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MONEY FOLLOWS THE PERSON

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MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION GRANT PROGRAM

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Post-Institutional Services of MFP Participants: Use and Costs of Community Services and Supports

By Carol V. Irvin, Alex Bohl, Victoria Peebles, and Jeremy Bary

The Money Follows the Person (MFP) Demonstration supports state efforts to help Medicaid beneficiaries living in long-term care facilities transition back to community-based residences and to make community-based long-term care services and supports more accessible. To make transitions more feasible, MFP participants are typically offered during their first year back in the community expanded home and community-based services (HCBS) and supports beyond those normally available to Medicaid enrollees.

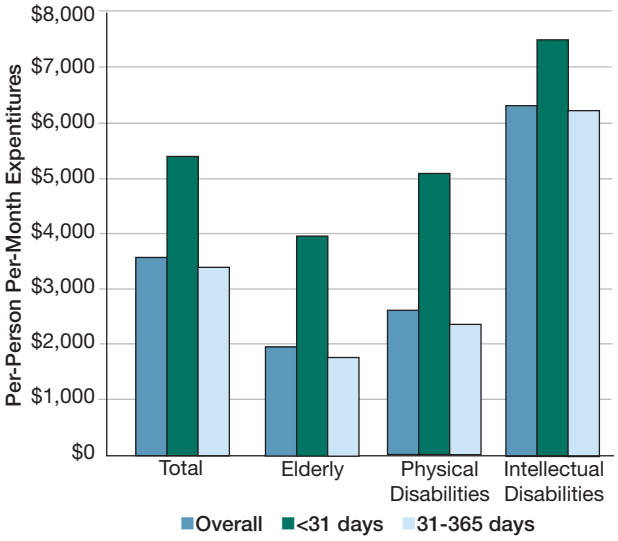
EXECUTIVE SUMMARY

This report uses aggregate data from annual financial reports and service claims records submitted by the grantees to examine the costs and types of community-based services MFP participants receive during the first year after the transition to community living. The analyses are descriptive and focus on portraying the community-based services and supports MFP participants use, and in doing so, this report lays some groundwork for later cost studies.

Key Findings

- *The annual per-person HCBS costs of MFP participants are nearly $40,000 during the first year of community living, ranging from $20,000 for the elderly to $75,000 for those with intellectual disabilities.*
- *Across all targeted populations, monthly HCBS costs incurred during the first 30 days after the initial transition to the community are anywhere from 20 percent higher to more than double those in subsequent months (Figure 1).*
- *Two categories of service dominate the HCBS expenditures of MFP participants: (1) home-based care, which includes personal assistance services, accounts for 44 percent of expenditures; and (2) round-the-clock residential services, such as 24-hour attendant care provided in group homes, account for 25 percent.*

Figure 1. Per-Person Per-Month HCBS Expenditures, Overall and by MFP Target Population



Source: MFP services and program participation data files submitted by 27 grantee states through March 2011.
Note: The District of Columbia, Kentucky, and Virginia were not included in this analysis due to incomplete data. Expenditures are weighted by length of participation in the MFP program. The <31 days category includes transition services provided either immediately before or at the time of the transition, as well as any HCBS provided during the first 30 days of community living.

ABOUT THE MONEY FOLLOWS THE PERSON DEMONSTRATION

The MFP Demonstration, first authorized by Congress as part of the Deficit Reduction Act of 2005 and then extended by the 2010 Patient Protection and Affordable Care Act, is designed to shift Medicaid's long-term care spending from institutional care to HCBS. Congress has now authorized up to $4 billion in federal funds to support a twofold effort by state Medicaid programs (1) to transition people living in nursing homes and other long-term care institutions 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 CMS, which initially awarded MFP grants to 30 states and the District of Columbia and awarded grants to another 13 states in February 2011. CMS contracted with Mathematica to conduct a comprehensive evaluation of the MFP demonstration and to report the outcomes to Congress.

The national MFP demonstration presents an important opportunity to understand the types of services needed to transition long-term residents of institutions to community living and to ensure these transitions are as successful as possible. For the purposes of evaluating the MFP demonstration, transitions to community living are considered a success when those leaving institutional care would have not done so without the program and they remain in the community on a long-term basis, ideally until the end of life. Previous research indicates that most MFP participants fare well in the community. Among early participants, 85 percent were able to live in the community for at least a year (Schurrer and Wenzlow 2011), and self-reported quality of life was higher, in some cases substantially so, a year after the transition (Simon and Hodges 2011).

Although conclusive evidence about the essential factors of successful transitions is lacking, key determinants are likely to include the delivery of services and supports to enable people to move back to the community and live independently in the community over the long term. Recent work by Lipson et al. (2011) suggests that program managers view the additional services provided at the time of the transition or during the first few months in the community as critical to achieving higher transition rates and lower reinstitutionalization rates. Given that MFP targets long-term institutional residents—those who have resided in institutional care for three months or longer—many participants might need extra services to make the transition and to adjust to community living. For example, some participants might need extra time and attention by transition coordinators or case managers to ensure that all services and supports are in place and well coordinated, that they are making the adjustment to new providers, and that their new home is fully accessible.

Any additional services required to achieve a successful transition from long-term institutional care to long-term community-based care will have cost implications. Even if the MFP demonstration increases the accessibility of community-based long-term services and supports and offers more choices to those with disabilities, the overall success of the program will be determined in large part by whether states can increase their transition rates beyond what would have occurred without MFP. More importantly, success at the programmatic level will be determined by states' ability to restructure their long-term care systems so that the overall health care provided by Medicaid programs to those living in the community is no more costly than when they reside in institutions.

This report first presents estimates of the costs associated with the HCBS that MFP participants have received during their first year of community living. Because the report is based on descriptive analyses, it represents only a first step to assessing the costs of moving people to community-based care. We estimated aggregate and per-person costs based on information from annual financial reports and service claims records submitted by the grantees. To better understand these costs, the study details the types of services MFP participants receive based on service claims records. The report also looks at how state grantees use the flexibility of the MFP program to offer supplemental services that Medicaid programs do not traditionally

cover outside of waiver programs.[1] How states use the demonstration's flexibility offers insight into which services state grantees believe are needed for some transitions, but might be difficult to finance either through traditional Medicaid options or other non-Medicaid options that exist within a particular state.

