

REPORT

FINAL REPORT

Money Follows the Person Demonstration: Overview of State Grantee Progress, January to December 2016

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I. OVERVIEW AND KEY FINDINGS

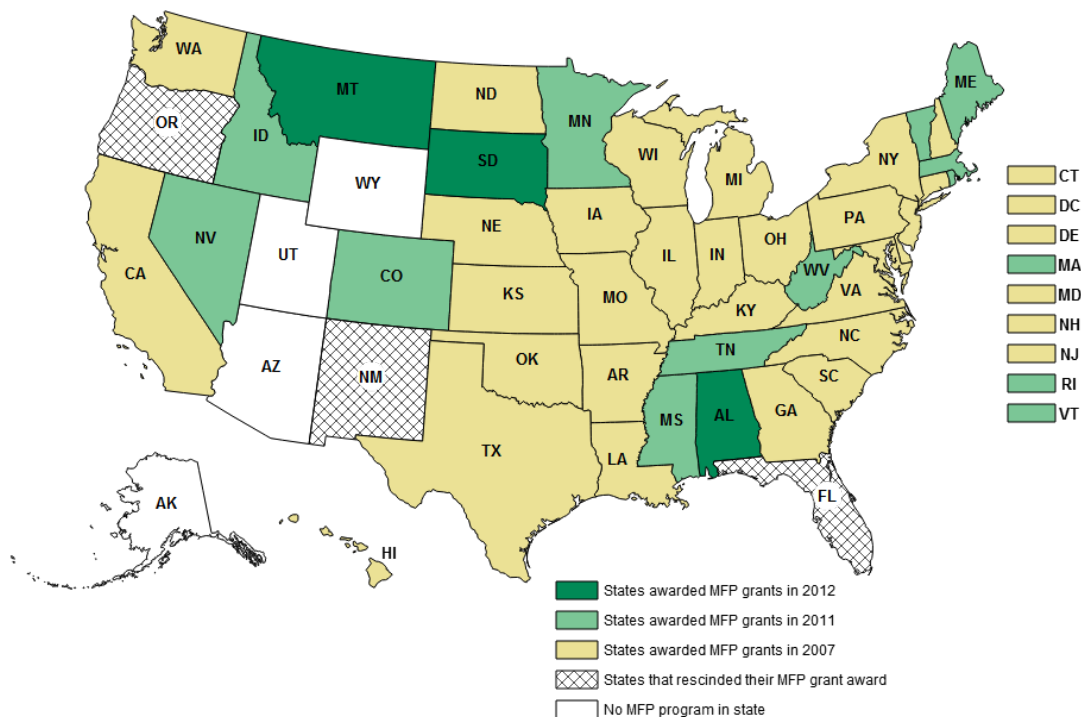
The Money Follows the Person (MFP) demonstration, established by Congress through the 2005 Deficit Reduction Act, is designed to help Medicaid beneficiaries who live in long-term care institutions transition into the community and to give people with disabilities more choice in deciding where to live and receive long-term services and supports (LTSS). Federal grant funds made available to participating state Medicaid programs are intended to transform states' service systems to expand access to community-based LTSS to those who wish to relocate from institutional settings to independent living so that these individuals can live closer to family, friends, and informal supports and engage in community life. An inherent goal of the MFP demonstration is to reduce the institutional bias in Medicaid by making it possible for individuals who need LTSS to live at home or in the community. Home and community-based LTSS is usually a much less costly alternative to nursing home care. Medicaid can pay for three people receiving community-based LTSS for every person in a nursing home (Houser et al. 2012; Ryan and Edwards 2015). As MFP grantee states have rebalanced their LTSS systems, community-based LTSS expenditures have comprised a larger share of total Medicaid spending on LTSS (Eiken et al. 2017).

In 2007, the Centers for Medicare & Medicaid Services (CMS) awarded MFP demonstration grants to 30 states and the District of Columbia.¹ As part of the Affordable Care Act, Congress in 2010 increased total MFP program funding to \$4 billion and expanded eligibility to include people who live in an institution for more than 90 (instead of 180) consecutive days. This additional funding allowed CMS to award grants to 13 more states in 2011 and 3 more states in 2012, to reach a total of 47 grantees (Figure I.1). Congress also extended the demonstration to 2016. MFP grantee states can enroll and transition people through MFP until the end of federal fiscal year 2018, and they may provide services under the demonstration using MFP grant funds until the end of federal fiscal year 2019.² Among the 47 grantee states, Florida and New Mexico were awarded MFP grants in 2011 but later rescinded them. Oregon implemented its program in 2008 but suspended operations in 2010 and later rescinded its MFP grant. At the end of 2016, 43 states and the District of Columbia (referred to as the 44 grantee states throughout this report) had active MFP grants and were transitioning participants to the community through their MFP programs.

¹ In the remainder of this report, we refer to the District of Columbia as a grantee state.

² MFP grant awards are available to grantee states for the fiscal year in which they received the award and subsequent years of the demonstration. Any unused grant funds are available to states until September 30, 2020.

Figure I.1. MFP grantees, by year of award



Note: South Carolina was awarded an MFP grant in 2007, rescinded the grant, and reinstated their MFP program in 2011.

Each state participating in the MFP demonstration must establish (1) a transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and helps them make the transition, and (2) an initiative designed to support the rebalancing of long-term services and supports toward community-based care. These statutory goals are outlined in the 2005 Deficit Reduction Act and specify that states are to make progress rebalancing their system and increasing the percentage of state Medicaid expenditures for long-term care services spent on community-based LTSS.

This chartbook summarizes the implementation progress of the MFP demonstration in the 44 grantee states that were actively transitioning participants from January 1 to December 31, 2016 (referred to as the “reporting period”)—the ninth full year of operation since the demonstration was launched. This chartbook is the last in a series of reports and chartbooks, the first of which was published in 2010. It compares performance data during 2016 to the previous year, and in some cases to five-year annual trends. For more information about annual trends, see the Money Follows the Person Annual Evaluation Reports and earlier chartbooks.³

³ Current reports are available at <https://www.medicaid.gov/medicaid/ltss/money-follows-the-person>. All reports produced by the national evaluation are available at <https://www.mathematica-mpr.com/our-publications-and-findings/projects/research-and-evaluation-of-the-money-follows-the-person-mfp-demonstration-grants>.

This chartbook presents key indicators of implementation progress, including the number of transitions to the community, grantees' progress toward achieving 2016 transition goals, aggregate community-based LTSS expenditure levels, rates of self-direction and re-institutionalization among MFP participants, types of qualified housing new enrollees move into upon transition, and employment supports and services for MFP participants. Data tables presenting state-level data on implementation progress are available in Appendix A. Chapter XIII contains technical notes and a discussion of data sources and limitations.

In addition to presenting grantee-reported data on implementation progress, this chartbook presents the perspectives of MFP participants, drawing on data from the MFP Quality-of-Life (QoL) survey.⁴ This chartbook uses QoL survey data to describe participants' reports of (1) overall life satisfaction, (2) quality of care, (3) satisfaction with living arrangements, and (4) community integration and other aspects of community life. Findings on implementation progress and participants' QoL are reported for the entire MFP population and for each of the five major MFP target populations: older adults age 65 and older, individuals with physical disabilities (PD) who are younger than age 65, individuals with intellectual or developmental disabilities (ID/DD), individuals with a primary diagnosis of serious mental illness (MI), and individuals who do not fall into one of the other categories (other). Appendix B presents state-level data from the Quality-of-Life survey.

Key findings

Participation and cumulative MFP transitions to date. Enrollment into the MFP demonstration continued to grow through 2016. At the end of 2016 there were 9,995 current participants, which means they were currently in their 365-day period of MFP eligibility. This is an increase from the start of the program, when there were 289 current participants in the first half of 2008. From January 2008 to December 2016, the cumulative number of individuals that transitioned to the community through MFP during the nine years of its operation totaled 75,151—a 19 percent increase over the cumulative number as of December 2015 (63,321).

The number of cumulative transitions varied widely across the 44 grantee states included in this report, ranging from 11,433 in Texas to fewer than 80 participants in South Carolina and South Dakota, which started transitioning individuals in January 2013 and July 2014, respectively. Seven MFP grantees (California, Connecticut, Michigan, Ohio, Pennsylvania, Texas, and Washington) with the largest programs comprised more than half (54 percent) of cumulative transitions. Variations in transition activity across state programs reflect, among other things, differences in the size of state populations, implementation start dates, program

⁴ Previous reports have examined participant quality of life and observed improvements across all domains upon transitioning to the community (Simon and Hodges 2011; Irvin et al. 2011, 2012, 2013, 2015, 2017). This is the first year these findings are included in the cross-state report. Participants are surveyed three times: (1) immediately before transitioning to the community; (2) one year after transitioning; and (3) two years after transitioning, one year after participation in the MFP demonstration has ended. More information about the Quality-of-Life survey is available in Chapter XIII, Technical Notes.

design, state infrastructure and capacity, and the availability of affordable and accessible housing.

Progress toward 2016 transition goals. In the aggregate, MFP grantees nearly achieved their annual total transition goal (98 percent), having transitioned 11,217 new participants of the 11,498 planned for 2016. This performance is higher than what the state grantees achieved in 2015 (95 percent) and 2014 (86 percent). This improvement in reaching their transition goals in 2016 may reflect maturation of MFP programs, in addition to grantees setting more realistic transition goals in 2016 compared to earlier years. States reporting shorter transition times were more likely to meet their goals in 2016 than states with longer average transition times. Success in meeting aggregate transition goals varied by target population; in 2016 states exceeded their goals for older adults, individuals with physical disabilities, and individuals with mental illness. States did not meet their goals for individuals with intellectual or developmental disabilities and individuals with other types of disabilities.

Qualified community-based LTSS expenditure goals. All state MFP grantees must set annual goals for Medicaid community-based LTSS spending. Qualified community-based LTSS expenditures include all federal and state funds spent on 1915(c) waiver services; home health, personal care, and other community-based expenditures provided as state-plan optional benefits for all Medicaid beneficiaries; and all demonstration dollars spent on MFP participants (divided into three subsets: qualified, demonstration, and supplemental services). Overall, the 44 grantee states reported qualified community-based LTSS expenditures for 2016 of approximately \$84.2 billion (Appendix A, Table A.5), which was 109 percent of the aggregate spending goal—an increase of 13 percent from 2015 (\$74.5 billion) and 19 percent from 2014 (\$70.6 billion) (Figure IV.1). However, total community-based LTSS expenditures for 2016 are likely to be underestimated because of incomplete information and lags in data reporting as of the date that states submitted their semiannual progress reports to CMS.

Spending and use of rebalancing funds. MFP rebalancing funds represent extra federal funds received by each state from the enhanced Federal Medical Assistance Percentages matching rate on the qualified and demonstration community-based LTSS they provide to MFP participants. In 2016, MFP grantees reported their total rebalancing spending and activities through December 2015. Total rebalancing funds expenditures grew 35 percent between 2014 and 2015, increasing from \$249.8 million at the end of 2014 (with 28 of the 44 states reporting) to \$336.6 million by the end of 2015 (with 33 of the 44 states reporting). Among the 33 MFP grantees that reported any rebalancing fund expenditures, cumulative state spending through 2015 ranged from a low of \$7,478 in Nevada to a high of approximately \$70.2 million in Missouri.

Reinstitutionalizations for more than 30 days. MFP grantees track the rate of reinstitutionalization during the 365 days of MFP enrollment among their participant populations. A reinstitutionalization is defined as any admission to a hospital, nursing home, intermediate care facility for people with intellectual disabilities, or institution for mental diseases, regardless of length of stay. During 2016, a total of 3,772 participants were reinstitutionalized for any length of time (Appendix A, Tables A.7 and A.8). Of these, nearly one-third, or 1,119 participants, were reinstitutionalized for more than 30 days; older adults and

people with physical disabilities experienced most of these reinstitutionalizations and comprised 47 and 36 percent of the total, respectively (Appendix A, Tables A.9 and A.10). Overall, approximately 5 percent of participants were reinstitutionalized for more than 30 days in 2016.

Self-direction. Of the 44 MFP grantees that were transitioning participants during 2016, 39 offered self-direction service options to MFP participants; in 32 of these states, MFP participants hired and supervised staff, managed their budgets, or did both (Appendix A, Table A.12). Among these grantee states, the majority (31 states) reported that 25 percent or fewer of their MFP participants were enrolled in the state's self-direction program, although four states (Delaware, Kentucky, Ohio, and Vermont) reported that more than half of their participants were self-directing their care.

Community residence type. Most MFP participants who transitioned to the community during this period moved into a home (38 percent), an apartment (40 percent), or a small group home (14 percent); 7 percent moved into apartments in qualified assisted-living facilities. Compared to other populations, individuals with intellectual or developmental disabilities were more likely to move to a small group home when they transitioned to the community. Nearly all grantee states reported challenges securing housing for participants; the two most common challenges were an insufficient supply of affordable accessible housing (32 states January to June 2016; 26 states July to December 2016) and rental vouchers (17 states January to June 2016; 18 states July to December 2016). Grantee states pursued several strategies to overcome these barriers in securing housing; the most common strategy was to increase the supply of affordable and accessible housing (13 states January to June 2016; 12 states July to December 2016).

Quality of life. Quality-of-Life survey data suggests substantial improvements in life satisfaction over time, affirming MFP's basic premise that people, when given the option, prefer to reside in the community. Sixty-two percent of participants reported being satisfied with the way they live their life while in institutional care; this increased to 78 percent reporting life satisfaction one year after transition. Improved life satisfaction was sustained after two years in the community (78 percent). Satisfaction with living arrangements also increased upon transitioning to the community; one year after transitioning 91 percent of participants reported liking where they lived (as compared to 62 percent pre-transition). This increase was sustained two years after transitioning. Participants also reported substantial improvements in choice and control over daily activities, such as when and what to eat, and the ability to get needed sleep.

