# Money Follows the Person 2009 Annual Evaluation Report

Final Report

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# EXECUTIVE SUMMARY

Since the early 1980s, the federal and state governments have been striving to improve long-term care services and supports and to increase the capacity of these systems to serve people in the community rather than in institutions. The Money Follows the Person (MFP) Demonstration program represents a major initiative to aid these efforts. Enacted by the Deficit Reduction Act (DRA) of 2005, the MFP program is based on the premise that many Medicaid beneficiaries who reside in institutions would rather live in the community, *could* do so with adequate support, and that such support would cost less than the institutional care they receive.

CMS awarded MFP demonstration grants to 17 states in January 2007, and another 14 states received awards in May 2007. Each state participating 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 initiative that allows a greater proportion of Medicaid long-term care expenditures to flow to community services and supports.

## Purpose of the Report

This first annual report for the MFP demonstration has two purposes: (1) to describe the status of the program from its inception through December 31, 2009, including how states are progressing toward their goals, and (2) to provide baseline information that sets the foundation for future analyses of program impacts and outcomes. The report presents two broad sets of analyses; (1) an implementation analysis of the initial years of the demonstration and (2) descriptive baseline analyses of state long-term care systems, transitions, and quality of life of MFP participants.

## Data Sources

Primary data sources of this report include semiannual progress reports that state grantees submit, administrative data files designed for the evaluation of this demonstration and states submit on a quarterly basis, and quality of life survey data that states collect from MFP participants. To the extent possible, these data cover the program since its inception through December 2009. Baseline information about each state's long-term care system and the size of the population eligible for MFP and their transition rates before the MFP demonstration was obtained from the Medicaid Analytical eXtract (MAX) system for calendar years 2005 through 2007.

## Summary of findings

### Initial Implementation Results

- **Approximately 5,600 people had transitioned from institutional care to community living through the MFP demonstration as of the end of 2009.**
  - Due to slower implementation of the MFP demonstration than anticipated in many states, the number transitioning was low in 2008, but began to grow during the second half of 2008 and continued to grow through 2009.

- **States have struggled to achieve their transition goals**. Based on yearly goals that states had in place as of June 2008, they attained 36 percent of their transition goal for 2008 and 47 percent of their 2009 goal.
- **MFP participants were nearly equally divided across three targeted populations**. Older adults (aged 65 and over), nonelderly people with disabilities, and people with mental retardation or developmental disabilities (MR/DD) each comprised about one-third of all MFP participants.
  - About two-thirds of participants were under 65.
  - Overall, there were almost equal numbers of women and men, but the elderly were disproportionately women, and people with developmental disabilities were disproportionately men.
- **MFP participants were about equally likely to move to a home, apartment, or group home.** About 28 percent moved into a home owned either by the participant or by a family member, 30 percent moved to an apartment, and 29 percent into a group home of no more than four people. The type of qualified residence was unknown for the remaining 13 percent of MFP participants.
- **The considerable challenges of implementing an MFP program have affected state transition goals.** MFP grantees have experienced challenges in all areas of program implementation including conducting outreach and recruitment, finding affordable and accessible housing, securing adequate services in the community, and assuring the quality of care and managing the risks of living in the community, and adjusting information systems to track MFP participants or fulfill federal reporting requirements.
  - While three states were able to begin transitions as early as October 2007, some did not start transitioning beneficiaries until mid 2009. September 2009 marked the month the last state grantee started MFP transitions.
  - The economic recession has made implementation even more difficult in most states as budget shortfalls have driven contractions in state resources, programs, and services.
- **The structure and processes for carrying out key transition activities vary across the 30 grantee states, and the MFP demonstration offers an important opportunity to identify the ingredients of successful transition programs.** While it is still too early to determine which program features matter most to success—as demonstrated by a cost effective program that has low rates of reinstitutionalization lasting more than 30 days and by high quality-of-life ratings—the initial qualitative information available about MFP programs suggest the importance of the following:
  - having Medicaid HCBS waiver programs that can accommodate or give priority to MFP participants (or policies that assure that money can follow the person from the institution to the community regardless of waiver capacity)
  - availability of HCBS and affordable, accessible housing in the communities in which MFP participants wish to live
  - strong quality assurance and monitoring systems that reduce problems associated with the quality of care or access to serves.

### Long-Term Care Systems at Baseline

- **While long-term care expenditures disproportionately flowed to institutional care, HCBS use was common and growing during the three years before the implementation of the MFP demonstration.** In 2005, 38 percent of all Medicaid long-term care expenditures were spent on HCBS in the MFP grantee states, although 60 percent of all long-term care users received HCBS.
  - Increases in the HCBS spending from 2005 to 2007 drove a 4 percent increase in long-term care expenditures in the grantee states, from $69.8 billion to $72.5 billion (in 2005 dollars).
  - By 2007, 26 of 27 MFP grantee states increased HCBS spending as a proportion of all long-term care expenditures and 20 of 27 states increased the proportion of all long-term care users who received HCBS by at least 2 percent.
  - Although the growth of HCBS spending was widespread across grantee states, the gap in spending between high HCBS sates (those that devoted at least 40 percent of long-term care expenditures to HCBS) and low HCBS states (those that devoted less than 30 percent of expenditures to HCBS) remained.

### Transition Rates at Baseline

- **The number of people who met MFP eligibility requirements declined during the baseline period, reflecting the overall general downward trend in nursing home and ICF-MR use.** Overall, the number of MFP eligibles declined by about 4 percent between 2005 and 2007 in the 30 MFP grantee states.
  - The change in federal statutory eligibility requirements enacted in March 2010, which eased the minimum institutional stay from 180 to 90 days (not counting Medicare rehabilitative care days), attenuated the decline somewhat. Preliminary estimates suggest the change in the institutional stay requirement will increase the number who met MFP eligibility requirements during the baseline period by no more than 12 percent in any given year.[1]
- **Medicaid beneficiaries in institutional care were transitioning to the community before the MFP demonstration was implemented.** Elderly people in nursing homes, people in ICFs-MR, and those with longer institutional stays had the lowest rates of transition.
  - Among those who met the six-month stay requirement, approximately 12 percent transitioned—2 percent used HCBS soon after the transition and 10 percent did not.

[1] The 12 percent represents an upper bound estimate. More precise estimates will be developed once the linking of Medicaid and Medicare records for those eligible for both programs has been completed.

- Among those eligible as a result of easing the institutional stay requirement from 180 to 90 days, 56 percent transitioned—9 percent used HCBS soon after the transition and 47 percent did not.

**Quality of Life at Baseline**

- **The majority of MFP participants were happy with the way they lived their lives and the care they received before transitioning to community living, but life satisfaction can be improved for MFP participants and state grantees have an opportunity to do so**. About 60 percent were satisfied with their lives and 71 percent were happy with the care they received in the institution.
- **People transitioning from ICFs-MR reported relatively high levels of life satisfaction at baseline (74 percent) compared to those transitioning from nursing homes (56 to 57 percent).** The differences seen across the different targeted populations may be partly explained by differences in the use of proxy respondents, who reported higher levels of satisfaction than self-responders.
  - People transitioning from ICFs-MR were more likely to have a proxy respond to the survey on their behalf compared to respondents living in nursing homes (48 percent compared to 7 to 10 percent of nursing home respondents).
- **Higher life satisfaction in an institution was associated with liking where they lived, getting needed assistance, being treated with respect by people who helped them, and having more choice and control over how they lived day to day.**
  - Among respondents who liked where they lived, 78 percent were satisfied with their life in the institution.
  - About 85 percent of respondents needed assistance with bathing, meals, medications, and using the bathroom, and unmet need for this assistance was associated with life satisfaction. Respondents with no reported unmet needs had life satisfaction that was nearly eight times higher than those with unmet need in three of four areas.
  - Among respondents who reported that staff treated them as they wanted and listened to them, 70 percent were satisfied with their lives.
  - Some respondents reported that while in institutional care they could not participate in community activities and sometimes missed medical care because they had no way of getting to an appointment. Only 49 and 45 percent respectively who faced these restrictions were satisfied with their lives.
  - The degree of choice and control respondents had over their lives was associated with life satisfaction. Respondents with choice and control in five or six areas of their lives were two and half times more likely to be satisfied with life than respondents who reported no areas of choice or control

## Conclusions

The evaluation of the MFP demonstration has only begun and a great deal of work remains to understand the impacts and outcomes of this program.

**Tracking Program Implementation.** The implementation analyses will be ongoing throughout the demonstration and will continue to track state achievement of their transition goals and the challenges states faces as their programs mature and they pursue their rebalancing initiatives. The work will expand to include the tracking of state HCBS expenditures and state achievements of their HCBS spending goals as this information becomes available. In addition, the MFP program is operating in a rapidly changing policy environment and how states adapt to these changes and weather the current fiscal crisis will be critical to understanding the achievements of MFP programs. In addition, at the time of this report work was beginning on identifying the ingredients of successful transition programs. With 30 states implementing 30 different transition programs, MFP offers an opportunity to determine which features or approaches are associated with more successful transitions to community living, defined as lower likelihood of returning to institutional care, fewer preventable emergency room visits and hospitalizations, and higher quality of life.

**Measuring Trends in State Long-Term Care Systems.** Identifying state-level outcomes that result from the MFP demonstration requires the evaluation to track the trends in state long-term care systems from the baseline period throughout the life of the demonstration. The initial focus of this work will be on determining whether the trends from the baseline period shift during the MFP demonstration period. Future analyses will include a broader array of trends and better controls for state differences in the health status of the targeted populations and other policies that may be affecting the balance of spending and use between institutional and community-based care.

**Estimating Program Impacts.** As all state grantees complete the initial implementation stage and their transition programs mature, the evaluation will evolve and begin the process of estimating program impacts. To measure impacts, the evaluation of the MFP demonstration will compare participants outcomes to those of two comparison groups drawn from the baseline period. One comparison group will include Medicaid beneficiaries who transitioned during the baseline period without the benefit of MFP and the other will be a group of beneficiaries who met the MFP eligibility requirements but did not transition. The immediate work will also include linking Medicaid and Medicare records for those dually eligible for both programs because the statutory change in MFP eligibility criteria that occurred in 2010 now require state grantees to exclude Medicare rehabilitative days of care when determining whether someone meets the minimum requirement of 90 days in institutional care. Future reports will summarize the evaluation's progress on estimating program impacts.

**Measuring the Change in Quality of Life.** As more MFP participants complete their first year of community living, the focal point of the quality of life analyses will shift to how life satisfaction and other indicators (such as access to community activities and mood) change after MFP participants have been living in the community for at least a year. While the assessment of changes in quality of life will focus on how life changes in a general sense, the evaluation will track how anticipated positive changes in choice and control and access to community activities are balanced with potentially negative changes in access to personal assistance and medical appointments.

# I. INTRODUCTION AND BACKGROUND

Since the early 1980s, the federal and state governments have been striving to improve long-term care services and supports and to increase the capacity of these systems to serve people in the community rather than in institutions. Progress in the provision of long-term services and supports in community settings accelerated after the 1999 Olmstead decision, which established the necessity of providing Medicaid services to people with disabilities in the setting that would best meet their needs.

The Money Follows the Person (MFP) initiative represents a major step in developing community-based long-term care programs. Enacted by the Deficit Reduction Act (DRA) of 2005, the MFP program is based on the premise that many Medicaid beneficiaries who reside in institutions would rather live in the community, *could* do so with adequate support, and that such support would cost less than the institutional care they receive.[1]

Programs designed to transition Medicaid beneficiaries from institutional to community care have been tested in the past. In 2003, the Centers for Medicare & Medicaid Services (CMS) awarded grants to nine states to implement MFP initiatives. Seven of the nine used the grant awards to develop infrastructure for MFP programs, and the other two strengthened existing MFP programs. Anderson and colleagues (2006) assessed these programs and found (1) that transition programs required substantial commitments of administrative resources, even to transition just a few beneficiaries; and (2) that identifying beneficiaries who wanted to transition, could be served in the community with the services available, and would not have transitioned without the program was extremely difficult. Overall, they concluded that because the few existing MFP programs were small, little was known about whether they effectively (1) provided greater choice for Medicaid beneficiaries and improved their satisfaction with services, (2) reduced long-term care expenditures or at least moderated their growth, and (3) helped states increase the proportion of the long-term care expenditures that flowed to HCBS. Now that 30 grantee states are implementing MFP programs, the evaluation of the national demonstration will fill this gap in knowledge.

## A. Background

### 1. Basic Features of the MFP Program

Each state participating 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 a greater proportion of Medicaid long-term care expenditures to flow to community services and supports. Like Medicaid programs in general, MFP programs are subject to general

[1] In addition to the MFP demonstration, the DRA of 2005 included initiatives designed to help Medicaid programs rebalance their long-term care systems. For example, it gave states the option to provide more home and community-based services as state plan benefits and the authority to allow people to self-direct personal care services.

federal requirements, but the design and administration of each MFP program is 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 the mentally retarded (ICFs-MR), or institutions for mental diseases (IMDs). Until the passage of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), people had to be institutionalized for a minimum of 180 days or six months and had to be eligible for full Medicaid benefits for at least the month before transition to the community. ACA reduced the limit to only 90 days of institutional care but required programs to exclude any rehabilitative care days covered by Medicare.[2]

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

MFP programs may provide up to three categories of services: (1) qualified HCBS, (2) demonstration HCBS, and (3) supplemental services. *Qualified HCBS* are those services the beneficiary would have received regardless of his or her status as an MFP participant, such as personal assistance services. *Demonstration HCBS* are either Medicaid services not included in the state's array of HCBS for regular Medicaid beneficiaries (such as assistive technologies) or qualified HCBS above what would be available to regular Medicaid beneficiaries (such as 24-hour personal care). States may also provide *supplemental services* to MFP participants: services that are not typically reimbursable under the Medicaid program but that make the transition to a community setting easier (such as a home computer or trial visit to the proposed community residence). States receive an enhanced federal match (known as the Federal Medical Assistance Percentage, or FMAP), which is drawn from the state's MFP grant funds, when they provide either qualified HCBS or demonstration HCBS.[3] They receive the regular FMAP, which is also drawn from its MFP grant funds, when they provide supplemental services. In general, MFP transition programs are designed to provide a richer mix of community services for a limited time to help make the transition to the community successful.

**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 how these funds are to be used or reinvested

[2] 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 ACA, states may now use a minimum of 90 days, but days for rehabilitative care and covered by the Medicare program cannot be counted toward the 90-day minimum.

[3] The MFP-enhanced FMAP is set in statute (state's regular FMAP + [1 − 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.

exist, and states can use the enhanced funds in a variety of ways, including (1) reducing the use of institutional care (such as financing the costs of closing beds or facilities), (2) supporting transitions of people not eligible for MFP, (3) expanding the availability of HCBS programs (such as increasing HCBS waiver slots or adding a self-direction program), or (4) improving the infrastructure (such as expanding the availability of affordable and accessible housing). Each state sets specific benchmarks for measuring the success of the selected rebalancing strategy.

### 2. MFP Grant Awards

CMS began awarding MFP demonstration grants in January 2007, when 17 awards were made. Another 14 states received awards in May 2007. Table I.1 lists the states and the number of people states proposed to transition in their approved program design documents (known as operational protocols). Across the 30 states and the District of Columbia, states initially proposed to transition 35,572 people. As discussed in Chapter II, the transition targets have declined over time. One state, South Carolina, has not implemented a program as of this report. Other states have found the implementation of an MFP program to be more challenging than anticipated and have reduced their transition targets as a result. As Chapter III describes, implementing an MFP program requires considerable effort and coordination among different agencies. Some programs were delayed while the state made key adjustments to their community services to ensure they could serve MFP participants. At a minimum, every program had to (1) establish processes for identifying eligible Medicaid beneficiaries who can be adequately served in the community, (2) hire and train transition coordinators who work one-on-one with beneficiaries to set up their community living arrangements and services and supports, (3) develop strategies for locating affordable and accessible housing in areas that beneficiaries want to live, and (4) implement risk assessment and management systems that balance beneficiary choices against the increased risks associated with living in the community.

**Table I.1. MFP Demonstration Grants: Number of Transitions Initially Proposed, by State**

| | Number of Transitions Proposed in the Initial Operational Protocols | | | | | |
|---|---|---|---|---|---|---|
| State | Overall | Elderly | PD | MR/DD | MI | Other |
| Arkansas | 305 | 92 | 146 | 60 | 7 | 0 |
| California | 2,000 | 419 | 897 | 316 | 183 | 185 |
| Connecticut | 700 | 267 | 175 | 68 | 141 | 49 |
| Delaware | 100 | 32 | 28 | 20 | 20 | 0 |
| District of Columbia | 400 | 0 | 0 | 400 | 0 | 0 |
| Georgia | 1,312 | 375 | 375 | 562 | 0 | 0 |
| Hawaii | 415 | 175 | 190 | 50 | 0 | 0 |
| Illinois | 3,457 | 1,517 | 1,000 | 255 | 685 | 0 |
| Indiana | 1,039 | 793 | 246 | 0 | 0 | 0 |
| Iowa | 528 | 0 | 0 | 475 | 0 | 53 |
| Kansas | 963 | 242 | 356 | 315 | 0 | 50 |
| Kentucky | 546 | 215 | 90 | 197 | 0 | 44 |
| Louisiana | 355 | 259 | 76 | 20 | 0 | 0 |
| Maryland | 1,994 | 1,361 | 371 | 250 | 0 | 12 |
| Michigan | 3,100 | 2,325 | 775 | 0 | 0 | 0 |
| Missouri | 250 | 48 | 52 | 125 | 0 | 25 |
| Nebraska | 900 | 400 | 200 | 200 | 0 | 100 |
| New Hampshire | 354 | 87 | 200 | 5 | 0 | 62 |
| New Jersey | 587 | 173 | 89 | 325 | 0 | 0 |
| New York | 2,000 | 850 | 850 | 0 | 0 | 300 |
| North Carolina | 304 | 22 | 202 | 80 | 0 | 0 |
| North Dakota | 110 | 42 | 34 | 30 | 0 | 4 |
| Ohio | 2,231 | 1,428 | 345 | 373 | 85 | 0 |
| Oklahoma | 2,007 | 1,575 | 282 | 150 | 0 | 0 |
| Oregon | 1,000 | 260 | 500 | 200 | 0 | 40 |
| Pennsylvania | 2,667 | 1,878 | 537 | 87 | 165 | 0 |
| South Carolina | 192 | 160 | 32 | 0 | 0 | 0 |
| Texas | 2,999 | 800 | 600 | 1,599 | 0 | 0 |
| Virginia | 1,041 | 325 | 358 | 358 | 0 | 0 |
| Washington | 660 | 348 | 172 | 80 | 60 | 0 |
| Wisconsin | 1,056 | 448 | 189 | 247 | 0 | 172 |
| **Totals** | **35,572** | **16,916** | **9,367** | **6,847** | **1,346** | **1,096** |
| **Percentage of Total** | **100** | **47.6** | **26.3** | **19.2** | **3.8** | **3.1** |

Source: State MFP operational protocols.

Note: This information is from the MFP operational protocols approved between September 2007 and July 1, 2008. States have been revising the transition numbers as they implement their programs.

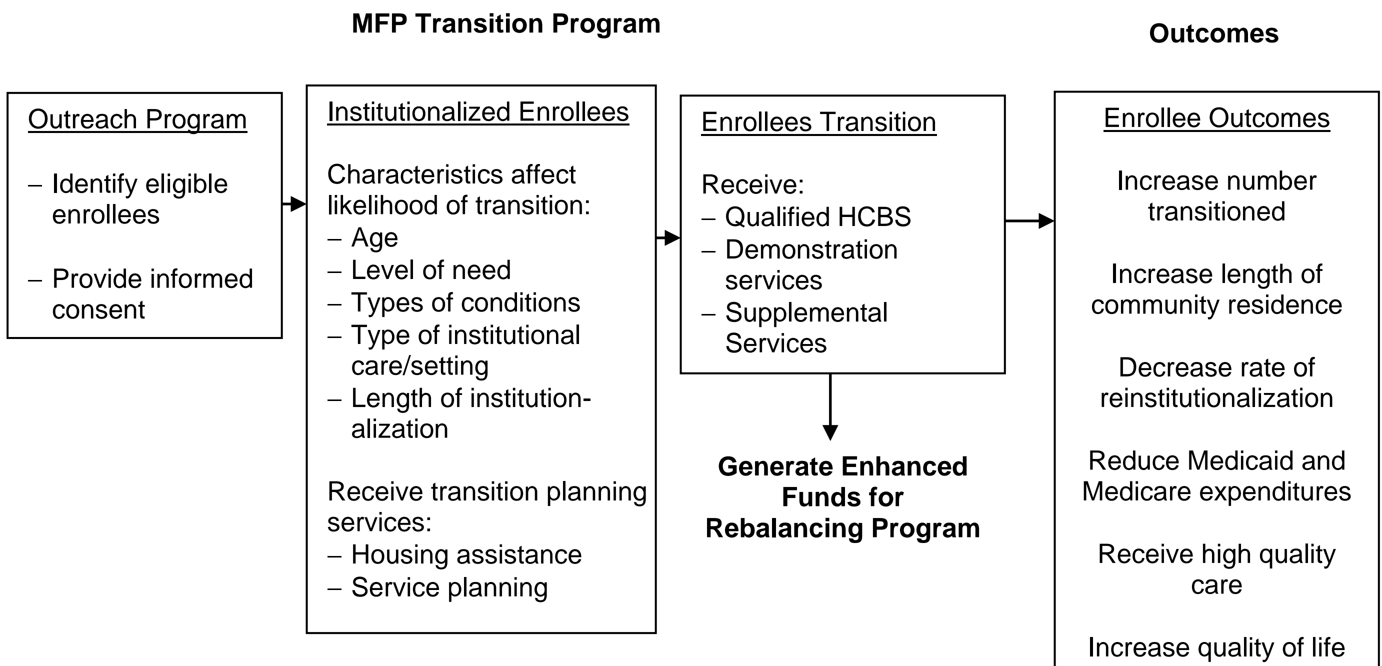
MI = people with mental illness; MR/DD = people with mental retardation or developmental disabilities; PD = people with physical disabilities.

## B. Purpose of this Report

In March 2007, CMS contracted with Mathematica Policy Research to conduct a national evaluation of the MFP demonstration (CMS Contract Number HHSM-500-2005-00025I TO#02). This first annual report for the MFP demonstration covers the program from its inception through December 2009. The primary purpose of the report is to describe the status of the program as of December 31, 2009, including how states are progressing on their goals.

The report also presents analyses that set the foundation for the national evaluation. The evaluation is guided by two basic logic models, one for the transition programs and the other for the rebalancing initiatives. As Figure I.1 illustrates, when designing a transition program, states determine which populations to target, how they will identify enrollees for transition, the types and amount of HCBS that will be available to MFP participants, and how they will ensure that MFP participants are safe and receive appropriate care. Some states may need to make system changes before implementing the MFP program (for example, amending a waiver program to create more waiver capacity or altering budget authority so that funds for institutional care flow more easily to community care when someone transitions). Once living in the community, each MFP participant receives HCBS according to his or her needs and what is available in the community. For many of these services (the qualified HCBS and the demonstration services), the states will receive enhanced FMAP funds from their grant allotments, which are then reinvested with the purpose of rebalancing their long-term care system. The availability of enhanced FMAP funds gives states an incentive to transition Medicaid beneficiaries: the more MFP participants use qualified HCBS and demonstration services, the more funds the state has to reinvest in rebalancing initiatives. However, the state does incur costs for its share of the new services provided.

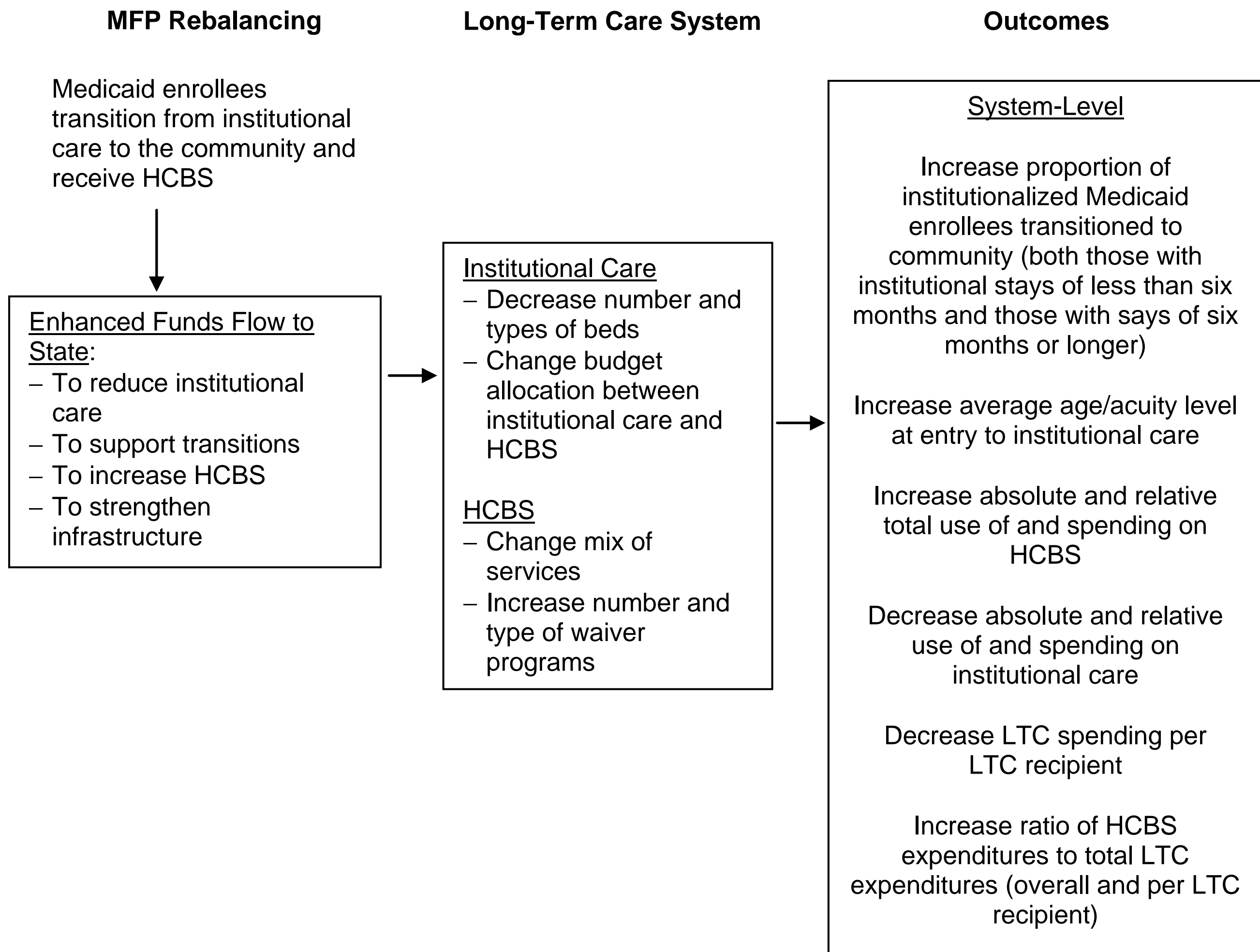
**Figure I.1. Logic Model for MFP Transition Programs**




As shown in Figure I.2, states may use the enhanced FMAP funds to reduce the use of, and spending on, institutional care by providing an enriched set of transition services or expanding subsidized housing options or downsizing institutions. Other states may target the funds to increase the use of, and spending on, HCBS by expanding HCBS waiver capacity or strengthening the HCBS workforce. Within each category, some states are investing in services for MFP participants, while other states are investing in the general long-term care system and in enrollees who do not qualify for MFP. Regardless of how states use the enhanced funding, the

rebalancing of the enhanced FMAP funds is expected to further state goals to create system change and rebalance the long-term care system.

**Figure I.2. Logic Model for the MFP Rebalancing Initiatives**




The national evaluation of the MFP program seeks to understand whether the program met its goals (1) to increase the number and proportion of long-term institutionalized Medicaid enrollees who can live successfully in the community, and (2) to 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, including increases in the likelihood and number of transitions from institutional to community settings and greater increases in HCBS use and expenditures than in institutional care.

## C. Road Map to the Report

The next chapters are organized around two broad types of analyses, (1) an implementation analysis of the initial years of the demonstration and (2) descriptive baseline analyses of state long-term care systems, transitions, and quality of life. Chapters II and III describe the implementation of the MFP demonstration during its initial years (from 2007 through the end of 2009). Chapter II provides a basic report on the status of the MFP demonstration, including the

cumulative number of Medicaid beneficiaries who transitioned to community living as a result of the MFP demonstration and the extent to which grantee states are achieving their transition goals. This chapter also presents preliminary information about program spending to date.

Chapter III addresses the broad question of why MFP programs have been difficult to implement. Mathematica's implementation analyses have identified an array of factors that have made it challenging for states to initiate and develop transition programs through the MFP demonstration. Before initiating transitions, several states needed first to make significant programmatic adjustments, such as modifying existing waiver programs or establishing new ones. Others needed to enhance information systems to track participants and to comply with program reporting requirements; still others needed to foster closer relationships with agencies and organizations that would conduct the transitions and support participants once they were living in the community. These types of activities can take considerable time before bearing desired results. Once transitions have begun, all states have experienced challenges with finding appropriate housing in the community. Affordable and accessible housing can be extremely difficult to find, particularly for people who have few connections to the community. The economic downturn has also made sustaining and expanding MFP programs more difficult.

Chapters IV and V present baseline information, starting at the state level and moving down to the participant level. Chapter IV lays the very basic foundation of the analyses of program impacts by assessing trends in long-term care during the baseline period, the three years before states began implementing their MFP programs. Trends in annual estimates of the balance of long-term care systems are presented first. Future work will examine whether these trends changed after MFP programs became operational and their rebalancing initiatives took hold. The second half of the chapter assesses baseline trends in the size of the population eligible for MFP and transition rates. This work also assesses the implications of changing the minimum institutional requirement from 180 to 90 days.

Chapter V presents analyses of the baseline quality of life of MFP participants immediately before they transitioned to the community. In support of the national evaluation of MFP, states are required to administer a quality-of-life survey about two weeks before an MFP participant transitions to community living. The analyses in Chapter V, which represent the first examination of the survey data, focus on determining the overall satisfaction MFP participants had with their lives before the transition. The analyses also examine how the level of satisfaction relates to factors such as (1) their participation in the selection of their housing arrangements, (2) their level of unmet need for personal care services, (3) how they are treated by service providers, (4) the level of choice in their lives, and (5) their connectedness to the community. In future work, the evaluation will assess how the quality of life changes for MFP participants once they have been living in the community for one to two years.

Chapter VI provides an overall summary of the report and discusses some of the future work planned for national evaluation.

## II. STATES' PROGRESS TOWARD THEIR MFP TRANSITION GOALS

The primary aim of the transition programs each MFP grantee establishes is to help Medicaid beneficiaries move from institutional care to community-based services and supports. Thus, a key indicator of progress for this demonstration, and of the implementation analysis, is the number of beneficiaries transitioned to community living. Given the importance of this demonstration, the federal MFP statute requires that the 30 grantees participating in the program (29 states and the District of Columbia) monitor their progress closely. They must establish numerical goals for the number of people to be transitioned each year and over the life of the demonstration program, and they must monitor and assure the quality of services and supports MFP participants receive.[5]

This chapter describes the progress that states made in transitioning people eligible for the program to community living from the start of the program in late 2007 to the end of December 2009. The data in this chapter come from two sources: (1) the web-based progress reports submitted semiannually by state grantees, and (2) the MFP Program Participation Data files.[6] The chapter begins by reviewing trends in MFP participation over the initial phase of program implementation, and assesses the progress states made in meeting their transition goals. It then describes the characteristics of MFP participants, their type of residence, and early information about the number leaving the program and why they leave. The chapter concludes with a brief overview of preliminary information about the costs of the HCBS MFP participants receive.

*Key Findings*

- Implementation of the MFP demonstration has been slower than anticipated in many states. Nevertheless, the number transitioning each month began to grow during the second half of 2008 and continued to grow through 2009. As a result, 2009 saw a three-fold increase in the number of people transitioning through MFP programs.
  - Approximately 5,600 people had transitioned from institutional care to community living through the MFP demonstration as of the end of 2009.

