

**THE NATIONAL EVALUATION OF THE
MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION GRANT PROGRAM**

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Implications of State Program Features for Attaining MFP Transition Goals

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With the support of federal grant funds from the Money Follows the Person (MFP) Demonstration Program, 30 state programs are seeking to transition about 34,000 Medicaid beneficiaries with disabilities from institutional to community-based care between 2007 and 2011. While state MFP transition programs share some similar features, they vary in other ways that can affect how quickly and completely transition programs can be implemented as well as how many people can be transitioned. States differ in their level of experience and infrastructure to undertake large-scale transition programs. States also are pursuing different strategies to (1) expand transition coordination capacity, (2) locate appropriate housing, (3) enhance long-term supports and services, and (4) change Medicaid home- and community-based programs or policies to ensure that those who transition can remain in the community after the MFP eligibility period ends. In this report, we describe states' experience with transition programs for institutionalized populations before the start of the MFP demonstration. We also discuss how differences in key program features can affect the pace and degree of implementation and, ultimately, the likelihood of meeting transition goals.

In 2005, Congress enacted the Money Follows the Person (MFP) demonstration¹ with the twin goals of (1) transitioning Medicaid beneficiaries in long-term institutional care to home- and community-based settings and (2) rebalancing state Medicaid long-term care systems so that states rely less on costly institutional care. As of January 2009, 29 states and the District of Columbia were participating in the program and collectively proposed to transition around 34,000 individuals between 2007 and 2011, supported by up to \$1.75 billion in federal grant funds. The demonstration will test the types of services and supports needed to move long-term residents into community settings, whether people who move to the community have better health care outcomes and quality of life, and whether such programs save money.

The federal MFP statute imposes some common requirements on all states participating in the pro-

gram. The program must be managed by the state Medicaid agency. Eligibility is restricted to Medicaid beneficiaries who have spent at least six months in nursing homes, hospitals, intermediate care facilities for the mentally retarded (ICFs-MR), and institutions for mental diseases. Once a beneficiary transitions to the community, states can claim federal MFP grant funds for that person at an enhanced federal medical assistance percentage (FMAP) for most home- and community-based services (HCBS) for up to a year post-discharge. The federal MFP statute requires state Medicaid agencies to monitor the quality of all HCBS provided to MFP participants, guarantee their health and welfare in the community, and develop continuous quality improvement systems for HCBS. Grantee states must make long-term HCBS services available to MFP participants after their one-year eligibility period ends, as long as they remain eligible for Medic-

¹ P.L. 109-171, Deficit Reduction Act (DRA), Section 6071.

ABOUT THE MONEY FOLLOWS THE PERSON DEMONSTRATION

The MFP demonstration, authorized by Congress as part of the 2005 DRA, is designed to shift Medicaid's long-term care spending from institutional care to HCBS. Congress authorized up to \$1.75 billion in federal funds to support a twofold effort by state Medicaid programs: (1) to transition people who have lived in nursing homes and other long-term care institutions for six months or more to homes, apartments, or group homes of four or fewer residents and (2) to 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 and Medicaid Services (CMS), which initially awarded MFP grants to 30 states and the District of Columbia. From 2007 to 2011, grantees will plan and implement programs to transition individuals from institutions to qualified community residences. CMS contracted with Mathematica Policy Research, Inc., (MPR) to conduct a comprehensive evaluation of the MFP demonstration and report the outcomes to Congress in 2012.

aid and require institutional-level care. Grantees must also agree to increase the absolute amount of Medicaid HCBS spending each year of the demonstration and invest in efforts to rebalance the long-term care system using net revenue from enhanced FMAP funds.

Beyond these requirements, states have considerable flexibility in designing their MFP programs. States choose one or more of five groups they wish to serve: adults age 65 and older; people with physical disabilities; people with mental retardation or developmental disabilities (MR/DD); people with mental illnesses; and those with dual diagnoses, traumatic brain injury, or other disorders. States establish their own targets for the number of people in each group to transition annually and over the entire demonstration period. States also decide how to provide and pay for transition coordination services to help individuals move out of institutions. Each state develops its own strategies to locate and increase the supply of affordable and accessible housing for MFP participants. States can decide whether to offer extra services to MFP participants not available to other Medicaid beneficiaries, and if they do, which types of services. They also choose the HCBS waiver programs² or other care models to offer to MFP participants after the one-year eligibility period ends.

