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Early Implementation Experiences of State MFP Programs

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The Money Follows the Person (MFP) demonstration provides federal grant funds to 29 states and the District of Columbia[1] to support state efforts to rebalance their long-term care systems over a seven-year period. Under the demonstration, MFP states are planning to transition about 34,000 individuals from institutional settings to community-based care between 2007 and 2013. MFP states are also implementing initiatives designed to rebalance state Medicaid long-term care systems so they rely less on costly institutional care and individuals have a choice of where they live and receive services.

Since the start of the program in October 2007 when the first three states obtained approval from the Centers for Medicare & Medicaid Services (CMS) to begin, and the end of December 2008, states have transitioned 1,482 people or 37 percent of their targeted transitions for this period. Establishing MFP programs and achieving transition targets have been extremely challenging and several key themes have emerged:

- *About two-thirds of the grantee states began MFP transitions later than anticipated due to problems or delays in meeting federal planning and data reporting requirements.*
- *In half of all MFP states, community-level barriers such as lack of affordable and accessible housing and rental vouchers, have hindered states' ability to transition as many people as originally planned.*
- *In many states, the economic downturn and worsening state budgets have strained state Medicaid management resources as well as home- and community-based service (HCBS) capacity, and the combination has reduced the number of people who can be transitioned through MFP, at least in the immediate future.*

This report describes states' early implementation experiences and state transition activity as of December 2008. It also discusses the challenges that states have encountered in trying to launch the program, and implications for making fundamental changes in the long-term care system.

Enacted by the Deficit Reduction Act of 2005, the MFP demonstration is the largest Medicaid demonstration program to date designed to assist states to make broad changes to their long-term care systems so they are more sustainable and better able to support individuals who want to live in the community. With up to $1.7 billion in federal grant funds, MFP states are implementing transition programs and rebalancing initiatives in an effort to shift their Medicaid long-term care systems from institutional to community-based care. The demonstration will test the types of services and supports needed to move long-term

[1] Hereafter, we refer to the 30 grantees, including the District of Columbia, as the 30 states.

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 CMS, which initially awarded MFP grants to 30 states and the District of Columbia. From 2007 to 2013, grantees will plan and implement programs to transition individuals from institutions to qualified community residences. CMS contracted with Mathematica Policy Research, Inc., to conduct a comprehensive evaluation of the MFP demonstration and report the outcomes to Congress in 2012.

institutional 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.

Establishing MFP programs and achieving transition targets have been challenging for states in several respects. First, all MFP states must follow certain requirements imposed by the federal MFP statute. For example, eligibility is restricted to Medicaid beneficiaries who have been institutionalized for at least six months in nursing homes, hospitals, intermediate care facilities for the mentally retarded (ICFs-MR), or institutions for mental diseases (IMDs).[2] Upon transition to the community, participants must reside in a qualified residence which include a home, an apartment, or a small-group home in which no more than four unrelated individuals reside.[3] Second, most MFP participants need to secure affordable and accessible housing which is limited in most states. Securing housing is especially challenging if the participant lost his or her home due to a long institutional stay or if major modifications are needed to make housing accessible. Third, MFP states must also have an adequate supply of HCBS to ensure participants' needs are safely met in the community. Lastly, MFP states must put in place a 24 hour back–up system, a risk assessment and mitigation process for MFP participants, and an incident reporting and management system which include discovery, remediation, and improvement procedures. These systems are in addition to the standard assurances for 1915(c) waivers.

This report describes MFP states' implementation experiences since October 2007, drawing on information in states' 2008 semiannual progress reports submitted to CMS.[4] First, it describes the status of MFP implementation in the 30 states and presents data on the number of people they have helped to transition from institutions to home or community residences as of December 2008. It also compares the numbers transitioned with state projections by that date. Then, it discusses some of the barriers states have encountered in the early stages of program implementation, including administrative challenges, problems finding adequate housing and supportive services for participants, and the effects of the economic downturn. It also describes how states have worked to overcome these challenges. The report concludes by discussing the implications of early implementation experiences for long-term care system change.

