kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

February 2011

Money Follows the Person: A 2010 Snapshot

EXECUTIVE SUMMARY

With the passage of health reform, the Money Follows the Person (MFP) demonstration grant program was extended five years through 2016 giving states further options to transition Medicaid beneficiaries living in institutions back to the community. Enacted into law in 2006 as part of the Deficit Reduction Act (DRA), the MFP demonstration provides states with enhanced federal matching funds for twelve months for each Medicaid beneficiary transitioned from an institutional setting to a community-based setting. Twenty-nine states and DC are currently participating in this demonstration program and more states plan to apply for MFP grants in the coming year. In July 2010, the Kaiser Commission on Medicaid and the Uninsured (KCMU) surveyed states about the current status of their MFP program including trends in enrollment, services and per capita spending. This year's survey is a follow-up to the 2008 KCMU MFP survey and highlights findings based on responses from twenty-six states.

Key Findings:

- **As of July 2010, nearly 9,000 individuals have been transitioned back to the community and another 4,000 transitions are currently in progress.** Although states were slow to start enrolling participants, with just under four hundred people transitioned by the summer of 2008,[1] significant progress has been made over the past two years. The majority of transitions to-date have been persons with physical disabilities and seniors. People with mental illness, developmental disabilities, and dual eligibles are less likely to be candidates for transition. States also reported low rates of reinstitutionalization – 322 individuals have returned to an institutional setting.

- **States identified a wide range of pre-transition services to target potential MFP participants and to successfully transfer individuals back to the community.** The most commonly reported key services included expanded case management to coordinate transition, help with home modifications and one-time housing expenses such as security deposits or household furnishings, use of assistive technology, transportation, and expanded access to DME. States also reported partnerships with key community stakeholders as key features of their MFP programs. Examples of these partnerships include collaboration with independent living centers, AAAs, and state housing authorities.

- **The average monthly cost of transitioning a MFP participant to the community is roughly $5,600 per person.** Amounts ranged from a high of $15,000 to a low of $2,000 per person per month and varied based upon the population target. When asked to compare the cost of serving Medicaid beneficiaries who reside in institutions with MFP participants, twenty-two states said MFP per capita costs were lower and only one state reported that the costs were comparable. When asked to compare MFP costs with costs for other Medicaid HCBS beneficiaries, responses were split. Eight states reported lower per capita costs, seven states said costs were comparable, and six states reported higher MFP per capita costs.

1330 G Street NW, Washington, DC 20005
Phone: 202-347-5270, Fax: 202-347-5274
Website: www.kff.org

- **Obstacles to transition include lack of affordable, accessible housing and inadequate community workforce supply.** Two years ago, states reported challenges finding safe, affordable housing and this challenge continues today for MFP officials and participants. To address these barriers, nineteen states reported partnerships with local public housing authorities and six states employed housing coordinators to assist individuals interested in transitioning to secure housing. Fourteen states reported an inadequate supply of direct care workers in the community. Strategies to expand the direct care workforce focus on elevating their standing as professionals (i.e., compensation, benefits, and authority). Other state efforts to strengthen the workforce include a direct care service registry website, ability to hire family caregivers through the consumer directed option, online training programs that provide education and competency-based training curriculum.

- **Over half (18) of the MFP states reported that the new reduced institutional residency requirement in the ACA will increase MFP transitions.** The ACA extended the MFP program through 2016 and reduced the institutional residency requirement to 90 consecutive days (the previous residency period was from six months to two years). This survey also addressed the question of the impact of ACA changes to Medicaid HCBS (i.e. Community First option, HCBS state plan option, state balancing incentive program) and only four states reported the changes will increase MFP transitions. The majority of states (16) indicated the new Medicaid HCBS options would have no change on transitions. Additionally, only a handful of states (6) reported actively exploring new ACA opportunities to expand Medicaid HCBS. Most states said they were still reviewing the new ACA options and future action was unknown at the time of the survey.