States' experience and capacity to conduct transition programs at the start of the demonstration, together

² HCBS waiver programs, called 1915(c) programs for the Social Security Act section under which they are authorized, provide the most long-term care in community settings for Medicaid beneficiaries who would otherwise need institutional care. Most states operate several HCBS waiver programs that target specific populations, such as older adults, people with physical disabilities, and people with developmental disabilities. States can limit the number of enrollees in an HCBS waiver program to contain program costs.

with the choices they make about how to structure MFP transition programs, can influence the pace or degree of program implementation. These factors can also affect the ability of state grantees to meet their transition targets. Any new program takes time to put in place, especially one as complex as MFP. Will states with more transition experience and capacity begin MFP programs earlier and implement them more fully than those without these advantages? Can states with less transition experience or capacity at the start of MFP meet or exceed their transition targets by implementing well-designed programs and strong HCBS delivery systems?

In this report, we describe how the following features of MFP transition programs vary from state to state and how such variance can affect implementation and the likelihood of meeting state-established transition goals:

- Level of transition program experience and current capacity
- Approach to expanding transition coordination capacity
- Strategies for finding and expanding the supply of affordable and accessible housing
- Choice of MFP demonstration and supplemental HCBS to facilitate transitions
- Changes to Medicaid policies and programs to ensure that MFP participants can continue to receive HCBS after the demonstration period ends

Although states may change the way they address some of these features over the course of the demonstration, understanding how states vary in the beginning may explain differences in eventual outcomes and impacts. Variation in states' HCBS delivery systems

and characteristics, such as the supply of HCBS, direct care workers, and affordable housing units, may also influence the success of state MFP programs in transitioning long-term residents from institutions to the community. However, this report is limited to key MFP program design elements over which states have greater control.

LEVEL OF TRANSITION PROGRAM EXPERIENCE AND CURRENT CAPACITY

State MFP transition programs follow in the steps of many previous initiatives. For example, from 1967 to 2004, nearly 150,000 people with intellectual or developmental disabilities were deinstitutionalized from ICFs-MR, and hundreds of public institutions were closed (Prouty et al. 2005). And between 1998 and 2006, federal grants supported efforts in many states to design transition programs for older adults and people with physical disabilities living in nursing homes, which helped to build transition program infrastructure and develop pilots.

Despite this long history, states participating in the MFP grant program begin with differing levels of experience and capacity to transition each population group and to transition larger numbers than they have in the past. In some states, transition programs established before MFP continue to operate alongside the MFP demonstration, serving as the foundation for expansion and an alternative for individuals not eligible for the MFP program. In other states, previous transition programs were small pilots that ended when grant funds ran out, requiring the states to rebuild transition infrastructure.

Seven of the 30 MFP grantee states have substantial transition program experience (first group of states in Table 1) and operate transition programs alongside the MFP demonstration. These parallel programs are typically open to all individuals who want to leave an institution, regardless of the length of time they have been there or the type of community residence they choose. These states already cover most transition coordination services through existing Medicaid programs. The MFP grants allow these states to offer additional services to people with special or greater needs who otherwise could not transition through regular Medicaid HCBS.

Thirteen MFP states had some transition program experience and capacity at the start of the MFP demonstration (second group of states in Table 1). These states include those with transition programs that focus exclusively on people with developmental disabilities in ICFs-MR. Also included are states that have conducted pilot programs to transition individuals out of nursing facilities or that have programs that do not operate statewide. To meet MFP goals, the states in this group must either develop transition programs for MFP population groups that were not targeted by previous transition programs or scale up operating capacity throughout the state.

The remaining 10 states (third group of states in Table 1) entered the MFP program with little or no transition experience and weak infrastructure. These states must put in place many basic elements of a transition program, such as outreach and education, qualified transition coordinators, and supplemental transition-related services.