[5] The federal MFP statute also required that state grantees establish numerical goals, or benchmarks, related to increasing state Medicaid financial support for qualified HCBS. CMS further required that states specify goals and benchmarks related to their rebalancing programs and their efforts to expand access to HCBS. The rebalancing programs are at least in part financed by the MFP rebalancing funds, the enhanced FMAP they receive when MFP participants receive qualified and demonstration HCBS (see Chapter I for details). This chapter does not address state goals or progress related to HCBS spending or on the use of the rebalancing funds, because states have not yet provided complete data to CMS and are not required to report on the use of MFP rebalancing funds until the summer of 2010. Progress toward these goals and benchmarks will be included in future evaluation reports.

[6] While the data in both sources are generally consistent, there are some discrepancies because of missing data from Arkansas, Connecticut, the District of Columbia, Kansas, Louisiana, Michigan, New Hampshire, North Carolina, Virginia, and Wisconsin. In the case of major differences, we relied generally on the data in the web-based progress reports.

- States have struggled to achieve their transition goals. Based on yearly goals that states had in place as of June 2008, they attained 36 percent of their transition goal for 2008 and 47 percent of their 2009 goal.
  - Many states started to reduce their transition goals for the entire demonstration period, but many may revise their goals upward again given the extension of the demonstration and the change in the institutional stay requirements from 180 days to 90 days.
- MFP participants were nearly equally divided across three targeted populations: older adults (aged 65 and over); nonelderly people with disabilities; and people with mental retardation or developmental disabilities (MR/DD).
  - About two-thirds of participants were under 65.
  - Overall, there were almost equal numbers of women and men, but the elderly were disproportionately women, and people with developmental disabilities were disproportionately men.
- MFP participants were about equally likely to move to a home, apartment, or group home. About 28 percent moved into a home owned either by the participant or by a family member, 30 percent moved to an apartment, and 29 percent into a group home of no more than four people. The type of qualified residence was unknown for the remaining 13 percent of MFP participants.
  - The elderly moved disproportionately (about half) into a home; younger people with disabilities were more likely to move into an apartment or assisted living (44 percent); and people with developmental disabilities moved primarily into small group homes (77 percent).
- Preliminary data from 27 states indicate that MFP grantee spending on HCBS of all three types—qualified, demonstration, and supplemental—averaged $24,631 per MFP participant transitioned since the start of the demonstration.
  - This information must be interpreted with caution since spending data from some states were incomplete or could not be confirmed.

## A. Trends in MFP Transitions

Calendar year 2009 marked a three-fold increase in the number of transitions, and state grantees reported that by December 2009 their MFP programs had transitioned a total of 5,673 people. MFP programs transitioned a total of 1,473 people[7] to the community in calendar year 2008 and 4,200 in 2009 (Table II.1). This increase in 2009, the program's second full year of operations, reflected substantial increases in state grantee capacity to identify MFP candidates and provide transition assistance.

[7] Three states reported transitioning through MFP a total of nine people in 2007, so for purposes of this report, they are combined with 2008 transition counts.

**Table II.1. Total Number of MFP Transitions by Year and Cumulative Overall**

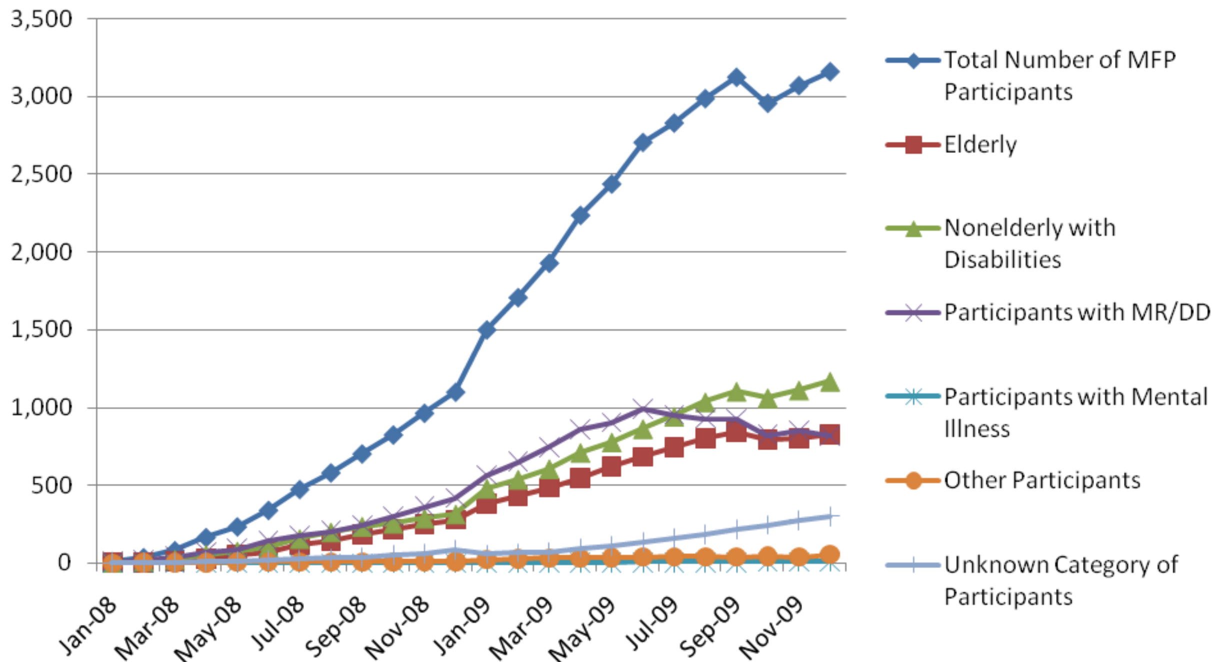
| State | Number of MFP Transitions that Occurred in 2008 | Number of MFP Transitions that Occurred in 2009 | Cumulative Transitions as of December 2009 |
|---|---|---|---|
| Arkansas | 22 | 51 | 73 |
| California | 2 | 126 | 128 |
| Connecticut | 0 | 129 | 129 |
| Delaware | 3 | 20 | 23 |
| District of Columbia | 15 | 37 | 52 |
| Georgia | 3 | 194 | 197 |
| Hawaii | 1 | 24 | 25 |
| Illinois | 0 | 53 | 53 |
| Indiana | 0 | 60 | 60 |
| Iowa | 9 | 53 | 62 |
| Kansas | 70 | 88 | 158 |
| Kentucky | 5 | 36 | 41 |
| Louisiana | 0 | 9 | 9 |
| Maryland | 154 | 330 | 484 |
| Michigan | 89 | 286 | 375 |
| Missouri[a] | 67 | 138 | 205 |
| Nebraska | 19 | 39 | 58 |
| New Hampshire[a] | 24 | 21 | 45 |
| New Jersey | 11 | 74 | 85 |
| New York | 0 | 87 | 87 |
| North Carolina | 0 | 31 | 31 |
| North Dakota | 5 | 14 | 19 |
| Ohio | 60 | 342 | 402 |
| Oklahoma | 0 | 28 | 28 |
| Oregon | 32 | 131 | 163 |
| Pennsylvania | 42 | 253 | 295 |
| Texas | 761 | 1,123 | 1,884 |
| Virginia | 16 | 73 | 89 |
| Washington | 38 | 325 | 363 |
| Wisconsin[a] | 25 | 25 | 50 |
| **Total** | **1,473** | **4,200** | **5,673** |

Source: MFP semiannual web-based progress reports.

[a] Counts include 9 transitions in 2007 in these states.

Individual-level enrollment records submitted quarterly by the states indicate that the monthly number of MFP participants receiving long-term services and supports in the community increased steadily throughout 2008 but increased at a greater rate in 2009. Enrollment of the elderly and nonelderly with disabilities increased at a fairly constant rate over the two years, while enrollment of beneficiaries with developmental disabilities reached a plateau in mid 2009. At that time, the nonelderly with disabilities became the largest group of MFP participants. Few people with mental illness as a primary diagnosis were enrolled over the two-year period. At the time of this report, not all states had submitted data covering the period ending December 2009. Therefore, data in Figure II.1 are preliminary and subject to change.

**Figure II.1. Total Number of MFP Participants by Month (Provisional Data), Overall and by Targeted Population**




Source: MFP Program Participation Data files.

Note: Arkansas and Virginia had not submitted any MFP Program Participation Data files when these analyses were conducted. In addition, data were available only through March 2009 for Michigan; June 2009 for the District of Columbia, Louisiana, and North Carolina; and September for Connecticut, Kansas, New Hampshire, and Wisconsin.

MR/DD = mental retardation/developmental disabilities.

## B. State Variation in Transitions

Considerable variation in the number of transitions to date is seen across states, which reflects the initial stage of a large demonstration being implemented by 30 different state grantees. Among the 23 states that reported any transitions in 2008, the number ranged from 1 in Hawaii to 761 in Texas, which had more than 60 percent of all people who ever participated in MFP that year. During the second year of the program, more states began enrolling participants, but Texas still accounted for 35 percent of the people ever enrolled in 2009. By the end of 2009, when all state MFP programs were operational, 8 states had transitioned fewer than 50 MFP participants; 12 had transitioned between 50 and 150, nine had transitioned between 150 and 500, and one (Texas) had transitioned nearly 1,900—a third of the total. After Texas, the five with the largest number of MFP participants were Maryland, Ohio, Michigan, Washington, and Pennsylvania.

State variation in the number of transitions reflects, among other things, the length of program operation, the size of the eligible population in each state, and state capacity and experience in operating transition programs of this type. For example, Texas had large numbers because it began its program in early 2008, had more MFP-eligible people in institutions than most other states (Chapter IV has more information on the size of the MFP-eligible population at

baseline), and had long operated transition programs similar to MFP. While California and Illinois also had large eligible populations, their MFP programs did not become fully operational until late 2008 or early 2009, and both states had to build capacity to conduct transition planning and coordination.

## C. Progress Relative to State MFP Transition Goals

**Overall Transition Goals.** An important indicator for the MFP program is grantees' progress in meeting their transition goals. The total goal among all states receiving initial grant awards in 2007 was 37,731.[8] At the time of their grant application, grantees believed they would transition this number of people within five years, between the grant award in 2007 and 2012. This overall goal has since changed several times as the states discovered the challenges of implementing a new transition program (see Chapter III for a discussion of these challenges), and this goal is expected to continue to change as the statute is revised. Consequently, this report assesses states' progress in meeting transition goals relative to those in effect at two points: (1) June 2008, when CMS had approved all states' MFP operational protocols, which describe in detail the policies and procedures for the state MFP program and specify transition goals and other key benchmarks; and (2) February 2010, after states submitted supplemental grant requests for calendar year 2010 containing "realistic as well as ambitious" transition goals. Starting in 2011, CMS will base grant awards for subsequent years on states' progress in meeting these new goals.[9] Consequently, the February 2010 goals continue to be interim goals, because they do not reflect how states plan to respond to changes in the statute that extend the demonstration through 2016 and ease the institutional stay requirement from 180 to 90 days.

The total transition goal for the entire MFP demonstration period for all 30 MFP state grantees declined 34 percent, from 35,380 in June 2008 to 23,352 in February 2010 (Table II.2). Sixteen states reduced their total transition goals, four by more than 74 percent: New Hampshire, New York, Oklahoma, and Virginia. Despite the overall decline in state transition goals, six states *increased* their total transition goals between June 2008 and February 2010. Another seven stayed the course and kept their total transition goals since June 2008, and one (North Carolina) had not yet submitted an updated total transition goal as of this report.

The overall goal for the total number of people to be transitioned through the MFP demonstration is likely to change again as a result of the federal health care reform legislation adopted in March 2010, which extended the MFP program through 2016 and changed program eligibility from a minimum of six months of institutional residency to 90 days (excluding time

[8] As of this report, one state awardee had decided not to implement an MFP program; after subtracting that state's transition goals, the total among the 30 MFP grantees was 37,539.

[9] The MFP statute required that CMS condition the release of grant funds in subsequent fiscal years, called "supplemental awards," on meeting annual transition and qualified HCBS spending goals. Starting in January 2011, those states meeting 90 percent of established benchmarks will be eligible for a full supplemental award; those achieving 75 to 89 percent of their benchmarks will be eligible for partial awards for six months; and those not meeting a minimum of 75 percent will have to submit a plan of correction to receive additional funding (CMS 2009).

spent in a nursing home for short-term rehabilitation paid for by Medicare). Because more people would be eligible for MFP, some grantee states may raise their transition goals.

**Table II.2. Interim State Goals for Total Number of MFP Transitions Over the Life of the Demonstration**

| | Total Transition Goal as of: | | |
|---|---|---|---|
| State | June 2008 | February 2010 | Percentage Change in Goal |
| **Total** | **35,380** | **23,352** | **-34** |
| Arkansas | 305 | 218 | -29 |
| California | 2,000 | 1,000 | -50 |
| Connecticut | 700 | 890 | 27 |
| Delaware | 100 | 100 | 0 |
| District of Columbia | 400 | 473 | 18 |
| Georgia | 1,312 | 618 | -53 |
| Hawaii | 415 | 415 | 0 |
| Illinois | 3,457 | 1,644 | -52 |
| Indiana | 1,039 | 775 | -25 |
| Iowa | 528 | 284 | -46 |
| Kansas | 963 | 331 | -66 |
| Kentucky | 546 | 546 | 0 |
| Louisiana | 355 | 565 | 59 |
| Maryland | 1,994 | 1,229 | -38 |
| Michigan | 3,100 | 3,100 | 0 |
| Missouri | 250 | 367 | 47 |
| Nebraska | 900 | 900 | 0 |
| New Hampshire | 354 | 93 | -74 |
| New Jersey | 587 | 321 | -45 |
| New York | 2,000 | 441 | -78 |
| North Carolina | 304 | NA | - |
| North Dakota | 110 | 110 | 0 |
| Ohio | 2,231 | 1,442 | -35 |
| Oklahoma | 2,007 | 314 | -84 |
| Oregon | 1,000 | 1,070 | 7 |
| Pennsylvania | 2,667 | 1,028 | -61 |
| Texas | 2,999 | 2,999 | 0 |
| Virginia | 1,041 | 209 | -80 |
| Washington | 660 | 1,413 | 114 |
| Wisconsin | 1,056 | 457 | -57 |

Source: MFP semiannual web-based progress reports.

NA = not available.

**Progress in Attaining Overall Transition Goals as of December 2009.** Overall, MFP grantees had achieved about 24 percent of their overall transition goals by December 2009, which would be slow progress for a five-year demonstration that had hit its midpoint during 2009 (Table II.3). When compared with goals in existence at either point in time, Missouri and Texas made the *most progress* as of December 2009, achieving more than 50 percent of their total transition goals. In both 2008 and 2009, progress in meeting transition goals varied by

target group (data not shown). Generally, states had more success transitioning people under 65 with disabilities and people with developmental disabilities, than they did with the people over 65.

**Table II.3. States' Progress toward Their Overall MFP Transition Goals**

| | | Cumulative Transitions as a Percentage of Overall Transition Goal as of: | |
|---|---|---|---|
| State | Cumulative Transitions as of December 2009 | June 2008 | February 2010 |
| **Total** | **5,673** | **16** | **24** |
| Arkansas | 73 | 24 | 33 |
| California | 128 | 6 | 13 |
| Connecticut | 129 | 18 | 14 |
| Delaware | 23 | 23 | 23 |
| District of Columbia | 52 | 13 | 11 |
| Georgia | 197 | 15 | 32 |
| Hawaii | 25 | 6 | 6 |
| Illinois | 53 | 2 | 3 |
| Indiana | 60 | 6 | 8 |
| Iowa | 62 | 12 | 22 |
| Kansas | 158 | 16 | 48 |
| Kentucky | 41 | 8 | 8 |
| Louisiana | 9 | 3 | 2 |
| Maryland | 484 | 24 | 39 |
| Michigan | 375 | 12 | 12 |
| Missouri | 205 | 82 | 56 |
| Nebraska | 58 | 6 | 6 |
| New Hampshire | 45 | 13 | 48 |
| New Jersey | 85 | 14 | 26 |
| New York | 87 | 4 | 20 |
| North Carolina | 31 | 10 | NA |
| North Dakota | 19 | 17 | 17 |
| Ohio | 402 | 18 | 28 |
| Oklahoma | 28 | 1 | 9 |
| Oregon | 163 | 16 | 15 |
| Pennsylvania | 295 | 11 | 29 |
| Texas | 1,884 | 63 | 63 |
| Virginia | 89 | 9 | 43 |
| Washington | 363 | 55 | 26 |
| Wisconsin | 50 | 5 | 11 |

Source: MFP semiannual web-based progress reports.

NA = not available.

Some states realized early that it would take them some time to fully implement their MFP programs, and they set modest goals in the initial years of this demonstration (Table II.4). In 2008, at least five states were able to exceed their goals for number of transitions in the year. In

2009, only three states exceeded their goal for the year, but another four achieved at least 75 percent of their 2009 goal.

**Table II.4. States' Progress Toward Yearly MFP Transition Goals**

| | 2008 | | | 2009 | | | |
|---|---|---|---|---|---|---|---|
| | Transition Goal | Actual Transitions | | Transition Goal | | Actual Transitions | |
| State | As of June 2008[a] | Number | Percentage of Goal Achieved | As of June 2008 | As of 2009[b] | Number | Percentage of Goal Achieved[c] |
| **Total** | **4,145** | **1,473** | **36** | **8,989** | **7,966** | **4,200** | **47** |
| Arkansas | 43 | 22 | 51 | 63 | 63 | 51 | 81 |
| California | 51 | 2 | 4 | 551 | 551 | 126 | 23 |
| Connecticut | 24 | 0 | 0 | 203 | 134 | 129 | 64 |
| Delaware | 3 | 3 | 100 | 25 | 25 | 20 | 80 |
| District of Columbia | 10 | 15 | 150 | 150 | 150 | 37 | 25 |
| Georgia | 87 | 3 | 3 | 350 | 350 | 194 | 55 |
| Hawaii | 20 | 1 | 5 | 110 | 110 | 24 | 22 |
| Illinois | 311 | 0 | 0 | 774 | 517 | 53 | 7 |
| Indiana | 216 | 0 | 0 | 324 | *220* | 60 | 19 |
| Iowa | 75 | 9 | 12 | 113 | 148 | 53 | 47 |
| Kansas | 363 | 70 | 19 | 198 | 417 | 88 | 44 |
| Kentucky | 22 | 5 | 23 | 200 | *22* | 36 | 18 |
| Louisiana | 58 | 0 | 0 | 65 | *65* | 9 | 14 |
| Maryland | 333 | 154 | 46 | 417 | *288* | 330 | 79 |
| Michigan | 75 | 89 | 119 | 300 | 300 | 286 | 95 |
| Missouri | 53 | 67 | 126 | 53 | 57 | 138 | 260 |
| Nebraska | 299 | 19 | 6 | 299 | 434 | 39 | 13 |
| New Hampshire | 86 | 24 | 28 | 86 | 95 | 21 | 24 |
| New Jersey | 89 | 11 | 12 | 180 | 180 | 74 | 41 |
| New York | 250 | 0 | 0 | 375 | *110* | 87 | 23 |
| North Carolina | 4 | 0 | 0 | 72 | 87 | 31 | 43 |
| North Dakota | 20 | 5 | 25 | 33 | 48 | 14 | 42 |
| Ohio | 266 | 60 | 23 | 687 | 687 | 342 | 50 |
| Oklahoma | 6 | 0 | 0 | 611 | *40* | 28 | 5 |
| Oregon | 112 | 32 | 29 | 232 | 394 | 131 | 56 |
| Pennsylvania | 215 | 42 | 20 | 873 | 873 | 253 | 29 |
| Texas | 592 | 761 | 129 | 769 | 769 | 1,123 | 146 |
| Virginia | 81 | 16 | 20 | 320 | 320 | 73 | 23 |
| Washington | 96 | 38 | 40 | 264 | 293 | 325 | 123 |
| Wisconsin | 285 | 25 | 9 | 292 | 219 | 25 | 9 |

Source: MFP semiannual web-based progress reports.

[a] Based on the goals set forth in the state's operational protocol approved as of June 2008.

[b] States could have revised their 2009 goal either through a revised operational protocol or as part of their request for supplemental funding.

[c] Percentage of transition goals as of June 2008.

## D. Characteristics of MFP Participants

CMS defined five target populations for state MFP transition programs: (1) older adults (aged 65 and over); (2) people under 65 with physical disabilities; (3) people with intellectual or developmental disabilities; (4) people with mental illness; and (5) others, such as those with two or more diagnoses or those who do not fit into one of the other categories. States were allowed to select the groups they wished to target and set transition goals for each. Some states chose to focus on certain groups. For example, MFP programs in Iowa and the District of Columbia are transitioning just people with developmental disabilities, although the District plans to transition people in other groups in subsequent years. In contrast, Indiana and Michigan chose to target two groups: elderly people, and non-elderly people with physical disabilities.

By the end of 2009, states reported through the semiannual web-based system that MFP participants were evenly distributed across the three target populations. People with physical disabilities made up 34 percent of ever-enrolled MFP participants, elderly people 33 percent, and people with developmental disabilities 31 percent. The remaining 2 percent were people with mental illness and "other" (Table II.5).

**Table II.5. Distribution of MFP Participants by Targeted Population**

| State | Cumulative Total | Percentage of Cumulative Total | | | | |
|---|---|---|---|---|---|---|
| | | Elderly | PD | MR/DD | MI | Other |
| **Total** | **5,673** | **33** | **34** | **31** | **1** | **1** |
| Arkansas | 73 | 19 | 43 | 38 | 0 | 0 |
| California | 128 | 11 | 31 | 53 | 2 | 4 |
| Connecticut | 129 | 43 | 40 | 2 | 16 | 0 |
| Delaware | 23 | 30 | 57 | 4 | 9 | 0 |
| District of Columbia | 52 | 0 | 0 | 100 | 0 | 0 |
| Georgia | 197 | 21 | 26 | 53 | 0 | 0 |
| Hawaii | 25 | 40 | 52 | 8 | 0 | 0 |
| Illinois | 53 | 19 | 30 | 0 | 51 | 0 |
| Indiana | 60 | 50 | 50 | 0 | 0 | 0 |
| Iowa | 62 | 0 | 0 | 100 | 0 | 0 |
| Kansas | 158 | 20 | 25 | 53 | 0 | 2 |
| Kentucky | 41 | 24 | 37 | 24 | 0 | 15 |
| Louisiana | 9 | 67 | 22 | 11 | 0 | 0 |
| Maryland | 484 | 34 | 41 | 24 | 0 | 2 |
| Michigan | 375 | 57 | 43 | 0 | 0 | 0 |
| Missouri | 205 | 15 | 34 | 47 | 0 | 4 |
| Nebraska | 58 | 17 | 14 | 64 | 0 | 5 |
| New Hampshire | 45 | 33 | 38 | 2 | 0 | 27 |
| New Jersey | 85 | 33 | 2 | 65 | 0 | 0 |
| New York | 87 | 37 | 54 | 0 | 0 | 9 |
| North Carolina | 31 | 26 | 3 | 71 | 0 | 0 |
| North Dakota | 19 | 26 | 37 | 37 | 0 | 0 |
| Ohio | 402 | 19 | 26 | 55 | 1 | 0 |
| Oklahoma | 28 | 0 | 7 | 93 | 0 | 0 |
| Oregon | 163 | 28 | 44 | 26 | 0 | 3 |

**Table II.5** *(continued)*

| State | Cumulative Total | Percentage of Cumulative Total | | | | |
|---|---|---|---|---|---|---|
| | | Elderly | PD | MR/DD | MI | Other |
| Pennsylvania | 295 | 68 | 29 | 4 | 0 | 0 |
| Texas | 1,884 | 35 | 33 | 32 | 0 | 0 |
| Virginia | 89 | 19 | 24 | 57 | 0 | 0 |
| Washington | 363 | 40 | 53 | 7 | 1 | 0 |
| Wisconsin | 50 | 32 | 34 | 34 | 0 | 9 |

Source: MFP semiannual web-based progress reports.

MI = mental illness; MR/DD = mental retardation/developmental disabilities; PD = physical disabilities.

**Demographic Characteristics.**[10] The individual records from the MFP Program Participation Data files that states submit each quarter indicate that most MFP participants have been working-age adults. The majority (68 percent) of participants transitioning in 2009 was under 65 (Table II.6). Among nonelderly people with physical disabilities, over three-quarters were between 45 and 65 years old. Fewer than 200 enrollees were under 21.

Overall, MFP participants were about equally divided by gender; 49 percent were female, and 51 percent were male. But there were differences in the age and gender distribution for each of the five target populations (Table II.6). Two-thirds of the MFP participants classified as elderly by their age were female. Conversely, two-thirds of participants identified as people with developmental disabilities were male. Among the physically disabled, the gender distribution was more balanced, and just over 46 percent were female.

[10] Data in this section are preliminary, because some states had not submitted complete data files by the time of this report, including Arkansas, Connecticut, the District of Columbia, Michigan, North Carolina, and Virginia.

**Table II.6. Demographic Characteristics MFP Participants in 2009 (Provisional Information)**

| Characteristic | Total Number of MFP Participants | Percentage of Total Number | | | | |
|---|---|---|---|---|---|---|
| | | Elderly | PD | MR/DD | Other | Unknown |
| **Total** | **4,984** | **1,344** | **1,788** | **1,393** | **110** | **349** |
| Age | | | | | | |
| <21 | 3.9 | 0.0 | 1.2 | 9.3 | 9.1 | 9.2 |
| 21-44 | 20.6 | 0.0 | 20.2 | 40.0 | 24.5 | 23.8 |
| 45-64 | 43.6 | 0.0 | 78.6 | 42.7 | 45.5 | 37.5 |
| ≥65 | 31.7 | 100.0 | 0.0 | 7.9 | 20.0 | 29.5 |
| Unknown | 0.2 | 0.0 | 0.5 | 0.1 | 0.9 | 0.0 |
| Gender | | | | | | |
| Female | 48.8 | 66.1 | 46.1 | 34.8 | 48.2 | 52.4 |
| Male | 51.0 | 33.9 | 53.6 | 65.1 | 51.8 | 47.6 |
| Unknown | 0.1 | 0.0 | 0.3 | 0.1 | 0.0 | 0.0 |

Source: MFP Program Participation Data files.

Notes: Arkansas and Virginia had not submitted any MFP Program Participation Data files when these analyses were conducted. In addition, data were available only through March 2009 for Michigan; June 2009 for the District of Columbia, Louisiana, and North Carolina; and September for Connecticut, Kansas, New Hampshire, and Wisconsin. The data reflect everyone who was an MFP participant in calendar year 2009 regardless of when the initial transition occurred.

MR/DD = mental retardation/developmental disabilities; PD = physical disabilities.

**Community Living Arrangements.** The MFP statute specified that program participants would be eligible if they chose to relocate to a "qualified" community residence, including a home, apartment, or small group home of four or fewer unrelated people. Preliminary information available from the administrative data submitted by the state grantees on a quarterly basis indicate that about 28 percent of participants moved to a home, 21 percent moved to an apartment, another 10 percent selected an apartment in an assisted living facility, and 29 percent moved to a group home of no more than 4 people.

The type of qualified residence varied considerably across the targeted populations. About half the elderly transitioned to a home owned by either the participant or a family member, while 44 percent of the nonelderly with disabilities transitioned either to a standard apartment or to assisted living. People with developmental disabilities transitioned predominantly to group homes (77 percent).

The available data show that few participants lived with family members after they transitioned to community living. However, grantees have been experiencing difficulty tracking this information, and for nearly half of all participants, the grantees had few details on living arrangements.

**Table II.7. Living Arrangements of MFP Participants Who Transitioned in 2009 (Provisional Information)**

| Characteristic | Total Number of MFP Participants | Percentage of Total Number of MFP Participants | | | | |
|---|---|---|---|---|---|---|
| | | Elderly | PD | MR/DD | Other | Unknown |
| **Total** | **4,984** | **1,344** | **1,788** | **1,393** | **110** | **349** |
| Type of Qualified Residence | | | | | | |
| Home[a] | 27.6 | 49.5 | 32.4 | 4.5 | 9.1 | 26.0 |
| Apartment | 20.8 | 17.9 | 34.0 | 9.4 | 9.1 | 21.2 |
| Assisted living | 9.6 | 14.3 | 10.4 | 3.1 | 4.5 | 23.4 |
| Group home[b] | 28.5 | 8.9 | 8.9 | 76.5 | 9.1 | 29.5 |
| Unknown | 13.4 | 9.4 | 14.2 | 6.5 | 68.2 | 35.0 |
| Lives with a Family Member | | | | | | |
| Yes | 8.6 | 14.7 | 9.5 | 2.5 | 9.1 | 4.6 |
| No | 43.1 | 31.8 | 45.1 | 51.2 | 20.9 | 50.7 |
| Unknown | 48.3 | 53.5 | 45.4 | 46.3 | 70.0 | 44.7 |

Source: MFP Program Participation Data files.

Note: Arkansas and Virginia had not submitted any MFP Program Participation Data files when these analyses were conducted. In addition, data were available only through March 2009 for Michigan; June 2009 for the District of Columbia, Louisiana, and North Carolina; and September for Connecticut, Kansas, New Hampshire, and Wisconsin. The data reflect everyone who was an MFP participant in calendar year 2009 regardless of when the initial transition occurred.

MR/DD = mental retardation/developmental disabilities; PD = physical disabilities.

[a]Home owned by the participant or by a family member.

[b]Group home of no more than four people.

## E. MFP Participants' Community Living Indicators—Reason for Leaving MFP

Early indicators suggest MFP participants were doing well in the community, although more research is needed. Among those who ever transitioned and enrolled in the MFP program, most left because they had completed 365 days of participation. As of the end of calendar year 2009, the state administrative records that grantees submit quarterly indicate that 1,710 ever-enrolled people disenrolled from MFP and had not returned to the program (Table II.8). Of those who left, about 60 percent had completed their 365 days of eligibility for MFP-financed services. Reinstitutionalization was the reason 14 percent of those who left ended their participation in MFP. About 11 percent of those who left had died. The reasons participants left MFP varied somewhat by targeted population: the elderly and nonelderly with disabilities who left were more likely to have been reinstitutionalized or to have died than participants with developmental disabilities, who were more likely to have left because they had exhausted their 365 days of eligibility.

**Table II.8. Reasons That MFP Participation Ended (Provisional Information), Overall and by Targeted Population**

| | | Percentage of Overall | | | | |
|---|---|---|---|---|---|---|
| Reason Participation Ended | Overall | Elderly | PD | MR/DD | Other | Unknown |
| **Total** | **1,710** | **486** | **542** | **537** | **53** | **92** |
| Completed 365 days | 60.4 | 50.0 | 55.4 | 80.1 | 28.3 | 54.3 |
| Reinstitutionalized | 14.2 | 21.2 | 19.0 | 5.6 | 7.5 | 3.3 |
| Died | 11.3 | 19.1 | 12.5 | 3.5 | 11.3 | 8.7 |
| Suspended eligibility | 0.5 | 0.4 | 0.9 | 0.0 | 1.9 | 0.0 |
| Moved | 0.8 | 0.4 | 1.0 | 0.2 | 1.9 | 2.2 |
| No longer needed services | 0.5 | 0.8 | 0.6 | 0.2 | 0.0 | 1.1 |
| Other | 5.7 | 4.5 | 6.6 | 2.6 | 47.2 | 1.1 |
| Unknown | 6.5 | 4.5 | 3.5 | 7.8 | 1.9 | 29.3 |

Source: MFP Program Participation Data files.

Note: Arkansas and Virginia had not submitted any MFP Program Participation Data files when these analyses were conducted. In addition, data were available only through March 2009 for Michigan; June 2009 for the District of Columbia, Louisiana, and North Carolina; and September for Connecticut, Kansas, New Hampshire, and Wisconsin.

MR/DD = mental retardation/developmental disabilities; PD = physical disabilities.

## F. MFP Grant Expenditures

One of the premises to be tested by the MFP demonstration is that Medicaid beneficiaries who reside in institutions can be cared for in the community at a cost less—or no greater—than that of institutional care. MFP expenditure information is incomplete for many states, but provisional spending data indicate enormous state variation in Medicaid HCBS spending on MFP participants. Federal and state Medicaid HCBS spending on MFP participants averaged $24,631 across 27 grantees,[11] ranging from $5,722 to $59,117 per person annually (Table II.9). Spending was above average in 13 states and below average in 14 states.

