

The Right Supports at the Right Time: How Money Follows the Person Programs Are Supporting Diverse Populations in the Community

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EXECUTIVE SUMMARY

The Money Follows the Person (MFP) demonstration supports states' efforts to help Medicaid beneficiaries living in long-term care facilities transition back to the community, where they have more choice about where they live and receive care. People exiting long-term care facilities need diverse types of long-term services and supports (LTSS) to relocate to a residential setting and live successfully in the community. MFP grantees are using the funds made available by the Centers for Medicare & Medicaid Services (CMS) to expand the mix of services to better meet people's support needs during their first year in the community. As MFP programs have matured, they have acquired valuable knowledge about what it takes to execute a successful transition and what is needed to effectively serve populations with complex needs in the community.

This report examines how six MFP grantees are serving populations with diverse needs in the community and the factors that have contributed to their strong performance on key outcome measures. The six states were selected based on having scored higher, relative to other state MFP grantees, on the number of people transitioned, rates of reinstitutionalization, changes in self-reported quality of life (QoL), and other indicators for each of four populations targeted by MFP programs: older adults and people with physical disabilities who transition from nursing homes, people with intellectual disabilities, and people with mental illness. This study relied on in-depth interviews with MFP program staff and state officials in the selected states to examine what aspects of their program model and service delivery system they believe have contributed to their strong performance.

The experiences of these six states offer several lessons that can help other states enhance their program models to better serve participants:

- First, thorough identification of a person's needs and preferences early in the transition process is essential to facilitate timely linkages to services in the community and avoid reinstitutionalization.
- Second, the federal funding made available to MFP grantees gives states the ability to test new service innovations on a small scale that help to meet participants' support needs in the community; states that performed better on key outcome measures made good use of this flexibility to ensure that all participants receive appropriate and timely supports in the community.
- Third, quality monitoring systems are key to track participants' outcomes in the community. Several states included in this study use the knowledge gained from its evaluation of quality monitoring data to improve service delivery for participants.
- Finally, MFP programs in these states formed strong partnerships with stakeholders, which led to close coordination in service delivery and propelled system transformation efforts forward.

About the Money Follows the Person Demonstration

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

INTRODUCTION

The Money Follows the Person (MFP) demonstration arose out of congressional interest in giving Medicaid beneficiaries living in long-term care facilities more choice about where they live and receive services and in strengthening state systems of long-term services and supports (LTSS) to serve more people in community settings. People transitioning from long-term care facilities, such as nursing homes and intermediate care facilities for individuals with intellectual disabilities (ICF-ID), need diverse types of supports. Some of these people have depleted their financial resources paying for initial nursing home expenses, and many lost their housing when they entered a facility (Reinhard et al. 2010). Most also have high health care needs due to a mental illness or chronic medical condition, such as hypertension, depression, diabetes, and stroke (Ross et al. 2012).

MFP grants enable states to establish formal transition programs to help long-term institutional residents transition back to the community. Under the demonstration, grant funds can be used to cover pre-transition planning and up-front expenses, such as environmental modifications, to help people set up residences in the community. States can also offer participants an enhanced set of home- and community-based services (HCBS) to sustain them during their first year of community living.¹ Many MFP programs have creatively used the funds made available by CMS to test service innovations on a small scale to help more people exit institutional settings and successfully reside in the community.² For example, some states have hired clinically trained staff to identify a transition candidate’s needs for services and supports while the individual still lives in an institution. Others have created new services to address identified gaps in the array of HCBS that are offered to people through an existing waiver or

¹ MFP programs receive a higher percentage of federal Medicaid matching dollars for all HCBS provided to MFP participants during the first year of community living. States are expected to invest the extra federal match funds, known as rebalancing funds, in initiatives that aim to shift the provision of LTSS from institutional settings to home- and community-based care.

² In 2010, CMS began to fund certain administrative activities with 100 percent grant funding. The funded activities support MFP programs and may include personnel, travel, training, one-time moving expenses, and marketing and outreach.

State plan. With the support of MFP grants, 45 states have transitioned 51,823 Medicaid beneficiaries to the community from 2008 through December 2014 (Medeiros et al. 2015). The success of the MFP demonstration depends on MFP grantees' ability to establish effective transition programs to move more people into the community, and to assemble a package of LTSS to ensure those who transition can live in the community for as long as possible.

This report examines how six MFP grantees are serving populations with diverse needs in the community and what factors have contributed to their strong performance on key program outcome measures. To identify programs that are leaders in supporting four MFP participant groups, we ranked states' performance on the following indicators:

1. **Transitions.** The cumulative number of transitions to date as a percentage of institutional residents in each state and year-by-year growth in transitions to identify programs that have transitioned a greater percentage of institutional residents and maintained relatively higher transition rates throughout the life of their MFP program
2. **Reinstitutionalizations.** Readmissions to institutions lasting 30 days or more among MFP participants to identify grantees with lower reinstitutionalization rates consistently over the life of their program
3. **Participants' quality of life.** Improved quality of life as measured by an increase in participants' (a) overall satisfaction with the way they live their lives, (b) community integration, and (c) a decrease in participants' unmet needs for assistance
4. **Expenditures.** Change in Medicaid and Medicare medical care expenditures of MFP participants after the transition as measured by the ratio of the percentage change in total average medical expenditures incurred by MFP participants during their 365 days of MFP eligibility to the percentage change in total average LTSS expenditures, which includes expenditures for both institutional and HCBS.

Data sources used to calculate these measures included (1) quality of life (QoL) surveys that grantees administer to MFP participants, (2) Medicaid and Medicare (for those dually eligible for Medicare and Medicaid) enrollment and claims information, (3) grantee semiannual progress report data for program results through June 2014, and (4) nursing home Minimum Data Set (MDS) 3.0 assessment records. Because the main populations targeted by MFP programs have vastly different service needs, we selected the top-performing states within each population: older adults and people with physical disabilities who transition from nursing homes, people with intellectual disabilities, and people with mental illness. For the population with mental illness, we also ranked MFP grantee states on two indicators specific to this group: (1) participants with severe mental illness (excluding depression) who transitioned from nursing facilities as a share of all MFP transitions in each state and (2) the cumulative number of participants with mental illness transitioned to date as a share of all cumulative transitions as of June 2014.

Because the indicators used to select high-performing states were designed to compare effectiveness in serving each of the four population groups, the leading states might not be the most successful on broader indicators of success, such as greatest number of people transitioned through the MFP program to date. Of the 45 MFP grantee states participating in the demonstration, only 23 states were eligible to be compared. Those excluded from the comparison were (1) 14 states whose MFP programs began transitioning participants in 2011 or later; (2) Oregon and South Carolina, 2 states awarded grants in 2007, because they were not actively

transitioning people during the period covered by the data; and (3) 6 states with fewer than 25 cumulative transitions as of the end of 2010, 2011, 2012, or 2013 or fewer than 20 QoL survey observations. Due to the methodology for constructing the indicators and weighting indicator scores, overall scores are not precise and might change if an indicator sensitive to participants' health or functional status were adjusted for risk or medical or functional acuity. Therefore, the approaches and policies that MFP program managers believe contribute to their success might be similar to those used in other states. The data and methods appendix has more information about the measures and data sources for each indicator. Figures 1 to 4 show the state rankings on each of these indicators.

The states that performed better relative to other states on these indicators were Illinois, Louisiana, Missouri, Nebraska, New Jersey, and Ohio. More details about the ranking methodology can be found in the data and methods appendix. We interviewed MFP program staff and state officials in these selected states to learn about the factors they believe have contributed to their strong performance.

The following case studies explore how six model MFP programs have used MFP funds to better serve populations with diverse needs through their community-based service systems. The first case study combines information about MFP programs serving older adults and people with physical disabilities because the LTSS service systems for these two groups are very similar and both populations primarily transition from nursing home care. In addition, the top-performing state for older adults (Missouri) was second best for people with physical disabilities, indicating similarity in how they approach the transition process. This report concludes with overall lessons.

