for people with disabilities, however. Approximately 17.5 million working-age people in the United States live with a disability, yet only 33 percent are employed, compared with 73 percent of those without a disability (Annual Disability Statistics Compendium 2011). As a group, people with disabilities have become economically less self-sufficient, and their household incomes have fallen further behind those of other American households (Erickson et al 2013).

To promote the employment goals of participants, MFP programs provide a range of employment services and supports as part of the diverse set of HCBS that individuals' access after transitioning to community living. Employment services available to participants through an HCBS waiver or optional state plan most often supplement core services funded by other systems such as vocational rehabilitation (VR), state agencies serving individuals with ID/DD, and One Stop Career Centers which are supported by the Workforce Investment Act. Historically, VR funds short-term services and supports to assist individuals with disabilities in obtaining employment and achieving job stability, whereas Medicaid most often funds long-term employment supports for individuals with ID/DD (Haines et all 2012).

This section examines the types of employment services and supports that MFP grantees offer to participants through the MFP service package. It also presents information on the types and costs of HCBS employment supports delivered to participants during their first year of community residence by examining service use and expenditures in the aggregate and by type of employment service. It concludes by discussing several strategies four MFP grantee states are implementing to promote employment among participants.

2. Types of Employment Supports and Services Provided Through MFP Programs

We analyzed state operational protocol documents submitted by MFP grantees to identify the types of employment services that are offered to participants through an HCBS waiver or optional state plan, or as MFP demonstration or supplemental services.[39] MFP grantees offer to individuals with a disabling impairment a range of employment services and supports that can be grouped into five broad categories: (1) services that assist individuals with disabilities to obtain or sustain employment; (2) transportation that enables individuals with a disabling impairment to safely and independently travel to and from a waiver provider or community activity; (3) equipment, modifications, or technologies that help an individual with a disabling impairment to maintain or improve his or her ability to function in a home and community-based setting; (4) services to help individuals acquire or improve skills that are needed in the workplace; (4) and (5) counseling and other support services that promote the health, community integration, and employment of individuals with disabilities (Table IV.3).

Most grantee states (30 out of the 38 states in our analysis) offer supported employment to participants, which CMS defines to be "assistance in obtaining and keeping competitive employment in an integrated work setting" (Figure IV.1) (CMS Employment Initiatives 2013). Many grantee states also offer non-emergency transportation to participants that can be used to travel to and from a provider, such as supported employment services or a day program. In addition, seven grantee states provide funds to cover the cost of vehicle modifications that enable

[39] Operational protocol documents describe each MFP program in detail. These documents vary in the level of detail of MFP service descriptions. State grantees may update these protocols at any time.

individuals with functional limitations to travel safely and independently within the community. For individuals with disabling impairments, accessible and reliable transportation not only promotes independence and integration in the community, it is critically important to obtaining and sustaining employment.

Table IV.3. Types of HCBS Employment Services and Supports Offered to MFP Participants

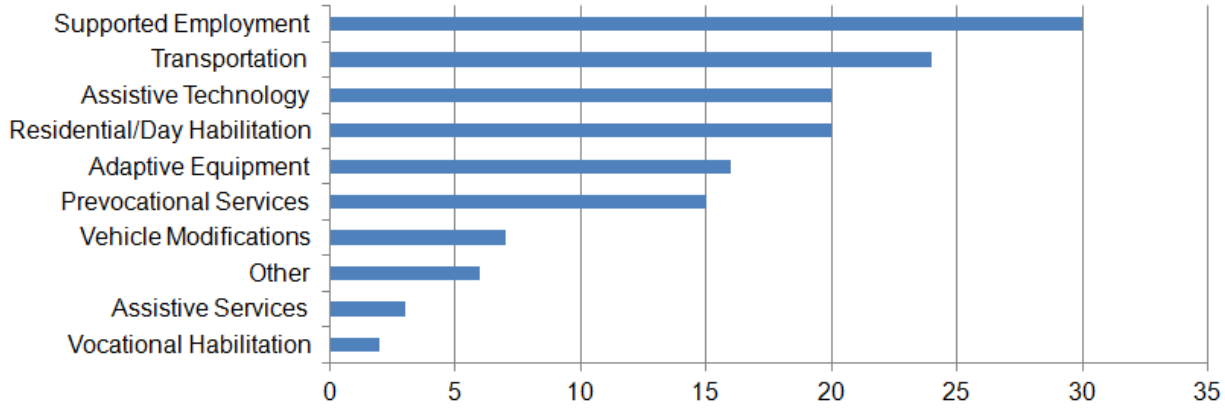
Employment Service/ Support Category	Service Description
Supported Employment[a]	Assistance to help a person to obtain and keep competitive employment in an integrated work setting.
Transportation[b]	Nonmedical transportation not provided as part of another service such as a round-the-clock service or a day service. This service may include (a) transportation to and from other waiver services; (b) transportation to community activities where waiver services are not provided; and/or (c) the purchase of public transit tokens or passes.
Assistive Technology/Adaptive Equipment[b]	The purchase or rental of items, devices, or product systems to increase or maintain a person's functional status. This service can include designing, fitting, adapting, and maintaining equipment, as well as training or technical assistance to use equipment.
Residential/Day Habilitation[b]	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills, that are necessary to reside successfully in home and community-based settings, including workplace settings.
Prevocational Services[b]	Time-limited services to provide learning and work experiences, including volunteer work, to acquire general skills that help a person obtain paid employment in integrated community settings.
Vehicle Modifications[b]	Physical changes to a private residence, automobile, or van, to accommodate the participant or improve his or her function.
Vocational Habilitation	Services that support an employment goal or outcome by assisting individuals with disabilities to get ready for, secure, or retain employment.
Assistive Services[c]	Supports or items designed to improve or promote the individual's health, independence, productivity, or integration into the community.
Other Services	"Other" services include employment specialist, job coaching, employment site modification, job stabilization services, sheltered workshop, and vocational futures planning.

Sources: [a]Centers for Medicare & Medicaid Services (CMS). "Employment Initiatives." Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html; [b]Medicaid Home and Community-based Services (HCBS) Taxonomy, Truven Health Analytics/Mathematica Policy Research, September 28, 2012; and [c]Kansas' operational protocol.

Besides supported employment and transportation related services, nearly two thirds of grantee states (20 states) provide some form of assistive technology to improve or maintain the functional capabilities of individuals. Sixteen grantee states provide adaptive equipment, which may include medical supplies or communication devices that help an individual to communicate within the environment in which they live. Fifteen grantee states also offer pre-vocational services to help prepare participants for successful employment in the workplace. In addition to these categories, many grantee states provide a range of other services, such as assistive services to promote successful integration into the community, employment specialists, job coaching, employment site modification, job stabilization services, sheltered workshop, and vocational futures planning.

Overall, a small share of participants are using employment services, ranging from less than 1 percent to more than 4 percent of current participants (4,882) as of the end of 2012. The most commonly accessed employment service was pre-vocational services, which assists individuals with preparing for work, accessed by 222 participants. The next most commonly accessed service was employment supports which 125 participants used to help find and maintain employment (Table IV.4). In 2012, 9 MFP participants in Ohio accessed vocational habilitation services, which teach and reinforce habilitation concepts related to work such as attendance, task completion, problem solving, social interaction, and safety (Ohio Department of Development Disabilities 2011). "Other" employment supports encompass community inclusion services provided to 53 participants with developmental disabilities in Oregon, which temporarily suspended its program in 2011.

Figure IV.1. Number of MFP Grantee States Offering Each Type of Employment Service/Support



Source: Mathematica analysis of MFP operational protocol documents from 38 states.

Note Service descriptions and level of detail in the operational protocol documents vary across MFP grantee states. The terms assistive technology and adaptive equipment are often used interchangeably, however they are shown separately here to reflect how MFP states defined the service offerings in the operational protocol documents. "Other" services include employment specialist, job coaching, employment site modification, job stabilization services, sheltered workshop, and vocational futures planning. Each of these sub-categories was reported by one state.

3. Use of Employment Supports and Services

We explored use and costs of employment services and supports by analyzing aggregated data from service claims records submitted by the MFP grantees through the end of 2012. The service records are for MFP participants who had transitioned from an institutional setting to the community by the end of December 2011. The analyses included service records submitted by 25 MFP grantee states that were operational throughout 2012. Of these states, 15 provided employment supports and services to MFP participants; most of these services were pre-vocational and supported employment services (see Table IV.4).

Table IV.4. Employment Support Utilization and Expenditures

Type of Employment Support	Number of States Provided	Number of Individuals Used	Total MFP Expenditures by Service Type	Percentage of Total MFP Expenditures Nationally
Pre-vocational Services	8	222	$1,713,752	0.36
Supported Employment	10	125	$1,041,599	0.22
Vocational Habilitation	1	9	$31,169	0.01
Other	1	53	$714,080	0.15

Source: Mathematica analysis of quarterly MFP services file submitted through December 2012.

Note The employment support service categories are mutually exclusive. The employment support service categories are derived from service codes and descriptions provided by MFP grantees in the MFP service crosswalks that are submitted quarterly. The analysis included service records for the following MFP grantees that were operational throughout 2012: California, Connecticut, Delaware, Georgia, Hawaii, Iowa, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, and Washington. Several MFP grantees provide HCBS to MFP participants through long-term managed care plans. The analysis excludes Arkansas, the District of Columbia, Rhode Island, Texas, Virginia, and Wisconsin because they either reported monthly capitated payments in the MFP claims records in 2012 or because data quality issues were identified in the submitted service claims.

When combined, employment supports and services totaled $3,500,600, which accounted for less than 1 percent of the $482,740,064 million of total HCBS spending by MFP programs by the end of 2012. However, these services might be underreported in service claims data if MFP states charge any portion as an administrative expense. Pre-vocational services mad up the majority of expenses ($1,713,752), followed by supported employment ($1,041,599), which may include job development, job coaching, supported employment enclave, and supports to maintain employment (Table IV.4).

4. Progress Toward Promoting Employment Among MFP Participants

CMS encourages MFP grantee states to implement initiatives to promote employment within their MFP programs. Employment for people with disabilities, including MFP participants, can help to ensure a successful transition from institutional to community living (CMS Policy Guidance 2011). Although many MFP grantee states provide supported employment services to participants through an HCBS waiver or optional state plan service, MFP programs may also request to use 100 percent administrative funds to hire specialized personnel or implement initiatives that enhance the program's transition and/or rebalancing efforts.[40] Several MFP grantee states have opted to use administrative funds to hire employment specialists to assist participants with identifying employment goals and finding and maintaining competitive work. Others have opted to use MFP grant funds to finance or expand vocational services; one state plans to add an MFP demonstration service to fund the cost of assistive technology to enable individuals who were previously employed to return to work.

We conducted telephone interviews with MFP program officials in Iowa, New Jersey, Ohio, and Texas to learn how their programs are promoting employment among participants. We selected these four states because they reported in their MFP semi-annual progress reports that they are implementing initiatives to increase employment among MFP participants. In some cases, the initiatives were an extension of activities that were conducted under the Medicaid Infrastructure Grants (MIG) program, which expired in December 2011. In other cases, MFP grantee states established mechanisms to identify and counsel individuals who expressed an interest in employment, hired staff to educate individuals about their employment options and support state workforce initiatives, and developed materials to guide individuals through the job search process (Table IV.5).

Table IV.5. Use of MFP Resources to Support Employment Goals of MFP Participants

MFP State	Established Referral Pathways to Employment Support Services	Hired Employment Specialist	Produced Informational Materials	Funded Services or Assistive Technology	Implemented Other System Changes
New Jersey	X	X	X	X	-
Ohio	X	-	-	X	X
Iowa	X	X	-	-	X
Texas	-	X	-	-	X

Source: Telephone interviews conducted with MFP program officials in April 2013.

[40] CMS issued policy guidance to MFP grantees on May 31, 2011, summarizing ways MFP grantees can promote employment among participants as part of their rebalancing plans.

Full descriptions of these employment initiatives are presented below. Although these grantee states are in the early stages of implementing employment-related initiatives, in-depth knowledge about their approaches can help to inform CMS or other MFP states considering strategies to promote employment among MFP participants.

New Jersey. New Jersey is engaged in several activities designed to support MFP participants' employment goals. First, in 2012 New Jersey developed an Employment Resource Packet that nurse liaisons give to MFP participants between the ages of 18 and 64 prior to transitioning to community living. The packet contains a (a) questionnaire capturing information about the individual's employment goals, (b) a resource manual that identifies state government and community organizations that serve people with disabilities, and (c) a copy of the Social Security Administration's (SSA) Red Book which summarizes SSA's disability-related policies. The packet provides individuals with useful information about employment resources as well as contact information for the employment specialist who assists participants with identifying and attaining their employment goals.

Second, New Jersey is hiring several dedicated staff with 100 percent administrative funds to talk with MFP participants about their employment options. In mid-2012, the state hired a full-time employment specialist who currently conducts targeted outreach to MFP participants who expressed an interest in pursuing employment when completing the baseline quality-of-life survey or who completed the employment questionnaire described above. The employment specialist also refers participants to employment services available through VR services, One-Stop Centers, and other organizations, and addresses any barriers to accessing these services. The state is also in the process of hiring two peer mentors who will conduct outreach targeting nursing home residents who had work experience prior to becoming disabled. Drawing on their personal experiences obtaining employment, the peer mentors will talk with individuals about their interests and work experience and counsel them about becoming employed post-transition. Peer mentors may also discuss interview skills with individuals and accompany them to appointments with employment agencies, such as VR.

Finally, New Jersey plans to add a new MFP demonstration service to provide participants, namely individuals with physical and sensory impairments, with assistive technology that will enable them to work in an integrated setting. MFP program officials have encountered individuals, particularly those with physical disabilities, who were previously employed and could return to work with technology that improves their functional capabilities in the workplace. Participants interested in employment currently indicate in the employment questionnaire administered upon discharge whether they are in need of any assistive technology. The employment specialist will then discuss with them their assistive technology needs and schedule a time for a certified technology assessor to acquire the necessary equipment, technology, or devices. The assistive technology demonstration service has been approved by CMS and will cover the cost of any technology that is not covered under the Medicaid state plan, which ordinarily funds costs of durable medical equipment and certain alternate communication systems (Moore 2006).

Ohio. In the past year, Ohio partnered with the state Rehabilitation Services Commission (RSC) to address systematic challenges that hindered individuals' access to employment services.[41] One systematic challenge the RSC encountered is the lack of funding for the state share of VR services which has resulted in waiting lists for individuals with disabilities who want to become employed. To address this challenge, in 2013, Ohio's MFP program began to leverage a portion of its MFP rebalancing funds to pay for the state share of vocational services. The services that are partly funded by MFP rebalancing funds include all services provided by the vocational counselors, from job placements, job readiness training, and prevocational skills training to job development and job coaching.

Because limited resources prevent all individuals eligible for VR services from being served, the RSC defines three categories that establish the order for waiting list for VR services. The priority categories are assigned based on how significantly the individual's disability impacts his or her ability to work (Ohio RSC 2012). Although MFP participants do not receive preferential treatment, most participants meet the first priority category, "most significant disability," which refers to an individual who needs multiple VR services and whose disability seriously limits three or more functional capacities in terms of an employment outcome (Ohio RSC 2012).

The RSC produces quarterly reports for the Ohio MFP program to track MFP participants who are progressing through the VR system and whether the services result in successful employment outcomes, such as sustained competitive employment. MFP program officials in Ohio report that in the future, they would like to compare MFP participants' employment outcomes with individuals who accessed the vocational services outside of MFP to determine whether MFP has expanded opportunities for participants interested in becoming employed.

Ohio has also used MFP funds to establish referral protocols and pathways to enhance MFP participants' access to RSC services. A small workgroup of MFP transition coordinators and RSC counselors developed and delivered joint trainings to transition coordinators and RSC counselors to raise awareness about the MFP program and the RSC and also to ensure that local staff know how and where to make referrals when identifying individuals who express an interest in employment. Ohio also formalized the referral protocols, so transition coordinators have an established process when making referrals to the RSC. The status of all referrals that transition coordinators place to the RSC are tracked via the quarterly reports described above.

Iowa. Iowa is promoting employment through its MFP program in several ways. The MFP program hired a dedicated employment specialist in 2011 to develop relationships with employment agencies, collaborate with employment agencies to address systemic policy barriers, and assist participants with obtaining employment. In Iowa, when the transition specialist first meets with the individual to discuss a transition plan, he or she also discusses employment and

[41] The RSC houses the Bureau of Vocational Rehabilitation, the Bureau of Services for Visually Impaired, and the Division of Disability Determination Services. The RSC's Bureau of Vocational Rehabilitation provides individuals with disabilities the services and support necessary to help them attain and maintain employment.

volunteer opportunities with the individual. Once the transition team decides employment is a goal, the transition coordinator refers the individual to the employment specialist who then develops a brief employee profile capturing information about the types of benefits received, as well as the individual's educational background, work history, and health. The employee profile is sent to community rehabilitation providers who assist individuals with job placement. If the provider thinks he or she can employ the individual, the provider meets with the participant so they can jointly decide whether they would like to work together. The employment profile serves as an initial screening to ensure only individuals who would likely be employed are referred to the provider for job placement.

In addition to screening participants for possible employment, the employment specialist refers participants who are interested in employment to existing agencies, most often the Vocational Rehabilitation Services (VRS). The specialist works with the individual and the VRS counselor to identify what role each will perform in supporting the individual's employment goals. The employment specialist also provides direct service to individuals when there is not an agency to work with. For example, the employment specialist helped one participant launch his own business by helping him to apply for a grant to cover start-up costs.

MFP program staff are also working with the VRS to improve payment methodologies to promote integrated employment outcomes among individuals with disabilities. Iowa was one of four states that was awarded an Employment First grant in 2012 by the Department of Labor. This grant initiative, which in Iowa is administered by the VRS, provides support and informational resources to help states align policies, regulations, and funding priorities to encourage integrated employment among individuals with significant disabilities (US DOL 2013). Through this grant, Iowa is implementing six Customized Employment Pilots to encourage Medicaid providers to use a customized approach to assist individuals with disabilities in obtaining employment in an integrated and competitive work setting.

Customized employment is a flexible process based on an individualized match between the strengths, conditions, and interests of a job candidate and the identified business needs of an employer (US DOL 2013). Each pilot is implementing customized employment with five individuals, some of whom are MFP participants, to gather information about service costs and implementation lessons learned to facilitate the replication and growth of customized employment. This information will be used to potentially modify the service rate structure to ensure providers do not lose money when they provide integrated employment as a service offering to individuals with disabilities. Under this grant, the employment specialist provides direct services to a small number of MFP participants to facilitate their obtaining integrated employment. As of May 2013, one MFP participant has obtained part-time employment through the Customized Employment Pilot; the employment specialist is currently working with another participant to secure employment.

Texas. Texas has focused its efforts on supporting individuals with ID/DD to obtain employment in an integrated and competitive setting. The state is using 100 percent administrative funds to implement a Customized Employment Project to provide individuals with ID/DD more opportunities to move out of segregated settings into integrated employment at

local businesses. In spring 2013, the Texas Health and Human Services Commission issued a request for proposal for one ICF/IID and two Medicaid 1915(c) waiver providers to design and implement policies and practices within their agencies over a three-year period that are consistent with the "Employment First" philosophies.[42] By the end of the first year of participation, each Medicaid provider is expected to create and begin implementing a plan to relocate individuals served from congregate day settings to competitive employment and initiate employment services for at least fifteen percent of the individuals with IDD currently receiving non-vocational day services (Texas HHSC 2013). By the end of the second year of participation, the Medicaid providers are expected support at least fifty percent of the individuals currently receiving segregated day services in competitive employment. The pilots are still in the planning phase. They have not yet begun to design or implement the organizational change activities. However, examples of how funds could be used include (1) obtaining training and technical assistance to implement the customized employment model, (2) obtaining training on Social Security Administration work incentives and the components of a benefits plan, (3) providing staff training to build competency so they can become benefits and work incentive counselors, and (4) and establishing relationships with local employers (Texas HHSC 2013).

Texas also hired an employment specialist in mid-2012, however the position was vacant as of April 2013. The employment specialist does not provide direct service to MFP participants, but rather supports the workforce initiatives within the entire Health and Human Services Commission, which includes HCBS waiver programs, vocational rehabilitation, and sister agencies. The employment specialist will also help to implement the MFP Customized Employment Pilot Project and provide training and technical assistance about the pilot to vocational rehabilitation counselors, Medicaid staff, and individuals receiving services.