[11] Data from New Hampshire and North Carolina were unavailable for this report and the accuracy of data from the District of Columbia could not be confirmed.

**Table II.9. MFP Expenditures (Provisional Information), 2007-2009**

| State | Total Number of Transitions | All HCBS Spending per MFP Participant[a] (in Dollars) |
|---|---|---|
| **Total** | **5,673** | **24,631** |
| Arkansas | 22 | 17,668 |
| California | 128 | 15,485 |
| Connecticut | 129 | 18,740 |
| Delaware | 23 | 24,575 |
| District of Columbia | 52 | NC |
| Georgia | 197 | 30,113 |
| Hawaii | 25 | 10,034 |
| Illinois | 53 | 5,722 |
| Indiana | 60 | 11,354 |
| Iowa | 62 | 35,268 |
| Kansas | 158 | 26,631 |
| Kentucky | 41 | 27,805 |
| Louisiana | 9 | 8,889 |
| Maryland | 484 | 34,994 |
| Michigan | 375 | 14,785 |
| Missouri | 205 | 37,992 |
| Nebraska | 58 | 44,541 |
| New Hampshire | 45 | NA |
| New Jersey | 85 | 10,485 |
| New York | 87 | 15,885 |
| North Carolina | 31 | NA |
| North Dakota | 19 | 27,152 |
| Ohio | 402 | 59,117 |
| Oklahoma | 28 | 32,718 |
| Oregon | 163 | 40,227 |
| Pennsylvania | 295 | 12,865 |
| Texas | 1,884 | 17,745 |
| Virginia | 89 | 36,143 |
| Washington | 363 | 15,077 |
| Wisconsin | 50 | 47,857 |

Source: State MFP Budget Worksheets submitted in February 2010.

[a]Total spending for qualified HCBS, demonstration HCBS, and supplemental services. Excludes federal and state administrative costs.

NA = not available. NC = data provided, but could not be confirmed

Differences in average state HCBS spending on MFP participants stem from several factors. States are transitioning different target populations, and those that have higher proportions of enrollees with developmental disabilities, who typically use a more costly array of services than older adults and younger people with physical disabilities, would be expected to have higher per-participant costs (these grantees include Georgia, Iowa, Missouri, Nebraska, Ohio, and Oklahoma). This difference is apparent when total HCBS waiver expenditures for the population

with developmental disabilities are compared to the same type of expenditures for older adults and people under 65 with physical disabilities (KCMU 2009).[12]

State expenditure differences will also reflect differences in the care needs of MFP participants and the array of services the grantee states provide. For example, Wisconsin reports that the waiver programs MFP participants enter offer a comprehensive set of services. Virginia reports that a large proportion of their MFP participants enter a waiver program that provides a costly array of services. Differences in expenditures may also reflect differences in payment rates. State variation in expenditures underscores the need to control for variation in participant characteristics, differences in the array of services provided, and provider payment rates whenever program costs are analyzed.

To provide some perspective on these costs, the provisional estimate of average HCBS expenditures of $24,631 of MFP participants is 40 percent lower than the average annual Medicaid spending on institutional care for elderly people residing in nursing homes for three months or more—$40,884 per person in 2006 (Mathematica calculation).[13] It is 9 percent higher than average expenditures for HCBS waiver participants—$22,610 in 2006 (KCMU 2009)—and 46 percent higher than all HCBS spending (including state plan personal care and home health services) per user ($16,899) in 27 MFP states in 2007.[14]

Higher per-person HCBS expenditures for MFP participants relative to other HCBS users may be explained partly by the added costs of transition planning, coordination, and the one-time services participants need to make the transition successful. In addition, many MFP grantee states are offering a substantially enriched package of services to MFP participants, relative to what the average HCBS user, including waiver and nonwaiver participants, would receive.

## G. Summary

At the end of December 2009, nearly 5,700 people who had lived in nursing homes, ICFs-MR, or other institutions for six months or more were able to transition to home or community residences with assistance from state MFP programs. That most states have not been able to transition as many people as originally projected is due to several factors, including slower-than-expected program startup and in some cases, goals that were overly ambitious given each state's experience and capacity with such transition programs. The next chapter discusses MFP program

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[12] In 2006, average HCBS waiver expenditures for people with MR/DD were $40,952 per person per year, compared to $9,544 for waivers that serve both elderly and younger people with physical disabilities, $8,954 per person for elderly people alone, and $15,882 for people under 65 with physical disabilities alone (Ng et al. 2009, tables 4 and 7).

[13] Mathematica analysis of MAX 2006 data. The 2006 spending amount is provided to illustrate the difference in spending between institutional and HCBS care; Medicaid spending per long-term institutional resident would be higher if it included Medicaid costs for long-term residents of ICFs-MR. Future analyses in this evaluation will compare Medicaid spending per user for all institutional long-term care users to HCBS spending per MFP enrollee.

[14] From Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 27 MFP grantee states, cited in Chapter IV. All HCBS expenditures include spending on HCBS waivers or nonwaiver personal care services, home health care, residential care, adult day care, private duty nursing, and hospice care.

design and implementation, and initial lessons learned about what it takes to transition large numbers of people from institutions to the community.

# III. IMPLEMENTATION CHALLENGES OF MFP TRANSITION PROGRAMS

The implementation of an MFP transition program requires each grantee to bring together an array of organizations, processes, and people to transition people effectively from long-term institutional residence to home- and community-based settings. All transition programs must offer transition planning and coordination, assistance in locating and arranging for suitable housing, and adequate HCBS. Once someone has relocated, the programs must assure the ongoing availability and quality of community services and supports. Each state grantee conducts these activities differently, and success will depend on support for the program, an adequate supply of affordable and accessible housing, the availability of sufficient HCBS in the neighborhoods or regions where people wish to reside, and the reliability of quality monitoring and backup support to ensure that participants can live independently and safely in the community.

This chapter describes the progress and challenges that states have faced in implementing MFP transition programs. These challenges partly explain the transition outcomes described in Chapter II. This chapter first discusses the implementation of the core functions of transition programs and describes state achievements and challenges during the first two years of the program. Next, it describes one result of the implementation challenges, which is the natural variability in the start dates of state MFP programs. The chapter concludes with preliminary observations about program structures, processes, and interventions that appear to be important to successful state transition programs based on the experiences of MFP programs so far.

*Key Findings*

- The considerable challenges of implementing an MFP program have affected state transition goals. MFP grantees have experienced challenges in all areas of program implementation including conducting outreach and recruitment, finding affordable and accessible housing, securing adequate services, and managing the quality of care and the inherent risks of living in the community.
- Transition goals have also been affected by late implementation start dates in some states. While three states were able to begin transitions as early as October 2007, some did not start transitioning beneficiaries until mid 2009. September 2009 marked the month the last state grantee started MFP transitions.
    - Those starting the program earliest tended to have more experience and capacity in operating transition programs, while those implementing later needed more time to put the necessary infrastructure in place and meet federal conditions for beginning MFP operations.
- The structure and processes for carrying out key transition activities vary across the 30 states. While it is too early to determine which program features matter most to success—as demonstrated by a cost effective program that has low rates of reinstitutionalization lasting more than 30 days and by high quality-of-life ratings—qualitative information suggests the importance of the following:

- having Medicaid HCBS waiver programs that can accommodate or give priority to MFP participants (or policies that assure that money can follow the person from the institution to the community regardless of waiver capacity)
- availability of HCBS and affordable, accessible housing in the communities in which MFP participants wish to live
- strong quality assurance and monitoring systems that reduce problems associated with the quality of care or access to services.

## A. Implementation Progress and Challenges

MFP grantees have faced implementation challenges in all aspects of their programs.

**Program Startup.** Once states received CMS approval to begin program operations, MFP grantees turned their attention to hiring staff and soliciting or issuing contracts with private vendors. Because CMS requires that MFP programs have full-time project directors and provides 100 percent funding for this position, nearly all states had project directors in place from the beginning of the grant. Some turnover in project directors has occurred, and in all but two states (New Hampshire and North Carolina), interim directors effectively managed the program until new directors were hired. In five states (Connecticut, Indiana, Iowa, Kentucky, and Maryland), however, it took many months to hire additional staff, which delayed program startup. Three states (Indiana, Georgia, and New York) did not begin their programs until late 2008 because of prolonged state procurement processes required for contracting with transition agencies.

Some states also reported problems gaining cooperation from other state agencies in developing, or agreeing to use, common screening, enrollment, and tracking tools. That made it hard to collect accurate or timely data on the status of MFP participants or to establish the quality assurance and management systems that CMS required. During 2008, for example, some states reported that it took a long time to set up common screening and assessment, and tracking systems across departments. By the last half of 2009, only eight states reported problems collaborating or coordinating with other agencies.

**Outreach, Marketing, and Recruitment.** Although MFP was well known to advocacy groups during the planning phase, it was not as familiar to the public or to people who were eligible. Consequently, during the first several months of program operations, most states spent time and resources publicizing MFP to providers, individuals and families, and community leaders. In 2008 and 2009, grantees cited numerous outreach and recruitment activities: development and distribution of brochures; media campaigns; outreach tool kits for transition coordinators, case managers, and providers; and training sessions for ombudsmen, discharge planners in institutions, and frontline workers in community agencies. Some states involved consumer advocates and peer counselors in outreach and marketing directly to potential

transition candidates. A number of states also used information from the Nursing Home Minimum Data Set to identify people interested in returning to the community.[15]

By the end of the first half of 2009, 13 states had reported increased referrals in response to direct outreach efforts and greater awareness of the program. But at the end of 2009, 14 states still reported problems generating referrals. They cited concerns on the part of individuals or family members about health and safety in the community. Some state programs also encountered resistance or opposition from institutional providers, driven by fears that transitions could threaten their financial viability, which was more common among facilities with a low patient census and were not always filling all their beds.

Another deterrent to recruitment and enrollment was the MFP statutory requirement that excluded assisted-living facilities (ALFs) from MFP-qualified community residences. In 2008, states reported that 51 people, or 5 percent of 1,039 assessed, were eligible for MFP but chose not to reside in an MFP-qualified residence in the community. In response to state requests to reconsider this policy, CMS issued guidance in July 2009 on the circumstances under which ALFs might qualify as apartments. The guidance lists the conditions that must be met for community residential settings, including ALFs, to be considered a qualified residence under MFP statute.[16] This guidance is expected to make it easier for people to transition to the community in states where this exclusion has hindered recruitment and enrollment.

Some MFP grantees also reported that the six-month minimum institutional residency requirement has constrained recruitment and enrollment. For example, in states with nursing facility transition programs that operate alongside MFP and have less-stringent criteria, residents in institutions for fewer than six months were helped to move to the community, but they could not enroll in MFP. As discussed in Chapter II, this problem might be alleviated by statutory changes to MFP adopted in 2010, which reduced the minimum length of institutional residency from six months to 90 days (excluding time spent in a nursing home for short-term rehabilitation paid for by Medicare).

**Housing for MFP Participants.** Evaluations of previous transition programs have found that the ability to find and arrange for affordable and accessible housing is a key determinant of success—as well as one of the barriers most frequently cited. MFP grantees have sought to find or secure such housing for MFP participants in three ways: (1) developing on-line registries or inventories of affordable and accessible housing; (2) increasing funding for home modifications or assistive technology; and (3) conducting outreach and collaborating with public housing authorities to encourage them to make rental vouchers available to MFP participants and people

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[15] The Nursing Home Minimum Data Set (MDS) is a comprehensive, clinical assessment that Medicare or Medicaid certified nursing homes must complete with all their residents. When completed, the MDS provides a comprehensive assessment of each resident's health status and functional capabilities.

[16] CMS specified the conditions under which community residential settings, including ALFs, can meet the requirements of a qualified residence under the MFP statute: (1) ALFs must offer apartment-style units; (2) residents must have a legally enforceable individual lease (not a resident agreement) that does *not* include admission and discharge provisions that could require a person to move when needs increase; and (3) the resident must have personal control over a separate eating, sleeping, bathing, and cooking area.

with disabilities or to give preference to MFP participants on waiting lists for subsidized housing. In addition, 10 states designated funds in their MFP budgets to obtain voucher priority or set-asides for MFP participants, and a few subsidize rent temporarily until MFP participants qualify for public housing vouchers.

In 2008, efforts to increase vouchers, housing options, and funds for home modifications began to pay dividends. Five states reported an increase in housing vouchers for MFP participants and others with disabilities, five reported an increase in the supply of housing for MFP participants, and six received funds for home modifications or assistive technology to adapt residences in the community to accommodate MFP participants' functional limitations. In 2009, the number of states reporting these accomplishments grew; six states reported an increase in rental vouchers for MFP participants, and another signed a memorandum of understanding to expedite the process for obtaining housing vouchers. Nine states reported growth in the supply of housing for MFP participants, particularly small group homes, after they assisted owners or operators of small businesses to become licensed providers of group homes or adult foster care homes, and held training to help them serve people with developmental disabilities and Alzheimer's disease. Eleven states also reported an increase in funds available for home modifications.

Nevertheless, shortages of affordable, accessible housing remain a major obstacle to meeting state MFP transition goals. In 2008, 15 MFP states (half of all grantees) reported that an inadequate supply either of affordable, accessible housing or of rental vouchers reduced the number of people who could transition. By the end of 2009, that number had risen to 20. The availability of housing vouchers for people with disabilities transitioning from institutions to the community is expected to increase in future years, once the Department of Housing and Urban Development makes available, to nonelderly people with disabilities, 4,000 Housing Choice Vouchers, of which 1,000 are designated for transitions from institutions to community care.

**Expanding the Availability of HCBS.** The ability of state MFP programs to serve disabled people in home and community settings depends on the supply and availability of a range of services and supports to maintain their health, and to provide help with activities of daily living. Making HCBS available to more people, particularly MFP participants, some of whom have intensive need for care, requires (1) that HCBS waiver programs have sufficient funding and capacity, since these are the dominant arrangements for serving MFP enrollees; (2) that Medicaid or the MFP program cover all the HCBS needed; (3) that an adequate supply of providers or direct care workers be available and willing to serve them; and (4) that self-direction options be available so that people can hire their own personal care aides and have more choice and control over how waiver and state plan funds are spent. While most states have made incremental progress in each of these areas, nearly every state also has gaps in service availability or coverage, which have been harder to overcome as state budget problems worsened in 2008 and 2009.

*Capacity of HCBS Waiver Programs*

- In 2008, six states (California, Missouri, Nebraska, Oklahoma, Pennsylvania, and Virginia) gained state or federal approval for new waivers, waiver renewals, and waiver expansions or secured reserved waiver slots for MFP participants. Pennsylvania had the largest increase, adding 2,100 slots to a waiver for the aged and

1,200 to the waiver for younger physically disabled people. Two states (Arkansas and Louisiana) reported problems gaining legislative approval or funds for waiver-related expansions.

- In 2009, nine states (Connecticut, Indiana, Michigan, Missouri, North Dakota, North Carolina, Pennsylvania, Texas, and Washington) received legislative or executive authority to spend more funds in key waiver programs or create additional waiver slots, and eight states changes policies that increased the capacity of HCBS waiver programs to serve MFP participants. For example, California secured priority for MFP participants in an HCBS waiver for elderly people and people with disabilities. However, high demand for HCBS and state budget shortfalls in 2009 began to affect availability of waiver slots for MFP participants in some states. In New Hampshire and Texas, authority to spend more funds or add waiver slots was delayed or disapproved; Georgia decreased waiver capacity set-asides for MFP and put potential participants on a waiting list. Arkansas reached the enrollment cap in two waivers in which MFP participants were slated to enroll, which required that new applicants to these programs be wait-listed.

*HCBS and Covered Benefits*

In addition to offering specialized or extra services to MFP participants during the one-year period after relocation to the community (see text box on following page), some states added these extra HCBS on a permanent basis to Medicaid waivers or state plan benefits, which will allow MFP participants to continue receiving these services after their 365-day enrollment period.

- In 2008, six states added new services to existing waivers (Iowa, Kansas, North Carolina, Nebraska, New Jersey, and Virginia), and three states (Missouri, Oklahoma, and Texas) added self-direction options to existing waivers.
- In 2009, four states added HCBS to existing waivers or to state plans. Arkansas, for example, added telehealth services to state plan benefits because they had been offered as an MFP demonstration service and led to cost savings and positive consumer outcomes. Connecticut began to offer addiction treatment prior to transition. Iowa developed a program to assist families and providers in managing the behaviors of people with a developmental disability and mental illness. Michigan began covering HCBS waiver services in licensed adult foster care homes.

*Supply of HCBS Providers and Direct Care Workers*

- In 2008, five states reported progress in expanding the number and type of HCBS providers available to serve MFP participants. For example, Oregon created a small congregate-setting option for elderly people with Alzheimer's or dementia. In Washington, a new law allowed nurses to delegate insulin injections to personal care aides, thus allowing more people who need such injections to live in the community. Hawaii provided in-service training for foster home providers to increase the number willing to accept complex clients with obesity, tube feeding, behavior problems, or respiratory problems.

- In 2009, efforts of the previous year in Oregon and Hawaii increased the number of small group homes for MFP participants, 10 other states reported an increasing number of HCBS providers contracting with Medicaid, and 5 states increased payment rates to HCBS providers despite poor budget situations. Yet about half the MFP states continued to report an insufficient supply of HCBS, providers, and direct care workers to serve MFP participants, especially in rural areas where services and transportation are limited.

**Extra Home- and Community-Based Services Available Through MFP**

While every state provides HCBS through waiver programs and state plan benefits to some extent, nearly state Medicaid program has some gaps in coverage of specialized services or supports needed by elderly and disable people transitioning from long-term institutional stays to the community. For example, although personal care services can be covered as a state Medicaid plan benefit, or through HCBS waiver programs, the maximum hours of personal care assistance may not be adequate during the first weeks or months following discharge from an institution. In addition, while states can choose to cover a wide variety of services under HCBS waiver programs, many do not cover specialized services that people with complex medical or behavioral health conditions need.

Recognizing that people transitioning from long-term institutional stays might need additional services during the initial period following discharge, the federal MFP statute allowed states receiving grants to offer two types of extra services—demonstration and supplemental—to be provided to MFP participants during the 365 days of enrollment:

- **MFP demonstration services**, which can be covered by Medicaid under current federal law but are not offered in the state's current HCBS waivers or through the state Medicaid plan. These include, for example, behavioral health services, telehealth, 24-hour personal care assistance, and assistive technology. The state may offer, but does not have to offer, these services to MFP participants after the 365-day period. These services are reimbursed at an enhanced FMAP rate established by formula for each state.
- **MFP supplemental services** are one-time costs that generally cannot be covered by Medicaid under current federal law but can facilitate transition to the community. These include security and utility deposits, housing locator services, trial visits to community residences, basic furnishings, groceries, and pest eradication. These services are reimbursed at the state's regular FMAP rate.

In the aggregate, the degree to which states offer extra MFP services represents a test of whether an expanded amount or array of services and supports can increase the rate of transitions (and the success of these transitions) among long-term institutionalized residents in the MFP grantee states. Twenty-six of the 30 MFP grantee states offer a wide range of MFP demonstration or supplemental services. Seventeen of the 26 offer services in both categories, 7 offer demonstration services only, and 2 offer limited supplemental services. Two of the most common MFP demonstration and supplemental services are intensive transition coordination services when the process takes longer than 180 days (the maximum time allowed by federal rules) and one-time expenses associated with the move to a home or community-based residence. Some states offer 24-hour personal care services when state Medicaid HCBS benefits do not cover care of this intensity.

Some states are offering particular MFP demonstration or supplemental services designed explicitly to test whether they help people with multiple or complex health conditions transition to the community, or allow them to remain in the community longer. For example, the behavioral health pilot program in Texas offers cognitive adaptive training and substance abuse treatment services as MFP demonstration services to adults with co-occurring physical and behavioral health conditions. Several rural states, including Arkansas, Hawaii, and Nebraska, offer telehealth as an MFP demonstration service.

*Self-direction*

- By the end of December 2009, 24 MFP states had self-direction programs in effect, and 3 (District of Columbia, Illinois, and Oklahoma) planned to make such options available in the future. At the end of 2009, 538 participants (14 percent of current participants) were self-directing HCBS; of these, 63 percent hired or supervised their own personal assistants, and 89 percent managed their own allowance or budget (the two categories are not mutually exclusive).[17]
- As authorized in the DRA or 2005, as of January 2007 states could add self-direction to the state Medicaid plan through a State Plan Amendment (SPA), referred to as a 1915(j) SPA for the Medicaid section under which it is authorized. Five MFP states had approved such SPAs in 2008 or 2009 (Arkansas, California, Oregon, New Jersey, and Texas). Arkansas plans to enroll 50 percent of MFP participants in self-directed care by the fourth year of the demonstration, but is the only state among the five that limits the number of people who can participate in the 1915(j) SPA program (CMS 2009).

**Quality Management and Assurance.** Many states needed to establish or strengthen quality-monitoring systems for MFP participants living in the community to assure they are receiving the right services at the right time, or to capture data from all agencies involved in serving MFP participants. MFP transition programs are required to have 24/7 backup provisions when emergencies arise. States needed to develop (1) procedures to assess and mitigate potential risks to health and safety; (2) common data collection and monitoring systems across all state and local agencies involved in MFP; and (3) systems to report and track critical incidents such as abuse and neglect, preventable or unexpected deaths, or criminal acts. Seven states reported progress developing on-line reporting and tracking systems or other means of sharing information on a real-time basis (California, Connecticut, District of Columbia, Iowa, Kansas, North Dakota, and Wisconsin). North Dakota and North Carolina, however, report that fiscal problems are hindering progress.

**Influence of the Economic Recession and State Budget Deficits.** Just as MFP programs began implementation, the United States entered a serious economic downturn, which resulted in budget shortfalls in nearly every state. To balance their budgets, most state governments have had to reduce spending and cut services. In FY 2009 (beginning in July 2008 in most states), Medicaid enrollment grew 5.4 percent, which forced 27 states to make cuts in Medicaid spending, and in FY 2010, 28 states planned to make such cuts (National Association of State Budget Officers December 2009). In 2008, 11 MFP states made cuts in medical, rehabilitative, home care, or other services for the elderly and people with disabilities (Johnson et al. 2009). More states would have had to make such reductions, or make cuts that were more severe,

[17] Ohio, which accounts for 169 self-directing MFP participants (a third of the total), defines these participants as anyone managing a community transition services budget (up to $2,000 per participant) for rental deposits, home furnishings, and other one-time expenses associated with community transitions.

without federal relief funds provided to them through the American Recovery and Reinvestment Act of 2009.

The economic downturn and resulting shortfalls affected the MFP program as well. For example, across-the-board budget cuts in three states reduced the availability of community-based services and the number of waiver slots for MFP participants. After a gubernatorial directive prohibited any new spending, one state withdrew a proposal to add transition and community-based services for MFP participants. The budget deficit in another state caused delays in HCBS provider payments, which made agencies reluctant to serve MFP participants.

By the end of 2009, despite the enhanced FMAP rate for MFP qualified and demonstration services, nearly two-thirds (19) of all MFP states reported that the recession or state budget shortfalls had adversely affected MFP programs. Nine states reported MFP staff reductions. Five reported cuts in HCBS available to MFP participants. One state removed the waiver capacity set-aside for MFP participants, which impeded the state's ability to transition more people, and two states reported that cuts in Medicaid provider rates reduced the availability of HCBS. Other states reported increasing reluctance among some providers and families to participate in the program out of concern that funding and support for people in the community would end when the grant period ended.

## B. MFP Implementation Start Dates

One result of all these challenges was the delays some grantees experienced. State MFP grantees began implementing transition programs over a period of almost two years, from October 2007 to September 2009. Of the 30 grantee states, 7 were "early implementers," having begun operations between October 2007 and May 2008. Sixteen began implementation between June 2008 and December 2008, and the remaining 7 began sometime in 2009 (Table III.1). Two factors explain varying program start dates: (1) state readiness or capacity and (2) ability to meet federal conditions.

**Table III.1 MFP Implementation Start Dates**

| October 2007–May 2008 | June 2008–December 2008 | | January 2009–September 2009 |
|---|---|---|---|
| Maryland | Arkansas | Kentucky | Connecticut |
| Missouri | California | Michigan | Illinois |
| New Hampshire | Delaware | Nebraska | Indiana |
| Oregon | District of Columbia | New Jersey | Louisiana |
| Texas | Georgia | North Dakota | New York |
| Washington | Hawaii | Ohio | North Carolina |
| Wisconsin | Iowa | Pennsylvania | Oklahoma |
| | Kansas | Virginia | |

Source: Mathematica analysis of MFP semiannual web-based progress reports.

**Transition Planning Experience and Capacity.** Transition planning and coordination involves labor-intensive activities for each potential participant: screening the people and assessing their potential to live in the community; finding affordable and accessible housing; and arranging for all needed long-term services and supports in the community.[18] MFP states began the program with different levels of experience and capacity to transition large numbers of people, and those with more experience and capacity were able to begin operations sooner.

Of the seven MFP grantee states that had substantial experience with transition programs (Table III.2), four began MFP program implementation before June 2008. Most of these states continue to operate "parallel" transition programs, which transition people not eligible for MFP either because they do not meet the minimum length-of-stay requirement or because they choose to live in a type of residence that does not qualify under MFP. These states also covered most transition coordination services under existing Medicaid policies, and with some exceptions, did not need to add services or expand existing waiver programs to accommodate MFP participants.

**Table III.2 Level of Transition Program Experience and Capacity Before MFP Began**

| Most Experience/Capacity | Some Experience/Capacity | | Least Experience/Capacity |
|---|---|---|---|
| Michigan | Arkansas[a] | Kansas[a] | California |
| New Jersey | Connecticut | Louisiana | District of Columbia |
| Oregon[a] | Delaware | Maryland[a] | Georgia |
| Pennsylvania | Hawaii | Missouri[a] | Kentucky |
| Texas[a] | Illinois | New Hampshire[a] | Nebraska |
| Washington[a] | Indiana | Ohio | New York |
| Wisconsin[a] | Iowa[a] | | North Carolina |
| | | | North Dakota |
| | | | Oklahoma |
| | | | Virginia |

Source: Mathematica analysis of previous state programs and views of MFP project directors.

[a]These states began implementation by June 2008.

Compared with the 7 states that had the most experience and capacity, the other 23 had less transition program experience or capacity and so took longer to begin or scale up MFP transition activities. Thirteen MFP states had some experience with transition programs, for example, from

[18] The range of functions performed by transition coordinators varies by state. In some states, they conduct outreach to institutions, while in others, central MFP program staff do this type of work. Transition coordinators may be responsible for finding and securing affordable and accessible housing in MFP-qualified residences, but some states are using housing specialists to do this work. In addition, states have been modifying the range of transition coordinators' responsibilities as more federal funding has become available to grantees to perform some of these activities. Beginning in 2009, grantees could apply for funding to support a state-level housing specialist and a state-level community-living specialist.

smaller pilots. In many of these states, previous programs were geared toward helping people in ICFs-MR move to the community, and transition programs for people in nursing facilities were smaller in scale. To meet MFP goals, these states needed to scale up or develop capacity throughout the state to serve population subgroups not targeted by previous transition programs.

The remaining 10 states entered the MFP program with less transition experience or little current capacity. To begin program operations, they needed to hire and train state or local government agency staff, or contract with private organizations, such as Area Agencies on Aging, Centers for Independent Living, or Aging and Disability Resource Centers, to carry out transition planning and coordination. Many of these 10 states also had to add new HCBS waiver programs to serve MFP participants, or arrange or contract for transition-related services not covered under existing Medicaid programs.

**Meeting Federal Conditions.** Before starting the program, MFP grantees had to prepare and obtain CMS approval of detailed operational protocols (OPs), which describe the policies and procedures of the MFP program, identify the state agencies and community organizations responsible for each activity, and establish goals and benchmarks to monitor progress. States could take up to one year after receiving the grant award to write the OPs and many took advantage of this flexibility. Two-thirds of MFP grantees did not submit proposed OPs to CMS for review and approval until mid-2008.

CMS also requires grantees (1) to track MFP participants separate from other Medicaid beneficiaries in Medicaid management information systems (MMIS), and (2) submit detailed MFP financial reports that identify the services eligible for financing through the grant and distinguish between services that do and do not received enhanced FMAP rates. Modifying the MMIS held up program start dates in some states, even though the program made available administrative funding for system upgrades needed to meet MFP reporting requirements. Grantees also needed to arrange for the administration of quality-of-life surveys before the first MFP participants were enrolled, which also delayed startup dates in some cases. Details about this survey are presented in Chapter V.

## C. Preliminary Observations on Features of Successful Transition Programs

One of the goals of the national MFP evaluation is to identify the program characteristics, implementation strategies, administrative structures, and services that foster the greatest success in state transition programs. The evaluation will measure success based on (1) number of transitions relative to the number eligible, (2) rates of reinstitutionalization lasting more than 30 days among MFP participants (during their first and second years in the community), (3) rates of preventable hospitalizations and emergency room visits among MFP participants, and (4) quality-of-life ratings by participants and how they change after the transition. Program costs will also be factored in to identify those programs that cost-effectively achieve success.

If state performance is to be compared fairly, it is important to control for the health status and functional levels among those who transition through MFP. States that transition people with lower need for care may be more successful on these measures than those who transition people with more chronic illnesses or more severe functional disabilities. These data have not yet been provided or collected, so this type of analysis could not be conducted at the time of this report. Several years of data would help in detecting any strong correlations between program features

and indicators of success, but the program has not operated long enough to permit such a rigorous assessment.

Based on two initial indicators—the number of MFP participants as a percentage of those eligible at baseline (before the program began) and reinstitutionalization rates—preliminary observations about the relationship between state attributes and program features and selected measures of success can be made. Table III.3 is sorted by MFP participants as a percentage of the number eligible before the program began, but overall success is judged on the other two indicators as well.

**Table III.3 Indicators of MFP Transition Success—Preliminary Assessment**

| | Number of Transitions Through December 2009 | Transitions as a Percentage of MFP Eligibles at Baseline (2006) | Reinstitutionalization Rate (Percentage of Participants) |
|---|---|---|---|
| Oregon | 163 | 2.70 | 4.9 |
| Washington | 363 | 2.69 | 3.9 |
| Maryland | 484 | 2.50 | 2.3 |
| Texas | 1,884 | 2.28 | 7.5 |
| District of Columbia | 52 | 1.46 | 1.9 |
| Kansas | 158 | 1.30 | 3.8 |
| Michigan | 375 | 1.14 | 20.5 |
| New Hampshire | 45 | 0.82 | 20.0 |
| Delaware | 23 | 0.78 | 13.0 |
| Hawaii | 25 | 0.74 | 24.0 |
| Missouri | 205 | 0.70 | 12.7 |
| Georgia | 197 | 0.62 | 3.0 |
| Nebraska | 58 | 0.61 | 6.9 |
| Ohio | 402 | 0.59 | 0.0 |
| Connecticut | 129 | 0.55 | 6.2 |
| Pennsylvania | 295 | 0.44 | 9.5 |
| Arkansas | 73 | 0.42 | 6.8 |
| North Dakota | 19 | 0.40 | 5.3 |
| Virginia | 89 | 0.40 | 1.1 |
| Iowa | 62 | 0.34 | 11.3 |
| New Jersey | 85 | 0.23 | 3.5 |
| Kentucky | 41 | 0.21 | 17.1 |
| Wisconsin | 50 | 0.19 | 20.0 |
| Indiana | 60 | 0.18 | 8.3 |
| California | 128 | 0.15 | 7.0 |
| Oklahoma | 28 | 0.15 | 0.0 |
| North Carolina | 31 | 0.09 | 6.5 |
| Illinois | 53 | 0.08 | 1.9 |
| New York | 87 | 0.07 | 10.3 |
| Louisiana | 9 | 0.03 | 0.0 |
| MFP Grantee Total | 5,673 | 0.60 | 7.19 |

Source: Mathematica analysis of MFP semiannual web-based progress reports and 2006 Medical Analytical Extract files.

In general, states that made the most progress on these indicators began their programs earlier than others, which gave them more time to help more people transition. Most of the states with the best performance so far (those near the top of Table III.3) also had more transition experience and capacity at the start of MFP (those classified as having more experience in Table II.2). In other words, states with more infrastructure already in place in general have made more progress than states that had to create or substantially expand their capacity to conduct transition planning and assistance. These advantages, however, will recede in importance as states gain more operational experience.