SPOTLIGHT ON MFP PROGRAMS SERVING OLDER ADULTS AND PEOPLE WITH PHYSICAL DISABILITIES



MISSOURI

As of December 2013, Missouri's MFP program, known as My Life, My Way, My Community, transitioned a total of 827 participants to the community, at least 75 percent of whom remained in the community one year post-transition as reported by the state. Nearly two-thirds of the cumulative transitions were older adults and people younger than 65 with physical disabilities.

Missouri has used the My Life, My Way, My Community program to strengthen its connection with nursing facilities to educate residents about their options to receive services in the community, identify what services and supports might be needed by each individual to reside safely and independently in the community, and then connect them with the appropriate formal and informal supports. Missouri officials believe that a critical element of the pre-transition planning process is a thorough and holistic person-centered assessment and transition plan that pinpoints up front a transition candidate's needs, potential risks, and factors that could prevent an individual from successfully residing in the community. When it initially developed its approach to person-centered transition planning, Missouri's MFP program managers solicited input from its contracted transition coordinators who work out of the Centers for Independent Living (CILs) and Area Agencies on Aging (AAAs) and incorporated several best practices into the transition planning process. State regional coordinators in Missouri use the International Resident

Assessment Instrument, or interRAI instrument, which is a nationally standardized assessment tool, to help determine what specific services and supports are appropriate for each individual.³ Officials reported that one barrier to transition is up-front costs associated with reestablishing a residence in the community. To address this barrier, Missouri offers up to \$2,400 to MFP participants as a demonstration service to help fund costs such as home modifications, security

“It’s really important to look at the whole package of an individual’s needs, so not only do we talk about what their service needs are but what are their risks that would prevent them from being successful [in the community].”

– State official who oversees waiver services for older adults and people with physical disabilities

deposits, household items, furniture, and groceries. Many MFP participants receive community-based LTSS through one of three 1915(c) waiver programs, although some participants live successfully in the community with State plan services only. Program administrators believe that the State plan personal care service and its three waiver programs, known as the Aged and Disabled waiver, Adult Day Care waiver, and the Independent Living waiver, offer participants a robust array of LTSS.^{4,5,6} The Aged and Disabled waiver includes homemaker, respite care, and chore services to help participants maintain their home environment, which officials view as a critical service for supporting older adults.

Although these program features are relatively common in most states, officials in Missouri attribute the MFP program’s success in part to two other factors: a web-based participant tracking system and strong collaborative partnerships with key stakeholders that began early and continued over time. Soon after implementing its program, Missouri developed a web-based system that enables all staff—including MFP program staff, MFP transition coordinators, and regional coordinators—to update and monitor in real time how participants are faring in the community. This system also serves as the infrastructure for MFP referrals, tracking the life cycle of each transition from the time of the initial referral (which is based on the information from Section Q of the nursing home MDS or direct referrals from any source) to the time when options counseling, transition planning, and post-transition follow-up occurs. Transition coordinators are able to report critical incidents and track participants’ outcomes through the system. The system also captures essential program monitoring information, such as why those who are interested in returning to the community cannot and the outcome of each transition, including those that were not successful or ended.

Strong collaborative partnerships are cited as another important reason for Missouri’s success. The MFP program developed an active group of stakeholders at the state and local

³ See <http://www.interrai.org/> for more information about the interRAI instrument.

⁴ The Aged and Disabled waiver allows certain disabled individuals ages 63 and older who are Medicaid-eligible to receive expanded services in their homes as an alternative to nursing home services.

⁵ The Adult Day Care waiver provides service coordination and authorization to Medicaid recipients who have reached age 21 and are no longer eligible to receive services through the Healthy Children and Youth program. Missouri is reinvesting a portion of its MFP rebalancing funds to add more slots to the waiver.

⁶ The Independent Living waiver, the state’s self-direction program, allows adults with physical disabilities who require nursing home level of care to hire and supervise their own workers.

levels, including the Department of Mental Health, the Department of Health and Senior Services, the Housing Development Commission, and public housing authorities. Missouri has leveraged its collaborations with the public housing authorities to secure preferences for MFP participants in select counties with high housing needs.

Another example of collaboration cited by Missouri MFP staff was strong working relationships with transition coordinators from the CILs and AAAs who provide options counseling and transition coordination. After the program was launched in 2007, and before it started to receive federal funds to cover the costs of pre-transition planning work, CIL staff provided support coordination for people transitioning, which was essential to launching the program. When the program was fully implemented, the contracted CILs and AAAs continued to provide transition coordination and work together to address issues such as handicap accessibility and transportation that create barriers to services and community integration for MFP participants. According to state officials, these collaborations among stakeholders have helped to propel the My Life, My Way, My Community program forward.

In addition to these factors, Missouri instituted pay-for-performance metrics designed to encourage transitions of nursing facility residents to community settings. Specifically, in 2012 Missouri built pay-for-performance metrics that tie payment to outcomes into its contracts with MFP transition coordinators who provide options counseling to nursing facility residents and transition coordination services to those who relocate to the community through MFP. Missouri set different payment rates for each completed options counseling session, each successful transition, and each individual who remains in the community 6 and 12 months post-transition (Missouri Department of Health & Senior Services 2012). Missouri later worked with the transition coordination agencies to incorporate two additional measures to incentivize improved performance. According to Missouri officials, each agency receives feedback on its agency's performance compared with the performance of all other agencies in the aggregate, which has helped to enhance participants' access to HCBS.


Missouri

Key factors to success

- Thorough assessment and transition process
- Web-based system to monitor participants' outcomes
- Strong collaboration among CILs, AAAs, and other stakeholders

Figure 1. Indicator rankings for older adult population, (n = 15 states)



State	INDICATOR 1	INDICATOR 2	INDICATOR 3	INDICATOR 4	Overall Rank Score	Rank Order
	Transitions	Reinstitutionalization rates	Participants' quality of life	Medical expenditures post-transition		
 Missouri	7.0	2.0	7.0	2.0	18.0	1
Ohio	6.0	10.0	1.5	3.0	20.5	2
Kentucky	11.0	3.0	5.0	5.0	24.0	3
New Jersey	3.0	1.0	12.0	10.0	26.0	4
California	9.0	6.5	8.0	8.0	27.5	5
Illinois	8.0	4.0	1.5	15.0	28.5	6
Wisconsin	1.0	6.5	8.0	14.0	29.5	7
Hawaii	4.0	11.0	14.0	4.0	33.0	8
Washington	5.0	5.0	10.5	13.0	33.5	9
New York	10.0	14.0	3.0	7.0	34.0	10
Texas	13.0	12.0	9.0	1.0	35.0	11
Connecticut	2.0	15.0	15.0	6.0	38.0	12
Pennsylvania	14.0	9.0	6.0	11.0	40.0	13
Michigan	12.0	13.0	10.5	9.0	44.5	14
Virginia	15.0	8.0	13.0	12.0	48.0	15

Note: The states are sorted in ascending order based on their overall rank score, whereby low scores suggest better performance based on the state rankings on the indicators shown.



As of June 2014, Louisiana’s MFP program, known as My Place Louisiana, transitioned 910 participants to the community, 36 percent of whom were older adults and more than 40 percent were people with physical disabilities. When My Place Louisiana was launched in 2009, it had few transitions, in part because the state had little experience transitioning participants from institutional settings, most of whom needed to secure affordable and accessible housing, which is scarce in many parts of the state. Also, at the time, older adults and people with physical disabilities received community-based services through the Elderly Disabled Adult (EDA) 1915(c) waiver, and its service package was not rich enough to adequately meet the needs of those desiring to transition.⁷ For example, although the EDA waiver provided environmental adaptations, it had a lifetime limit of \$3,000 and thus did not provide the level of support needed by many long-term nursing home residents with functional limitations. Before Louisiana could fully implement My Place, it secured MFP funds to cover the cost of items that nearly 200 participants had purchased to help reestablish a residence or achieve stabilization in the community. From 2011 to 2014, the most common expenses were housing and utility deposits, utility carts to transport medical equipment, household items, furniture, electric hospital beds, and durable medical equipment. Louisiana also set up financing for pre-transition services, which it did within the flexibility of the MFP administrative funding policy (email communication with Paul Prejean, January 26, 2015).