Quality of care. One year after moving to the community, participants reported improvements in three of the four self-reported quality-of-care domains assessed—satisfaction with care received, treatment with respect and dignity by LTSS providers, and unmet needs for personal assistance services. Unmet medical care needs (the fourth domain assessed) were practically unchanged between pre- and post-transition. Among MFP target populations, older adults and individuals with physical disabilities reported similar patterns of improvement across quality-of-care domains as compared to the total population. Individuals with mental illness reported smaller improvements in quality of care, particularly in unmet needs for personal assistance.

Participants' experience with community living. After moving to the community, participants reported improvements across nearly all domains of community living. Community integration increased in several areas, with higher proportions of participants reporting that they were able to do fun things in the community, get to places they needed to go, and not miss events due to a lack of transportation. The percent reporting that there were things they wanted to do outside the home but were unable to do declined (which represents an improvement) from 51 percent pre-transition to 34 percent one year post-transition and 31 percent two years post-transition. The ability to see family and friends when participants wanted to did not change after moving to the community. One year after transitioning, approximately 9 percent of participants reported volunteering in the community and 7 percent reported working for pay.

Tribal initiatives. In 2014, five states (Minnesota, North Dakota, Oklahoma, Washington, and Wisconsin) launched efforts through the MFP Tribal Initiative (TI) to improve and expand access to community-based LTSS for eligible tribal members, allowing members to access LTSS in the setting of their choice. Among all five TI programs, established MFP programs are collaborating with tribal nations to expand existing services or create new ones. Current and future efforts are focused both on increasing access to services and providing culturally-relevant services. For example, tribes in North Dakota have become non-emergency medical transportation service providers or are in the process of applying to become providers. In Washington, the MFP TI and tribal nations collaborated to incorporate the Savvy Caregiver curriculum, which focuses on American Indian culture, into required in-home aide certification. As of 2016, only one individual had transitioned through the TI, and that transition occurred in 2015. Grantee states cited challenges in building partnerships with tribal entities and aligning Medicaid and tribal administrative infrastructures.

II. MFP ENROLLMENT, PARTICIPATION, AND TRANSITIONS

A. Number of transitions over time

Overall. By the end of 2016, a total of 75,151 individuals had enrolled in MFP and transitioned to community living since transitions began in 2008. Cumulative enrollment increased by 19 percent between the end of 2015 and the end of 2016 (from 63,321 to 75,151), continuing a strong trend in growth from the previous year, when cumulative enrollment increased by 23 percent (Figure II.1 and Appendix A, Table A.1).

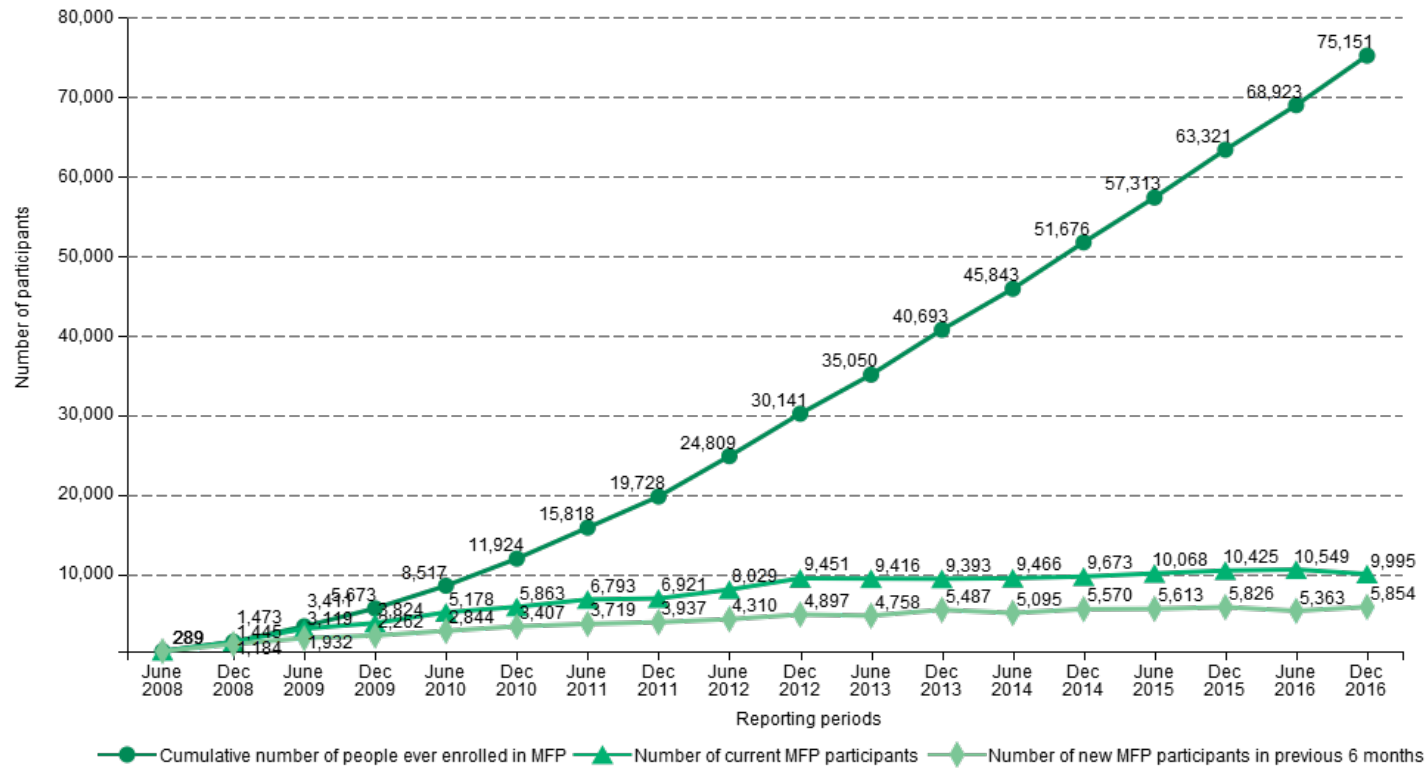
The number of current participants, or those currently in their 365-day period of MFP eligibility, has increased since the start of the program from 289 in 2008 to 9,995 in 2016. Between 2008 and 2012, the number of current participants rose steadily each year, peaking at 9,451 at the close of 2012. The number decreased from 2012 to 2013 before again increasing steadily from the end of 2013 to June of 2016, when 10,549 current participants were reported across all state MFP programs. However, the number of current participants dropped by five percent to 9,995 between June and December 2016. This is the lowest number of current participants since December 2014 (Figure II.1 and Appendix A, Table A.3).

State variation. The number of cumulative transitions greatly varies across states, ranging from 68 in South Carolina and 75 in South Dakota to 9,310 in Ohio and 11,433 in Texas.⁵ Variation in program size reflects differences in program start dates and design, a state's history with transition programs, program infrastructure and capacity, and the availability of affordable and accessible housing, among other factors.

The majority of MFP enrollment is concentrated in a subset of the 44 grantees states. As of December 2016, the 7 states with the largest programs (California, Connecticut, Michigan, Ohio, Pennsylvania, Texas, and Washington) accounted for slightly more than half (54 percent) of all cumulative transitions. The next 15 states collectively accounted for approximately 37 percent of the total number of cumulative transitions, transitioning between 774 and 2,731 participants each. The remaining 22 states comprised 10 percent of cumulative enrollment; many of these states began to transition individuals in 2012 or later (Figure II.2 and Appendix A, Table A.1).

⁵ South Carolina began transitioning participants in the first period of 2013; South Dakota began in July 2014.

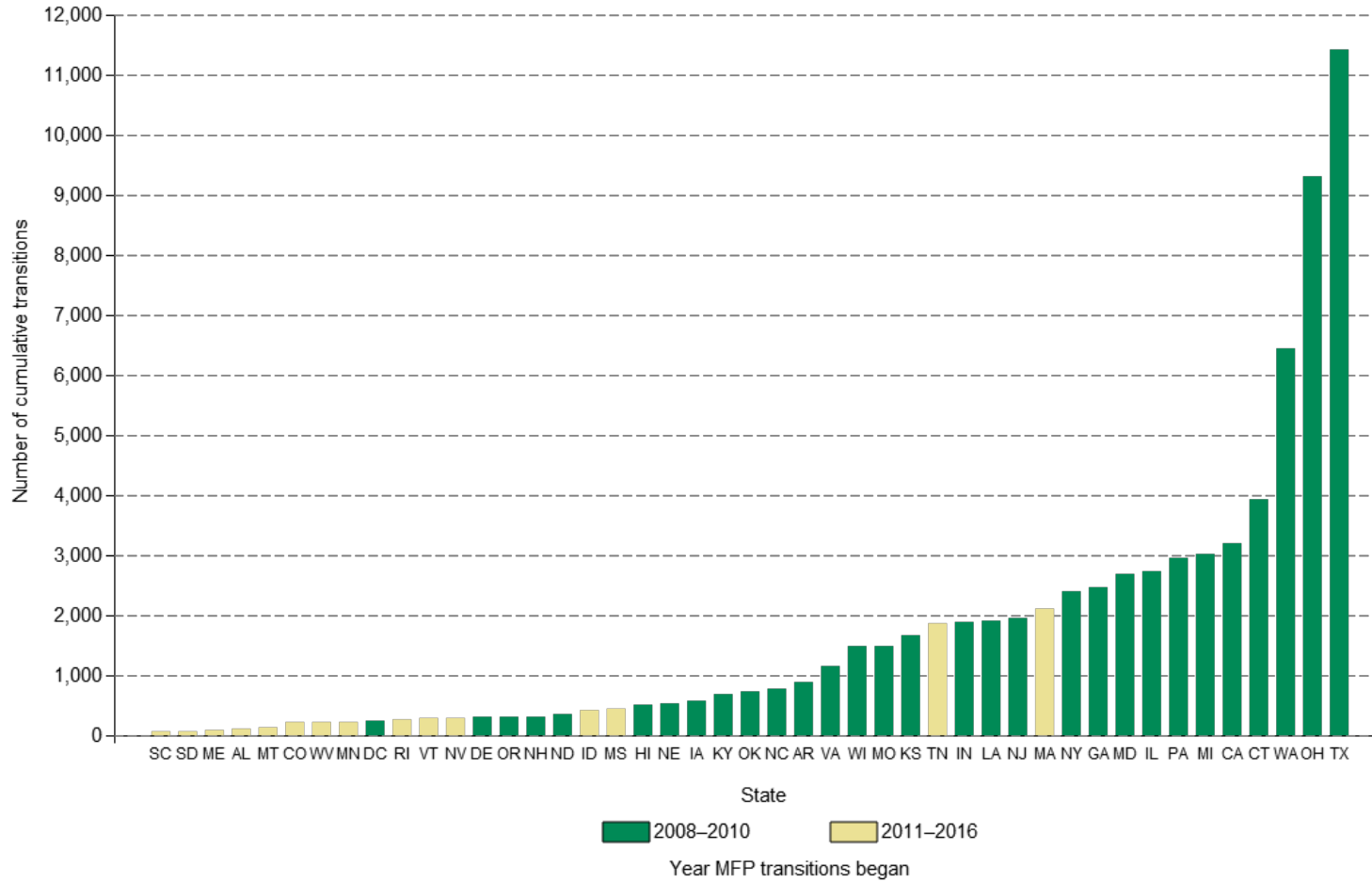
Figure II.1. MFP transitions and current MFP participants, June 2008 to December 2016



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2008–2016.

Note: Numbers in the figure may not match numbers from previous reports due to efforts to improve data quality retrospectively. The counts are based on data from 10 grantee states in June 2008; 30 grantee states in December 2008 through June 2011; 34 grantee states in December 2011; 35 grantee states in June 2012; 37 grantee states in December 2012; 41 grantee states in June 2013; 42 grantee states in December 2013; 43 grantee states in June 2014; and 44 grantee states December 2014 through December 2016.

Figure II.2. Cumulative MFP transitions by state and year MFP transitions began, January 2008 to December 2016



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2008–2016.

Note: Oregon suspended program operations in 2010 and later rescinded its MFP grant; however, this figure includes the state’s previously reported transitions.

N = 45 grantee states.

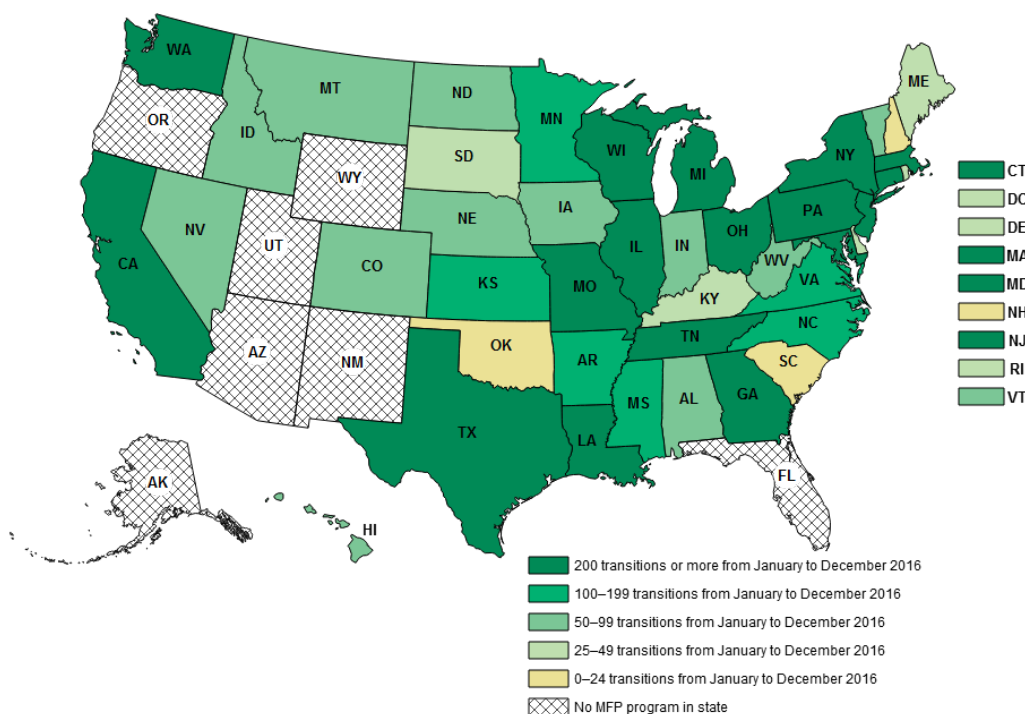
B. Total transitions during 2016

Overall. In 2016, MFP grantee states transitioned 11,217 new participants to the community, a 2 percent decrease from 2015 (11,439). Despite this decrease, the 2016 transitions total is the second highest annual total since the first states began transitioning participants in 2008 and 5 percent greater than the 2014 total of 10,665. The three states with the largest percentage increases in transitions from 2015 to 2016 were West Virginia (70 percent), Maine (74 percent), and Alabama (129 percent). All three are smaller programs and relatively young, transitioning their first participants in 2012 (Maine) and 2013 (Alabama and West Virginia).