[42] Under the Employment Pilot Project, "Employment First" presumes that employment in the general workforce is the preferred outcome in the provision of publicly funded services for all working-age citizens with disabilities; all working-age adults and youth with disabilities can work in competitive jobs fully integrated within the general workforce; employment services will be the first service option considered in the course of service planning; and all efforts will be made to encourage and assist individuals in obtaining the support needed to succeed in a competitive employment before other day services are pursued (Texas HHSC 2013).

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V. CHARACTERISTICS OF MFP PARTICIPANTS

To understand the outcomes and effects of any demonstration requires an understanding of who takes up the demonstration and is directly affected by it. In this chapter we assess the basic demographic characteristics of MFP participants. We also assess the level of care needs among those who transition from nursing homes, relying on information from the nursing home minimum data set (MDS) and using a measurement approach developed by Ikegami et al. (1997) and refined by Mor et al. (2007). Unfortunately, assessment data, such as that available from the MDS, are not available for individuals who transition from intermediate care facilities or long-term psychiatric facilities or hospitals. This chapter concludes with a description of the MFP participants use and costs of home and community-based services (HCBS) while eligible for MFP benefits.

A. Demographic Characteristics of MFP Participants

The general demographic makeup of the MFP participants has remained relatively stable since calendar year 2009. By the end of 2012, 61 percent of MFP participants were working-age adults (Table V.1) between ages 21 and 64, and the average MFP participant was 58 years old at the time of the transition.[43] The population continued to be relatively evenly divided between men and women, although men dominated the group transitioning from an intermediate care facility for individuals with intellectual disabilities (ICFs/IID), and women made up a larger proportion among the elderly transitioning from nursing homes.

People eligible for both Medicaid and Medicare benefits are some of the most costly individuals in both programs and they are particularly costly if they use LTSS (MedPAC 2012). Among all MFP participants, approximately 65 percent were dually eligible for both Medicaid and Medicare benefits, although the data used for this analysis likely understated Medicare enrollment for the most recent MFP participants.[44] Although nearly all elderly were Medicare-Medicaid enrollees, less than half of those in the "other" group (primarily those with traumatic brain injury or dually diagnosed with mental illness and another disabling condition) were dually eligible for Medicare and Medicaid. Approximately half (52 percent) of the nonelderly with physical disabilities were eligible for Medicare and Medicaid coverage, and 61 percent of MFP participants with intellectual disabilities received both Medicaid and Medicare benefits.

[43]Women tend to be slightly older than men–the average age for female MFP participants was 62 years as compared with an average age 54 years among men (data not shown).

[44]Information on dual eligibility in Medicare and Medicaid is likely to be underreported for the most recent MFP participants. The MFP grantee states reported this information, and Medicare enrollment was confirmed for most participants, but lags in the Medicare data mean that we could not confirm Medicare enrollment for many who transitioned in 2012.

Table V.1. Demographic Characteristics of All MFP Participants Through December 2012

Characteristic	Overall	Elderly	Physical Disabilities	Intellectual Disabilities	Other	Unknown
Number	28,961	8,340	11,285	4,245	743	4,348
Average age (in years)	58	77	51	45	50	55
Age Distribution	-	-	-	-	-	-
Younger than 21	3.2	0.0	1.0	9.8	19.5	5.8
21 to 44	16.4	0.0	19.5	37.0	17.6	19.2
45 to 64	44.5	0.0	79.5	39.7	31.2	46.0
65 to 79	23.0	62.9	0.0	10.3	18.0	19.3
80 and older	13.0	37.1	0.0	3.2	13.6	9.7
Gender	-	-	-	-	-	-
Male	49.6	35.2	55.0	60.9	48.0	52.3
Female	50.4	64.8	45.0	39.1	52.0	47.7
Medicare Eligibility	-	-	-	-	-	-
Medicare-Medicaid Enrollee	65.1	87.8	51.5	61.2	49.1	63.4

Source: Mathematica analysis of MFP program participation data files and MFP Finder's files and Medicare enrollment records from 2007—2012.

Note: Arkansas, California, Indiana, Kansas, Missouri, Oklahoma, Tennessee, and Virginia accounted for 83 percent of the participants who could not be classified into a targeted population. Age was determined at the start of a MFP eligibility period. The data used likely underreport those eligible for both Medicare and Medicaid benefits. The information was reported by the MFP grantees, but we were not able to verify the Medicare eligibility of all MFP participants with cross checks to Medicare eligibility records.

B. Types of Community Residences

Of all the MFP participants who had transitioned by the end of 2012, 30 percent transitioned to apartments in their community, 28 percent to a home owned by the participant or a family member, and 15 percent moved to a group home of four or fewer people (Table V.2). Assisted living was less common (at 9 percent), presumably because most assisted living units do not meet the qualified residence requirements established by CMS. Elderly MFP participants most commonly move into a home (43 percent), while the nonelderly with physical disabilities were more likely to move to an apartment (45 percent). Those with intellectual disabilities predominantly moved into small-group homes of four or fewer individuals (61 percent).

Table V.2. Types of Qualified Residences of MFP Participants At the Time of the Transition

Type of Residence	Overall	Elderly	Physical Disabilities	Intellectual Disabilities	Other	Unknown
Number	28,961	8,340	11,285	4,245	743	4,348
Home	27.9%	43.4%	31.0%	5.1%	37.0%	11.0%
Apartment	30.3%	25.6%	45.1%	18.3%	14.7%	15.4%
Assisted living	8.9%	13.9%	8.1%	7.1%	8.3%	3.4%
Group home of no more than four	15.2%	7.1%	6.6%	61.3%	10.2%	9.0%
Unknown	17.6%	10.0%	9.3%	8.2%	29.7%	61.2%

Source: Mathematica analysis of MFP program participation data files from 2007—2012.

Note: Most MFP participants in Arkansas, Delaware, Kansas, Maryland, Missouri, and Virginia, qualified residence information was missing in the data. These six states account for approximately 71 percent of those with an unknown residence. The data present only the type of qualified residence a participant moves to upon transition to the community. They do not reflect the type of residence participants might move to after the initial transition.

The proportion of MFP participants moving to homes has held steady at about 28 to 29 percent of participants. The percentage moving to apartments grew from 21 percent at the end of 2009 to 30 percent two years later in 2011, and the percentage moving to small-group homes declined from 29 percent at the end of 2009 to 20 percent at the end of 2011 to 15 percent at the end of 2012 (Irvin et al. 2012). These trends appear to be driven primarily by the changing composition of MFP participants over that time, as people transitioning from ICFs/IID who more often move to small-group homes made up an increasingly smaller share of all participants.

C. Level of Care Needs Among MFP Participants Transitioning from Nursing Homes

MFP programs are transitioning nursing home residents with a range of care needs. Previous work by Ross et al. (2012) found that during the first years of the MFP program (2008 through 2009), participants who transitioned from nursing homes disproportionately had low care needs compared with other nursing home residents in the same states who transitioned without the benefit of the MFP program. Although providing critical insight into understanding the types of nursing home residents transitioned by MFP programs and for placing program outcomes into context, the work captured only the early years of MFP program implementation (2008—2009), and there is reason to believe that the care needs of MFP participants may have changed over time as programs matured.

This section builds on this previous work by analyzing the level of care among all MFP participants transitioning from nursing homes through the end of calendar year 2012. The work

is necessarily limited to former nursing home residents because assessment data are available for this population only and we have no assessment data for MFP participants who transitioned from intermediate care facilities, psychiatric facilities, or hospitals. We examine the trends in level of care needs of former nursing home residents overall, by year, subpopulation, and by state. When measuring the level of care needs, we used a methodology developed by Ikegami et al. (1997) and further refined by Mor et al. (2007). Appendix D, Table D.1 illustrates how we defined each level of care need. In addition to assessing level of care need, we also examined the components that contribute to someone's level of need including the degree of functional dependence, cognitive impairment, mental illness, and behavioral problems. The following analyses are descriptive only and do not include tests for statistical significance.

1. Level of Care and Clinical Characteristics Overall (2008—2012)

Approximately 29 percent of MFP participants who transitioned from nursing homes during the first five years of the program (2008—2012) had low care needs based on their most recent MDS assessment that could be matched with MFP enrollment information (Table V.3). This result is consistent with the relatively young profile of program participants—58 percent of those transitioning from nursing homes were under 65—and their lack of cognitive impairment. These findings are also consistent with those reported for the first two years of program implementation by Ross et al. (2012). Although meeting the definition for low care indicates that an individual does not require physical assistance in any of the four late-loss activities of daily living (ADLs), it does not mean they are entirely physically independent.[45] The average ADL summary score of 11.5 (out of a maximum of 28.0) indicates that most MFP participants needed at least partial physical assistance with one or more of seven ADLs (the four late-loss ADLs, plus locomotion, dressing, and hygiene).

Many MFP participants experienced a severe mental illness while in the nursing home. Approximately 64 percent were reported with anxiety disorder, depression, manic depression, psychotic disorder, schizophrenia, or post-traumatic stress disorder (PTSD). Excluding depression from this category, the figure drops to 31 percent. This finding is consistent with high levels of depression generally observed among nursing home residents (Kasper and O'Malley 2007), and suggests that MFP programs may need to monitor mental and behavioral health issues to ensure successful transitions for at least some former nursing home residents. Finally, we observed that slightly less than 19 percent of MFP participants were reported to have at least one behavior problem (for example, verbal or physical abuse, or resistance to care) occurring on four or more days per week while they were residing in the nursing home.

[45] The four late-loss ADLs are eating, bed mobility, toileting, and transferring.

Table V.3. Level of Care and Other Characteristics of MFP Participants Transitioning from Nursing Homes (2008—2012)

Characteristic	Percentage or Mean Among MFP Participants (N=21,125)
Gender (Percentage)	-
Male	46.5
Female	53.5
Age (Percentage)	-
< 18 years	0.2
18—24	1.2
25—44	10.2
45—64	46.3
65—74	18.6
75—84	15.1
85+	8.4
Level of Care (Percentage)	-
Low	28.6
Medium	43.9
High	27.0
Uncategorized	0.6
ADL Summary Score (mean)	11.5
Cognitive Performance Score (mean)	-
MDS 2.0 (0-6) (n = 8,438)	1.5
MDS 3.0 (0-15) (n = 11,584)	13.1
Severe Mental Illness, Including Depression	63.7
Severe Mental Illness, Excluding Depression	30.9
One or More Frequent Behavioral Problem	18.9

Source: Mathematica analysis of MFP administrative files from 2008—2012, MDS 2.0 data from January 1, 2008–September 30, 2010, and MDS 3.0 data from October 1, 2010—December 31, 2011.

Note: Appendix D, Table D.1 presents the definitions for each level of care need. Under the MDS 2.0 scale, cognitive impairment is identified by a cognitive performance score of 2 or higher. Under the MDS 3.0 scale, cognitive impairment is identified by a cognitive performance score of 12 or lower. A frequent behavioral problem is reported if the resident wanders, is verbally abusive, physically disruptive, engages in other disruptive behaviors, or refuses care at least four days per week.

2. Level of Care Among Subpopulations of MFP Participants (2008—2012)

Subgroup analyses reveal that nonelderly adult MFP participants (under age 65) who transition from nursing homes had lower care needs than elderly participants who also transition from nursing homes (65 years or older) (Table V.4). While 32 percent of nonelderly participants had low care needs, only 23 percent of older adults did so. They also had lower ADL summary scores (10.8 compared with 12.5) and cognitive impairment relative to elderly MFP participants. Further subgroup analyses provide only a limited amount of additional information, but it appears that at least among the elderly transitioning from nursing homes, those with behavioral problems have above average rates of cognitive impairment.

Table V.4. Level of Care and Other Characteristics of MFP Participants, by Subpopulation Transitioning from Nursing Homes (2008—2012)

Characteristic	Older Adults Overall (N=8,893)	Older Adults with SMI (N=5,224)	Older Adults with BP (N=1,407)	Non-Elderly Adults Overall (N=12,232)	Non-Elderly Adults with SMI (N=8,225)	Non-Elderly Adults with BP (N=2,572)
Level of Care (Percentage)	-	-	-	-	-	-
Low	23.4	24.5	21.8	32.3	34.2	32.0
Medium	45.6	46.3	48.8	42.7	43.1	44.8
High	30.4	28.7	29.3	24.4	22.5	23.1
Uncategorized	0.5	0.4	0.1	0.6	0.3	0.1
ADL Sum Score (mean)	12.5	12.3	13.1	10.8	10.4	10.8
Cognitive Performance Score (mean)	-	-	-	-	-	-
MDS 2.0 (0-6)	1.8	1.8	2.4	1.3	1.2	1.7
MDS 3.0 (0-15)	12.2	12.3	10.9	13.7	13.7	13.2

Source: Mathematica analysis of MFP administrative files from 2008—2012, MDS 2.0 data from January 1, 2008—September 30, 2010, and MDS 3.0 data from October 1, 2010—December 31, 2011.

Note: Appendix D, Table D.1 presents the definitions for each level of care need. The MDS 2.0 assessment defined cognitive impairment as a score of 2 or higher on the Cognitive Performance Scale. The MDS 3.0 assessment defines cognitive impairment as a score of 12 or lower on the Cognitive Impairment Scale.

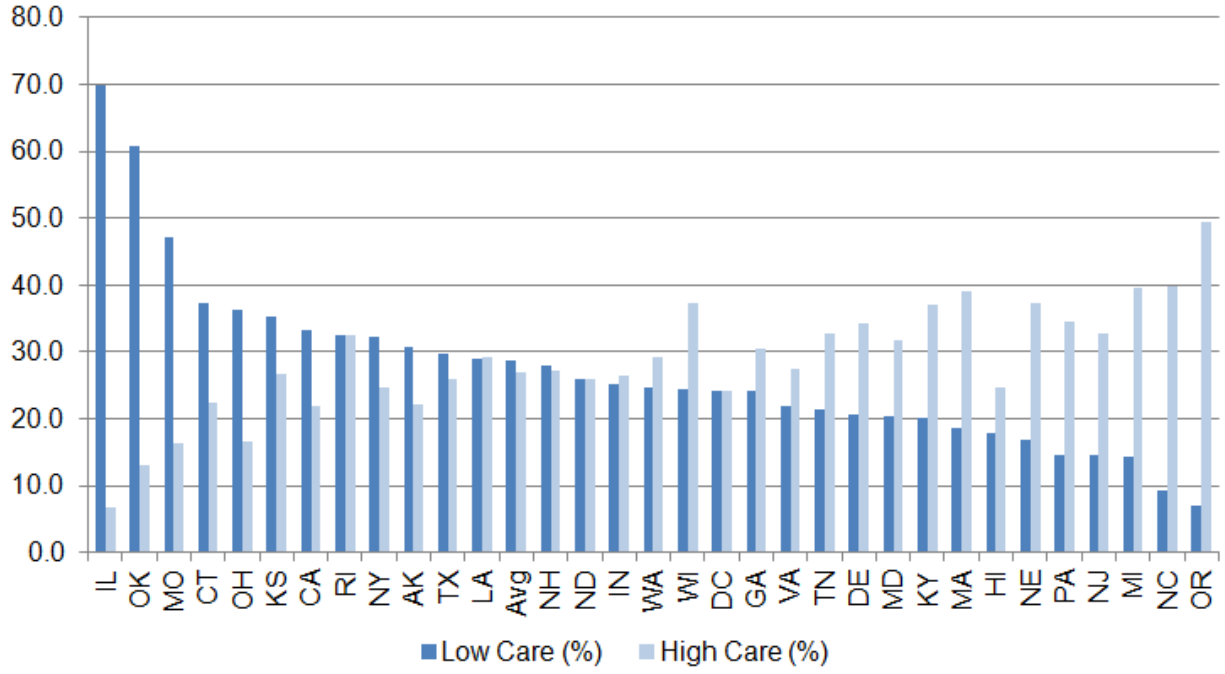
ADL = activity of daily living; BP = behavioral problems; MDS = Minimum Data Set; SMI = severe mental illness.

3. Level of Care by State (2008—2012)

Our state-level analysis of MFP participant care needs from 2008 to 2012 suggests that although some states transitioned nursing home residents with low care needs primarily, others

transitioned residents with higher needs (Figure V.1). Specifically, we observe that the MFP program in Illinois, Oklahoma, Missouri, Connecticut, Ohio, and Kansas transitioned a higher proportion of low care needs individuals than other states, on average. On the other hand, Oregon, North Carolina, Michigan, New Jersey and Pennsylvania transitioned a higher proportion of higher care MFP participants than other states on average during this period (2008—2012). State-level differences are difficult to interpret because they can reflect numerous factors including state-level differences in the population residing in nursing home as well as targeting by MFP programs. Regardless, these trends appear to be stable over time. That is, if certain states had disproportionately higher rates of MFP participants with low care needs in the initial years, their participants in later years continued to have disproportionately higher rates of low care needs as well.

Figure V.1. Percentage of MFP Participants with Low and High Care Needs, by State (2008—2012)



Source: Mathematica analysis of MFP administrative files from 2008—2012, MDS 2.0 data from 2008—20120, and MDS 3.0 data from 2010—2011.

Note: Results for Idaho, Mississippi, and Vermont are not included because these states had less than 30 participants in our data file. Iowa is not included because it does not transition nursing home residents.

D. HCBS Expenditures of MFP Participants

MFP programs provide participants a rich mix of HCBS to prepare for and support the transition from institutional to community-based care and to help them continue living in the community once they have settled into their new homes. Because states have flexibility in the services they provide MFP participants, examining the level of spending and service variation across states will be important to the understanding who enrolls and the outcomes of the MFP demonstration.

1. MFP Expenditures on HCBS from 2007 through 2011

Upon returning to the community, MFP participants receive long-term services and supports (LTSS) through 1915(c) waivers or optional state plan services (such as personal assistance services). MFP demonstration programs can offer a variety of services grouped into three FMAP categories: (1) qualified HCBS, (2) demonstration HCBS, and (3) one-time supplemental services that support transitions to the community. Qualified HCBS are services that the state provides to all Medicaid beneficiaries who need these services either through their state plan or through 1915(c) HCBS waivers, regardless of their participation in the MFP program. States also have the option to offer MFP participants demonstration HCBS, which are allowable services not otherwise available to Medicaid beneficiaries in the state. Examples may include extra hours of personal care assistance beyond what is allowed or a specific type of behavioral health service. These extra services are typically short in duration to help with the transition. Lastly, states may provide supplemental services as one-time benefits to support the transition back to the community. In some instances, supplemental services are not typically covered by Medicaid programs (such as payment of overdue electrical bills) or not available outside a waiver program. States are not required to provide demonstration HCBS or supplemental services. All qualified HCBS and demonstration services provided to MFP participants are reimbursed at an enhanced Federal Medical Assistance Percentage (FMAP), making it appealing for states to offer either or both categories of services. States receive their regular FMAP for the supplemental services they provide.

Aggregate data from state budget worksheets show that state MFP programs spent nearly $657 million on HCBS from the program's inception through the end of 2011 (Table V.5). HCBS expenditures in a calendar year represent HCBS paid for individuals who transitioned in 2012 and individuals who transitioned in 2011 but whose enrollment crossed into the following calendar year.

More than two-thirds of HCBS expenditures were for qualified HCBS and demonstration HCBS accounted for more than one-quarter of expenditures (Table V.5). Supplemental services, on the other hand, represented a very small proportion of total expenditures. Of the states that provided supplemental services point between 2008 and 2011, approximately 88 percent have reduced their supplemental services expenditures between 2010 and 2011 (data not shown). This change most likely resulted from CMS guidance to reclassify supplemental services as demonstration services whenever it made sense to do so to help the states maximize their FMAP rate. In total, despite a disproportionately large share of expenditures going to qualified HCBS, 23 states offered HCBS demonstration services, 16 states offered supplemental services, and 15 offer both demonstration and supplemental services.