- **Looking ahead, the lack of affordable, accessible housing will remain the toughest challenge for MFP states.** While states are making strides in forming strategic partnerships with state housing entities, locating adequate housing remains an ongoing challenge for MFP officials. States also reported concern around necessary infrastructure growth to support the expansion of HCBS. Officials stressed the importance of ensuring that the community has the necessary tools, resources and training to support individuals with high medical and long-term services needs. Lastly, states mentioned the ongoing economic downturn as having a potentially negative impact on the success of the MFP program. Cutbacks could lead to a possible decline in the number of community providers due to reduced rates or a reduction of key services that are crucial to successful transition back to the community.

Conclusion

After a slow start due to difficulty getting approval of operational protocols and problems locating affordable, accessible housing, states have made significant gains in transitioning MFP participants over the last two years. Still, states today face challenges related to housing, poor economic conditions, and weak community infrastructure that are critical to ensuring that the program meets its intended goals. With new federal funding support in the ACA and the ongoing efforts by states to strategically partner with other state agencies to address housing challenges, MFP is likely to continue to help states reorient their long-term services and supports systems towards more community-based care. This program in conjunction with other ACA Medicaid policy options has the potential to expand Medicaid home and community-based services for many more seniors and persons with disabilities who desire to live in the community.

INTRODUCTION

The Money Follows the Person (MFP) demonstration grant program was authorized by Congress as part of the 2005 Deficit Reduction Act (DRA) and provides states with enhanced federal matching funds for twelve months for each Medicaid beneficiary transitioned from an institutional setting to a community-based setting. The enhanced federal support is designed to encourage states efforts to reduce reliance on institutional care for individuals needing long-term services and supports and expand options for individuals with disabilities and the elderly to receive services in the community. Currently, twenty-nine states and DC have operational MFP programs.

This year's survey is a follow-up to a 2008 MFP survey conducted by the KCMU. Two years ago states were just getting started with their MFP programs. Only eleven states had actually transitioned individuals back to the community but many more transitions were in progress. The major challenges facing MFP states in 2008 were finding safe, affordable, and accessible housing and gaining CMS approval of states' operational protocol. While early successes of the MFP program were modest in terms of the number of people transitioned, states anticipated that these early successes would grow considerably as more states began enrolling participants and as states ramped up their MFP programs.

More recently, with the passage of health reform, the MFP demonstration grant program w0as extended five years through 2016 giving states further options to reduce reliance on institutional settings for individuals in need of long-term services and supports. The Affordability Care Act (ACA) appropriates an additional $2.25 billon to the program and expands the potential pool of participants. Under the ACA, individuals that reside in an institution for more than 90 consecutive days are now eligible to participate. The previous residency period was from six months to two years. However, days that an individual resides in an institution for the sole purpose of receiving short-term rehabilitation under Medicare cannot count for the 90 day period required for MFP eligibility.

On July 26, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a new MFP grant solicitation to encourage states not yet part of the MFP demonstration to apply for grant funds. States have until January 7, 2011 to submit their grant application. On August 4th, CMS released a solicitation for MFP planning grants, recognizing that states will be required to provide resources to develop and submit an operational protocol. The solicitation affords states the opportunity to receive a one-year MFP planning grant (up to $200,000 per state) to produce the operational protocol based on the criteria of the MFP solicitation.[2]

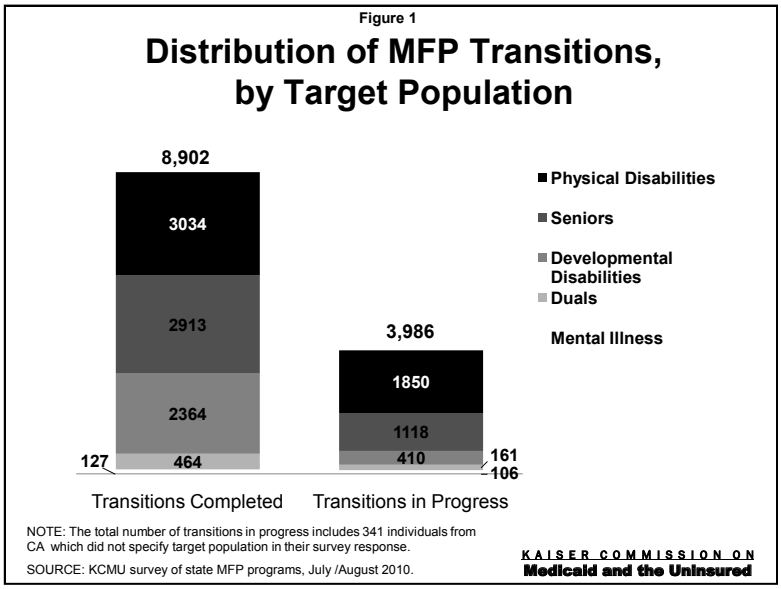
Methodology – This report is based on a Kaiser Commission on Medicaid and the Uninsured (KCMU) survey of state MFP programs conducted in July and August 2010. At the time of the survey, a total of thirty states had operational programs. The survey was designed to obtain information on MFP enrollment, services and per capita costs in each state. We also asked states to respond to questions about the current economic downturn and the impact that health reform will have on Medicaid home and community-based services. The full survey instrument can be found in Appendix A of this report.