States with less transition experience and capacity may take longer to implement MFP programs and are at greater risk of not meeting their transition goals. In contrast, MFP grantees that begin the program with large parallel programs may be able to launch MFP programs more quickly and meet transition goals more easily. However, some states have well-established nursing facility transition programs that have less stringent criteria than MFP but are more familiar to state staff, providers, and consumers; if institutional residents move to the community through these programs, it may be difficult for the state to meet MFP transition targets.

APPROACH TO EXPANDING TRANSITION COORDINATION CAPACITY

Transition coordination involves assessing consumers' potential to live in the community; arranging for long-term services and supports; and finding affordable, accessible housing. Regardless of current transition experience and capacity, nearly all MFP grantee states must recruit additional transition coordinators to carry out these functions effectively and to achieve the number of MFP transitions planned.

Before scaling up transition coordination capacity, states must (1) decide whether to use state or local government staff or to contract with private organizations and (2) determine the scope of the transition coordinator's role and relationship to other HCBS agencies and

programs. The time needed to implement these decisions can affect how quickly an MFP program can be launched and reach maturity.

With regard to staffing, state MFP programs are pursuing three models to increase transition coordination service capacity (see Table 1). Eleven MFP programs plan to rely on current or new staff from state or local government agencies. Ten states will contract with private or publicly funded organizations, such as Area Agencies on Aging, Centers for Independent Living, case management agencies, or Aging and Disability Resource Centers, for all MFP target groups. Nine states are combining these two approaches—contracting with private organizations to transition individuals from nursing facilities and relying on staff employed by the state’s developmental disability program to serve individuals living in ICFs-MR.

The ability to scale up transition capacity quickly using these approaches depends on a variety of state-specific conditions. States that use government employees or individual contractors to serve as transition coordinators can hire new staff using MFP grant funds. In theory, this allows these states to expand transition capacity rapidly as long as state government hiring policies do not delay the process. However, at a time when many state and local governments have severe budget deficits that trigger civil service hiring freezes, states that contract with private agencies may have the advantage in expanding transition capacity. States that have not contracted with transition coordination agencies in the past may have difficulty finding qualified contractors or negotiating a rate and other contract terms, which can slow the implementation process.

The roles and responsibilities of transition coordinators (who may be called relocation specialists, case managers, or other titles) vary by state. For example, some states expect transition coordinators to conduct outreach to residents of institutions, while others delegate this task to other agencies. Some transition coordinators are responsible for finding and securing affordable and accessible housing in MFP-qualified residences, while in other states MFP programs hire housing specialists for this task. Some transition coordinators set up a care plan but transfer responsibility for monitoring the plan to community professionals, such as HCBS waiver case managers, managed long-term care planners, or nurses.

In other states, transition coordinators work for the same organizations that provide ongoing case manage-

ment to all Medicaid HCBS waiver enrollees, including MFP participants, so they continue to monitor MFP participant care plans. States that consolidate these functions may be able to initiate programs more quickly than states that divide the roles among staff and agencies, which requires more time to coordinate.

Regardless of the scope of the transition coordinator’s functions, states that hire experienced transition coordinators who understand the MFP program can transition MFP participants more quickly, while states lacking skilled coordinators may need more time to hire staff, train them, and apply their knowledge.

STRATEGIES FOR FINDING AND EXPANDING THE SUPPLY OF AFFORDABLE AND ACCESSIBLE HOUSING

The ability to find and secure affordable, accessible housing is a key determinant of successful transition programs—as well as the most frequently cited barrier (Siebenaler et al. 2005). Housing options are frequently limited, especially if a beneficiary has lost his or her home due to a long institutional stay or if major modifications are needed to make housing accessible. Most housing markets around the country do not have enough units suitable for individuals with varying levels of disability. Public housing authorities typically have long waiting lists for Section 8 housing vouchers, and individuals leaving institutions often cannot afford to rent an apartment without extra financial support.