Louisiana replaced the EDA waiver in 2012 when the Community Choices waiver (CCW) was established. This waiver offers a more complete array of services for older adults and people with physical disabilities who meet nursing facility level-of-care requirements, which can continue beyond the one-year MFP post-transition period. Based on the results of a standardized assessment, each individual receiving services is provided an annual budget based on his or her medical acuity to create a service package; each individual is given choices to decide what services and supports to purchase with the allocated funds to meet his or her needs. The CCW offers a wide array of services, some of which were previously covered by the EDA waiver, in addition to several new services that enable a plan of care to be tailored to address each participant’s needs.⁸ Under the CCW, three preauthorized services can be paid for before the transition; (1) transition-intensive support coordination provided by nursing facility staff, which covers the costs of pre-transition planning, assessment, service planning, and social networking; (2) home and environmental modifications (beyond the previous \$3,000 limit); and (3) transition services to determine service needs, develop

“We work with [providers] to get things done so that more and more people have an opportunity to get the additional assistance that My Place can provide so these people’s transitions work. It’s not to get a transition; it’s to get [participants] into a situation where they can actually be successful living in the community.”
– *Waiver program manager*

⁷ The EDA waiver program provided a range of services to qualified elderly disabled adults, such as coordination of supports, personal assistance services, adult day health care, environmental accessibility adaptations, and personal emergency response systems. The waiver also offered transition assistance but did not promote these services because the program did not have a mechanism for covering the costs of pre-transition planning services.

⁸ Additional services offered by the CCW include assistive devices and medical supplies, skilled maintenance therapy services, nursing services, home-delivered meal services, caregiver temporary support services, and nonmedical transportation.

the individual plan of care, make referrals to help participants obtain needed services, and follow-up and monitoring activities (Louisiana 2014). Officials report that these services and the flexibility provided by the annual budget have helped participants with variable needs move from nursing facilities to the community.

To further improve access to LTSS, Louisiana implemented a new policy in 2012 that allows MFP participants to use the budget allotment from their maximum service hour allocation of resources, or SHARe, if the funds available under the CCW are not sufficient to cover the costs of certain non-recurring services or supports during the individual's first year of community living (Louisiana Office of Aging and Adult Services 2014).⁹ The ability to leverage the additional funds to cover costly home modifications (beyond the \$3,000 limit) has been instrumental in supporting community living for participants with physical disabilities. Additionally, this policy has reduced the program's reliance on MFP administrative funds available from CMS, which suggests the state's commitment to sustaining these services after the MFP demonstration ends. Officials from Louisiana believe this policy has enabled many more transitions to occur through the My Place Louisiana program.

Officials in Louisiana attribute the MFP program's success in part to the state contracted support coordination staff, who ensure that the transition process and plans address each participant's support needs. More than half of the participants who have transitioned through My Place Louisiana have a dual diagnosis with support needs for both a physical impairment and a mental illness. According to officials, it has been important to cross-train support coordination providers to equip them with the knowledge to effectively serve this population. The state provided extensive training to staff in all of the support coordination agencies to increase their knowledge about available community-based services and increase their competency with assembling a support structure to successfully meet the needs of people transitioning from nursing facilities. The state also developed two training curricula for service providers, one to help them effectively manage participants with behavioral support needs and a second that focuses on training related to medical, nursing, and physical supports to help providers support participants who have acute medical needs. At the time of this report, the state was exploring the possibility of adding these training offerings to its waiver programs as part of its MFP sustainability planning effort.¹⁰

In addition, officials in Louisiana attribute the MFP program's success to the oversight and monitoring provided by transition coordinators who operate out of each region in the state. The state used 100 percent MFP administrative funds to hire nine transition coordinators, one in each region, who meet monthly with support coordination agencies to assist them with supporting participants as needed. The regional transition coordinators also conduct home visits to each participant's residence one week post-transition as well as 30, 60, 90 days and six months following an individual's move to monitor service utilization and ensure each participant has adequate supports to reside successfully in the community.

⁹ These CCW services can include environmental accessibility adaptations, assistive technology, medical supplies, nursing evaluations, housing transitions, crisis intervention services, and skilled maintenance therapy evaluations.

¹⁰ According to CMS policy guidance issued on July 18, 2014, any portion of a state grant award that remains at the end of federal fiscal year 2016 will remain available to the state through September 30, 2020, provided the MFP grantees "submit a sustainability plan that details projected methods for satisfying the statute including the grantee's efforts to rebalance the long-term care system and maintain increasing transition activities during the final years of the program. The sustainability plan is a tool to help guide both programmatic activities and budget projections through the end of the program."

Louisiana

Key factors to success

- Funding for critical pre-transition services and supports
- One-time SHARe budget maximization to improve access to LTSS
- Extra funding to purchase needed items to reside independently in the community
- Ongoing training to strengthen competencies of supports coordination staff and providers

Figure 2. Indicator rankings for population of participants with physical disabilities, (n = 19 states)



State	INDICATOR 1 Transitions	INDICATOR 2 Reinstitutionalization rates	INDICATOR 3 Participants' quality of life	INDICATOR 4 Medical expenditures post-transition	Overall Rank Score	Rank Order
Louisiana	1.0	4.0	7.0	4.0	16.0	1
Missouri	10.0	3.0	9.0	1.0	23.0	2
California	11.5	1.0	1.5	12.0	26.0	3
Georgia	4.7	7.0	16.0	2.0	29.7	4
Wisconsin	2.0	8.0	12.0	10.0	32.0	5
Ohio	4.7	11.5	14.0	3.0	33.2	6
Illinois	8.0	5.0	4.0	17.0	34.0	7
Nebraska	8.0	11.5	3.0	13.0	35.5	8
New York	16.0	14.0	1.5	5.0	36.5	9
Arkansas	4.7	18.0	7.0	11.0	40.7	10
Kentucky	14.0	2.0	10.5	16.0	42.5	11
Connecticut	3.0	16.0	18.0	7.0	44.0	12
Pennsylvania	19.0	6.0	10.5	9.0	44.5	13
Hawaii	8.0	18.0	15.0	6.0	47.0	14
Virginia	13.0	13.0	5.0	19.0	50.0	15
Washington	11.5	9.0	19.0	14.0	53.5	16
Indiana	17.5	15.0	7.0	15.0	54.5	17
Michigan	17.5	18.0	13.0	8.0	56.5	18
Texas	15.0	10.0	16.0	18.0	59.0	19

Note: The states are sorted in ascending order based on their overall rank score, whereby low scores suggest better performance based on the state rankings on the indicators shown.

SPOTLIGHT ON MFP PROGRAMS SERVING PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES



As of June 2014, people with intellectual disabilities comprised 20 percent of the state's cumulative transitions, and enrollment of this population has grown substantially since 2010. To help all populations transition to the community, transition coordinators employed by the state proactively reach out to transition candidates, nursing facility and ICF-ID staff, and other stakeholders to educate them about the LTSS options available in the community. Also, Nebraska recently began using some of its rebalancing dollars to fund home and vehicular modifications and assistive technology to expand access to LTSS, especially for participants who have functional limitations and who desire to live independently in the community.¹¹ When in the community, adults with intellectual disabilities who meet an ICF-ID level of care are primarily served through the Comprehensive Developmental Disabilities (DD) Waiver for Adults, which gives participants the choice to purchase a combination of services that meet their needs and preferences. Examples of services that participants can self-direct include community living and day supports, respite services, extended family home residential habilitation, and companion home residential habilitation (Nebraska Department of Health and Human Services [NDHHS] 2011). Other services offered through the Comprehensive DD Waiver for Adults include prevocational services, team behavioral consultation, community inclusion day habilitation services, behavioral and medical risk services, and residential habilitation services (NDHHS 2011). State officials view the flexibility to match services to each person's needs to be a key factor in the program's success serving this population.

The launch of Nebraska's MFP program coincided with key changes in the service system for participants with developmental and intellectual disabilities. State leadership began transforming its developmental disability service system in 2007 to prioritize high quality service delivery, improved access to services, and community integration for all people with intellectual disabilities (Nebraska Health and Human Services System 2007). Other efforts have included four changes that officials believed to be important factors that contributed to the success of the state's MFP program.