State variation. The number of new transitions varied widely across the 44 grantee states. Ohio transitioned the most participants in 2016—1,804—nearly double that of the next two states, Washington (963) and Texas (937). These three states accounted for 33 percent of all transitions in 2016. Twenty states transitioned between 101 and 757 participants in 2016, comprising the majority (57 percent) of new transitions. Twenty-one states transitioned fewer than 100 participants each, accounting for 10 percent of new transitions.

Newer MFP programs tended to transition fewer individuals during the year compared to states with more mature programs; of the 14 states that began their MFP programs in 2011 or later, only 4 (Massachusetts, Minnesota, Mississippi, and Tennessee) transitioned more than 100 participants in 2016 (Figure II.3 and Appendix A, Table A.2).

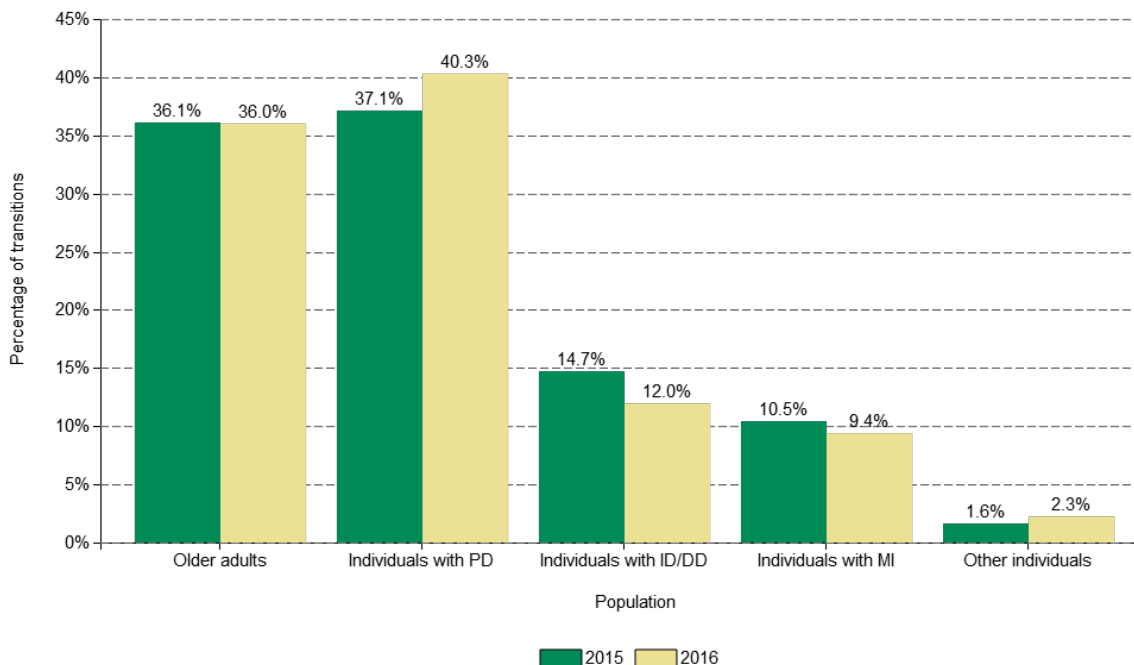
Figure II.3. Number of MFP participants transitioned, January to December 2016



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Distribution of transitions by target population. Similar to trends seen in prior years, the majority of MFP participants who transitioned in 2016 were individuals under the age of 65 with physical disabilities (40 percent) or older adults (36 percent). Grantee states transitioned smaller numbers of individuals with intellectual or developmental disabilities (12 percent), mental illness (9 percent), and other individuals⁶ (2 percent) (Figure II.4).

Figure II.4. Distribution of MFP participants transitioned by target population, 2015 and 2016



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2015 and 2016.

Note: The analysis is based on data from 44 grantee states.

ID/DD = intellectual or developmental disabilities; MI = mental illness; PD = physical disabilities.

⁶ States can identify other target populations in their operational protocols, in addition to the four populations specified by CMS. These other populations include individuals with dual diagnoses, HIV/AIDS-related conditions, or traumatic brain injuries, among others.

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III. ACHIEVEMENT OF 2016 ANNUAL TRANSITION GOALS

A. Overall

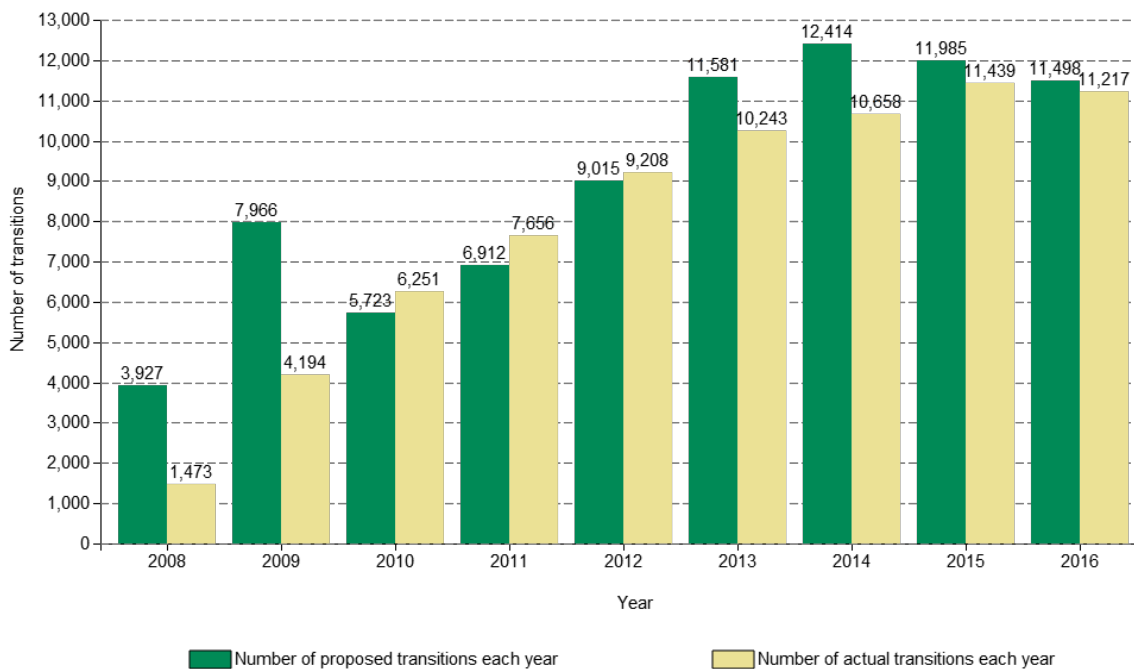
MFP grantee states are required to establish annual transition goals for each target population group and then monitor their progress toward those goals. In 2016, states reported a slight increase in attaining the goals, achieving 98 percent of their objective (11,217 transitions of 11,498) compared to 95 percent in 2015 (Figure III.1). This marks the highest achievement since 2012, when grantees attained 102 percent of the annual transition goal. Some states decreased their transition goals over the past two years, perhaps contributing to the increase in the overall percent of annual transition goals achieved.⁷

Two factors have generally explained state grantees' inability to meet the total annual transition goal since 2012. First, states may set ambitious transition goals for the early years of their programs that prove difficult to achieve until procedures and systems are fully operational. Collectively, the 29 states that began transitioning participants in 2008 or 2009 achieved 97 percent of their transition goal for 2016 (9,355 transitions of 9,644 planned). In comparison, the 7 states that began transitioning participants to the community in 2013 (Alabama, Colorado, Minnesota, South Carolina, and West Virginia) and 2014 (Montana and South Dakota) collectively achieved 65 percent of their transition goals in 2016 (426 transitions of 656 planned). While this was an increase over 2015, when these 7 states as a group met 43 percent of their total transitions target, only Montana and South Dakota among this group were able to meet or exceed their targets for 2016. Second, in 2016, 58 percent of MFP grantees (26 states) reported unanticipated challenges transitioning the projected number of individuals they proposed to transition during 2016.⁸

⁷ In 2016, 15 grantee states increased their transition goals by a total of 420 transitions, and 18 states reduced their goals by a total of 900 transitions. Eleven states did not change their goals.

⁸ Challenges cited by MFP grantee states included the reduction in the number of referrals received; a shortage of providers; housing challenges, especially availability; lengthy transition periods; lack of cooperation from relevant state agencies; and a decrease in the number of available housing vouchers.

Figure III.1. Actual versus proposed annual number of MFP transitions, 2008 to 2016



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2008–2016.

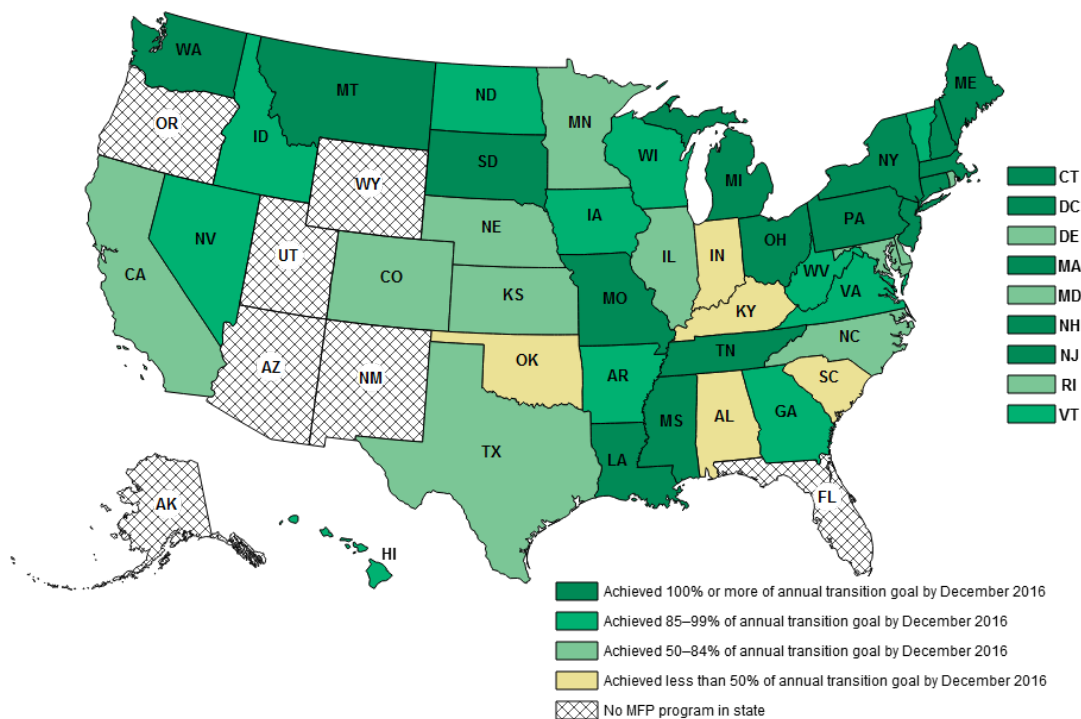
Note: Analysis based on data from 30 states in 2009 and 2010; 34 states in 2011; 37 states in 2012; 42 states in 2013; and 44 states in 2014 through 2016.

B. State variation in the achievement of transition goals

MFP grantee states varied in the degree to which they attained their transition goals for 2016 (Figure III.2 and Appendix A, Table A.4). Seventeen grantee states achieved 100 percent or more of their annual transition goals by the end of December 2016. Of these, 7 (Louisiana, Maine, New Hampshire, New Jersey, Ohio, Tennessee, and Washington) achieved 125 percent or more of their annual transition goals. Among the 27 grantee states that did not achieve their transition goals, 11 (Arkansas, Georgia, Hawaii, Idaho, Iowa, Nevada, North Dakota, Vermont, Virginia, West Virginia, and Wisconsin) achieved between 85 and 99 percent of their 2016 transition goals, 11 (California, Colorado, Delaware, Illinois, Kansas, Maryland, Minnesota, Nebraska, North Carolina, Rhode Island, and Texas) achieved between 50 and 84 percent of their 2016 transition goals, and the remaining 5 (Alabama, Indiana, Kentucky, Oklahoma, and South Carolina) achieved less than 50 percent of their goals. The two states that began transitioning participants in 2014, Montana and South Dakota, met or exceeded their 2016 transition goals. The state grantees achieving less than 85 percent of their goals over a two-year period may need to adjust program design or future transition goals so as not to jeopardize their receipt of

supplemental MFP grant funds.⁹ Twelve MFP grantees reported that they intend to seek CMS approval to change their transition goals in 2017 or subsequent years, including 5 states that achieved less than 85 percent of their goals over the past two years.¹⁰

Figure III.2. MFP grantees' achievement of 2016 transition goals, January to December 2016, by state



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

⁹ According to CMS guidelines, when grantees do not reach at least 85 percent of their average annual transition goals over a two-year period (the first year of program operations may be excluded), they are required to provide an Action Plan to CMS describing how the transition goals will be achieved over the next year. A grantee may receive a full supplemental grant award once the Action Plan is approved.

¹⁰ New York is considering decreasing its transition goal for individuals with intellectual or developmental disabilities. Nebraska intends to adjust its goals to reflect the extension of its MFP program to 2020. Oklahoma is considering adding a fourth population: those who transition from psychiatric residential treatment facilities. Four states (Idaho, North Carolina, Rhode Island, and Tennessee) intend to decrease their transition goals. The remaining five states (California, Illinois, Indiana, Minnesota, and South Carolina) did not specify how they would amend their transition goals.