MFP STATES' TRANSITION ACTIVITY SINCE PROGRAM START

The implementation of MFP transition programs has been gradual across the states and the first programs began moving beneficiaries into community living in October 2007. As shown in Table 1, 7 states began transitions between that time and May 2008, 16 states began between June 2008 and December 2008, and the remaining 7 states began in 2009.

[2] Eligibility for Medicaid coverage of care received in institutions for mental diseases (IMDs) is restricted to individuals age 65 and over, or under age 21. Consequently, working age individuals between the ages of 21 and 65 and residing in IMDs are not eligible.

[3] The DRA statute defines a qualified residence as either a home owned or leased by the individual or individual's family member; an apartment with an individual lease, with lockable access and egress, that includes living, sleeping, bathing, and cooking areas; or a residence in a community-based residential setting in which no more than four unrelated individuals reside.

[4] The semiannual progress reports are rich in detail but have their limitations which are described on page 10 of this report.

TABLE 1. START DATES FOR MFP PROGRAM IMPLEMENTATION			
October 2007 – May 2008	**June 2008 – December 2008**		**January 2009 – August 2009**
Maryland	Arkansas	Kentucky	Connecticut
Missouri	California	Michigan	Illinois
New Hampshire	Delaware	Nebraska	Indiana
Oregon	District of Columbia	New Jersey	Louisiana*
Texas	Georgia	North Dakota	New York
Washington	Hawaii	Ohio	North Carolina
Wisconsin	Iowa	Pennsylvania	Oklahoma
	Kansas	Virginia	
*Louisiana planned to begin transitions by August 2009.			

Variability in the period during which states began implementing their programs is a function of several factors: (a) when states submitted MFP operational protocols (OPs), which explain in detail all policies and procedures, and obtained CMS' approval to begin program implementation; (b) states' ability to comply with federal reporting requirements to ensure proper use of funds; and (c) the extent to which states have infrastructure in place to operate transition programs. For example, among states that began implementation earliest, most had prior experience with nursing home or ICF-MR transition programs. This enabled them to launch their MFP programs more quickly because they could rapidly craft their plans and policies and build upon existing infrastructure.

CMS required states to set their own program goals and targets, including the number of Medicaid enrollees in one or more of five subgroups that they planned to transition to the community during each year of the demonstration. The number of proposed transitions in 2008 varies greatly across states (Table 2), due in part to states' prior experiences and capacity with transition programs, the number of institutionalized Medicaid enrollees who are eligible for MFP in a given state, and states' expectations for transitions during the first full year of the demonstration. For example, four states with little current transition capacity proposed transitioning 10 individuals or fewer in 2008, which likely reflects their expectation that it would take time to put the program into operation during the first year of the demonstration. Other states set much higher goals for the number of proposed transitions, suggesting they had either substantive experience operating transition programs or the individuals they targeted for transition could be easily relocated to the community and their service needs could be readily accommodated.

During 2007 and 2008, MFP states proposed to transition a total of 3,997 individuals to the community. States collectively transitioned 37 percent (1,482) of this projected number of participants by the end of 2008. But only four states met their 2008 transition goals and two other states achieved more than 50 percent of their 2008 transition goals (see Table 3). Five states achieved between 25 percent and 50 percent, 18 states achieved less than 25 percent of their total 2008 transition goals, and one did not plan to transition anyone until 2009. Based on this experience, 70 percent of MFP states have already revised or intend to amend their transition goals.[5] Some states intend to redistribute transitions across target populations and grant years, expecting that the rate of transitions will increase in later years of the demonstration. Other states plan to reduce the total number of transitions over the entire demonstration period in response to delays or challenges encountered. However, a couple of states may increase the planned number of transitions over the course of the demonstration in response to higher than expected rates of transition.

Of those individuals who transitioned to the community, some MFP participants were reinstitutionalized because of one or more contributing factors, such as a decline in health, a medical episode, or inadequate HCBS upon discharge. In 2008, a total of 104 individuals were reinstitutionalized, 54 percent of whom

[5] Revisions to transition targets that CMS approved after July 2008 are not reflected in Table 2.