1. In 2010, the state amended its Comprehensive DD Waiver for Adults and its Day Services Waiver for Adults with developmental disabilities by expanding day habilitation services to include alternatives to sheltered workshops that provide a greater focus on vocational opportunities and integrated employment within the community (Hovis 2010). As part of this effort, the state restructured the reimbursement rates for community rehabilitation providers to incentivize them to support participants with intellectual disabilities in securing and maintaining competitive employment.¹²

¹¹ Assistive technologies are supports such as specialized equipment and supplies that assist individual's capabilities. Home modifications are physical adaptations of an individual's private residence (State of Nebraska 2011).

¹² See waiver application for additional information on federal financial participation claiming for incentives.

2. In 2011, flexibility in funding was built into the waivers to move the system toward more self-directed and person-centered decision making. Specifically, the allotted amounts for monthly day and residential services were converted to an annualized individual budget. Participants, with support from their families and support teams, are now able to purchase from a menu of services and supports to meet their needs and preferences.
3. In 2011, additional specialized services were added to the Comprehensive DD Waiver for Adults and its Day Services Waiver for Adults with developmental disabilities, such as team behavioral consultation services, to address challenging behaviors in a residential or work setting that might put the person or others at risk of harm and/or contact with law enforcement.¹³
4. Finally, the state modified the job responsibilities of the service coordinator in 2011 to reduce potential for conflict of interest between the eligibility determination for services and provision of service, as articulated in CMS policy.¹⁴

“Successful [service delivery] systems will always depend on breaking down siloes. That’s what rebalancing is all about.” – *State official who oversees waiver services for individuals with intellectual disabilities*

Nebraska has used its rebalancing dollars accrued under MFP to design and deploy a web-based system, known as Therap Services, to support incident reporting, referral intake, service authorizations, and provider billing for all people served by the Division of Developmental Disabilities. Allowing providers to submit their billings through Therap results in real-time

updates to the individual’s budget to allow for maximum flexibility for service delivery (Nebraska 2014). Officials believe that establishing an online information system for program monitoring is key to tracking service utilization and participants’ health status in the community. A committee of cross-agency and divisional stakeholders meets quarterly to review these data in an effort to track and assess program performance. As they share data and analysis, they make recommendations for any necessary changes and can form ad hoc committees to address issues that arise.

Nebraska

Key factors to success

- Flexibility in funding allows for person-centered decision making
- Specialized services to better support the needs of population
- Web-based system to monitor service utilization and participants’ outcomes

¹³ Other specialized services include retirement services that provide ongoing medical supports to adults with intellectual disabilities ages 65 years or older who have complex medical conditions, medical risk services, and behavioral risk services.

¹⁴ Conflict-free case management is a system in which eligibility determination is separated from direct service; case managers and evaluators of the beneficiaries are not related; and there is oversight, monitoring, and grievance management (Kako 2013).



NEW JERSEY

As of June 2014, New Jersey transitioned a total of 1,244 participants to the community through MFP, 42 percent of whom were people with intellectual disabilities exiting one of seven developmental centers that operate in the state. When the MFP program launched in 2008, New Jersey already had a transition program in place for this population that was established under the state's Olmstead plan. New Jersey's MFP program, known as I Choose Home, was folded into the existing transition program. When in the community, people with intellectual disabilities are served through the Community Care waiver (CCW), which offers them a broad array of services, such as behavioral supports and habilitation services. Despite its relative success, the state seeks to amend the CCW to add services to better support this population in the community.¹⁵ MFP participants also can access supplemental and demonstration services designed for those who are reestablishing a residence in the community, although most participants transitioning from developmental centers do not need these services because they enter group homes that meet their housing needs.¹⁶

New Jersey officials report that many participants transitioning from developmental centers have complex medical and behavioral needs. New Jersey has used the flexible funding made available through MFP to provide intensive supports to people with intellectual disabilities during their first 90 days in the community. Specifically, New Jersey has used MFP administrative funds to implement an Olmstead resource team that provides an additional set of habilitation services for MFP participants who could benefit from supports in managing their physical, nutritional, and/or behavioral health well-being. The Olmstead resource team is staffed by professionals with clinical backgrounds in (1) physical/nutritional management, (2) behavioral support, and (3) medical management. These staff are organized in a training team, a physical/nutritional management team, and a behavioral support team, each of which performs a distinct function. The training team provides technical training to providers to increase their competency in helping MFP participants improve their self-management skills and reduce the risks of critical incidents and reinstitutionalization (New Jersey n.d.). The physical/nutritional management team provides clinical assessment, treatment, and monitoring for participants with intellectual disabilities who experience problems in the areas of physical and/or nutritional self-management. The behavioral resource team provides behavioral health consultation and staff training to direct service providers of participants with intellectual disabilities who might present with behavioral challenges that could threaten their continued placement in the community (New Jersey n.d.).

“The flexibility to be able to create a specialized program for the individual is especially essential and important to make sure an individual has a positive outcome.” – *State official who oversees waiver services for people with intellectual disabilities*

¹⁵ Under the amendment, the state proposes to add behavioral management; physical therapy; occupational therapy; speech, language, and hearing therapy; and prevocational training and career planning. Supported employment will also be separated into individual- and group-supported employment.

¹⁶ Supplemental services include one-time funds to cover the purchase of clothing and groceries up to \$1,500. Demonstration services include the purchase of other one-time individual goods and services up to \$5,000.

The team can also provide crisis response to evaluate safety and clinical risk, implement behavioral strategies, and monitor a participant's progress in the community. After the end of the demonstration, New Jersey will research other federal sources to sustain the program, supplementing with state dollars. The Olmstead resource team service model could be sustained through adding this service as a permanent amendment to one of its waivers.

New Jersey officials also noted that their robust risk management system, which monitors the quality and adequacy of services provided to participants in the community, has helped to minimize readmissions to institutions. The state hired a quality assurance specialist (QAS) in 2012 to monitor provision of services to the MFP population and investigate unusual incident reporting. The QAS collects and analyzes data collected from the case managers who hold in-person meetings with each participant 30, 60, and 90 days post-transition. If the case managers identify an issue, those meetings will continue on 30-day intervals until issues are resolved. As in other states, all MFP participants also complete a QoL survey at three points in time: immediately before transitioning and one and two years after transitioning. New Jersey MFP program managers analyze the QoL data provided by each participant to identify triggers for potential risks, which then prompt the QAS to investigate and address the issue with the participant's case manager. The QAS is tasked with reporting the outcomes of all investigations to senior leadership within the state. In cases in which a participant returns to a developmental center or another type of long-term care facility or is not connected to a managed care organization, the QAS meets with the individual to learn what events led to the person returning to institutional-level care, what aspects of his or her experience in the community were positive, and if there were aspects of service provision that could have been improved upon to better meet the participant's needs in the community. This information is then used to improve program performance and/or service delivery.

Like many other MFP states, New Jersey has a shortage of affordable and accessible housing, including small group homes, in most parts of the state. To address this barrier to transitioning, New Jersey has used its rebalancing funds to cover capital costs, such as housing acquisition and/or rehabilitation, to develop four-bedroom group homes for people transitioning from a developmental center. Capital funding was allocated to qualified providers in 2013 through a competitive bidding process. According to state officials, up to \$250,000 per four-bedroom home was made available through this process and providers leveraged other resources for the remaining development costs (the average total development cost for a four-bedroom group home in New Jersey is \$400,000 to \$500,000) (New Jersey 2015). Twelve new group homes were created under this opportunity, contributing to the program's success serving this population in the community.

“New Jersey knows that [the goals of MFP] are a good thing.... Our leadership [within the state] ... all share the same vision.” – *State MFP program director*

“They [state leadership] want to see people realize meaningful lives in the community and to recognize that it's our job as a division to support that.” – *State official who oversees waiver services for people with intellectual disabilities*

Officials from New Jersey also noted that their relative success stems in part from the leadership and collaboration of stakeholders at the state and local levels. MFP has been a collaborative effort among multiple divisions, including the Division of Developmental Disabilities, the Division of Aging Services, and the ombudsman's office. Leaders within these

divisions have a shared vision and understanding of the importance of supporting participants to live safely and independently in the community.