Table V.5. HCBS Expenditures by FMAP Category, by State

State	Total MFP Expenditures 2007—2011 (Dollars)	Qualified HCBS (Percentage)	Demonstration HCBS (Percentage)	Supplemental Services (Percentage)
Total	657,458,731	69	27	3
Arkansas	8,115,211	87	13	0
California	16,840,141	91	9	0
Colorado[a]	-	-	-	-
Connecticut	21,239,158	77	1	22
Delaware	2,381,944	15	65	20
District of Columbia	10,936,858	100	0	0
Florida[a]	-	-	-	-
Georgia	34,648,337	94	5	1
Hawaii	2,583,078	99	1	0
Idaho[b]	20,570	100	0	0
Illinois	3,756,555	91	2	7
Indiana	6,113,160	76	1	23
Iowa	12,574,811	87	12	1
Kansas	17,664,723	89	11	0
Kentucky	24,372,271	99	0	1
Louisiana	6,996,533	100	0	0
Maine[a]	-	-	-	-
Maryland	61,069,217	100	0	0
Massachusetts[b]	165,758	100	0	0
Michigan	18,039,153	100	0	0
Minnesota[a]	-	-	-	-
Mississippi[a]	-	-	-	-
Missouri	20,572,305	99	1	0
Nebraska	5,353,219	100	0	0
Nevada[a]	-	-	-	-
New Hampshire	4,368,029	97	2	0
New Jersey	10,440,448	100	0	0
New York	32,212,059	100	0	0
North Carolina	3,438,029	97	3	0
North Dakota	3,945,138	92	6	3
Ohio	66,719,029	70	13	17
Oklahoma	9,253,471	80	20	0
Oregon	19,783,135	90	0	10
Pennsylvania	17,090,493	100	0	0
Rhode Island[b]	453	100	0	0
Tennessee[b]	204,633	97	3	0
Texas	150,243,193	0	100	0

Table V.5 (continued)

State	Total MFP Expenditures 2007—2011 (Dollars)	Qualified HCBS (Percentage)	Demonstration HCBS (Percentage)	Supplemental Services (Percentage)
Vermont[a]	-	-	-	-
Virginia	22,166,328	81	15	5
Washington	36,779,539	85	15	0
West Virginia[a]	-	-	-	-
Wisconsin	7,371,752	100	0	0

Source: Mathematica analysis of MFP Budget Worksheets for 2012 including expenditures from 2007 through the end of 2011.

Note: Annual expenditures are inflated to 2012 US dollars using the medical care component of the Consumer Price Index available from the Bureau of Labor Statistics.

[a]Colorado, Florida, Maine, Minnesota, Mississippi, Nevada, Vermont, and West Virginia had not begun their MFP grants by the end of 2011 and therefore have no expenditures to report.

[b]These states have low expenditures because they began transitioning MFP participants near the end of 2011.

2. HCBS Spending by Target Population

From the initial transition to the end of enrollment in MFP, per-person spending on HCBS among the participants in the sample was approximately $37,600 for the year, or approximately $3,625 per person per month (Table V.6).[46] HCBS expenditures varied considerably across the targeted populations. For example, elderly participants and those participants with intellectual disabilities had a more than three-fold difference in overall per-person, per-month expenditures. Data for this study did not provide enough detail to explain this difference in expenditures between these two groups. However, any cost difference across groups most likely reflects differences in the type and intensity of services delivered to each population. As the data in

[46] We analyzed individual service records for 12,839 MFP participants who had transitioned by the end of December 2011 from 25 states and for whom a year's worth of service claims records were available. This sample size represents about 63 percent of everyone who had transitioned by the end of December 2011 and includes spending on HCBS delivered by the end of 2012 and reported in quarterly MFP Services files. Some HCBS that may have been provided by the state's regular Medicaid program were not included in this analysis, which suggests that the data presented most likely underestimates total HCBS spending.

Table V.2 indicate, most MFP participants with intellectual disabilities move to small-group homes of four or fewer people, and group homes frequently provide 24-hour attendant care.[47]

Our analyses excluded three important groups of MFP participants. We excluded 6,144 MFP participants from Arkansas, the District of Columbia, Texas, and Virginia because many were enrolled in managed care plans and their claims information would not be equivalent to others who receive HCBS in a fee-for-service system. Additionally, the analysis excluded MFP participants who did not have a MFP service record on file (roughly 6 percent of all individuals who transitioned to MFP by the end of 2011). Finally, Idaho, Massachusetts, Rhode Island, and Tennessee began transitioning MFP participants in 2011 but were excluded because complete information on claims are not yet available for these states.

Monthly expenditures also varied over the year of community living, and a disproportionate amount of HCBS expenditures were incurred within the first 30 days of enrollment (Table V.6). The data indicate that monthly service expenditures during the first 30 days after the initial transition were on average more than 54 percent higher than those for the remainder of the year. Services delivered during the first month of enrollment include transition planning and coordination services, home modifications and set-up, and HCBS to support care needs. Some services—such as transition planning and coordination—can be provided while the patient still lives in the facility, in preparation for the actual transition. As a result, the costs associated with the first 30 days included many services specific to the transition and were likely to be of short duration. The costs incurred after the initial 30 days were more likely to reflect costs associated with the ongoing care that MFP participants need to live in the community on a long-term basis.

3. HCBS Spending by Enrollment Cohort

Spending on MFP participants has decreased over time (Figure V.3). For example, per-participant per-month HCBS spending decreased by 40 percent—from $5,250 in 2008 to $3,100 in 2011. In addition, the average per-participant spending estimate of $37,600 (Table V.6) is lower than the estimate presented in the 2011 Annual Report, which was $41,000. MFP participants who are elderly, have physical disabilities, or have intellectual disabilities all have

[47] Of the MFP participants who transitioned by the end of 2011 in the 25 states of our analyses, 8 percent did not have a service record for HCBS, and were excluded from our analyses. Most individuals without a record of receiving HCBS were participants in the programs operating in California, Indiana, and Washington. Although these individuals had no record of receiving HCBS, it is possible that they received services. Some states, such as California, pay for certain transition services through MFP administrative funds, which would not result in specific service claim records of the type used in this analysis. Another possibility is incomplete data. At the time this report was written, 16 states—including Indiana and Washington—had not submitted MFP service files for at least one quarter for the period of study. If all individuals with no service records are included in the sample and treated as having zero expenditures (rather than being deleted from the sample due to missing data), then average HCBS expenditures would decrease by 7 percent.

declining per-participant, per-month spending over time. Reasons behind the decrease are unclear given available data, but the decline may be attributable to (1) changes in the level of care needs for MFP participants who transition from nursing homes; (2) changes in the types of services offered and delivered to MFP participants; (3) a program maturation effect that reflects learning how to provide services more cost effectively or a reduction in per person costs as the volume of participants increase; and (4) a shorter run-out period to observe claims for MFP participants transitioning near the end of 2011.

Table V.6. Per-Person and Per-Person, Per-Month HCBS Expenditures During the First 30 Days and After the First 30 Days of Community Living by Target Population

			Per-Person, Per-Month Expenditures[b]		
Target Population	Number of MFP Participants	Per-Person Expenditures[a]	Overall	First 30 Days[c]	After First 30 Days
Total	12,839	37,600	3,622	5,312	3,447
Elderly	3,408	22,968	2,298	3,792	2,136
Physical Disabilities	5,367	32,243	3,060	5,365	2,824
Developmental Disabilities	1,628	84,825	7,797	8,913	7,688
Mental Disabilities	52	35,255	4,158	4,840	4,077
Other	381	39,230	4,124	4,936	4,031
Unknown	2,003	38,214	3,666	4,930	3,537

Source: Mathematica analysis of MFP services files and program participation data files submitted by 25 grantee states through December 2012.

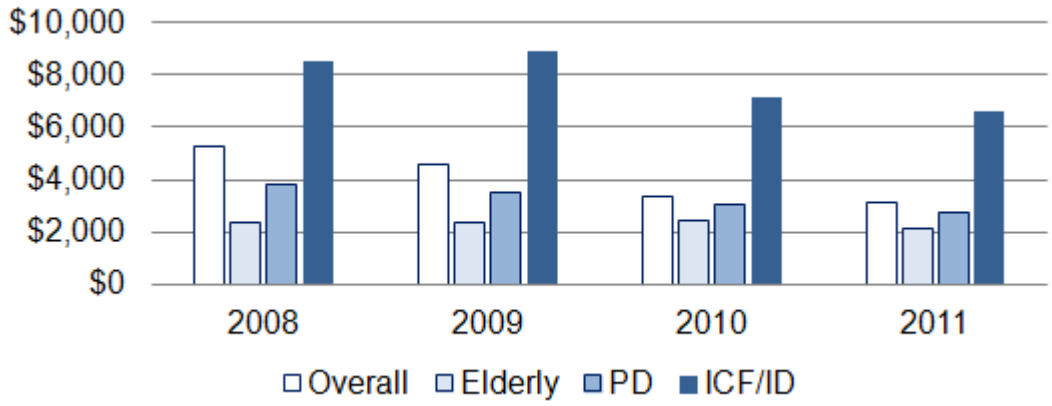
Note: Expenditures include qualified, demonstration, and supplemental services. Arkansas, the District of Columbia, Texas, and Virginia were not included in this because a high proportion of MFP participants receive HCBS through managed care. Therefore, their claims information is not equivalent to that for participants in fee-for-service systems. Idaho, Massachusetts, Rhode Island, Tennessee, and Wisconsin were excluded because they lack all the data needed for analysis.

[a] Calculated as the total expenditures divided by the total number of MFP participants. These figures are not weighted for length of participation in the MFP program.

[b] Weighted by length of participation in the MFP program.

[c] Includes transition services provided either immediately before or at the time of the transition, as well as any HCBS provided during the first 30 days of community living.

Figure V.2. Average Per-Person, Per-Month HCBS Expenditures by Year of MFP Transition



Source: Mathematica analysis of MFP services files and program participation data files submitted by 25 grantee states through December 2012.

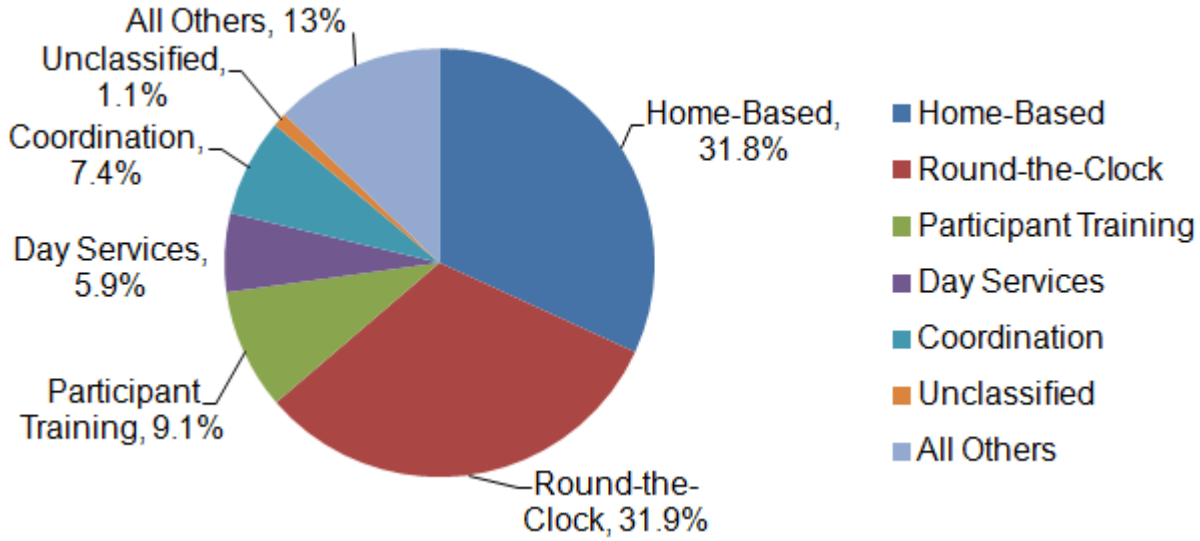
Note: Expenditures include qualified, demonstration, and supplemental services. Arkansas, the District of Columbia, Texas, and Virginia were not included because a high proportion of MFP participants receive HCBS through managed care. Therefore, their claims information is not equivalent to that for participants in fee-for-service systems. Idaho, Massachusetts, Rhode Island, Tennessee, and Wisconsin were excluded because they lack all the data needed for analysis. The overall group contains expenditures for all MFP 12,839 participants with data.

4. Array of Home- and Community-Based Services Provided

To meet the care needs of its participants, each MFP program relies on a diverse set of HCBS. The HCBS provided to MFP participants spans many professional competencies and technology categories. For this work, we used the HCBS taxonomy that Truven Health Analytics and Mathematica have been developing and testing for the Centers for Medicare & Medicaid Services (CMS) (Eiken 2011 and Wenzlow et al. 2011). We analyzed the HCBS claims records reported by 25 state grantees.[48] Whenever possible, we indicate when we adapted the HCBS taxonomy to better meet the needs of this study. The services are organized into 16 mutually exclusive service categories; similar to the HCBS taxonomy. We added a 17th category to capture services that we could not classify because of inadequate information on the claims record. We also further disaggregated the information into 39 mutually exclusive subcategories to provide more information about the types of services within each category. This analysis used far fewer subcategories than the HCBS taxonomy, which includes 66 subcategories, because the volume of claims did not always support the level of detail that the HCBS taxonomy was designed to capture.

[48] The analysis was based on data available from the quarterly MFP Services files that grantees submit. Some HCBS that may have been provided by the state's regular Medicaid program were not included in this analysis.

Figure V.3. MFP Expenditures by Service Category



Source: Mathematica analysis of MFP services files and program participation data files submitted by 25 grantee states through December 2012 for participants transitioning by the end of 2011.

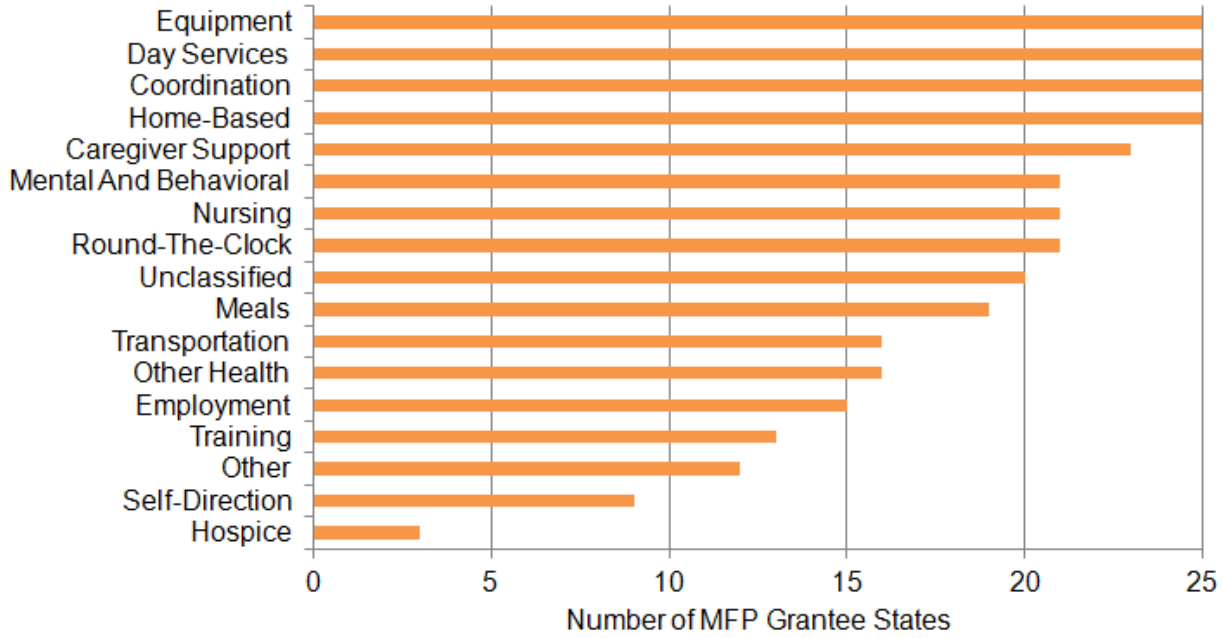
Notes: Expenditures include qualified, demonstration, and supplemental services. Arkansas, the District of Columbia, Texas, and Virginia were not included because a high proportion of MFP participants receive HCBS through managed care. Therefore, their claims information is not equivalent to that for participants in fee-for-service systems. Idaho, Massachusetts, Rhode Island, Tennessee, and Wisconsin were excluded because they lack all the data needed for analysis. The "All Others" group was broadly defined to include all other service categories not otherwise included in the six largest categories of expenditures, and it includes the "other service" category.

Of the 17 categories of services MFP programs provided, home-based and round-the-clock services dominated, each making up 32 percent of total HCBS expenditures for MFP participants (Figure V.4).[49] Home-based services consist primarily of personal care assistance to help people perform activities of daily living, such as transferring in and out of a chair or bed, using the toilet, or showering. Round-the-clock services consist primarily of residential services, such as

[49] These calculations included 12,839 MFP participants who transitioned by December 2011. Although we could link 92 percent of participants' MFP enrollment records with their claims, we could not create this link for all participants included in this part of the analysis.

residential habilitation.[50] The dominance of residential services is consistent with the makeup of the MFP population and their community residences; by the end of 2012, people with intellectual disabilities accounted for 15 percent of the MFP transitions.

Figure V.4. Number of States Providing Each Service Category



Source: Mathematica analysis of MFP services files and program participation data files submitted by 25 grantee states through December 2012 for participants transitioning by the end of 2011.

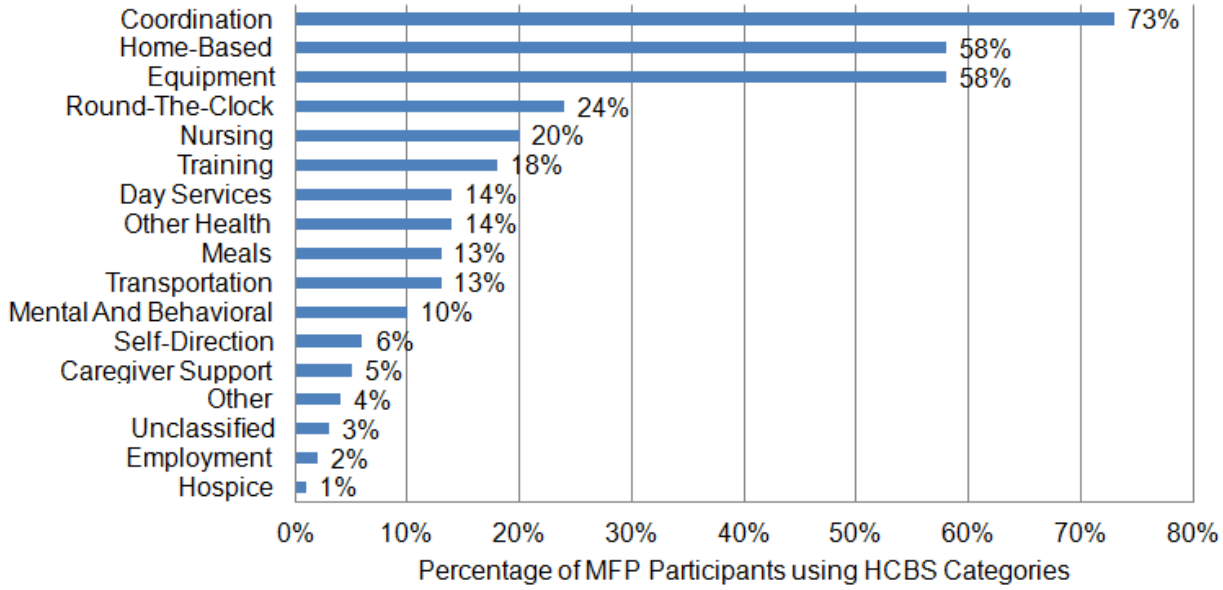
Note: Expenditures include qualified, demonstration, and supplemental services. Arkansas, the District of Columbia, Texas, and Virginia were not included because a high proportion of MFP participants receive HCBS through managed care. Therefore, their claims information is not equivalent to that for participants in fee-for-service systems. Idaho, Massachusetts, Rhode Island, Tennessee, and Wisconsin were excluded because they lack all the data needed for analysis.

[50] Residential habilitation is defined as services that assist in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills. To be considered residential services, they must be delivered in a residential setting, such as a group home or private residence, rather than a clinical or nonresidential setting. We could not differentiate most of the claims allocated to the round-the-clock category as group living or shared living, so they have been classified as residential, unspecified.

After accounting for home-based care and round-the-clock services, the remaining categories made up less than 10 percent of expenditures each (Figure V.4). Participant training, which includes community supports and independent living skills, accounted for 9 percent of total expenditures. Day services, which include day habilitation and adult day health, totaled 6 percent of MFP expenditures. Another 7 percent of expenditures were allocated to coordination and management, which includes case management, housing supports, and transition services.