HCBS COSTS OF MFP PARTICIPANTS

Because MFP participants receive transition services, as well as additional HCBS during the early months of community living, MFP participants appear to incur more Medicaid expenditures for HCBS than other Medicaid beneficiaries who use such services and supports under Medicaid HCBS waiver programs (also known as 1915(c) waiver programs). Nevertheless, MFP participants' HCBS costs remain below those of institutional-based care. The aggregate financial reports provided by 29 state grantees[2] indicate that as of December 31, 2010, state grantees had spent approximately $371 million on HCBS (adjusted to 2010 dollars) for 11,849 MFP participants, or about $31,318 per participant (Irvin et al. 2011). To provide a context for understanding these costs, we compared these per-person costs with the national per-person costs for HCBS provided through Medicaid 1915(c) waiver programs and per-resident costs for institutional care. These comparisons are not ideal and should not be interpreted as indicating that the MFP program is either saving or increasing Medicaid costs because they do not adjust for differences in the population mix or differences in acuity levels between MFP participants and those in HCBS waiver programs or in institutional care. In addition, neither our estimates nor the national estimates adjust for the length of enrollment or institutionalization.

At approximately $31,000 per person, the HCBS costs of MFP participants are about 22 percent greater than the national HCBS costs among HCBS waiver participants, which were $25,623 per person in 2007 (Ng et al. [2011], adjusted to 2010 dollars). We compare MFP participants with HCBS waiver participants because most MFP participants either enter an HCBS waiver program when they transition to the community or will transition to a waiver program when they exhaust their 365 days of eligibility for MFP program benefits. Compared with institutional care costs, the HCBS costs of MFP participants are 34 percent lower than what Medicaid programs typically pay on a per-resident basis for nursing home care, which was approximately $47,231 per person in 2006 for elderly residents of nursing homes for at least three months,[3] and they are 77 percent lower than pre-resident expenditures for intermediate care facilities for the mentally retarded (ICFs-MR).[4] Although the data were not available at the time this report was written, future studies will compare an MFP participant's HCBS spending with his or her pre-transition institutional care costs.

The additional services MFP participants receive to support their transition to community living partly explain why their HCBS costs are higher than the average person in an HCBS waiver program. MFP participants may receive three categories of HCBS. The first includes all of the HCBS they would have received under Medicaid regardless of their status as demonstration participants—known within the demonstration as qualified HCBS. States receive an enhanced federal matching rate for the qualified HCBS they provide MFP participants. The state grantees report that approximately two-thirds of all HCBS expenditures for MFP participants are for qualified HCBS (Irvin et al. 2011).

The MFP demonstration also allows states to provide additional HCBS above and beyond what typical HCBS users receive. This second category of services—known as demonstration services—includes Medicaid-allowable services that are not otherwise offered by the state to similar beneficiaries. For exam-

[1] With approval from the Centers for Medicare & Medicaid Services (CMS), states may design and implement programs that waive certain sections of the statutes that govern Medicaid programs. At the time of this report, all but one state had 1915(c) waiver programs, also known as HCBS waivers, which enable them to offer HCBS to specific groups of Medicaid enrollees who need long-term services and supports. Through these HCBS waivers, states frequently offer services that are not necessarily allowed under the Medicaid statutes (such as security deposits for apartments).

[2] The District of Columbia was excluded from this analysis due to inaccuracies in its data.

[3] The reported information is based on Mathematica's analyses of Medicaid Analytic Extract (MAX) 2006 data. The 2006 spending amount is provided to illustrate the difference in spending between nursing home and HCBS care; Medicaid spending per long-term institutional resident would be higher if it included Medicaid costs for long-term residents of ICFs-MR. Future analyses in this evaluation will compare Medicaid spending per user for all long-term institutional care users with HCBS spending per MFP enrollee.

[4] In 2007, the average expenditure for ICF-MR residents was $138,234 (Lakin et al. 2010, adjusted to 2010 dollars).

ple, a state that does not normally offer caregiver training might make such services available to caregivers of MFP participants. States may also use this category to offer services that are normally provided to Medicaid beneficiaries with similar needs and characteristics, but in an amount not otherwise available to non-MFP Medicaid beneficiaries. Like the qualified HCBS, states receive an enhanced federal matching rate for demonstration services. Demonstration services account for approximately 29 percent of all HCBS expenditures for MFP participants (Irvin et al. 2011).

State grantees also have the option of providing a third category of services, known as supplemental services. Although states receive only their regular federal matching rate for these services, they are intended to be one-time services designed to help support the participant's initial transition. States may use this category to offer services typically not allowable by Medicaid rules and requirements outside of waiver programs, such as a security deposit on an apartment. Based on the most recent data available, supplemental services accounted for approximately 4 percent of all HCBS expenditures for MFP participants (Irvin et al. 2011).

VARIATION IN HCBS SPENDING ACROSS MFP PARTICIPANTS

The estimates presented above are based on aggregated data states present in their routine financial reporting for the MFP demonstration. To obtain a more detailed understanding of the HCBS costs of MFP participants, we analyzed individual service records for 5,484 MFP participants who had transitioned by the end of December 2009 and for whom a year's worth of service claims records were available.

