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THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

June 2009

Money Follows the Person: An Early Implementation Snapshot

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EXECUTIVE SUMMARY

The Money Follows the Person (MFP) Demonstration is a Medicaid initiative designed to support state efforts to rebalance their Medicaid long-term care programs by providing more services in the community and fewer services in institutional settings. It targets individuals who have been residing in institutions for at least six months to two years and includes an enhanced federal matching rate (75-90% FMAP) for a twelve-month period for all long-term services costs for each person who successfully transitions to the community. Enacted into law in 2006, the MFP demonstration authorizes the Secretary of Health and Human Services to conduct a competitive process for awarding MFP grants to states. Following applications by 38 states, the Bush Administration announced grant awards to 31 states in 2007. In late summer 2008, the Kaiser Commission on Medicaid and the Uninsured surveyed states to elicit an early snapshot of progress to-date under the demonstration.[1] Survey responses were received from 29 of 31 states. This brief provides a first look at the program's successes and challenges to date.

Key Findings

- **States are just getting started.** Twenty-six of 29 states reported that their plans had been approved by CMS. Of the 14 states that had started enrolling participants, ten of these became operational in the summer of 2008.
- **MFP has already enabled several hundred people to move into the community.** Eleven states reported that they had completed 349 transitions and thirteen states reported that 465 transitions were currently in progress as of late summer/early fall 2008.
- **States are providing a broad range of services under the demonstration.** Commonly offered services include case management, transition assistance (that can cover rental deposits, utility hook-up expenses, and household set-up expenses), assistive technology, housing assistance, and home modifications to make the residence accessible to people with disabilities.

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[1] This brief is not intended to provide a comprehensive evaluation of the program. The Centers for Medicare and Medicaid Services (CMS) has contracted with Mathematica Policy Research to provide technical assistance to states and conduct a five-year evaluation of the program. It is anticipated that research reports will be produced beginning this year with a comprehensive report produced at the conclusion of the program.

- **Addressing housing issues is a major challenge for states.** Identifying safe, affordable, and accessible community housing for MFP participants in a major challenge for states. States report a serious undersupply of housing and inadequate support for housing vouchers and other forms of housing assistance. They also report challenges in addressing housing that require collaboration across multiple stakeholders including public housing authorities, and other internal and external stakeholders. At the same time, many states cite their progress in forming collaborative partnerships with these stakeholders as one of their key early accomplishments.

- **Nearly all states report not having to make budget cuts or programmatic changes to MFP as a result of the severe economic downturn.** The economic downturn has worsened significantly since this survey was conducted. In early 2009, we followed up with participating states to ask about the impact of the economic downturn on their programs. Since our initial survey, South Carolina has dropped its MFP program, but for reasons not directly related to the downturn. While most states reported no changes to-date, the serious economic situation may mean that cuts could arise in the future.

While states are just getting started with their MFP programs, it seems apparent that states have brought a great deal of energy and enthusiasm to their early MFP efforts. To the extent that MFP implementation has created an impetus for new or reinvigorated stakeholder collaboration and new partnerships with housing providers, this will provide benefits that extend beyond the life of this demonstration. Further, while the numbers are modest, it is still a clear achievement that the program has already enabled more than three hundred people who had resided in institutions for a considerable period of time to move into the community. It is anticipated that these early successes will grow considerably as more states begin enrolling participants and as programs ramp up their operations. Despite this progress, challenges remain that merit further monitoring, and may require additional policy responses.

INTRODUCTION AND OVERVIEW OF MONEY FOLLOWS THE PERSON

There is a well-known bias in Medicaid policy that extends an entitlement to nursing facility care to Medicaid beneficiaries when medically necessary, but does not entitle needy individuals to comparable community-based services. While all states provide some community services and, over time, they have been expanding their offerings of community services, progress has been slow. Even though community services are often cost-effective compared to institutional care on a per person basis and many people are isolated in institutions when they would prefer to live in the community, community services can be limited and waiting lists for Medicaid home and community-based services waiver programs can be large. Average wait times to receive services can exceed two years.

The Money Follows the Person (MFP) Demonstration is a Medicaid initiative to provide enhanced federal support for state efforts to rebalance their Medicaid long-term care programs to provide more services in the community and fewer services in institutional settings. It targets one of the hardest segments of the long-term services population—individuals who have been residing in institutions for at least six months to two years (the actual minimum residency requirement in each state is established at state discretion). Because these individuals have already relinquished a community residence, it is often more challenging for them to establish a community residence when compared to persons who are at risk for institutional placement and could be served by diversion programs or persons who have been institutionalized for a shorter time period and may still have a home to which they could return.