When the variety of HCBS is assessed at the state level, we find that all 25 MFP grantees analyzed provide home-based services, day services, coordination and management, and equipment, technologies, and modifications (Figure V.5). Overall, states provide a large variety of services. When excluding hospice, unclassified, and the other service categories, we find that more than half of the 25 states (16 grantees) provided 11 or more of the remaining 14 categories of services. Six states provided 13 categories; two of which provided all categories except self-direction; two provided all service categories except participant training; and two provided all categories except other health and therapeutic services.

Figure V.5. Percentage of MFP Participants Using Each Service Category



Source: Mathematica analysis of MFP services files and program participation data files submitted by 25 grantee states through December 2012 for participants transitioning by the end of 2011.

Note: Expenditures include qualified, demonstration, and supplemental services. Arkansas, the District of Columbia, Texas, and Virginia were not included because a high proportion of MFP participants receive HCBS through managed care. Therefore, their claims information is not equivalent to that for participants in fee-for-service systems. Idaho, Massachusetts, Rhode Island, Tennessee, and Wisconsin were excluded because they lack all the data needed for analysis.

More than 73 percent of MFP participants received coordination and management services, making it the most frequently used HCBS category (Figure V.5), but this percentage likely under represents the number of MFP participants who receive this service. Some states finance this service with state administrative fund and the service does not generate a claim. Most likely, almost all MFP participants received some type of coordination and management service, which includes transitional care, housing supports, and case management.

Only two other service categories were used by more than half of MFP participants: (1) home-based services; and (2) equipment, technology, and modifications (Figure V.5). Roughly 25 percent of MFP participants used round-the-clock services; all other services were used by less than 20 percent of MFP participants.

Although states offer 17 broad categories of HCBS, the average MFP participant used three categories of HCBS. Some services were often used together by MFP participants. For example, 71 percent of MFP participants who used equipment, technology, or modifications also used home-based services.

The use of certain HCBS categories also varied by target population. MFP participants with intellectual disabilities were more than five-times more likely to use round-the-clock services than MFP participants with physical disabilities. Elderly MFP participants and those with physical disabilities were twice as likely as those with intellectual disabilities to use home-based services. Although the number of categories used was similar across target populations, MFP participants with physical or intellectual disabilities used slightly more categories of service than elderly MFP participants.

Table V.7 provides a detailed breakdown of the categories and subcategories of HCBS provided to MFP participants through calendar year 2012. Home-based and round-the-clock services make up 32 percent of expenditures each, but 58 percent of individuals used home-based services, compared with only 24 percent with reported round-the-clock services. Behavioral and mental health services were reported in 21 states, but only among 10 percent of individuals, and accounting for less than 1 percent of expenditures.

Table V.7. Categories and Subcategories of HCBS Provided to MFP Participants Who Transitioned by the end of Calendar Year 2011

HCBS Category[a]	Description	Number of Individuals Used	Individuals Used[b] (%)	Number of States Provided	Total National MFP Expenditures (%)
1 Home-Based Services	-	7,465	58	25	31.8
1.1 Home health aide	Home health aide	1,137	9	12	0.6
1.2 Personal care	Personal or attendant care	6,518	51	23	27.6
1.3 Companion	Adult companion	304	2	9	0.6
1.4 Homemaker	Homemaker and chore services	1,299	10	15	2.1
2 Round-the-Clock Services	-	3,051	24	21	31.9
2.1 Group living	Group living	508	4	6	1.2
2.2 Shared living	Shared living, including adult foster care or adult family care	714	6	9	3.1
2.3 Residential, unspecified	Health and social services provided in the person's home or apartment in which a provider has round-the-clock responsibility for the person's health and welfare	23	14	17	27.6
3 Coordination and Management	-	9,339	73	25	7.4
3.1 Transition[b]	Transition coordination, transition specialist	6,489	51	21	4.5
3.2 Housing supports[c]	Assistance with finding housing and housing specialists	802	6	4	0.2
3.3 Case management[d]	Case coordination, plan development	6,322	49	21	2.7
4 Supported Employment	-	308	2	15	0.7
4.1 Employment[e]	Prevocational, supported employment, other employment services	308	2	15	0.7
5 Day Services	-	1,795	14	25	5.9
5.1 Day habilitation	Assistance in self-help, socialization, and/or adaptive skill provided in a fixed site during the working day	969	8	14	3.4

Table V.6 (continued)

HCBS Category[a]	Description	Number of Individuals Used	Individuals Used[b] (%)	Number of States Provided	Total National MFP Expenditures (%)
5.2 Adult day health	Health and social services provided in a fixed site during the working day	884	7	23	2.5
6 Nursing	-	2,578	20	21	3.6
6.1 Nursing	RN and LPN services	2,578	20	21	3.6
7 Meals	-	1,691	13	19	0.5
7.1 Home-delivered	Meals delivered to the home	1,585	12	18	0.5
7.2 Other meals	Meals (does not include home-delivered meals)	106	1	2	0.0
8 Caregiver Support	-	702	5	23	0.5
8.1 Caregiver support	Respite, caregiver counseling and training	702	5	23	0.5
9 Mental and Behavioral Health Services	-	1,316	10	21	0.7
9.1 Behavioral health	Behavioral health, psychosocial rehabilitation, day treatment, substance abuse, psychologist or social worker services	1,316	10	21	0.7
10 Other Health and Therapeutic Services	-	1,798	14	16	1.0
10.1 Nutrition	Nutrition counseling and supplies	127	1	9	0.0
10.2 Physician services	Services provided by a physician, NP, PA	1,146	9	3	0.4
10.3 Prescription drugs	Prescription drugs and anesthesia	307	2	7	0.0
10.4 Dental services	Services provided by a dentist or in a dentist's office	79	1	3	0.0
10.5 OT/PT/ST	Occupational therapy, physical therapy, speech therapy	96	5	14	0.4
10.6 Administration of drugs	Medication administration and injections by a health professional (includes drug screenings)	451	4	6	0.1

Table V.6 (continued)

HCBS Category[a]	Description	Number of Individuals Used	Individuals Used[b] (%)	Number of States Provided	Total National MFP Expenditures (%)
10.7 Other therapies	Other health and therapeutic services, including communication aids, service animals, and drug infusion therapy	810	6	7	0.1
11 Services Supporting Participant Self-Direction	-	745	6	9	0.5
11.1 Self-directed funds	Funds allocated for self-direction	376	3	4	0.4
11.2 Assistance in self-direction	Assistance with the management of self-directed services and/or training in self-direction	516	4	7	0.1
12 Participant Training	-	2,273	18	13	9.1
12.1 Training	Other training (exclusive of home care or skills training)	78	1	5	0.1
12.2 Community support	Community supports, including independent living	2,200	17	12	9.0
13 Equipment, Technology, and Modifications	-	7,482	58	25	4.2
13.1 Personal systems	Personal emergency response systems (PERS)	3,290	26	21	0.2
13.2 Modifications	Home, vehicle, or workplace modifications	1,778	14	21	1.7
13.3 Equipment/ Supplies	Equipment and supplies, including hospital beds, wheel chairs, surgical supplies, orthotics	5,421	42	22	2.3
14 Transportation	-	1,664	13	16	0.7
14.1 Medical	Ambulance services	22	<1	2	0.0
14.2 Nonmedical	All other transportation services (nonmedical, transportation escort, unspecified)	1,648	13	16	0.7
15 Hospice	-	27	<1	3	0.0
15.1 Hospice services[f]	Hospice services	27	<1	3	0.0
16 Other	Services that do not fit within the categories above	498	4	12	0.3

Table V.6 (continued)

HCBS Category[a]	Description	Number of Individuals Used	Individuals Used[b] (%)	Number of States Provided	Total National MFP Expenditures (%)
17 Unclassified	Services that could not be identified because of missing information on the claims records	361	3	20	1.1

Sources: Mathematica analysis of MFP services files and program participation data files submitted by 25 grantee states through December 2012 for MFP participants transitioning by the end of 2011.

Note: Expenditures include qualified, demonstration, and supplemental services. Arkansas, the District of Columbia, Texas, and Virginia were not included because a high proportion of MFP participants receive HCBS through managed care. Therefore, their claims information is not equivalent to that for participants in fee-for-service systems. Idaho, Massachusetts, Rhode Island, Tennessee, and Wisconsin were excluded because they lack all the data needed for analysis.

[a]The HCBS taxonomy developed by Eiken (2011) and tested by Wenzlow et al. (2011) served as a guide for the categories and subcategories presented in this table. The order of services represents the hierarchy of how services were classified. See the Data and Methods sections for more details.

[b]The percentage of individuals used is based on 12,839 MFP participants who had transitioned by the end of December 2011 from 25 states.

[c]One state refers to transition services as relocation services.

[d]The HCBS taxonomy includes housing supports in the "other" category of services. We included this service type in transition and case management services because of its critical role for the demonstration and potential similarities to the other service types in this category.

[e]The HCBS taxonomy treats case management as a stand-alone category, which includes transition coordination. We separated transition coordination from case management given the important role of this service in the demonstration.

[f]In the HCBS taxonomy, prevocational services and supported employment are separate subcategories. We combined them because of the low volume of claims.

[g]The HCBS taxonomy does not treat hospice as a separate category but as a subcategory under "other."

LPN = licensed practical nurse; NP = nurse practitioner; OT = occupational therapy; PA = physician assistant; PT = physical therapy; RN = registered nurse; ST = speech therapy.

The claims data available for this study contained little information about the use of self-direction options and the provision of hospice care. Self-direction, which provides Medicaid beneficiaries with the option of hiring or supervising their caregivers and managing a budget that they can use to obtain a variety of services, is a method for providing services and will typically not generate service claims. As a result, the claims data used for this study underreport participation in self-direction. Although we were able to identify self-direction for only 9 grantees, according to aggregate data reported by the grantees for 2011, 27 MFP state grantees had operational self-direction programs in place. Of these, 18 state grantees had MFP participants who self-directed at least some aspect of their services, and about one-third of participants in those states use self-direction in at least one type of service (Williams et al. 2012).

Hospice, a service that most Medicaid programs provide and is allowable as an MFP service, also appears to be underreported in the claims data used for this study. Only three state grantees reported claims for hospice services. Because some MFP participants who died while in the community may have received hospice care through the Medicare program, the information presented here probably underreports the extent of hospice services received because Medicare claims records were not included in the analysis.

5. MFP Spending on Initial Community Living Setup

An important component of the MFP program is the initial services offered to a participant at the beginning of his or her transition to the community. Transition services are part of the coordination and management service category and include transition coordinators working before and after discharge from an institution, assistance with rent or utility payments, and funds for home furnishings or food.

Spending on initial community setup is not directly available through any one data source, but we can approximate this amount. MFP supplemental services are often used for initial housing setup. Using the FMAP variable to identify MFP supplemental service claims, 2 percent of spending is on services that support transition to the community; the state budget worksheets indicate that 3 percent of spending is for MFP supplemental services. When reviewing claims categorized as transition services by the taxonomy, roughly one-half of 1 percent (0.5 percent) of all MFP expenditures is for initial household setup. Through a combination of claims and service descriptions, we can document that 17 states had expenditures on initial community setup: Connecticut, Delaware, Georgia, Iowa, Illinois, Indiana, Kansas, Kentucky, Maryland, Missouri, New Jersey, North Dakota, Ohio, Oregon, Virginia, Washington, and Wisconsin. The services provided varied and included transition coordination and case management; assessments of the home, physical and family environment; utility and security deposits; moving expenses; and payment of debt.

6. Conclusion

Analyzing the HCBS use of MFP participants allows us to understand just a small component of what happens when someone transitions to the community. We have yet to fully understand how HCBS spending and use relates to a successful transition, how states can tailor their programs to ensure success, and how enrollees fare after MFP participation ends. Further research into the program could define a successful transition and investigate how HCBS expenditures and use relate to the duration of time spent and quality of life achieved in the community. The analysis of HCBS use indicates that most HCBS expenditures incurred by MFP

participants are for ongoing services that they will likely need for the rest of their lives: personal assistance and round-the-clock residential care. Understanding the long-term implications for Medicaid programs will require accounting for total health care costs the first several years after the transition and comparing those total costs with what they would have been had they remained in institutional care. The overall effect of MFP on Medicaid spending will be determined, in part, by the ability of community-based services to harness the need for acute care services so that costly hospitalizations and other acute care services do not wipe away the savings realized when someone transitions from institutional-based to community-based long-term services and supports.

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VI. MFP PARTICIPANTS' QUALITY OF LIFE TWO YEARS AFTER THE RETURN TO COMMUNITY LIVING

Institutional care is expected to provide important safeguards to ensure the safety and well-being of individuals. These safeguards, however, can reduce one's sense of autonomy and satisfaction with life. An operating premise of the MFP program is that many Medicaid beneficiaries who reside in institutions would rather live in their communities; that community living contributes to an increased sense of life satisfaction; and that this increased life satisfaction is a function of enhancements across multiple domains of life.[51] However, people transitioning from institutional to community-based settings may not realize the improved quality of life that they were expecting if the home care services they receive are not adequate, the available and affordable housing is of poor quality, or family and friends cannot provide the support they need. Further, individuals may experience a sense of social isolation in the community after living in a more structured and socially integrated institutional setting, particularly for individuals with longer institutional lengths of stay. Therefore, monitoring changes for participant-reported measures in these areas is fundamental to testing the premise that living in the community improves the quality of life for people who transition from institutional settings to the community.

Previous reports have examined the extent to which MFP participant quality of life changed during the first year of community living (Simon and Hodges 2011; Irvin et al. 2011, 2012). In general, work to date has shown that participants experience significant improvements in reported quality of life across several domains. This chapter examines whether these improvements are sustained after two years of community living and one year following the end of MFP participation.

We report findings for all participants and, where applicable, report results for three MFP target populations: (1) aged participants (age 65 years or older) transitioning from nursing facilities; (2) participants with physical disabilities (age 64 years and younger) transitioning from nursing facilities; and (3) participants with intellectual disabilities transitioning from intermediate care facilities.[52]

[51] These domains include quality of care, access to care; satisfaction with living arrangements, community involvement; a sense of autonomy and being treated well by providers; and overall health and well-being.

[52] Analyses also include information for participants transitioning from institutions for mental diseases (IMDs)—whose results are combined with people transitioning from institutions characterized as "other"—while participant records lacking data for qualified institution are characterized as "missing."

A. Key Findings

Results presented in this chapter are consistent with, and extend, previous findings based on earlier samples of participants (Simon and Hodges 2011; Irvin et al. 2011, 2012). Our findings in this report include the following:

- Quality of life improves upon transition to the community and is sustained after two years of living in the community. Four out of five participants were satisfied with the way they lived their lives after one year in the community, and this level of satisfaction is sustained a year after participants have left the MFP program. In addition to overall quality of life, this sustained pattern of improvement was observed for access to personal care, treatment by providers, satisfaction with living arrangements, and community integration. This finding suggests that the quality-of-life effects of the transition is sustainable after participants leave the MFP program.
- Some areas of participant experience showed continued improvement during the second year of community living. Participants reported statistically significant improvements in barriers to community integration and access to personal care between the first and second years of community living.
- Although improvement in participant-reported outcomes after two years in the community was sustained, several findings may warrant further attention from program administrators. Aged participants demonstrated diminished reports of quality of life after two years in the community. Further, although the percentage of participants who reported depressed mood declined significantly between pre-transition and second year of community living, more than one-third of all participants reported low mood after two years in the community.

B. Background

The following key research questions guided the analysis presented in this chapter.

- Overall, compared with pre-transition status, how do key aspects of MFP participants' experiences change after two years of community living? MFP participants demonstrate significant improvements in quality of life after one year of living in the community (Irvin et al. 2012). Therefore, we examine the extent to which those improvements are maintained one year after MFP participation ends. We examine the percentage point change in the proportion of participants reporting general satisfaction with life, care received, and living arrangements, access to personal care, and community integration, comparing results obtained at the second-year assessment with pre-transition results as well as with results from the first-year assessment.
- Compared with their status before the transition, what proportion of MFP participants experienced an improvement or a decline in key aspects of quality of life during the first and then the second year of community living? In particular, we seek to understand the trend for participant satisfaction with life and with the services they receive over time.

- How prevalent is decline in quality of life between the first and second year in the community? What aspects of participant experience are associated with a decline in quality of life between the first and second year in the community? We examine whether decreases in quality of life are linked with decreases in access to care, satisfaction with living situation, community integration, or satisfaction with care.

1. Quality of Life Survey

Quality of life is measured using the MFP-Quality of Life (MFP-QoL) survey administered by grantees. The instrument is based largely on the Participant Experience Survey, although a few items are drawn from other instruments (Sloan and Irvin 2007).[53] The MFP-QoL instrument captures three areas of participant quality of life around which the findings in this chapter are organized: (1) life satisfaction, (2) quality of care, and (3) community life. Simon and Hodges (2011) previously addressed details concerning grantee responsibility for the survey and the timing of its administration relative to participant transition. Irvin et al. (2012), examined the relationship between the level of care needs and the change in quality of life as well as work status and its association with the quality of life after returning to community living.

2. Analytic Data

Table VI.1 shows the number of participants with pre-transition and post-transition survey data submitted by grantees through March 2013. Pre-transition surveys were submitted for a total of 13,290 participants who confirmed participation in the MFP program. Of the 13,290 participants with a pre-transition survey who transitioned by December 2012, 7,329 participants had only a pre-transition survey submitted on their behalf. Another 2,609 participants had a baseline and a one-year follow-up survey submitted; 1,709 participants had a two-year follow-up survey in addition to the pre-transition and one-year surveys.[54] To be included in the analytic sample, survey timing must meet the following restrictions. First, the one-year post-transition survey must be conducted at least six months following the pre-transition survey. Second, the two-year follow-up survey must occur 18 to 32 months following their pre-transition survey. [55]

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

[54] 1,643 participants had a pre-transition survey and follow-up data that either could not be classified or was completed out of sequence (for example, participants who had a pre-transition and two-year follow-up survey but were missing the one-year follow-up survey).

[55] Grantees are asked to administer the two-year follow-up surveys approximately 12 months after the first-year follow-up survey; however extenuating circumstances, such as the burden of coordinating the survey result in survey administration earlier or later than the target date.

Table VI.1. Analytic Sample Construction

Number of Records	Description
7,329	Participants with Pre-Transition Survey Only
2,609	Participants with Pre-Transition Survey + Year One Survey
1,709	Participants with Pre-Transition Survey + Year One Survey + Year Two Survey
1,578	All three surveys assessed within approximately one year[a]

Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

Notes: Includes MFP-QoL surveys that could be matched with administrative data to confirm MFP participation. Surveys with incomplete or missing identifiers cannot be matched with administrative data and therefore are not included in this analysis.

Excludes data from Alabama, Arkansas, Colorado, Delaware, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

[a]First follow-up conducted more than 6 months after pre-transition survey; second followup conducted 18—32 months following pre-transition surveys. Pre-transition surveys are to be conducted several weeks prior to transition to the community.

The analytic sample for this report consists of 1,578 MFP participants with surveys from pre-transition, one year post-transition, and two years post-transition. These data represent survey and administrative data—including demographic information and details concerning program participation—submitted to CMS through March 2013. The sample includes participants from 21 MFP grantee states.[56] Overall, the analytic sample used in this chapter represents about 5 percent of participants who transitioned to community living by December, 2012 (Williams et al. 2013).[57] Several reasons may have contributed to the low rate at which records were matched for analysis. First, Medicaid identifiers in the quality-of-life data are not

[56] Data from Washington, Connecticut, Missouri, Oregon, and Texas comprise more than half (56 percent) of all participants included in the analytic sample. The following MFP states are not in the analytic sample: Alabama, Arkansas, Colorado, Delaware, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

[57] The semiannual reports MFP grantees submit to CMS indicated that they had transitioned 30,141 participants as of December 31, 2012.

always recorded properly, and without accurate identifiers, these data cannot be linked to administrative data.[58] Second, some states had trouble submitting their data according to the schedule established for the evaluation, and such difficulties can affect the availability of either the quality-of-life data or the administrative data. Third, at program start-up, the survey was not administered to many of the first MFP participants and some grantees lagged behind in establishing formal procedures for identifying and gaining access to participants before transitions began; where possible, baseline surveys were later administered to participants who had already transitioned. Finally, this report includes participants with all three QoL surveys and therefore is affected by participants who were lost to follow-up, or refused any follow-up assessment. Mathematica and CMS continue to work with grantees to improve the timeliness of data collection and submission and the quality of the Medicaid identifiers.