From the initial transition to the end of enrollment in MFP, per-person spending on HCBS among the participants in this study is nearly $40,000 (Table 1). This estimate differs from the previous per-person cost estimate because it relies on claims (as opposed to grantee aggregate budget reports) and reflects transitions occurring through the end of 2009 (as opposed through the end of 2010).[5]

When per-person HCBS expenditures are adjusted for varying lengths of program enrollment that occur when some participants are readmitted to institutional care or die before completing 365 days of community living, we find that the HCBS costs of MFP participants are approximately $3,600 per person per month (Table 1).[6] This estimate of per-person per-month costs is substantially lower (62 percent lower) than the $9,430 per-person per-month costs reported by the Kaiser Family Foundation (2011). Differences between the estimates can be attributed to differences in the data available to each study and study methods. The Kaiser Family Foundation report relied on self-reported aggregate data from 15 states, whereas the data in Table 1 are based on claims records from 27 states. Kaiser's survey did not advise states on how to calculate per-person per-month costs, so that different states may have used different approaches to calculating the information they provided on the survey, whereas the data presented in Table 1 relied on the same methodology across all states. In addition, the question on the Kaiser Family Foundation's survey was sufficiently broad in its wording that some states may have included non-HCBS costs, such as administrative costs, in their estimates.[7] Lastly, the Kaiser data were not adjusted for either the length of enrollment in MFP or the size of the program, whereas the data in Table 1 account for both factors.

The overall per-person costs mask a high level of variability across the targeted populations. For example, we see more than a three-fold difference in overall per-person per-month expenditures between the elderly and those with intellectual disabilities. Data available for this study did not provide enough detail to explain this difference in expenditures between these two groups. However, any cost difference across groups most likely reflects differences in the type and intensity of services delivered to each population. Other research has shown that most MFP participants with intellectual disabilities move to small-group homes of four or fewer people, and group homes frequently provide 24-hour attendant care. When more detailed information becomes available, fur-

[5] In addition, the current analysis was restricted to those MFP participants with sufficient information about their MFP enrollment status during the 365 days after their initial transition to the community.

[6] Among the MFP participants used in this analysis, 10 percent had been readmitted to institutional care for at least 30 days and 6 percent had died before completing 365 days of community living. These reinstitutionalization and mortality rates are similar to what Schurrer and Wenzlow (2011) found with a slightly different group of MFP participants.

[7] The survey administered by the Kaiser Family Foundation asked the grantees to report the "…average monthly cost of serving a MFP participant…" (see page 13 of the Kaiser Family Foundation [2011]).

TABLE 1. PER-PERSON AND PER-PERSON PER-MONTH HCBS EXPENDITURES AMONG MFP PARTICIPANTS DURING THE FIRST 30 DAYS AND AFTER THE FIRST 30 DAYS OF COMMUNITY LIVING, BY TARGET POPULATION

Target Population	Number of Observations	Per-Person Expenditures[a]	Per-Person Per-Month Expenditures[b]		
			Overall	First 30 Days[c]	After First 30 Days
Total	5,484	$39,395	$3,601	$5,413	$3,423
Elderly	1,628	$20,706	$2,007	$3,984	$1,801
Physical Disabilities	2,013	$28,294	$2,610	$5,080	$2,365
Intellectual Disabilities	1,466	$74,732	$6,384	$7,564	$6,275
Other	108	$45,793	$4,649	$6,659	$4,427
Unknown	269	$40,428	$3,440	$4,215	$3,369

Sources: Mathematica analysis of MFP services files and program participation data files submitted by 27 grantee states through March 2011.
Note: Expenditures include qualified, demonstration, and supplemental services. The District of Columbia, Kentucky, and Virginia were not included in this analysis due to incomplete data.
[a] Calculated as the total expenditures divided by the total number of MFP participants. These figures are not weighted for length of participation in the MFP program.
[b] Weighted by length of participation in the MFP program.
[C] Includes transition services provided either immediately before or at the time of the transition, as well as any HCBS provided during the first 30 days of community living.

ther research will explore the specific services utilized by each target population and the associations between those services and overall average expenditures.

Monthly expenditures also vary over the year of community living and a disproportionate amount of HCBS expenditures are incurred within the first 30 days of enrollment (Table 1). The data indicate that monthly service expenditures during the first 30 days after the initial transition are on average more than 50 percent higher than those for the remainder of the year. Services delivered during the first month of enrollment include transition planning and coordination services, home modifications and set-up, and HCBS to support care needs. Some services—such as transition planning and coordination—can be provided while the patient still lives in the facility in preparation for the actual transition. As a result, the costs associated with the first 30 days include many services specific to the transition and are likely to be of short duration. The costs incurred after the initial 30 days are more likely to reflect costs associated with the ongoing care MFP participants need to live in the community on a long-term basis.

The magnitude of the difference between costs during the first 30 days and monthly costs after this initial period varies by population (Table 1). Among the elderly and non-elderly transitioning from nursing homes, costs during the first month of community living are more than double their monthly costs in later months. In contrast, among those with intellectual disabilities, costs during the first month are only 21 percent higher than their ongoing per-person per-month costs. Again, the target group differences in cost patterns are likely to be attributable to differences in the types of services each group receives.

Within each targeted population, we further disaggregated the per-person per-month expenditures by those who were or were not continuously enrolled in MFP for 365 days (data not shown). The expenditure patterns among these smaller groups are similar to those presented in Table 1, where expenditures during the first 30 days of community living are more than what is incurred in later months.

ARRAY OF SERVICES PROVIDED

To meet the care needs of its participants, the MFP demonstration relies on a diverse set of HCBS. The HCBS provided to MFP participants span many professional competencies and technology categories. For this work, we used as a guide the HCBS taxonomy that Thomson Reuters and Mathematica have been developing and testing for the Centers for Medicare & Medicaid Services

(CMS) to categorize HCBS waiver services (see Eiken 2011 and Wenzlow et al. 2011). We analyzed the HCBS used by MFP participants that were reported in the claims records from 28 state grantees. Whenever possible, we indicate when we adapted the HCBS taxonomy to better meet the needs of this study. As shown in Table 2, the services are organized into 16 mutually exclusive service categories; similar to the HCBS taxonomy, we added a 17th category to capture services that we could not classify because of inadequate information about what was provided. We also further disaggregated the information into 37 mutually exclusive subcategories to provide more information about the types of services within each category. These are far fewer subcategories than the HCBS taxonomy, which includes 66 subcategories, because the volume of claims did not always support the level of detail that the HCBS taxonomy was designed to capture.