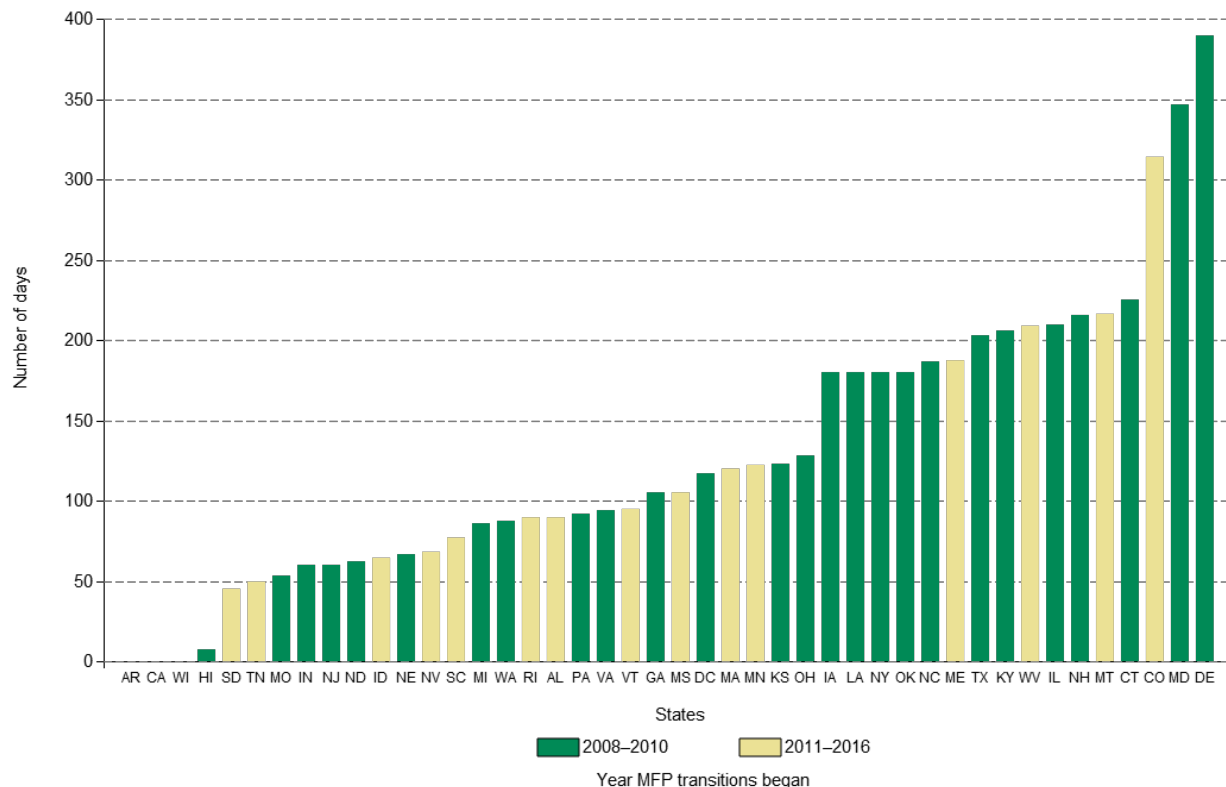
States reporting shorter transition times were more likely to meet their transition goals in 2016 than states with longer average transition times. The average number of days from the time of assessment to actual transition of MFP participants was 141 days across all states, ranging from 7 days in Hawaii to 13 months in Delaware (Figure III.3). During 2016, six states (Hawaii, Indiana, Missouri, New Jersey, South Dakota, and Tennessee) reported that the average length of time required from assessment to actual transition was two months or less (0–60 days). Of these six states, Missouri, New Jersey, South Dakota, and Tennessee met or exceeded their 2016 transition goals, and Hawaii nearly did (99 percent). Indiana’s program was temporarily on hold for the first half of 2016 while the state resolved budget and operational issues, and the state transitioned just 16 percent of its goal for the year. Indiana is planning to update their transition goals.

Twenty-three states reported an average length of time of two to six months (61–180 days), and 12 states (Colorado, Connecticut, Delaware, Illinois, Kentucky, Maine, Maryland, Montana, New Hampshire, North Carolina, Texas, and West Virginia) reported an average transition time of more than six months (181 days or more) from the time of assessment to actual transition. Of the 12 states that reported an average of more than six months, only 4 states (Connecticut, Maine, Montana, and New Hampshire) achieved their transition goals for 2016. Three states (Arkansas, California, and Wisconsin) did not report an average transition time in either period in 2016.

C. Variation in the achievement of transition goals by target population

Grantee states exceeded their transition goals for older adults, individuals with physical disabilities, and individuals with mental illness. States fell short of their goals for individuals with intellectual or developmental disabilities and individuals with other types of disabilities (Figure III.4). Grantee states were most successful meeting their 2016 goals for individuals with mental illness, achieving 115 percent of their collective goal of 914. As was true in 2015, this progress was largely driven by Ohio, which accounted for 73 percent of all individuals with mental illness transitioned in 2016 and exceeded its annual transition goal for this group by 28 percent. During 2016, MFP grantee states in aggregate transitioned 4,525 individuals under 65 with physical disabilities, 111 percent of the goal (4,076). MFP grantees also transitioned 102 percent of their collective goal for older adults, transitioning 4,042 (compared to a goal of 3,967). MFP grantees fell short of meeting the total 2016 transition goals for individuals with intellectual or developmental disabilities by 25 percent and for people with other disabling impairments by 66 percent.

Figure III.3. Average number of days from time of initial assessment to actual transition, January to December 2016, by state and year program began

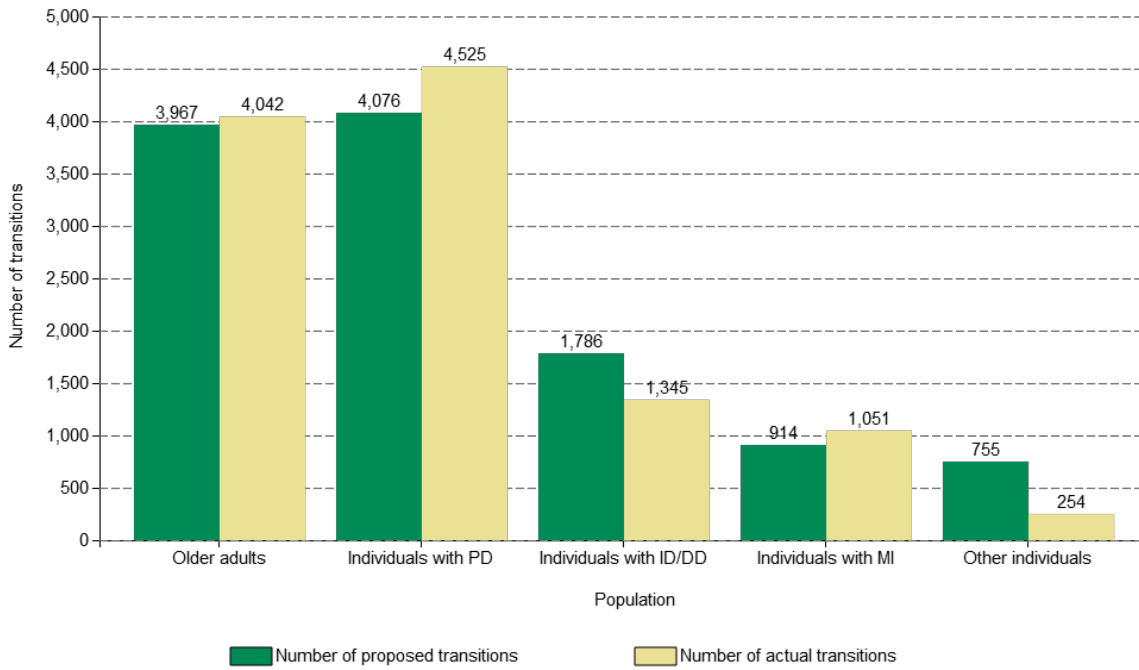


Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Note: For states that reported an average number of days from the time of assessment to transition for both reporting periods in 2016, we took the average of those two reported averages. Arkansas, California, and Wisconsin did not report an overall average number of days from the time of assessment to transition for all participants for the second period of 2016. Alabama, Delaware, Indiana, Kansas, Massachusetts, Michigan, Montana, and New Hampshire only reported the average number of days from the time of assessment to transition for one of the two reporting periods in 2016. In these cases, the graph displays the value from the one period where information was reported—an average across both periods is not shown. Louisiana reported an average for only two of the three populations for which it had transitions in 2016, and we used this reported average.

N = 44 grantee states.

Figure III.4. MFP grantees' progress toward 2016 transition goals, by target population



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.
 N = 44 grantee states.

PD = physical disabilities; ID/DD = intellectual and developmental disabilities; MI = mental illness.

IV. QUALIFIED COMMUNITY-BASED LTSS EXPENDITURE GOALS

The federal statute establishing MFP requires grantee states to set an annual goal for total Medicaid spending on qualified community-based LTSS (by statute, known as home and community-based long term care services) and report actual spending relative to this goal.¹¹ Qualified expenditures include total Medicaid community-based LTSS expenditures for all Medicaid beneficiaries (in other words, federal and state funds and not limited to MFP participants), including: (1) all funds spent on 1915(c) waiver services; (2) home health, personal care, and other community-based LTSS expenditures provided as state-plan optional benefits for all Medicaid beneficiaries; and (3) all spending on community-based LTSS services for MFP participants (qualified, demonstration, and supplemental services).¹²

A. Overall

Community-based LTSS expenditures by all grantee states totaled \$84.2 billion in 2016, a 13 percent increase from 2015 (\$74.5 billion) and a 19 percent increase from 2014 (\$70.6 billion) (see Figure IV.1). Actual community-based LTSS expenditures for 2016 by the 44 grantees represented 109 percent of the aggregate expenditure goal (\$77.4 billion) for the year, which is more than 2015 (98.1 percent) and 2014 (97.9 percent).^{13,14}

Grantees are able to modify the previous years' (2015) reported spending on qualified community-based LTSS when reporting for the current program year (2016). States reported a \$24 million decrease in the previously reported 2015 spending amount when they updated their expenditure data in the 2016 progress reports. This adjusted 2015 spending included increases in previously reported expenditures for 4 states (District of Columbia, Minnesota, Mississippi and New Jersey) and decreases in previously reported expenditures for 2 states (California and West

¹¹ Qualified "community-based LTSS" means, with respect to the Medicaid program, home and community-based services (including home health and personal care services) that are provided under the State's qualified Home and Community-Based program or that could be provided under such a program but are otherwise provided under the Medicaid program.

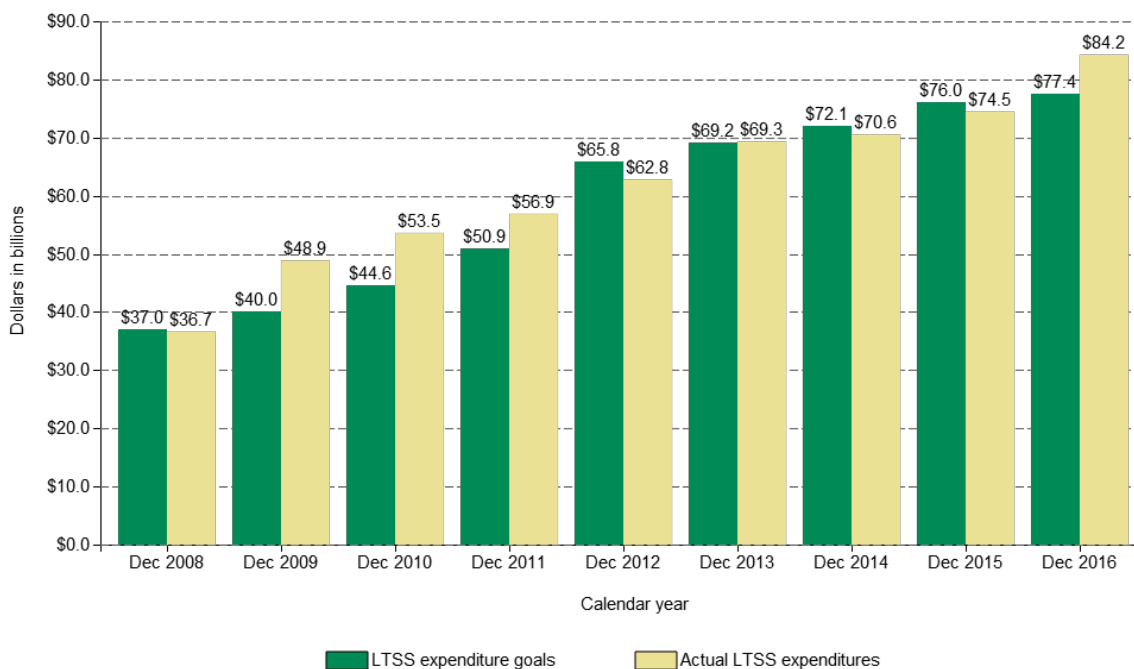
¹² The MFP demonstration includes three types of community-based LTSS: (1) qualified services, which are services that are already available through a state plan or waiver program and which MFP participants would have received regardless of their status as an MFP participant; (2) demonstration services, which are allowable Medicaid services but not otherwise included in the state's approved community-based LTSS (for example, transition coordination and crisis intervention); and (3) supplemental services, which are intended to help participants transition to the community but might not otherwise be reimbursed by Medicaid programs (for example, vehicle modification, moving assistance, and service animals) (Peebles and Kehn 2014).

¹³ Some states experience lags in their systems when trying to process claims and provide updated expenditure reports once their systems process all claims associated with a given year. As a result, spending for 2016 may be underestimated and prior year expenditures might not be consistent with amounts reported in previous MFP reports.

¹⁴ North Dakota reported estimated total expenditures in 2016, instead of actual. Oregon is not included in the total spending.