In light of problems with housing availability, every MFP program needs to develop strategies to expand the supply of housing options that meet MFP criteria as qualified residences.³ Developing and implementing such strategies will take time, especially for states that have not devoted much effort in the past.

Almost all states (28 of 30 MFP grantees) plan to establish or use existing registries to make information

³The MFP statute restricts MFP participation to those who live in “qualified residences,” defined as homes, apartments, or small-group homes. This requirement excludes assisted living facilities as an option in most states. The DRA statute defines a qualified residence as either (1) a home that is owned or leased by the person with the disability or by the person’s family; (2) an apartment with an individual lease, with lockable access and egress, that includes living, sleeping, bathing, and cooking areas over which the beneficiary or his or her family has domain and control; or (3) a residence in a community residential setting in which no more than four unrelated individuals reside.

on vacant and accessible units available to transition coordinators. Twenty-two states also plan to conduct outreach to landlords, public housing authorities (PHAs), or other housing agencies to broaden awareness about the MFP program and to foster collaboration. They plan to encourage housing agencies to make vouchers available to people with disabilities or to give preference to MFP participants on waiting lists. In addition, 19 MFP states set up a housing-related task force or committee to explore other ways to address the chronic shortage of affordable, accessible housing for individuals with disabilities.

Because developing new housing units or support programs can be a lengthy process, 10 states are designating funds in their MFP budgets to obtain priority status or set-asides for MFP participants in existing housing programs. For example, Indiana's Home Again pilot program provides incentives to developers to build new units for MFP participants. Washington and Maryland will pay for or subsidize rent on a temporary basis through state-funded "bridge subsidy" programs until the MFP participant qualifies for a Section 8 housing voucher.

Thirteen state MFP programs established explicit housing-related goals.⁴ A few states, such as New York, New Jersey, and Texas, plan to visit a specified number of PHAs each year to provide information and training to the staff. Some states go further by agreeing to set aside affordable housing units for MFP participants. For example, Michigan will work with the state housing development authority to classify people wishing to transition from a nursing home as "homeless," which would give them priority for Department of Housing and Urban Development vouchers.

While all states face an enormous challenge in finding affordable, accessible housing options for MFP participants, some states may face greater challenges than others. For example, some states lack necessary relationships with PHAs and local housing providers, while others lack funds to subsidize rental payments for those on long waiting lists for public housing units or Section 8 vouchers. Even if states are able to secure set-asides or priority status for some MFP participants in housing programs, there are no guarantees that a quali-

⁴ States were required to develop at least five annual goals, called benchmarks, as part of their MFP operational protocols (OPs)—detailed descriptions of each state's MFP policies and procedures. These benchmarks were intended to help measure the state's progress in transitioning individuals and rebalancing its long-term care system.

fied residence will be available for everyone who wants to leave an institution. With limited funding, states that can tap into existing development projects or other funding sources may find greater success in meeting the needs of MFP participants. In addition, states pursuing multiple strategies to increase the supply of and access to appropriate housing options may have greater success than those with limited approaches.

CHOICE OF MFP DEMONSTRATION AND SUPPLEMENTAL HCBS TO FACILITATE TRANSITIONS

In the past, a significant barrier to transitions has been gaps in state Medicaid coverage for critical services or supports needed by those seeking to move into the community. For example, 19 of 51 state Medicaid programs (10 of the 30 MFP grantees) do not cover personal care services as a state Medicaid plan benefit, so only people enrolled in HCBS waiver programs can receive this service. Even when personal care is available, the maximum weekly or monthly hours of personal care assistance may not be enough during the initial weeks or months following discharge from an institution. In addition, while states can choose to cover a variety of services under 1915(c) HCBS waiver programs, they do not necessarily cover all specialized care and mental health services that people with complex medical or behavioral health conditions need when moving into community settings.