Of the 17 different categories of services MFP programs provide, home-based and round-the-clock services dominate HCBS spending for MFP participants (Figure 2). Home-based services accounted for 44 percent of total HCBS expenditures for participants through the end of 2010, whereas round-the-clock services accounted for 25 percent.[8] Home-based services consist primarily of personal care assistance (see Table 2) to help people perform activities of daily living, such as transferring in and out of chairs and bed, using the toilet, or showering. The next largest category—round-the-clock services—consists primarily of residential services, such as residential habilitation.[9] The dominance of residential services is consistent with the makeup of the MFP population and their community residences; by the end of 2010, people with intellectual disabilities accounted for 26 percent of the MFP transitions and most of these participants transitioned to small-group homes of four or fewer people (Irvin et al. 2011), a setting that states frequently use to deliver an array of residential services.

MFP programs devote considerable resources to coordinating and managing the transition to community living. Overall, these services accounted for 7 percent of total HCBS spending by MFP programs by the end of 2010. However, these services might be underreported in claims data if states charge any portion as administrative expenses. A recent report by Lipson et al. (2011) underscores the importance of transition coordination to the progress of MFP programs. Transition coordinators have a variety of responsibilities that can include (1) conducting program outreach, (2) performing comprehensive assessments of transition candidates, (3) confirming Medicaid eligibility, (4) securing family or guardian support, (5) obtaining approval for HCBS waiver enrollment, (6) locating suitable housing, (7) arranging HCBS and other supports, and (8) developing contingency plans. MFP participants who transitioned to community living by the end of 2010 received an average of nearly $2,600 in coordination and management services, which included the array of transition planning services, as well as case management and care coordination services that 1915(c) waiver programs typically provide to manage the care of waiver participants.

The 13 service categories that remain—after accounting for home-based, round-the-clock, coordination and management, and unclassified services—made up 23 percent of the total HCBS costs of MFP participants, which suggests that of the array of different services MFP programs provide, many are either low-volume or low-cost services, or both. Day services (both day habilitation and adult day health); participant training; and equipment, technologies, and modifications accounted for about half of the expenditures in the remaining categories; however, alone each category accounted for only about 4 percent of overall HCBS expenditures.

When the variety of HCBS is assessed at the state level, we find that all programs provide home-based services and all but one state provides coordination and management services through a provider-claims process (Figure 3). The one state that did not have any claims records for coordination and management services provides transition and case management services, but pays for these services as administrative expenses.[10] Overall, states provide a large variety of

[8] These calculations include 5,620 participants who transitioned by the end of 2009 and 6,229 participants who transitioned in 2010. Although we could link most participants' MFP enrollment records with their claims, we could not create this link for all participants included in this part of the analysis.

[9] Residential habilitation is defined as services that assist in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills. To be considered residential services, they must be delivered in a residential setting rather than a clinical or nonresidential setting.

[10] The category of coordination and management includes housing supports and assistance. Only four state grantees reported claims for this service type. Because the analysis is based on service claims records, we assume most states provide housing assistance, but pay for this service through administrative funds rather than through a provider billing process.

TABLE 2. CATEGORIES AND SUBCATEGORIES OF HCBS PROVIDED TO MFP PARTICIPANTS THROUGH CALENDAR YEAR 2010

HCBS Category[a]	Description	Number of States Provided	Percentage of Total MFP Expenditures Nationally
1 Home-Based Services		28	43.6
1.1 Home health aide	Home health aide	11	1.0
1.2 Personal care	Personal or attendant care	26	40.8
1.3 Companion	Adult companion	7	0.2
1.4 Homemaker	Homemaker and chore services	17	1.5
2 Round-the-Clock Services		23	25.3
2.1 Group living	Group living	7	2.0
2.2 Shared living	Shared living, including adult foster care or adult family care	11	2.6
2.3 Residential, unspecified	Health and social services provided in the person's home or apartment in which a provider has round-the-clock responsibility for the person's health and welfare	18	20.7
3 Coordination and Management		27	6.7
3.1 Transition[b]	Transition coordination, transition specialist	22	4.9
3.2 Housing supports[c]	Assistance with finding housing and housing specialists	4	0.3
3.3 Case management[d]	Case coordination, plan development	23	1.4
4 Supported Employment		11	0.6
4.1 Employment[e]	Prevocational, supported employment, other employment services	11	0.6
5 Day Services		26	4.5
5.1 Day habilitation	Assistance in self-help, socialization, and/or adaptive skill provided in a fixed site during the working day	14	2.3
5.2 Adult day health	Health and social services provided in a fixed site during the working day	23	2.2
6 Nursing		23	2.0
6.1 Nursing	RN and LPN services	23	2.0
7 Meals		19	0.4
7.1 Home-delivered	Meals delivered to the home	18	0.4
7.2 Other meals	Meals (does not include home-delivered meals)	2	< 0.05
8 Caregiver Support		22	0.4
8.1 Caregiver support	Respite, caregiver counseling and training	22	0.4
9 Mental and Behavioral Health Services		19	0.5
9.1 Behavioral health	Behavioral health, psychosocial rehabilitation, day treatment, substance abuse, psychologist or social worker services	19	0.5
10 Other Health and Therapeutic Services		19	0.4
10.1 Nutrition	Nutrition counseling and supplies	10	< 0.05
10.2 Physician services	Services provided by a physician, NP, PA	6	0.1
10.3 Prescription drugs	Prescription drugs, medication administration and injections	10	< 0.05
10.4 Dental services	Services provided by a dentist or in a dentist's office	5	< 0.05
10.5 OT/PT/ST	Occupational therapy, physical therapy, speech therapy	14	0.2
10.6 Other therapies	Other health and therapeutic services, including communication aids, service animals, and drug infusion therapy	9	< 0.05