TABLE 2. MFP TRANSITIONS: OCTOBER 1, 2007 – DECEMBER 31, 2008

State	2007 & 2008 Total Transition Targets[a]	Percentage of 2007 & 2008 Transition Target Achieved	Number of Participants Transitioned to Date	Number of Elders Transitioned	Number of People with Physical Disabilities Transitioned	Number of People with Developmental Disabilities Transitioned	Number of People with Mental Illness Transitioned	Number of "Other" People Transitioned	Number of MFP Participants Living in: Home	Number of MFP Participants Living in: Apartment	Number of MFP Participants Living in: Group Home
Arkansas	43	51.2	22	1	7	14	0	0	7	14	0
California	51	3.9	2	0	2	0	0	0	0	2	0
Connecticut	24	0.0	0	0	0	0	0	0	0	0	0
Delaware	3	100.0	3	1	2	0	0	0	2	1	0
District of Columbia	10	150.0	15	0	0	15	0	0	0	2	13
Georgia	87	3.4	3	2	1	0	0	0	2	0	1
Hawaii	20	5.0	1	0	1	0	0	0	0	1	0
Illinois	311	0.0	0	0	0	0	0	0	0	0	0
Indiana	216	0.0	0	0	0	0	0	0	0	0	0
Iowa	75	12.0	9	0	0	9	0	0	2	5	2
Kansas	363	19.3	70	3	5	60	0	2	2	12	56
Kentucky	22	22.7	5	1	4	0	0	0	1	3	1
Louisiana	58	0.0	0	0	0	0	0	0	0	0	0
Maryland	333	46.2	154	54	65	33	0	2	40	60	54
Michigan	75	118.7	89	48	41	0	0	0	40	36	0
Missouri	91	80.2	73	9	32	27	0	5	17	31	18
Nebraska	299	6.4	19	0	3	16	0	0	3	1	14
New Hampshire	96	26.0	25	5	11	1	0	8	5	17	3
New Jersey	89	12.4	11	2	1	8	0	0	3	0	7
New York	36	0.0	0	0	0	0	0	0	0	0	0
North Carolina	0	NA	0	0	0	0	0	0	0	0	0
North Dakota	20	25.0	5	1	1	3	0	0	0	5	0
Ohio	266	22.6	60	1	3	56	0	0	1	20	39
Oklahoma	6	0.0	0	0	0	0	0	0	0	0	0
Oregon	112	28.6	32	6	12	12	0	2	4	14	14
Pennsylvania	215	19.5	42	37	5	0	0	0	21	21	0
Texas	592	128.5	761	281	212	266	2	0	362	133	266
Virginia	81	19.8	16	1	3	12	0	0	5	0	11
Washington	96	39.6	38	9	21	8	0	0	0	19	13
Wisconsin	307	8.8	27	7	6	14	0	0	10	4	5
TOTAL	**3,997**	**37%**	**1,482**	**469**	**438**	**554**	**2**	**19**	**527**	**401**	**517**

Source: MFP semi annual web-based progress reports for 2007 and 2008.
Note: The total number of participants residing in each type of qualified residence reflects the number of current participants.
[a] The reported information reflects targets as of the end of June 2008. States may revise their targets at any time. Only Missouri, New Hampshire, and Wisconsin set 2007 transition targets, as these programs began in October 2007.

TABLE 3. PERCENTAGE OF 2008 TRANSITION TARGETS MET BY MFP STATES				
Less than 25%			25 to 50%	Greater than 50%
California	Iowa	New York	Maryland	Arkansas
Connecticut	Kansas	Ohio	New Hampshire	Delaware
Georgia	Kentucky	Oklahoma	North Dakota	District of Columbia
Hawaii	Louisiana	Pennsylvania	Oregon	Michigan
Illinois	Nebraska	Virginia	Washington	Missouri
Indiana	New Jersey	Wisconsin		Texas

Note: Since North Carolina did not plan to transition anyone until 2009 it is not included in this table.

were reinstitutionalized for more than 30 days.[6] MFP grantees reported that most participants returned to the community after a stay in a hospital or nursing home. But some of these MFP participants were unable to go back to the community because their medical needs were too serious or they chose to remain in the institution. To strengthen the transition planning process and reduce the likelihood of reinstitutionalization, one state modified its transition planning processes so that transition candidates receive a more thorough clinical assessment early in the process to ensure that plans of care are appropriate, adequate, and viable.