New Jersey
Key factors to success

- Olmstead resource team to meet specialized needs of participants
- Quality Assurance Specialist (QAS) to monitor participants' outcomes
- Leadership and collaboration of stakeholders
- Increased supply of small group homes using MFP rebalancing funds

Figure 3. Indicator rankings for population of people with intellectual disabilities, (n = 12 states)



State	INDICATOR 1	INDICATOR 2	INDICATOR 3	INDICATOR 4	Overall Rank Score	Rank Order
	Transitions	Reinstitutionalization rates	Participants' quality of life	Medical expenditures post-transition		
Nebraska	9.0	1.5	1.0	3.0	14.4	1
New Jersey	2.0	8.0	4.0	4.0	18.0	2
Washington	1.0	5.0	3.0	10.0	19.0	3
Georgia	3.0	1.5	12.0	6.0	22.5	4
Virginia	4.0	7.0	5.0	8.0	24.0	5
Kentucky	6.0	9.0	7.5	2.0	24.5	6
Oklahoma	7.0	11.0	6.0	1.0	25.0	7
Ohio	11.5	6.0	2.0	9.0	28.5	8
Missouri	5.0	4.0	11.0	12.0	32.0	9
Iowa	8.0	12.0	7.5	5.0	32.5	10
District of Columbia	10.0	3.0	9.5	11.0	33.5	11
Texas	11.5	10.0	9.5	7.0	38.0	12

Note: The states are sorted in ascending order based on their overall rank score, whereby low scores suggest better performance based on the state rankings on the indicators shown.

SPOTLIGHT ON MFP PROGRAMS SERVING PEOPLE WITH MENTAL ILLNESS



OHIO

Ohio's MFP program, known as HOME Choice, is a leader in transitioning participants with mental illness to the community. Of the 2,508 MFP participants with mental illness who ever transitioned to the community in all MFP states, Ohio accounted for 1,582 (63 percent) of them.¹⁷

The HOME Choice program serves all target populations; however, it discovered early on that a high proportion of transition candidates had behavioral health needs and required more specialized supports in the community. Based on these data, Ohio decided to strengthen its assessment and transition planning process to ensure that adequate services and supports were in place at the time participants with behavioral health needs transitioned to the community. Specifically, Ohio integrated the CAGE

“As part of our work around MFP, we ... have used the experience and knowledge of how do folks with mental illness end up in nursing homes and why do they end up in nursing homes, to then look at what we can do on the front end to more effectively divert folks from going into [the nursing home] in the first place.”

– *State MFP program director*

questionnaire into its readiness assessment tool to better screen for alcoholism and behavioral health needs up front.¹⁸ The information that the tool provided enabled staff to more effectively place participants in the community, by matching identified needs with appropriate services before the actual transition occurred. These services might include independent living skills training and community support coaching, both demonstration services that officials regard as critical supports for this population. Ohio also uses behavioral health clinicians to serve as transition coordinators. Having specialized transition coordinators who are clinically trained to work with the unique needs of people with mental illness ensures they are connected to appropriate behavioral health services, provides continuity of care for MFP participants, and increases the likelihood that participants remain engaged with service providers after transitioning to the community.

Ohio has also used the flexible financing under MFP to test service innovations on a small scale to address identified gaps in services. For example, Ohio analyzed its quality monitoring data and learned that many of the participants who returned to an institution returned within 90 days post-discharge. As a result, the program extended transition coordination for 90 days post-discharge, leading to fewer reinstitutionalizations and emergency room visits as indicated by the program's quality monitoring system.¹⁹ Ohio also discovered that many transition candidates

¹⁷ This analysis is based on state-reported data and the number of people states transitioned and classified in the targeted population with mental illness. It most likely includes some MFP participants in the other targeted populations that had a secondary diagnosis of mental illness.

¹⁸ The CAGE questionnaire, the name of which is an acronym of its four questions, is a widely used screening tool designed to identify alcoholic behaviors and can be adapted to identify behavioral issues (Adams et al. 1996).

¹⁹ Transition coordinators can provide benefits coordination, housing navigation, assessment of service needs, community linkages, purchase of goods and services, and support during the first 90 days following transition.

were housing burdened because they could not access housing subsidies due to criminal backgrounds, poor credit, or utility arrears. To help address such barriers, the state launched a new initiative in 2014 known as “Recovery Requires a Community” that uses state Medicaid dollars transferred to the Department of Mental Health and Addiction Services to help people with serious and persistent mental illness, including many MFP participants, exit an institutional setting and move to the community. The funds are projected cost savings and for participants can be used in combination with MFP funds to cover non-Medicaid services and supports needed by that individual to reestablish community living (Anderson 2013). In addition, Ohio learned that at times, some waiver services do not start until four to six weeks after the participant moves from a facility because of the time it takes for Medicaid eligibility to change from institutional to HCBS waiver coverage. To cover the gap, the Recovery Requires a Community program assists by funding waiver-like services and other nonwaiver supports—such as bridge housing support, funds to cover utility payment arrears, and income bridging before Supplemental Security Income is approved—during that period to ensure critical supports are in place on day one.

Officials attribute the HOME Choice program’s success serving people with mental illness in part to its ability to build strong collaborative relationships with state and local stakeholders. As part of this effort, the state created a behavioral health liaison position in 2011 to conduct community outreach to educate behavioral health boards about MFP and recruit behavioral health providers to serve as transition coordinators. The position, which is jointly funded with MFP administrative funds and funds from the Department of Mental Health and Addiction Services, serves as a collaborative link between the state mental health agency and the MFP program to proactively address challenges faced by those transitioning.

“We were siloed before ... the behavioral health liaison role was the way for the state mental health agency to become intimately familiar with the challenges that folks [with behavioral health needs] are facing when transitioning.”
- *State MFP program director*

Ohio also draws strong support from the nursing home industry. Recognizing the importance of a collaborative relationship, the state Medicaid agency sought to develop a cooperative relationship with nursing facilities that has helped to inform program design and service delivery. For example, Ohio analyzed data collected from the Preadmission Screening and Resident Review tool that is administered to all nursing facility residents to identify the facilities serving the highest proportion of people who appear to have mental illness. Ohio’s nursing home trade association then connected the state with these nursing facility staff owners so they and their staff could be educated about how the HOME Choice program could help residents with mental illness transition to the community. This strategy not only increased the staff’s knowledge about the transition services and supports that are available through HOME Choice, but it also established a strong partnership with each facility so that HOME Choice staff were involved early to work with people who desire to receive services in the community. Ohio also has a strong relationship with the local legal rights agency, which has helped to address intractable issues with a facility or guardian that can complicate a transition.

Ohio

Key factors to success

- CAGE screening tool to identify behavioral health needs up front
- Specialized transition coordination extended 90 days post transition
- Recovery Requires a Community initiative and behavioral health liaison to help address barriers to transition
- Collaborative partnerships with stakeholders



ILLINOIS

As of June 2014, 30 percent (422) of all new MFP participants to Illinois' MFP program, Pathways to Community Living, had a primary diagnosis of mental illness and cumulative transitions totaled 1,387.²⁰ The state has a large nursing facility population with serious mental illness and has been committed to using the MFP program to strengthen access to and availability of service supports in the community for this population. Unlike most states, MFP participants with mental illness in Illinois do not enroll in an HCBS waiver upon transition and mental health services are covered under the Medicaid State plan.

The state attributes three pillars that anchor its supports for people with mental illness: (1) housing subsidies, (2) specialized training programs, and (3) a team-based approach. Officials from Illinois report that housing subsidies are a key support for people with mental illness. One of the state's MFP rebalancing initiatives provides bridge subsidies to people with serious mental illness who are in need of housing. The bridge program provides temporary funding until these people can secure a permanent source of funding for housing assistance. The state also hired three housing coordinators in 2014 to strengthen resources in the state, which have included outreach to local public housing agencies, increased housing development, and the development of a statewide housing registry of available housing units. Housing coordinators in Illinois, along with the Illinois Housing Development Authority, have established a number of interagency committees focused on implementing the Section 811 Paperwork Reduction Act program in Illinois.