The analytic sample of 1,578 participants with three assessments through the second year post-transition represents about 13 percent of all MFP participants who had transitioned by the end of calendar year 2010. (Figure II.1 indicates that grantees had reported 11,924 transitions by December 2010.) Therefore, we examined the representativeness of the analytic sample by comparing the demographic characteristics of the analytic sample with the characteristics of participants who had survey data submitted but did not contain all three QoL assessments and therefore could not be used in our analyses. Table VI.2 presents demographic characteristics of the analytic sample (N = 1,578) as well as characteristics for a broader representation of participants with fewer surveys completed and submitted to CMS.[59] Compared with participants for whom a baseline or baseline and a one-year follow-up survey was available, the analytic sample was less likely to include aged participants who transitioned from a nursing home and more likely to include participants who transitioned from an intermediate care facility for individuals with intellectual disabilities (ICF/IID) (Chi-square = 588.3, $p < 0.001$). The analytic sample also comprised a larger proportion of participants under age 45, and correspondingly fewer participants over age 65 compared with MFP participants with fewer QoL assessments submitted (Chi-square=139.0, $p < 0.001$). The characteristics of the analytic sample are consistent with the early history of the MFP program, when grantees were transitioning greater proportions of younger people and residents of ICFs/IID.

[58] For privacy concerns, CMS chose to keep identifiable data to a minimum on the MFP-QoL instrument. Therefore, Medicaid identifiers are the only method used to track participants in the quality-of-life data.

[59] We include participants only when we could confirm participation through administrative records. We have QoL survey data from a total of 35 grantees.

Table VI.2. Demographic Characteristics by Survey Status

-	Pre-Transition Only		Pre-Transition and One Year Post-Transition Only		Pre-Transition, One and Two Years Post-Transition	
Characteristics	Number	Percentage	Number	Percentage	Number	Percentage
Total	7,329	100.0%	2,609	100.0%	1,578	100.0%
Targeted Population	-	-	-	-	-	-
Aged	2,154	29.4%	745	28.6%	345	21.9%
PD	3,099	42.3%	1,089	41.7%	594	37.6%
ID	463	6.3%	330	12.6%	407	25.8%
IMD/Other	148	2.0%	27	1.0%	13	0.8%
Unknown	1,465	20.0%	418	16.0%	219	13.9%
Age Group	-	-	-	-	-	-
< 21	98	1.3%	46	1.8%	54	3.4%
21 to 44	1,056	14.4%	451	17.3%	354	22.4%
45 to 64	3,448	47.0%	1,223	46.9%	761	48.2%
65 to 74	1,211	16.5%	415	15.9%	199	12.6%
75 to 84	968	13.2%	303	11.6%	130	8.2%
> = 85	548	7.5%	171	6.6%	80	5.1%
Gender	-	-	-	-	-	-
Female	3,713	50.7%	1,305	50.0%	759	48.1%
Male	3,616	49.3%	1,304	50.0%	819	51.9%

Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

Note: Excludes data from Alabama, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

ID = Participants with intellectual disabilities who transitioned from an ICF/IID; PD = Participants with physical disabilities who transitioned from nursing homes.

C. General Trends in Quality of Life Following Transition to Community Living

The MFP-QoL survey reflects the view that participants' quality of life is multidimensional and a function of life satisfaction, quality of care received, and community integration. Because MFP participants are no longer eligible to receive services through the MFP program for 365 days after transitioning to community living, we examine quality-of-life outcomes after people leave the program. This section describes how reported quality of life across several domains changes between the pre-transition period and the first year post-transition and pre-transition and the second year post-transition. Table VI.3 summarizes participants' rating of quality of life at each assessment.

Similar to what was observed in prior studies of MFP participants' quality of life, participants in the analytic sample experienced a significant improvement for many aspects of life after one year of living in the community (Irvin et al. 2012). With the addition of another year of data, we find that quality-of-life improvements are largely sustained after two years of community residence and in some cases, show continued improvement (Table VI.3). In particular, fewer participants reported barriers to community integration over time; the proportion reporting a barrier to doing things they enjoyed in the community dropped significantly from 35 percent after one year in the community to 28 percent after two years ($p < 0.05$).[60] Unmet need for personal assistance also showed continuing declines after two years, falling to 6.2 percent with any unmet need after one year to 4.6 percent after two years ($p < 0.05$).

Satisfaction with care was generally high (> 90 percent) across all three assessments, but is somewhat lower after the transition. Aged participants report a significant decline in their satisfaction with care following the first year of community living ($p < 0.05$; Appendix Table C.1). About 90 percent of aged participants were satisfied with their care after one year of community living, whereas this percentage dropped to 83 percent after two years in the community.

1. Global Life Satisfaction

The MFP-QoL survey includes a question to assess the overall status of participant quality of life.[61] Among all participants, satisfaction increased significantly (18.4 percentage points) from the pre-transition period to one year post-transition. The level of satisfaction was sustained (80 percent at both points in time) after the participant lived in the community for two years but was no longer in the MFP program.

The life satisfaction results in Table VI.3 rely on a dichotomous assessment of satisfaction ("happy with life" versus "unhappy with life"), but the survey was designed to capture slightly finer gradations of satisfaction and the more detailed information suggests that the improvement is driven by improvements in the middle range of satisfaction. Figure VI.1 shows the percentage of participants that were very happy, a little happy, a little unhappy, and very unhappy at each administration of the survey. The percentage of participants who indicated they were "very happy" was similar across each administration of the survey. However, the percentage of participants who responded they were a "a little happy" increased by nearly 20 percentage points from pre-transition to one year post-transition and at two years post-transition. The percentage of participants who indicated they were a "a little unhappy" or "very unhappy" decreased from pre-transition to one year post-transition and remained low at two years post-transition.

[60] The difference between (a) the pre-transition and year one assessments, (b) the pre-transition and year two assessments, and (c) the year one and year two assessments were all significantly different.

[61] Taking everything into consideration, during the past week, have you been happy or unhappy with the way you live your life?

When we further assess the change in life satisfaction, we find that after a year of community living, 35 percent of participants had improved overall life satisfaction; 41 percent had the same level of satisfaction at both points in time; and 24 percent experienced a decline in overall life satisfaction (Figure VI.2). After leaving the MFP program, overall life satisfaction remained the same for more than half of participants (58 percent), improved for about one-fifth of participants, and declined for another one-fifth of participants.

Table VI.3. Survey Outcomes Over Time (N=1,578)

-	.	Time Period	.
Quality-of-Life Domain	Pre-Transition	One Year Post-Transition	Two Years Post-Transition
Overall Life Satisfaction	62.4	80.8*	80.3**
Mood Status[#]	42.6	35.8*	35.2**
Satisfaction with Care	91.7	93.0	90.5***
Access to Personal Care[a#]	18.0	6.6*	4.9****
Respect and Dignity	71.1	88.6*	89.1**
Satisfaction with Living Arrangements	58.9	93.5*	91.7**
Barriers to Community Integration[b#]	48.0	34.7*	28.0****

Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

Note: Excludes data from Alabama, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

[#]A lower percentage is better.

*Change between pre-transition and one year post-transition is significant at $p < 0.05$.

**Only change between pre-transition and two years post-transition is significant at $p < 0.05$.

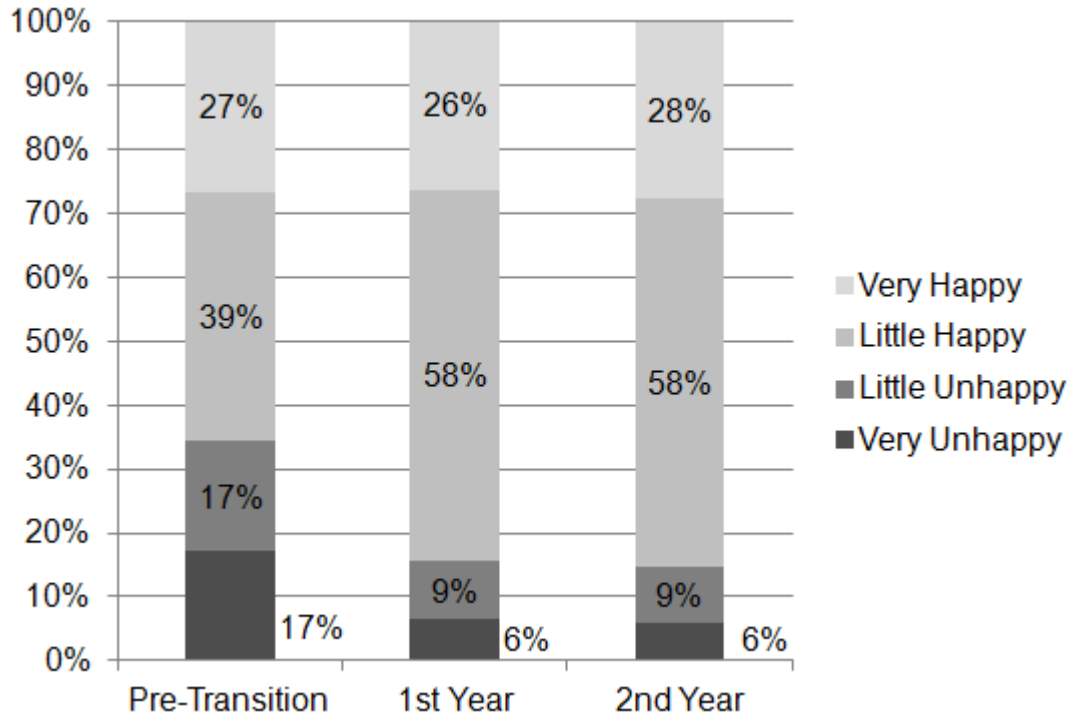
***Only change between one year post-transition and two years post-transition is significant at $p < 0.05$.

****Change between pre-transition and two years post-transition and one year post-transition and two years post-transition are both significant at $p < 0.05$.

[a]Measured as “Any unmet care need” in the areas of bathing, eating, medication and toileting.

[b]Measured as “Is there anything you want to do outside [the facility/your home] that you cannot do now?”

Figure VI.1. Satisfaction with Life By Length of Time In The Community



Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

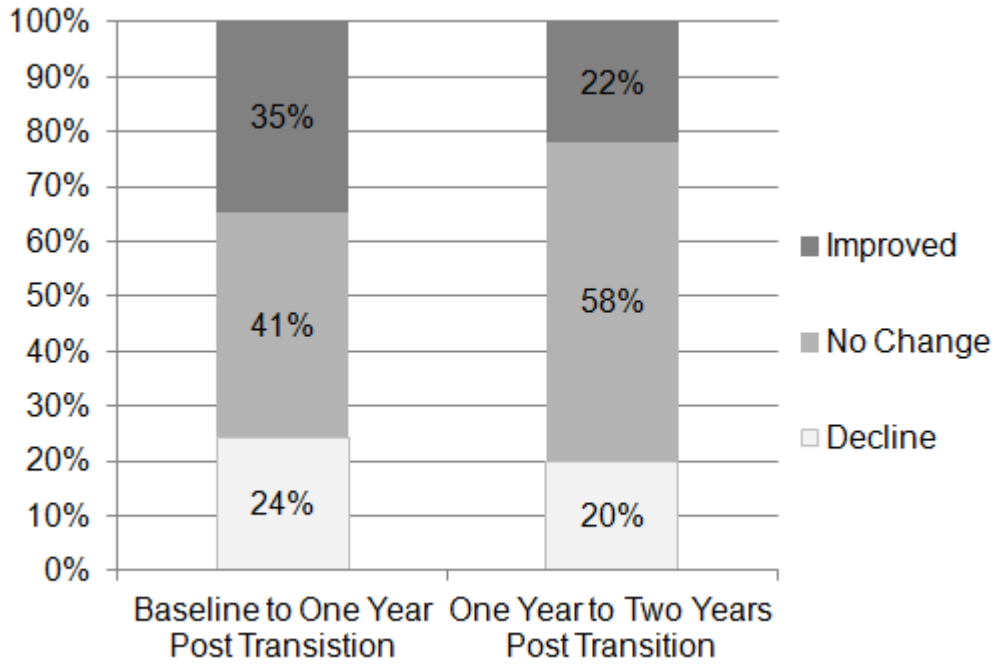
Note: Excludes data from Alabama, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

2. Factors Associated with Declines in the Quality of Life

We explored the factors associated with declining quality of life to understand the association between decreases in participant-reported quality of life and other aspects of participants' experiences. Among the subset of participants who experienced a decline in overall life satisfaction between the first and second year of community living, the strongest associations with this decline were declines in satisfaction with care and satisfaction with living arrangements (both significant at $p < 0.001$), although declines in community integration ($p = 0.002$) and participant reported unmet needs for personal care assistance ($p = 0.02$; Table VI.4) were also associated with the decline in quality of life.[62] These findings suggest that when overall quality of life declines, the decline is widely across the various domains that make up quality of life.

[62] Decline in unmet need for personal care assistance was defined as an increase in the number of areas a participant reported unmet personal care need (for example, bathing, meal preparation, toileting).

Figure VI.2. Change in Life Satisfaction by Length of Time in the Community



Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

Note: Excludes data from Alabama, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

3. Quality of Care

Quality of care was inferred through three measures; (1) satisfaction with the help they received, [63] (2) unmet need for assistance with the activities of daily living (ADL), and (3) whether they were treated with respect and dignity by providers. [64] MFP Participants were

[63] To assess satisfaction with help, the survey asks: "Taking everything into consideration, during the past week, have you been happy or unhappy with the help you get with things around the house or getting around your community?" This question was assessed as a dichotomous question ("happy" versus "unhappy") and as a four level question ("very happy"; "a little happy"; "a little unhappy"; "very unhappy").

[64] A combination of questions assess whether participants believe they are being treated with respect and dignity by providers: "You said that you have people who help you. Do the people who help you treat you the way you want them to?" and "Do the people who help you listen carefully to what you ask them to do?"

predominantly satisfied with the care they received prior to discharge from institutional settings (92 percent). Following their transition to the community, satisfaction with care remained about the same (93 percent), but then declined slightly to approximately the same level of satisfaction reported pre-transition. Aged participants reported significant decreases in satisfaction with care after two years in the community. Younger participants with physical disabilities also reported decreases in satisfaction with care, although the decreases were not statistically significant.

Table VI.4. Factors Associated with Quality of Life Decline Between Years One and Two

Type of Decline	Participants Who Reported Decline in Quality of Life Between Year One and Two (N = 316)	All Participants (N = 1,578)	Chi-Square Significance
Decline in Unmet Care Needs	5.0%	2.8%	0.020
Decline in Community Integration Index Score[a]	24.1%	17.1%	0.002
Decline in Satisfaction with Care	49.3%	19.1%	<0.001
Decline in Satisfaction with Living Arrangement	9.5%	4.7%	<0.001

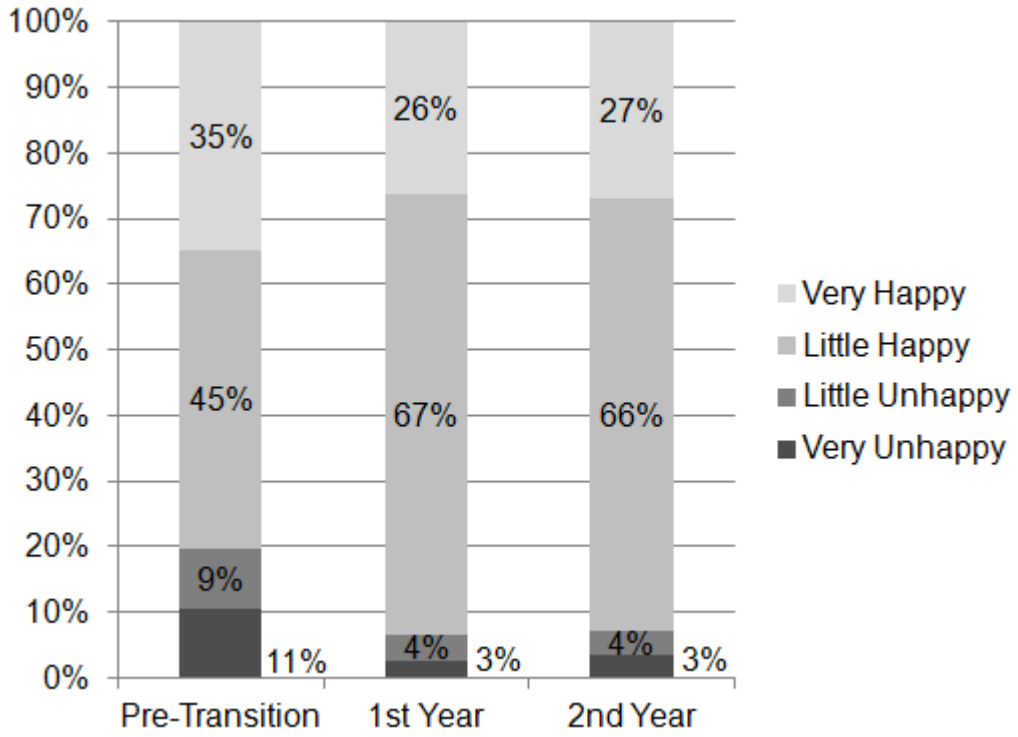
Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

Note: Excludes data from Alabama, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

[a]The community integration index score is a sum of affirmative responses to the following five questions : (1) “Can you see your friends and family when you want to see them?” (2) “Can you get to the places you need to go, like work, shopping, or the doctor’s office?” (3) “Do you go out and do fun things in the community?” (4) “Do you miss things or have to change plans because you don’t have a way to get around easily?” (5) “Is there anything you want to do outside [your home] that you can’t do now?” The questions are recoded so that higher scores indicate greater community integration.

The changes in satisfaction with care are primarily driven by changes in the mid-range of satisfaction rather than at the extremes. Among all participants, the proportion of participants who indicated they were “very happy” with the help they received getting around their homes and their communities decreased from pre-transition to one year post-transition. However, the percentage of participants who were “a little happy” increased more than 20 percentage points and the percentage of participants who were a “a little unhappy” or “very unhappy” decreased, as well (Figure VI.3). This change indicates that although participants were largely happy with the care they received in the community, fewer participants reported being “very happy” with the care they received compared with care received in institutional settings.

Figure VI.3. Satisfaction with Care by Length of Time in the Community



Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

Note: Excludes data from Alabama, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

In general, unmet care needs for personal assistance and reported respect and dignity shown by providers improved from pre-transition to one year post-transition and continued to improve during the second year of community living (Table VI.3). Pre-transition, 18 percent of participants reported one or more unmet care needs for personal assistance (with one or more of four ADLs for eating, bathing, toileting, and medication administration), whereas at one year post-transition, only 6 percent reported any unmet care needs. By two years post-transition the number of participants reporting unmet care needs further decreased to 5 percent.

All populations also reported a large improvement in being treated with respect and dignity between pre-transition and one year post-transition and a smaller improvement between one year post-transition and two years post-transition. Participants' rating of being treated with respect and dignity by providers increased 18 percentage points (from 71 to 89 percent) from pre-transition to one year post-transition and stayed consistently high at two years post-transition. One exception to this finding was among aged individuals who transitioned from a nursing home. These participants saw a statistically significant decrease from one year post-transition to two years post-transition. All other MFP participants reported an increase in providers' treatment of participants with respect and dignity during the same time period.

From pre-transition to one year post-transition, 27 percent of participants experienced an increase in satisfaction with the care they receive at home (see Figure VI.4) and 25 percent experienced a decrease. From one year post-transition to two years post-transition, most participants (63 percent) reported the same satisfaction with care, and less than two-fifths of participants reported an increase (18 percent) in their satisfaction with care or a decrease (19 percent).

4. Community Living

Community living was assessed through questions about participants' satisfaction with their living arrangements, the number of activities and aspects of their lives in which participants report having choice and control, and a summary score assessing community integration. [65,66] For two of these indicators, participants' satisfaction in this domain increased markedly after a year in the community and was sustained during the second year.

Participants' satisfaction with their living arrangements improved significantly between the pre-transition and the one year post-transition assessments (35 percentage points), such that after one year in the community, most participants indicated they were satisfied with their living arrangements (94 percent). This level of satisfaction remained high in the second year although it showed a small but statistically insignificant drop (Table VI.3).

