Money Follows the Person 2012
Annual Evaluation Report

Executive Summary

October 25, 2013

Carol V. Irvin
Noelle Denny-Brown
Matthew Kehn
Rebecca Sweetland Lester
Debra Lipson
Wilfredo Lim
Jessica Ross
Alex Bohl
Victoria Peebles
Samuel Simon
Bailey Orshan
Susan R. Williams
Eric Morris
Christal Stone
Money Follows the Person 2012
Annual Evaluation Report

Executive Summary

October 25, 2013

Carol V. Irvin
Noelle Denny-Brown
Matthew Kehn
Rebecca Sweetland Lester
Debra Lipson
Wilfredo Lim
Jessica Ross
Alex Bohl
Victoria Peebles
Samuel Simon
Bailey Orshan
Susan R. Williams
Eric Morris
Christal Stone
EXECUTIVE SUMMARY

The Money Follows the Person (MFP) demonstration program represents a major federal initiative to give people needing long-term services and supports (LTSS) more choice about where they live and receive care, and to increase the capacity of state long-term care systems to serve people in community settings. Calendar year 2012 marked the fifth full year of implementation of the national MFP demonstration. Cumulative MFP enrollment climbed to 30,000 transitions by the end of December 2012, a 50 percent growth over the total number at the same point in 2011. In early 2012, three more states received planning grants bringing the total number of states to have received MFP grants to 47 (46 states plus the District of Columbia).

At the end of 2012 the total number of operating programs stood at 37, which included the four states that launched their transition programs during the year and began serving their first MFP participants: Maine, Mississippi, Nevada, and Vermont. Oregon’s program was still suspended as the state conducted a review of its program’s overall design and 5 states were in various stages of planning. During the year, New Mexico formally withdrew from the grant program and Florida also formally withdrew in September 2013, just as this report was being finalized.

A. Purpose of the Report

This fourth annual report presents four broad sets of analyses that shed light on the overall progress and effects of the MFP demonstration: (1) an implementation analyses of the first five years; (2) descriptive analyses of participants benefiting from the MFP demonstration and the costs and types of home and community-based services (HCBS) they receive; (3) trend analyses to detect shifts in the balance of state long-term care systems that may have occurred during the first years of the demonstration; and (4) an assessment of how participant quality of life changes after they exhaust their MFP benefits and leave the program. To the extent possible, the analyses cover the program from its inception through December 2012.

B. Overview of Findings

The MFP demonstration appears to be achieving its broad goals of (1) transitioning people successfully, and (2) helping states establish the infrastructure necessary to increase the capacity of long-term care systems to serve people in the community. Most programs are achieving required transition and expenditure goals and data indicate that states are continuing to shift expenditures for long-term services and supports toward community-based services. In 2012 states were still in the initial phase of expending their MFP rebalancing funds that they accumulated as they provide services to MFP participants. In addition, at the time of this report at least 16 states with MFP programs were also launching a Balancing Incentive Program. These particular states spent most of 2012 developing their work plans, including how they will build upon what they started with their MFP rebalancing funds and how they will leverage both MFP and Balancing Incentive Program funds to accomplish more than what they could have done by participating in only one program. In more detailed analyses of select implementation issues, several states are reporting notable progress and innovative approaches to blending MFP and managed long-term care systems, addressing the challenges of finding affordable and accessible
housing and ensuring an adequate direct service workforce, and providing employment supports to those participants who want to work.

C. Summary of Findings

1. Program Implementation Results

- By the end of December 2012, more than 30,000 people had transitioned to community living through the MFP program, which represented a 53 percent increase from a year earlier in the cumulative number of MFP participants (Figure ES.1).

- Of the 29 states that had implemented MFP transition programs by the end of 2009 and had an operating program in 2012, 14 experienced notable growth in 2012 in the number of annual transitions because they either expanded their capacity to conduct transitions, or had stable leadership focused on growth, or strengthen and expanded their marketing efforts. Another nine states experienced relatively stable growth while six states experienced declines in their annual number of transitions.\(^1\)

Figure ES.1 Total MFP Enrollment, 2008 - 2012


\(^1\) Oregon was not included because the program was closed to new participants during 2012.
• State MFP rebalancing programs were still in an early phase in 2011, the most recent period for which we had information. By the end of 2011, the thirty 2007 grantees had accumulated nearly $142.9 million in MFP rebalancing funds, and had spent a little more than 44 percent of those funds in the same time period (Figure ES.2).

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

![Cumulative Rebalancing Funds and Expenditures](chart.png)


• We find that overall HCBS accounted for a larger share of long-term care expenditures among MFP states after the implementation of the program, but not until the third year of the program (calendar year 2010). That is, beginning in 2010, the HCBS share of total long-term care expenditures was 2.5 percentage points greater than they would have been had the grantee states not implemented MFP (Figure ES.3). These results were primarily driven those with intellectual and developmental disabilities and established long-term care users who had been using long-term care services for a year or more.
Figure ES.3. Trends in the HCBS Share of LTC Expenditures With and Without MFP, 2005—2010 (regression adjusted)