Since people transitioning from institutions might need additional services during the period following discharge, the federal MFP statute allowed state grantees to offer two types of services to MFP participants during their one-year eligibility period:

- **MFP Demonstration Services.** These services include 24-hour personal care, transition coordination, and assistive technology. These are optional services that states can choose to cover but have not done so yet under their HCBS waivers or state Medicaid plan. States may, but are not required to, offer these services to MFP participants after the one-year MFP eligibility period. These services, and all other waiver and state plan-covered HCBS provided to MFP participants during the eligibility period, are reimbursed at an enhanced FMAP rate established by the MFP program.
- **MFP Supplemental Services.** These one-time or limited-duration services are associated with

TABLE 1. STATE MFP TRANSITION PROGRAM CHARACTERISTICS

State	Approach to Expanding Transition Coordination Capacity				Strategies for Finding and Expanding the Supply of Affordable, Accessible Housing					Categories of MFP Services to Facilitate Transitions				Alterations to Medicaid Policies and Programs			
	Government Staff	Private Contractors	Both		Registries	Outreach	Task Force	MFP Set-Aside Funds	Additional Benchmarks	Qualified plus Demo. AND Supplemental	Qualified plus Demo. OR Supplemental	Qualified Only	New HCBS Waivers	HCBS Waiver Amendments	Consumer Direction Benchmark		
TOTAL (N=30)	11	10	9		28	22	19	10	13	17	9	4	6	6	7		
Most Transition Experience and Capacity at Start of MFP (7 states)																	
Michigan		✓			✓	✓	✓		✓		✓				✓		
New Jersey			✓		✓				✓		✓						
Oregon	✓				✓	✓	✓				✓						
Pennsylvania			✓		✓				✓			✓					
Texas			✓		✓	✓		✓	✓		✓ ¹						
Washington			✓		✓	✓		✓									
Wisconsin	✓				✓	✓					✓	✓					
Some Transition Experience and Capacity at Start of MFP (13 states)																	
Arkansas	✓				✓	✓	✓				✓		AR Home ² Chronic Care	✓	✓		
Connecticut			✓		✓	✓		✓			✓			✓			
Delaware	✓ ³				✓	✓	✓		✓		✓				✓		
Hawaii		✓			✓	✓	✓				✓						
Illinois		✓			✓	✓		✓	✓		✓		Mental illness	✓			
Indiana		✓			✓	✓	✓	✓	✓		✓						
Iowa	✓				✓	✓	✓		✓		✓						
Kansas		✓			✓	✓	✓				✓						
Louisiana	✓				✓	✓		✓				✓	MR/DD & A/D		✓		
Maryland		✓			✓	✓		✓	✓		✓				✓		
Missouri ⁴	✓				✓	✓			✓		✓ ⁵						
New Hampshire		✓			✓	✓	✓				✓						
Ohio			✓		✓	✓	✓	✓			✓			✓	✓		
Least Transition Experience and Capacity at Start of MFP (10 states)																	
California			✓		✓						✓						
District of Columbia	✓				✓	✓	✓				✓						
Georgia		✓			✓			✓			✓			✓	✓		
Kentucky	✓				✓	✓	✓				✓		NF transition				
Nebraska	✓				✓	✓	✓				✓ ⁶						
New York		✓			✓	✓			✓			✓					
North Carolina	✓				✓	✓	✓				✓						
North Dakota			✓		✓		✓										
Oklahoma			✓		✓	✓					✓		Aged/PD				
Virginia			✓			✓	✓	✓	✓		✓ ⁷			✓			

Source: MPR analysis of state MFP OPs, approved by CMS as of June 2008. A/D = aged/disabled; NF = nursing facility; PD = people with physical disabilities.

¹Texas' OP states that all MFP participants will be enrolled in HCBS waiver programs or combined 1915(b)(c) waiver managed long-term care plans.

²Implementation of the Arkansas Home waiver has been put on hold, but the state expects to move forward after clearing some legislative delays.

³Delaware plans to start with government agency staff and then switch to private contractors.

⁴Missouri has substantial transition experience with the MR/DD population, which makes up 50 to 60 percent of its total MFP transition targets. However, the state has limited experience transitioning individuals from nursing facilities.

⁵Missouri is offering limited MFP supplemental services.

⁶Nebraska is offering telehealth services funded by enhanced FMAP revenues; technically, these services are not demonstration or supplemental services but can be regarded as such.