An assessment of grantees' progress reports and site visits, the characteristics of successful transition programs are beginning to emerge. Some of them are attributes of state long-term care systems, and some are features of MFP programs themselves. Some of these elements appear to be *essential* for successful transition programs, while others may be *beneficial,* that is, they are necessary but not sufficient to more or faster progress in MFP program implementation. These factors, however, may be more important in the initial startup period than in later stages of the program, so they need further testing and examination as the program evolves.

*May Be Essential to Initial Success*

- State policies which assure that money can follow the person from the institution to the community regardless of waiver capacity.
- Availability of core HCBS, such as personal care assistance, home health care, environmental modifications that make homes accessible, therapies, and transportation to medical care, in the communities in which MFP participants live. Available informal support may also be crucial to provide backup for paid workers.
- Availability of affordable and accessible housing that meets the requirements of qualified MFP residences, which may require that MFP programs secure housing subsidies or vouchers that give priority to MFP participants and other people transitioning from institutions.
- Quality assurance, 24-hour backup, and risk mitigation, all of which help reduce the potential for quality or access problems that lead to reinstitutionalization.
- Systems to track MFP participants in Medicaid enrollment and claims files, to ensure that states can submit the reports and financial statements required to secure federal funds.

*May Be Beneficial to Initial Success*

- Transition capacity or infrastructure in place at the start of the program, which means there are skilled, experienced transition coordinators in the state who can help MFP program operations get started quickly. But the range of responsibilities assigned to transition coordinators can also affect success in meeting transition goals. Other aspects of transition coordination and planning may be important as well, such as transition coordinators' qualifications and caseload size (number of clients per worker), which can affect how much time and effort is invested in each transition.

- Committed and stable state leadership can help overcome difficulties in securing resources and cooperation from other units or agencies within state government; engage and maintain support from advocates, providers, and other stakeholders; overcome resistance from nursing facility and ICF-MR administrators or discharge staff; and create strong partnerships with agencies that carry out transition planning and coordination.
- Medicaid or MFP coverage of HCBS of all types, including those related to the transition process and those needed to maintain health and function in the community, ensures that a wide array of services can be tailored to meet each individual's needs. In general, states performing better so far offer HCBS in all three categories (qualified, demonstration, and supplemental). Some states already offered a comprehensive range of HCBS through waiver and state plan benefits, so they might not have needed to offer extra MFP HCBS.

Several other factors appear to have played a role in program startup, but it is difficult to determine how essential or beneficial they are to success in the long term. They include support for and engagement in the MFP program by state and community-based stakeholders; strong partnerships with local transition agencies, relocation contractors, and case managers; public awareness of the program; interagency coordination and collaboration; and collaboration and coalitions between state and local HCBS programs and public housing authorities. Some states had such advantages at the start of the program, as in Texas, where years of operating a transition program helped local agencies and housing authorities develop strong working relationships early in the program. Over time, the availability of federal funds for state programs to hire housing specialists may help other states emulate Texas' success.

## D. Summary and Implications for Long-Term Care System Rebalancing

After a slow startup phase in some states, all 30 MFP states now have in place the infrastructure for program administration and transition assistance at the state and local levels. Some states got their programs off the ground quickly, some have taken longer to launch but are making good progress, and some are still encountering major hurdles.

The structure and processes for carrying out key transition activities vary across the 30 states. While it is not yet known which of the differences matter most to success, as measured by higher numbers of enrollees relative to those eligible, low rates of reinstitutionalization, and high quality-of-life ratings, this early assessment of MFP programs' achievements and challenges points to the importance of (1) having Medicaid HCBS waiver programs that can accommodate or give priority to enrollment of MFP participants (or state policies which assure that money can follow the person from the institution to the community regardless of waiver capacity); (2) the availability of HCBS and affordable, accessible housing in the communities in which MFP participants wish to live; (3) reliable quality assurance and monitoring systems to reduce the potential for quality or access problems to lead to reinstitutionalization; and (4) systems to track MFP participants in Medicaid enrollment and claims files to ensure that states can submit reports and financial statements necessary to secure federal funds.

Despite the advances made so far, nearly all states are facing similar challenges to greater progress: shortages of affordable, accessible housing; insufficient HCBS workers or provider

agencies; state hiring or new-spending freezes that make it hard to replace staff who leave; and state budget cuts that require reductions in provider rates or jeopardize the availability of funds to keep people in their homes after they exhaust their 365 days of MFP benefits. The availability of additional federal dollars to support state program administrative costs will help to address this issue to some degree. However, even if the national economy improves, experience with previous economic downturns suggests that state budgets will be strained for at least another year or two. This will make it harder to add HCBS to Medicaid benefits, increase rates to expand HCBS provider supply, or support housing subsidies.

The MFP program offers extra federal funds to states to help them strengthen the HCBS system. But to generate these funds, states must first transition more people. Enhanced federal Medicaid matching funds are paid to states only after people relocate to the community under MFP transition programs and use MFP-qualified or demonstration HCBS during their first year in the community. The relatively low numbers of people transitioned through MFP in some states suggest that it may take several more years before the federal MFP "rebalancing funds" produce enough money for broader system improvements. A comprehensive assessment of states' use of MFP rebalancing funds will be provided in future reports after states begin reporting on this in the summer of 2010.

# IV. LONG-TERM CARE SYSTEMS AT BASELINE—THE BALANCE BETWEEN INSTITUTIONAL AND COMMUNITY-BASED CARE AND PRE-MFP TRANSITION RATES

To understand the outcomes of the MFP demonstration, the evaluation will assess grantees' success in achieving two primary demonstration goals: (1) rebalancing state long-term care systems; and (2) transitioning to community living long-term institutionalized Medicaid beneficiaries in nursing homes, ICFs-MR, and psychiatric facilities. To gauge the effects of the demonstration, the evaluation will in part compare post-MFP balance and transition levels with the same outcomes measured prior to the start of the demonstration. However, because HCBS programs have been expanding over the past decade (Ng et al. 2009) and nursing home and ICF-MR use has been declining (Alecxih 2006; Lakin 2009), the evaluation will also need to compare pre- and post-MFP *trends* in these outcomes to determine whether MFP was effective in achieving its goals. Although sufficient data are not yet available to evaluate the success of MFP, baseline information can be used to assess the status of state long-term care systems and identify notable pre-MFP trends in key outcomes within and across MFP grantee states prior to the demonstration. These statistics and trends provide a glimpse of the trends in long-term care that might have been seen had the MFP program not been implemented. They also provide a sense of the starting point for grantee states and the initial conditions grantees faced when they started to implement their MFP programs.

This chapter presents baseline statistics derived from Medicaid Analytic eXtract (MAX) data system on the balance of long-term care and characterizes MFP eligibles and their rates of transition to the community in the period immediately prior to its implementation—2005 through 2007. The chapter first describes trends in the balance of long-term care in grantee states, overall and by level of long-term care spending directed to HCBS. Next, data are presented that characterize trends in the population eligible for MFP, including those who will be newly eligible under Section 2403 of ACA, and their rates of transition to the community prior to the demonstration. Further details on the data and methods used to identify population subgroups and measure balance and transition rates are in the Appendix A.

*Key Findings*

- While long-term care expenditures disproportionately flowed to institutional care, HCBS use was common and growing during the three years before the implementation of the MFP demonstration. In 2005, 38 percent of all Medicaid long-term care expenditures were spent on HCBS in the MFP grantee states, although 60 percent of all long-term care users received HCBS.
    - Increases in the HCBS spending from 2005 to 2007 drove a 4 percent increase in long-term care expenditures in the grantee states, from $69.8 billion to $72.5 billion (in 2005 dollars).
- The balance of long-term care systems varied considerably across states, but most MFP grantees were rebalancing in the baseline period. Depending on the state, between 13 and 59 percent of long-term care expenditures were due to HCBS in 2005 and between 24 to 83 percent of long-term users received HCBS.

  - By 2007, 26 of 27 MFP grantee states increased HCBS spending as a proportion of all long-term care expenditures and 20 of 27 states increased the proportion of all long-term care users who received HCBS by at least 2 percent.
  - Although the growth of HCBS spending was widespread across grantee states, the gap in spending between high HCBS states (those that devoted at least 40 percent of long-term care expenditures to HCBS) and low HCBS states (those that devoted less than 30 percent of expenditures to HCBS) remained.

- The number of people who met MFP eligibility requirements declined during the baseline period, reflecting the overall general downward trend in nursing home and ICF-MR use.
  - Overall, the number of MFP eligibles declined by about 4 percent between 2005 and 2007 in the 30 MFP grantee states.
  - The change in federal statutory eligibility requirements enacted in March 2010, which eased the minimum institutional stay from 180 to 90 days (not counting Medicare rehabilitative care days), attenuated the decline somewhat. Preliminary estimates suggest the change in the institutional stay requirement will increase the number who met MFP eligibility requirements during the baseline period by no more than 12 percent in any given year.

- Medicaid beneficiaries in institutional care were transitioning to the community before the MFP demonstration was implemented.
  - Among those who met the six-month stay requirement, approximately 12 percent transitioned—2 percent used HCBS soon after the transition and 10 percent did not.
  - Among those eligible as a result of easing the institutional stay requirement from 180 to 90 days, 56 percent transitioned—9 percent used HCBS soon after the transition and 47 percent did not.
  - Elderly people in nursing homes, people in ICFs-MR, and those with longer institutional stays had the lowest rates of transition.

## A. Rebalancing Analysis

A primary goal of the MFP demonstration is to support states' efforts to modify their long-term care delivery systems to enable more people who require long-term services and supports to continue living in the community. Rebalancing long-term care delivery and spending away from an emphasis on institutional care and toward greater provision of HCBS holds the potential to increase the quality of life of many long-term care recipients while reducing Medicaid expenditures for long-term care (Kaye et al. 2009).[19] To support this goal of rebalancing, the

[19] To date, however, the evidence on whether greater emphasis on HCBS actually reduces Medicaid costs has been mixed (Grabowski 2006).

MFP demonstration mandates that a portion of the enhanced FMAP that states receive when they provide qualified and demonstration HCBS to MFP participants be reinvested in their long-term care systems to finance rebalancing efforts.

Mathematica's evaluation of the MFP demonstration will assess how the balance of long-term care spending and utilization in grantee states changes after the implementation of the MFP program. The analysis presented here establishes baseline statistics—2005 through 2007—and thus constitutes a first step in evaluating the nature and extent of rebalancing. As expenditure and utilization data during the post-implementation period become available, they will be incorporated into future reports, which will compare the balance of long-term care systems during the demonstration with the baseline statistics presented here.

The analysis of the balance of long-term care in grantee states addresses two questions:

1. How was the balance of care changing in the pre-implementation period?
2. How did states directing a disproportionate share of resources to HCBS differ from those directing disproportionate resources to institutional care?

To address these questions, two complementary sets of baseline statistics were computed both for the full population of Medicaid long-term care recipients and for selected population subgroups: (1) measures of balance in 2005 and (2) trends in balance measures from 2005 through 2007. The point-in-time statistics represent a starting point against which pre-implementation trends are assessed. Trends in this report are measured as simple unadjusted percentage changes from 2005 to 2007 and will provide the starting point for assessing whether the MFP program is associated with an acceleration of rebalancing (in states that were already rebalancing prior to MFP). Because Irvin and Ballou (2010) discuss many of the point-in-time statistics in detail, the discussion here is focused on baseline trends.

The analyses presented below focus on three primary balance measures: (1) the percentage of long-term care expenditures directed to HCBS; (2) the percentage of long-term care recipients using HCBS; and (3) HCBS spending intensity, defined as HCBS spending per HCBS user. Each of these measures alone is an imperfect indicator of the balance of a state's long-term care system,[20] but together they provide a fuller picture of how states allocated long-term care resources between institutional care and HCBS before they implemented their MFP programs.

For reasons detailed in Appendix A, data from Kentucky, Michigan, and New Hampshire were considered unreliable and were excluded from all analyses.[21]

[20] For example, a state might direct most of its long-term care expenditures to HCBS but fail to spend enough on *either* institutional care or HCBS to serve its Medicaid population adequately, and high spending intensity might sometimes reflect wasteful spending rather than generous per-user benefits.

[21] Data from Texas was also of concern. During the pre-implementation period, the MAX data for Texas showed a substantial increase in HCBS users but little change in HCBS expenditures, which resulted in a sharp drop in HCBS spending intensity for this state (Table IV.2). At the time of this report, investigation into whether these unusual changes likely reflected errors in data reporting was incomplete, and the analysis includes Texas.

### 1. Overview of the Balance of Care and Trends in Rebalancing Prior to MFP

While long-term care expenditures disproportionately flowed to institutional care during the baseline period, HCBS use was common and growing. In 2005, while 38 percent of long-term care expenditures were for HCBS, 60 percent long-term care users received HCBS. In the three years leading up to the implementation of MFP, long-term care expenditures in the MFP grantee states grew by about 4 percent, from $69.8 billion in 2005 to $72.5 billion (in 2005 dollars) in 2007. The data presented below indicate that this growth was driven by increases in HCBS spending.

**Table IV.1. The Balance of Medicaid-Financed Long-Term Care Expenditures in 2005 and from 2005 through 2007, Aggregate Across MFP Grantee States**

| Measures of Long-Term Care Systems | 2005 | Percentage Change, 2005–2007 |
|---|---|---|
| Overall Expenditure and Utilization | | |
| Total long-term care expenditures (millions of 2005 dollars) | 69,774 | +4 |
| Total HCBS expenditures (millions of 2005 dollars) | 26,524 | +12 |
| Total institutional expenditures (millions of 2005 dollars) | 43,249 | –1 |
| Number of long-term care users (thousands) | 2,741 | +3 |
| Balance Between Institutional and Community-based Care | | |
| Percentage of long-term care expenditures due to HCBS | 38 | +8 |
| Percentage of long-term care recipients who used HCBS | 60 | +4 |
| Percentage of long-term care recipients who used institutional care | 46 | –6 |
| HCBS expenditures per HCBS user (2005 dollars) | 16,094 | +5 |

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 27 MFP grantee states.

Note: Includes all MFP grantee states except Kentucky, Michigan, and New Hampshire. HCBS users include beneficiaries who received 1915(c) waiver services or nonwaiver personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care. All expenditure quantities are in 2005 dollars.

HCBS = home- and community-based services.

During the three years prior to the implementation of MFP, HCBS receipt grew among long-term care users and more long-term expenditures flowed to HCBS. The proportion of long-term care recipients using HCBS rose 4 percent, while the proportion of spending devoted to HCBS increased 8 percent. Spending per HCBS recipient increased about $837 in 2005 dollars. At the same time, the percentage of long-term care recipients using institutional care declined 6 percent.

Although these statistics are consistent with an overall rebalancing of long-term care systems toward greater provision of HCBS in grantee states, they may also reflect other trends that could lead to increased use of HCBS, decreased use of institutional care, and declines in overall long-term care utilization and spending independent of states' efforts to increase the relative emphasis on HCBS. Examples of other trends include changes in the underlying health status of long-term care users or differential price trends between institutional care and HCBS.

## 2. State-Level Summary of Selected Balance Measures

Underlying the results in Table IV.1 is wide variation in the balance of long-term care systems across states (Table IV.2). In 2005, the percentage of Medicaid-financed long-term care expenditures accounted for by HCBS ranged from 13 percent (Pennsylvania) to 59 percent (Washington), with the proportions of long-term care recipients using HCBS generally higher in states devoting a larger share of their long-term care expenditures to HCBS. The intensity of HCBS spending similarly varied broadly across states, from $8,733 per HCBS user in Oregon to $31,033 per user in New York.

**Table IV.2. The Balance of Medicaid-Financed Long-Term Care by State**

| State | Percentage of Long-Term Care Expenditures Due to HCBS, 2005 | Percentage of Long-Term Care Recipients Using HCBS, 2005 | HCBS Expenditures per HCBS User, 2005 | Percentage Change in Percentage of Long-Term Care Expenditures Due to HCBS, 2005–2007 | Percentage Change in Percentage of Long-Term Care Recipients Using HCBS, 2005–2007 | Percentage Change in HCBS Expenditures per HCBS User, 2005–2007 |
|---|---|---|---|---|---|---|
| **All States** | **38** | **60** | **16,094** | **+8** | **+4** | **+5** |
| Washington | 59 | 76 | 13,030 | +13 | +4 | +24 |
| California | 54 | 82 | 10,243 | +6 | +2 | +7 |
| Oregon | 52 | 83 | 8,733 | +1 | –1 | +18 |
| Kansas | 51 | 63 | 16,394 | +4 | +4 | +1 |
| New Hampshire[a] | - | - | - | - | - | - |
| New York | 43 | 63 | 31,033 | +5 | –2 | +12 |
| Wisconsin | 42 | 46 | 25,209 | +8 | +3 | +1 |
| North Carolina | 42 | 70 | 11,040 | +8 | +0 | +10 |
| Maryland | 39 | 57 | 20,295 | +9 | +8 | +6 |
| Missouri | 39 | 66 | 9,122 | +9 | –0 | +17 |
| Virginia | 38 | 62 | 17,043 | +12 | +9 | +8 |
| Hawaii | 37 | 50 | 25,008 | +6 | +6 | +4 |
| Iowa | 36 | 59 | 13,946 | +5 | +7 | –1 |
| Oklahoma | 36 | 52 | 13,127 | +9 | +9 | +8 |
| Nebraska | 35 | 46 | 19,532 | +3 | +3 | +1 |
| Delaware | 32 | 44 | 29,341 | +3 | +2 | +17 |
| Texas | 33 | 45 | 15,292 | +7 | +27 | –29 |
| Connecticut | 32 | 49 | 24,783 | +1 | +3 | +2 |
| Ohio | 31 | 53 | 17,950 | +14 | –0 | +10 |
| Illinois | 30 | 50 | 12,083 | +9 | +3 | +4 |
| New Jersey | 30 | 56 | 17,704 | +5 | +2 | +4 |
| Louisiana | 27 | 38 | 15,979 | +18 | +11 | +16 |
| Georgia | 27 | 44 | 13,245 | +7 | –6 | +27 |
| Indiana | 26 | 27 | 30,268 | +14 | +20 | –7 |
| North Dakota | 26 | 52 | 14,544 | +12 | +5 | +5 |
| Arkansas | 23 | 45 | 10,173 | –3 | –2 | +5 |
| Kentucky[a] | - | - | - | - | - | - |
| District of Columbia | 17 | 37 | 18,058 | +117 | +42 | +66 |
| Pennsylvania | 13 | 24 | 17,576 | +11 | +7 | +9 |
| Michigan[a] | - | - | - | - | - | - |

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 27 MFP grantee states.

Note: HCBS users include beneficiaries who received 1915(c) waiver services or nonwaiver personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care. All expenditures are in 2005 dollars.

[a] Kentucky, New Hampshire, and Michigan were excluded because their data were considered unreliable.

HCBS = home and community-based services.

Most states rebalanced toward greater provision of HCBS during the 2005–2007 period. Over three quarters of the grantee states for which reliable 2005–2007 data were available increased their share of HCBS in total Medicaid-financed long-term care expenditures by 5 percent or more, with eight increasing their share by at least 10 percent and only Arkansas experiencing a decline (3 percent). With a few exceptions, such as Washington, the largest increases occurred in states that in 2005 spent disproportionately on institutional care rather than on HCBS.

The proportion of long-term care recipients using HCBS increased in 21 of the grantee states for which reliable 2005–2007 data were available. Although trends were relatively flat for some states, several experienced substantial growth during this time, including the District of Columbia, where the number of HCBS users increased by 42 percent. Medicaid-financed HCBS expenditures per user rose in most states from 2005 to 2007 and also revealed significant interstate variation in the amount of change, from a decrease in per-user spending in 3 states to double-digit increases in 10.

### 3. The Balance of Long-Term Care in High, Moderate, and Low HCBS States

To facilitate the presentation of results and enable meaningful comparisons across states, the 27 states with reliable data were ranked according to the percentage of Medicaid-financed long-term care expenditures due to HCBS in 2005 and then grouped into three categories. The 7 states allocating 40 percent or more of their long-term care expenditures to HCBS were classified as *high HCBS* states, and the 7 states allocating less than 30 percent were classified as *low HCBS;* the 13 remaining states were designated *moderate HCBS.*

By construction, the percentage of long-term care expenditures allocated to HCBS was highest for the high HCBS states, at 47 percent, and lowest for the low HCBS states (21 percent) in 2005 (Table IV.3). During the two subsequent years, however, HCBS's share of expenditures grew more than twice as rapidly in the low HCBS states—15 percent versus 6 percent for the high HCBS states—which suggests that low HCBS states were rebalancing their long-term care expenditures more rapidly than the high HCBS states during this baseline period.

Similarly, the proportion of long-term care recipients using HCBS was substantially higher in the high HCBS states in 2005 (73 percent) than in the low HCBS states (34 percent), but growth in the proportion of long-term care recipients using HCBS was greater for the low HCBS states (6 percent) than for the high HCBS states (1 percent). Finally, although spending per HCBS user was similar across state groups in 2005—$16,229 in the high HCBS states compared with $16,514 in the low HCBS states—the low HCBS states increased their HCBS spending intensity by 13 percent, compared with an 8 percent increase in the high HCBS states.

**Table IV.3. The Balance of Medicaid-Financed Long-Term Care in High, Moderate, and Low HCBS States**

| Measure of Balance | High HCBS States, 2005 | Moderate HCBS States, 2005 | Low HCBS States, 2005 | Percentage Change for High HCBS States, 2005–2007 | Percentage Change for Moderate HCBS States, 2005–2007 | Percentage Change for Low HCBS States, 2005–2007 |
|---|---|---|---|---|---|---|
| Percentage of long-term care expenditures due to HCBS | 47 | 33 | 21 | +6 | +9 | +15 |
| Percentage of long-term care recipients who used HCBS | 73 | 53 | 34 | +1 | +7 | +6 |
| Percentage of long-term care recipients who used institutional care | 32 | 54 | 69 | –4 | –8 | –3 |
| HCBS expenditures per HCBS user (2005 dollars) | 16,229 | 15,745 | 16,514 | +8 | –1 | +13 |

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 27 MFP grantee states.

Note: Includes all MFP grantee states except Kentucky, Michigan, and New Hampshire. HCBS users include beneficiaries who received 1915(c) waiver services or nonwaiver personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care. All expenditures are in 2005 dollars.

HCBS = home and community-based services.

The low HCBS states rebalanced their long-term care systems toward HCBS during the baseline period at a greater rate than high HCBS states partly because the low HCBS states began the period at a much lower starting point.[22] By 2007, the percentages of long-term care expenditures due to HCBS and long-term care recipients using HCBS continued to be significantly lower in the low HCBS states (24 percent of long-term care expenditures and 36 percent of long-term care users, respectively) than in the high HCBS states (50 percent and 74 percent, respectively), which suggests ample room for further growth (data not shown).

[22] For example, a 5-percentage-point increase in HCBS' share of expenditures represents a 25 percent increase for a state beginning the baseline period allocating 20 percent of spending to HCBS but only a 10 percent increase for a state beginning the period with 50 percent of all long-term care spending directed to HCBS.

Moreover, the 26-percentage-point gap between the share of expenditures due to HCBS in high and low HCBS states did not change over the baseline period.

### 4. The Balance of Care for Population Subgroups

In addition to analyzing the full population of Medicaid-enrolled long-term care users, measures of balance for separate subgroups, including the elderly, nonelderly disabled, and people with developmental disabilities, were also assessed. Both high and low HCBS states increased the percentage of long-term care spending for HCBS for both the elderly and persons with developmental disabilities in the period from 2005 through 2007. High HCBS states increased the percentage of HCBS spending by 9 percent for the elderly and 6 percent for beneficiaries with developmental disabilities, while low HCBS states increased HCBS' share of expenditures by 12 percent and 11 percent for the elderly and beneficiaries with developmental disabilities, respectively (data not shown).

The percentage of spending allocated to HCBS for the nonelderly disabled increased 3 percent for the high HCBS states, compared with a 12 percent increase in the low HCBS states.

### 5. Discussion of the Analysis of Baseline Balance of Long-Term Care Systems

The results reported here and by Irvin and Ballou (2010) revealed broad variation across states in both the balance of long-term care and the size and structure of states' HCBS programs prior to the implementation of MFP. Some states allocated a large percentage of their Medicaid-financed long-term care expenditures to HCBS, made benefits available to all eligible beneficiaries through state plans, and enrolled large numbers of long-term care recipients in HCBS. Other states had more modest HCBS programs, provided HCBS to targeted populations through waiver programs, and relied more on institutional care.

In general, states were rebalancing their systems toward greater provision of HCBS before the MFP demonstration began. Nevertheless, the difference between the high and low HCBS states in the percentage of long-term care spending due to HCBS was essentially unchanged from 2005 to 2007. As a consequence, the MFP demonstration will provide low HCBS states with a significant opportunity to continue rebalancing their long-term care systems and narrow the gap with the high HCBS states.

The statistics reported here will serve as the point of reference for gauging states' success at making HCBS more accessible. Appendix A presents information on some of the technical limitations presented by the data. In addition to the technical issues discussed in Appendix A, the information presented is of limited value in making comparisons across states because they lack adjustments for interstate differences that likely influence long-term care expenditure and utilization patterns (such as differences in the cost of living and health of the population). The assessment was also unable to determine whether greater levels of spending, or relative spending, on HCBS reflect programs that are more generous, less efficient, or both, just as many studies are unable to determine satisfactorily the breadth of services available and quality of care provided through HCBS or institutions more generally. Future analyses will address some of these shortcomings—for example, by adjusting estimates for the overall infirmity of states' long-term care users—but others will remain.

## B. Transition Analysis

MFP grantees' success in rebalancing their long-term care systems will depend on their investments in HCBS, their efforts to divert people in need of long-term care from entering institutions altogether, and their ability to transition into the community those already in institutions. This section focuses on the last of these contributing factors, one of the primary aims of the demonstration: transitioning eligible enrollees from institutions to the community. Trends in the population eligible for MFP are described first, then estimates of their rates of transition before the demonstration are presented. Finally, the characteristics of people who successfully transitioned are compared with those of people who remained in institutions.

### 1. Trends in the Size of the MFP-Eligible Population

At least two national trends have the potential to affect outcomes of MFP in ways that will be challenging to address in its evaluation. First, the general decline in nursing home and ICF-MR use (Alecxih 2006; Lakin 2009) would suggest that the number of people eligible for MFP has been declining and their characteristics changing over time, although whether there has been a decline in the number of MFP eligibles (long-term institutional residents) and various targeted subgroups (elderly, physically disabled, MR/DD, and those with mental illness) has been unclear. Second, the recent economic downturn and its effect on state budgets is constraining the ability of states to implement the MFP program (Denny-Brown and Lipson 2009) and has the potential to slow state expansion of Medicaid HCBS programs and reduce Medicaid coverage more generally.

MFP eligibility requirements are also changing. Through 2009, a six-month institutional stay was required for MFP program participation. ACA has now extended MFP eligibility to people receiving institutional care for only three months (90 days), although rehabilitative care days are excluded. The next section summarizes trends for MFP eligibles who have resided in institutions for six months or more, as well as for those meeting the new three-month residence requirement. Because the new criteria had not been implemented when this report was written and only six-month residents were eligible in the first two years of the demonstration, the two groups are analyzed separately. As grantee states implement the new, more-lenient eligibility requirements, the evaluation will assess both original eligibles and MFP expansion eligibles together as well as by subgroup. People meeting the original MFP eligibility requirements are referred to as "MFP six-month stay eligibles" and the newly eligible population as "MFP expansion eligibles."

#### a. MFP Six-Month Stay Eligibles

In 2005, almost a million (963,935) Medicaid enrollees had been institutionalized for six months or more in the 30 MFP grantee states (Table IV.4). By 2006, the number of such eligibles had declined by 2 percent. It declined by another 1.6 percent (to 929,615) the next year, for an overall 3.6 percent decline since 2005. Earlier estimates based on 2004 data identified more than a million MFP eligibles in the 30 MFP grantee states (Wenzlow and Lipson 2009), which suggests that the downward trend extends beyond the three-year observation period presented in this report. Furthermore, the number of eligibles declined every year in all but three states (Arkansas, Kentucky, and North Dakota), suggesting that the trend was widespread (see Appendix Table A.10 for state-level detail).

**Table IV.4. Trends in the Number of Medicaid Enrollees Institutionalized for Six Months or More Who Would Have Been Eligible for MFP Had the Program Been in Place in 2005–2007**

| | Number of MFP Eligibles | | | Percentage Change | | |
|---|---|---|---|---|---|---|
| Measure | 2005 | 2006 | 2007 | 2005–06 | 2006–07 | 2005–07 |
| Number Institutionalized for Six Months or More | 963,935 | 944,784 | 929,615 | -2.0 | -1.6 | -3.6 |
| Nursing Home, Aged ≥65 | 731,105 | 712,345 | 697,354 | -2.6 | -2.1 | -4.6 |
| Nursing Home, Aged <65 | 137,362 | 139,353 | 141,092 | 1.4 | 1.2 | 2.7 |
| ICF-MR | 84,546 | 82,214 | 80,502 | -2.8 | -2.1 | -4.8 |
| Inpatient Psychiatric Hospital, Aged <22 | 7,362 | 7,460 | 7,215 | 1.3 | -3.3 | -2.0 |
| Mental Hospital, Aged ≥65 | 3,560 | 3,412 | 3,452 | -4.2 | 1.2 | -3.0 |

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 30 MFP grantee states.

ICF-MR = intermediate care facility for people with mental retardation.

The downward trend in the number of eligibles was driven by declines of 2 percent or more each year in the number of nursing-home residents 65 or older and people in ICFs-MR. Over the two-year period, the number of eligibles 65 or older in nursing homes declined by 4.6 percent and people in ICFs-MR declined by 4.8 percent. In contrast, the number of Medicaid beneficiaries under 65 in nursing homes for six months or more (primarily those aged 45 to 64) increased by over 1 percent each year. Combined with reduced elderly nursing home and ICF-MR use, these results imply that the composition of the MFP eligibles in terms of their age and institutional residence was changing during the baseline period. The trends in the much smaller population of MFP eligibles using Medicaid psychiatric or mental hospital care were inconsistent across years.

### b. MFP Expansion Eligibles

The ACA MFP eligibility expansion enables certain Medicaid beneficiaries receiving institutional care for less than six months to enroll in MFP. Specifically, those receiving Medicaid-covered services for three to five consecutive months (excluding periods of Medicare-covered rehabilitative service use) will now also be eligible for the MFP program. However, many beneficiaries dually enrolled in Medicaid and Medicare first enter institutions for rehabilitative care covered primarily by Medicare. Medicaid claims records often contain insufficient information for determining which months of service use are for Medicare-covered services. Therefore, the number of MFP expansion eligibles was estimated in two ways: a lower-bound measure that includes only non-dual beneficiaries receiving institutional services for at

least 90 days but less than six months, and an upper-bound measure that includes both non-dual and dual beneficiaries meeting the three-month (but not the six-month) requirement.[23]

Estimates show that between 20,000 and 112,000 Medicaid beneficiaries were eligible for MFP each baseline year under the ACA MFP eligibility expansion in the 30 grantee states (Table IV.5). This represents an increase of between 2 and 12 percent in the number of MFP eligibles over the number under pre-ACA rules. Trends in the number of expansion eligibles over the 2005–2007 period are less clear than those for six-month stay MFP eligibles, although small sample sizes and substantial variation across states may have resulted in spurious observed trends in this subgroup.