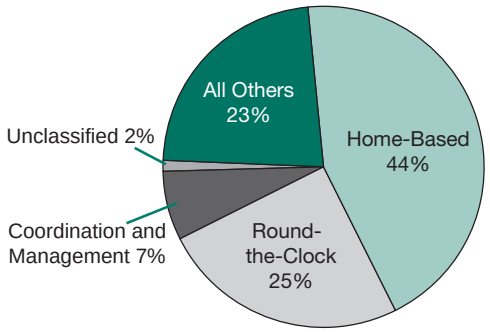
(continued)

TABLE 2. CATEGORIES AND SUBCATEGORIES OF HCBS PROVIDED TO MFP PARTICIPANTS THROUGH CALENDAR YEAR 2010 *(continued)*

HCBS Category[a]	Description	Number of States Provided	Percentage of Total MFP Expenditures Nationally
11 Services Supporting Participant Self-Direction		7	0.6
11.1 Self-directed funds	Funds allocated for self-direction	3	0.5
11.2 Assistance in self-direction	Assistance with the management of self-directed services and/or training in self-direction	5	0.1
12 Participant Training		15	4.6
12.1 Training	Other training (exclusive of home care or skills training)	5	< 0.05
12.2 Community support	Community supports, including independent living	13	4.6
13 Equipment, Technology, and Modifications		27	4.0
13.1 Personal systems	Personal emergency response systems (PERS)	23	0.2
13.2 Modifications	Home, vehicle, or workplace modifications	22	1.8
13.3 Equipment/Supplies	Equipment and supplies, including hospital beds, wheel chairs, surgical supplies, orthotics	27	2.0
14 Transportation		17	0.7
14.1 Medical	Ambulance services	2	< 0.05
14.2 Nonmedical	All other transportation services (nonmedical, transportation escort, unspecified)	17	0.7
15 Hospice		2	< 0.05
15.1 Hospice services[f]	Hospice services	2	< 0.05
16 Other	Services that do not fit within the categories above	12	4.3
16.1 Managed care[g]	Managed care capitation payments	1	3.4
16.2 Service tracking	Service-tracking claims[h]	1	0.7
16.3 Other	Services that do not fit within the categories above	12	0.3
17 Unclassified	Services that could not be identified because of missing information on the claims records	16	1.7

Source: Mathematica analysis of quarterly MFP services files submitted through May 2011.
Note: The service categories are mutually exclusive. The District of Columbia and Virginia were excluded from this analysis because of incomplete data.
[a] The HCBS taxonomy developed by Eiken (2011) and tested by Wenzlow et al. (2011) served as a guide for the categories and subcategories presented in this table. The order of services represents the hierarchy of how services were classified. See the Data and Methods sections for more details.
[b] One state refers to transition services as relocation services.
[c] The HCBS taxonomy includes housing supports in the "other" category of services. We included this service type in transition and case management services because of its critical role for the demonstration and potential similarities to the other service types in this category.
[d] The HCBS taxonomy treats case management as a stand-alone category, which includes transition coordination. We separated transition coordination from case management given the important role of this service in the demonstration.
[e] In the HCBS taxonomy, prevocational services and supported employment are separate subcategories. We combined them because of the low volume of claims.
[f] The HCBS taxonomy does not treat hospice as a separate category, but as a subcategory in the "other" category.
[g] We are aware of three MFP state grantees that provide HCBS to MFP participants through long-term managed care plans (Hawaii, Texas, and Wisconsin). Only one of these states reported monthly capitated payments in the MFP claims records used for this study.
[h] Service-tracking claims represent services (such as transportation) that were paid in bulk and cannot be assigned to specific participants.
LPN = licensed practical nurse; NP = nurse practitioner; OT = occupational therapy; PA = physician assistant; PT = physical therapy; RN = registered nurse; ST = speech therapy.

Figure 2. MFP Expenditures by Service Category



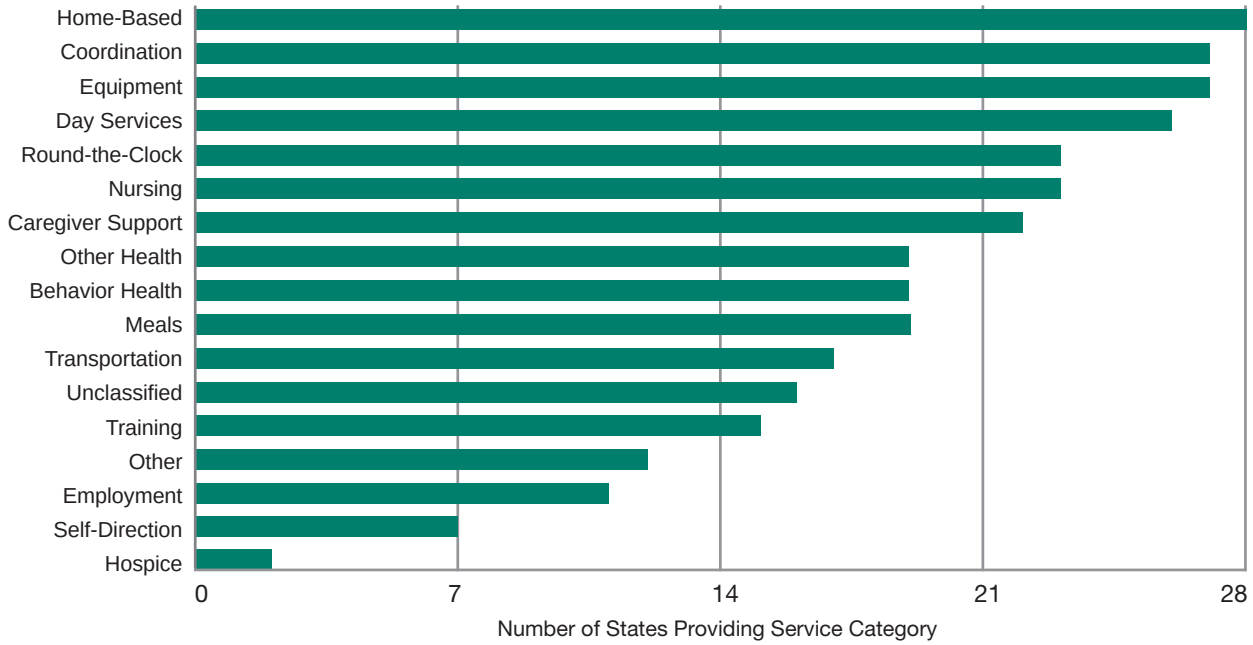
Source: Mathematica analysis of quarterly MFP services files submitted through May 2011.
Notes: The service categories are mutually exclusive. Percentages sum to 101 percent because of rounding. The District of Columbia and Virginia were excluded from this analysis because of incomplete data. "All Others" includes the remaining 14 service categories listed in Table 2, which include the Other Services and the monthly capitation payments MFP grant funds financed for those MFP participants in managed long-term care systems. Claims records that did not provide enough information to identify a detailed type of service, primarily because the records did not include descriptions for service codes, were labeled "unclassified."