⁷Oklahoma will enroll MR/DD participants in its qualified HCBS waiver program, and A/D individuals will receive HCBS services as MFP demonstration services.

transitioning to the community and normally would not be covered by Medicaid. These costs and services include (1) security and utility deposits; (2) basic furnishings, groceries, and pest eradication; and (3) environmental, home, and vehicle modifications to make them accessible to disabled persons. These services are reimbursed at the state's regular FMAP rate. States can elect to cover some of these services on an ongoing basis through HCBS waiver programs. However, some supplemental services, such as roommate location and trial visits to community residences, cannot be covered by Medicaid after the MFP eligibility period ends.

Grantee states were permitted to decide whether to offer some or all of these extra services to MFP participants. Among the 30 MFP grantee states, 26 are offering MFP demonstration or supplemental services to enhance benefits received through qualified services under 1915(c) HCBS waiver programs and state plan services (see Table 1). Seventeen of the 26 states are offering both types of services, 7 are offering demonstration services only, and 2 (Missouri and Nebraska) are offering limited supplemental services.

The two most common MFP demonstration and supplemental services are (1) transition coordination beyond what is available through regular Medicaid programs and (2) one-time expenses associated with the move to a home- or community-based residence. While several MFP states covered transition coordination services through existing Medicaid options before MFP began,⁵ the transition coordination benefit may not cover all needed services. For example, for some states the transition process may take longer than 180 days, which is the maximum time allowed by federal rules. MFP state grantees can increase the time or intensity of such services by designating them as MFP supplemental services. In addition, many states are offering 24-hour personal care services since state Medicaid HCBS benefits often do not include this type of care at the necessary level of intensity. Connecticut, Georgia, and Hawaii will cover housing-related services, such as roommate match, housing locator services, and trial vis-

⁵ In September 2004, 11 of the MFP grantee states covered nursing facility transition services in one or more HCBS waivers: Indiana, Louisiana, Maryland, Nebraska, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Texas, and Wisconsin (Eiken et al. 2005). Other states added nursing facility transition services to HCBS waiver programs after 2004, but an updated list could not be found at the time of this report.

its to community residences, as a supplemental service. Oregon and Washington will pay for short-term rental subsidies with state funds.

A few MFP grantee states are offering extra services specifically to test whether the services help individuals with multiple or complex health conditions transition to or stay in the community longer. For example, Texas' behavioral health pilot program will offer two MFP demonstration services—cognitive adaptive training and substance abuse treatment services—to adults with co-occurring physical and behavioral health conditions who transition to the community from nursing facilities. If the state finds that the services reduce inappropriate reinstitutionalization, Texas may offer them statewide through its HCBS waiver programs.

Several states, including Arkansas and Hawaii, plan to offer telehealth services. For example, Arkansas will install telemonitors in an individual's home to collect and transmit clinical information, such as vital signs, to the patient's home health agency and to remind the MFP participant to take medications or blood glucose readings. The state plans to evaluate whether telehealth services help to maintain or improve functional independence and whether they reduce costs for skilled nursing services, compared to a control group with similar health and functional profiles. Hawaii plans to offer a "Virtual Care Office" as a demonstration service to MFP participants with complex medical or behavioral problems and to track whether the service reduces the number of rehospitalizations, emergency room visits, or transports between islands.

Due to the innovative nature of these services, they may take longer to put into place. For example, during the first year of its MFP demonstration, Texas encountered challenges enrolling as many individuals in its behavioral health pilot programs as planned. It also may prove difficult to determine service impacts if only a small number of individuals receive the services.

Over the five-year demonstration, the extra services offered by 26 MFP states represent a broad test of whether and to what degree additional services and supports increase the rate of transitions among long-term institutionalized residents. But the short-term challenge is to make sure the extra services are actually available. Initial reports from some grantees suggest that deciding on the scope of services, setting appropriate payment rates, and finding providers qualified and willing to provide new services can take

considerable time for Medicaid programs. In states with less transition capacity or providers who are disinclined to participate in Medicaid, implementation may be delayed.