This year's survey is a follow-up to a 2008 KCMU MFP survey and resulting brief that can be found at: http://www.kff.org/medicaid/7928.cfm. The data for this report was provided directly from state officials in response to a written survey. Survey responses were received from 26 of 30 states.

KEY FINDINGS

Enrollment

As of July 2010, nearly 9,000 individuals have been transitioned back to the community and another 4,000 transitions are currently in progress (Figure 1). Although states were slow to start enrolling participants with just several hundred people transitioned by the summer of 2008[3], significant progress has been made over the past two years. Most states started enrolling individuals by 2008 with the exception of five states (IN, LA, NY, NC, and OK) that began enrolling participants the following year. Implementing a MFP program involves extensive planning at the state level and extensive review and collaboration with CMS. In addition, state variation in level of experience and community-based infrastructure is wide and can affect the speed in which transitions occur.



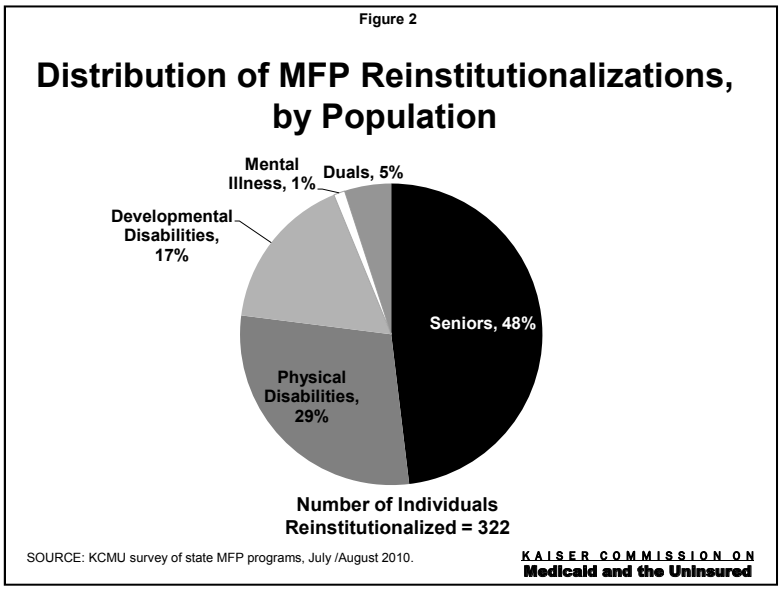
The majority of transitions to-date have been persons with physical disabilities and seniors. People with mental illness, developmental disabilities, and dual eligibles are less likely to be candidates for transition due to their extensive health and long-term services needs. In addition, states reported nearly 4,000 transitions currently in progress. Once again, those individuals most likely to be targeted for transition are persons with physical disabilities. In contrast, two years ago states had completed just over 400 transitions and only 465 transitions were in progress.

When the MFP program first began, states collectively set a goal of transitioning nearly 38,000 individuals back to the community during the initial five-year demonstration period. In this year's survey, we asked states whether their program was on pace with original transition targets. For a number of reasons, most states were unable to match their original transition targets.