Several states have reported that certain MFP statutory requirements have hindered enrollment into the MFP program and transitions to the community. In 2008, states reported that 51 individuals, or 5 percent of the 1,039 who could not be enrolled in MFP, qualified for the program but did not choose to reside in an MFP-qualified residence in the community. Several MFP grantees have anecdotally reported that the MFP statutory exclusion of assisted living facilities as qualified community residences is a barrier to transition for those participants who prefer that type of housing in the community, particularly for those states that have a shortage of affordable and accessible housing that meets the MFP requirements for qualified residences. CMS examined the appropriateness of assisted living facilities as qualified residences and issued policy guidance to MFP states in July 2009. The guidance describes seven conditions that must be met for community residential settings, including assisted living facilities, to be considered a qualified residence under MFP statute.

[6] MFP participants who have been reinstitutionalized for more than 30 days are disenrolled from the MFP program. However, states may reenroll a former MFP participant back into the program without reestablishing the institutional residency requirement as long as the state reevaluates the former MFP participant's plan of care to determine if additional supports in the community are needed as a result of a change in the participant's health status (CMS 2007).

Some MFP grantees have also anecdotally reported that the six-month minimum institutional residency requirement is a barrier to recruitment and enrollment efforts because many candidates interested in transitioning to the community have not been instititionalized long enough to qualify, and beneficiaries who do meet the requirement frequently have complex medical or mental health conditions that make it very difficult to serve them safely in the community. Some states have parallel nursing facility transition programs that have less stringent criteria than MFP. In states with these programs, residents who have been institutionalized for fewer than six months can and do move to the community, but they are not counted toward the state's MFP transition targets. To bolster enrollment, some MFP grantees are developing more intensive outreach strategies to identify individuals who are eligible for MFP, who want to move to eligible community settings, and who can do so safely with available supports and services.

ADMINISTRATION AND REPORTING BARRIERS

Delays in meeting federal planning and reporting requirements contributed to many states missing their 2008 transition goals. Two-thirds of all MFP grantees did not submit their initial or revised OPs to CMS for review and approval until May or June 2008, which delayed implementation of their programs.[7] These states took a year or more to develop their plans for

[7] MFP states were required to prepare and submit an OP to CMS by June 30, 2008 that explains in detail all policies and procedures that would be implemented in the program. Before MFP states could begin program implementation, the OPs had to be reviewed and approved by CMS. Any programmatic changes over the course of the demonstration must be documented in an amendment to the OP.

program implementation and to obtain CMS approval. Only after these states received approval of their OPs were they able to initiate start-up activities for their transition programs.

Several states could not begin program implementation until late in 2008 because of delays in negotiating and securing contracts with transition specialists or case management contractors. Five states (Connecticut, Indiana, Iowa, Kentucky, and Maryland), had to delay program startup due to lengthy procurement processes to hire key staff who would either provide outreach, transition coordination, or case management services.

Even if a state has adequate capacity to conduct transition planning, other issues have delayed the start of MFP transitions. Wisconsin, for example, has substantial experience operating large-scale transition programs and obtained federal approval to begin its MFP program in October 2007. But the state could not enroll individuals participating in Family Care, a managed long-term care program, into the MFP program because it could not reliably track them in the state's Medicaid Management Information System (MMIS). Wisconsin's MFP transition numbers are expected to increase once the MMIS is upgraded and fully operational in early 2010. New Jersey, which also has experience in transitioning institutional residents, delayed the start of transitions until September 2008 when the state was ready to implement the MFP Quality of Life survey which is administered to participants near the time they transition to the community. Getting survey operations established delayed program implementation and affected enrollment and attainment of the state's 2008 transition goals.

In some states, the need for interagency collaboration has affected the pace of MFP program startup. The complexity and scope of the MFP demonstration requires that several different agencies in each state work together to plan, implement, and deliver services to participants. Coordinating across state agencies can be difficult when one agency manages the overall program and other agencies manage the waiver programs; everyone has to agree on assessment, care planning, and quality assurance and risk mitigation processes. Also, each state department or service system has separate data collection and reporting systems and different protocols and procedures for performing agency functions. Since the program started, MFP states have had to establish systems to facilitate tracking and sharing of information among the state Medicaid agency, state agencies that manage HCBS waiver programs, and contracted vendors. For example, 6 MFP programs spent 2008 establishing common screening and assessment tools, 12 developed common systems to track enrollment, and 16 enhanced systems to collect and report financial or service data in a timely manner.