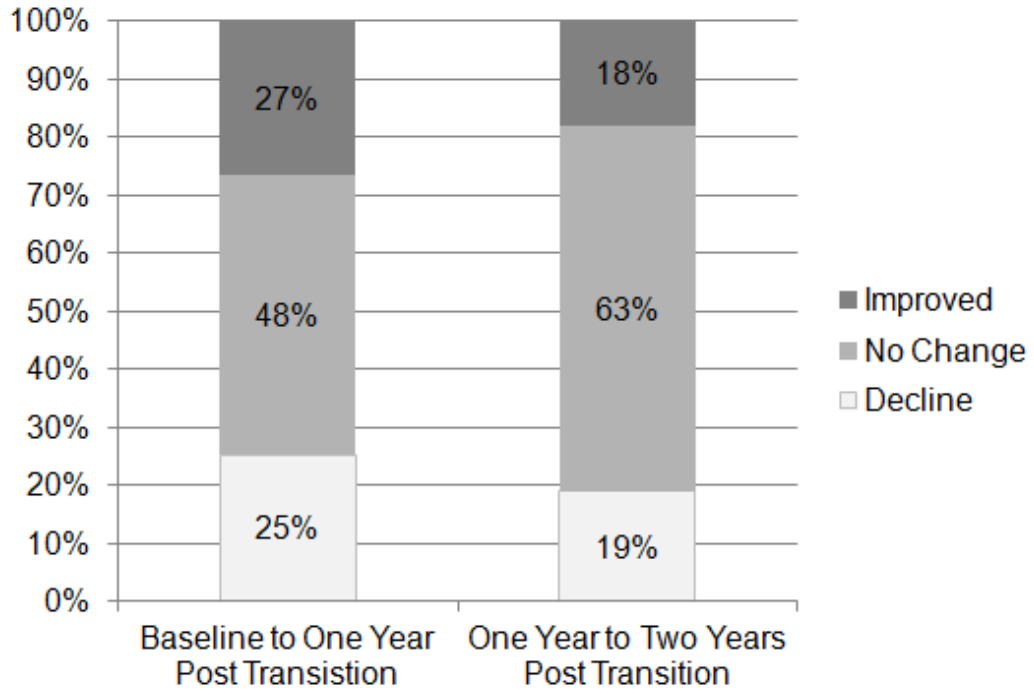
The MFP-QoL survey assesses choice and control in five areas. On average, participants reported an increase of 1.1 areas of choice and control after a year of living in the community. At two years, the average number of areas of choice and control reported by participants remained similar to the level reported after one year in the community (Table VI.5). This finding suggests that leaving the MFP program had little effect on choice and control.

Community integration measured using a summary index score showed a similar trend; upon transition to the community, participants were more engaged after a year in the community, and remained so after two years. Exiting the MFP program did not appear to impact participants' level of community integration.

[65] The MFP-QoL survey assesses six areas of choice and control: being able to go to bed when one desires, the ability to be alone when one chooses, the ability to eat food of one's choice and when one chooses, and the ability to use the telephone or watch television when one chooses.

[66] The community integration index score is a sum of affirmative responses to the following five questions: (1) "Can you see your friends and family when you want to see them?" (2) "Can you get to the places you need to go, like work, shopping, or the doctor's office?" (3) "Do you go out and do fun things in the community?" (4) "Do you miss things or have to change plans because you don't have a way to get around easily?" (5) "Is there anything you want to do outside [your home] that you can't do now?" The questions are recoded so that high scores are indicative of greater community integration.

Figure VI.4. Change in Satisfaction with Care By Length of Time In The Community



Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

Note: Excludes data from Alabama, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

D. Conclusions and Limitations

We found evidence to suggest that gains in quality of life are largely maintained after another year of community living, and in some cases continue to improve. In particular, access to personal care and community integration continued to improve when assessed after two years of community living. We conclude that many MFP participants have enjoyed an improved quality of life for an extended time period.

Among these positive findings, several indicators provide insight into why some MFP participants reported a decline in their quality of life during the second year of community living. Participant-reported quality of life significantly decreased over time for aged participants, and this decline was associated with diminishing satisfaction with care and living arrangements and increasing unmet ADL needs. In addition, more than one-third of MFP participants reported sad mood in the most recent seven-day period. This finding indicates an opportunity for grantees to provide access to mental health services for further assessment.

Table VI.5. Change in Community Life Outcomes Over Time (N=1,578)

Community Life Outcomes	Pre-Transition	One Year Post-Transition	Two Years Post-Transition
Average Number of Areas of Choice and Control Reported (SD)	3.9 (1.5)	5.1 (1.2)*	5.0 (1.3)**
Average Community Integration Index Score (SD)	2.3 (0.8)	2.5 (0.7)*	2.5 (0.7)**

Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

Notes: Excludes data from Alabama, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

The minimum possible value for areas of choice and control is 0; the maximum possible value is 6. Areas of choice and control assessed include: being able to go to bed when one desires, the ability to be alone when one chooses, the ability to eat food of one's choice and when one chooses, and the ability to use the telephone or watch television when one chooses. Higher values indicate more choice and control.

The minimum possible value for the integration summary score is 0; the maximum possible value is 5, which indicates the highest level of community integration.

*Only change between pre-transition and one year post-transition is significant at $p < 0.05$.

**Only change between pre-transition and two years post-transition is significant at $p < 0.05$.

1. Limitations

Several important limitations apply to the data and analyses reported in this chapter. First, the findings should be viewed with caution and as preliminary results subject to change, because our analytic sample represents only a small portion of all people who had transitioned by the end of 2010 (about 13 percent). We do not know how representative this sample is of all MFP participants. When compared with all people who had transitioned by the end of 2010, the current analytic sample is younger and includes a disproportionate number of participants with an intellectual disability. It is possible that the sample has had different quality-of-life outcomes compared with all MFP participants. Overcoming this limitation requires a two-fold approach: (1) replicating these findings with larger, more representative samples; and (2) getting states to improve the quality of their data reporting. Both steps would enhance the external validity of future findings.

Second, program administration will always vary by state, affecting the method, timing, and quality of survey administration. Each grantee has established a unique set of goals for transitioning target populations—such as which beneficiaries will be the focus of their program and how many in each target population will be transitioned—and other related objectives. When transition coordinators or case managers administer the survey, participants might feel compelled to emphasize reports of satisfaction or to conflate feelings of satisfaction with their living

arrangement with feelings about the program. Although there is no evidence that this situation occurred, it cannot be ruled out as a bias in the data. Frequency of data collection may also be a concern, because the planned timing for the first-year follow-up assessment and second-year assessments are often not attainable.

Third, we have not controlled for a range of unmeasured program and individual-level factors that are likely to affect a participant's reported quality of life and changes to quality of life. Future analyses will explore how quality-of-life changes vary with participants' characteristics, as well as with program-level characteristics, such as model of caregiver employment and survey administration.

Finally, because the MFP-QoL survey can be administered with assistance or even by a proxy respondent, data reported may not always reflect the direct perceptions and experiences of MFP participants and they may be biased if the proxy or assistance is a service provider. Proxy respondents and survey assisters provided information on community-based quality of life for more than one-third of all participants.[67] The use of proxies varied widely by target population; proxy use was significantly higher among those with intellectual disabilities, with proxies completing 39 percent of all 2 year post-transition interviews. Proxy use was lower among nursing home residents at the two-year post-transition survey (6 percent of those under 65 and 16 percent of those 65 and older). We note that proxy reported quality of life in the community was significantly higher than participant reported quality of life when measured one and two years post-transition (Chi-square $p = 0.05$ and $p = 0.007$, respectively).[68] Proxy respondents may have different expectations than participants; program administrators should be aware of the differences in reported quality of life. Future analyses will identify domains of quality of life that may contribute to the observed differences between proxy and participant reported quality of life.

[67] A proxy respondent is defined as someone who responds to survey questions on behalf of a participant. A survey assister is defined as someone who assists the participant in interpreting and providing responses to survey questions and may serve as a proxy respondent for some questions. After one year in the community, 13.8 percent of surveys were completed by a proxy respondent and 21.5 percent were completed with assistance. After two years in the community, 18.1 percent were completed by a proxy and 19.7 percent were completed with assistance.

[68] Pre-transition quality of life did not vary by proxy status.

REFERENCES

Anderson, W., J. Weiner, A. Greene, and J. O'Keeffe. "Direct Service Workforce Activities of the Systems Change Grantees, Final Report." Prepare for U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, April 2004.

Annual Disability Statistics Compendium 2011, Section 2 Employment. Available at [http://disabilitycompendium.org/compendium-statistics/employment]. Accessed June 10, 2013.

Centers for Medicare & Medicaid Services. "Guidance to States Using 1115 Demonstration or 1915(b) Waivers for Managed Long Term Services and Supports Programs." CMS, May 20, 2013. Available at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf].

Centers for Medicare & Medicaid Services, Employment Initiatives. Medicaid Services that Support Employment. Available at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html]. Accessed on June 12, 2013.

Centers for Medicare & Medicaid Services Policy Guidance. Opportunities to Promote and Support Employment within MFP through Policies and Services. March 31, 2011. Available at [http://www.mfp-tac.com/]. Accessed on May 16, 2013.

Centers for Medicare & Medicaid Services, Money Follows the Person Demonstration Policy Guidance, "Conditional Approval of Out-year Supplemental Grant Awards for Meeting Benchmarks." December 2009.

Cooper, Emily, Ann O'Hara, Nikki Singer, and Andrew Zovistoski. "The Housing Crisis for People with Disabilities." Boston: Technical Assistance Collaborative, Inc., May 2013.

Denny-Brown, Noelle, Christal Stone, Debra Lipson, and Jessica Ross. "Money Follows the Person Demonstration: Overview of State Grantee Progress, July to December 2010." Final report submitted to the Centers for Medicare & Medicaid Services, Division of Community Services Transformation, Disabled and Elderly Health Programs Group. Cambridge, MA: Mathematica Policy Research, May 2011.

Department of Justice, Office of Public Affairs. "Justice Department Obtains Comprehensive Agreement Regarding the State of Georgia's Mental Health and Developmental Disability System." October 19, 2010. Available at [http://www.justice.gov/opa/pr/2010/October/10-crt-1165.html]. Accessed on May 15, 2013.

Direct Service Workforce Resource Center. "Connecting Older Adults and Persons with Disabilities with Personal Care Assistance: The Potential of ADRCs as Hosts for Publically-Funded Matching Service Registries." August 2012.

Eiken, Steve, Kate Sredl, Lisa Gold, Jessica Kasten, Brian Burwell, and Paul Saucier. "Medicaid Expenditures for Long Tem Services and Supports in 2011." Truven Health Analytics, 2013.

Erickson, W., C. Lee, S. von Schrader. Disability Statistics from the 2011 American Community Survey (ACS). Ithaca, NY: Cornell University Employment and Disability Institute (EDI). Available at http://www.disabilitystatistics.org. Accessed August 23, 2013.

Feldman, P., M. Ryvicker, R. Rosati, T. Schwartz, G. Maduro. "Home Health Aide (HHA) Partnering Collaborative Evaluation: Final Report." Prepared for Office of the Assistant Secretary of Planning and Evaluation, U.S. Department of Health and Human Services, September 2007.

Haines, Kelly, Joseph Marrone, John Halliday, Michael Tashjian, Martha Klemm, Susan Foley, and Susan M. Stoddard. "Description of Supported Employment Practices, Cross-System Partnerships, and Funding Models of Four Types of State Agencies and Community Rehabilitation Providers." University of Massachusetts Boston, Institute for Community Inclusion, July 2012.

Ikegami, Naoki, John N. Morris, and Grant E. Fries. "Low-Care Cases in Long-Term Care Settings: Variation Among Nations." Age and Ageing, vol. 26, suppl. 2, September 1997, pp.67-71.

Irvin, Carol V., and Rebecca Sweetland Lester. "Synthesis of Findings from System Change Grant Programs." Final report submitted to the Centers for Medicare & Medicaid Services, Division of Community Services Transformation, Disabled and Elderly Health Programs Group. Cambridge, MA: Mathematica Policy Research, October 18, 2012.

Irvin, Carol V., Debra Lipson, Audra Wenzlow, Samuel Simon, Alex Bohl, Matthew Hodges, and John Schurrer. "Money Follows the Person 2010 Annual Evaluation Report." Final report submitted to the Centers for Medicare & Medicaid Services, Division of Community Services Transformation, Disabled and Elderly Health Programs Group. Cambridge, MA: Mathematica Policy Research, October 7, 2011.

Irvin, Carol V., Debra Lipson, Samuel Simon, Matthew Hodges, Alex Bohl, Victoria Peebles, Jeremy Bary, Matthew Sweeney, Laura Ruttner, Sean Orzol, and John Schurrer. "Money Follows the Person 2011 Annual Evaluation Report." Final report submitted to the Centers for Medicare & Medicaid Services, Division of Community Services Transformation, Disabled and Elderly Health Programs Group. Cambridge, MA: Mathematica Policy Research, October 31, 2012.

Jones, Walter C. "Problems from Mental Health Closings Outlined." The Augusta Chronicle, February 2, 2011. Available at [http://chronicle.augusta.com/news/government/elections/georgia-elections/georgia-legislature/2011-02-02/problems-mental-health]. Access August 16, 2013.

Kasper, J., and O'Malley, M. Changes in characteristics, needs, and payment for care of elderly nursing home residents: 1999—2004 (No. 7663)." Washington, DC: Henry J. Kaiser Family Foundation, 2007.

The Lewin Group. "Quick Tip Sheet: Using the Money Follows the Person Demonstration to Develop Direct Service Workforce Infrastructure." July 2011.

Lipson, Debra J. and Christal Stone Valenzano. "Toward a More Perfect Union: Creating Synergy Between the Money Follows the Person and Managed Long-Term Services and Supports Program." Reports from the Field #11, Mathematica Policy Research, February 2013.

Lipson, Debra J., Denise Hoffman, and Matthew Kehn. "The Non-Elderly Disabled Category 2 Housing Choice Voucher Program: An Implementation and Impact Analysis." Washington, DC: Mathematica Policy Research [to be released].

Lipson Debra J., Christal Stone Valenzano, and Susan J. Williams. "What Determines Progress in State MFP Transition Programs?" Reports from the Field #8, Mathematica Policy Research, October 2011.

Medicare Payment Advisory Commission. "Report to Congress: Medicare and the Health Care Delivery System." Washington, D.C., June 2013.

Moore, Terry. "Compendium of Home Modification and Assistive Technology Policy and Practice Across the States. Volume II: State Profiles". Report prepared by Abt Associates for the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, October 2006. Available at [http://aspe.hhs.gov/daltcp/reports/2006/HM-ATII2.htm#NJ]. Accessed May 30, 2013.

Mor, Vincent, Jacqueline Zinn, Pedro Gozalo, Zhanlian Feng, Orna Intrator, and David C. Grabowski. "Prospects for Transferring Nursing Home Residents to the Community." Health Affairs, vol. 26, no. 6, 2007, pp. 1762-1771.

National Association of States United for Aging and Disabilities. "State Medicaid Integration Tracker." 12th ed. NASUAD, April 23, 2013. Available at [http://www.nasuad.org/medicaid_integration_tracker.html].

Ohio Department of Development Disabilities. "The Individuals Options Waiver Handbook: A Guide to Services and Eligibility." Revised July 2011. Available at [https://doddportal.dodd.ohio.gov/INF/finditfast/publications/Documents/IO%20Waiver%20Handbook,%20New%20Rev.%207-15-11.pdf]. Accessed June 6, 2013.

Ohio Rehabilitative Services Commission. Bureau of Services for the Visually Impaired Fact Sheet, April 4, 2012. Available at [http://ood.ohio.gov/docs/default-source/internet-documents/bsvi-fact-sheet-4-12614F9DBC06BD.pdf?sfvrsn=4]. Accessed on May 31, 2013.

PHI. "Who Are Direct Care Workers?" Issue Brief. New York, New York. February 2011 update. Available at http://www.phinational.org.

Robert Wood Johnson Foundation. "Better Jobs Better Care: Building a Strong Long-Term Care Workforce." Program Results Report, April 27, 2011.

Robbins, Erika and Sue Flanagan. "Using the Money Follows the Person Demonstration to Develop Direct Service Workforce Infrastructure." Falls Church, VA: The Lewin Group, July 2011.

Ross, Jessica, Sam Simon, Carol Irvin, and Dean Miller. "Institutional Level of Care Among Money Follows the Person Participants." The National Evaluation of the Money Follows the Person Demonstration Grant Program, Reports from the Field no. 10. Cambridge, MA: Mathematica Policy Research, October 2012.

Saucier, Paul, Jessica Kasten, Brian Burwell, and Lisa Gold. "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." Truven Health Analytics, July 2012. Available at [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf].

Simon, Samuel E., and Matthew R. Hodges. "Money Follows the Person: Change in Participant Experience During the First Year of Community Living." The National Evaluation of the Money Follows the Person Demonstration Grant Program, Reports from the Field no. 6. Cambridge, MA: Mathematica Policy Research, May 2011.

Sloan, Matt, and Carol Irvin. "Money Follows the Person Quality of Life Survey." Prepared for the Centers for Medicare & Medicaid Services. Washington, DC: Mathematica Policy Research, 2007.

Texas Health and Human Services Commission (HHSC), Request for Proposal for Employment Pilot Project (RFP No. 539-3-79432), March 14, 2013. Available at [http://pacstx.org/full_article.php?article_no=74]. Accessed May 24, 2013.

United States Department of Housing and Urban Development. "Worst Case Housing Needs 2011: Report to Congress." Washington, DC: HUD, February 2013.

United States Department of Labor, Office of Disability and Employment Policy. What is Customized Employment? Available at [http://www.dol.gov/odep/categories/workforce/CustomizedEmployment/what/index.htm]. Accessed May 25, 2013.

United States Department of Health and Human Services. "Personal and Home Care Aide State Training (PHCAST) Demonstration Program: Report to Congress on Initial Implementation." Available at [http://bhpr.hrsa.gov/nursing/grants/phcast.html]. Accessed October 2, 2013.

Wenzlow, Audra, Victoria Peebles, and Stephen Kuncaitis. "The Application of the HCBS Taxonomy in Claims Data: A First Look at Expenditures for Medicaid HCBS." Final report submitted to the Centers for Medicare & Medicaid Services. Ann Arbor, MI: Mathematica Policy Research, May 2011.

Williams, Susan R., Eric Morris, Bailey Orshan, Noelle Denny-Brown, Matthew Kehn, Jessica Ross, Christal Stone. "Money Follows the Person Demonstration: Overview of State Grantee Progress, July to December 2012." Final report submitted to the Centers for Medicare & Medicaid Services, Division of Community Services Transformation, Disabled and Elderly Health Programs Group. Cambridge, MA: Mathematica Policy Research, July 30, 2013.

Wisconsin Department of Health Services. "An Overview of Wisconsin's Family Care Program." September 2011. Available at [http://www.dhs.wisconsin.gov/ltcare/pdf/FCoverview.pdf]. Accessed May 20, 2013.

Wright, B. "Strategies for Improving DSW Recruitment, Retention, and Quality: What We Know About What Works and What Doesn't, and Research Gaps." Prepared by The Lewin Group, 2009.

Yallowitz, W., and B. Hofland. "Better Jobs Better Care: A Foundation Initiative Focusing On Direct Care Workers." The Gerontologist, vol. 48, no. 1, pp 11—16, 2008.