Virginia). Typically, annual expenditures for previous years increase when more complete data become available; however, this year, California adjusted its previous 2015 expenditures downwards by nearly \$500 million, which led to a net decrease in 2015 expenditures. Excluding California, states reported a \$452 million increase in the updated 2015 spending amount, as compared to what they originally reported.

Figure IV.1. Projected and actual qualified community-based LTSS expenditures, December 2008 to December 2016



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Note: N = 29 states in 2010; 33 states in 2011; 37 states in 2012; 42 states in 2013; 45 states in 2014; 44 states in 2015; 44 states in 2016.

LTSS = long-term services and supports.

B. State variation in the achievement of community-based LTSS expenditure goals

Spending as a percentage of 2016 goals ranged from 47 percent (Connecticut) to 270 percent (New Jersey).¹⁵ New Jersey also exceeded its expenditure target by a higher percentage than any other grantee in 2014 and 2015.¹⁶ Twenty-four grantee states met or exceeded their spending goals in 2016. Of them, 13 states (Colorado, Idaho, Massachusetts, Michigan, Missouri, Nebraska, Nevada, New Jersey, North Dakota, Pennsylvania, South Carolina, Texas, and Washington) achieved 110 percent or more of their goals. Conversely, of the 20 states that spent below their goals, 13 (Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, New Hampshire, Oklahoma, Virginia, and West Virginia) achieved less than 90 percent of their 2016 expenditure targets (see Appendix A, Table A.5). Grantee-reported reasons for lower-than-expected achievement of expenditure targets included (1) incomplete claims data due to processing lags in state systems, (2) state budget issues and delays in budget approvals, (3) decreases in MFP transitions, and (4) changes to state delivery systems and waiver programs that resulted in lower community-based LTSS expenditures.

¹⁵ New Hampshire was not counted for purposes of this measure because it ended its program early in the year and stopped transitioning individuals as of March 31, 2016.

¹⁶ The difference in New Jersey reflects the state's approach to estimating its spending goals. When the state started its MFP demonstration in 2007, it set goals for community-based LTSS expenditures through the duration of the demonstration, and maintained these goals despite changing state circumstances. In addition, the state did not include all community-based LTSS spending in its reported actual expenditures until 2013.

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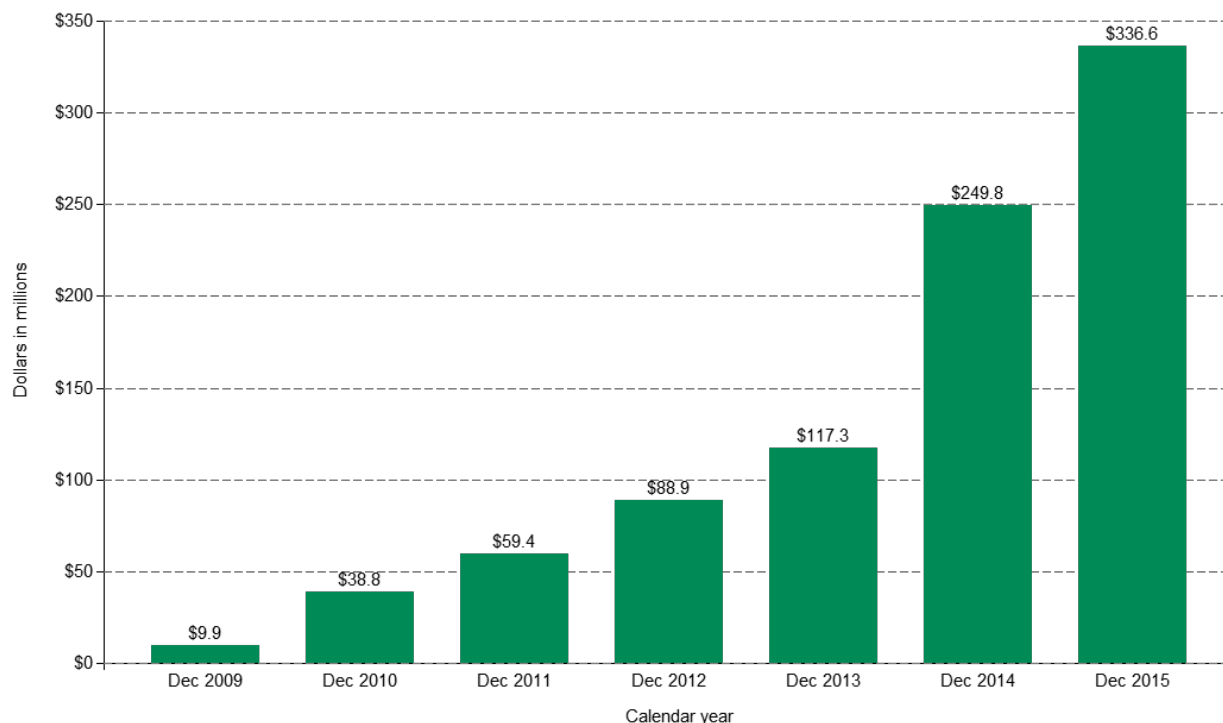
V. SPENDING AND USE OF REBALANCING FUNDS

Once a year, MFP grantees report on their cumulative spending and use of rebalancing funds, which represent extra grant funds each state receives from the MFP-enhanced Federal Medical Assistance Percentages (FMAP) rate based on the qualified and demonstration community-based LTSS they provide to MFP participants during their 365 days of MFP eligibility. Grantee states receive an enhancement to their FMAP, which is drawn from their MFP grant funds, when they provide either qualified or demonstration services, whereas supplemental services are reimbursed at the state's regular FMAP rate. Grantees are required to reinvest these funds in initiatives that will help rebalance the long-term care system toward community-based care. In 2016, MFP grantees reported their total rebalancing spending and activities through December 2015.

MFP rebalancing fund expenditures have steadily increased since the demonstration was launched (see Figure V.1). Total cumulative spending grew to \$336.6 million by the end of 2015, a 35 percent increase from 2014 (\$249.8 million). Some MFP grantees saw significant growth in cumulative spending between 2014 and 2015, most notably Missouri and Pennsylvania.

Of the 44 states participating in the demonstration in 2016, 33 reported spending of MFP rebalancing funds in 2015, an increase from 28 states in 2014. Four states (Idaho, Louisiana, Mississippi, and West Virginia) reported the amount spent from MFP rebalancing funds for the first time, and 1 state (New Hampshire) reported for the first time in five years. Among the MFP grantees that reported any rebalancing fund expenditures, state spending through 2015 ranged from a low of \$7,478 in Nevada to a high of approximately \$70.2 million in Missouri. Among the 11 states that did not report MFP rebalancing fund expenditures, 6 states (California, Delaware, Georgia, Hawaii, Kentucky, and Vermont) reported rebalancing spending in at least one prior year and 5 states (Alabama, Colorado, Minnesota, South Carolina, and South Dakota) have never reported any spending of rebalancing funds (Appendix A, Table A.6).

Figure V.1. Cumulative expenditures of state rebalancing funds between December 2009 and December 2015



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016

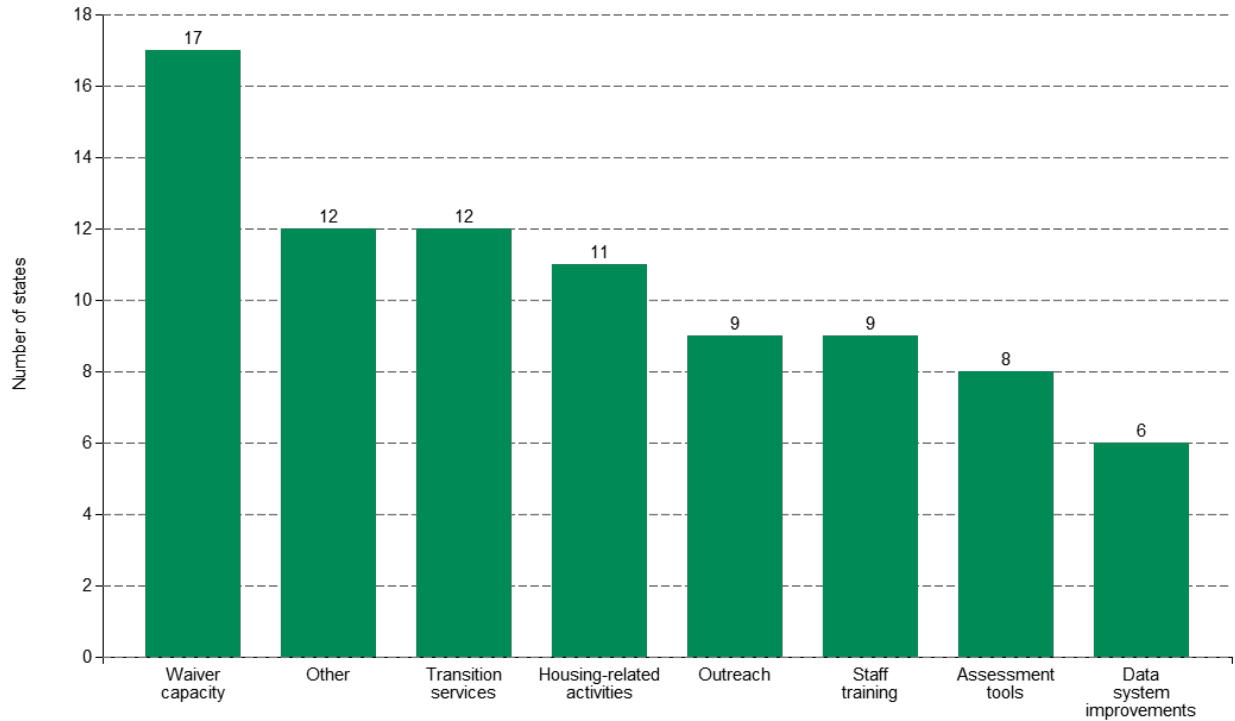
Note: Analysis based on data from 16 states in 2009; 19 states in 2010; 20 states in 2011; 25 states in 2012; 22 states in 2013; 28 states in 2014; 33 states in 2015.

MFP grantees are required to invest their rebalancing funds in programs or initiatives that help shift the balance toward community-based LTSS. Thirty-five MFP grantees reported a wide range of rebalancing initiatives that were either planned or already under way by the end of 2015 (Figure V.2 and Appendix A, Table A.6). These activities can be broadly classified under the following common themes:

- Expanding or enhancing the capacity of community-based LTSS waiver programs (17 states)
- Promoting awareness, use, or access to transition services (12 states)
- Improving participants' access to affordable and accessible housing (11 states)
- Outreach (9 states)
- Training direct care workers and medical professionals (9 states)
- Supporting the development or use of tools to assess consumer needs and preferences (8 states)
- Developing or improving administrative data or tracking systems (6 states)

Twelve states also detailed other types of rebalancing initiatives that do not fall into the above categories, such as strategic planning, incentive payments to managed care organizations for each new MFP participant, developing department-wide standards for core transition concepts, or creating a loan program for durable medical equipment for participants upon their discharge to the community while they wait for delivery of permanent equipment.

Figure V.2. Types of rebalancing initiatives in 2015



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Note: States may spend rebalancing funds on multiple types of initiatives and can be counted in multiple categories.

N = 35 grantee states.

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VI. REINSTITUTIONALIZATIONS LASTING MORE THAN 30 DAYS

The number of participants who remain in the community throughout the first year after transition is a key indicator of the extent to which MFP transitions are successful and how MFP participants fare in the community. Consequently, MFP grantees track the rate of reinstitutionalization among current MFP participants who have transitioned to the community. A reinstitutionalization is defined as any admission, regardless of the length of stay, to a hospital, nursing home, intermediate care facility for people with intellectual disabilities, or institution for mental diseases. Common reasons for reinstitutionalization are listed in Table VI.1. Because short-term hospital admissions lasting fewer than 30 days are common among this population and many states disenroll MFP participants from the program when they are readmitted to institutional care for more than 30 days, this analysis focuses on reinstitutionalizations that last more than 30 days¹⁷ (Irvin et al. 2015).

Table VI.1. Number of states reporting common reasons for reinstitutionalization

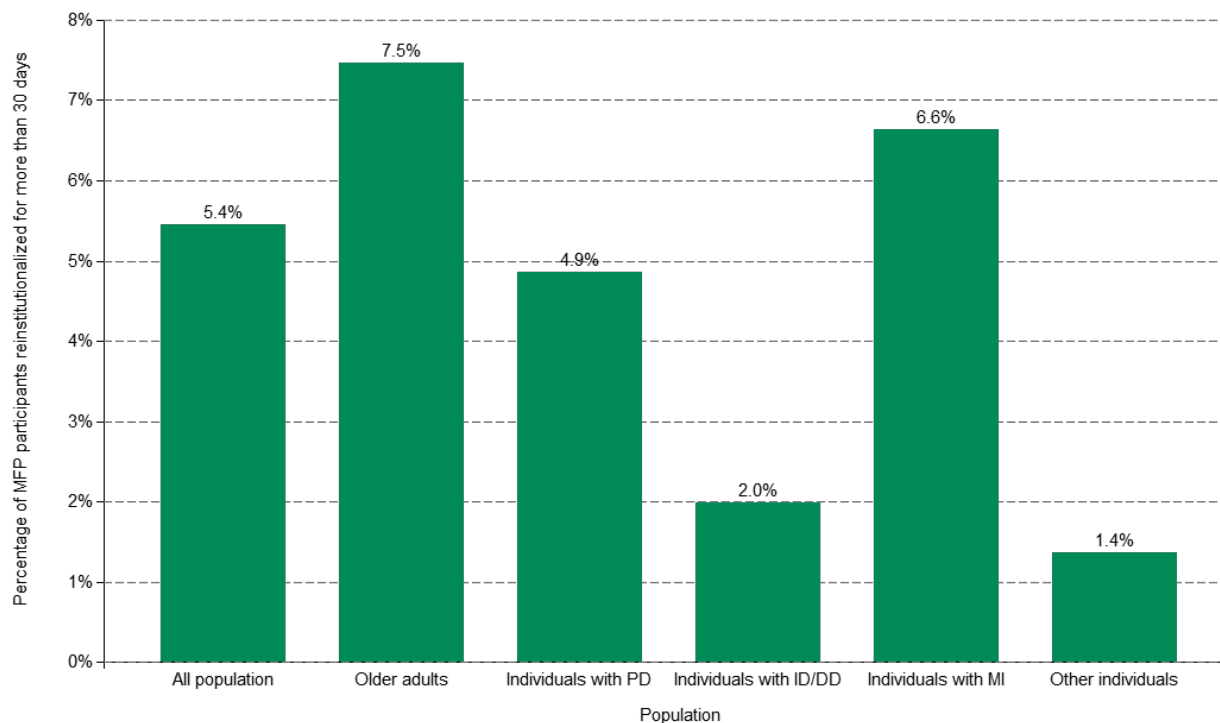
Reasons for reinstitutionalization (admissions lasting more than 30 days)	January to June 2016	July to December 2016
Deterioration in physical or mental health status	28	23
Events that led to a hospitalization (for example, acute medical events, falls, or accidents)	10	11
The existence of a complex or chronic condition requiring more care than could be received at home	7	5
Inadequate community or family member support	6	4
Requests by either the family or the participant to return to an institutional setting	5	5
Loss of caregiver	3	3
Loss of housing	1	2
Lack of sufficient home care services in area	1	2
Other (for example, change in Medicaid eligibility, difficulty meeting spend-down, failure to follow transition plan, overmedication)	4	2

Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

¹⁷ If an MFP participant is admitted for more than 30 days, CMS guidance issued in June 2011 gives states discretion to disenroll or suspend an individual from MFP, which “stops the clock,” allowing them to receive MFP services for up to 365 days (need not be continuous). Individuals who are disenrolled or suspended from MFP may reenroll without meeting the 90-day institutional residency requirement, provided they meet any applicable state requirements for reenrollment.