Delays in program implementation were compounded by the fact that it can take considerable time to publicize a new program such as MFP and ensure that providers, individuals and families, and community leaders understand and support it. Eight states (Delaware, the District of Columbia, Georgia, Hawaii, Kentucky, Nebraska, Oregon, and Virginia) reported that obtaining referrals from agencies and providers was a significant challenge to the program's recruitment efforts. Four of these states (Georgia, Hawaii, Nebraska, and Virginia) also experienced challenges obtaining referrals from individuals and families themselves. These states attribute the problem to resistance by providers or family members, who cite concerns about the health and safety of individuals if they were to move out of the institution. Some providers may also oppose MFP if they perceive it as a threat to their financial viability.

To allay such concerns, CMS required state MFP programs to adopt health and welfare protections that go above and beyond what the standard HCBS waiver requires. For all MFP participants, states must arrange for 24-7 emergency back-up, establish a process to assess risks and mitigate them before problems arise, and set up systems to report and remedy all critical incidents. To build support for broader system changes, MFP states also are educating individuals, families, and providers about the benefits of transitioning to the community. To market their MFP program to consumers and families, program staff in Hawaii began filming a video in which participants are interviewed before and after their discharge to the community. Over time, such outreach should produce an increase in referrals from providers, individuals, and families.

HOUSING CHALLENGES

As MFP states began to implement transition programs and other rebalancing initiatives, many states were challenged by shortages of affordable and accessible housing. Locating housing for elders and individuals with disabilities is particularly challenging because these individuals are more likely to live on fixed incomes,

making it difficult to find affordable housing. They are also more likely to require architectural features or services to accommodate varying degrees of mobility and functional limitations (Kochera 2001). MFP grantees reported that of 1,039 individuals who could not transition through the MFP program in 2008, about 7 percent (71 people) could not do so because they could not locate or secure affordable and appropriate housing. But the problem is likely greater than this number indicates since half of all MFP states reported that an inadequate supply of affordable and accessible housing and rental vouchers adversely affected the program's ability to transition as many participants as planned in 2008. The search for appropriate housing is often complicated by the need to live near service providers and social networks.

Housing shortages are compounded by long waiting lists for public housing, slow rental turnover among older persons in subsidized housing, and lack of accessible features that help individuals with varying mobility and functional disabilities maintain their independence (Kochera 2006). The U.S. Department of Housing and Urban Development (HUD) sent letters to all state housing authority directors of MFP states—one in October 2006 and one in July 2007—encouraging them to support the MFP demonstration. The first correspondence asked all public housing authorities to set local preferences for the use of public housing units and rental vouchers to promote the MFP initiative (Jackson 2006). The second correspondence requested that the directors submit to HUD their strategies for helping to implement MFP (Jackson 2007). Most MFP project directors are also contacting local housing authorities to educate them about MFP and to create opportunities for collaboration and partnership. In 2008, participants in six states received funds for home modifications or assistive technology so residences in the community could be adapted to accommodate participants' functional limitations. In addition, MFP participants in 12 states received one or more types of housing supplements funded by HUD.[8] The availability of HUD housing vouchers for individuals with disabilities transitioning from institutions to the community is expected to increase in future years as the Department of Health and Human Services (HHS) recently announced that HUD will make 4,000 Housing Choice Vouchers available for people transitioning; 1,000 will have preference for nonelderly people transitioning from institutions to community care and an additional 3,000 will serve nonelderly people at risk of institutionalization. Under the "Year of Community Living" initiative, HUD will also encourage public housing authorities to form working relationships with state Medicaid agencies interested in addressing community living needs of beneficiaries.