Twenty out of twenty-six states reported experiencing delays, and the top reason for delay was lack of affordable, accessible housing options. States also reported a lack of community-based providers necessary to support transition, especially in rural areas. Another barrier mentioned was the fact that individuals who choose to transition from institutions to assisted living services or to group living situations with more than four residents are ineligible for MFP. Other reasons for delays included problems hiring transition coordinators, complex referrals that required more time than originally anticipated, and the existence of other programs that transfer individuals from institutions.

Recognizing the length of time it took to transition these Medicaid beneficiaries with complex needs, an initial success of the MFP program is the fact that reinstitutionalization rates are low. Only about 300 individuals (or 4% of all transitions) have returned to an institutional setting (Figure 2).

Figure 2



Services

States identified a wide range of pre-transition services to target potential MFP participants and to successfully transfer individuals back to the community. We asked states to list the key features of their MFP programs and responses included services designed to meet both housing and long-term services needs of MFP participants. The most commonly reported services included expanded case management to coordinate transition, help with home modifications and one-time housing expenses such as security deposits or household furnishings, use of assistive technology, transportation and expanded access to DME.

Other notable services are as follows: North Dakota has developed a 24-hour back-up nursing service for all MFP participants. New Hampshire allows overnight stays before discharge to new home. Texas offers overnight companion services. Ohio's MFP program, known as HOME Choice, includes independent living skills training as well as nursing services and social work/counseling. California conducts preference interviews, or wellness assessments, to determine preference for moving to the community.

States also reported partnerships with key community stakeholders as key features of their MFP programs. Examples of these partnerships include collaboration with independent living centers, AAAs, and state housing authorities. Maryland is working to expand its Aging and Disability Resource Center network across the state, funding some temporary housing subsidies through their Developmental Disabilities Administration, and its Mental Hygiene Administration is funding provider incentives to expand community capacity. In Louisiana, the MFP project managers and housing coordinators participate in a DHH interagency housing task force that develops priorities to propose to the Transformation Grant Housing Advisory Group. Georgia has partnered with the state Housing Finance Authority to develop a housing choice voucher (HCV) program that has provided 100 vouchers for use by MFP participants.

Financing

The average monthly cost of transitioning a MFP participant to the community is roughly $5,600 per person. The MFP program is one option states have to direct a greater share of their long-term services and supports dollars to community-based services. By increasing access to Medicaid HCBS, states are responding to consumer demand, complying with the Olmstead decision, and attempting to control long-term services costs which represent a third of total Medicaid spending. We asked MFP states to report average monthly per capita costs of MFP participants and found that amounts ranged from a high of $15,000 to a low of $2,000 per person per month. The average per capita cost was about $5,600, based on responses from 14 states. In comparison, the national average per person spending on Medicaid HCBS, including HCBS 1915c waivers, the home health and personal care services benefit, was $14,768 in 2007, with great variation in spending across the states due to the types of services offered and the different populations served (i.e. adults with physical disabilities, individuals with developmental disabilities, seniors, etc).[4] As with HCBS waiver expenditures, states that transitioned a greater number of individuals with developmental disabilities had higher per capita costs since these individuals have extensive health and long-term services needs.

When asked to compare the cost of serving Medicaid beneficiaries who reside in institutions with MFP participants, twenty-two states said MFP per capita costs were lower. Iowa was the only state to report that the costs were comparable. The remaining three states did not answer the survey question. When asked to compare MFP costs with costs for other Medicaid HCBS beneficiaries, responses were split. Eight states reported lower per capita costs, seven states said costs were comparable, and six states reported higher MFP per capita costs.

KEY ISSUES GOING FORWARD

Nineteen states highlighted their partnerships with local public housing authorities as a critical component to addressing housing barriers. Two years ago, states reported challenges finding safe, affordable housing and this challenge continues for MFP officials and beneficiaries today. In this year's survey, states were asked how they were responding to the shortage of adequate housing. Housing remains a pivotal issue for states looking to increase the number of MFP transitions. Additionally, at the time this survey was in the field, the US Department of Housing and Urban Development (HUD) released a notice of funding availability for new vouchers for non-elderly people with disabilities.[5] An estimated 1,000 housing choice vouchers will enable non-elderly persons with disabilities to transition from nursing homes and other

health care institutions into the community. This partnership between public housing authorities and state Medicaid agencies will be a critical part of MFP's success. A number of states mentioned that they would be applying for these housing choice vouchers.