**Table IV.5. Trends in the Number of Medicaid MFP Expansion Eligibles in 2005–2007, Before the Implementation of MFP**

| | Number of MFP Eligibles | | | Percentage Change | | |
|---|---|---|---|---|---|---|
| Measure | 2005 | 2006 | 2007 | 2005–06 | 2006–07 | 2005–07 |
| Number of MFP expansion eligibles—lower bound excludes duals | 21,896 | 21,513 | 22,064 | -1.7 | 2.6 | 0.8 |
| Nursing home, aged ≥65 | 2,694 | 2,298 | 2,353 | -14.7 | 2.4 | -12.7 |
| Nursing home, aged <65 | 12,221 | 12,175 | 12,654 | -0.4 | 3.9 | 3.5 |
| ICF-MR | 743 | 693 | 954 | -6.7 | 37.7 | 28.4 |
| Inpatient psychiatric hospital, aged <22 | 5,799 | 5,951 | 5,743 | 2.6 | -3.5 | -1.0 |
| Mental hospital, aged ≥65 | 439 | 396 | 360 | -9.8 | -9.1 | -18.0 |
| Number of MFP expansion eligibles—upper bound includes duals | 112,359 | 109,945 | 108,506 | -2.1 | -1.3 | -3.4 |
| Nursing home, aged ≥65 | 82,496 | 79,998 | 77,843 | -3.0 | -2.7 | -5.6 |
| Nursing home, ages <65 | 21,863 | 21,813 | 22,563 | -0.2 | 3.4 | 3.2 |
| ICF-MR | 1,211 | 1,185 | 1,458 | -2.1 | 23.0 | 20.4 |
| Inpatient psychiatric hospital, aged <22 | 5,850 | 6,017 | 5,826 | 2.9 | -3.2 | -0.4 |
| Mental hospital, aged ≥65 | 939 | 932 | 816 | -0.7 | -12.4 | -13.1 |

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 30 MFP grantee states.

ICF-MR = intermediate care facility for people with mental retardation.

Compared to MFP six-month stay eligibles who are primarily elderly nursing home residents, non-dual expansion eligibles are far younger and more likely to reside in inpatient psychiatric hospitals (Table IV.6). The larger group of dual and non-dual expansion eligibles has characteristics that fall in between six-month stay and non-dual expansion eligibles. The extent of the true difference between the original and expansion eligibles in age and age-related

[23] Once Medicare inpatient and skilled nursing facility claims are added to the MFP Minimum Data Set, the estimates of MFP expansion eligibles will be refined to include only people with three to five months of institutional care that excludes Medicare-covered rehabilitative services.

characteristics will depend on the actual composition of those who meet the ACA rehabilitative care exclusion requirement.

**Table IV.6. Characteristics of MFP Six-Month Stay and Expansion Eligibles in 2007, Before the Implementation of MFP**

| | | MFP Expansion Eligibles (Three- to Five-Month Stay Eligibles) | |
|---|---|---|---|
| Measure | MFP Six-Month Stay Eligibles | Non-Duals | Duals and Non-Duals[a] |
| Number of Enrollees | 929,615 | 22,064 | 108,506 |
| Median Length of Institutional Stay | 691 | 125 | 124 |
| Age Distribution in January (Percentage) | | | |
| <21 | 1.6 | 31.4 | 6.4 |
| 21-44 | 6.2 | 15.4 | 4.9 |
| 45-64 | 16.2 | 42.8 | 17.5 |
| 65-74 | 13.5 | 3.2 | 14.7 |
| 75-84 | 27.5 | 3.8 | 28.3 |
| ≥85 | 34.3 | 3.4 | 28.2 |
| Sex | | | |
| Female | 66.7 | 45.7 | 62.2 |
| Male | 33.3 | 54.3 | 37.8 |
| Race Distribution (Percentage) | | | |
| White | 74.0 | 50.5 | 70.4 |
| Black | 17.4 | 29.5 | 18.6 |
| Native American/Alaskan Native | 0.5 | 1.1 | 0.6 |
| Asian | 1.5 | 1.3 | 1.6 |
| Native Hawaiian or Pacific Islander | 0.5 | 0.6 | 0.7 |
| Hispanic | 4.9 | 10.4 | 6.5 |
| Missing | 1.2 | 6.7 | 1.5 |
| Percentage Dually Enrolled in Medicare and Medicaid during the Year | 87.6 | 0.0 | 79.7 |
| Percentage Who Died during the Year | 17.4 | 6.9 | 22.2 |
| Percentage in Each Target Population | | | |
| Nursing home, aged ≥65 | 75.0 | 10.7 | 71.7 |
| Nursing home, aged <65 | 15.2 | 57.4 | 20.8 |
| ICF-MR | 8.7 | 4.3 | 1.3 |
| Inpatient psychiatric hospital, aged <22 | 0.8 | 26.0 | 5.4 |
| Mental hospital, aged ≥65 | 0.4 | 1.6 | 0.8 |

Source: Mathematica analysis of the 2007 Medicaid Analytic Extract files for 30 MFP grantee states.

[a]The number of duals and non-duals with 90- to 180-day institutional stays overestimates the number of MFP expansion eligibles, because many duals may be using Medicare-covered rehabilitative nursing home services during a portion of their stay.

### 2. Rates of Transition from Institutions to the Community Among MFP Eligibles

An important component of the MFP evaluation will be to determine the degree to which the demonstration increased transitions to the community versus provided services to people who would have transitioned without the program. Baseline transition rates were calculated as the

percentage of MFP eligibles in 2007 who used HCBS in the month or within two subsequent calendar months after their institutional stay ended (excluding people who died or used hospice during this period).[24] The percentage of eligibles who left institutions and who did not use HCBS upon completing their stay was also estimated. These beneficiaries may not need long-term care services once they leave the institution, but with the exception of those in hospitals, they would be eligible to receive HCBS if they had enrolled in MFP in 2007.[25] Because their HCBS data were considered unreliable, Kentucky, Michigan, and New Hampshire were excluded from the transition analyses.

Among MFP six-month stay eligibles, 2.1 percent (an estimated 20,000 in all MFP states) transitioned to HCBS, and an additional 9.5 percent (about 88,000) left an institution but did not subsequently use community-based long-term care services (Figure IV.1).[26] Elderly people in nursing homes and people in ICFs-MR had the lowest rates of transition to HCBS (1.6 and 2.6, respectively), whereas people under 65 in nursing homes, people under 21 in psychiatric hospitals, and elderly in mental hospitals left institutions to use HCBS at a higher rate (3.6, 5.2, and 3.6, respectively). The percentage who left an institution after a stay of six months or more but did not use HCBS varied substantially across facility, from 2.7 percent of those leaving ICFs-MR to 65.9 percent of those under age 22 leaving inpatient psychiatric facilities. Subsequent analyses will attempt to improve the estimates of transitions to non-HCBS to ensure that people receiving inpatient care or Medicare-covered skilled nursing facility care are properly excluded.

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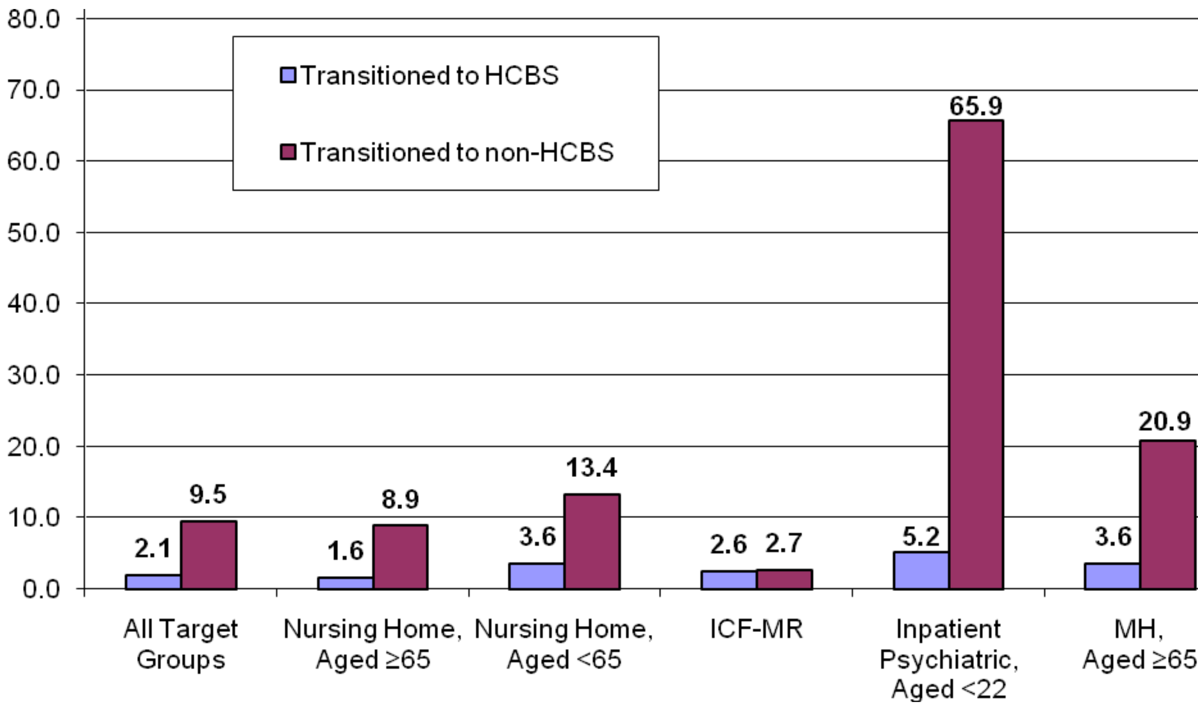
[24] The observation period was censored in December of 2007. Therefore, the transition rates may slightly underestimate the percentage of eligibles who transitioned at the end of the year. Transition rates for 2005 and 2006 were also estimated but no notable trends were observable.

[25] Future analyses will include linked Medicaid and Medicare data to distinguish beneficiaries who leave institutions to receive inpatient care from those who use other non-HCBS.

[26] The transition estimates presented in Figure IV.10 are somewhat different from those reported in Figure 2 of Wenzlow and Lipson (2009). While the latter used aggregate calendar year data and excluded people who died at any time during the year to infer transition rates, the statistics in this report are based on analyses of claims and more accurately reflect use of HCBS in the months immediately following an MFP-qualified institutional stay.

**Figure IV.1. Percentage of MFP Eligibles Who Transitioned to the Community and Used HCBS or Non-HCBS Services in 2007, Before the Implementation of MFP**



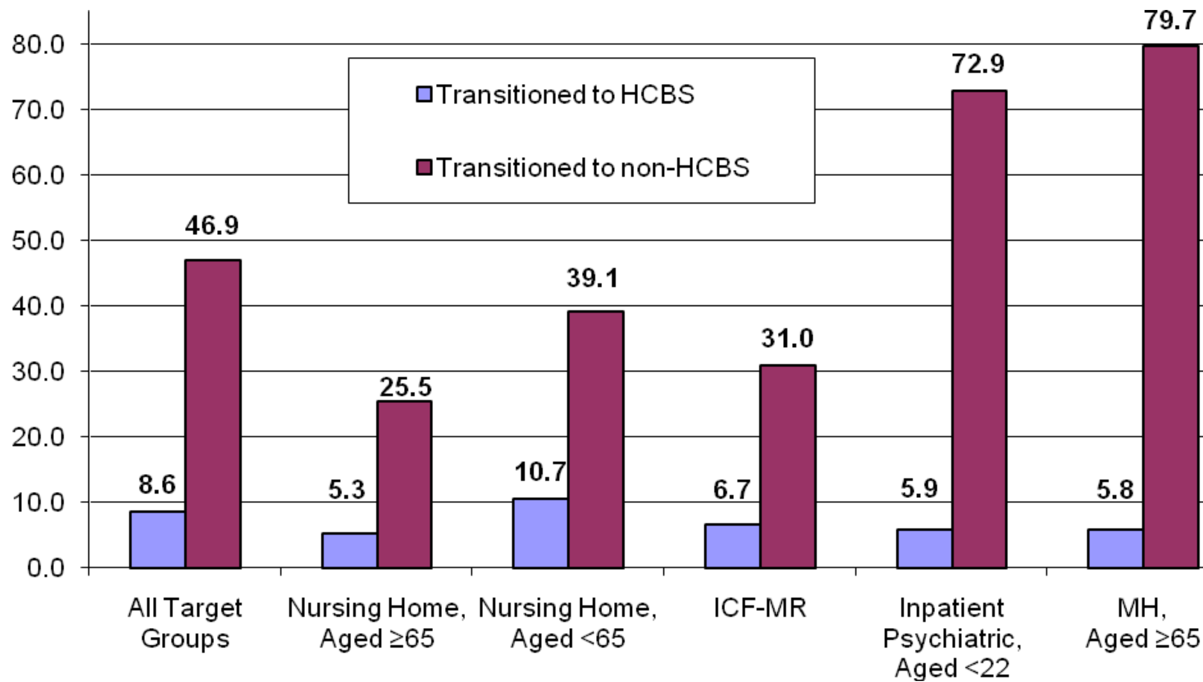

Source: Mathematica analysis of the 2007 Medicaid Analytic Extract files for 27 MFP grantee states.

Note: Includes all MFP grantee states except Kentucky, Michigan, and New Hampshire. Rates of transition to non-HCBS include transitions to inpatient care and are preliminary.

ICF-MR = intermediate care facility for people with mental retardation; MH = mental hospital.

As expected, MFP expansion eligibles transitioned at an even higher rate than eligibles who had remained in institutions for six months or more. Figure IV.2 presents 2007 transition rates for the expansion group among non-duals. Because non-duals were younger than duals and typically leave institutions at a higher rate, the estimates in Figure IV.2 should be viewed as upper-bound transition rates for expansion eligibles. Overall, 8.6 percent transitioned to HCBS, and 46.9 percent transitioned to non-HCBS. That is, more than half of non-dual expansion eligibles left institutional care in 2007, and the vast majority of these eligibles were not using Medicaid long-term care services after leaving the institution. The rates varied but were substantially higher than those for six-month stay eligibles across the age and facility subgroups.

**Figure IV.2. Percentage of Non-dual MFP Expansion Eligibles Who Transitioned to the Community and Used HCBS or Non-HCBS Services in 2007, Before the Implementation of MFP**




Source: Mathematica analysis of the 2007 Medicaid Analytic Extract files for 30 MFP grantee states.

Note: Includes all MFP grantee states except Kentucky, Michigan, and New Hampshire. Rates of transition to non-HCBS include transitions to inpatient care and are preliminary.

ICF-MR = intermediate care facility for people with mental retardation; MH = mental hospital.

### 3. Characteristics of MFP Eligibles by Transition Status

To facilitate understanding of the types of beneficiaries who typically transition to HCBS and those who would not transition without assistance, Table IV.7 summarizes the demographic, eligibility, and service use characteristics of MFP six-month stay eligibles and MFP expansion eligibles (for non-duals only) by transition status in 2007 for the 27 states with reliable HCBS data. Those who transitioned to either HCBS or non-HCBS care had shorter institutional stays and were far younger than beneficiaries who remained in institutions among both the six-month stay eligibles and the non-dual expansion group. For those who had been in institutions for six months or more, median length of stay was 455 days (about 15 months) for people who transitioned to HCBS non-HCBS, but over two years for those who remained in institutions. Over 16 percent of people who transitioned to HCBS were under age 45, compared with 11.9 percent of those transitioning to non-HCBS and only 7.5 percent of those who remained in institutions. The three subgroups also varied in characteristics correlated with age. Beneficiaries who transitioned were more likely to be male, more likely to be black or Hispanic, and less likely to be enrolled in Medicare or to die during the year. Compared to those who remained in institutions, a larger percentage were under 65 and had been residing in a nursing facility or receiving psychiatric care during their institutional stay.

Similar patterns were evident among non-dual MFP expansion eligibles, although differences between those who transitioned to HCBS versus non-HCBS were more pronounced. For example, among those who transitioned but did not use HCBS, 46.6 percent were under age 21, compared with only 22.8 percent for beneficiaries who transitioned to HCBS and 17.9 percent of those who remained in institutions. The results suggest that many potential MFP expansion eligibles are likely to be quite young, often receive care in psychiatric hospitals, and seldom use Medicaid HCBS after leaving an institution. Differentiating those needing long-term care from those not needing it, both in practice and in the evaluation, may be challenging, depending on how the new MFP minimum residency requirements are implemented by the grantee states.

**Table IV.7. Characteristics of MFP Eligibles in MFP Grantee States in 2007 by Transition Status, Before the Implementation of MFP**

| | MFP Six-Month Stay Eligibles (Institutionalized for ≥6 Months) | | | | Non-dual MFP Expansion Eligibles (Institutionalized for 3-5 Months) | | | |
|---|---|---|---|---|---|---|---|---|
| Measure | All | Remained in Institution | Transitioned to HCBS | Transitioned to Non-HCBS | All | Remained in Institution | Transitioned to HCBS | Transitioned to Non-HCBS |
| Number of Enrollees | 872,702 | 771,651 | 17,928 | 83,123 | 20,873 | 9,287 | 1,795 | 9,791 |
| Median Length of Institutional Stay | 691 | 729[a] | 455 | 455 | 125 | 128 | 123 | 123 |
| Age Distribution in January (Percentage) | | | | | | | | |
| <21 | 1.7 | 1.1 | 4.4 | 6.1 | 31.8 | 17.9 | 22.8 | 46.6 |
| 21-44 | 6.5 | 6.4 | 11.9 | 5.8 | 15.5 | 14.4 | 19.2 | 15.8 |
| 45-64 | 17.3 | 17.0 | 24.9 | 18.7 | 42.7 | 52.2 | 52.1 | 32.0 |
| 65-74 | 13.5 | 13.3 | 15.6 | 15.2 | 3.2 | 4.5 | 2.5 | 2.2 |
| 75-84 | 27.2 | 27.3 | 24.9 | 26.8 | 3.6 | 5.4 | 2.4 | 2.0 |
| ≥85 | 33.8 | 34.9 | 18.3 | 27.4 | 3.2 | 5.4 | 1.1 | 1.5 |
| Sex | | | | | | | | |
| Female | 66.4 | 66.9 | 63.0 | 62.2 | 45.6 | 45.5 | 50.3 | 44.8 |
| Male | 33.6 | 33.1 | 37.0 | 37.8 | 54.4 | 54.5 | 49.7 | 55.2 |
| Race Distribution (Percentage) | | | | | | | | |
| White | 73.3 | 74.1 | 65.5 | 67.3 | 49.5 | 51.7 | 52.2 | 46.9 |
| Black | 17.7 | 17.1 | 22.6 | 21.8 | 29.7 | 30.2 | 27.2 | 29.7 |
| Native American/Alaskan Native | 0.5 | 0.5 | 0.5 | 0.6 | 1.1 | 0.8 | 1.2 | 1.4 |
| Asian | 1.5 | 1.5 | 1.5 | 1.5 | 1.3 | 1.7 | 1.6 | 0.9 |
| Native Hawaiian or Pacific Islander | 0.5 | 0.5 | 0.5 | 0.5 | 0.7 | 0.7 | 0.6 | 0.7 |
| Hispanic | 5.2 | 5.0 | 6.8 | 6.6 | 10.9 | 8.4 | 10.3 | 13.5 |
| Missing | 1.3 | 1.2 | 2.7 | 1.6 | 6.7 | 6.4 | 6.9 | 6.9 |
| Percentage Dually Enrolled in Medicare and Medicaid During the Year | 87.3 | 88.2 | 77.5 | 80.6 | 0.0 | 0.0 | 0.0 | 0.0 |
| Percentage Who Died during the Year | 17.3 | 18.2 | 8.2 | 10.7 | 7.0 | 14.4 | 1.7 | 1.0 |

**Table IV.7** *(continued)*

| | MFP Six-Month Stay Eligibles (Institutionalized for ≥6 Months) | | | | Non-dual MFP Expansion Eligibles (Institutionalized for 3-5 Months) | | | |
|---|---|---|---|---|---|---|---|---|
| Measure | All | Remained in Institution | Transitioned to HCBS | Transitioned to Non-HCBS | All | Remained in Institution | Transitioned to HCBS | Transitioned to Non-HCBS |
| Percentage in each Target Population | | | | | | | | |
| Nursing home, aged ≥65 | 74.3 | 75.2 | 58.8 | 69.5 | 10.3 | 16.0 | 6.4 | 5.6 |
| Nursing home, aged <65 | 15.4 | 14.5 | 27.1 | 21.6 | 57.3 | 64.7 | 71.1 | 47.8 |
| ICF-MR | 9.1 | 9.8 | 11.4 | 2.6 | 4.5 | 6.3 | 3.5 | 3.0 |
| Inpatient psychiatric hospital, aged <22 | 0.8 | 0.3 | 2.0 | 5.5 | 26.2 | 12.5 | 17.8 | 40.7 |
| Mental hospital, aged ≥65 | 0.4 | 0.3 | 0.7 | 0.9 | 1.7 | 0.6 | 1.2 | 2.9 |

Source: Mathematica analysis of the 2007 Medicaid Analytic Extract files for 30 MFP grantee states.

Note: Includes all MFP grantee states except Kentucky, Michigan, and New Hampshire. Transitions to non-HCBS include transitions to inpatient care and are preliminary.

ICF-MR = intermediate care facility for people with mental retardation.

[a] Length of stay was censored at 2 years.

### 4. Discussion of the Analyses of Baseline Transitions

In summary, the number of MFP eligibles declined by about 2 percent each year between 2005 and 2007—the pre-MFP baseline period—primarily among elderly beneficiaries residing in nursing homes and people in ICFs-MR. At the same time, the number of nursing home residents under 65 has been rising. These changes, along with the ACA regulations that expand MFP eligibility to people institutionalized for only 90 days (excluding rehabilitative services), have the potential to substantially affect the demonstration and the results of its evaluation.

If the pre-MFP trends (observed in all but three states) continue throughout the demonstration period, the MFP-eligible population will decline substantially, with young people in nursing homes representing an ever-larger portion of those eligible for the program. These eligibles tend to transition to community settings and use HCBS at almost twice the rate of the two subgroups that have been declining in number (elderly nursing home residents and people in ICFs-MR). Furthermore, as ACA eligibility changes are implemented, the downward trend in number of eligibles will be attenuated somewhat, but the increasing size and share of the disabled young population among eligibles will be bolstered. The patterns seen in the data seem to suggest that the new ACA MFP expansion will extend MFP eligibility to beneficiaries who were more likely to leave institutions and use HCBS before the implementation of the program.

In addition to the expansion of HCBS and the reduced use of nursing home care, there are several other potential explanations for the decline in the number of MFP eligibles. The analyses presented exclude enrollees in the Program of All-Inclusive Care for the Elderly and other managed long-term care programs, and to the degree to which these programs have been expanding over the baseline period, the trend statistics will be biased. Also, between 2005 and 2006, there was a 1 percent decline in the number of elderly and disabled Medicaid beneficiaries who were eligible for full Medicaid benefits, which suggests that general Medicaid enrollment declines (whether due to changes in state policies or to characteristics of population) are contributing to the trend.

If the pace of the decline seen in the baseline period continues throughout the demonstration period, the number of MFP eligibles who have resided in institutions six months or more are projected to decline from over a million in 2004 to about 900,000 by 2009, and to just 800,000 by 2016, when the demonstration is scheduled to end. Depending on how the new eligibility expansion requirements are implemented, an additional 12,000 to 110,000 people may be eligible for the program each year. However, changes in state budgets, as well as health care reforms that are expected by 2014, could also affect the trend moving forward.

The changing policy environment is likely to affect the types of people enrolled in MFP and will make it critical that appropriate comparison groups are identified to evaluate the program. As Medicaid and Medicare service use data and the Nursing Facility Minimum Database become available, the evaluation will assess the extent to which adequate comparison groups can be identified. Future reports will compare program outcomes during the demonstration with the baseline statistics presented here.

# V. QUALITY OF LIFE AT BASELINE—ASSESSMENT OF QUALITY OF LIFE BEFORE THE TRANSITION TO COMMUNITY LIVING

Concern over quality of life (QoL) in institutional settings has been a driving force in long-term care policy for several decades. The MFP program is based on the premise that many institutionalized Medicaid beneficiaries prefer to live in the community and could do so if they had adequate support, and that such an arrangement would cost Medicaid less than it currently spends for institutional care. A key assumption of the MFP demonstration is that community-based care will enhance beneficiaries' QoL. Consequently, monitoring MFP participants' QoL is a critical aspect of the evaluation of the MFP demonstration.

This chapter reports on the QoL of MFP participants before they transitioned to community living, and by doing so, it identifies the baseline, or institutional, status of participants' QoL. [27] As a result, the analyses identify target populations and subgroups of MFP participants with the potential to show the largest (and smallest) gains in QoL when they transition to community living. Following a brief description of approaches to survey administration and the data used for this report, this chapter describes MFP participants' pre-transition QoL along six domains: (1) life satisfaction, (2) satisfaction with living arrangements, (3) unmet need for or access to personal care, (4) respect and dignity, (5) choice and control, and (6) community integration and inclusion. Within each domain, key measures are examined and how they vary by target population is assess. In addition, how each measure is associated with life satisfaction is analyzed.

*Key Findings*

- The majority of MFP participants were happy with the way they lived their lives and the care they received during the weeks and days before transitioning to community living, but there is room for improving satisfaction. About 60 percent were satisfied with their lives and 71 percent were happy with the care they received.
- People transitioning from ICFs-MR reported relatively high levels of life satisfaction at baseline compared to those transitioning from nursing homes (74 percent compared to 56 to 57 percent). The difference seen across the different targeted populations may be partly explained by differences in the use of proxy respondents, who reported higher levels of satisfaction than self-responders.
- Higher life satisfaction in an institution was associated with liking where they lived, getting needed assistance, being treated with respect by people who helped them, and having more choice and control over how they lived day to day.
    - Among respondents who liked where they lived, 78 percent were satisfied with their lives in the institution.

[27] *Quality of life* refers here to participants' direct reports of satisfaction with the way they live their life, satisfaction with the care they receive and their living situation, access to personal care, help with activities of daily living, feelings of respect and dignity, adequacy of community integration, and mood.

- About 85 percent of respondents needed assistance with bathing, meals, medications, and using the bathroom, and unmet need for this assistance was strongly correlated with life satisfaction. Respondents with no reported unmet needs had life satisfaction that was nearly eight times higher than those with unmet need in three of four areas.
- Among respondents who reported that staff treated them as they wanted and listened to them, 70 percent were satisfied with their lives.
- Some respondents reported that while in institutional care they could not participate in community activities and sometimes missed medical care because they had no way of getting to an appointment. Only 49 and 45 percent respectively who faced these restrictions were satisfied with their lives.
- The degree of choice and control someone had over their life was associated with life satisfaction. Respondents with choice and control in five or six areas of their lives were two and half times more likely to be satisfied with life than respondents who reported no areas of choice or control

## A. Background

While the key point is to determine the QoL at baseline, before MFP participants transition to the community, other key research questions addressed in this chapter include:

- How well do institutional settings serve MFP participants just prior to their transition to the community, and how does this differ by target population? The expectations for changes associated with participation in the MFP program have to be steeped in the reality of participants' baseline experiences. If, at baseline, participants express a high degree of satisfaction with their living arrangements, it will be more difficult to show subsequent improvement in QoL. In this case, the analysis will need to focus on the maintenance of QoL.
- Which domains and items of QoL are most closely associated with life satisfaction ratings for MFP participants? Examination of these pre-transition relationships will help guide future analyses of how QoL changes after the transition to community living. In addition, the information may help grantees focus on those factors that maximize participants' QoL.

QoL is measured with the MFP-Quality of Life (MFP-QoL) survey administered by grantees. The instrument is based largely on the Participant Experience Survey, though a few items are drawn from other instruments.[28] Grantees are instructed to administer the MFP-QoL instrument at three points: at baseline, defined as immediately prior to transition from an

[28] These 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.

institution, and at one and two years post-transition.[29] The survey is being administered by grantees through in-person interviews with participants or their proxies using survey and data collection instruments provided by Mathematica.

### 1. The Survey

The MFP-QoL instrument captures seven aspects of participants' QoL, and the findings in this chapter are organized around the six key domains that are measured: (1) life satisfaction, (2) satisfaction with living arrangements, (3) unmet need for or access to personal care, (4) respect and dignity, (5) choice and control, and (6) community integration and inclusion. Data concerning mood are also collected by the survey but are not reported as a key domain at baseline. Future reports will examine change in mood status associated with transition.

The analyses use the baseline QoL data that states collected through December 2009 and had submitted to CMS by the end of March 2010. As Chapter III presents, although MFP grantees began transitioning participants in October 2007, program startup was slower than anticipated, and the analyses below represent the first opportunity the evaluation has had to assess the baseline QoL for a sufficient number of participants.[30]

### 2. Survey Administration

Grantees are responsible for survey administration, data entry, tracking, and transmission of the data to CMS. The survey, which takes about 20 minutes to administer, consists of 41 questions and is designed to be conducted in person and in a private setting.[31]

Administration of the survey via a proxy respondent is permitted. Most surveys were answered by the participant, without assistance (65.4 percent). Another 17.0 percent of participants received assistance from someone other than the surveyor, and 17.6 percent of surveys were completed by a proxy respondent. The use of proxies varied widely by target population; rates of proxy use were significantly higher among ICF-MR respondents, where 48.0 percent of all interviews were completed by proxies. Proxy use was considerably lower among nursing home residents (6.9 percent of those under 65 and 10.1 percent of those 65 and older). Rates of survey assistance followed the same pattern as proxy use: highest among residents of ICFs-MR (30.8 percent) and lowest among younger nursing home residents (10.4 percent).

Methods and staff used to administer the survey vary by state, as reported elsewhere. Grantees use one of four staff types to administer the instrument and collect QoL data: (1)

[29] Grantees are instructed to administer the MFP-QoL survey immediately prior to transition and no later than two weeks post-transition. Overall, 93.3 percent of all respondents contacted were surveyed in an institution and are therefore included in our analyses. The other 6.7 percent were surveyed in the community and excluded from this analysis.

[30] As of December 2009, MFP grantees transitioned 5,673 participants. When this report was written, the evaluation had 5,488 baseline surveys on hand.

[31] Of the 41 questions in the survey, 6 are not relevant to an institutional setting and are not collected during the baseline interview. Three other questions assess abuse and neglect and are optional.

transition coordinators, (2) private contractors (such as universities), (3) office-based staff, and (4) volunteers. Use of transition coordinators is the most common approach, followed by use of office based-staff and private contractors. Only one grantee relied on a volunteer model.

### 3. The Data

The analytic sample for this report was restricted to 1,890 baseline surveys (conducted prior to the transition to community living) that could be matched with administrative data.[32,33] Data in this report were drawn from baseline surveys conducted with MFP participants from program inception through December 2009 and represent 25 of the 30 grantees.[34] Because ratings of QoL on baseline surveys conducted post-transition are significantly different from those conducted in institutional settings, the analytic sample included only those surveys conducted while participants were institutionalized (Simon et al. 2009).[35]

Table V.1 shows the analytic sample construction and the number of cases excluded because of lack of (1) participant identifiers in survey data, or (2) matching identifiers in administrative data. Overall, the analysis sample represents 37.0 percent of participants with administrative data confirming participation in MFP. Several factors contribute to the low matching rate. At program startup, the survey was not administered to many of the first MFP participants, as grantees were not always prepared for the speed with which some participants transitioned; this problem was compounded by the simultaneous lag in establishing formalized procedures for identifying and gaining access to participants prior to transitions. For example, some participants transitioned more quickly than an assessor could reach them for an interview in the institution. Second, some states had trouble submitting their data on time, and such difficulties can affect the availability of either the QoL data or the administrative data. Third, Medicaid identifiers in the QoL data are not always recorded properly, and without accurate identifiers, the QoL data cannot be linked to administrative data.[36] Last, a small percentage of cases were dropped because the baseline interview was not completed in an institutional setting (6.7 percent).

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[32] Enrollment records from the MFP Program Participation Data files were used to identify program participation and membership in specific target population groups. Due to missing information in the survey and administrative data, the number of missing responds varies by question.

[33] Because the sample available for analysis does not necessarily represent the full MFP population, results must be interpreted cautiously and are subject to change.

[34] The remaining five grantees submitted QoL data; however, their survey data could not be matched with administrative data due to inaccuracies in the identifiers provided with the quality of life data (Kentucky and Michigan) or missing administrative data (Arkansas, Louisiana, and Virginia).

[35] As noted earlier, the evaluation had 5,488 baseline surveys at the time of this report. This much larger number includes baseline surveys for people who had not transitioned to community living as of December 30, 2009. Because it is critical that the survey be completed before the transition, grantees are allowed to conduct the baseline interview several months before the transition occurs. In addition, states are reimbursed $100 for each QoL survey conducted, regardless of whether the beneficiary transitions to the community. As a result, the evaluation is expected always to have more baseline surveys than can be linked to administrative data.

[36] For security, identifiable data are kept to a minimum on the QoL instrument; Medicaid identifiers are the only method used to track participants.

**Table V.1. Analytic Sample Construction**

| Number of Records | Description |
|---|---|
| 5,103 | Administrative records with participation data |
| 2,026 | Administrative records linked with a baseline QoL survey |
| 1,890 | Final analytic sample: administrative records linked with a baseline QoL survey conducted in institutional setting |

Source: MFP Program Participation Data files and QoL data files representing program operations through December 2009.