Congress enacted the MFP demonstration after several years of advocacy by the disability community and critical support from the Bush Administration. Legislative authority was needed because the demonstration authorizes an enhanced federal matching rate (FMAP) for a twelve-month period for each person who successfully transitions to the community (Figure 1). During this one-year transition period, the federal government pays 75-90% of total long-term services costs for the individual and states must continue providing the same package of community services at the regular matching rate after the first year in the community.

Figure 1

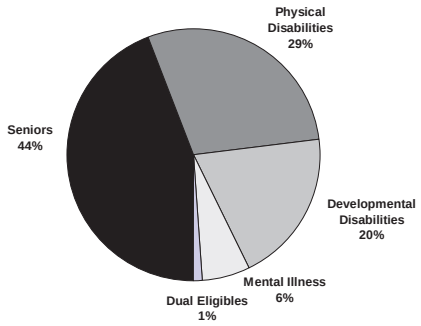
Key Money Follows the Person Provisions in the Deficit Reduction Act

- **Competitive Demonstrations:** Secretary awards grants to increase use of Medicaid community-based services over the use of institutional services
- **Incentive for Community Services:** Provides for enhanced FMAP for an individual's costs for 12 months from date of institutional discharge; after 12 months, state continues services at regular FMAP
- **Enhanced Federal Payments (FMAP):** Federal share of community long-term services is increased to 75-90%, depending on state
- **Eligible Participants:** Medicaid beneficiaries in institutions for residency period set by state (from 6 months to 2 years)
- **Funding:** $1.75 billion appropriated over the 2007-2011 period

CMS awarded MFP grants to 31 states through two separate award announcements in 2007. Collectively, MFP states have set a goal of transitioning nearly 38,000 people out of institutions during the initial five-year period of the MFP demonstration (Figure 2). See Table 1 (next page) for a break down on individual grants to states and specific population goals for each state.

Figure 2

Distribution of Planned Transitions, by Target Population



Total = 37,731 Planned Transitions Over Five Years

Source: Centers for Medicare and Medicaid Services, compilation of tiers one and two award summaries, as of July 1, 2007.

STUDY APPROACH

States were queried about their initial experience with the MFP demonstration via a Kaiser Commission on Medicaid and the Uninsured survey (See the Appendix for the complete survey instrument) that was emailed to the lead MFP contacts in each state. Responses were received by most states from July through September 2008. Two states completed the survey in 2009, but responses given were reflective of their experience as of August 31, 2008. All MFP states completed the KCMU survey with the exception of New Hampshire and New York.

As an initial snapshot, the quantitative data should be considered preliminary estimates only. States reported on their estimates as of the date they were completing the survey, and as this occurred over a four month period, these numbers provide only a general estimate of states' experience in late summer and early fall of 2008. States were also asked several qualitative questions which we reviewed for common responses or evidence of unusual or innovative approaches.

In January-February 2009, we followed up with participating states to ask them three questions related to the economic downturn: Has your state reduced funding for the MFP program since September 2008 on account of the economic downturn?; Has your state made any programmatic changes (since September 2008) to the MFP initiative on account of the economic downturn (i.e. limiting enrollment, reducing services, etc.); and, How would you describe the outlook for your MFP program in the future given concerns about the economic crisis?. Responses were received from all 29 states participating in the initial survey.