Since the program started, MFP grantees have improved housing options for participants in three ways: (1) by developing housing registries or inventories of affordable and accessible housing; (2) by increasing funding for home modifications or for developing assistive technology; and (3) by increasing the number of rental vouchers or earmarking vouchers for MFP participants. MFP states are also employing strategies to increase the overall supply of housing. Maryland is encouraging assisted living providers that are currently licensed for more than four residents to reduce their licensed capacity so they meet the standards of a qualified residence. Oregon began developing 10 small group homes to serve individuals with mental retardation/developmental disabilities (MR/DD), and Hawaii and Indiana have enrolled several new adult foster care providers. Five states have established coalitions of housing and human service organizations to identify housing needs in their states and/or create housing-related initiatives.

HCBS SYSTEM CHALLENGES

In addition to housing shortages, two states reported delays in implementing HCBS waiver programs in which MFP participants were expected to enroll, which reduced the number of transitions they could achieve by December 2008. In New York, several problems contributed to a delay in the implementation of the Nursing Home Transition and Diversion (NHTD) waiver in which the state planned to enroll MFP participants. As a result, there were no MFP transitions in 2008. The state expects the rate of transitions to increase in 2009 now that the NHTD waiver has been implemented statewide and with the addition of two more waiver programs as options for MFP participants. Similarly, implementation of Hawaii's 1115 managed care program, in which many MFP participants were expected to enroll, was delayed until February 2009.

[8] Housing supplements funded by HUD include Section 202 funds, community development block grant funds, HOME dollars, housing choice vouchers, housing trust funds, low-income housing tax credits, and Section 811 grant funds.

Many states encountered another set of challenges relating to the capacity of the HCBS system to accommodate the needs of those transitioning to the community. Twelve MFP states reported that inadequate service capacity, both shortages of direct service workers or providers and insufficient supply of HCBS, were significant challenges to transitioning many beneficiaries. This challenge reflects the growing shortages of direct service workers who are needed to support the needs of elders and individuals with disabilities residing in community settings. Direct service workers have direct contact with participants and perform an instrumental role in their lives by providing critical personal and home care support (Scala et al. 2008). Shortages of direct service workers or providers have prevented some MFP participants from moving to the residential setting or community of their choice. Nebraska, for example, has encountered difficulty finding providers who are willing or able to serve MFP participants who might be spread across long distances in this relatively rural state. In Iowa, some providers are reluctant to provide services to individuals with developmental disabilities who are transitioning from ICFs-MR to the community.

MFP grantees are working to improve HCBS provider capacity by increasing payment rates, helping more providers to become Medicaid contractors, and increasing the number of transition coordinators to support participants. States also enhanced access to HCBS by training workers and providers and expanding existing transportation programs. Iowa, for instance, implemented in February 2009 a web-based training curricula designed for direct support professionals, families, and caregivers to improve their skills in caring for people with disabilities. Hawaii provided in-service training for foster home providers to increase the number willing to accept clients with complex medical conditions. Indiana awarded funds to several Area Agencies on Aging and Aging and Disability Resource Centers (AAA/ADRCs) to develop new or expand existing transportation programs.

INFLUENCE OF THE ECONOMIC DOWNTURN ON MFP PROGRAMS

In 2007 and throughout 2008, the national economy experienced a large and profound downturn. Most state governments are now in a fiscal crisis. To balance operating budgets, state governments must cut expenditures, raise taxes, or draw down reserve funds. In many states, budget shortfalls have led to deep cuts in services to vulnerable state residents, such as the elderly and disabled, which may directly affect MFP programs. Since 2008, 11 MFP states have cut medical, rehabilitative, home care, or other services for low-income elders and individuals with disabilities (Johnson, Oliff, and Koulish 2009). The longer the economic recession persists, the more likely that cuts in services will deepen and have an even greater impact on the populations MFP programs serve.