Nursing home residents under 65 were the largest target population group in the analytic sample (37.9 percent), followed by elderly nursing home residents (27.5 percent) and residents of ICFs-MR (21.0 percent) (Table V.2).[37,38] Compared to the population that successfully transitioned through MFP during the same period (as reported in Chapter II), the analytic sample under-represents ICF-MR residents and elderly nursing home residents. The analytic sample was diverse in terms of age, with nearly half of all respondents between 45 and 64 (45.4 percent). A sizable proportion of participants was under 45 (19.9 percent), of which 9 percent were under 22. Data from five states constituted 55 percent of the sample: Texas (13.7 percent), Ohio (13.4 percent), Pennsylvania (10.6 percent), Washington (8.9 percent), and Missouri (8.3 percent) (Appendix B, Table B.1, provides state-level information).

**Table V.2. Sample Demographics**

| Characteristics | N | Percentage |
|---|---|---|
| **Total** | 1,890 | 100.0 |
| Site of Institutionalization (Target Population) | | |
| Nursing home, residents aged 65 and older | 520 | 27.5 |
| Nursing home, residents under age 65 | 717 | 37.9 |
| ICF-MR residents | 396 | 21.0 |
| IMD residents[a] | 3 | 0.2 |
| Unknown | 254 | 13.4 |
| Age | | |
| <22 | 33 | 1.8 |
| 22-44 | 342 | 18.1 |
| 45-64 | 859 | 45.4 |
| 65-74 | 287 | 15.2 |
| 75-84 | 198 | 10.5 |
| ≥85 | 148 | 7.8 |
| Unknown | 23 | 1.2 |
| Sex | | |
| Male | 955 | 50.5 |
| Female | 933 | 49.4 |
| Unknown | 2 | 0.1 |

[37] Data on participant race were not available for analysis but will be examined in subsequent reports.

[38] A nontrivial percentage (13.4 percent) of the sample did not have information available on site of institutionalization.

**Table V.2** *(continued)*

Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia.

[a] Because the number of IMD residents is small, these cases are not reported in subsequent tables.

ICF-MR = intermediate care facility for the mentally retarded; IMD = Institutions for mental disease.

## B. Pre-Transition QoL

This section describes findings across the domains measured by the MFP-QoL instrument, which is administered prior to transition to the community. Findings for key domain outcomes are reported by the target population but otherwise data are pooled across target populations to maximize analytic power. All differences, unless noted, are significant at $p<.01$. Appendix B contains additional tables showing the number of participants by grantee and valid number of observations for each question.

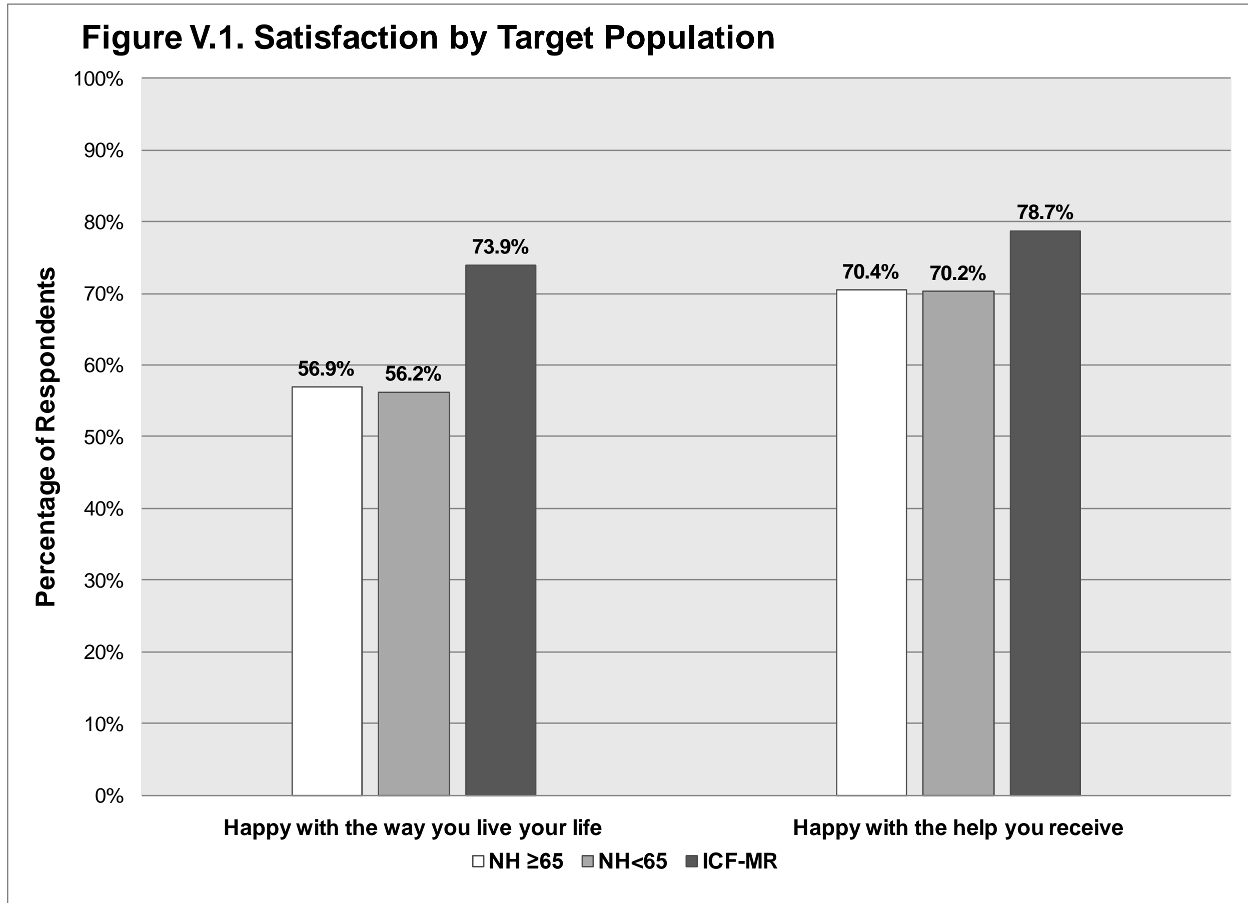
### 1. Life Satisfaction

Participant satisfaction is a fundamental concern for all MFP stakeholders. The MFP-QoL survey assesses satisfaction through two broad measures of general satisfaction. Life satisfaction is assessed with respect to the way respondents live their life, and specific to the care they receive in the institution. The life measure of satisfaction is the central outcome used to infer participant satisfaction with life.[39]

Taken together, about 60 percent of the institutionalized population reported feeling "happy with the way they live their life" (60.4 percent) (table not shown).[40] Life satisfaction was highest among MFP participants residing in ICFs-MR (73.9 percent). Elderly and younger nursing home residents reported much less contentment with the way they lived their life, with 56.9 percent of elderly and 56.2 percent of younger nursing home residents reporting the same level of life satisfaction. Overall, 71 percent of respondents indicated they were satisfied with the care they received (71.0 percent). Satisfaction with care received in the institution followed a pattern similar to, but less pronounced than, that observed for life satisfaction, with residents of ICFs-MR reporting higher levels of satisfaction with care received compared with the other target populations (Figure V.1).

[39] This question reads, "Taking everything into consideration, during the past week have you been happy or unhappy with the way you live your life?"

[40] For all measures, refusals are excluded and responses of "don't know" are included in denominators.




Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia.

Because residents of ICFs-MR reported the highest life satisfaction and satisfaction with care, and because a significant proportion of ICF-MR residents relied on proxy respondents, the association between the use of a proxy respondent and overall life satisfaction ratings was examined for each target population. The presence of a proxy respondent had differential effects on the report of life satisfaction for each target population. Among residents of ICFs-MR, where a proxy was used for nearly half of all surveys, proxies were significantly more likely than self-reporting respondents to indicate life satisfaction (Table V.3).[41] In contrast to the findings for residents of ICFs-MR, proxy-reported life satisfaction was lower than self-reported life satisfaction among elderly (p=.10) and younger nursing home residents.

[41] Details concerning the relationship between proxy and respondent are not available.

**Table V.3. Percentage of Participants Reporting Satisfaction with Life, by Proxy Status and Target Population**

| | Percentage of Participants Reporting They Are Happy with the Way They Live Their Life[a] | |
|---|---|---|
| Target Population | Respondent: Participant/Assisted (N = 1,278) | Respondent: Proxy (N = 273) |
| Nursing home aged 65 or over | 62.2 | 34.1 |
| Nursing home under age 65 | 57.8 | 45.5 |
| ICF-MR | 74.1 | 93.2 |

Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia.

[a] Proxy status was unknown for 339 respondents.

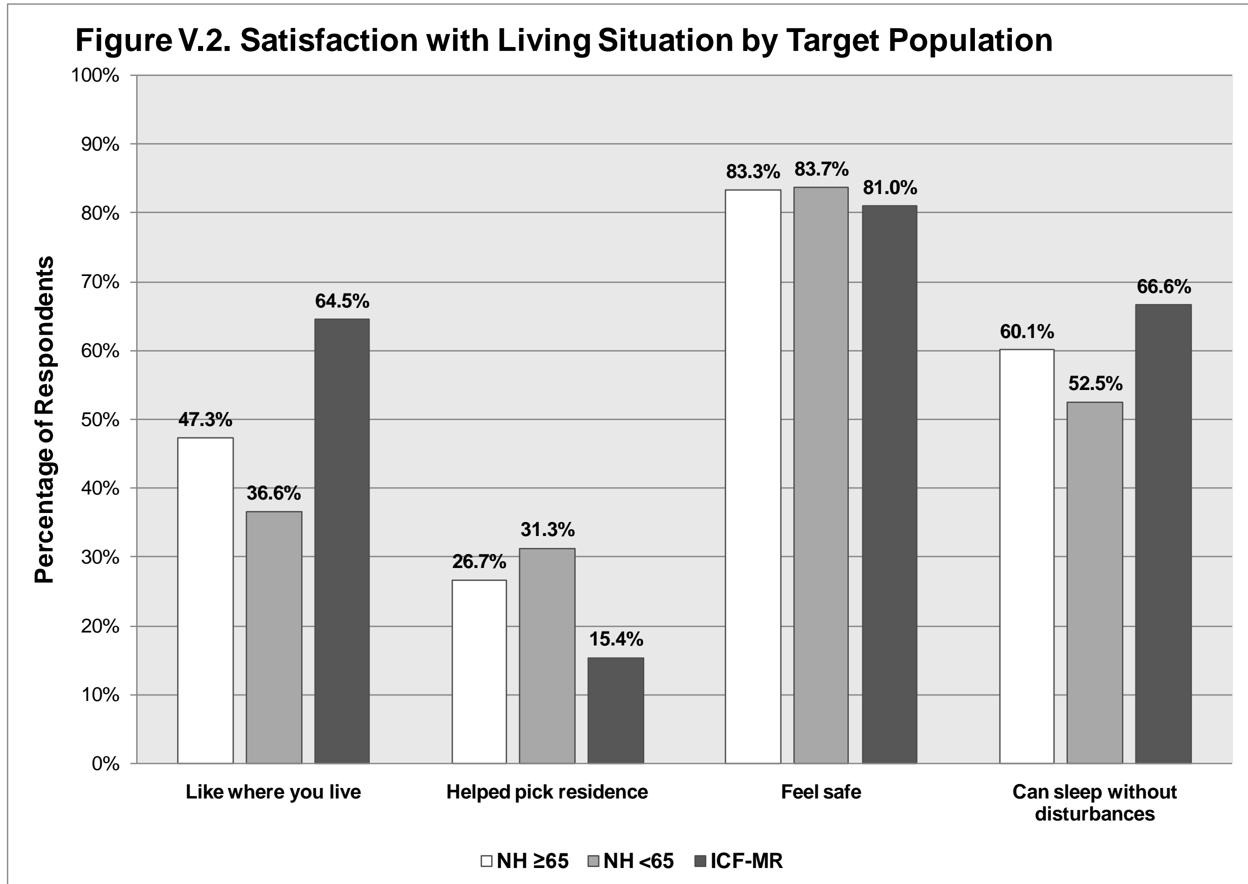
Differences between male and female participant ratings of overall life satisfaction were not significantly different (61.4 percent and 57.3 percent, respectively, p=.072). Irrespective of site of institutionalization, age was negatively correlated with life satisfaction. Life satisfaction was highest among those under age 21 (69.7 percent) and lowest among participants 85 and older (54.5 percent) (data not shown).

## 2. Living Situation

Four items from the MFP-QoL instrument relate to participants' satisfaction with their current (institutional) living arrangement. Of these, indication of whether respondents like where they live is the primary outcome measure.

Overall, less than half of all residents reported liking where they lived (45.1 percent) (data not shown). Residents of ICFs-MR were most likely to report that they liked where they lived (64.5 percent) compared to participants in nursing homes (47.3 percent among elderly residents and 36.6 percent among residents under 65) (Figure V.2).

Among items assessed in this domain, liking the living arrangements showed the strongest relationship with life satisfaction (Table V.4). Participants who liked where they lived were most likely to report satisfaction with care received and to have helped choose the institution (data not shown).




Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia.

**Table V.4. Association Between Living-Situation and Life Satisfaction**

| Living-Situation Domain Items | N | Percentage Reporting Life Satisfaction |
|---|---|---|
| Sample Mean | | 60.4 |
| Like where you live | 827 | 78.1 |
| Helped pick residence | 464 | 64.0 |
| Feel safe | 1,495 | 65.0 |
| Can sleep without disturbances | 1,057 | 69.2 |

Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia. Reported number of observations represents participants indicating an affirmative response to the question.

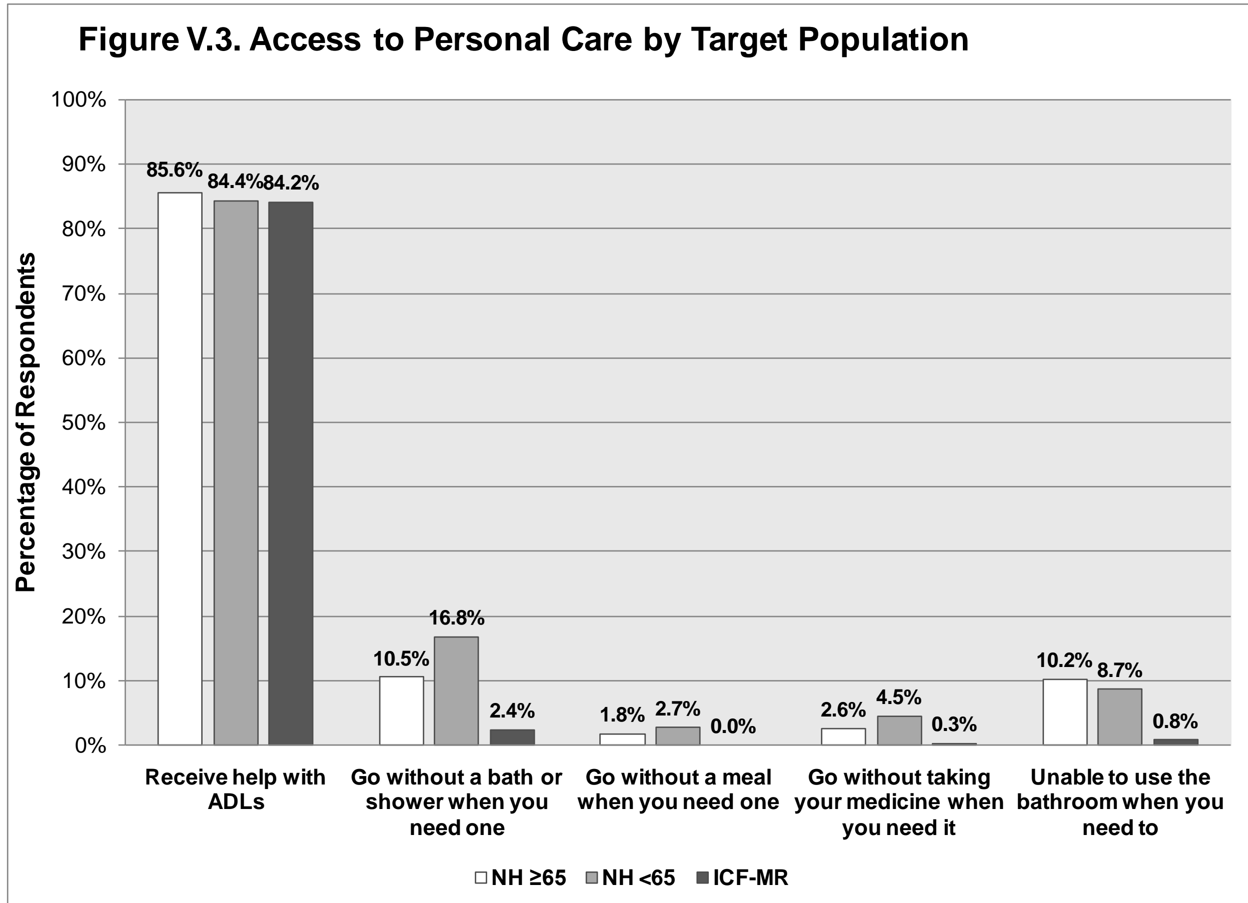
### 3. Access to Personal Care

A prominent feature of institutional care is direct access to assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). While community residence offers more freedom, a notable shortcoming of community-based care is the inconsistent availability of paid and unpaid caregivers who provide essential assistance with ADLs and IADLs. This section reports whether participants receive help with ADL or IADLs and whether respondents have any unmet ADL/IADL needs in (1) bathing, (2) meal preparation, (3) medication management, or (4) toileting. Unmet needs are defined as ever going without a particular activity because of a lack of assistance.

As expected, most institutionalized participants (84.7 percent) received ADL assistance (data not shown). Nursing home residents were slightly more likely than residents of ICFs-MR to receive help.

Most participants who received assistance did not report access to care issues (82.3 percent, data not shown). Younger, physically disabled nursing home residents were the most likely to go without personal care in three of four areas (Figure V.3).[42] The most common activities that did not occur owing to a lack of assistance were bathing and toileting. Lower levels of access to bathing assistance were most common for young nursing home residents, whereas poor access to toileting assistance was more common among elderly nursing home residents.

[42] The MFP-QoL instrument assesses whether ADLs did not occur because of a lack of assistance.




Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia.

**Table V.5. Association Between Access to Personal Care and Life Satisfaction**

| Access to Personal Care Domain Items | N | Percentage Reporting Life Satisfaction |
|---|---|---|
| Sample Mean | | 60.4 |
| Receive Help with Activities of Daily Living | 1,540 | 58.3 |
| Go Without a Bath/Shower[a] | 192 | 36.5 |
| Go Without a Meal[a] | 31 | 29.0 |
| Go Without Taking Medicine[a] | 49 | 40.8 |
| Unable to Use Bathroom When Needed[a] | 128 | 28.9 |
| Unmet Need in | | |
| Three of four areas[a] | 12 | 8.3 |
| Two of four areas[a] | 57 | 33.3 |
| One of four areas[a] | 224 | 40.5 |
| Does not go without care[a] | 1,361 | 64.0 |

Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia. Reported number of observations represents participants indicating an affirmative response to the question.

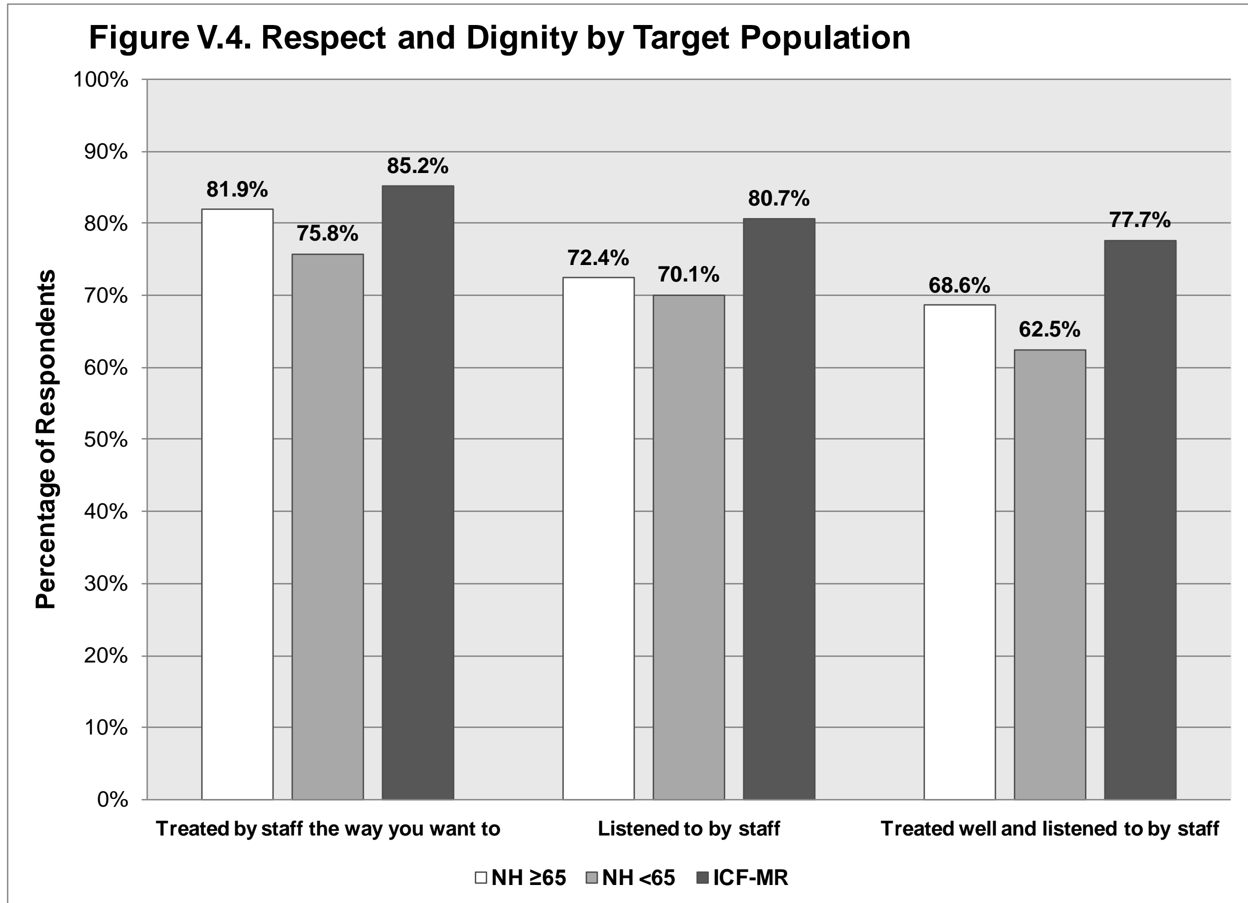
[a] Participant goes without care because of a lack of available assistance.

Reduced access to care demonstrated a strong (negative) correlation with satisfaction with the care received. Overall, 71.4 percent of participants were happy with the care they received, but only 32.3 percent of those who went without a meal because of the lack of assistance were satisfied with their care (data not shown). Satisfaction with care has a strong negative correlation with the number of unmet care needs. Among participants without any unmet care needs, 76.8 percent reported being happy with the care they receive, while among participants with three areas of unmet care needs, only 16.7 percent were satisfied with their care (data not shown).

### 4. Respect and Dignity

Institutional settings have structured systems designed to maintain and enhance the respect and dignity of residents (such as states' annual survey and certification process). Once transitioned to the community, MFP participants lose some of these safeguards. Thus, it is important to assess how participants rate their feelings about the way they are treated once they are living in the community. For participants who receive help from facility staff, whether they felt that they were treated with respect and dignity was captured by two items. These measures summarize whether participants are treated how they wish to be treated and are listened to.

Overall, the majority of participants reported being treated with respect and dignity. Residents of ICFs-MR were most likely to acknowledge being well treated and listened to by staff, whereas nursing home residents under 65 were least likely (Figure V.4).




Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia.

Both measures of respect and dignity—being treated well and listened to by staff—were also significantly associated with life satisfaction, whether people were satisfied with the way they live their life. Two of every three respondents who reported being treated well or listened to by staff were happy with their life (Table V.6).

Physical abuse was reported by 4.7 percent of all participants, with slightly higher rates reported by younger residents of nursing homes (5.0 percent).[43] Elderly nursing home residents were least likely to report physical abuse (4.1 percent) (data not shown).

[43] Although optional, this question was answered by 1,549 respondents.

**Table V.6. Association Between Respect and Dignity and Life Satisfaction**

| Respect and Dignity Domain Items | N | Percentage Reporting Life Satisfaction |
|---|---|---|
| Sample Mean | | 60.4 |
| Treated by Staff as You Want to Be | 1,363 | 66.1 |
| Listened to by Staff | 1,246 | 67.6 |
| Treated by Staff as You Want to Be *and* Listened to | 1,146 | 69.9 |
| *Not* Treated by Staff as You Want *and* Not Listened to | 238 | 26.5 |

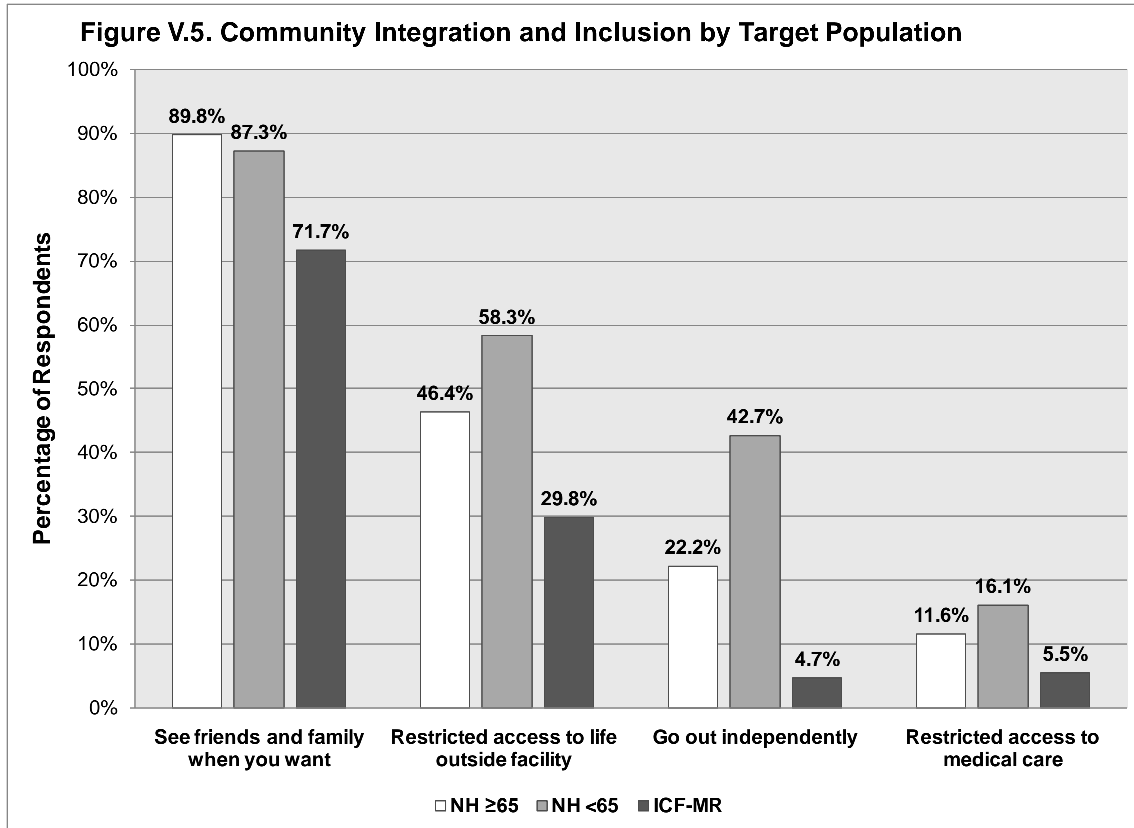
Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia. Reported number of observations represents participants indicating an affirmative response to the question.

### 5. Community Integration and Inclusion

Community integration is expected to be a critical goal for many MFP participants. Just under half of all MFP participants reported wanting to do something outside the institution that they could not currently do (48.2 percent) (data not shown). Figure V.5 shows that among all MFP participants, younger nursing home residents were the most likely to express a desire to do things outside the facility (58.3 percent). Younger nursing home residents were nearly twice as likely as elderly ones and nine times more likely than residents of ICFs-MR to leave the facility independently.[44]

[44] The question is: "When you go out, can you go by yourself or do you need help?"




Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia.

Items assessed in the community integration domain showed associations with life satisfaction (Table V.7). Participants who reported they did not receive or could not get to needed medical care were least likely to report satisfaction with the way they lived their life.

**Table V.7. Association Between Community Integration and Life Satisfaction**

| Community Integration Domain Items | N | Percentage Reporting Life Satisfaction |
|---|---|---|
| Sample Mean | | 60.4 |
| Can See Friends and Family | 1,526 | 62.1 |
| Can Get to Places You Need to Go | 1,507 | 63.5 |
| Something that You Want to Do Outside Facility But Cannot | 874 | 49.2 |
| Go Out Independently | 475 | 61.3 |
| Missed Medical Appointments | 218 | 44.9 |

Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia. Reported number of observations represents participants indicating an affirmative response to the question.

### 6. Choice and Control

A significant advantage to community-based care is the potential for enhanced participant choice and control. Six questions address participants' overall choice and control concerning activities associated with their living arrangement.

Residents of ICFs-MR reported lower levels of choice and control compared with nursing home residents in four of six areas assessed (Figure V.6). Lowest overall levels of choice and control were observed for choices related to what and when participants ate. Most participants were able to go to sleep and watch TV when they wanted.

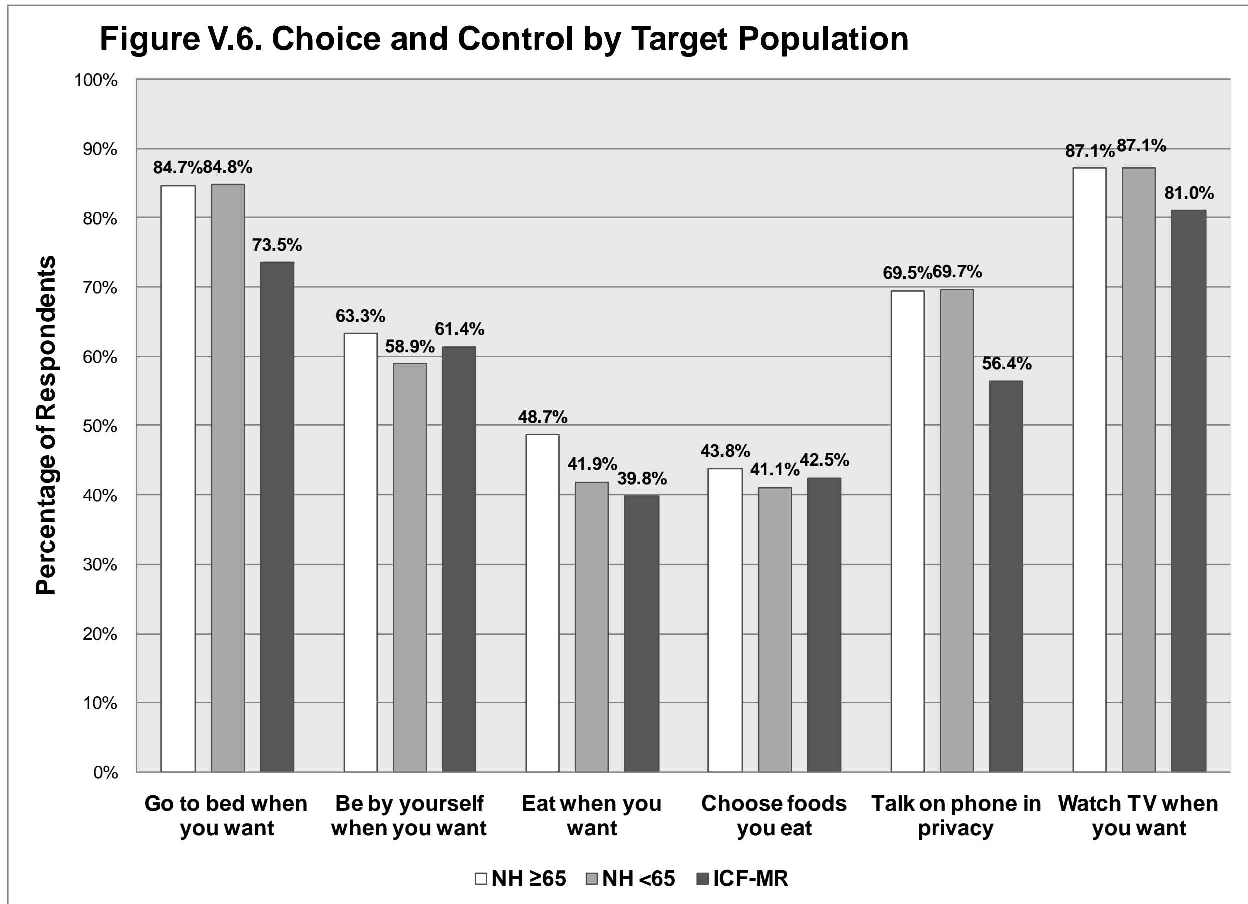


**Figure V.6. Choice and Control by Target Population**

Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia.