Table 1: Overview of MFP Grants to States Awarded in 2007

State	Five-Year Funding	Total Planned Transitions	Transition Goals, by Population				
			Seniors	Physical Disabilities	Developmental Disabilities	Mental Illness	Duals
AR	$20,923,775	305	92	146	60	7	0
CA	$130,387,500	2,000	400	899	331	185	185
CT	$24,207,383	700	280	140	70	140	70
DE	$5,372,007	100	32	28	20	20	0
DC	$26,377,620	1,110	215	645	150	100	0
GA	$34,091,671	1,347	375	375	562	35	0
HI	$10,263,736	415	115	242	58	0	0
IA	$50,965,815	528	0	0	528	0	0
IL	$55,703,078	3,357	1,517	1,000	105	735	0
IN	$21,047,402	1,039	768	200	71	0	0
KS	$36,787,453	934	242	406	286	0	0
KY	$49,831,580	431	108	107	216	0	0
LA	$30,963,664	760	364	76	320	0	0
MD	$67,155,856	3,091	1,617	1,149	250	75	0
MI	$67,834,348	2,500	1,500	1000	0	0	0
MO	$17,692,006	250	50	50	125	0	25
NC	$16,897,391	552	22	202	172	42	114
ND	$8,945,209	110	46	34	30	0	0
NE	27,538,984	900	400	300	200	0	0
NH	$11,406,499	370	325	45	0	0	0
NJ	$30,300,000	590	174	87	329	0	0
NY	$82,636,864	2,800	1,190	1,190	140	280	0
OH	$100,645,125	2,231	1,428	158	584	61	0
OK	$41,805,358	2,100	1,575	300	225	0	0
OR	$114,727,864	780	300	301	179	0	0
PA	$98,196,439	2,600	1,400	600	420	180	0
SC	$5,768,496	192	152	40	0	0	0
TX	$142,700,353	2,616	780	420	1,216	160	40
VA	$28,626,136	1,041	325	358	358	0	0
WA	$19,626,869	660	348	172	80	60	0
WI	$56,282,998	1,322	554	229	337	202	0
TOTAL	**$1,435,709,479**	**37,731**	**16,694**	**10,899**	**7,422**	**2,282**	**434**

SOURCE: Money Follows the Person Award Summary, Updated July 1, 2007.
http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp

FINDINGS:

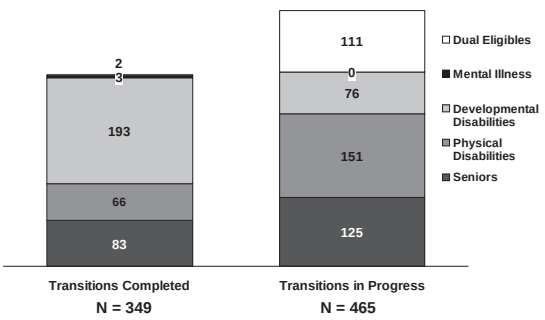
Progress-to-Date

Implementing a MFP program involves extensive planning at the state level, and extensive review and collaboration with CMS, which must approve each state's plan. As of the summer of 2008, 26 of the 29 states participating in the KCMU survey had their plans approved by CMS. States still awaiting federal approval were Louisiana, Nebraska, and Oklahoma. Once CMS gives approval, however, it does not immediately become effective with enrollment beginning. Of the 29 surveyed states, 14 states had begun enrolling participants, and 15 states had not yet started enrolling participants.

In the states that have begun enrolling participants, transitions are occurring. Eleven states reported that they have successfully transitioned 349 individuals into the community (Figure 3). Further, the thirteen states with programs in operation reported that an additional 465 transitions were in progress.

Figure 3

Distribution of Community Transitions To-Date, by Target Population



Notes: Figure provides an estimate as of late summer/early fall 2008 based on 14 states that had been enrolling participants. Totals also include 1 child and 1 person with a traumatic brain injury in both the "Completed" and "In Progress" categories which were not specified in a population category. Source: KCMU MFP survey, 2008.

Program Features

States were asked to identify key features of their programs—with the understanding that each state program has numerous features and service options. While a broad range of features were identified, four service categories were commonly cited by states:

- **Transition Services:** This is a relatively broad category that can include an emphasis on case management to assist individuals in managing the numerous complex actions that must be performed to establish a community residence, such as identifying housing and assisting with the steps needed to lease an apartment and coordinate a move. A key part of transition assistance in many states, however, includes flexible funding for a variety of activities, such as paying rental deposits, paying fees associated with hooking up utilities, and covering household set-up expenses, such as purchasing a bed and bedding or purchasing kitchen supplies and other items needed to maintain a household.
- **Assistive Technology:** States reported that a variety of assistive technology could be covered that enables individuals to reside in their own home. Technology specifically identified by states includes security devices, reminder systems, and medication dispensing devices.

- **Housing Assistance:** Housing assistance includes dedicated staff who are responsible for assisting MFP participants to identify housing options, as well as identifying financial supports, such as rental subsidies, housing vouchers, or other forms of financial assistance.

- **Home Modifications:** Many individuals with disabilities are prevented from living in their own homes—or accessing identified community housing—because the house is physically inaccessible. In some cases, relatively simple or inexpensive modifications can able individuals to live where they choose and can be an effective way of expanding housing options. States report that they use funds for things such as constructing ramps to provide wheelchair access, modifying bathrooms so that they are accessible, and installing safety equipment.