Overall. Approximately 5 percent of MFP participants, or 1,119 individuals, were reinstitutionalized for more than 30 days during 2016 (Figure VI.1).¹⁸ The majority of these were older adults and people with physical disabilities, comprising 47 and 36 percent of all reinstitutionalizations, respectively. (See Appendix A, Tables A.9 and A.10. Tables A.7 and A.8 include state-level data for reinstitutionalizations for any length of stay.) Among the five main populations targeted by MFP programs, older adults also had the highest percentage (8 percent) of participants reinstitutionalized for more than 30 days in 2016. Individuals with mental illness and individuals with physical disabilities had the next-highest percentages (7 percent and 5 percent, respectively) of participants reinstitutionalized for more than 30 days. These populations were followed by individuals with intellectual or developmental disabilities (2 percent) and “other” individuals (1 percent).

Figure VI.1. Percentage of participants reinstitutionalized for more than 30 days between January and December 2016, by MFP target population



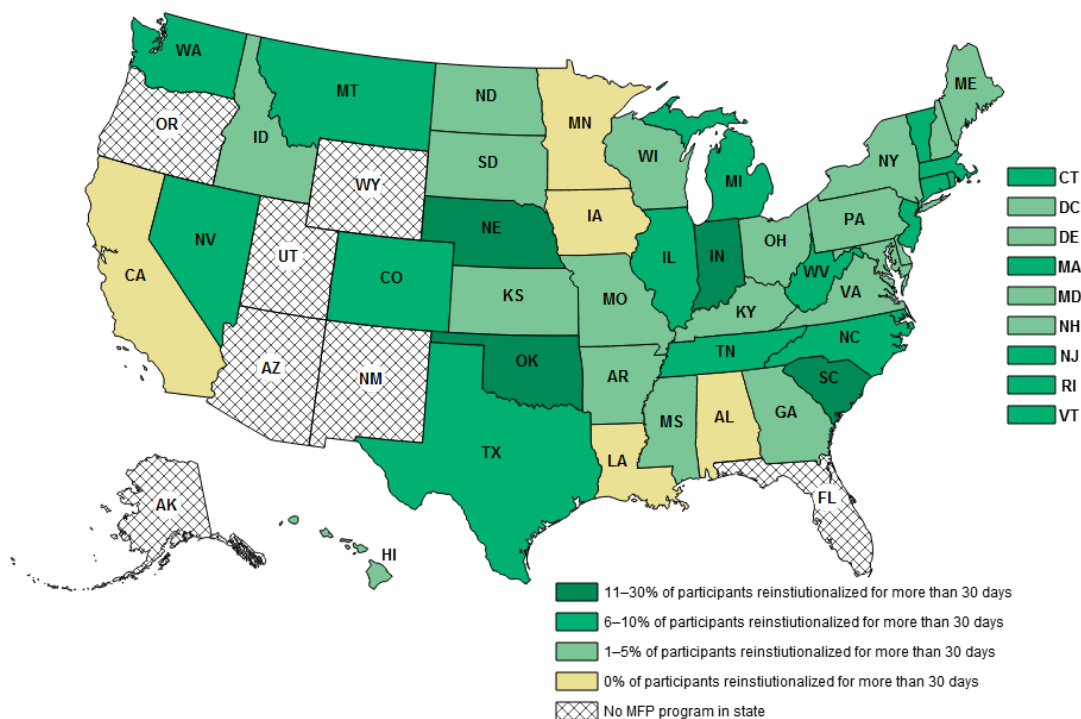
Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016. N = 44 grantee states.

ID/DD = intellectual or developmental disabilities; MI = mental illness; PD = physical disabilities.

¹⁸ The percentage of participants reinstitutionalized for more than 30 days is calculated by dividing the total number of participants reinstitutionalized for more than 30 days during each reporting period of 2016 by the total number of current participants as of the end of each reporting period and averaging the results.

State variation in reinstitutionalizations. Among the grantee states, the percentage of participants reinstitutionalized for more than 30 days ranged from 0 to 30 percent. This variation across states may be partly due to both differences in participants’ level of care and differences in grantee reporting of these events.¹⁹ Nearly half the grantee states reported that less than 5 percent of participants were reinstitutionalized for more than 30 days. The four grantee states with the highest percentages (Indiana, Nebraska, Oklahoma, and South Carolina) ranged between 11 and 30 percent of current MFP participants (Figure VI.2). All four of these states are small programs; consequently, a small number of reinstitutionalizations result in a higher-than-average rate relative to all MFP participants. Five states reported that less than 1 percent of participants were reinstitutionalized for more than 30 days in 2016; of these, three states (Alabama, Iowa, and Minnesota) reported that no participant was reinstitutionalized for more than 30 days in 2016. California and Louisiana reported so few reinstitutionalizations that the average rate is 0 percent for this state.

Figure VI.2. Percentage of current participants reinstitutionalized for more than 30 days, January to December 2016, by state

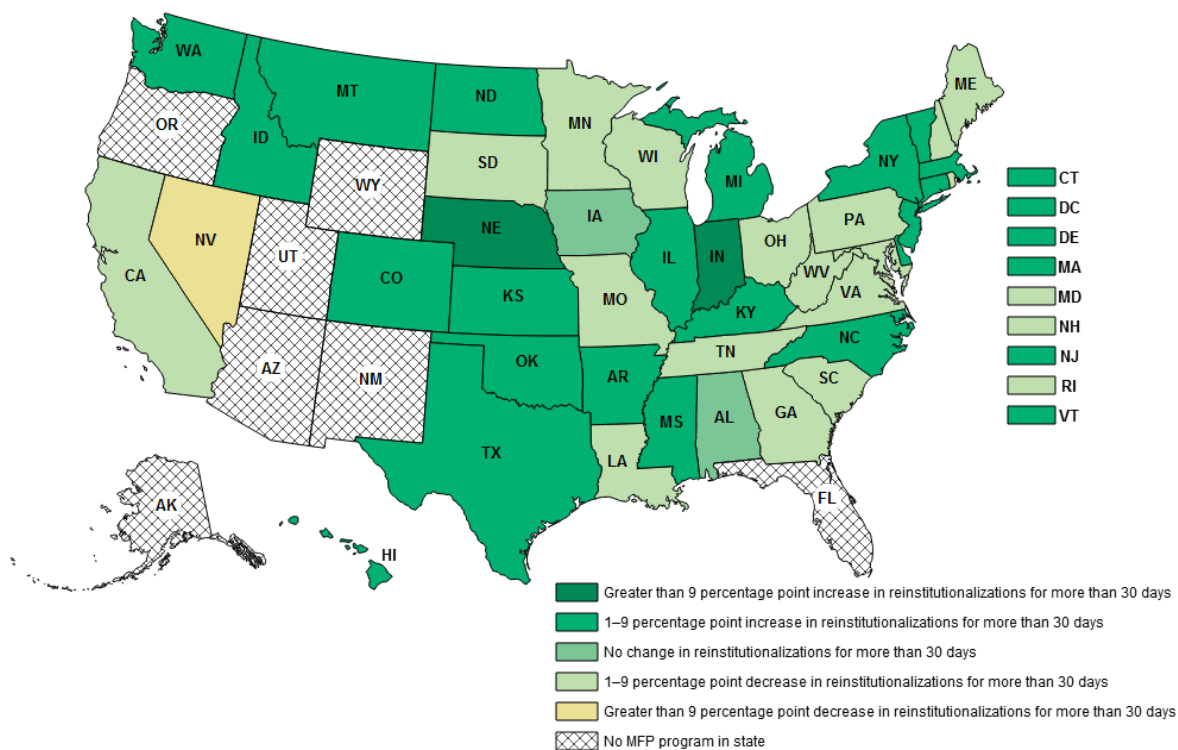


Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

¹⁹ State-level variation in reported reinstitutionalizations may also be attributable to differences in the quality and completeness of data. States vary in their ability to accurately track and report the number of participants reinstitutionalized and the number of current participants. Also, for states with a small number of current participants, a few reinstitutionalizations can inflate the percentage of reinstitutionalizations among current participants.

Between 2015 and 2016, 18 states experienced a decrease in their percentage of reinstitutionalizations for more than 30 days. Two states experienced no change in the percentage of reinstitutionalizations for more than 30 days, and the other 24 state grantees experienced an increase (Figure VI.3). States with low enrollment are more likely to have greater changes between years. For example, Indiana had the largest percentage point increase (25 percentage points) in reinstitutionalizations longer than 30 days, a reflection of the small and decreasing size of the program (628 current participants as of the end of 2015 and 69 as of December 2016). Nevada, another state with relatively few MFP participants, saw the largest percentage point decrease (16 percentage points) of participants reinstitutionalized from 2015 to 2016.

Figure VI.3. Percentage point change in participants reinstitutionalized for more than 30 days between the January to December 2015 and January to December 2016 reporting periods, by state

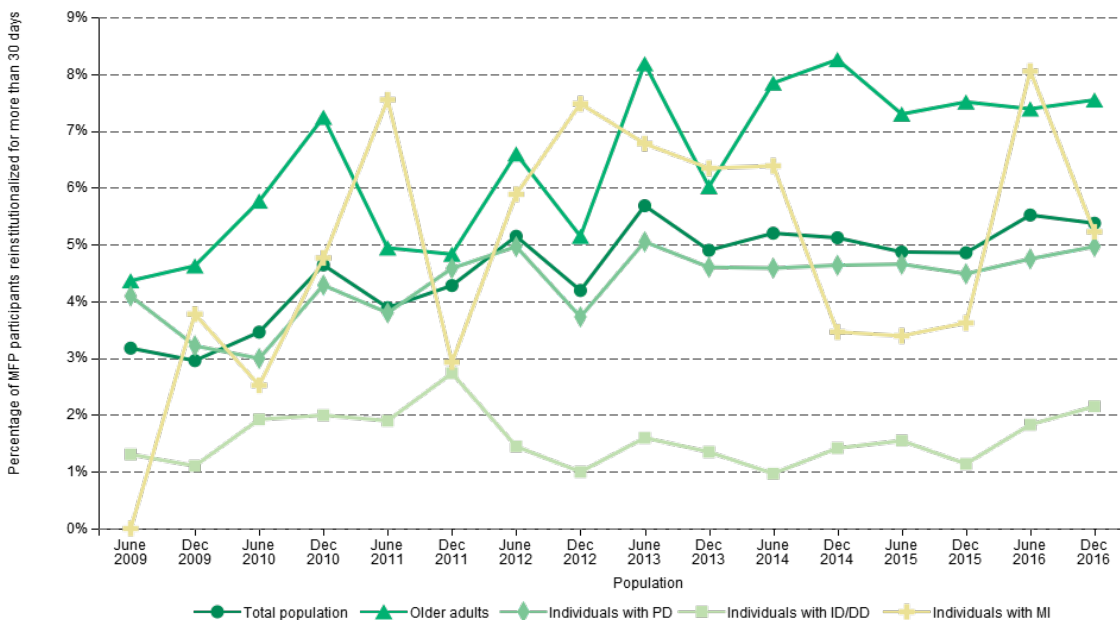


Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2015 and 2016.

Variation in reinstitutionalizations by target population. The overall percentage of participants reinstitutionalized for more than 30 days was close to 5 percent for the seventh straight period, below the high of 6 percent in June 2013 (Figure VI.4). That percentage has not varied significantly for most of the target groups. The reinstitutionalization rates for older adults increased from 6 percent at the end of 2013 to more than 8 percent at the end of 2014 before falling to 7 percent in December 2015 and 2016. The reinstitutionalization rate has ranged between 3 and 5 percent of participants over time for individuals with physical disabilities, settling around 5 percent since June 2013. After December 2011, the reinstitutionalization rates for individuals with intellectual and developmental disabilities declined and then remained relatively stable at about 1 percent, increasing to 2 percent in 2016. Individuals with mental illness were the only group to show substantial changes over time, with reinstitutionalization rates fluctuating between approximately 3 percent and 8 percent. This could be because, historically, the population of individuals with mental illness is smaller than other target groups, so small changes will have larger effects on the reinstitutionalization rate (Appendix A, Table A.1). For all groups, variations in reinstitutionalization rates over time could be caused by many reasons: changes in quality of care, community-based providers developing more experience in serving these populations, improved data reporting systems or data collection procedures, more successful supports as programs mature, and changes in the makeup of MFP participants if programs add new populations over time.