services. When excluding hospice, unclassified, and the "other" service category, we find that more than half of the 28 states (15 grantees) provide 11 or more of the remaining 15 categories of services and three states provide 13 or 14 categories.

Besides home-based care and coordination and management services, most state grantees provide equipment, which also includes supplies, modifications, wheelchairs, and personal response systems. Of the 27 states with claims records indicating they provide equipment, 24 spent more than $7 million on equipment and related supplies, and 22 states spent another $7 million on modifications. Five states spent an additional $1 million on wheelchairs and accessories, including custom back cushions and pressure-ulcer prophylactic seats.

Day services and caregiver support are also provided by most state grantees (26 and 22 grantees, respectively). The most common caregiver supports were respite care—both in and out of the home—and caregiver training. Although listed as a day service, adult day services also support family members by relieving them of care-giving responsibilities during the day, and providing services to the participant. Adult day services were reported by 23 states and totaled more than $7 million.

Figure 3. Number of States Providing Each Service Category



Source: Mathematica analysis of quarterly MFP services files submitted through May 2011.

Note: The District of Columbia and Virginia were excluded from this analysis because of incomplete data.

In addition to providing transition services to plan and support community living, many MFP grantees provide training and counseling on financial management issues to help participants learn or relearn how to manage their finances successfully. By the end of 2010, the 15 grantee states providing this type of assistance had paid more than $15 million in claims for this service category.

The claims data available for this study contained little information about the use of self-direction options and the provision of hospice care. Self-direction is a method for providing services and will typically not generate service claims. As a result, the claims data used for this study underreport participation in self-direction, which provides Medicaid beneficiaries with the option of hiring or supervising their caregivers and managing a budget that they can use to obtain a variety of services they might need. According to aggregate data reported by the grantees, as of the end of 2010, 16 state grantees had MFP participants who self-directed at least some aspect of their services (Denny-Brown et al. 2011).

Hospice, a service that most Medicaid programs provide and is allowable as an MFP service, also appears to be underreported in the claims data used for this study. Only two state grantees reported claims for hospice services. If some of the participants who died while in the community received hospice care through the Medicare program, then the information presented here underreports the extent of hospice services because Medicare claims records were not included in the analysis.

SUPPLEMENTAL SERVICES

The MFP demonstration offers state grantees flexibility in the types of services they provide MFP participants. As noted before, through the category of supplemental services state grantees have the option of offering services not typically covered by Medicaid programs outside of waiver programs. This category is intended to include one-time or limited-duration services that are needed either near the time of the transition or soon afterward; it is intended to provide states the opportunity to cover services they believe are important, but which are not allowable under the Medicaid statute.

Based on a review of the recent operational protocols available at the time of this study, 17 of the 30 state grantees that had active transition programs at the end of 2010 took advantage of the demonstration's flexibility and offered MFP supplemental services.[11] Grantees' financial reports indicate that by the end of 2010, supplemental services accounted for 4 percent of the overall HCBS expenditures, a percentage that varies by state.[12, 13] Many of the supplemental services offered were not identifiable in the claims records either because of data reporting issues or because these services had not yet been provided by the end of 2010. As a result, the following description of supplemental services reflects only what state grantees make available to MFP participants, rather than actual payments for such services.

The supplemental services offered can be grouped into seven categories (Table 3). The first includes planning and coordination services that are likely to be provided before the transition occurs. Of the 17 states offering supplemental services, 6 use this category of services to offer transition services and 3 offer housing assistance that includes trial visits to the community residence, roommate-matching services, and environmental assessments. Presumably, these services go beyond what a program's transition coordinators or housing specialists may provide. States may offer many of these services through 1915(c) waiver programs, but if some MFP participants do not enter a waiver program upon transition to the community, these services will still be available to them.

In general, supplemental services are composed of nonclinical services that help MFP participants establish a residence in the community. For example, these services include helping participants with the actual move, such as the transportation participants might need to get to their community residence; payment for security deposits, utility hook-ups, and rent deposits to secure a lease; or help with stocking kitchen pantries or purchasing household cleaning supplies or some furnishings. States vary in the specific types of supplemental services offered, as well as the breadth of supplemental services. Only one state offers all seven categories of MFP supplemental services, and four state grantees offer five of the seven categories.

[11] Operational protocols describe each MFP program in detail. State grantees may update these protocols at any time.

[12] This figure was derived using MFP budget worksheets submitted by states.

[13] State-by-state supplemental service use is reported in the 2010 MFP Annual Evaluation Report (Irvin et al. 2011).