Six states employed housing coordinators who assist individuals interested in transitioning to secure housing and several other states mentioned that care managers work with housing authorities to provide housing assistance. For example, Michigan has twenty housing coordinators throughout the state, and Ohio has a housing specialist within the Medicaid Agency under the umbrella of the MFP grant that participates in key stakeholder groups and builds partnerships with housing officials.

Georgia has number of state-wide strategic initiatives including a state-wide referral network and state-wide inventory of available, affordable and integrated housing. Oregon developed new specialized adult foster homes for target populations such as those experiencing dementia, neurological disorders, and traumatic brain injuries, and then moved MFP participants into those homes. Other state actions to address housing shortages include expanded environmental modifications to address accessible housing (IA, KS, PA, and WI), rental assistance programs (PA, CT) and partnerships with realtors and housing developers (CT).

About half (14 states) reported an inadequate supply of direct care workers in the community. To build a successful and sustainable community infrastructure, many states have implemented strategies designed to expand the direct care workforce. Most efforts are intended to strengthen the capacities of direct support professionals and elevate their standing as professionals (re: compensation, benefits and authority). Examples of workforce strategies adopted by states include: a direct care service registry website, ability to hire family caregivers through the consumer directed option, online training programs that provide education and competency-based training curriculum. Looking to the future, Georgia has plans to convene several stakeholder forums with direct service workers, agencies who employ direct service workers, and entities who train direct service workers. These forums will address issues related to compensation, training, education, reimbursement rate structures, image of direct service workers, and data collection. Ohio's MFP has entered into a sub-grant with Ohio State University to study employment trends and develop a career lattice for direct support workers. Texas' Promoting Independence Initiative Work Force Council is working to address the shortage of direct care workers by hiring an individual (with 100% administrative funding) to work with the council to generate ideas to expand the workforce and also work to expand enrollment for consumer directed services.

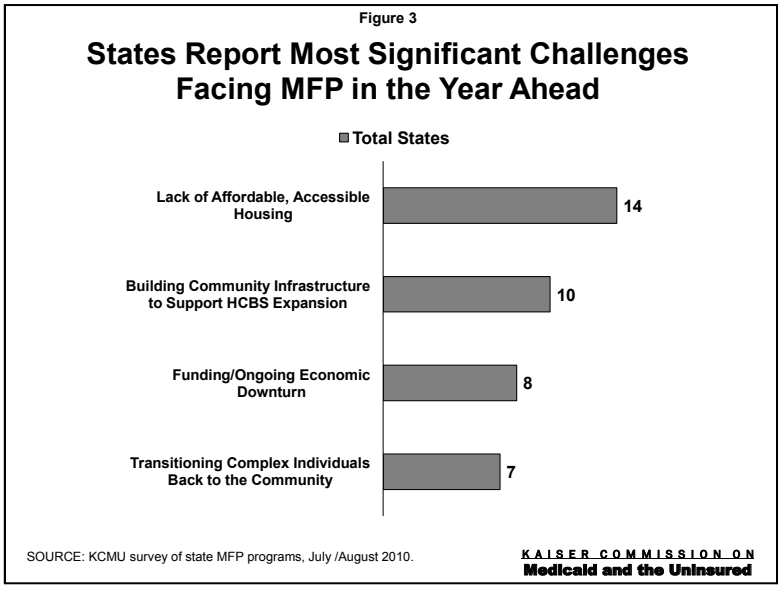
Most officials reported that the current economic downturn is not directly affecting MFP programs. Because the MFP program is a demonstration grant, funding is guaranteed once a state gets approval of their operational protocol. However, several states pointed to indirect impacts of the economic downturn such as reductions in Medicaid provider payment rates and services as having an impact on MFP. For example, Iowa cut Medicaid provider payment rates and consolidated Medicaid eligibility field offices across the states, many of which help facilitate MFP enrollment. Arkansas reduced the number of waiver slots in its adults with physical disabilities waiver resulting in a waiting list for the first time in the state's history. Connecticut instituted a financial cap for anyone moving from an institution that limits community-based services costs to no greater than what they currently pay for institutional care. In contrast, North

Dakota reported several positive changes: increasing the number of services offered, adjusting financial eligibility, increasing personal care hours, and raising provider reimbursement by 10 percent.