In Illinois, a high proportion of participants with mental illness have a chronic medical condition such as diabetes, chronic obstructive pulmonary disease, or congestive heart failure (University of Illinois at Chicago 2014). The state emphasizes the need for all staff working with people with mental illness to be equipped with specialized skills to address the range of needs exhibited by these people. Illinois has partnered with staff from the University of Illinois at Chicago (UIC), the contracted quality assurance vendor, to provide educational supports for transition coordinators, providers, and program staff to increase their competence serving those with complex medical and behavioral health care needs. Regular multidisciplinary webinars provide forums for various topics that increase awareness and education and foster stronger

²⁰ This analysis is based on state-reported data and the number of people states transitioned and classified in the targeted population with mental illness. It most likely includes some MFP participants in the other targeted populations that have mental illness as a secondary diagnosis and classified in the targeted population with mental illness. Most likely, some MFP participants are in the other targeted populations.

partnerships. After transitioning to the community, MFP participants are also provided with training opportunities on various topics, such as medication management, budgeting and money management, and crisis planning. To better learn how to manage their finances, participants have a representative payee for six months post-transition. During this period, participants control their budgets but receive guidance from the representative payee to learn how to better manage their federal disability benefits.

Illinois also emphasizes the use of an assertive community treatment team-based approach in its service model. Participants are matched with a treatment team based on individual needs. The team is composed of multiple service specialists, such as a nurse, psychiatrist, or addiction specialist. Together, they develop a plan of support for these participants who might face complex challenges, such as addiction, isolation, and comorbidities. The team focus is intensive and looks at a wide range of needs together, such as employment and recovery, to help break down the silos that can sometimes exist between different disciplines. A multidisciplinary team allows for specialists to focus on specific needs, and promotes some stability in times of staff turnover. Designated transition coordinators are critical in this process, as they act as the initial point of contact for potential MFP participants and continue to partner with the team of specialist to determine the feasibility of a move to the community.

The state continually assesses its MFP program operations to improve service delivery and outcomes for MFP participants transitioning to the community. At the end of each year, the UIC produces a report that provides analyses of several areas of the Pathways to Community Living program: enrollment, participants' demographics, disenrollments, critical incidents, and outcomes related to community living (such as quality of life, health care utilization, and mortality). A cross-departmental group of stakeholders reviews the report each year to draw lessons for improvements related to transition, post-transition supports, and quality management plans. Knowledge about factors that have influenced successful community integration are incorporated into the program's ongoing training efforts for providers and program staff, described previously. Improved employment integration has been an area of focus that the state has addressed with increased supports. Illinois has an Employment First initiative that started in 2005, and was signed into law as the Employment First Act in 2013 (Illinois Government News Network 2013). The law was established to improve integrated employment opportunities for people with all disabilities, and the state hopes to strategically connect that initiative with MFP participants.

Illinois invests its MFP rebalancing funds in system improvements to support more community transitions among participants with mental illness. Additional supports funded under the Balancing Incentive Program target service gaps identified by evaluations of current services, including in-home peer-provided recovery supports, enhanced skills training and assistance targeting independent living skills, and substance abuse intensive crisis residence. The state is also piloting a nursing home diversion program that would educate

“Having the quality requirements and structure is absolutely an essential part of doing the work. It brings a different level of collaboration and accountability.”
– State official who oversees waiver services for people with mental illness

“As we have found service gaps in our rebalancing efforts, we have developed ways to fill the gap and sustain it. . . Fix the problem using the data, and if it works, move it to other parts of the state.”
– State official who oversees waiver services for people with mental illness

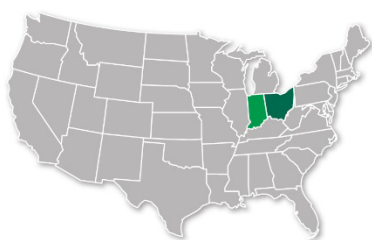
people about community options and potentially divert some of them from initially entering an institutional setting.

Moving forward, Illinois noted that its strong network of provider agencies and collaborations are key to rebalancing for people with mental illness. Managed care is growing for the LTSS population and the state plans to take steps to ensure that the provider expertise and community collaboration is maintained as part of the state’s new managed care models. The state continues to use flexible rebalancing funds to strengthen the capacity of current programs and services, focusing on its three pillars of service: housing, education and training, and a team-based approach.

Illinois
Key factors to success

- Housing subsidies are a bridge to support transitions
- Educational support for providers and program staff to improve service delivery
- Team-based treatment to address specialized needs of participants
- Strong network of provider agencies and collaborations

Figure 4. Indicator rankings for population with mental illness, (n = 4 states)



State	INDICATOR 1 Transitions	INDICATOR 2 Reinstitutionalization rates	INDICATOR 4 Medical expenditures post-transition	INDICATOR 5 Transitions among participants with MI	INDICATOR 6 Share of participants with MI who transitioned from NF	Overall Rank Score	Rank Order
Ohio	1.0	2.0	4.0	1.0	2.0	10.0	1
Illinois	3.0	3.0	3.0	2.0	1.0	12.0	2
California	4.0	1.0	1.0	4.0	4.0	14.0	3.5
Connecticut	2.0	4.0	2.0	3.0	3.0	14.0	3.5

Note: The states are sorted in ascending order based on their overall rank score, whereby low scores suggest better performance based on the state rankings on the indicators shown.

LESSONS LEARNED TO IMPROVE TRANSITIONS AND LTSS SYSTEM PERFORMANCE

The success of the MFP demonstration depends on MFP grantees' ability to provide the right combination of services to each participant at the right time to support their ability to live independently in the community and avoid lengthy reinstitutionalizations. The long-term success of the MFP demonstration also depends on grantees' ability to sustain structural changes to state LTSS systems initiated under the MFP demonstration to help more participants with disabilities receive timely, appropriate, and adequate community-based care. As MFP programs have matured, they have acquired valuable knowledge about what it takes to execute a successful transition and what is needed to effectively serve populations with complex needs. These MFP programs have translated several lessons learned from program development to improve service delivery for populations with complex medical and support needs.

- **Early identification of an individual's needs and preferences is essential to facilitate timely linkages to services in the community and avoid reinstitutionalization.** Thorough identification of a person's needs during the transition planning process helps to ensure that the right combination of LTSS are provided up front so that all of the individual's needs are adequately addressed upon exiting the long-term care facility. Each person's holistic needs and preferences must be identified through an assessment instrument, completed by the transition candidate and the transition coordinator. Both Missouri and Ohio strengthened their assessment processes to improve identification of needed supports and potential risks that could jeopardize the individual's placement in the community. For example, Ohio added CAGE questionnaire to the assessment tool to more comprehensively identify, early in the process, behavioral health issues, such as active use of alcohol or other drugs. By strengthening the assessment process, the program was able to put individualized supports in place for participants to give them the best chance at successfully maintaining their independence in the community.
- **MFP programs and flexible funding offer states the ability to test service innovations that stabilize participants soon after transitioning to the community.** The flexible funding made available to MFP grantees under the demonstration gives states the ability to test new services or supports that help to stabilize participants soon after leaving the institution and meet their support needs so they can successfully reside in the community. New Jersey has established an Olmstead resource team that provides intensive supports for participants in the areas of physical, nutritional, and/or behavioral management during their first 90 days in the community. As part of the sustainability planning process, New Jersey is exploring continuing this service model after the end of the demonstration. Illinois uses highly trained designated transition coordinators to provide a single point of coordination for participants who often have complex behavioral health needs.

All of the states included in this study made good use of the flexible funding to address identified gaps in services so that that all participants receive appropriate and timely supports in the community. For example, through evaluation of its quality monitoring data, Ohio learned that participants with behavioral health needs tend to be at greater risk of reinstitutionalization during their first 90 days in the community. Ohio extended its transition coordinator service to provide all participants with services that support their physical, social, and emotional well-being during the first 90 days post-transition.

Louisiana, Missouri, and New Jersey use MFP dollars to fund the up-front costs associated with reestablishing a residence in the community, such as moving expenses, purchasing furniture and household items, assistive technology, and environmental adaptations. Illinois uses rebalancing funds to provide bridge subsidies to participants with mental illness as a way to move them into the community sooner while they find a permanent source of housing assistance.