TABLE 3. SUPPLEMENTAL SERVICES OFFERED BY MFP PARTICIPANT STATES

Type of Supplemental Service	Number of States Offering
Planning and Coordination	11
Transition	6
Housing locator assistance	3
Trial visit	4
Roommate match	3
Environmental assessment	1
Initial Transition Services	7
Transportation	4
Moving assistance	3
Household Set-Up	11
General expenses	3
Security, rent, or utility deposit	8
Lock and key	1
Furniture, appliances, and furnishings	6
Food/grocery stocking	6
Pest eradication	3
Cleaning services and supplies	3
Clothing	3
Assistance with existing debt	1
Modification or Repair	6
Home	6
Vehicle	3
Employment site	1
Assistive Devices and Technology	6
General technology	4
Durable medical equipment	1
Internet installation	1
Service animals	2
Community Living and Decision Support	5
General financial counseling	3
Training in problem solving	2
Peer counseling and facilitation	1
Caregiver Support	3
Caregiver training	2
Provider/family support	2

Source: Mathematica review of the most recently available state MFP operational protocols available as of October 2011.

Because grantees do not receive an enhanced federal matching rate for supplemental services, CMS has helped grantee states convert many of their supplemental services to demonstration services whenever doing so would maximize the federal contribution. Transition planning and coordination is an example of a service that could qualify as a demonstration service. At the time this report was written, 22 states offered transition coordination (Table 2), but only 6 states classified these services as supplemental services (Table 3).

DISCUSSION

MFP state grantees have expended considerable time and resources establishing transition programs and ensuring they had providers in place who could serve the needs of participants (see Irvin et al. [2010] for a summary of the early implementation of MFP transition programs). The analyses presented in this study document that when participants transition to the community, states expend considerable resources to help MFP participants remain there. By the end of 2010, 29 state grantees had spent approximately $371 million on

HCBS for 11,849 MFP participants, or about $31,000 per participant (Irvin et al. 2011). These per-participant costs are higher than the national per-person costs of HCBS waiver participants, but the additional services MFP participants receive at least partly explain these higher costs. The demonstration was designed to provide states the flexibility to determine the type and amount of services people might need for their transition and help them adjust to community-based care. For many participants, the move will involve a change in service providers. Although HCBS expenditures per MFP participant are lower than national per-resident costs for nursing home and ICF-MR care, future studies are needed to develop more meaningful comparisons focused on the pre-transition institutional care costs of MFP participants, as well as their pre- and post-transition acute care costs.

Using MFP claims data to conduct a more detailed analysis of the HCBS expenditures of MFP participants, the current study found that HCBS expenditures incurred during the first 30 days of community living are higher than those in later months. This expenditure pattern is consistent with state grantee efforts to provide services that support the initial transition and help participants adjust to community-based care. The more detailed data also helped to identify the considerable variation in costs across the three main targeted populations. A three-fold difference in overall per-person per-month HCBS expenditures is seen between the elderly and the MFP participants with intellectual disabilities. More research is needed to understand these population differences in expenditures, but they are likely to reflect, in part, service utilization differences.

The grantees provide a wide range of services, although nearly 70 percent of the HCBS expenditures of MFP participants are for home-based personal care assistance and round-the-clock residential services, such as supervision and support provided in a group home. Personal care assistance and round-the-clock services are costly because they are ongoing services. Most people who use these services are likely to need this care not only throughout their MFP enrollment, but for the rest of their lives. The sizable share of expenditures accounted for by round-the-clock residential services aligns with previous research, which indicates that as of the end of 2010, approximately 24 percent of MFP participants moved into small-group homes that frequently provide 24-hour attendant care (Irvin et al. 2011).

Although home-based and round-the-clock residential services account for a sizable proportion of overall HCBS expenditures, state grantees provide 17 different categories of services and, within these categories, 37 service types. After home-based care and round-the-clock services, the most commonly provided service categories include coordination and management, equipment and modifications, day services, nursing, and caregiver support. Half of the grantee states provide 11 or more categories of services. This variety reflects a participant population that has wide-ranging needs and grantees' efforts to meet those needs.

More than half of the grantee states also take advantage of the flexibility the MFP demonstration affords by offering supplemental services generally not allowable by Medicaid statute outside of waiver programs. Most of these services are typically needed once, either right before or at the time that a participant moves to a community residence. Making these extra services available to participants—including roommate-locating services, security deposits, and home modifications—ensures that relatively small, one-time expenditures do not create a barrier to realizing someone's preference to live in the community.

This report describes the services MFP participants use in community-based settings and represents an incremental step toward determining the overall cost implications of the MFP program. Earlier research indicates that MFP has the potential to be a very effective alternative to institutional care, but these results are far from definitive. Among early participants, 85 percent were able to live in the community for at least a year (Schurrer and Wenzlow 2011) and self-reported quality of life was higher a year after the transition (Simon and Hodges 2011). More robust assessments of cost savings are required, including the incorporation of costs for acute care services. Although the statute authorizing MFP did not mention cost savings as an overall goal for the demonstration, the sustainability of MFP transition programs will be influenced, in part, by the overall financial results of moving long-term institutional residents to community-based care.

The basic descriptive information presented in this report has a number of limitations. The comparison of HCBS expenditures per MFP participant with national estimates for waiver participants does not account for differences between MFP participants and the people represented in the national data, including how the

overall populations are distributed across states and targeted populations, the time frames examined, the types of disabilities represented, or impairment levels and comorbidities. The comparison of HCBS costs with institutional costs nationally cannot be interpreted as savings for the same reasons, even if the comparison was done individually for each state and with risk-adjusted comparisons of MFP participants' costs with institutional cost estimates derived from the same state. To draw such inferences correctly would require that the analyses take account of whether MFP participants would have transitioned without the added services provided by the demonstration, and would require looking at all Medicaid costs incurred. A question for all transition programs is whether the benefits of improved quality of life and more independence outweigh the additional risks associated with living in the community and, for some, reduced levels of provider supervision. If MFP participants experience more adverse events—such as falls, infections, or dehydration—then the associated costs of treating these outcomes may outweigh any savings a Medicaid program might realize by moving more long-term institutional residents to community living. Ultimately, this issue is a question that can be empirically tested only with the full array of health care claims records—not just those for HCBS—from both MFP participants and a robust comparison group. Finally, the analyses looked over the year after transition only—the period when the participant was enrolled in the MFP program. Longer follow-up is necessary to determine the full impact of the program on costs and other outcomes.