Looking ahead, state budgets are expected to continue to see the adverse effects of the economic downturn with severely depressed state revenues and higher demand for human services, including Medicaid. States benefited from federal fiscal relief through the American Recovery and Reinvestment Act of 2009 (ARRA) which provided a temporary increase in the federal Medicaid matching rate (FMAP) from October 2008 through December 2010. All states used ARRA funds to address Medicaid and state budget funding shortfalls, to support Medicaid enrollment growth and to help avoid or mitigate program restrictions.[6] Although legislation to extend federal fiscal relief in Medicaid through June 2011 was enacted this past summer, state budget shortfalls are expected to continue for the foreseeable future.

Over half the states (18) reported that the new reduced institutional residency requirement for MFP participation will increase MFP transitions. As mentioned earlier, the ACA law extended the MFP program through 2016 and reduced the institutional residency requirement to 90 consecutive days (the previous residency period was from six months to two years). This policy change addressed concerns by advocates that the length of time an institutionalized individual is away from their home may negatively impact their ability to return home or to the community. This survey also addressed the question of the impact of ACA changes to Medicaid HCBS (i.e. Community First option, HCBS state plan option, state balancing incentive program) and only four states reported the changes will increase MFP transitions. The majority of states (16) indicated the new Medicaid HCBS options would have no change on transitions. Additionally, only a handful of states (6) reported actively exploring new ACA opportunities to expand Medicaid HCBS. Most states said they were still reviewing the new ACA options and future action was unknown at the time of the survey. One potential reason for the limited interest in taking up these new options could be the lack of guidance from CMS at the time of the survey.

Looking ahead, the lack of affordable, accessible housing will remain the toughest challenge for MFP states (Figure 3). While states are making strides in forming strategic partnerships with state housing entities, locating adequate housing remains an ongoing challenge for MFP officials. States reported concern around necessary infrastructure growth to support the expansion of HCBS. Officials stressed the importance of ensuring that the community has the necessary tools, resources and training to support individuals with high medical and long-term services needs. States also mentioned the ongoing economic downturn as having a potentially negative impact on the success of the MFP program. Cutbacks could lead to a possible decline in the number of community providers due to reduced rates or a reduction of key services, such as personal care or case management, that are crucial to successful transition back to the community.



CONCLUSION

In 2007, CMS awarded thirty states with $1.7 billion dollars over five years to help transition people with disabilities and seniors out of institutional settings and into the community. While the initial funding for the MFP program was modest, states were ambitious in their goals of transitioning nearly 38,000 individuals back to the community. After a slow start due to difficulty getting approval of operational protocols and problems locating affordable, accessible housing, states have made significant gains in transitioning MFP participants over the last two years. Still, states today face challenges related to housing, poor economic conditions, and weak community infrastructure that are critical to ensuring that the program meets its intended goals.

New interest in MFP across the states is apparent, given the extension of and policy modifications to the MFP program through the ACA. In a recent KCMU survey of state Medicaid budget officials, all but two current MFP grantee states indicated plans to apply for an extension and an additional seven states responded they would apply as a new grantee.[7] With new federal funding support and the ongoing efforts by states to strategically partner with other state agencies to address housing challenges, MFP is likely to continue to help states reorient their long-term services and supports systems towards more community-based care. This program in conjunction with other ACA Medicaid policy options has the potential to expand Medicaid home and community-based services for many more seniors and persons with disabilities who desire to live in the community.

This brief was prepared by Molly O'Malley Watts, consultant to the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

Money Follows the Person Rebalancing Demonstration Program: A 2010 Program Snapshot

The Kaiser Commission on Medicaid and the Uninsured (KCMU) is monitoring state experience with their Money Follows the Person (MFP) demonstration programs. As part of an ongoing KCMU project, we are seeking to develop an issue brief that highlights recent state experience and reactions to the extension of MFP as part of the Accountable Care Act (ACA). The first report released last year (http://www.kff.org/medicaid/7928.cfm) identified early successes including a broad range of services that helped transition several hundred people into community settings and acknowledged housing for MFP participants as a major challenge for states.