Other services that at least one state indicated that they cover include home-delivered meals, overnight companion services, access to urgent or emergency services 24 hours a day, individual and caregiver education, as well as specific behavioral health services, such as crisis intervention services. Several states also indicated that stakeholder collaboration was a central component of their MFP programs and several states indicated that promoting access to self-direction was a key policy goal of their program.

Case Management: All states reported that they cover case management services as part of their MFP program. One quarter of the states (7 of 29 states) report that they limit the number of days of case management that individuals can receive. When asked to report the average number of days case management needed for MFP participants, responses varied widely. One state reported that individuals need 24 days of case management, whereas other states reported that individuals need 6 months of case management prior to a transition in addition to case management during the full year that the individual resides in the community.

Medicaid policy allows states to provide case management and targeted case management services to assist in a transition of a Medicaid beneficiary from an institution to the community. Federal reimbursement is available for case management provided within the last 180 days of the stay in the institution. This policy was issued in 2000 in response to the U.S. Supreme Court's *Olmstead* decision, which found that the Americans with Disabilities Act requires states to provide services in the most integrated community settings that are appropriate to beneficiaries' needs. Under the Bush Administration, CMS issued a case management interim final rule that restricted payment for transitional case management but that rule has since been partially rescinded as of May 6, 2009.[2]

Housing Assistance: Nearly all states (26 of 29 states) reported that they assist individuals with meeting their housing needs. The level of types of assistance varies. In some cases, states indicated that they have formed collaborative relationships with the public housing authority, whereas other states reported that they have established registries to help link landlords/housing providers with prospective renters. Still other states reported that they have established housing coordinators to assist individuals in identifying appropriate housing.

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[2] Federal Register, May 6, 2009, Volume 74, Number 86.

Self-Direction: Nearly all states (26 of 29 states) reported that self-direction is a component of their MFP programs. Self-direction refers to various initiatives that give individual beneficiaries greater control over where, when, and how certain long term services are provided. Under one common model, an individual is given an individual budget to cover some portion of their long-term services and they are permitted to identify and arrange for these services on their own. Other models continue to rely on agencies to provide long-term services, but give individuals greater rights and responsibilities for recruiting, supervising, and firing direct care workers. States varied in their estimate of what portion of the MFP population would choose to direct their own services. Estimates of the percentage of participants who will self direct varied from three to eighty percent. The median estimated percentage of individuals who will self direct was 17.5 percent.

Quality: States were asked to identify key aspects of their quality strategy. The most common response, provided by at least half of the states was that they applied the same quality requirements as exist under the HCBS waiver program. Other states identified elements of this quality strategy. Previously, states were required to provide an assurance to the federal government that they would protect the health and welfare of waiver participants. In response to a concern that this assurance was not adequate and out of a desire to ensure that states operate a comprehensive state quality management system, CMS has outlined its expectations in the HCBS waiver Appendix H document. This document addresses seven domains:

1. Participant access;
2. Participant-centered service planning and delivery;
3. Provider capacity and capabilities;
4. Participant safeguards;
5. Participant rights and responsibilities;
6. Participant outcomes and satisfaction, and;
7. System performance.

Other ways that states address quality include the establishment of full-time quality improvement staff, formalized procedures for identifying qualified providers, assuring the availability of 24/7 back-up services, and the establishment of incident reporting procedures. Some states also indicated that their approach to quality assurance was a focus on remediation.

State Experience To-Date

Challenges: When asked to highlight their biggest challenges, four issues were most commonly reported by states:

- Gaining CMS approval of their operational protocol;
- Identifying appropriate housing;
- Working with numerous internal and external stakeholders; and,
- Meeting CMS reporting requirements.

Successes: States reported that their programs were so new their successes were limited. Commonly identified successes include:

- Gaining CMS approval of their operational protocol;
- Developing strong buy-in and achieving positive collaboration from a range of stakeholders;
- Obtaining the assistance and support from both hospitals and nursing homes to assist in education and recruitment; and,
- Positive partnerships that they have formed with public housing authorities.

Since the time of this survey, South Carolina has eliminated its MFP program. The state reported, however, that this was not directly related to the economic downturn. Rather, the state determined that the administrative costs associated with operating the program outweighed the benefit to the state given their low projected participation in the MFP program. Additionally, the state was previously awarded a nursing home transition grant which remains operational, and this grant provides additional flexibility to the state by requiring residency in a nursing home for only 90 days, as opposed to the 180 day minimum requirement for the MFP program.