Each of the six areas of choice and control was significantly related to life satisfaction (Table V.8). For any given area of choice, life satisfaction was higher than average. For example, among those who reported they could be alone when they wanted, 67.0 percent were satisfied with the way they lived their life compared to an overall average of 60.4 percent. The degree of choice and control that respondents reported was significantly associated with general satisfaction. Participants with choice and control in five or six areas were two and half times more likely to report life satisfaction than were participants who reported no areas.

**Table V.8. Association between Choice and Control and LIfe Satisfaction**

| Choice and Control Domain Items | N | Percentage Reporting LIfe Satisfaction |
|---|---|---|
| Sample Mean | | 60.4 |
| Can Go to Bed When You Want | 1,488 | 63.2 |
| Can Be Alone When You Want | 1,117 | 67.0 |
| Can Eat When You Want | 792 | 69.8 |
| Can Chose Foods You Eat | 767 | 68.2 |
| Can Talk on the Telephone in Private | 1,202 | 64.6 |
| Can Watch TV When You Want | 1,553 | 61.8 |
| Sum of Choice and Control Items | | |
| 5-6 areas | 668 | 73.7 |
| 1-4 areas | 1053 | 51.8 |
| 0 areas | 58 | 29.3 |

Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia. Reported number of observations represents participants indicating an affirmative response to the question.

## C. Conclusions and Implications

The majority of MFP participants reported feeling happy with their life and the care they received. Residents of ICFs-MR were more likely than those in nursing homes to report general life satisfaction and satisfaction with care. In addition, ICF-MR residents more often provided positive responses to questions specific to each of the other domains representing aspects of QoL, though some exceptions included responses concerning community integration and inclusion and satisfaction with living arrangements.

Life satisfaction was associated with most measures within specific domains representing various aspects of QoL. This finding reflects the multifaceted and interrelated nature of QoL. To the extent that MFP is able to address and improve these individual aspects of life (such as satisfaction with living arrangements, caregivers who listen and treat participants as they wish, provision of highest-possible choice and control, maintaining access to medical care), the program should be able to maintain and potentially increase QoL for participants who transition to the community (Table V.9).

**Table V.9. Participant Characteristics Associated with Life Satisfaction**

| Characteristics Associated with Highest Life Satisfaction | Characteristics Associated with Lowest Life Satisfaction |
|---|---|
| Participant likes where they live<br><br>Treated well and listened to by staff<br><br>5 or 6 areas of choice and control reported | Go without 2 or more areas of care because of lack of assistance<br><br>Missed medical appointments |

Source: Mathematica analysis of linked baseline MFP-QoL surveys and MFP Program Participation data through December 2009.

Note: Excludes data from Arkansas, Kentucky, Louisiana, Michigan, and Virginia.

### 1. Limitations

The analyses presented have several limitations. First, the sample represents 37 percent of all participant records submitted by grantees where a record of MFP participation exists. As noted previously, there are several reasons why a large proportion of cases did not enter the analysis sample. Mathematica has been working with and continues to work with grantees to improve data reporting and submission practices.

The analytic sample also is dominated by a small group of states, over half of the sample (55 percent) is made up of participants from Ohio, Pennsylvania, Texas, and Washington. Therefore, the findings are driven largely by participants from these programs and may not be representative of the MFP program as a whole. Further, as previously noted, the sample under-represents ICF-MR residents and elderly nursing home residents As states continue to improve their data collection and submission processes, future samples for analyses of QoL should become more representative of the MFP demonstration program.

Survey administration also creates challenges for the analysis of these data. As described elsewhere, how states administer the MFP-QoL surveys varied by grantee. For example, some states are using highly trained people with experience in survey research, others are relying on state staff with no formal survey training. The bulk of grantees utilize transition coordinators or case managers to conduct the assessment.

Proxies were used prominently by residents of ICFs-MR (nearly half of all respondents). In ICFs-MR, proxy-reported life satisfaction was significantly higher than responses obtained through direct assessment. While not an explicit limitation of our analysis, others have observed that proxy reporting is most useful for objective, observable aspects of QoL (Addington-Hall and Kalra 2001; Allen and Mor 1997; Sprangers and Aaronson 1992). Any bias related to the use of an interview proxy will likely affect the magnitude of change in QoL once people transition to community-based settings. Analyses of changes in QoL over time will account for proxy status using regression-based approaches.

### 2. Implications

For all residents, it is assumed that participants, once transitioned from an institution into a community setting, will experience an enhanced QoL because their living situation is more

home-like in terms of greater autonomy and enhanced community integration. The strength of the association between life satisfaction, which this analysis considered the strongest bellwether for QoL, and key measures for the other aspects of QoL captured in the MFP-QoL survey suggests that enhancing the latter will positively affect the former. However, because access to personal care and medical care and respectful treatment by caregivers also have significant associations with life satisfaction, the quality and adequacy of care in the community will be paramount to maintaining or improving life satisfaction for MFP participants.

With lower levels of satisfaction with life, care, and current living situation and a higher interest in activities outside the institution, younger nursing home residents have the potential to show the greatest gains in post-transition QoL. However, these anticipated gains are at least partially contingent on unmet needs being addressed or reduced once participants have transitioned to the community. Conversely, because a greater proportion of ICF-MR residents reported higher levels of life satisfaction, it is very possible that they will experience comparatively smaller gains in overall life satisfaction than either nursing home target population.

# VI. CONCLUSIONS

The Money Follows the Person demonstration provides participating states an important opportunity to improve access to community-based long-term services and supports. MFP programs are increasing access to HCBS both through transition programs and rebalancing initiatives. To fulfill the promise that MFP holds for giving all Medicaid beneficiaries now living in institutions the choice to live in the most integrated setting possible will hinge on whether states are able to bring their programs to full scale and supply the housing and community-based services that beneficiaries who transition to community living need. Success will also be determined by the ability of MFP programs to serve beneficiaries in the community on a long-term basis, beyond the 365-day MFP eligibility period, and to do so at less cost than if participants had remained in institutional care. In addition, MFP programs will have to balance the enhanced choice and control that community living offers beneficiaries with sound management of the inherent risks of community living.

## A. Early Implementation Results

The early results from the implementation analysis of the MFP demonstration indicate that the majority of the state grantees have been slow to launch their MFP programs. While the first transitions from institutional to community-based care began in late 2007, the number of transitions facilitated by MFP programs only began to accelerate in the second half of calendar year 2008. The growth in the monthly number of MFP transitions continued throughout calendar year 2009 and by the end of the year the 30 grantee states had transitioned a cumulative total of 5,673 Medicaid beneficiaries. Participants were equally split between the elderly, nonelderly with physical disabilities, and beneficiaries with developmental disabilities. Approximately two-thirds of participants are working-age adults (between 21 and 65 years of age).

States are clearly struggling to achieve the transition goals they established for themselves. As Chapters II and III describe, and reported in more detail in Denny-Brown and Lipson (2009), about two-thirds of the grantee states began MFP transitions later than anticipated because of problems or delays related to federal planning and data reporting requirements. The early implementing states typically had more experience with transition programs and more capacity to serve the populations targeted by the MFP program than later implementing states. About half of the grantee states have reported that a lack of affordable and accessible housing have hindered their progress and several programs began later than expected as a result of delays in implementing new or modified HCBS waiver programs that would serve MFP participants. More than a third of states reported challenges related to the capacity of their community-based services and supports that resulted from shortages of direct service workers or providers and insufficient supply of HCBS.

While it is still too early to determine which program features matter the most to the success of MFP programs, the initial information available suggests the importance of (1) having Medicaid HCBS waiver programs that can accommodate MFP participants (or policies that assure money can follow the person from the institution to the community regardless of waiver capacity); (2) the availability of HCBS and affordable, accessible housing where MFP

participants want to live; (3) well functioning quality assurance and monitoring systems that quickly address issues related to quality of care or access to services; and (4) information systems that program managers can use to track MFP participants and manage program activities.

## B. Long-Term Care Systems at Baseline

Analyses of data from the years leading up to the implementation of MFP reveal that while HCBS use was common, in the majority of grantee states institutional care accounted for a disproportionate amount of Medicaid expenditures for long-term care. In 2005, 60 percent of the 2.5 million Medicaid beneficiaries receiving long-term care in the MFP grantee states used HCBS. However, HCBS constituted only 38 percent of the $69.8 billion in Medicaid-financed long-term care expenditures. Nevertheless, baseline trends suggest that states were already slowly making progress at rebalancing their long-term care systems before they began to implement MFP.

### 1. State Long-Term Care Systems

During the three years leading up to the first MFP transitions, the percentage of long-term care recipients using HCBS increased by four percent and Medicaid-financed long-term care spending directed to HCBS increased by eight percent. This progress was wide spread across the grantee states, but the 26 percentage point gap between the high and low HCBS states in the proportion of long-term care spending due to HCBS was essentially unchanged from 2005 to 2007.

### 2. The Eligible Population

Baseline trends also indicate that in the three years leading up to MFP the number of Medicaid beneficiaries who met the eligibility requirements for MFP was on a downward trend, consistent with other research that shows overall declines in nursing home and ICF-MR use. The recent federal statutory changes in eligibility criteria that reduced the institutional stay requirement from 180 to 90 days (not counting Medicare rehabilitative care days) will increase the number of people eligible for the program. Preliminary estimates suggest this change will result no more than a 12 percent increase in the number of MFP eligibles.

Regardless of the size of the MFP eligible population, some beneficiaries who would have been eligible for MFP during the baseline period were transitioning to community living. Estimates indicate that about 12 percent of the MFP eligible population transitioned during the baseline period. Programs face the challenge of increasing their baseline transition rates, while ensuring the transitions they effect are successful and MFP participants are able to stay in the community after their MFP benefit period ends.

## C. Quality of Life at Baseline

The first analyses of the baseline QoL data collected by MFP grantees indicate that the majority of participants were satisfied with the way they lived life in the institution (60 percent), although there were large differences in life satisfaction across different groups. Those in ICFs-MR were much more satisfied with their lives than those in nursing home care (74 percent

compared to 56 to 57 percent). The data indicate that life satisfaction is enhanced when survey respondents liked their living arrangements, got the assistance they needed with activities of daily living, were treated with respect by the staff who care for them, could connect with the community and access medical services, and had some choice and control over aspects of their daily lives such as eating meals or being alone when they wanted. While the data suggest room for improving the quality of life of MFP participants, they also suggest that do so MFP programs will need to ensure the living and service arrangements they establish in the community are satisfactory and that the programs effectively manage the risks and quality of care in community settings while providing the choice and control that many MFP participants are seeking.

## D. Future Analyses

It is still too soon to assess fully the impacts of the MFP demonstration. The evaluation of the MFP demonstration has only begun and a great deal of work remains to understand the impacts and outcomes of this program. Under recently adopted legislations, the MFP demonstration has been extended and will run through the end of 2016 and the MFP grantees will receive funding through 2020. As a result, the evaluation will need to track the progress of the grantee states and estimate program impacts and outcomes over a longer period than originally planned.

### 1. Tracking Implementation

The implementation analyses, which will be ongoing throughout the demonstration, will continue to track state achievement of their transition goals. The work will expand to include the tracking of state HCBS expenditures and state achievements of their HCBS spending goals as this information becomes available. The implementation analysis will also continue to track the challenges the grantee states face. While some challenges experienced in the initial years are likely to persist, grantees will also face new challenges as their programs mature. Grantees are likely to face other challenges as they seek to leverage the rebalancing funds they accumulate as MFP participants use qualified and demonstration HCBS.

Monitoring how states adapt their programs to the changing policy environment and how they weather the current fiscal crisis will also be critical to understanding the achievements of MFP programs. MFP continues to be a dynamic program with recent changes in program eligibility requirements and the level of funding available. In addition to the changes introduced by ACA, during 2009 CMS clarified the conditions under which assisted living facilities may be consider qualified residences and made more funding available to cover administrative costs. State grantees may now apply for funding to cover the costs for housing and community living specialists. The intention of this funding is to provide states with resources to help them develop leadership in these areas and to enhance their ability to pursue statewide policies and initiatives related to affordable and accessible housing and community integration issues for people who are frail or have considerable medical needs or disabling conditions.

In addition, at the time of this report work was beginning on identifying the ingredients of successful transition programs. With 30 states implementing 30 different transition programs, MFP offers an opportunity for developing insights into how transition programs move beneficiaries to community living successfully. Success may be defined in various ways, but for purposes of this evaluation, it means low rates of people returning to institutional care, low rates

of preventable emergency room visits and hospitalizations, and high quality of life. The first step to assessing the ingredients of successful transition programs will be to identify programs that have above average results on these three dimensions: (1) low reinstitutionalization rates, (2) low preventable emergency room visits and hospitalizations rates, and (3) gains in participants' quality of life. These states will be compared to another group of grantees that are not achieving the same level of participant outcomes, and differences in how the programs operate, the populations served, and they types of HCBS offered to MFP participants will be analyzed. The results of this comparison will be used to identify best practices that other states can apply.

### 2. Measuring Trends in State Long-Term Care Systems

Identifying state-level outcomes that result from the MFP demonstration will be based on tracking the trends in state long-term care systems from the baseline period throughout the life of the demonstration. Therefore, the state-level trends presented in Chapter IV will be tracked each year as more data become available. The initial focus of this work will be on determining whether the trends that were seen in the baseline period shift during the MFP demonstration period. Of particular interest will be whether the growth in HCBS spending as a percentage of total Medicaid long-term care spending continues or accelerates after MFP was implemented. Because the start up of transition programs has been slower than anticipated and many of the rebalancing initiatives did not begin immediately, many of the state-level impacts that result from the MFP demonstration may appear in later years. Future analyses will also refine those presented in this report to better control for state differences in the health status of the targeted populations and other programs that may be affecting the balance of spending and use between institutional and community-based care.

### 3. Estimating Program Impacts

As all state grantees complete the initial implementation stage and their transition programs mature, the evaluation will evolve and begin the process of estimating program impacts. To measure impacts, the evaluation of the MFP demonstration will compare the outcomes of MFP participants to those of two comparison groups drawn from the baseline period. The assessment of the size of the MFP eligible population at baseline and the estimates of baseline transition rates presented in this report reflect the initial steps needed to construct these comparison groups. As described in Brown et al. (2008), the two comparison groups will include Medicaid beneficiaries who would have been eligible for MFP if the program had existed during the baseline period. One comparison group will include Medicaid beneficiaries who transitioned during the baseline period and the other will be a group of beneficiaries who met the MFP eligibility requirements but did not transition.

The eligibility requirements for MFP changed in 2010 and now require state grantees to exclude Medicare rehabilitative days of care when determining whether someone meets the minimum requirement of 90 days in institutional care. As a result, the identification of the comparison groups will require the linking of Medicaid and Medicare records for those dually eligible for both programs. Thus, the next steps in this work will include linking in Medicare claims records, a process that was started but not completed at the time of this report. If possible, the record linkage step will also include records from the Nursing Home Minimum Data Set to allow the development of indicators that could be used to adjust for differences in level of need for both the comparison groups and MFP participants.

### 4. Measuring the Change in Quality of Life

As more MFP participants complete their first year of community living, the focal point of the quality of life analyses will shift to how life satisfaction and other indicators (such as access to community activities and mood) change after MFP participants have been living in the community for at least a year. While the assessment of changes in quality of life will focus on how life changes in a general sense, the evaluation will track how potentially positive changes in choice and control and access to community activities are balanced with potentially negative changes in access to personal assistance and medical appointments. Grantees are collecting quality of life information at three points in time—just before the transition to community living and twice after the transition (one and two years later). It is anticipated that the next annual report will estimate the changes in quality of life that occur one year after the transition. By that time, grantees should have completed the one-year follow-up interviews with everyone they had transitioned through 2009.

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# APPENDIX A

# REBALANCING AND TRANSITION ANALYSIS METHODS

# REBALANCING AND TRANSITION ANALYSIS METHODS

This appendix provides technical details regarding the use of MAX data to construct baseline statistics for the rebalancing and transition analyses that appear in Chapter IV.

## A. DEFINITIONS OF LONG-TERM CARE USERS AND SUBGROUP POPULATIONS

### 1. Institutional Care and HCBS Users

For the rebalancing analysis, we defined an *institutional care user* in a given year as any person with a service claim from a nursing facility, intermediate care facility for the mentally retarded (ICF-MR), inpatient psychiatric hospital, or mental hospital for the elderly in any month of that year. We defined an *HCBS user* in a given year to be any person with a claim for a waiver service or one of six different state plan services in any month of that year.[45]

Because we cannot adequately observe expenditures and utilization for people when they are enrolled in managed long-term care programs, we excluded from all analyses anyone who was enrolled in a Program of All-Inclusive Care for the Elderly or other managed long-term care program during the calendar year. Moreover, we included in the analysis only fee-for-service expenditures attributable to individuals, as opposed to services billed in bulk.

### 2. HCBS Enrollees and HCBS Users

For our analysis, we distinguished between HCBS *enrollees*—people enrolled in a 1915(c) waiver program or receiving HCBS services—and HCBS *users* (defined above). Several states report large numbers of Medicaid beneficiaries enrolled in waiver programs but having no claims. Some might have enrolled in waiver programs but not used any services. Others might have incurred claims for services that were not included in MAX files. Thus, when determining whether HCBS is accessed through waivers, state plans, or a combination, we consider all HCBS "enrollees." However, when examining expenditure-related measures of balance or comparing institutional and home or community-based care, we consider only HCBS "users"—those who had at least one HCBS claim during the calendar year. The vast majority of HCBS enrollees were also classified as HCBS users (94 percent in 2005 and 2006; 96 percent in 2007).

### 3. Likely Long-Term Care Users

Not all users of institutional care or HCBS are necessarily long-term care users. For example, short stays in nursing facilities might represent post-acute rather than long-term care. Similarly, people who use certain types of HCBS only infrequently might not be true long-term care users. Ultimately, it is the true long-term care users—and not simply the institutional care or HCBS users—that will be of interest in evaluating the effectiveness of the MFP demonstration.

[45] The state plan services were home health care if received for three months or more, hospice or private-duty nursing care if received in the home, personal care, adult day care, and residential care.

However, MAX data do not permit a definitive determination of which institutional care or HCBS users were true long-term care users. On the institutional side, we considered excluding people whose nursing home stays never exceeded three months during a calendar year, but we ultimately decided to follow the common practice in the literature of analyzing all Medicaid-financed institutional care expenditures, with the caveat that some of them likely represent cost-sharing expenditures for episodes of post-acute care with Medicare as the primary payer.

### 4. MFP Eligibles

For the transition analysis, we determined a beneficiary's MFP eligibility status by length of stay in an institutional care setting. MFP-eligible beneficiaries were defined as those who had resided in an institution for six months (181 days) or more at any time during the year. Because spells can span multiple years, we examined service use in the previous year to determine a beneficiary's length of stay. We defined MFP expansion beneficiaries as those who had resided in an institution for three months or more but less than six months (90 to 180 days) during the year. As discussed in detail in Chapter IV, the new ACA MFP provision extends MFP eligibility to beneficiaries with three months or more of non-rehabilitative (post-acute) care. Medicaid data do not always allow us to differentiate periods of Medicaid service use from rehabilitative Medicare service use. Therefore, we used non-dual MFP expansion eligibles as a lower-bound estimate, and the total of beneficiaries institutionalized for three months or more as an upper-bound estimate of the number of people newly eligible for MFP under ACA.

### 5. MFP Target Populations and Other Subgroups

The elderly, the nonelderly disabled, people with MR/DD, and people with chronic mental illness (CMI) were defined as follows. People who had at least one claim from an ICF-MR or were enrolled in a waiver program for MR/DD were classified as having MR/DD. Of the rest, those with at least one claim from a mental hospital for the elderly or an inpatient psychiatric hospital, as well as people enrolled in a waiver program for mental illness, were classified as having CMI. Among those not classified as having either MR/DD or CMI, people 65 and older were classified as elderly and those under 65 as nonelderly disabled. Because people with CMI typically constituted less than 1 percent of HCBS users, our analysis of subgroup populations in the rebalancing analysis focused on the elderly, the nonelderly disabled, and people with MR/DD only.

We used age at the end of the analytic year and type of service used at the end of the institutional care spell to define the five institutional target populations for the transition analysis. Age is measured in years and is rounded down to the nearest whole number. The five groups are nursing home (65 or older), nursing home (under 65), ICF-MR (all ages), inpatient psychiatric hospital (21 or younger), and mental hospital (65 or older).

## B. STATE GROUPINGS AND EXCLUSIONS

### 1. Grouping States into Categories Based on Percentage of Long-Term Care Spending Allocated to HCBS

Following Irvin and Ballou (2010) and Kaye et al. (2009), we ranked states according to the percentage of Medicaid-financed long-term care expenditures devoted to HCBS, separating the

states into groups based on their ranking. We designated all states devoting more than 40 percent of their Medicaid long-term care expenditures to HCBS as high HCBS, states spending less than 30 percent as low HCBS, and states spending between 30 and 40 percent as moderate HCBS. Prior to implementing exclusion criteria (discussed in the next section), there were 8 states in the high group, 13 states in the middle group, and 9 states in the low group.

We considered two other methods of grouping states. The first was to form groups based on natural break points in the rankings—that is, to look for three natural clusters of ranked states separated by sizable gaps in the percentage of long-term care expenditures due to HCBS. The second was to form groups of approximately equal numbers of states (tertiles). The natural break points considered under the first alternative were 50 percent and 40 percent (to separate high from moderate HCBS states) and 20 percent (to separate moderate from low HCBS states). The 50 percent break point would have yielded only four high HCBS states, whereas the 40 percent break point yielded eight—one of which, New Hampshire, was ultimately excluded from analysis—the same number as our adopted approach. The 20 percent break point would have resulted in only three low HCBS states, including Michigan, which was also excluded. Because we sought to emphasize comparisons between high and low HCBS states, we rejected this approach in favor of others that yielded larger numbers in the high and low categories. The second approach, of separating the states according to tertiles, generated results qualitatively similar to those reported in the chapter.

### 2. Exclusions

We excluded states from the rebalancing and transition where we believed the data to be unreliable, judged by comparison to data from CMS Form 64 and Form 372. To gauge reliability, we compared our 2005 ranking of states to a ranking generated by Burwell and colleagues (2009) from 2005 Form 64 expenditure data and identified the four states ranked more than five places apart in the two rankings: Indiana, New Hampshire, Michigan, and Texas. Of these four, HCBS expenditures as measured in the Form 64 data exceeded expenditures measured in the MAX data by 78 percent in Michigan. Moreover, the number of beneficiaries enrolled in 1915(c) waivers in the MAX data exceeded waiver counts from the Form 372 data, as reported by Ng and Harrington (2010), by 34 percent in New Hampshire. Known waiver claims reporting problems in Kentucky in 2006 and 2007 make the number of users and/or expenditures unreliable. Given these problems, Michigan, New Hampshire, and Kentucky were excluded from the transition and rebalancing analyses. However, because the data issues in these states only affected only waiver expenditures or enrollment, not institutional care, we include all MFP states when presenting the total number of MFP eligible beneficiaries at baseline.

After all exclusions were applied there were 7 high HCBS states (California, Kansas, New York, North Carolina, Oregon, Washington, and Wisconsin), 13 moderate HCBS states (Connecticut, Delaware, Hawaii, Iowa, Illinois, Maryland, Missouri, Nebraska, New Jersey, Ohio, Oklahoma, Texas, and Virginia), and 7 low HCBS states (Arkansas, District of Columbia, Georgia, Indiana, Louisiana, North Dakota, and Pennsylvania) in the rebalancing analysis. Because California and New York are both large states that spend heavily on long-term care, the results reported for high HCBS states, and their comparisons with other groups, were heavily influenced by the inclusion of these two states in the high HCBS group.

## C. EXPENDITURES

HCBS expenditures included claims for 1915(c) waiver services and those for personal care services, home health care, residential care, adult day care, private duty nursing, and hospice care. Moreover, for anyone who was identified as an HCBS user, we also included claims for rehabilitation, targeted case management, durable medical equipment, and transportation.

Using the Consumer Price Index for All Urban Consumers (CPI-U), we deflated to 2005 levels all expenditure measures considered in the rebalancing analysis. We did this to allow the reported trends to more meaningfully capture changes over time in resource use alone, rather than changes in both resource use and inflation. We also considered deflating according to the Consumer Price Index's Medical Care and Shelter series but opted for the CPI-U because it was the more comprehensive series, capturing both medical costs and shelter, as well as changes in other prices.[46]

Because the rebalancing analysis emphasizes comparisons both across states and over time, we considered adjusting expenditures for differences in the cost of living across states. Unfortunately, a suitable comprehensive measure that indexes living costs across states is not currently available. While the Bureau of Labor Statistics does compute separate price indices for different areas of the United States, it does so only at the Census Region level and explicitly states that these indices are not designed to make inter-regional comparisons. The Council for Community and Economic Research maintains the ACCRA Cost of Living Index, which does permit comparisons across states, but this index is designed to reflect the purchasing patterns of more affluent Americans and therefore is not well suited for measuring cross-state variations in living costs for Medicaid beneficiaries.

## D. ESTIMATING TRANSITIONS FROM INSTITUTIONS TO THE COMMUNITY

If an MFP-eligible beneficiary had multiple spells that could qualify him or her for MFP, we examined in our transition analysis the first spell ending during the year. To account for missing claims, we allowed a one-calendar-month gap between claims within a spell. For example, if a beneficiary had a claim that began on February 2, 2006, and ended on March 5, 2006, and another that began on May 2, 2006, and ended on September 26, 2006, we considered the spell to have spanned February 2 through September 26, 2006.

To examine transition rates, we identified people who transitioned both to HCBS and to a non-HCBS care. We looked for HCBS service use (claims for 1915(c) waiver services or state plan services) or HCBS enrollment (enrollment in 1915(c) waiver programs) after the institutional spell ended. We classified a beneficiary as having transitioned to HCBS if he or she used non-hospice HCBS service and did not die either in the same calendar month the institutional care ended or in the subsequent two calendar months. Of the remaining MFP eligibles, we classified as transitioners to non-HCBS anyone who did not die or use hospice care

[46] Over the 2005–2007 period, the three different series were highly correlated, though the more comprehensive series increased the least: the CPI-U rose 6.2 percent, compared with 8.6 and 7.2 percent for the medical care and shelter series, respectively.

before the beginning of the third calendar month after the end of the institutional spell. We classified as non-transitioners those who died or used hospice care immediately after their institutional stay.[47]

## E. DETAILED STATE-LEVEL STATISTICS

As a supplement to the primarily group-level findings reported in the main text, we present in this appendix detailed state-level measures of balance in 2005 and also trends in balance and number of MFP eligibles from 2005 through 2007.

[47] Our understanding is that MFP is not targeting people who leave institutions for end-of-life care, in which case counting these people as transitioners would have artificially inflated death rates among those in the community. We will reassess the treatment of hospice care and deaths in the MFP evaluation once we learn more about the role of end-of-life care in MFP from grantee states and CMS.

**Table A.1. The Balance of Medicaid-Financed Long-Term Care by State, 2005**

| States | Total Long-Term Care Expenditures (Millions of 2005 Dollars) | Total HCBS Expenditures (Millions of 2005 Dollars) | Percentage of Long-Term Care Expenditures Due to HCBS | HCBS Expenditures Per HCBS User (2005 Dollars) | Total Institutional Care Expenditures (Millions of 2005 Dollars) | Total Institutional Care or HCBS Users (Thousands) | Percentage of Long-Term Care Recipients Using HCBS | Percentage of Long-Term Care Recipients Using Institutional Care |
|---|---|---|---|---|---|---|---|---|
| **All States** | **72,729** | **27,141** | **37** | **16,056** | **45,588** | **2,861** | **59** | **47** |
| Arkansas | 912 | 209 | 23 | 10,173 | 702 | 45 | 45 | 59 |
| California | 9,128 | 4,941 | 54 | 10,243 | 4,188 | 587 | 82 | 21 |
| Connecticut | 2,108 | 683 | 32 | 24,783 | 1,425 | 56 | 49 | 58 |
| Delaware | 277 | 89 | 32 | 29,341 | 187 | 7 | 44 | 60 |
| District of Columbia | 307 | 52 | 17 | 18,058 | 255 | 8 | 37 | 67 |
| Georgia | 1,495 | 402 | 27 | 13,245 | 1,093 | 69 | 44 | 59 |
| Hawaii | 311 | 116 | 37 | 25,008 | 195 | 9 | 50 | 54 |
| Illinois | 3,293 | 980 | 30 | 12,083 | 2,313 | 161 | 50 | 57 |
| Indiana | 1,851 | 484 | 26 | 30,268 | 1,367 | 60 | 27 | 75 |
| Iowa | 1,111 | 402 | 36 | 13,946 | 709 | 49 | 59 | 46 |
| Kansas | 817 | 421 | 51 | 16,394 | 397 | 40 | 63 | 40 |
| Kentucky | 1,179 | 265 | 23 | 13,456 | 913 | 50 | 40 | 65 |
| Louisiana | 1,535 | 421 | 27 | 15,979 | 1,114 | 70 | 38 | 66 |
| Maryland | 1,754 | 687 | 39 | 20,295 | 1,068 | 59 | 57 | 46 |
| Michigan | 1,395 | 172 | 12 | 11,210 | 1,222 | 56 | 28 | 81 |
| Missouri | 1,450 | 561 | 39 | 9,122 | 889 | 93 | 66 | 43 |
| Nebraska | 588 | 205 | 35 | 19,532 | 383 | 23 | 46 | 60 |
| New Hampshire | 382 | 179 | 47 | 24,796 | 203 | 14 | 51 | 53 |
| New Jersey | 3,386 | 1,000 | 30 | 17,704 | 2,386 | 101 | 56 | 47 |
| New York | 17,438 | 7,575 | 43 | 31,033 | 9,863 | 384 | 63 | 45 |
| North Carolina | 2,683 | 1,127 | 42 | 11,040 | 1,556 | 145 | 70 | 34 |
| North Dakota | 317 | 83 | 26 | 14,544 | 234 | 11 | 52 | 54 |
| Ohio | 4,871 | 1,499 | 31 | 17,950 | 3,372 | 157 | 53 | 60 |
| Oklahoma | 982 | 353 | 36 | 13,127 | 629 | 52 | 52 | 53 |
| Oregon | 629 | 327 | 52 | 8,733 | 302 | 45 | 83 | 24 |
| Pennsylvania | 3,957 | 503 | 13 | 17,576 | 3,454 | 122 | 24 | 79 |
| Texas | 3,971 | 1,301 | 33 | 15,292 | 2,670 | 190 | 45 | 60 |
| Virginia | 1,495 | 571 | 38 | 17,043 | 925 | 54 | 62 | 55 |
| Washington | 1,301 | 774 | 59 | 13,030 | 527 | 78 | 76 | 29 |
| Wisconsin | 1,805 | 760 | 42 | 25,209 | 1,046 | 65 | 46 | 58 |

**Table A.1** *(continued)*

Source: Mathematica analysis of the 2005 Medicaid Analytic Extract files for 30 MFP grantee states.

Note: HCBS users include beneficiaries who received personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care through either state plan or 1915(c) waivers. All expenditures are in 2005 dollars.