Once again, we are requesting your assistance in completing the following short survey. `Surveys may be emailed to ***momalley8@gmail.com***. Should you have any questions about this project, please feel free to contact Molly O'Malley Watts at (703) 371-8596 or Jhamirah Howard, KCMU, at (202) 347-5270 or jhoward@kff.org.

*****

1. Program Status: Is your program operational? ☐ YES ☐ NO

If yes, when did enrollment begin? _____

If no, when did your program end and why? _____

2. Key Features: Please list the key services that make up your MFP program, such as expanded access to durable medical equipment, supplemental services (*i.e. housing coordination, one-time expenses, telehealth services*), or partnerships with key community stakeholders. Please be as specific as possible.

_____

_____

3. Transitions Since Implementation:

	Number of Transitions Completed	Number of Transitions in Progress	Number of Participants Re-institutionalized
Seniors			
People with Physical Disabilities			
People with Developmental Disabilities			
People with Mental Illness			
Dual Eligibles			

Is your program on pace with original transition targets? ☐ YES ☐ NO

If no, please describe the top two reasons for delays in meeting transition goals.

_____

4. Per Capita Costs: Please estimate the average monthly Medicaid cost per person for a MFP participant: _____

Compared to costs for institutional beneficiaries is this cost ☐ higher ☐ comparable ☐ lower?

Compared to costs for other HCBS beneficiaries is this cost ☐ higher ☐ comparable ☐ lower?

5. Housing: How does your program address shortages in safe, affordable, and accessible housing?

_____

6. Community Workforce: Does your state have an adequate supply of direct care workers?

☐ YES ☐ NO

Please describe strategies to expand direct care workers in your state:

_____

7. Economic Downturn: Has your program had to make any changes or cutbacks due to the economic downturn (i.e. limiting enrollment, reducing services, etc.)? If so, please describe:

_____

_____

8. **Health Reform:** What impact will the reduced institutional residency requirement (90 consecutive days) have on transitions? ☐ Increase ☐ Decrease ☐ No Change

What impact will new options that expand Medicaid HCBS (i.e. Community First Choice option, HCBS state plan option) have on transitions? ☐ Increase ☐ Decrease ☐ No Change

Is your state actively exploring new ACA opportunities to expand Medicaid HCBS? If so, please describe:

_____

9. **Future Outlook:** What do you see as the most significant issues or challenges your MFP program faces in the next year or two?

_____

_____

Thank you for your participation in this survey.

[1] M. O'Malley Watts, Money Follows the Persons: An Early Implementation Snapshot, Kaiser Commission on Medicaid and the Uninsured, June 2009, http://www.kff.org/medicaid/upload/7928.pdf.
[2] CMS, http://www.cms.gov/CommunityServices/20_MFP.asp, accessed August 30, 2010.
[3] M. O'Malley Watts, Money Follows the Persons: An Early Implementation Snapshot, Kaiser Commission on Medicaid and the Uninsured, June 2009, http://www.kff.org/medicaid/upload/7928.pdf.
[4] Terence Ng et. al., Medicaid Home and Community-Based Services: Data Update, Kaiser Commission on Medicaid and the Uninsured, 2010.
[5] Department of Housing and Urban Development, http://portal.hud.gov/portal/page/portal/HUD/program_offices/administration/grants/fundsavail/nednofa.pdf
[6] V. Smith et. al., Hoping for Recovery, Preparing for Reform: Medicaid Spending, Coverage and Policy Trends in the Midst of a Recession, Kaiser Commission on Medicaid and the Uninsured, September 2010.
[7] V. Smith et. al., Hoping for Recovery, Preparing for Reform: Medicaid Spending, Coverage and Policy Trends in the Midst of a Recession, Kaiser Commission on Medicaid and the Uninsured, September 2010.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

This publication (#8142) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.