CHANGES TO MEDICAID POLICIES AND PROGRAMS TO ENSURE THAT MFP PARTICIPANTS CAN CONTINUE TO RECEIVE HCBS AFTER THE DEMONSTRATION PERIOD ENDS

The federal MFP statute requires states to continue to make regular HCBS available to participants after MFP eligibility ends, as long as the person still needs community services and meets state Medicaid eligibility rules concerning income and functional status (DRA, Section 6071(c)(6)(C)). To meet this requirement, one-third of the grantee states plan to make significant changes to Medicaid HCBS policies or programs to ensure that all MFP participants can remain in the community after their MFP eligibility ends.

However, some of these changes take significant time to bring about, leading to delays in program implementation. Significant changes fall into three categories:

New HCBS Waiver Program. Six MFP grantee states plan to develop new HCBS waiver programs tailored to the needs of people transitioning from institutions (see Table 1). This change may be the most time-consuming since new waiver programs require lengthy applications and negotiations with CMS over the terms of the waivers, which can take a year or more to complete.

HCBS Waiver Amendments. Six states must modify existing waivers to increase the number of MFP participants they can serve on a continuing basis (see Table 1). While such waiver amendments tend to take less time than new waiver applications, expanding waiver capacity usually requires additional state appropriations and budget approval. States with HCBS waiver programs that can accommodate MFP participants after the one-year eligibility period can initiate MFP transitions without having to request waiver amendments or new appropriations.

Expanding Self-Direction Options. Several MFP states plan to increase options for MFP participants to self-direct services and supports during and after the MFP eligibility period. Consumer-directed care increases the likelihood that people needing HCBS obtain more of the paid care for which they are eligible,

compared to those who rely on traditional agency-provided services (Carlson et al. 2007).

Recent changes to federal Medicaid law and rules have made it easier for states to expand consumer-directed care options, making the process less time-consuming than other types of Medicaid HCBS program changes.⁶ However, they still take time to implement.

Because the federal MFP statute required CMS to give preference to states proposing to offer self-direction options, nearly all MFP grantees are planning to expand these options. Seven MFP states went further by establishing MFP benchmarks to increase the number or percentage of people choosing to self-direct services (see the last column in Table 1). For example, Arkansas, which has substantial experience in the Cash and Counseling Demonstration Program, aims to enroll 50 percent of MFP participants in self-directed care by the fourth demonstration year. To reach this goal, Arkansas is adding self-direction to the Medicaid state plan for those receiving personal care services. Delaware projects that 60 percent of MFP participants will choose to self-direct their care by 2011 because the state will provide training and education in person-centered planning and self-direction to consumers and staff.

In sum, states needing to make major Medicaid program and policy changes to make HCBS available to the initial set of MFP “graduates”—those completing a year of MFP enrollment—are more likely to encounter delays implementing their MFP programs than states not needing to do so.

WHAT ARE THE KEYS TO SUCCESS IN MFP TRANSITION PROGRAMS?

To achieve the MFP demonstration goals, state MFP programs must be able to implement effective programs and meet ambitious transition goals. In this report, we have identified numerous state and program characteristics that can help or hinder states in meeting their transition targets. Relative to states with less transition experience and capacity at the start of the program, those with greater experience are more likely

⁶ In 2005, the DRA authorized a new Medicaid plan option (1915j) that allows states to offer a comprehensive set of self-direction choices for people receiving personal assistance services, relieving states of the need to submit waiver or demonstration applications. Changes to 1915(c) waiver renewals also made it easier to offer self-direction options; as of 2007, at least 32 states offered some self-direction options in HCBS waiver programs.

to have adopted a combined approach to expanding transition coordinator capacity and to have set MFP goals related to expanded housing options; they were also less likely to plan major changes to Medicaid HCBS waiver programs to accommodate MFP participants after the eligibility period—perhaps because they had less need to do so. However, these patterns do not necessarily predict greater success in achieving MFP transition goals.