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APPENDIX A

MFP GRANTEE TRANSITION GOALS FROM 2007—2016

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Table A.1. MFP Grantee Transition Goals from 2007—2016, by State

State	Implementation Start Date	2007 Total	2008 Total	2009 Total	2010 Total	2011 Total	2012 Total	2013 Total	2014 Total	2015 Total	2016 Total	Cumulative Total
Alabama	*Not known	0	0	0	0	0	0	60	165	195	195	615
Arkansas	July 1, 2008	0	22	51	77	122	197	165	198	238	275	1,345
California	September 1, 2008	0	2	126	273	278	331	1,244	1,368	1,461	758	5,841
Colorado	March 1, 2013	0	0	0	0	0	0	100	100	100	100	400
Connecticut	December 8, 2008	0	0	129	276	384	465	946	946	946	946	5,038
Delaware	October 1, 2008	0	3	20	15	28	43	30	35	40	45	259
District of Columbia	June 27, 2008	0	15	37	23	35	22	60	60	60	60	372
Florida	*Not known	0	0	0	0	0	0	328	357	367	192	1,244
Georgia	September 1, 2008	0	3	194	245	304	449	275	275	275	275	2,295
Hawaii	December 1, 2008	0	1	24	45	66	66	73	73	73	73	494
Idaho	November 1, 2011	0	0	0	0	4	134	65	80	82	37	402
Illinois	April 1, 2009	0	0	53	180	238	343	550	631	725	834	3,554
Indiana	Spring 2009	0	0	60	227	246	209	350	350	350	355	2,147
Iowa	September 1, 2008	0	9	53	56	55	56	75	75	75	75	529
Kansas	July 1, 2008	0	70	88	185	252	284	147	147	147	147	1,467
Kentucky	September 1, 2008	0	5	36	115	158	89	120	120	120	120	883
Louisiana	April 1, 2009	0	0	9	81	167	194	180	154	142	106	1,033
Maine	October 1, 2012	0	0	0	0	0	1	21	27	26	26	101
Maryland	March 1, 2008	0	154	330	315	359	329	462	532	614	709	3,804
Massachusetts	July 18, 2011	0	0	0	0	52	227	451	373	373	373	1,849
Michigan	June 1, 2008	0	89	286	265	313	361	375	400	425	480	2,994
Minnesota	*Not known	0	0	0	0	0	0	562	563	563	563	2,251
Mississippi	March 1, 2012	0	0	0	0	0	59	100	145	135	140	579
Montana	*Not known	0	0	0	0	0	0	33	62	70	70	235
Missouri	January 1, 2007	7	67	138	80	140	222	143	143	143	149	1,232

Table A.1 (continued)

State	Implementation Start Date	2007 Total	2008 Total	2009 Total	2010 Total	2011 Total	2012 Total	2013 Total	2014 Total	2015 Total	2016 Total	Cumulative Total
Nebraska	June 20, 2008	0	19	39	44	36	98	131	131	131	131	760
Nevada	September 1, 2012	0	0	0	0	0	5	120	126	128	30	409
New Hampshire	October 1, 2007	2	24	21	27	33	62	49	49	49	49	365
New Jersey	July 1, 2008	0	11	74	72	185	275	469	396	465	325	2,272
New York	May 1, 2009	0	0	87	169	250	335	288	315	345	378	2,167
North Carolina	February 9, 2009	0	0	31	29	88	104	130	130	130	130	772
North Dakota	September 1, 2008	0	5	14	24	32	47	39	39	39	39	278
Ohio	October 20, 2008	0	60	342	448	683	1,033	419	443	375	376	4,179
Oklahoma	April 1, 2009	0	0	28	124	108	108	674	730	785	873	3,430
Oregon	April 1, 2008	0	32	131	136	7	0	140	140	90	90	766
Pennsylvania	July 1, 2008	0	42	253	283	230	224	314	309	332	364	2,351
Rhode Island	April 1, 2011	0	0	0	0	6	44	120	120	120	120	530
South Carolina	January 1, 2013	0	0	0	0	0	0	84	106	106	106	402
South Dakota	*Not known	0	0	0	0	0	0	25	31	37	43	136
Tennessee	October 1, 2011	0	0	0	0	62	399	489	487	427	376	2,240
Texas	January 10, 2008	0	761	1,123	1,695	1,721	1,260	1,125	1,125	1,125	1,125	11,060
Vermont	May 1, 2012	0	0	0	0	0	30	75	85	90	30	310
Virginia	July 1, 2008	0	16	73	129	120	151	144	156	168	180	1,137
Washington	Spring 2008	0	38	325	586	816	767	575	623	621	600	4,951
West Virginia	April 1, 2013	0	0	0	0	0	0	100	110	120	120	450
Wisconsin	October 1, 2007	2	25	25	27	81	162	165	193	205	205	1,090
TOTAL	-	11	1,473	4,200	6,251	7,659	9,185	12,590	13,223	13,633	12,793	81,018

Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2008—2012, New Editions 2012 TA Needs Assessment Survey Data, and 2012 MFP Supplemental Budget Worksheets prepared and submitted by MFP grantees in 2012. Implementation start dates were reported by MFP program staff in each state.

Table A.1 (continued)

Note: The transition counts for 2007 through 2012 are the actual number of people states transitioned. The transition counts for 2013 through 2016 are state projections of the number of people they plan to transition each year.

*Anticipated start date

NA = Not applicable.

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APPENDIX B

DATA AND METHODS FOR TREND ANALYSES OF LONG-TERM CARE EXPENDITURES

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DATA AND METHODS FOR TREND ANALYSES OF LONG-TERM CARE EXPENDITURES

We use a regression framework to assess the association of MFP with the balance of long-term care (LTC) systems for the 2007 MFP grantees (hereafter "grantees") in the three years post MFP (2008—2010), while accounting for pre-existing trends in the three years prior (2005—2007). This framework also allows us to control for observed demographic characteristics (such as age and gender) as well as unobserved state characteristics. We also conduct several sensitivity tests to verify the robustness of our results, including using non-MFP states as a control group.

DATA AND SAMPLE

These analyses are based on data from the Medicaid Analytic eXtract (MAX) data system.[69] MAX eligibility and claims files provide Medicaid data in a uniform format across all states and include demographic and eligibility characteristics and Medicaid service use for every Medicaid enrollee. Data for 2005—2009 were available for all 30 2007 MFP grantees, though 2010 data were available only for 17 of these states.[70] These data files enabled us to compute Medicaid LTC expenditure and use data described in further detail later in this section. We supplemented the MAX data with MFP administrative data to determine the number of transitions in each state and year, to construct a proxy of the intensity of the MFP program in a state-year.

With the MAX data, we computed monthly Medicaid LTC expenditure data, broken down into home- and community-based services (HCBS) and institutional care. We computed our main outcome of interest, HCBS share of LTC expenditures, as HCBS expenditures divided by the sum of HCBS and institutional long-term care expenditures. We also classified HCBS expenditures as waiver or state-plan HCBS. We included only fee-for-service expenditures, and did not include expenditures for services billed in bulk to the state. We identified HCBS users each month based on monthly enrollment for Section 1915(c) waiver programs or having positive HCBS expenditures in the month. We identified institutional long-term care users each month based on whether they had positive institutional care expenditures.

[69] Beta-MAX files (early release versions of MAX data) were used when MAX data were not available.

[70] The 2007 MFP grantee states are Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Virginia, Washington, and Wisconsin. The MAX 2010 data were available only for the following grantee states: Arkansas, California, Connecticut, Delaware, Georgia, Iowa, Illinois, Indiana, Kentucky, Louisiana, Michigan, Nebraska, Ohio, Oregon, Pennsylvania, Texas, and Virginia.

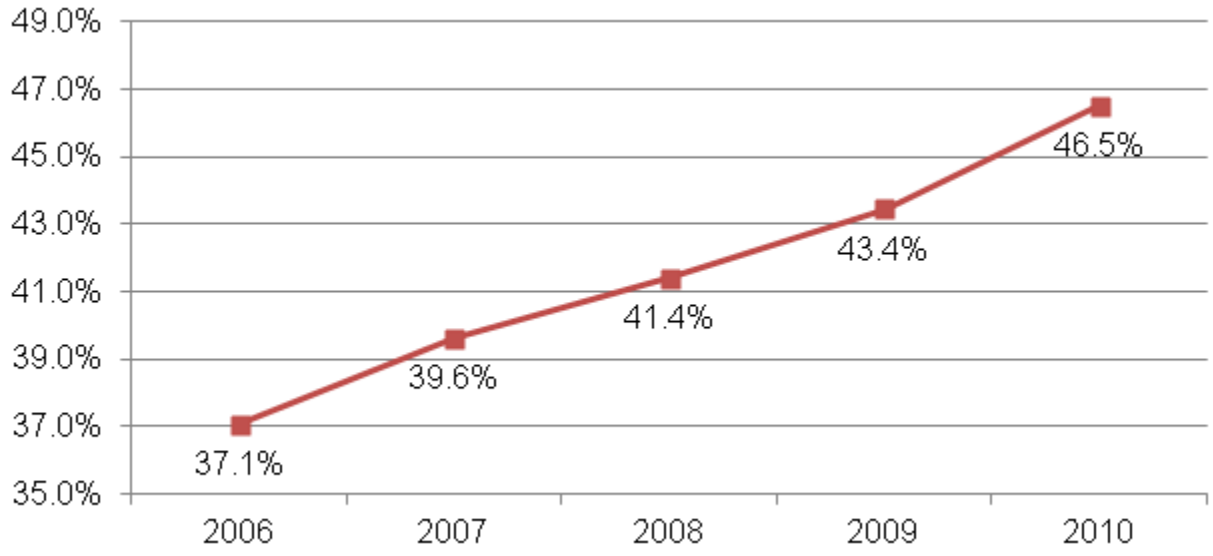
For the subgroup analyses, we identified beneficiaries as new users if they had no Medicaid-financed LTC utilization in the previous calendar year. We identified beneficiaries as established users if they were not new users. To classify beneficiaries into MFP target populations—elderly, nonelderly individuals with physical disabilities, individuals with intellectual and developmental disabilities, and individuals with mental illness—we used type of facility and age if the beneficiary received institutional care, and used waiver type and age to classify all other beneficiaries.

DESCRIPTIVE EVIDENCE AND METHODOLOGY

Figure B.1 shows that from 2005—2009—the time period during which we have data for all grantees—the HCBS share of LTC expenditures among MFP grantees rose from about 36 percent to 45 percent. In particular, the HCBS share was increasing even prior to MFP, reflective of states' earlier efforts at rebalancing their systems. Thus, any changes in the balance of state systems after 2008 cannot be fully attributed to MFP. To address this issue, we estimate regression models that contain trend terms that account for pre-existing trends in the balance of state systems that were occurring in the years leading up to the implementation of the MFP program, specifically 2005—2007.

Effectively, this methodology attributes any deviations from the 2005—2007 trend to MFP. As Figure B.1 shows, there was little deviation from the pre-MFP trend in the first quarters of 2008. However, there is a noticeable shift upward in 2009. This shift may indicate a possible delayed positive effect of MFP on the HCBS share of LTC expenditures, which reflects the delays inherent in how MFP programs accumulate their rebalancing funds. MFP programs must first transition people before they can accumulate funds and spend them. The regression models are used to estimate this deviation, while accounting for demographic characteristics and state fixed effects, in addition to pre-existing trends.

Figure B.1. Trends in HCBS Share of LTC Expenditures Over Time for MFP Grantees



Source: Mathematica Analysis of 2005—2009 MAX data for 30 states.

The regression models are estimated using observations at the state-month level. We included state fixed effects to control for fixed state-specific characteristics. We included

calendar-month fixed effects to flexibly control for seasonality. We also included state-month averages of age, age squared, race, and gender computed among the Medicaid population.

Our main outcome of interest is the HCBS share of LTC expenditures, which is equal to HCBS expenditures divided by the sum of HCBS and institutional care expenditures. Other outcomes included HCBS share of LTC users and waiver share of HCBS expenditures, all computed similarly. Regressions were weighted by the denominator values of the outcome variable to reflect population averages. Thus, states with more LTC expenditures will have a greater influence on the average than states with less LTC expenditures.

Our key explanatory variables are indicators of the post-MFP years 2008, 2009, and 2010. We also refine this measure in a sensitivity analysis, where instead of a binary ("on-off") variable, we constructed a measure of MFP intensity as the number of MFP transitions in a year divided by the average number of monthly LTC users that year.

Formally, we estimate the model below:

$$\text{outcome}_{jt} = \beta_{08} \cdot \text{year}_{08} + \beta_{09} \cdot \text{year}_{09} + \beta_{10} \cdot \text{year}_{10} + \text{trend}_t + \alpha \cdot X_{jt} + \varepsilon_{jt}$$

where outcome_{jt} is the outcome of interest, year_k is an indicator for year k, trend_t is a linear time trend, and X_{jt} represents the set of controls, including demographic characteristics and state fixed effects. The parameter β_k is the estimate of the association between MFP and the outcome of interest in year k.

For our main results, we estimate the model for the entire set of states and months over which we have available data. However, in a later section we describe how our results are robust to various selections of states, including restricting to the set of states for which we have all years of data.

RESULTS

MFP's Association with the HCBS Share of LTC Expenditures and Users

Although the unadjusted data may suggest that the trend in the proportion of long-term care expenditures accounted for by HCBS may have shifted as early as 2009, regression results in the first column of Table B.1 indicate that the post-MFP trend in HCBS expenditures was not statistically different from the pre-MFP trend until 2010. This result is not surprising, given that most states started their programs slowly and only 21 states transitioned people in 2008. However, in 2010, MFP is associated with a statistically significant 2.5 percentage point increase in the HCBS share of expenditures. In other words, the 2010 HCBS percentage in grantee states was 2.5 percentage points higher than what it would have been in the absence of MFP. These results suggest that MFP's influence on the balance of state long-term care systems was not immediate but increased over time as states refined and expanded their MFP programs.

Table B.1. Association Between MFP and the HCBS Share of LTC Expenditures and Users

MFP Association with HCBS Share of:	Expenditures	Users
2008	-0.002	0.008
-	(0.006)	(0.005)
2009	0.012	0.008
-	(0.008)	(0.007)
2010	0.025*	0.015+
-	(0.010)	(0.009)

Source: Mathematica Analysis of 2005—2010 MAX data for 30 states.

Note: The analysis is based on 2,004 state-month observations of the HCBS share of long-term care expenditures.

+Significantly different from zero at the 10 percent level.

*Significantly different from zero at the 5 percent level.

**Significantly different from zero at the 1 percent level.

A similar analysis of long-term care users found similar results—that beginning in 2010 we find a statistically significant but weaker increase in the trend of HCBS users as a proportion of all long-term care users. The second column of Table 2 shows that there is no statistically significant association between MFP and the HCBS share of LTC users in 2008 and 2009. In 2010, the association was 1.5 percentage points, which is only weakly statistically significant. The results from both analyses of the proportions of expenditures and users accounted for by HCBS highlight an important point. Because institutional services are more expensive, a change in the percent of HCBS users is likely to lead to a disproportionately larger change in HCBS expenditures.

Association with State Plan vs. Waiver HCBS Expenditures

We estimated the association between MFP and the share of state plan HCBS expenditures and found no strong evidence that MFP is linked to an increased share of state plan HCBS expenditures (versus waiver).

Subgroup Analyses

Target Population

We estimated MFP's association with the balance of HCBS expenditures separately for different population subgroups—elderly, nonelderly with physical disabilities, individuals with intellectual and developmental disabilities, and individuals with mental illness. We found that the increase in the trend of HCBS expenditures as a proportion of total LTC expenditures was most pronounced among individuals with intellectual and developmental disabilities. Specifically, by 2010, the HCBS share of LTC expenditures among this population was 2.7 percentage points higher than it would have been if MFP had not been implemented. This result is consistent with

Irvin et al.'s (2012) findings that MFP was associated with increased transitions among this population beginning with the first year of implementation (2008). We also found weaker evidence among the elderly and individuals with mental illness. Among the nonelderly with physical disabilities, we saw no evidence of an association between MFP and the trend of HCBS expenditures as a proportion of total LTC expenditures.

Table B.2. Association Between MFP and the HCBS Share of LTC Expenditures, by MFP Target Population.

MFP Association with HCBS Share of Expenditures	Elderly	Physical Disabilities	Intellectual/ Developmental Disabilities	Mental Illness
2008	0.003	-0.001	-0.002	0.003
-	(0.002)	(0.003)	(0.004)	(0.004)
2009	0.012**	-0.006	0.011	0.018**
-	(0.003)	(0.005)	(0.007)	(0.007)
2010	0.007+	0.010	0.027**	0.012+
-	(0.004)	(0.007)	(0.010)	(0.007)

Source: Mathematica analysis of 2005—2010 MAX data for 30 states.

Note: The analysis is based on 2,004 state-month observations of the HCBS share of long-term care expenditures.

+Significantly different from zero at the 10 percent level.

*Significantly different from zero at the 5 percent level.

**Significantly different from zero at the 1 percent level.

New versus Established Users

In this section, we look separately at users without long-term care utilization in the previous calendar year ("new users"), and users with long-term care utilization in the previous year, ("established users"). This breakdown of the long-term care population is useful because MFP may have differential effects on these two groups. MFP should have fewer direct effects on new users, given the eligibility requirement that beneficiaries reside in an institution for a minimum period of time (six months, prior to the Affordable Care Act; 90 days, following the Affordable Care Act) to be eligible for the MFP transition program. Thus, the primary effect on new users is likely to be reflective of MFP's overall influence on states' LTSS systems and general improvements in access to HCBS. For established users, particularly those in institutional care, MFP may have a more direct and immediate effect on their care relative to new users. We find that MFP's association with the increasing HCBS share of LTC expenditures was driven primarily by established users. This finding indicates that the influence of MFP during its early years was primarily through the MFP transition program and how the rebalancing program affected access to HCBS for those who had been in long-term care for a year or more. MFP's lack of influence for people new to long-term care services, at least in the first years of the program, suggests that it takes time for states to change their systems so that HCBS is more accessible to those entering long-term care for the first time.

Table B.3. Association Between MFP and the HCBS Share of LTC Expenditures, New and Established Users.

MFP Association with HCBS Share of Expenditures	New Users	Established Users
2008	0.000	-0.002
-	(0.008)	(0.005)
2009	0.001	0.012
-	(0.011)	(0.008)
2010	-0.010	0.028**
-	(0.015)	(0.010)

Source: Mathematica analysis of 2005—2010 MAX data for 30 states.

Note: The analysis is based on 2,004 state-month observations of the HCBS share of long-term care expenditures.

+Significantly different from zero at the 10 percent level.

*Significantly different from zero at the 5 percent level.

**Significantly different from zero at the 1 percent level.

Robustness to Inclusion and Exclusion of Various States

One limitation of this analysis is that we lack 2010 data for several states. Although we included 2005—2009 data for these states to use as much information as possible, the imbalance of 2010 data may yield spurious results for the estimated influence of MFP, even when controlling for state fixed effects. Thus, we repeated the previous analyses on the sample of 17 states for which we had 2005—2010 data. Overall, our main findings are robust to the sample of states for which we have complete data through 2010. If anything, the estimated overall association is larger, at 2.1 percentage points in 2009 and 2.8 percentage points in 2010.

Similarly, we might be concerned that Texas, which had a state MFP program before the national program was implemented, may have a disproportionate influence on the overall results. In fact, the second column shows that MFP had a substantial association with HCBS share, even as early as 2008. The third column shows that our results are little changed by excluding Texas from the sample. Lastly, given that MFP transitioned very few people in the first year and that we would not expect a sizeable association in 2008, we also estimate a model that treats 2008 as a pre-MFP year. Again, the results for 2009 and 2010 are little changed from the main results.

Robustness to Specifying the Intensity of MFP

In the previous analyses, we compared MFP grantee states before and after 2008, without regard to the extent to which MFP was implemented in the state. For example, some 2007 grantees did not transition institutional beneficiaries until 2009, or may have taken a while to ramp up. As a proxy for MFP intensity, we construct a variable at the state-year level equal to the number of MFP transitioners in the state-year, divided by the number of LTC users in the state-year. We used this variable instead of the indicators for the post MFP years. We find that each additional MFP transitioner per thousand LTC users in the state is statistically significantly associated with a 0.9 percentage point increase in the HCBS share of LTC expenditures (for

reference, the average 2010 value for this variable across grantee states was 1.2 MFP transitioners per thousand LTC users). This result indicates that states in which MFP participants accounted for a larger share of the population of long-term care users tended to have higher HCBS shares of LTC expenditures.

Table B.4. Association Between MFP and the HCBS Share of LTC Expenditures, Sensitivity to Sample and Specification.

MFP Association with HCBS Share of Expenditures	Excluding States Without 2010 Data	Texas Only	Excluding Texas	Count 2008 as Pre-MFP
2008	0.011+	0.058**	-0.005	-
-	(0.006)	(0.017)	(0.006)	-
2009	0.021*	0.045+	0.009	0.013**
-	(0.008)	(0.027)	(0.008)	(0.005)
2010	0.028*	0.049	0.023*	0.027**
-	(0.011)	(0.039)	(0.011)	(0.007)

Source: Mathematica analysis of 2005—2010 MAX data for 30 states.

Note: The first column is restricted to the 17 states with 2005—2010 data. The second column includes only Texas state-month observations. The third column excludes TX observations. The fourth column counts 2008 as a pre-MFP year when estimating the regression model.

+Significantly different from zero at the 10 percent level.

*Significantly different from zero at the 5 percent level.