Despite these limitations, the data and analysis presented here provide policymakers, program managers, researchers, and others interested in the MFP demonstration with a picture of the resources and multitude of services needed to support long-term institutional residents in the community. Future analyses will address the limitations noted earlier when sufficient claims data on MFP participants have accumulated. That research will look in more detail at program effects on the rate of transitions to the community, the health care utilization patterns and costs of MFP participants, and quality of care indicators to develop a comprehensive understanding of how MFP programs, and transition programs more generally, influence overall health care costs for people in institutions who wish to transition to the community and are able to do so with sufficient long-term services and supports.

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DATA AND METHODS

Data Sources

The data presented in this brief came from four sources. Aggregate information came from the most recently available (1) state supplemental budget worksheets, (2) state operational protocols, (3) person-level records from the quarterly MFP program participation data files, and (4) service records from the quarterly MFP services files. Aggregate estimates of HCBS spending and the proportion of expenditures by category (qualified HCBS, demonstration HCBS, and supplemental services) came from the supplemental budget worksheets submitted each year by states.

Data on MFP participants' age, target population, time of enrollment, and post-transition outcomes come from the MFP program participant data files that states submit each quarter. The MFP services file includes records for each service an MFP program provided to a participant and includes only HCBS financed with MFP grant funds. Person-level expenditure and utilization estimates were created by using Medicaid identification numbers to link records from the MFP services files with records in the MFP program participation data files.

The most recently available state operational protocols were used to describe MFP supplemental services. These protocols are required by CMS and must detail the service package that will be provided to each population (CMS 2007).

Data Integrity

Virginia and the District of Columbia were excluded from the analysis entirely because the MFP service files were either unavailable or incomplete. Kentucky is excluded in the person-level analysis because it switched from identifying participants through Social Security numbers to Medicaid Statistical Information System (MSIS) IDs, confounding our ability to match claims to participants. Data from Kentucky are included in the categorization of services.

Data Period

The analyses were focused on HCBS delivered through the end of calendar year 2010. To track person-level expenditures and utilization, we restricted the analysis to those individuals enrolled in MFP by the end of calendar year 2009 to ensure that we had complete information on services received during their first 365 days of enrollment. For this component of the analysis, we only used claims with service dates through December 2009. The categorization of services assessed claims over a longer time period and used all claims with service dates through December 2010.

Methods

Identification of target populations. The elderly, people with physical disabilities, and those with intellectual disabilities were defined based on their age and the type of institution from which they transitioned. We used data on age and institutional setting from the MFP program participation data files to assign MFP participants to one of these three subgroups. The elderly are individuals ages 65 and older who transitioned from a nursing home; people with physical disabilities are those younger than 65 who were in a nursing home; and people with intellectual disabilities transitioned from an ICF-MR. Those in the "other" category transitioned from other types of facilities, such as psychiatric hospitals. Participants classified as unknown could not be placed into a target population because of missing information on age or institutional setting.

Expenditure estimates. To improve the comparability of our aggregate cost estimates to national estimates, we adjusted all expenditures to 2010 dollars. The inflation factor was based on the national consumer price index for medical goods and services found on the Bureau of Labor Statistics web site (U.S. Department of Labor 2011). The cost estimates based on the person-level information were not adjusted.

Calculation of monthly expenditures. To calculate monthly expenditures and to control for length of participation in the MFP program, we summed the HCBS expenditures of every participant in the study and then divided

the result by the total number of days every participant had in the MFP program. We then multiplied the expenditure per day by 365 and divided by 12 to obtain the per-person per-month expenditure amounts. We conducted this calculation for everyone in the analysis and separately for each targeted population.

Post-transition outcomes. We constructed three mutually exclusive post-transition outcomes following the methodology developed by Schurrer and Wenzlow (2011). To summarize, those classified as "died" included people for whom death was the reason that participation ended. The "continuously enrolled" were people who did not die and completed 365 days of MFP program participation in the community. Finally, "reinstitutionalized" MFP participants include those who had a reported reinstitutionalization within 365 days after transition to the community and remained reinstitutionalized for at least 30 days.

Categorizing HCBS. MFP service claims for HCBS were categorized into 17 categories and 37 subcategories, based on service code descriptions, procedure codes, and the type of service field. Descriptions of services come from national Health Care Procedural Coding System descriptions and state-provided MFP cross-walks relating service codes to descriptions. Categories were adapted from the taxonomy for HCBS waiver services that CMS is developing with the assistance of Thomson Reuters (Eiken 2011). Under other work, Mathematica has tested the HCBS taxonomy that is under development (Wenzlow et al. 2011). Following this previous work, the numbering of the services represents the hierarchy of how the services were identified and classified for this current study. For example, home-based services were identified first and then the remaining records were searched for round-the-clock services, and so on. The type-of-service data element was also used to categorize service codes missing a description. The definition of the type-of-service data element conforms to that used in the national MSIS.

Limitations

Several important limitations of our analysis warrant consideration and caution. The information in this report should be considered preliminary and might not be representative of the overall program when we have more years of information. As a result, our findings have to be replicated for a larger proportion of participants, and the analyses must control for baseline characteristics of participants.

The comparison of HCBS expenditures per MFP participant with national estimates for waiver participants does not account for differences between MFP participants and the people represented in the national data, including how the overall populations are distributed across states and targeted populations, the time frames examined, the types of disabilities represented, or impairment levels and comorbidities. The comparison of HCBS costs with institutional costs nationally cannot be interpreted as savings for the same reasons, even if the comparison was done individually for each state and with risk-adjusted measures. Finally, the analyses looked over the year after transition only —the period when the participant was enrolled in the MFP program. Longer follow-up is necessary to determine the full impact of the program on costs and other outcomes.

For more information on this report, contact Carol Irvin at cirvin@mathematica-mpr.com.

Princeton, NJ Ann Arbor, MI Cambridge, MA Chicago, IL Oakland, CA Washington, DC

Visit the Mathematica website at www.mathematica-mpr.com.