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

- How a grantee implements the MFP program has important implications for its ultimate success. The report explores four select implementation topics that have been the focus of considerable technical assistance to the grantees and recent policy development.
  - The interplay between MFP and managed long-term services and supports (MLTSS). To ensure that MFP and MLTSS programs support and complement each other, state Medicaid programs can use MFP program resources to improve monitoring of care quality, provide incentives for MFP transitions, and train health plan staff on how to support individuals with challenging transitions.
  - The housing challenge. MFP programs are using federal and state resources to modify existing housing units; employ housing specialists to facilitate transitions; provide tenant assistance and support by tapping the expertise of staff at public housing authorities and by employing transition coordinators who have developed an expertise in tenant assistance; and promote long-term collaboration between state health and housing agencies.
o **The direct service workforce.** States are leveraging MFP funds to implement web-based training portals for providers, provide more behavioral support for MFP participants with challenging behaviors, and market and recruit direct service workers that include bonuses for completion of specific training milestones.

o **Employment supports.** The majority of MFP programs offer supported employment to MFP participants. Depending on the state, between one and four percent of participants received MFP-financed employment supports and services. Some MFP programs are using federal funding to hire employment specialists, finance or expand vocational services, or fund assistive technology. The employment specialists assist participants with identifying employment goals and finding and maintaining competitive employment.

2. MFP Participants: Their Characteristics, HCBS costs, and Quality of Life

- MFP participants continue to be predominately working-age adults 21 through 64 years of age (61 percent of MFP participants).
  - The average MFP participant was 58 years old at the time of the transition.

- Most MFP participants transitioned to an apartment (30 percent) or a home that they themselves or a family member owned (28 percent).

- Among those transitioning from nursing homes, approximately 29 percent had low care needs, although this rate varied greatly across the MFP programs (Figure ES.4).

- Approximately 64 percent of MFP participants who transitioned from nursing homes were reported to have some type of mental illness such as an anxiety disorder, depression, manic depression, psychotic disorder, schizophrenia, or post-traumatic stress disorder. When depression was excluded, the incidence dropped to 31 percent. Approximately 19 percent had a behavioral disorder.
Through the end of 2011, the most recent year for which we had data, the HCBS expenditures of MFP participants had climbed to approximately $657 million across the 36 states that reported aggregate financial data.

- HCBS expenditures during the first year of community living were nearly $38,000 per MFP participant, ranging from $23,000 among the elderly who transitioned from nursing homes to $32,000 for the nonelderly who transitioned from nursing homes to nearly $85,000 among those who transitioned from intermediate care facilities for individuals with intellectual disabilities.

- Per-person per-month expenditures were $3,600 on average, ranging from $2,300 among the elderly to nearly $7,800 among those with intellectual disabilities.

- HCBS expenditures during the first 30 days were 54 percent greater on average than expenditures that occurred after that time, which reflects the additional services most MFP participants receive for the transition itself.
• Of the 17 different categories of services MFP programs provided, home-based and round-the-clock services dominated HCBS spending for MFP participants. Each of these categories made up 32 percent of total HCBS expenditures for participants.
  o All 25 MFP grantees analyzed provided home-based services; day services’ coordination and management; and equipment, technologies, and modifications.
  o Although most MFP participants received some type of coordination or management services, approximately 58 percent received personal care assistance during their first year of community living and 58 percent received some type of equipment, technology, or home, vehicle, or workplace modification.

• MFP participants have been able to maintain their quality of life after leaving the MFP program. Approximately 75 percent of MFP participants were satisfied with the way they lived their lives after one year in the community and this level of satisfaction was sustained a year after participants left the MFP program.

• Some areas of participant experience showed continued improvement during the second year of community living. Participants reported statistically significant improvements in barriers to community integration and access to personal assistance services between the first and second years of community living.

• Although improvement in participant-reported outcomes after two years in the community was sustained, several results may warrant further attention from program administrators.
  o Aged participants demonstrated diminished reports of quality of life after two years in the community.
  o Although the percentage of participants who reported depressed mood declined significantly between pre-transition and two years of community living, more than one-third of all participants reported low mood after two years in the community.

D. Conclusions

The MFP demonstration continued on its path of growth and expansion during 2012. Additional states received grants, more states had operating programs, and the total cumulative number of transitions continued to show strong growth. Looking forward to 2013 and beyond, we anticipate MFP will continue its growth, both in terms of transitions and HCBS expenditures. For those states still developing their programs in 2012, they will implement their transition programs and then launch their rebalancing programs. We also know that several of the established programs have plans to expand both their transition and rebalancing programs and the states participating in the Balancing Incentive Program will be implementing those programs as well.

Mathematica will continue evaluating the MFP demonstration and the Balancing Incentive Program by expanding the work to include more years of data and more analyses. We need to track state-level long-term care expenditures and transition and reinstitutionalization rates over a longer time period to determine whether the gains we detected in the early years of MFP are
sustained over the long run. In tracking the trend in long-term care expenditures, in particular, we will be investigating the extent to which the Balancing Incentive Program accelerates the rebalancing of long-term spending in the participating states. At the person level, we need to more fully explore post-transition outcomes and what happens during the first 12 and 24 months after the initial transition to community living. In particular, the evaluation needs to assess the cost implications of the MFP program. Part of MFP’s success will be determined by whether programs are able to ensure that it is no more costly to Medicaid programs to serve people in the community rather than in institutional settings. This work will include assessments how access and utilization of primary and acute care services changes after participants enter the community. Only if MFP programs can ensure that people receive quality home services and minimize the risks for acute care services, will Medicaid programs realize the full benefits of moving people from institutional- to community-based long term services and supports.