Older adults and individuals younger than age 65 with physical disabilities are the two largest groups transitioning through the MFP demonstration. There was considerable state variation in the percentage of participants from these populations reinstitutionalized for more than 30 days in 2016. Within the older adult population, the percentage of participants reinstitutionalized for more than 30 days ranged from 0 percent in 6 states (Alabama, Iowa, Kentucky, Louisiana, Minnesota, and New Hampshire) to 20 percent or greater in 3 states (Indiana, North Dakota, and Nebraska). Six states (Alabama, Delaware, Iowa, Maine, Minnesota, and South Carolina) reported no reinstitutionalizations for more than 30 days for individuals with physical disabilities, and 6 states (Illinois, Indiana, Massachusetts, Michigan, Nevada, and Rhode Island) reported that 8 percent or more of individuals with physical disabilities were reinstitutionalized for more than 30 days in 2016.

Figure VI.4. Percentage of participants reinstitutionalized for more than 30 days for the total population and subpopulations, June 2009 to December 2016



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2009–2016.

Note: We calculated the percentage of participants reinstitutionalized by dividing the aggregate number of participants reinstitutionalized for more than 30 days reported by MFP grantees by the total number of current participants at the end of each reporting period from 2009 to 2016.

The analysis is based on data from 30 states in June 2009, December 2009, June 2010, December 2010, and June 2011; 34 states in December 2011; 35 states in June 2012; 37 states in December 2012; 41 states in June 2013; 42 states in December 2013; 43 states in June 2014; and 44 states in December 2014–December 2016.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

VII. SELF-DIRECTION

Self-directed or participant-directed service models allow MFP participants to have more choice and control over the delivery of their long-term services and supports than what might be available to them when an agency or provider manages services on behalf of the participant. Of the 44 grantee states that were actively transitioning MFP participants during 2016, 39 reported offering participants the option to self-direct their services during at least one period of 2016 (Figure VII.1).

States design their self-direction programs to allow participants to hire and supervise their personal care assistants, manage their allowance or budget, or both. Of the 39 states with self-direction programs, 31 reported that at least one MFP participant was self-directing his or her community-based LTSS through either of these two models, and Ohio reported that participants only managed their budget for one-time moving expenses (Figure VII.2). Of these, 31 reported that at least one MFP participant had hired or was supervising his or her own personal assistant in 2016, and 25 reported that at least one participant managed his or her own budget, with Ohio again noting that participants only manage the one-time moving expenses. Six states (Alabama, Hawaii, Massachusetts, Maine, Tennessee, and Virginia) reported that participants only hired and supervised staff in 2016 (Appendix A, Table A.12).

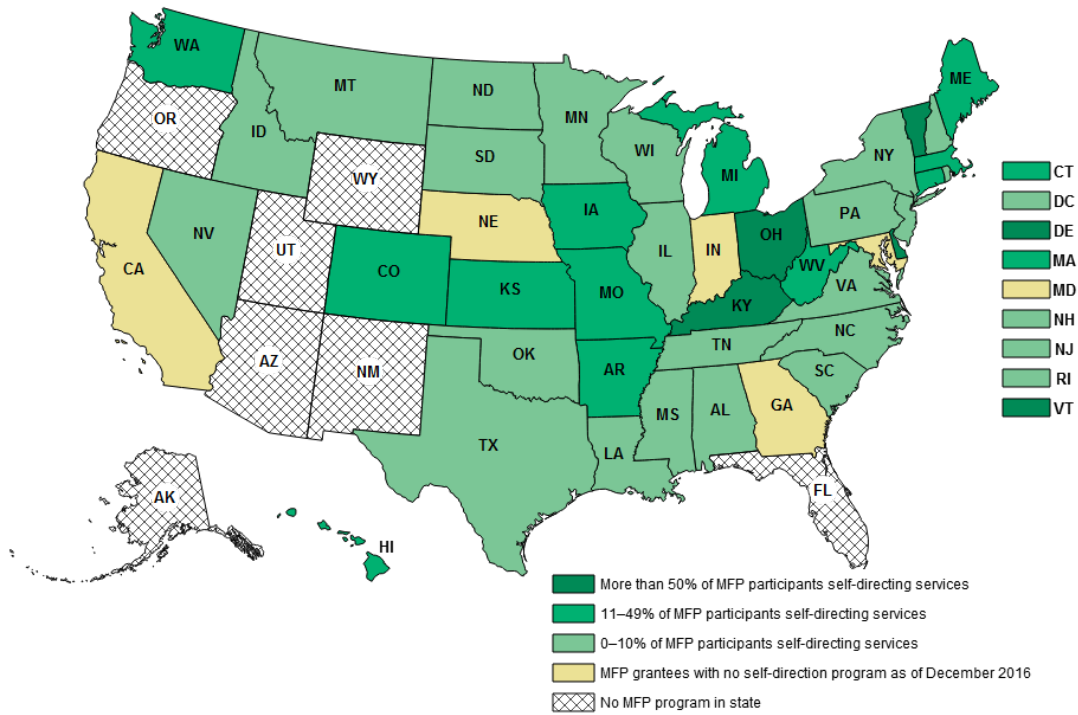
More than 26 percent of all MFP participants were reported to be self-directing services in 2016, ranging from none in 7 of the grantee states that offer self-direction services to all participants in Delaware and Ohio.²⁰ The majority (31) of the 39 grantee states offering a self-direction program reported that 25 percent or fewer of their MFP participants were enrolled in the state's program. Four states (Delaware, Kentucky, Ohio, and Vermont) reported that more than half of their participants self-directed services.²¹

Several grantees reported moderate changes in the percentage of participants self-directing their services between the second half of 2015 and the second half of 2016. Among the 30 states that had participants self-directing services in at least one period of 2015 and 2016, 17 reported increases in the percentage of participants self-directing in 2016 over the previous year, ranging from under 1 percentage point (Mississippi, Vermont, and Washington) to more than 16 percentage points (Delaware). In contrast, the percentage of participants self-directing their services decreased in 12 states during 2016, with decreases ranging from less than 1 percentage point (Louisiana and Wisconsin) to more than 10 percentage points (Kansas and Maine).

²⁰ All MFP participants in Ohio receive \$2,000 to use as they wish for one-time moving expenses and are considered self-directing. However, this model does not meet Medicaid's self-direction guidelines requiring an individualized budget and person-centered planning process. More information about Medicaid's self-direction guidelines can be found at <https://www.medicaid.gov/medicaid/ltss/self-directed/index.html>.

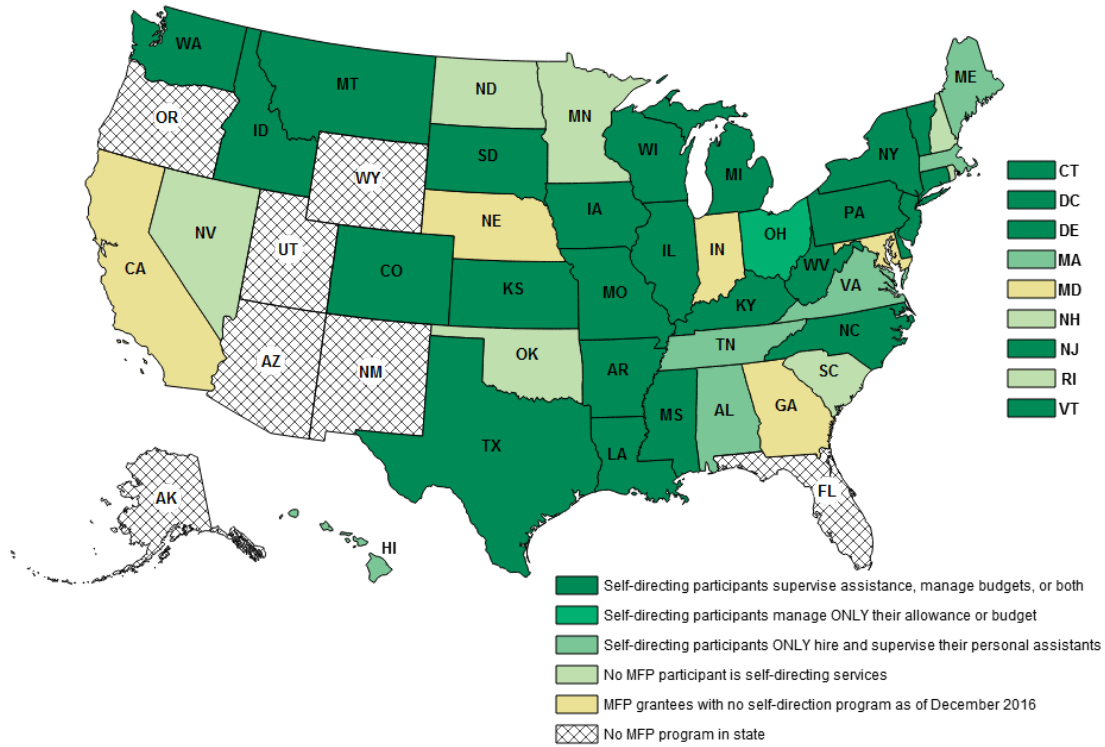
²¹ Kentucky reported 62 percent of participants self-directing their services during the second half of 2016. The state reported more than 100 percent of participants self-directing services in the first half of 2016, which appears to be a reporting error.

Figure VII.1. Percentage of MFP participants self-directing services, January to December 2016, by state



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Figure VII.2. Types of self-direction service options used by MFP participants, January to December 2016, by state



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

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VIII. HOUSING FOR MFP PARTICIPANTS

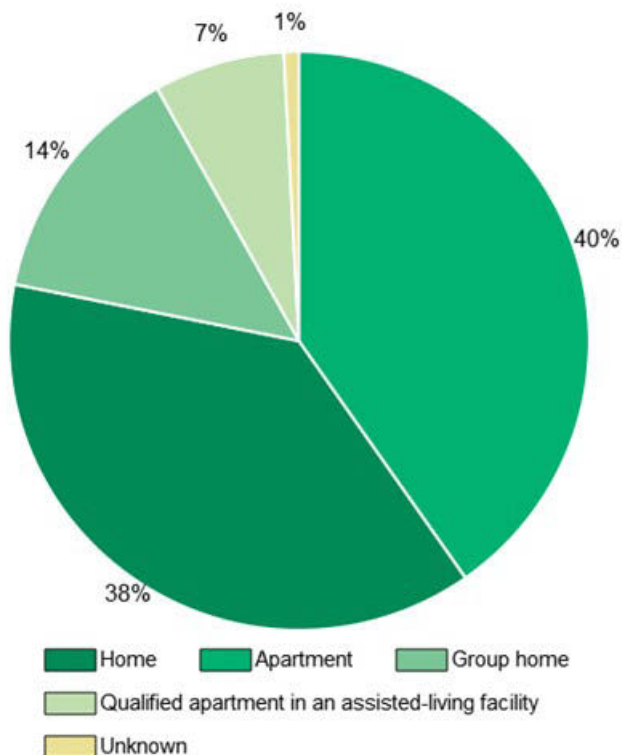
MFP participants have a choice of the type of qualified housing they move into upon transitioning to the community.²² This section presents the types of qualified residences to which new MFP participants transitioned during 2016 and breaks down housing types by target population. It also examines the challenges that states faced in trying to secure affordable, accessible housing for MFP participants and the strategies used to overcome these challenges.

Of the 11,217 MFP participants who transitioned to the community during 2016, 38 percent (4,248 individuals) moved to a home, 40 percent (4,517 individuals) moved to an apartment, 14 percent (1,541 individuals) moved to group home settings with four or fewer residents, and 7 percent (817 individuals) moved to a qualified assisted-living facility (Figure VIII.1, Appendix A, Tables A.14 and A.15).²³ These distributions are similar to what state grantees reported in 2015, with slightly higher percentages of participants transitioning to homes and slightly lower percentages transitioning to apartments and qualified assisted-living facilities in 2016.

²² There are four types of qualified housing: (1) homes owned or leased by individuals or families, (2) apartments, (3) group homes or other residences in which four or fewer unrelated individuals live, and (4) apartments in qualified assisted-living facilities.

²³ Within each grantee state, the number of MFP participants that transitioned during the reporting period should equal the total number of individuals who moved to all qualified residences during that period. In a few grantee states, the total number of newly transitioned participants with an identified type of qualified housing did not match the total number of newly transitioned participants. The reason most commonly cited for this discrepancy is delay in data entry; grantees may not have known the type of housing for all newly transitioned participants at the time they submitted their semiannual progress reports.

Figure VIII.1. Percentage of new MFP participants who transitioned to each type of qualified residence, January to December 2016



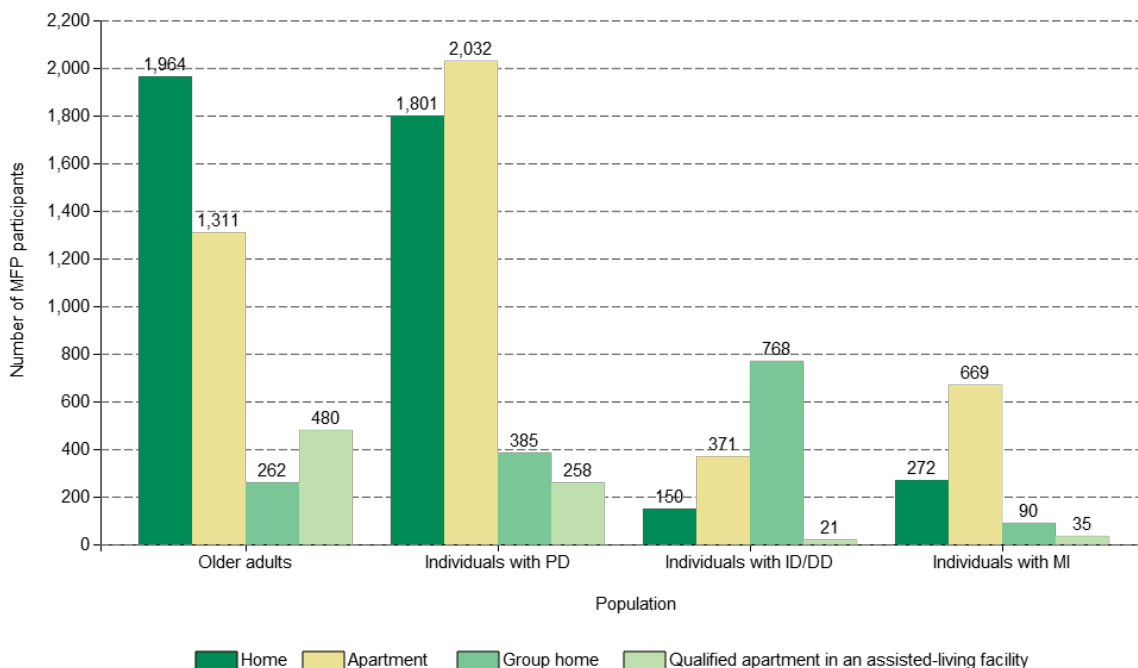
Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Note: Percentages are based on data reported for both reporting periods in 2016, and the data reported by states in each reporting period was summed.