Many state grantees, including those with more transition experience, report that implementation challenges are slowing the pace of transitions. At the end of 2008, state MFP grantees reported a total of 1,505 transitions, compared to 4,250 transitions that states projected they would make by then. As a result, some grantees have modified total transition targets.⁷ The total number of transitions projected by MFP grantees for the five-year demonstration has fallen from almost 38,000 in states' original 2006 grant applications to about 34,000 as of January 2009, suggesting that some states' initial targets were overly ambitious.

Although the factors described in this report can affect states' progress in implementing programs, other program elements and state characteristics can have as much or more influence on whether states meet their transition goals. Indeed, states that begin the program with little transition experience and those that experience delays still could achieve transition goals with well-designed and -managed programs as well as good HCBS delivery systems.

For example, like most HCBS waiver programs, MFP programs are overseen by state Medicaid agencies. However, day-to-day operations are often managed by many other organizations, including state human service departments and local provider agencies. Thus, states with strong interagency collaboration may be better at resolving the problems that confront transition programs than states with poor collaboration. The strength of the partnership between state program managers and local transition staff may be another important key to success. In addition, hiring and retaining experienced staff who can ably manage this complex program may contribute to program success. Support

⁷ Between July and December 2008, four states significantly reduced total transition targets, eight states shifted large numbers of planned transitions to latter years of the demonstration, and one state (South Carolina) withdrew from the MFP demonstration.

from top leadership in state government is also likely to be essential, particularly for a program like MFP that can conflict with the interests of some stakeholders.

Involving consumers in MFP program oversight and implementation may be another critical factor. Consumers are involved in most MFP programs, at minimum as members of advisory committees. But some states planned to involve consumers more directly—for example, by having them serve as peer mentors or coaches for other consumers or by recruiting them to help overcome opposition by providers, family members, or unions to large-scale transitions. Will states that directly involve consumers be more successful in reaching transition goals?

The ability to meet transition goals may also depend on the characteristics of the MFP population targeted by each state. For example, Oregon and Washington are targeting people with complex medical conditions and higher levels of need. Connecticut, Illinois, and Pennsylvania are targeting individuals with chronic mental illness or people with physical disabilities and behavioral health problems. Such states may have a harder time finding appropriate community residences and securing all needed services and supports. By contrast, if a state's pool of MFP candidates includes more people with lower levels of need and without comorbidities, the program may have greater success in reaching transition targets because it is easier to move such people into community settings.

Finally, state economic conditions and budgetary circumstances may affect state MFP implementation and the ability to attain transition targets. The recent economic crisis has affected nearly every state, and shrinking revenues have forced most states to make cuts to agency budgets and staff. Local service agencies have also pared back services and staff as public and private revenues and grants declined. To the extent that these cuts reduce the availability of long-term supports and services in communities, they could impede the success of MFP transition programs, no matter how well they are designed and implemented.

In evaluating the MFP demonstration, Mathematica will employ several techniques to assess how state transition experience, MFP program features, and other state characteristics affect the attainment of transition targets and other program outcomes (Brown et al. 2008). First, we regularly monitor state MFP grantee reports to CMS, which provide progress indi-

cators and explain achievements and barriers to implementation. A future report in this series will focus on grantees' early implementation experiences and challenges in greater depth. Second, when results are available on program impacts and outcomes for MFP participants, such as rates of reinstitutionalization and changes in quality of life, we will assess whether states showing greater success on these outcomes are more likely to have certain program characteristics. Third, we will compare the health status, types of disabilities, and functional need levels of MFP participants in each state to determine whether success rates differ significantly by such characteristics. We will also interview program managers to understand how states' political and economic circumstances affect implementation progress and outcomes. Together, these analyses will provide important insights that all states can use to design effective transition programs for different populations and state conditions.

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DATA AND METHODS

Mathematica assessed each state's previous experience and approach to key elements of their transition programs based on information in their MFP OPs, which are descriptions of each state's MFP policies and procedures that must be approved by CMS. Program characteristics described in this report were based on MFP OPs approved by CMS as of June 2008. We verified the accuracy of the information with MFP project directors in early 2009. State MFP program features may change over the course of the demonstration if states make changes to their OPs with CMS approval or strategies are not implemented as planned.

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