The American Recovery and Reinvestment Act (ARRA) provided approximately $140 billion in relief funds for state governments, which might help some states to offset revenue shortfalls and minimize or avoid reductions in essential services and mitigate tax increases. As of May 2009, nine MFP states plan to use ARRA funds to reverse previously proposed budget cuts and/or mitigate potential cuts in states' budgets (Johnson, Oliff, and Koulish 2009).[9] But in 18 states with MFP grants, the economic downturn and worsening state budgets have affected almost all aspects of the MFP program. State agencies in three MFP states (the District of Columbia, Georgia, and Pennsylvania) have had to make across-the-board budget reductions which might affect the availability of community-based services and the number of waiver slots for MFP participants. In Arkansas, submission of a waiver amendment to add transition and community-based services for MFP participants was suspended due to a gubernatorial directive that prohibited any new spending. In Illinois, the budget deficit has led to delays in payments to service providers, which has made providers reluctant to contract with the state to serve MFP participants. In Iowa, concerns about needing to continue providing HCBS after participants complete one year of MFP eligibility have made some providers hesitant to serve them. In Connecticut, the approval process for allocating funds became more stringent; as a result some activities planned under MFP have been either delayed or disallowed. As of December 2008, most MFP project directors report uncertainty about how budget shortfalls and cuts in services would affect their programs in the long-term.

IMPLICATIONS OF EARLY MFP IMPLEMENTATION EXPERIENCE FOR BROADER CHANGES IN THE LONG-TERM CARE SYSTEM

The MFP program seeks to make fundamental changes in the long-term care system not only by transitioning

[9] The nine MFP states referenced include California, Connecticut, Georgia, Hawaii, Kansas, Maryland, New York, Virginia, and Washington.

long-term institutional residents to the community, but by making broader changes that will ensure more people needing long-term services and support can live in homes or community residences if they so desire. The MFP program provides states with federal funds to strengthen HCBS, but to gain access to these funds, states must first transition people. Enhanced federal Medicaid matching funds are paid to states only after individuals relocate to the community under MFP transition programs and use MFP-qualified or demonstration HCBS during their first year in the community. The length of time required for some states to launch MFP transition programs suggests it will be several years before the federal government's MFP financial commitment will lead to broader long-term care system improvements.

In the meantime, states participating in the MFP program are providing important lessons about the challenges involved in establishing successful transition programs for long-term institutional residents, and how they might be addressed. First, although any new program requires some time to get started, the lack of affordable and accessible housing options has proved to be a major obstacle to faster progress for about half of the MFP grantee states. About a third of the states also report shortages of HCBS, providers, and direct care workers, which make it hard to ensure individuals will receive safe and adequate care in the community. The extent to which states can overcome these barriers through housing subsidies, payment rate increases, and other strategies is not yet known.

Second, some state reports suggest that certain MFP statutory requirements, such as the institutional residency requirement and need for participants to reside in certain types of qualified residences in the community, can hinder state MFP transition programs. In states with transition programs that operate in parallel with the federal MFP program, such as those in Texas, Wisconsin, and Missouri, individuals who do not meet the MFP requirements can still transition to the community but not through MFP. Such transitions help to rebalance the long-term care system toward community-based care, but they will not be reflected in states' progress toward MFP transition goals.

Third, the economic downturn will undoubtedly affect states that need to make cuts in services to close budget shortfalls. Nearly every state has been affected by the decline of economic conditions and many states have cut agency budgets or staff. The extent to which budget cuts have adversely affected the availability of HCBS and MFP programs remains uncertain.

Finally, implementing a demonstration program of this nature requires a substantial period of time to put essential program components in place. Although MFP programs have been challenging to implement in many states, MFP transition numbers are rising as programs get underway and public awareness grows. Preliminary data indicate that enrollment has grown at a steady pace; the total number of participants enrolled in MFP has increased about 130 percent between January 1 and June 30, 2009. The number of people helped to transition through MFP programs will continue to increase as MFP programs become fully operational and states overcome initial barriers associated with program startup.

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DATA, METHODS AND LIMITATIONS

The information presented in this paper was gathered during Mathematica’s review of each state’s 2008 semiannual progress reports for CMS, which MFP states completed in August 2008 and February 2009. The progress reports are designed to capture information on states’ progress toward their annual goals to transition eligible individuals to the community and increase state Medicaid support for HCBS. The progress reports also capture information on states’ progress and challenges encountered in all dimensions of the program. Information presented is based on self-reported information and represents a point in time. States’ progress implementing their programs will change over time; state approaches described in this report may be modified as programs mature and states gain experience and knowledge.

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