ISSUES LOOKING FORWARD

Housing

Many states raised the need for additional support with housing. States have reported that greater funding is needed for housing assistance. While this is admittedly outside the purview of the MFP demonstration and Medicaid, they also would like to see increased CMS leadership in working with the Department of Housing and Urban Development (HUD) to facilitate collaboration between Medicaid and public housing authorities to prioritize access to housing vouchers for persons seeking to transition out of institutions. A few states indicated that they see the minimum six-month institutional residency requirement as a barrier to their program's success. Two states also indicated that they would like CMS to redefine congregate care settings so that residences with five or fewer individuals are treated as community residences under the program. Current rules designate a residence with five or more unrelated individuals as congregate care settings, which are not qualified community residences under the MFP program. A small number of states also indicated that they are challenged by billing issues, saying that their payment systems are not well-suited to paying for one-time transition expenses and other states reported that making programming changes to their information management systems was challenging.

Economic Downturn

In early 2009, states were queried about the impact of the economic downturn on their MFP programs. Most states reported that it has not yet had a tangible effect on their programs. Twenty-six of 29 states reported that their state had not yet reduced funding (since September 2008) for MFP or made any programmatic changes as a result of the downturn. While most states said that, to date, the downturn has had no impact on their program, two states represent the divergence of experience. Maryland, for example, reported that they are very worried about the sustainability of MFP after the demonstration ends. Michigan reported that while they have focused on nursing home transitions since 2006 and they have tangible evidence that it saves money, they are observing reductions in nursing home spending for the first time that they can recall.

CONCLUSION

While states are just getting started with their MFP programs, it seems apparent that states have brought a great deal of energy and enthusiasm to their early MFP efforts. To the extent that MFP implementation has created an impetus for new or reinvigorated stakeholder collaboration and new partnerships with housing providers, this will provide benefits that extend beyond the life of this demonstration. Further, while the numbers are modest, it is still a clear achievement that the program has already enabled more than three hundred people who had resided in institutions for a considerable period of time to move into the community. It is anticipated that these early successes will grow considerably as more states begin enrolling participants and as programs ramp up their operations. Despite this progress, challenges remain that merit further monitoring, and may require additional policy responses.

This brief was prepared by Molly O'Malley Watts, Kaiser Commission on Medicaid and the Uninsured. The KCMU would like to thank Jeffery Crowley, formerly of the Health Policy Institute at Georgetown University, for his assistance in the development of this survey and his comments on an earlier draft of the report.

Appendix: Survey Instrument

THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Kaiser Commission on Medicaid and the Uninsured (KCMU) is monitoring state experience with their Money Follows the Person (MFP) Demonstration Grant Programs. We are seeking to develop a quick snapshot of state experience to date in implementing these important programs.

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1. **Program Status:** Has CMS approved your plan? (Circle one) YES NO

   Is your program operational? YES NO

   If yes, what was the program start date? _____

2. **Key Features:** Please list or describe the key components of your program, such as expanded access to durable medical equipment, supplemental services (*i.e. housing coordination*), or partnerships with key community stakeholders.

_____

_____

3. **Transitions Since Implementation:**

   How many transitions have been completed for each target population?

   Seniors _____
   People with Physical Disabilities _____
   People with Developmental Disabilities _____
   People with Mental Illness _____
   Dual Eligibles _____

   How many are in progress?

   Seniors _____
   People with Physical Disabilities _____
   People with Developmental Disabilities _____
   People with Mental Illness _____
   Dual Eligibles _____

4. **Challenges:** Please list or describe the biggest challenges so far.

_____

_____

5. **Successes:** Please list or describe the biggest successes so far.

_____

_____

6. **Case Management:** Do MFP participants receive case management? YES NO

Is there a limit on the amount or number of days a participant can receive case management? YES NO

Please estimate the average number of days of case management needed for MFP participants. _____

7. **Housing:** Does your program address shortages in safe, affordable, and accessible housing? YES NO

If yes, please describe.

_____

_____

8. **Self-Direction:** Does your program permit self-direction? YES NO

Please estimate the percentage of participants who will direct their own services. _____

9. **Quality:** Please list or describe the key components of your quality management strategy.

_____

_____

10. **Future Issues:** Are there changes that the federal government could make to facilitate your transition efforts? If so, please describe.

_____

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THE HENRY J. KAISER FAMILY FOUNDATION

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