**Significantly different from zero at the 1 percent level.

Robustness to Using Nongrantee States as a Control Group

An alternative methodology would be to use nongrantee states as a control group. This methodology has the benefit of allowing us to control for systemic factors other than MFP that might have influenced the balance of grantee's LTC systems, particularly post-MFP. The underlying assumption behind this approach is that trends in differences between grantee and nongrantee states would be unchanged if MFP had never been implemented. Table B5 below shows the association between MFP and HCBS share based on this approach.[71] The results are

[71] We implemented the differences-in-differences approach by estimating the following model: $\text{outcome}_{jt} = \sum_{t=2005}^{2010} \beta_t \cdot \text{grantee}_j \cdot \text{year}_t + \alpha \cdot X_{jt} + \varepsilon_{jt}$. The main difference from the trend analysis is that nongrantee state-month observations are included, so the key variables of interest are post-MFP indicators interacted with grantee status. Time fixed effects were also included.

consistent with our findings from the trend analysis. That is, there is no statistically significant increase in the trend of expenditures during 2008 and 2009, but there is by 2010. Specifically, by 2010, the HCBS percentage in grantee states was estimated to be 3.9 percentage points higher than what it would have been in the absence of MFP. Moreover, there is a positive, but slightly lower and statistically insignificant change in the proportion of long-term care users receiving HCBS.

Table B.5. Association Between MFP and the HCBS Share of LTC Expenditures and Users.

MFP Association with HCBS Share of:	Expenditures	Users
2008	0.009	0.011
-	(0.007)	(0.014)
2009	0.022	0.002
-	(0.014)	(0.014)
2010	0.039*	0.025
-	(0.017)	(0.023)

Source: Mathematica analysis of 2005—2010 MAX data for 48 states.

Note: Differences-in-differences analysis. The analysis is based on 3,228 state-month observations of the HCBS share of long-term care expenditures. Data for Minnesota and Tennessee were excluded because of apparent data anomalies that generated biased program effects.

+Significantly different from zero at the 10 percent level.

*Significantly different from zero at the 5 percent level.

**Significantly different from zero at the 1 percent level.

APPENDIX C

DIRECT SERVICE WORKFORCE INITIATIVES BY STATE AND BY GRANT/TECHNICAL ASSISTANCE OPPORTUNITY

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Table C.1. Direct Service Workforce Initiatives by State and by Grant/Technical Assistance Opportunity

State	RCSC Grants, 2001[a]	CMS DSW Grants 2003—2004[b]	BJBC Initiative, 2002—2008[c]	DSW RC intensive TA 2006—2008[d]	Using MFP to Enhance DSW in 2011[e]
Alabama	-	-	-	-	-
Alaska	Education, Training, and Credentialing; Infrastructure and Data Improvements	-	-	-	-
Arizona	-	-	-	Infrastructure and Data Improvements	-
Arkansas	Marketing, Recruitment, and Retention; Education, Training, and Credentialing; Infrastructure and Data Improvements; Wages and Benefits	Marketing, Recruitment, and Retention; Education, Training, and Credentialing; Infrastructure and Data Improvements	-	-	-
California	-	-	-	-	-
Colorado	-	-	-	-	-
Connecticut	-	-	-	-	Marketing, Recruitment, and Retention; Work Environment; Education, Training, and Credentialing
District of Columbia	-	-	-	-	Education, Training, and Credentialing

Table C.1 (continued)

State	RCSC Grants, 2001[a]	CMS DSW Grants 2003—2004[b]	BJBC Initiative, 2002—2008[c]	DSW RC intensive TA 2006—2008[d]	Using MFP to Enhance DSW in 2011[e]
Delaware	-	Marketing, Recruitment, and Retention; Education, Training, and Credentialing; Merit-Based Recognition	-	Marketing, Recruitment, and Retention; Strategic Planning and Partnership	-
Florida	Marketing, Recruitment, and Retention; Education, Training, and Credentialing	-	-	-	-
Georgia	Infrastructure and Data Improvements	-	-	Education, Training, and Credentialing; Infrastructure and Data Improvements	-
Guam	Education, Training, and Credentialing	-	-	-	-
Hawaii	-	-	-	-	Education, Training, and Credentialing
Idaho	-	-	-	-	-
Illinois	-	-	-	-	-
Indiana	-	Marketing, Recruitment, and Retention; Education, Training, and Credentialing; Wages and Benefits; Merit-Based Recognition	-	Education, Training, and Credentialing; Strategic Planning and Partnership	-

Table C.1 (continued)

State	RCSC Grants, 2001[a]	CMS DSW Grants 2003—2004[b]	BJBC Initiative, 2002—2008[c]	DSW RC intensive TA 2006—2008[d]	Using MFP to Enhance DSW in 2011[e]
Iowa	-	-	Infrastructure and Data Improvements; Wages and Benefits; Merit-Based Recognition	-	Education, Training and Credentialing
Kansas	-	-	-	-	-
Kentucky	Education, Training and Credentialing; Infrastructure and Data Improvements	Marketing, Recruitment and Retention; Education, Training and Credentialing; Infrastructure and Data Improvements; Merit-Based Recognition	-	-	-
Louisiana	-	Education, Training and Credentialing; Merit-Based Recognition	-	Marketing, Recruitment and Retention; Wages and Benefits	Work Environment; Education, Training and Credentialing
Maine	Work Environment	Education, Training and Credentialing; Wages and Benefits; Merit-Based Recognition	-	-	-
Maryland	Marketing, Recruitment and Retention	-	-	-	-
Massachusetts	-	-	-	-	-

Table C.1 (continued)

State	RCSC Grants, 2001[a]	CMS DSW Grants 2003—2004[b]	BJBC Initiative, 2002—2008[c]	DSW RC intensive TA 2006—2008[d]	Using MFP to Enhance DSW in 2011[e]
Michigan	-	-	-	Infrastructure and Data Improvements; Strategic Planning and Partnership	-
Minnesota	Infrastructure and Data Improvements	-	-	-	-
Mississippi	-	-	-	-	-
Missouri	-	-	-	-	-
Montana	Marketing, Recruitment and Retention; Work Environment; Education, Training and Credentialing; Infrastructure and Data Improvements; Wages and Benefits	-	-	-	-
Nebraska	-	-	-	-	-
Nevada	Marketing, Recruitment and Retention	-	-	-	-
New Hampshire	Infrastructure and Data Improvements; Wages and Benefits	-	-	-	Education, Training and Credentialing

Table C.1 (continued)

State	RCSC Grants, 2001[a]	CMS DSW Grants 2003—2004[b]	BJBC Initiative, 2002—2008[c]	DSW RC intensive TA 2006—2008[d]	Using MFP to Enhance DSW in 2011[e]
New Jersey	Infrastructure and Data Improvements	-	-	Marketing, Recruitment and Retention; Education, Training and Credentialing	Education, Training and Credentialing
New Mexico	-	Wages and Benefits	-	-	-
New York	-	-	-	Marketing, Recruitment and Retention; Strategic Planning and Partnership	-
North Carolina	Marketing, Recruitment and Retention; Work Environment; Education, Training and Credentialing; Infrastructure and Data Improvements; Wages and Benefits; Merit-Based Recognition	Education, Training and Credentialing; Wages and Benefits; Merit-Based Recognition	Work Environment	Marketing, Recruitment and Retention; Education, Training and Credentialing; Strategic Planning and Partnership	Education, Training and Credentialing
North Dakota	-	-	-	-	Marketing, Recruitment and Retention

Table C.1 (continued)

State	RCSC Grants, 2001[a]	CMS DSW Grants 2003—2004[b]	BJBC Initiative, 2002—2008[c]	DSW RC intensive TA 2006—2008[d]	Using MFP to Enhance DSW in 2011[e]
Ohio	-	-	-	Education, Training and Credentialing; Infrastructure and Data Improvements	Marketing, Recruitment and Retention; Work Environment; Education, Training and Credentialing
Oklahoma	-	-	-	-	-
Oregon	Marketing, Recruitment and Retention; Education, Training and Credentialing; Infrastructure and Data Improvements	-	Work Environment	-	-
Pennsylvania	-	-	Education, Training and Credentialing; Wages and Benefits; Merit-Based Recognition	-	-
Rhode Island	-	-	-	-	-
South Carolina	-	-	-	Marketing, Recruitment and Retention; Infrastructure and Data Improvements	-
South Dakota	-	-	-	-	-

Table C.1 (continued)

State	RCSC Grants, 2001[a]	CMS DSW Grants 2003—2004[b]	BJBC Initiative, 2002—2008[c]	DSW RC intensive TA 2006—2008[d]	Using MFP to Enhance DSW in 2011[e]
Tennessee	-	-	-	-	-
Texas	-	-	-	Education, Training and Credentialing; Infrastructure and Data Improvements; Wages and Benefits; Strategic Planning and Partnership	Marketing, Recruitment and Retention; Infrastructure and Data Improvements
Utah	-	-	-	Marketing, Recruitment and Retention	-
Vermont	Work Environment; Wages and Benefits	-	Education, Training and Credentialing	-	-
Virginia	-	Marketing, Recruitment and Retention; Education, Training and Credentialing	-	-	-

Table C.1 (continued)

State	RCSC Grants, 2001[a]	CMS DSW Grants 2003—2004[b]	BJBC Initiative, 2002—2008[c]	DSW RC intensive TA 2006—2008[d]	Using MFP to Enhance DSW in 2011[e]
Washington	-	Marketing, Recruitment and Retention; Education, Training and Credentialing; Infrastructure and Data Improvements; Wages and Benefits; Merit-Based Recognition	-	-	-
West Virginia	-	-	-	-	-
Wisconsin	Education, Training and Credentialing; Infrastructure and Data Improvements	-	-	Education, Training and Credentialing	-
Wyoming	-	-	-	-	-

Source: [a]Anderson et al. 2004. [b]According to a Lewin Group assessment of the 2003—2004 DS workforce grants. [c]Yallowitz and Hofland, 2008. [d]States that requested and received intensive TA from the DSW RC between 2006 and 2008.[e] According to a 2011 survey of MFP states conducted by the Lewin Group.

APPENDIX D

LEVEL OF CARE ASSIGNMENTS FOR RUG-III AND RUG IV

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Table D.1. Level of Care Assignments for RUG-III and RUG-IV

Care Need	RUG-III Description/ADL Score	RUG-III	RUG-IV	RUG-IV Description/ADL Score
Low	Cognitive Impairment with Nursing Rehab / ADL 4 - 5	IA2	-	-
Low	Cognitive Impairment / ADL4 -5	IA1	-	-
Low	Behavior Problem with Nursing Rehab / ADL 4 - 5	BA2	BA2	Behavior/Cognitive w Rest. Nursing/ADL 0-1
Low	Behavior Problem / ADL4 - 5	BA1	BA1	Behavior/Cognitive w No Rest. Nursing/ ADL 0-1
Low	Reduced Physical Function with Nursing Rehab / ADL4 - 5	PA2	PA2	Physical Function w Rest. Nursing/ADL 0-1
Low	Reduced Physical Function / ADL4 -5	PA1	PA1	Physical Function w No Rest Nursing /ADL 0-1
Low	-	-	CA1	Clinically Complex w/o Depression/ADL 0-1
Low	-	-	CA2	Clinically Complex w/Depression /ADL 0-1
Medium	Rehabilitation Medium / ADL 15 - 18	RMC	RMC	Rehabilitation Medium / ADL 11 - 16
Medium	Rehabilitation Medium / ADL8 - 14	RMB	RMB	Rehabilitation Medium / ADL6 - 10
Medium	Rehabilitation Medium / ADL4 -7	RMA	RMA	Rehabilitation Medium / ADL 0 - 5
Medium	Rehabilitation Low / ADL 14 - 18	RLB	RLB	Rehabilitation Low / ADL 1 - 16
Medium	Rehabilitation Low / ADL4 - 13	RLA	RLA	Rehabilitation Low/ADL 0 - 10
Medium	Extensive Special Care 1 / ADL > 6	SE1	ES1	Extensive Special Care 1 / ADL >= 2
Medium	Special Care / ADL4 - 14	SSA	-	-
Medium	Clinically Complex / ADL4 - 11	CA1	-	-
Medium	Clinically Complex with Depression / ADL4 - 11	CA2	-	-
Medium	-	-	CC2	Clin. Complex with Depression / ADL 6 - 10
Medium	-	-	CC1	Clinically Complex / ADL 6 - 10
Medium	-	-	CB2	Clin. Complex with Depression / ADL 2 - 5
Medium	-	-	CB1	Clinically Complex / ADL 2 - 5
Medium	Physical Function with Nursing Rehab / ADL11 - 15	PD2	PD2	Physical Function with Nursing Rehab / ADL11 - 14
Medium	Physical Function / ADL11 - 15	PD1	PD1	Physical Function / ADL11 - 14
Medium	Cog. Impairment with Nursing Rehab / ADL6 - 10	IB2	-	-
Medium	Cognitive Impairment / ADL6 - 10	IB1	-	-
Medium	Behavior Problem with Nursing Rehab / ADL 6 – 10	BB2	BB2	Behavior Problem with Nursing Rehab / ADL 2 - 5

Table D.1 (continued)

Care Need	RUG-III Description/ADL Score	RUG-III	RUG-IV	RUG-IV Description/ADL Score
Medium	Behavior Problem / ADL6 - 10	BB1	BB1	Behavior Problem with No Nursing Rehab / ADL 2 – 5
Medium	Physical Function with Nursing Rehab / ADL9 - 10	PC2	PC2	Physical Function with Nursing Rehab / ADL6 - 10
Medium	Physical Function / ADL9 - 10	PC1	PC1	Physical Function / ADL6 - 10
Medium	Physical Function with Nursing Rehab / ADL6 -8	PB2	PB2	Physical Function with Nursing Rehab / ADL2 -5
Medium	Physical Function / ADL6 -8	PB1	PB1	Physical Function / ADL2 -5
Medium	-	-	RUL	Rehabilitation Ultra High & Extensive /ADL 2-10
Medium	-	-	RVL	Rehabilitation Very High & Extensive /ADL 2-10
Medium	-	-	RHL	Rehabilitation High & Extensive /ADL 2-10
Medium	-	-	RML	Rehabilitation Medium & Extensive /ADL 2-10
Medium	-	-	HC2	Special Care High with Depression/ADL 6-10
Medium	-	-	HC1	Special Care High No Depression/ ADL 2-5
Medium	-	-	HB2	Special Care High with Depression/ADL 6-10
Medium	-	-	HB1	Special Care High No Depression/ ADL 2-5
Medium	-	-	LC2	Special Care Low w Depression/ADL 6-10
Medium	-	-	LC1	Special Care Low No Depression/ADL 6-10
Medium	-	-	LB2	Special Care Low w Depression/ADL 2-5
Medium	-	-	LB1	Special Care Low No Depression / ADL 2-5
High	Rehabilitation Ultra High / ADL 16 - 18	RUC	RUC	Rehabilitation Ultra High / ADL 11 - 16
High	Rehabilitation Ultra High / ADL9 - 15	RUB	RUB	Rehabilitation Ultra High / ADL6 - 10
High	Rehabilitation Ultra High / ADL4 -8	RUA	RUA	Rehabilitation Ultra High / ADL0 -5
High	Rehabilitation Very High / ADL 16 - 18	RVC	RVC	Rehabilitation Very High / ADL 11 - 16
High	Rehabilitation Very High / ADL9 - 15	RVB	RVB	Rehabilitation Very High / ADL6 - 10
High	Rehabilitation Very High / ADL4 -8	RVA	RVA	Rehabilitation Very High / ADL0 -5
High	Rehabilitation High / ADL 13 - 18	RHC	RHC	Rehabilitation High / ADL 11 - 16
High	Rehabilitation High / ADL 8 - 12	RHB	RHB	Rehabilitation High / ADL 6 - 10
High	Rehabilitation High / ADL 4 - 7	RHA	RHA	Rehabilitation High / ADL 0 - 5
High	Extensive Special Care 3 / ADL > 6	SE3	ES3	Extensive Special Care 3 / ADL >= 2
High	Extensive Special Care 2 / ADL > 6	SE2	ES2	Extensive Special Care 2 / ADL >= 2
High	Special Care / ADL 17 - 18	SSC	-	-
High	Special Care / ADL 15 - 16	SSB	-	-

Table D.1 (continued)

Care Need	RUG-III Description/ADL Score	RUG-III	RUG-IV	RUG-IV Description/ADL Score
High	Clin. Complex with Depression / ADL 17 - 18	CC2	-	-
High	Clinically Complex / ADL 17 - 18	CC1	-	-
High	Clin. Complex with Depression / ADL 12 - 16	CB2	-	-
High	Clinically Complex / ADL 12 - 16	CB1	-	-
High	-	-	CD2	Clin. Complex with Depression / ADL 11-14
High	-	-	CD1	Clinically Complex / ADL 11-14
High	-	-	CE2	Clin. Complex with Depression / ADL 15-16
High	-	-	CE1	Clinically Complex / ADL 15-16
High	Reduced Physical Function with Nursing Rehab / ADL16 - 18	PE2	PE2	Reduced Physical Function with Nursing Rehab / ADL15 - 16
High	Reduced Physical Function / ADL16 - 18	PE1	PE1	Reduced Physical Function / ADL15 - 16
High	-	-	RUX	Rehabilitation Ultra High & Extensive /ADL 11-16
High	-	-	RVX	Rehabilitation Very High & Extensive /ADL 11-16
High	-	-	RHX	Rehabilitation High & Extensive /ADL 11-16
High	-	-	RMX	Rehabilitation Medium & Extensive /ADL 2-16
High	-	-	RLX	Rehabilitation Low & Extensive /ADL 2-16
High	-	-	HE2	Special Care High with Depression/ADL 15-16
High	-	-	HE1	Special Care High No Depression/ ADL 15-16
High	-	-	HD2	Special Care High with Depression/ADL 11-14
High	-	-	HD1	Special Care High No Depression/ ADL 11-14
High	-	-	LE2	Special Care Low with Depression/ADL 15-16
High	-	-	LE1	Special Care Low No Depression/ ADL 15-16
High	-	-	LD2	Special Care Low with Depression/ADL 11-14
High	-	-	LD1	Special Care Low No Depression/ ADL 11-14

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APPENDIX E

QUALITY-OF-LIFE DETAILED DATA

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Table E.1. Key Quality of Life Indicators by Population and Survey Administration

-	All Populations			Aged			PD			ID			MI		
Domain	Pre-Transition	Year 1	Year 2	Pre-Transition	Year 1	Year 2	Pre-Transition	Year 1	Year 2	Pre-Transition	Year 1	Year 2	Pre-Transition	Year 1	Year 2
Overall Life Satisfaction	62.4	80.8*	80.3**	54.9	78.0*	72.9**	55.6	75.8*	77.2**	80.0	89.3*	89.7**	0.0	0.0	0.0
Mood Status[a]	42.6	35.8*	35.2**	49.5	37.8*	38.1**	50.5	42.8*	42.9	25.4	22.8	22.7	100.0	100.0	100.0
Satisfaction with Care	91.7	93.0	90.5***	90.3	89.6	82.8****	92.3	91.0	88.8	92.3	95.9*	96.0**	0.0	0.0	100.0
Limited Access to Personal Care[#]	17.7	6.2*	4.6****	23.7	9.0*	8.7**	25.6	8.7*	6.3**	2.4	1.2	0.2**	0.0	0.0	0.0
Respect and Dignity	71.1	88.6*	89.1**	69.8	87.9*	81.7****	64.8	87.3*	89.9**	80.8	91.0*	93.1**	100.0	100.0	100.0
Satisfaction with Living Arrangements	58.9	93.5*	91.7**	55.3	94.4*	92.0**	46.2	91.4*	90.0**	75.5	94.6*	92.9**	0.0	100.0	100.0
Community Integration Barriers[a]	48.0	34.7*	28.0****	45.7	37.2	31.3**	62.5	43.7*	37.6****	31.2	23.1*	14.7****	100.0	100.0	0.0

Source: MFP Quality of Life surveys and program participation data submitted to CMS through March 2013.

Note: The All Populations category also includes MFP participants in the “other” and “unknown” categories. Excludes data from Alabama, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Vermont, West Virginia, and Wisconsin.

Table E.1 (continued)

[a]A lower percentage is better.

*Change between baseline and one year post-transition is significant at $p < 0.05$.

**Only change between baseline and two years post-transition is significant at $p < 0.05$.

***Only change between one year post-transition and two years post-transition is significant at $p < 0.05$.

****Change between baseline and two years post-transition and one year post-transition and two years post-transition are both significant at $p < 0.05$.

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