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

## Table A.2. The Balance of Medicaid-Financed Long-Term Care by State, 2006

| States | Total Long-Term Care Expenditures (Millions of 2005 Dollars) | Total HCBS Expenditures (Millions of 2005 Dollars) | Percentage of Long-Term Care Expenditures Due to HCBS | HCBS Expenditures Per HCBS User (2005 Dollars) | Total Institutional Care Expenditures (Millions of 2005 Dollars) | Total Institutional Care or HCBS Users (Thousands) | Percentage of Long-Term Care Recipients Using HCBS | Percentage of Long-Term Care Recipients Using Institutional Care |
|---|---|---|---|---|---|---|---|---|
| **All States** | **74,057** | **29,873** | **40** | **17,181** | **46,573** | **2,875** | **60** | **45** |
| Arkansas | 937 | 217 | 23 | 10,740 | 750 | 45 | 45 | 59 |
| California | 9,721 | 5,520 | 57 | 10,981 | 4,515 | 606 | 83 | 21 |
| Connecticut | 2,245 | 743 | 33 | 26,113 | 1,575 | 57 | 50 | 58 |
| Delaware | 295 | 103 | 35 | 33,438 | 202 | 7 | 45 | 59 |
| District of Columbia | 330 | 92 | 28 | 24,227 | 249 | 8 | 45 | 59 |
| Georgia | 1,449 | 424 | 29 | 15,508 | 1,072 | 66 | 42 | 60 |
| Hawaii | 320 | 127 | 40 | 26,155 | 203 | 9 | 52 | 52 |
| Illinois | 3,234 | 1,059 | 33 | 12,993 | 2,279 | 160 | 51 | 56 |
| Indiana | 1,802 | 502 | 28 | 29,797 | 1,358 | 60 | 28 | 74 |
| Iowa | 1,158 | 446 | 39 | 14,397 | 749 | 51 | 61 | 44 |
| Kansas | 831 | 455 | 55 | 16,872 | 403 | 41 | 65 | 38 |
| Kentucky | 1,210 | 321 | 27 | 8,827 | 928 | 51 | 72 | 62 |
| Louisiana | 1,509 | 434 | 29 | 16,736 | 1,123 | 67 | 39 | 64 |
| Maryland | 1,854 | 806 | 43 | 21,135 | 1,108 | 61 | 62 | 43 |
| Michigan | 1,412 | 190 | 13 | 12,130 | 1,268 | 55 | 28 | 81 |
| Missouri | 1,440 | 610 | 42 | 10,328 | 876 | 90 | 65 | 44 |
| Nebraska | 597 | 220 | 37 | 19,594 | 397 | 23 | 48 | 57 |
| New Hampshire | 410 | 211 | 51 | 27,564 | 213 | 14 | 53 | 52 |
| New Jersey | 3,454 | 1,090 | 32 | 19,224 | 2,476 | 100 | 57 | 47 |
| New York | 17,583 | 8,189 | 47 | 34,376 | 9,961 | 379 | 63 | 44 |
| North Carolina | 2,653 | 1,179 | 44 | 11,550 | 1,560 | 144 | 71 | 33 |
| North Dakota | 313 | 90 | 29 | 15,643 | 233 | 11 | 53 | 54 |
| Ohio | 4,853 | 1,675 | 35 | 20,041 | 3,335 | 161 | 52 | 57 |
| Oklahoma | 1,043 | 413 | 40 | 14,247 | 664 | 54 | 54 | 51 |
| Oregon | 645 | 350 | 54 | 10,109 | 316 | 42 | 82 | 24 |
| Pennsylvania | 3,984 | 559 | 14 | 19,775 | 3,554 | 120 | 24 | 79 |
| Texas | 3,991 | 1,423 | 36 | 15,276 | 2,697 | 196 | 47 | 57 |
| Virginia | 1,572 | 644 | 41 | 18,277 | 978 | 55 | 65 | 53 |
| Washington | 1,476 | 990 | 67 | 16,081 | 534 | 79 | 78 | 27 |
| Wisconsin | 1,733 | 791 | 46 | 26,598 | 997 | 63 | 47 | 57 |

**Table A.2** *(continued)*

Source: Mathematica analysis of the 2005 Medicaid Analytic Extract files for 30 MFP grantee states.

Note: HCBS users include beneficiaries who received personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care through either state plan or 1915(c) waivers. All expenditures are in 2005 dollars.

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

**Table A.3. The Balance of Medicaid-Financed Long-Term Care by State, 2007**

| States | Total Long-Term Care Expenditures (Millions of 2005 Dollars) | Total HCBS Expenditures (Millions of 2005 Dollars) | Percentage of Long-Term Care Expenditures Due to HCBS | HCBS Expenditures Per HCBS User (2005 Dollars) | Total Institutional Care Expenditures (Millions of 2005 Dollars) | Total Institutional Care or HCBS Users (Thousands) | Percentage of Long-Term Care Recipients Using HCBS | Percentage of Long-Term Care Recipients Using Institutional Care |
|---|---|---|---|---|---|---|---|---|
| **All States** | **75,598** | **32,482** | **43** | **17,239** | **47,777** | **2,999** | **63** | **43** |
| Arkansas | 952 | 224 | 24 | 11,370 | 786 | 44 | 44 | 59 |
| California | 10,088 | 6,130 | 61 | 11,648 | 4,580 | 629 | 84 | 20 |
| Connecticut | 2,234 | 775 | 35 | 26,969 | 1,597 | 57 | 51 | 57 |
| Delaware | 316 | 112 | 35 | 36,529 | 224 | 7 | 45 | 59 |
| District of Columbia | 365 | 143 | 39 | 31,889 | 244 | 9 | 52 | 52 |
| Georgia | 1,518 | 462 | 30 | 17,823 | 1,150 | 63 | 41 | 61 |
| Hawaii | 333 | 140 | 42 | 27,741 | 213 | 10 | 53 | 51 |
| Illinois | 3,224 | 1,110 | 34 | 13,308 | 2,313 | 162 | 52 | 55 |
| Indiana | 1,814 | 572 | 32 | 29,911 | 1,354 | 60 | 32 | 70 |
| Iowa | 1,167 | 473 | 41 | 14,652 | 766 | 51 | 63 | 42 |
| Kansas | 854 | 484 | 57 | 17,598 | 423 | 42 | 66 | 37 |
| Kentucky | 1,222 | 398 | 33 | 9,148 | 899 | 52 | 83 | 59 |
| Louisiana | 1,695 | 585 | 35 | 19,415 | 1,214 | 72 | 42 | 61 |
| Maryland | 1,864 | 848 | 45 | 22,817 | 1,131 | 61 | 61 | 42 |
| Michigan | 1,461 | 248 | 17 | 3,346 | 1,303 | 112 | 66 | 39 |
| Missouri | 1,510 | 675 | 45 | 11,337 | 928 | 90 | 66 | 43 |
| Nebraska | 592 | 226 | 38 | 20,995 | 403 | 23 | 48 | 58 |
| New Hampshire | 423 | 227 | 54 | 28,141 | 222 | 15 | 55 | 51 |
| New Jersey | 3,468 | 1,136 | 33 | 19,630 | 2,545 | 101 | 57 | 46 |
| New York | 17,968 | 8,718 | 49 | 36,980 | 10,358 | 380 | 62 | 45 |
| North Carolina | 2,733 | 1,317 | 48 | 12,938 | 1,585 | 144 | 71 | 33 |
| North Dakota | 315 | 97 | 31 | 16,177 | 237 | 11 | 55 | 51 |
| Ohio | 4,792 | 1,783 | 37 | 21,008 | 3,304 | 160 | 53 | 57 |
| Oklahoma | 1,115 | 464 | 42 | 14,998 | 719 | 55 | 56 | 49 |
| Oregon | 660 | 368 | 56 | 10,917 | 332 | 41 | 82 | 25 |
| Pennsylvania | 3,924 | 588 | 15 | 20,269 | 3,577 | 115 | 25 | 78 |
| Texas | 4,194 | 1,565 | 37 | 11,560 | 2,887 | 238 | 57 | 47 |
| Virginia | 1,639 | 746 | 46 | 19,552 | 994 | 56 | 68 | 51 |
| Washington | 1,513 | 1,075 | 71 | 17,181 | 530 | 79 | 79 | 26 |
| Wisconsin | 1,648 | 792 | 48 | 27,100 | 958 | 61 | 48 | 56 |

**Table A.3** *(continued)*

Source: Mathematica analysis of the 2005 Medicaid Analytic Extract files for 30 MFP grantee states.

Note: HCBS users include beneficiaries who received personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care through either state plan or 1915(c) waivers. All expenditures are in 2005 dollars.

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

**Table A.4. Change in the Balance of Medicaid-Financed Long-Term Care by State, 2005–2007**

| State | Percentage Change in Total Long-Term Care Expenditures | Percentage Change in Total HCBS Expenditures | Percentage Change in Percentage of Long-Term Care Expenditures Due to HCBS | Percentage Change in HCBS Expenditures Per HCBS User | Percentage Change in Total Institutional Care Expenditures | Percentage Change in Total Institutional Care or HCBS Users | Percentage Change in Percentage of Long-Term Care Recipients Using HCBS | Percentage Change in Percentage of Long-Term Care Recipients Using HCBS |
|---|---|---|---|---|---|---|---|---|
| **All states** | **+ 17** | **+ 23** | **+ 5** | **– 4** | **+ 13** | **+ 18** | **– 1** | **– 13** |
| Arkansas | + 4 | + 1 | – 3 | + 5 | + 5 | – 2 | – 2 | + 1 |
| California | + 11 | + 17 | + 6 | + 7 | + 3 | + 7 | + 2 | – 8 |
| Connecticut | + 6 | + 7 | + 1 | + 2 | + 6 | + 2 | + 3 | – 2 |
| Delaware | + 14 | + 18 | + 3 | + 17 | + 13 | – 1 | + 2 | – 2 |
| District of Columbia | + 19 | + 158 | + 117 | + 66 | – 10 | + 9 | + 42 | – 23 |
| Georgia | + 2 | + 8 | + 7 | + 27 | – 1 | – 9 | – 6 | + 4 |
| Hawaii | + 7 | + 14 | + 6 | + 4 | + 3 | + 2 | + 6 | – 6 |
| Illinois | – 2 | + 7 | + 9 | + 4 | – 6 | + 0 | + 3 | – 3 |
| Indiana | – 2 | + 11 | + 14 | – 7 | – 7 | – 0 | + 20 | – 6 |
| Iowa | + 5 | + 11 | + 5 | – 1 | + 2 | + 4 | + 7 | – 8 |
| Kansas | + 5 | + 8 | + 4 | + 1 | + 0 | + 3 | + 4 | – 7 |
| Kentucky | + 4 | + 41 | + 36 | – 36 | – 7 | + 5 | + 110 | – 9 |
| Louisiana | + 10 | + 31 | + 18 | + 14 | + 3 | + 2 | + 12 | – 7 |
| Maryland | + 6 | + 16 | + 9 | + 6 | – 0 | + 2 | + 8 | – 8 |
| Michigan | + 5 | + 36 | + 29 | – 72 | + 0 | + 101 | + 140 | – 52 |
| Missouri | + 4 | + 13 | + 9 | + 17 | – 2 | – 3 | – 0 | + 1 |
| Nebraska | + 1 | + 4 | + 3 | + 1 | – 1 | – 1 | + 3 | – 2 |
| New Hampshire | + 11 | + 19 | + 8 | + 7 | + 3 | + 5 | + 7 | – 5 |
| New Jersey | + 2 | + 7 | + 5 | + 4 | + 0 | + 0 | + 2 | – 2 |
| New York | + 3 | + 8 | + 5 | + 12 | – 1 | – 1 | – 2 | + 1 |
| North Carolina | + 2 | + 10 | + 8 | + 10 | – 4 | – 1 | + 0 | – 1 |
| North Dakota | – 0 | + 11 | + 12 | + 5 | – 5 | + 1 | + 5 | – 5 |
| Ohio | – 2 | + 12 | + 14 | + 10 | – 8 | + 2 | – 0 | – 6 |
| Oklahoma | + 13 | + 24 | + 9 | + 8 | + 8 | + 6 | + 9 | – 7 |
| Oregon | + 5 | + 6 | + 1 | + 18 | + 4 | – 9 | – 1 | + 4 |
| Pennsylvania | – 1 | + 10 | + 11 | + 9 | – 2 | – 6 | + 7 | – 2 |
| Texas | + 6 | + 13 | + 7 | – 29 | + 2 | + 26 | + 27 | – 22 |
| Virginia | + 10 | + 23 | + 12 | + 8 | + 1 | + 4 | + 9 | – 9 |
| Washington | + 16 | + 31 | + 13 | + 24 | – 5 | + 1 | + 4 | – 10 |
| Wisconsin | – 9 | – 2 | + 8 | + 1 | – 14 | – 6 | + 3 | – 3 |

**Table A.4** *(continued)*

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 30 MFP grantee states.

Note: HCBS users include beneficiaries who received personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care through either state plan or 1915(c) waivers.

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

**Appendix Table A.5. Trends in the Number of Medicaid Enrollees Institutionalized for Six Months or More Who Would Have Been Eligible for MFP Had the Program Been in Place in 2005–2007, by Grantee State**

| | Number of MFP Eligibles | | | Percentage Change | | |
|---|---|---|---|---|---|---|
| State | 2005 | 2006 | 2007 | 2005–2006 | 2006–2007 | 2005–2007 |
| **All Grantee States** | **963,935** | **944,784** | **929,615** | **-2.0** | **-1.6** | **-3.6** |
| Arkansas | 17,336 | 17,453 | 17,342 | 0.7 | -0.6 | 0.0 |
| California | 85,728 | 84,747 | 83,814 | -1.1 | -1.1 | -2.2 |
| Connecticut | 23,814 | 23,595 | 23,431 | -0.9 | -0.7 | -1.6 |
| Delaware | 3,061 | 2,954 | 2,938 | -3.5 | -0.5 | -4.0 |
| District of Columbia | 3,856 | 3,558 | 3,443 | -7.7 | -3.2 | -10.7 |
| Georgia | 32,508 | 31,900 | 30,973 | -1.9 | -2.9 | -4.7 |
| Hawaii | 3,402 | 3,396 | 3,316 | -0.2 | -2.4 | -2.5 |
| Illinois | 70,681 | 67,539 | 66,174 | -4.4 | -2.0 | -6.4 |
| Indiana | 33,402 | 32,787 | 32,439 | -1.8 | -1.1 | -2.9 |
| Iowa | 18,302 | 18,000 | 17,380 | -1.7 | -3.4 | -5.0 |
| Kansas | 12,719 | 12,132 | 11,974 | -4.6 | -1.3 | -5.9 |
| Kentucky | 19,385 | 19,377 | 19,247 | 0.0 | -0.7 | -0.7 |
| Louisiana | 30,387 | 28,501 | 27,846 | -6.2 | -2.3 | -8.4 |
| Maryland | 19,689 | 19,364 | 19,085 | -1.7 | -1.4 | -3.1 |
| Michigan | 33,525 | 32,901 | 32,257 | -1.9 | -2.0 | -3.8 |
| Missouri | 29,769 | 29,130 | 28,763 | -2.1 | -1.3 | -3.4 |
| Nebraska | 9,568 | 9,467 | 9,217 | -1.1 | -2.6 | -3.7 |
| New Hampshire | 5,576 | 5,499 | 5,409 | -1.4 | -1.6 | -3.0 |
| New Jersey | 37,229 | 37,001 | 36,720 | -0.6 | -0.8 | -1.4 |
| New York | 123,610 | 121,810 | 120,145 | -1.5 | -1.4 | -2.8 |
| North Carolina | 35,700 | 35,158 | 34,843 | -1.5 | -0.9 | -2.4 |
| North Dakota | 4,661 | 4,699 | 4,510 | 0.8 | -4.0 | -3.2 |
| Ohio | 69,173 | 67,918 | 67,397 | -1.8 | -0.8 | -2.6 |
| Oklahoma | 19,065 | 18,618 | 18,284 | -2.3 | -1.8 | -4.1 |
| Oregon | 6,244 | 6,045 | 5,949 | -3.2 | -1.6 | -4.7 |
| Pennsylvania | 67,425 | 66,916 | 65,709 | -0.8 | -1.8 | -2.5 |
| Texas | 84,191 | 82,543 | 81,838 | -2.0 | -0.9 | -2.8 |
| Virginia | 22,546 | 22,324 | 21,674 | -1.0 | -2.9 | -3.9 |
| Washington | 13,785 | 13,256 | 12,809 | -3.8 | -3.4 | -7.1 |
| Wisconsin | 27,598 | 26,196 | 24,689 | -5.1 | -5.8 | -10.5 |

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 30 MFP grantee states.

**Appendix Table A.5a. Trends in the Number of Medicaid Enrollees Institutionalized for Six Months or More Who Would Have Been Eligible for MFP Had the Program Been in Place in 2005–2007, by Grantee State: Nursing Home, Aged ≥65**

| | Number of MFP Eligibles | | | Percentage Change | | |
|---|---|---|---|---|---|---|
| State | 2005 | 2006 | 2007 | 2005–2006 | 2006–2007 | 2005–2007 |
| **All Grantee States** | **731,105** | **712,345** | **697,354** | **-2.6** | **-2.1** | **-4.6** |
| Arkansas | 12,980 | 12,894 | 12,716 | -0.7 | -1.4 | -2.0 |
| California | 62,009 | 61,116 | 60,378 | -1.4 | -1.2 | -2.6 |
| Connecticut | 19,356 | 18,965 | 18,785 | -2.0 | -0.9 | -2.9 |
| Delaware | 2,445 | 2,349 | 2,345 | -3.9 | -0.2 | -4.1 |
| District of Columbia | 2,468 | 2,248 | 2,157 | -8.9 | -4.0 | -12.6 |
| Georgia | 26,689 | 25,949 | 25,025 | -2.8 | -3.6 | -6.2 |
| Hawaii | 2,924 | 2,962 | 2,917 | 1.3 | -1.5 | -0.2 |
| Illinois | 43,078 | 40,182 | 38,589 | -6.7 | -4.0 | -10.4 |
| Indiana | 25,005 | 24,398 | 24,128 | -2.4 | -1.1 | -3.5 |
| Iowa | 13,803 | 13,502 | 12,953 | -2.2 | -4.1 | -6.2 |
| Kansas | 10,672 | 10,147 | 9,949 | -4.9 | -2.0 | -6.8 |
| Kentucky | 15,858 | 15,788 | 15,711 | -0.4 | -0.5 | -0.9 |
| Louisiana | 20,143 | 18,577 | 17,764 | -7.8 | -4.4 | -11.8 |
| Maryland | 15,263 | 14,910 | 14,582 | -2.3 | -2.2 | -4.5 |
| Michigan | 29,591 | 28,993 | 28,331 | -2.0 | -2.3 | -4.3 |
| Missouri | 23,760 | 22,899 | 22,297 | -3.6 | -2.6 | -6.2 |
| Nebraska | 7,100 | 6,935 | 6,702 | -2.3 | -3.4 | -5.6 |
| New Hampshire | 5,143 | 5,044 | 4,952 | -1.9 | -1.8 | -3.7 |
| New Jersey | 28,373 | 28,182 | 27,815 | -0.7 | -1.3 | -2.0 |
| New York | 94,739 | 92,954 | 91,179 | -1.9 | -1.9 | -3.8 |
| North Carolina | 27,406 | 26,927 | 26,530 | -1.7 | -1.5 | -3.2 |
| North Dakota | 3,637 | 3,671 | 3,513 | 0.9 | -4.3 | -3.4 |
| Ohio | 50,785 | 49,253 | 48,623 | -3.0 | -1.3 | -4.3 |
| Oklahoma | 13,961 | 13,399 | 13,061 | -4.0 | -2.5 | -6.4 |
| Oregon | 4,863 | 4,844 | 4,766 | -0.4 | -1.6 | -2.0 |
| Pennsylvania | 56,037 | 55,497 | 54,777 | -1.0 | -1.3 | -2.2 |
| Texas | 60,729 | 59,149 | 58,239 | -2.6 | -1.5 | -4.1 |
| Virginia | 17,379 | 17,150 | 16,583 | -1.3 | -3.3 | -4.6 |
| Washington | 11,625 | 11,102 | 10,654 | -4.5 | -4.0 | -8.4 |
| Wisconsin | 23,284 | 22,359 | 21,333 | -4.0 | -4.6 | -8.4 |

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 30 MFP grantee states.

**Appendix Table A.5b. Trends in the Number of Medicaid Enrollees Institutionalized for Six Months or More Who Would Have Been Eligible for MFP Had the Program Been in Place in 2005–2007, by Grantee State: Nursing Home, Aged <65**

| | Number of MFP Eligibles | | | Percentage Change | | |
|---|---|---|---|---|---|---|
| State | 2005 | 2006 | 2007 | 2005–2006 | 2006–2007 | 2005–2007 |
| **All Grantee States** | **137,362** | **139,353** | **141,092** | **1.4** | **1.2** | **2.7** |
| Arkansas | 1,883 | 1,959 | 1,993 | 4.0 | 1.7 | 5.8 |
| California | 15,116 | 15,088 | 15,155 | -0.2 | 0.4 | 0.3 |
| Connecticut | 2,926 | 3,038 | 3,089 | 3.8 | 1.7 | 5.6 |
| Delaware | 403 | 423 | 430 | 5.0 | 1.7 | 6.7 |
| District of Columbia | 640 | 613 | 602 | -4.2 | -1.8 | -5.9 |
| Georgia | 4,718 | 4,891 | 4,853 | 3.7 | -0.8 | 2.9 |
| Hawaii | 378 | 351 | 315 | -7.1 | -10.3 | -16.7 |
| Illinois | 16,758 | 16,649 | 16,948 | -0.7 | 1.8 | 1.1 |
| Indiana | 4,123 | 4,120 | 4,103 | -0.1 | -0.4 | -0.5 |
| Iowa | 1,684 | 1,697 | 1,649 | 0.8 | -2.8 | -2.1 |
| Kansas | 1,253 | 1,213 | 1,262 | -3.2 | 4.0 | 0.7 |
| Kentucky | 2,504 | 2,634 | 2,632 | 5.2 | -0.1 | 5.1 |
| Louisiana | 4,443 | 4,259 | 4,367 | -4.1 | 2.5 | -1.7 |
| Maryland | 3,167 | 3,276 | 3,349 | 3.4 | 2.2 | 5.7 |
| Michigan | 3,718 | 3,709 | 3,699 | -0.2 | -0.3 | -0.5 |
| Missouri | 4,843 | 5,191 | 5,503 | 7.2 | 6.0 | 13.6 |
| Nebraska | 1,226 | 1,248 | 1,286 | 1.8 | 3.0 | 4.9 |
| New Hampshire | 403 | 421 | 430 | 4.5 | 2.1 | 6.7 |
| New Jersey | 4,838 | 4,818 | 4,928 | -0.4 | 2.3 | 1.9 |
| New York | 18,849 | 19,185 | 19,459 | 1.8 | 1.4 | 3.2 |
| North Carolina | 3,790 | 3,904 | 3,891 | 3.0 | -0.3 | 2.7 |
| North Dakota | 398 | 413 | 398 | 3.8 | -3.6 | 0.0 |
| Ohio | 10,772 | 11,124 | 11,275 | 3.3 | 1.4 | 4.7 |
| Oklahoma | 2,877 | 2,957 | 2,971 | 2.8 | 0.5 | 3.3 |
| Oregon | 956 | 968 | 1,002 | 1.3 | 3.5 | 4.8 |
| Pennsylvania | 6,149 | 6,352 | 6,433 | 3.3 | 1.3 | 4.6 |
| Texas | 10,989 | 11,278 | 11,666 | 2.6 | 3.4 | 6.2 |
| Virginia | 3,136 | 3,187 | 3,170 | 1.6 | -0.5 | 1.1 |
| Washington | 2,099 | 2,088 | 2,095 | -0.5 | 0.3 | -0.2 |
| Wisconsin | 2,323 | 2,299 | 2,139 | -1.0 | -7.0 | -7.9 |

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 30 MFP grantee states.

**Appendix Table A.5c. Trends in the Number of Medicaid Enrollees Institutionalized for Six Months or More Who Would Have Been Eligible for MFP Had the Program Been in Place in 2005–2007, by Grantee State: ICF-MR**

| | Number of MFP Eligibles | | | Percentage Change | | |
|---|---|---|---|---|---|---|
| State | 2005 | 2006 | 2007 | 2005–2006 | 2006–2007 | 2005–2007 |
| **All Grantee States** | **84,546** | **82,214** | **80,502** | **-2.8** | **-2.1** | **-4.8** |
| Arkansas | 1,627 | 1,624 | 1,647 | -0.2 | 1.4 | 1.2 |
| California | 8,542 | 8,498 | 8,242 | -0.5 | -3.0 | -3.5 |
| Connecticut | 1,199 | 1,195 | 1,176 | -0.3 | -1.6 | -1.9 |
| Delaware | 178 | 147 | 140 | -17.4 | -4.8 | -21.3 |
| District of Columbia | 733 | 692 | 681 | -5.6 | -1.6 | -7.1 |
| Georgia | 1,101 | 1,060 | 1,095 | -3.7 | 3.3 | -0.5 |
| Hawaii | 100 | 83 | 84 | -17.0 | 1.2 | -16.0 |
| Illinois | 9,361 | 9,231 | 9,131 | -1.4 | -1.1 | -2.5 |
| Indiana | 4,093 | 4,097 | 4,023 | 0.1 | -1.8 | -1.7 |
| Iowa | 2,256 | 2,237 | 2,210 | -0.8 | -1.2 | -2.0 |
| Kansas | 637 | 630 | 618 | -1.1 | -1.9 | -3.0 |
| Kentucky | 757 | 704 | 651 | -7.0 | -7.5 | -14.0 |
| Louisiana | 5,458 | 5,327 | 5,270 | -2.4 | -1.1 | -3.4 |
| Maryland | 369 | 339 | 327 | -8.1 | -3.5 | -11.4 |
| Michigan | 156 | 143 | 127 | -8.3 | -11.2 | -18.6 |
| Missouri | 1,156 | 1,030 | 952 | -10.9 | -7.6 | -17.6 |
| Nebraska | 613 | 612 | 585 | -0.2 | -4.4 | -4.6 |
| New Hampshire | 22 | 25 | 22 | 13.6 | -12.0 | 0.0 |
| New Jersey | 3,063 | 3,014 | 2,971 | -1.6 | -1.4 | -3.0 |
| New York | 8,618 | 8,309 | 8,129 | -3.6 | -2.2 | -5.7 |
| North Carolina | 4,333 | 4,076 | 4,083 | -5.9 | 0.2 | -5.8 |
| North Dakota | 616 | 611 | 594 | -0.8 | -2.8 | -3.6 |
| Ohio | 7,607 | 7,529 | 7,490 | -1.0 | -0.5 | -1.5 |
| Oklahoma | 1,747 | 1,743 | 1,696 | -0.2 | -2.7 | -2.9 |
| Oregon | 45 | 42 | 40 | -6.7 | -4.8 | -11.1 |
| Pennsylvania | 4,076 | 4,004 | 3,932 | -1.8 | -1.8 | -3.5 |
| Texas | 12,261 | 11,918 | 11,712 | -2.8 | -1.7 | -4.5 |
| Virginia | 1,886 | 1,812 | 1,694 | -3.9 | -6.5 | -10.2 |
| Washington | 58 | 59 | 58 | 1.7 | -1.7 | 0.0 |
| Wisconsin | 1,878 | 1,423 | 1,122 | -24.2 | -21.2 | -40.3 |

Source: Mathematica analysis of the 2005–2007 Medicaid Analytic Extract files for 30 MFP grantee states.

ICF-MR = intermediate care facility for people with mental retardation.

# APPENDIX B

# QUALITY OF LIFE SAMPLE DETAILS

**Table B.1. Analytic Sample: State Distribution, Representation of Transitioned Population and Use of Proxy Respondents**

| State | Number of QoL Surveys[a] | Percentage of Analytic Sample | Total Transitioned | Percentage of Transitioned Participants in Analytic Sample (Surveys/Total Transitioned) | Percentage of Analytic Sample Respondents with Proxy Respondent |
|---|---|---|---|---|---|
| CA | 95 | 5.0 | 128 | 74.2 | 16.5 |
| CT | 65 | 3.4 | 129 | 50.4 | 7.7 |
| DC | 20 | 1.1 | 52 | 38.5 | 31.6 |
| DE | 15 | 0.8 | 23 | 65.2 | 13.3 |
| GA | 125 | 6.6 | 197 | 63.5 | 16.9 |
| HI | 13 | 0.7 | 25 | 52.0 | 15.4 |
| IA | 52 | 2.8 | 62 | 83.9 | 6.4 |
| IL | 29 | 1.5 | 53 | 54.7 | 3.6 |
| IN | 23 | 1.2 | 60 | 38.3 | 0.0 |
| KS | 63 | 3.3 | 158 | 39.9 | 5.0 |
| MD | 60 | 3.2 | 484 | 12.4 | 13.0 |
| MO | 157 | 8.3 | 205 | 76.6 | 9.7 |
| NC | 3 | 0.2 | 31 | 9.7 | 66.7 |
| ND | 6 | 0.3 | 19 | 31.6 | 0.0 |
| NE | 46 | 2.4 | 58 | 79.3 | 54.6 |
| NH | 30 | 1.6 | 45 | 66.7 | 13.8 |
| NJ | 49 | 2.6 | 85 | 57.6 | 28.6 |
| OH | 249 | 13.2 | 402 | 61.9 | 46.9 |
| OK | 2 | 0.1 | 28 | 7.1 | 0.0 |
| OR | 129 | 6.8 | 163 | 79.1 | 30.3 |
| PA | 200 | 10.6 | 295 | 67.8 | 3.2 |
| TX | 259 | 13.7 | 1884 | 13.7 | 3.9 |
| WA | 168 | 8.9 | 363 | 46.3 | 5.4 |
| WI | 32 | 1.7 | 50 | 64.0 | 0.0 |
| **Total** | **1,890** | **100.0** | **4,999** | **37.8** | **17.6** |

Source: Total transitions are reported via web-based reports from grantees. QoL surveys include surveys that could be matched with administrative data confirming program participation.

Note: Data reflect program operations through December 2009.

Data from five states are not represented in this table. Arkansas and Louisiana did not submit administrative data. Kentucky, Michigan and Virginia administrative data could not be matched with QoL surveys.

[a] QoL surveys matched with administrative data confirming MFP participation.

**Table B.2. MFP-QoL Analytic Sample: Valid N by Item**

| Item | Respondents with Valid Values[a] |
|---|---|
| Do you like where you live? | 1,873 |
| Did you help to pick this place to live? | 1,873 |
| Do you feel safe living here? | 1,856 |
| Can you sleep without disturbances? | 1,869 |
| Can you go to bed when you want? | 1,867 |
| Can you be by yourself when you want? | 1,872 |
| Can you eat when you want to? | 1,869 |
| Can you choose the foods you eat? | 1,873 |
| Can you talk on the phone without someone listening in? | 1,851 |
| Can you watch TV when you want to? | 1,857 |
| Does anyone help you with things like bathing, dressing, or preparing meals? | 1,860 |
| Do you ever go without a bath or shower when needed? | 1,805 |
| Do you ever go without a meal when you need one? | 1,826 |
| Do you ever go without taking your medicine when you need to? | 1,818 |
| Are you ever unable to use the bathroom when you need to? | 1,773 |
| Do the people who help you treat you the way you want to be? | 1,725 |
| Do the people who help you listen to you? | 1,717 |
| Have you ever been physically hurt? | 1,452 |
| Are the people who help you mean to you or yell at you? | 1,412 |
| Have the people who help you ever taken your money or things without asking? | 1,399 |
| Can you see family or friends when you want? | 1,850 |
| Can you get to the places you need to go? | 1,847 |
| Is there anything you want to do outside the facility that you cannot do now? | 1,834 |
| When you go, do you go by yourself, or do you need help? | 1,839 |
| Do you go out and do fun things in your community? | 1,836 |
| Is there any medical care you have not received or could not get to in the past month? | 1,839 |
| Are you happy with the help you receive? | 1,846 |
| Are you happy with the way you live your life? | 1,839 |
| In the past week, have you felt sad or blue? | 1,845 |
| In the past week, have you felt irritable? | 1,853 |
| In the past week, have you felt aches and pains? | 1,852 |
| Proxy status | 1,785 |

[a]Valid values include responses of ”don’t know” and refusals.

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