Flexible funding beyond what is traditionally available in a waiver program has enabled some states to provide wrap-around services or supports to meet the needs of participants who require more intensive levels of support. For example, Ohio and Louisiana implemented policies and programs that enable participants to maximize their budget allotment if the resources available under the waiver might benefit from enhancement to cover the costs of nonrecurring services or supports associated with moving to the community. Nebraska also restructured its funding system by converting the allotted amounts of monthly expenditures for day and residential services to an annualized budget; participants, with support from their team, then decide what services and supports they will purchase with the budget to address their identified needs. Officials stressed that the ability to leverage a flexible source of funds to cover the costs of executing a transition and/or supporting an individual's needs in the community are instrumental in sustaining a transition.

- **Quality monitoring systems are key to tracking participants' outcomes in the community.** All of the states included in this study described having strong quality systems in place to monitor how participants are faring in the community. Three states, Louisiana, New Jersey, and Ohio, have dedicated quality assurance staff who collect and analyze service utilization and quality data for the MFP population and investigate potential issues that arise. Illinois contracts with an outside vendor, UIC, which provides quality assurance monitoring and reporting as well as transition coordinator training. Nebraska and Missouri have used MFP funds to develop web-based program monitoring systems to track service utilization and participants' health status in the community. Illinois, Missouri, New Jersey and Ohio reported using these data to improve program design and service delivery. Through analysis of its data, New Jersey learned that some participants with intellectual disabilities were prone to reinstitutionalization during their first 90 days in the community. New Jersey applied this knowledge to strengthen the specialized supports provided to this population during the first 90 days in the community.
- **Strong partnerships with stakeholders are important to coordinate efforts around service delivery and propel system transformation efforts forward.** Building strategic partnerships with stakeholders—including public housing agencies, state behavioral health agencies, state divisions of developmental disabilities, family members, legal advocacy organizations, CILs, and AAAs—is key to advance system transformation efforts. Past research of the care needs of MFP participants who transitioned from nursing facilities show that nearly a third of participants (32 percent) were classified as having high care needs, many of whom require different types of services that are often administered by different agencies within each state's long-term service and support system (Ross et al. 2012). In many grantee states, the MFP demonstration has been a collaborative effort among multiple state and local agencies and these strong partnerships can help to break down silos across organizational divisions so that resources can be targeted to improve service delivery and participants' outcomes. For example, Ohio created a behavioral health liaison position, which is jointly funded with the Department of Mental Health and Addiction Services, to

recruit behavioral health providers to serve as transition coordinators. The state MFP program also partnered with the department to launch an initiative that provides wrap-around supports to help those with serious and persistent mental illness, including many MFP participants, exit an institutional setting and move to the community. Missouri worked with its public housing authorities to obtain housing preferences for MFP participants in counties where participants transitioning from an institution have the greatest housing needs.

DATA AND METHODS APPENDIX

INDICATORS AND DATA SOURCES

We assessed MFP grantees' performance serving older adults, people with physical or intellectual disabilities, and people with mental illness using the following six indicators:

- **Indicator 1: Transitions.** The cumulative number of transitions to date as a percentage of the institutional residents in each state, and year-by-year growth in transitions to identify programs that have transitioned a greater percentage of institutional residents and maintained relatively higher transition rates throughout the life of their MFP program
- **Indicator 2: Reinstitutionalizations.** Readmissions to institutions lasting 30 days or more among MFP participants to identify grantees with lower reinstitutionalization rates consistently over the life of their program
- **Indicator 3: Participants' quality of life.** Improved quality of life as measured by an increase in participants' (1) overall satisfaction with the way they live their lives, (2) community integration, and (3) a decrease in participants' unmet needs for assistance
- **Indicator 4: Medical expenditures post-transition.** The ratio of the percentage change in total average medical expenditures incurred by MFP participants during their 365 days of MFP eligibility to total long-term services and supports (LTSS) expenditures.
- **Indicator 5:** Rates of transitions among participants with mental illness as a share of all MFP cumulative transitions as of June 2014.
- **Indicator 6:** The number of participants with severe mental illness, excluding depression, who transitioned from Medicaid certified nursing facilities as a share of all cumulative transitions as of January 2014.

These indicators are based on data from the (1) semiannual progress reports submitted by grantees from January 2010 to June 2014, (2) QoL survey data, (3) Medicaid and Medicare enrollment and claims information, and (4) the nursing home Minimum Data Set (MDS) 3.0 assessment records. Table 1 shows the definitions, measure specifications, and data sources for each of the performance indicators. Three of the six indicators apply to all populations: indicator 3 (MFP participants' quality of life) applies to older adults and people with physical or intellectual disabilities, and indicators 5 (transitions among participants with mental illness) and 6 (share of participants with severe mental illness transitioning from nursing facilities) apply only to MFP participants with mental illness (Table 2).

When combined, these indicators can be used to compare several different aspects of state LTSS service systems, such as a program's ability to coordinate LTSS to transition a long-term institutional resident to the community, a service system's ability to sustain an individual in the community and avoid a prolonged reinstitutionalization, participants' perceptions of their quality of life post-transition, and average medical expenditures incurred by participants post-transition. When comparing grantees' performance, larger declines in total medical expenditures can indicate better performance, suggesting that community-based LTSS might have prevented or slowed the progression of participants' impairments, resulting in lower overall medical costs for participants.

Table 1. Data sources and measures

Indicator descriptions	Measures	Data sources
Indicator 1: Number of Transitions. Growth in the cumulative number of transitions to identify programs that consistently increased transitions from 2010 to 2013 and are transitioning high percentages of institutional residents	<p>a. Annual percentage change in the cumulative number of participants transitioned from 2010 to 2013</p> <p>b. The cumulative number of transitions as of June 2014 as a share of the number of all Medicaid beneficiaries residing in institutional settings in 2010</p>	<p>a. Semiannual progress report data submitted by grantees from January 2010 to June 2014</p> <p>b. Semiannual progress report data submitted by grantees from January 2010 to June 2014</p> <p>c. 2010 MAX data</p>
Indicator 2: Rates of reinstitutionalizations of 30 days or more from 2010 through 2013	Annual unadjusted rates of reinstitutionalizations of 30 days or more among MFP participants, from 2010 to 2013	Semiannual progress report data submitted by grantees from January 2010 through June 2014
Indicator 3: Participants' improved quality of life	The percentage change in MFP participants' quality of life; measured percentage increases in participants' (a) overall satisfaction with the way they live their lives, (b) community integration, and (c) percentage decreases in participants' unmet need for assistance	Quality of life survey data submitted by grantees through June 2014, for two points in time (either baseline, follow-up 1, or follow-up 2), linked with administrative data; the number of MFP participants included in the analytic sample totaled 7,960
Indicator 4: Medical expenditures among participants 12 months post-transition	Ratio of the average percentage change in total Medicaid and Medicare (for dually eligible participants) medical expenditures among participants 12 months post-transition from an institutional setting to total LTSS expenditures. Total LTSS expenditures include expenditure for both institutional care and HCBS	Medicaid and Medicare medical expenditure data (12 months before and after transition) from 2008 through 2010

Table 1 (continued)

Indicator descriptions	Measures	Data sources
Indicator 5: The number of participants with serious mental illness transitioned as a share of the cumulative transitions as of June 2014	Rates of MFP participants with mental illness transitioned to the community as a share of the cumulative number of transitions, among the 10 states serving this population	Semiannual progress report data submitted by grantees from January 2010 through June 201
Indicator 6: The percentage of participants transitioned from nursing facilities with serious mental illness (excluding depression)	The percentage of all MFP participants who transitioned from nursing facilities with serious mental illness, excluding depression	Nursing facility Minimum Data Set (3.0) from October 2010 to December 31, 2013 and MFP administrative data

HCBS = home and community-based services; LTSS = long-term services and support; MAX = Medicaid Analytic eXtract.

Table 2. Indicators used to assess MFP states' LTSS system performance, by population

Case study population	Number of states included in ranking	Indicator 1: Transitions	Indicator 2: Reinstitutionalization rates	Indicator 3: Participants' quality of life	Indicator 4: Average Medicaid and Medicare expenditures post-transition	Indicator 5: Transitions among participants with mental illness	Indicator 6: Share of participants with serious mental illness transitioning from nursing homes
Older adults	15	✓	✓	✓	✓	.	.
Participants with physical disabilities	19	✓	✓	✓	✓	.	.
Participants with intellectual disabilities	12	✓	✓	✓	✓	.	.
Participants with mental illness	4	✓	✓	.	✓	✓	✓

SELECTION OF MFP GRANTEES FOR INCLUSION IN THE STUDY

The states eligible for inclusion in this study were limited to the 30 states and the District of Columbia that were awarded MFP demonstration grants in 2007. We excluded the 14 states awarded grants in 2011 and 2012 because they were in the early stages of program development and implementation during the period when data used to compare states were available. We excluded two states awarded grants in 2007—Oregon and South Carolina—because they were not actively transitioning people during the period covered by the data that were used to compare state program performance. We further excluded from the group of 2007 grantee states those that had fewer than 25 cumulative transitions as of the end of 2010, 2011, 2012, or 2013, because low transition counts inflate the percentage change in enrollment from year to year, which would skew the rankings. Finally, we excluded those states with fewer than 20 quality of life survey observations. After applying these exclusions, Table 2 shows the number of states compared in each of the four MFP population groups.

RANKING METHODOLOGY

We compared the LTSS system performance of the eligible states and ranked them from highest to lowest performance on each measure for each of the following populations: older adults, people with physical disabilities, and people with intellectual disabilities. For indicators 1 through 3, we formed composite indicators to assess states' performance on certain measures over time. Specifically, for each of these indicators, we summed the rankings across the measures for each state and target population to arrive at a total indicator score. As a result, indicators 1 through 3 carry greater weight in the overall rankings. Then, we summed the rank scores across indicators 1 through 4 applicable to these populations to arrive at an overall ranking for each state and population, which are presented in Figures 1 through 4. We used the same approach to compare the performance of the four ranked states that serve people with mental illness on indicators 1, 2, and 4 through 6 (Table 2). For each population, we then sorted state overall rankings in ascending order. We considered grantee states with an overall low score to be those that appear to be serving a particular population well in the community relative to other MFP programs.

APPROACH TO RECONCILING TIED VALUES AND IMPUTING FOR MISSING VALUES

In the case of ties for a rank, we assigned values to the tied scores that are the average of the ranks they would have received if there were no ties. For example, if the summed rankings for a particular indicator were (1, 2, 3, 3, 4, and 5). The tied 3 integers were assigned the average rank of 3.5 and the adjusted rankings were therefore (1, 2, 3.5, 3.5, 5, and 6). In a small number of cases in which data were missing for a particular state, the missing cells were filled with the mean value from the MFP states with available data on the affected measure.

CASE STUDY APPROACH

We purposively selected for this study MFP grantees featured as case studies based on their overall rankings on the indicators applicable to each population. Specifically, the six grantee states included in the study were identified to have, based on their ranking on the indicators of LTSS system performance, an overall top score that suggests the state is serving a particular population well in the community relative to other MFP programs. We selected the two top-

scoring states for each population as case studies, with one exception. We combined information about the populations of older adults and participants with physical disabilities into a single case study because the noninstitutional LTSS service systems for these two groups are very similar and both populations primarily transition from nursing home care.

We collected information about LTSS system performance from the six states through semistructured telephone interviews with MFP program directors and state officials who manage the waiver program(s) serving the population featured in the case study. For the case study focusing on the populations of older adults and participants with physical disabilities, we interviewed a senior official responsible for overseeing the Medicaid waiver serving that population in the state. For the case study focusing on the population of people with developmental disabilities, we interviewed an administrator of the state's division of developmental disabilities. For the case study focusing on the population of people with mental illness, we interviewed an administrator and program manager within the state's mental/behavioral health services agency. The interviews covered the factors that have contributed to MFP program performance, how HCBS are provided, how the state ensures a quality comprehensive system of LTSS for people, and how the state's Medicaid program has used MFP resources to rebalance the provision of LTSS from institutional settings to home- and community-based care.

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REFERENCES

- Adams, Wendy L., Kristen L. Barry, Michael F. Fleming. "Screening for Problem Drinking in Older Primary Care Patients." *JAMA*, vol. 276, no. 24, 1996, pp. 1964–1967.
- Anderson, Adam. "Recovery Requires a Community." Ohio Department of Mental Health and Addiction Services, Columbus, OH, July 29, 2013.
- Hovis, Pam. "What's Happening in Nebraska?" *Sower*. Lincoln, NE: Nebraska Department of Health and Human Services, Division of Developmental Disabilities, April 2010.
- Illinois Government News Network. "Governor Quinn Signs Employment First Act to Expand Opportunities for People with Disabilities." Springfield, IL: Illinois Government News Network, July 16, 2013. Available at <http://www3.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=11350>. Accessed February 25, 2015.
- Kako, Ed. "The Balancing Incentive Program: Implementation Manual." San Francisco, CA: Mission Analytics Group, February 2013. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Downloads/BIP-Manual.pdf>. Accessed February 27, 2015.
- Louisiana Office of Aging and Adult Services. "L-Service Hour Allocation of Resources (SHARe) Exceptions, Waiver Procedures Manual." Baton Rouge, LA: Louisiana Department of Health and Hospitals, Office of Aging and Adult Services, May 19, 2014.
- Louisiana. "Money Follows the Person Rebalancing Demonstration Operational Protocol, v.1.2." Baton Rouge, LA: Bureau of Health Services Financing, April 25, 2014.
- Medeiros, Melissa, Eric Morris, Noelle Denny-Brown, Rebecca Coughlin, Rebecca Sweetland Lester, Bailey Orshan, Victoria Peebles, Susan R. Williams, and Brynn Hagen. "Money Follows the Person Demonstration: Overview of State Grantee Progress, January to December 2014." Cambridge, MA: Mathematica Policy Research, 2015.
- Nebraska Department of Health and Human Services, Division of Developmental Disabilities. "Application for a §1915(c) Home and Community-Based Services Waiver: Comprehensive DD Waiver for Adults." Lincoln, NE: Nebraska Department of Health and Human Services, January 1, 2011. Available at http://dhhs.ne.gov/developmental_disabilities/Documents/Nebraska-DDAC-waiver-2011.pdf.
- Nebraska. MFP semi-annual progress report for the January to June 2014 period. Submitted August 31, 2014.
- New Jersey. MFP semi-annual progress report for the July to December 2014 period. Submitted February 26, 2015.

- New Jersey, Money Follows the Person Project. “Olmstead Resource Teams.” Trenton, NJ: New Jersey, Department of Human Services, Division of Developmental Disabilities. n.d.
- Reinhard, Susan C., Enid Kassner, and Ari Houser. “How the Affordable Care Act Can Help Move States Toward a High-Performing System of Long-Term Services and Supports.” *Health Affairs*, vol. 30, no.3, 2011, pp. 447–453.
- Ross, Jessica, Sam Simon, Carol Irvin, and Dean Miller. “Institutional Level of Care Among Money Follows the Person Participants.” *The National Evaluation of the Money Follows the Person Demonstration Grant Program, Reports from the Field no. 10*. Cambridge, MA: Mathematica Policy Research, October 2012.
- State of Nebraska Health and Human Services System. “Three-Year State Plan.” *Developmental Disabilities System*. Lincoln, NE: Nebraska Health and Human Services System, June 2007.
- State of Nebraska Department of Health and Human Services. “Developmental Disabilities Home- and Community-Based Services Rate Development.” *Division of Developmental Disabilities*. Lincoln, NE: Nebraska Department of Health and Human Services, October 4, 2011.
- State of Nebraska. “Nebraska Money Follows the Person Operational Protocol.” Version 1.4. Amended May 1, 2011.
- The University of Illinois at Chicago, College of Nursing. “Pathways to Community Living: 2013 Year-End Report.” Chicago: UIC, December 22, 2014.