N = 44 grantee states.

The types of qualified residences chosen by MFP participants were similar for older adults, individuals with physical disabilities, and individuals with mental illness but differed for individuals with intellectual or developmental disabilities (Figure VIII.2). The vast majority of older adults (82 percent) and individuals with physical disabilities (85 percent) transitioned to a home or an apartment during the year; homes were the most common type of housing for older adults, and apartments were most common for individuals with physical disabilities. Most individuals with intellectual or developmental disabilities transitioned to a qualified group home (59 percent), and the majority of individuals with mental illness moved to an apartment (63 percent). Except for older adults, a qualified apartment in an assisted-living facility was the least common type of housing among the target populations. For older adults, qualified group homes were the least common.

Figure VIII.2. Type of qualified residence by new MFP participants, by target population, January to December 2016



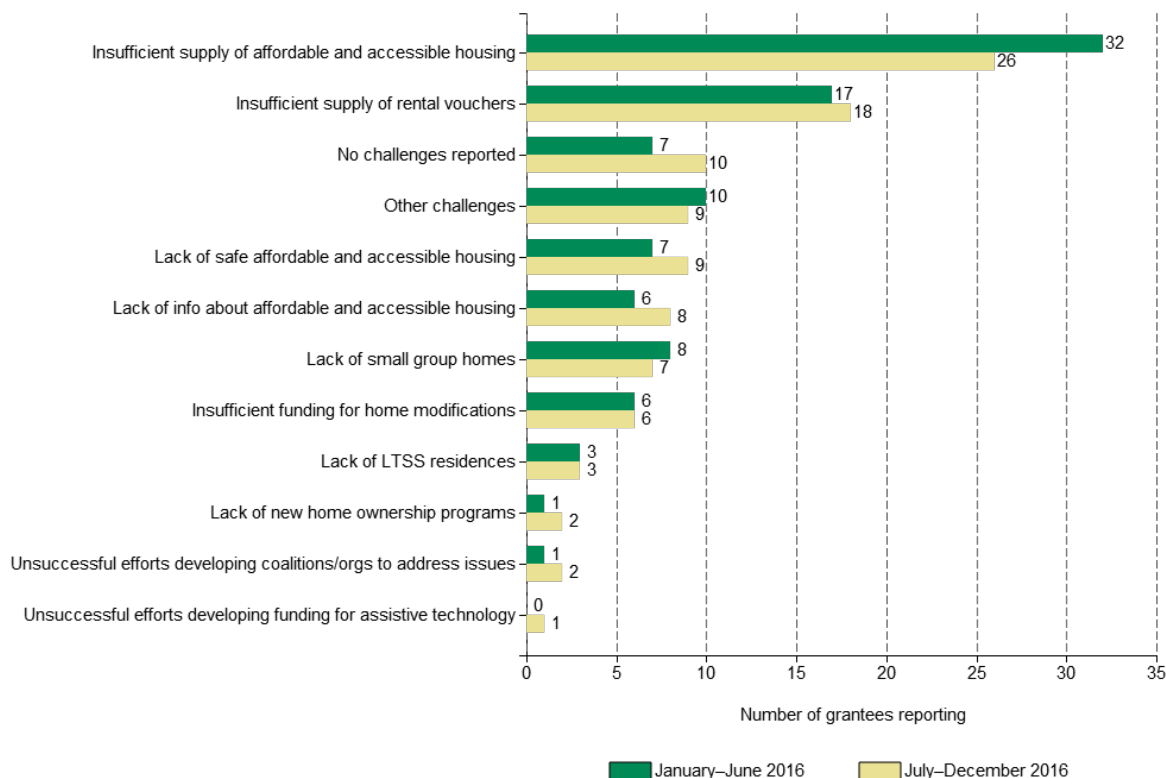
Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2015.

N = 44 grantee states.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

Identifying housing is a central challenge for grantee states. Thirty-eight of 44 grantee states reported at least one challenge securing housing for MFP participants. The two most commonly reported challenges in both periods of 2016 were (1) an insufficient supply of affordable and accessible housing (32 states January to June 2016; 26 states July to December 2016) and (2) an insufficient supply of rental vouchers (17 states January to June 2016; 18 states July to December 2016). Grantee states continued to cite shortages in housing and rental vouchers as key challenges, as they have done since the beginning of the MFP demonstration (Figure VIII.3, Appendix A, Table A.15).

Figure VIII.3. MFP grantees’ reported challenges securing housing for participants, by type of challenge, January to June 2016 and July to December 2016



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Note: Grantee states may report more than one type of challenge.

“Other challenges” included: housing shortages creating a tight rental market across a state; difficulty filling a housing coordinator position on a state’s MFP staff; unwillingness of some landlords to accept vouchers; stringent background checks during the housing application process; lack of funding allocated to rental subsidies; and difficultly accessing available funds to assist with the move from the facility.

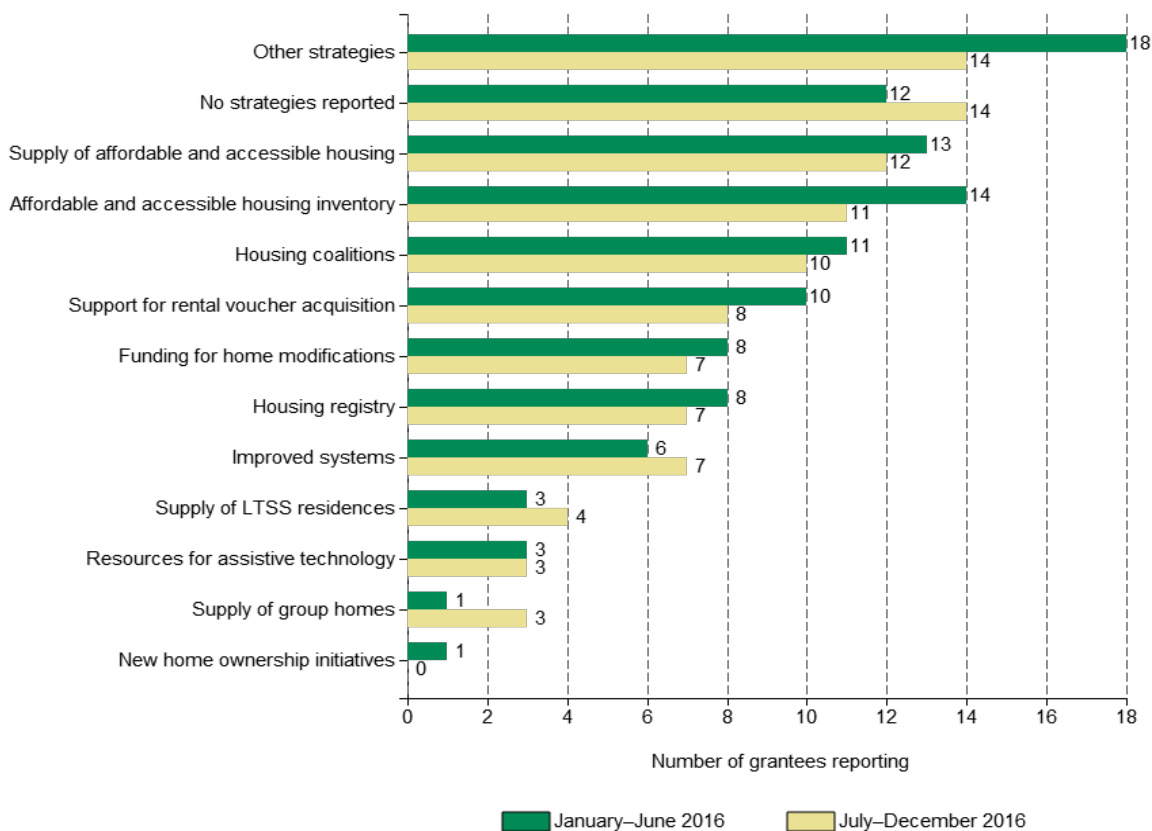
N = 44 grantee states.

LTSS = long-term services and supports; orgs = organizations.

Thirty-four of the 44 states reported implementing at least one strategy to address housing challenges and improve housing options for MFP participants during the year (Figure VIII.4, Appendix A, Table A.15). Among a defined set of strategies, the two most frequently cited in 2016 were (1) increasing the supply of affordable and accessible housing (13 states January to June 2016; 12 states July to December 2016) and (2) developing an inventory for affordable and accessible housing (14 states January to June 2016; 11 states July to December 2016). In previous reporting periods, the development of state or local coalitions of housing and human service organizations to create housing initiatives was the most commonly reported strategy. The decrease in this strategy during 2016 may suggest that many states already have coalitions in place. During 2016, many states also reported other strategies for addressing housing challenges,

including developing partnerships with other agencies or landlords/developers to discuss the needs of the MFP population; increasing funding for home modifications; applying for or receiving grant funding; training; holding housing conferences; and conducting education and outreach activities.

Figure VIII.4. MFP grantees’ efforts to improve housing for participants, by type of strategy, January to December 2016



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Note: Grantee states may report more than one type of effort to improve housing.

“Other” housing-related strategies included developing partnerships with other agencies or landlords/developers to discuss the needs of the MFP population, applying for or receiving grant funding, training, holding housing conferences, and conducting education and outreach activities.

N = 44 grantee states.

LTSS = long-term services and supports.

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IX. TRENDS IN QUALITY OF LIFE FOLLOWING THE TRANSITION TO COMMUNITY LIVING

The MFP demonstration is based on the belief that many Medicaid beneficiaries who reside in institutions would rather live independently in their communities and that community living contributes to improved quality of life and an increased sense of autonomy. This chapter uses Quality-of-Life survey data to examine the participant experience in the demonstration and how it changes after transitioning to the community.²⁴ Specifically, this chapter describes changes in participants' reported satisfaction with living arrangements, overall life satisfaction, quality of care, choice and control over daily activities, and sleep quality.

A. Satisfaction with living arrangements

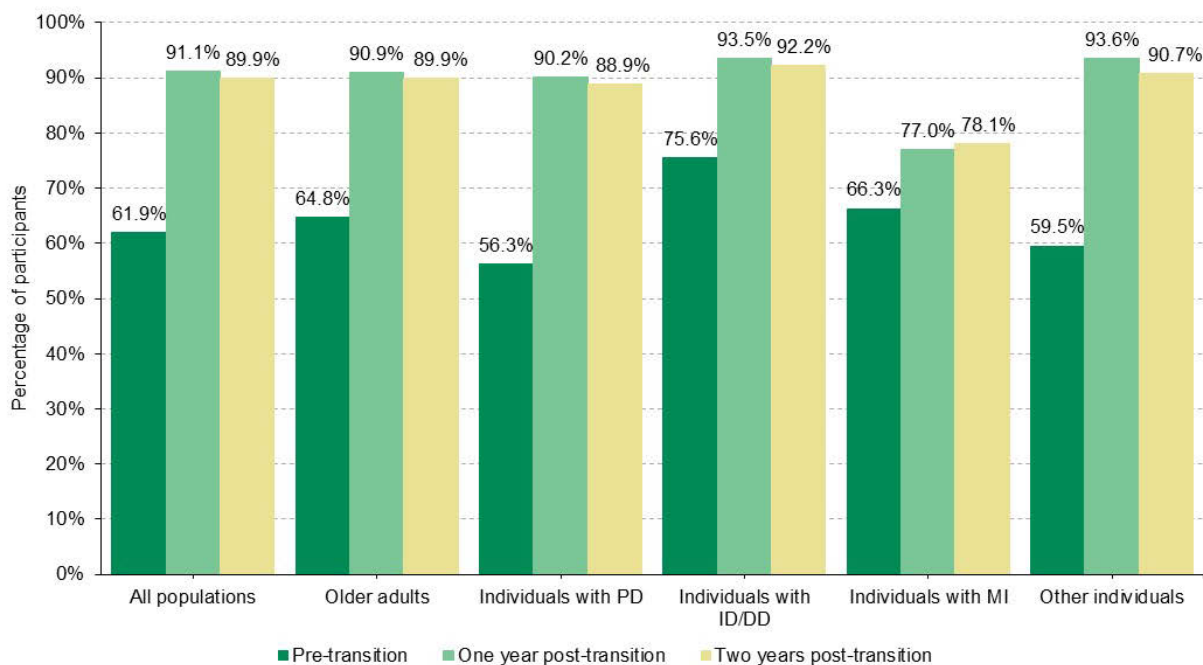
As described in the previous chapter, a key focus of MFP grantee states is to identify affordable and accessible housing for participants. Responses to the QoL survey indicate that these efforts are successful. One year after transitioning to the community, the vast majority of participants—91 percent—reported that they liked where they lived.²⁵ This reflects a significant increase from pre-transition satisfaction, when 62 percent of participants were satisfied with their living arrangements. Satisfaction with living arrangements increased for all target populations in the first year after transition, and this increase was sustained in the second year.²⁶ Pre-transition, satisfaction levels ranged from 56 percent among individuals with physical disabilities to 76 percent among individuals with intellectual or developmental disabilities. One and two years post-transition, more than 88 percent of individuals in each target population reported that they were satisfied with their living arrangements, except among individuals with mental illness. Among individuals with mental illness, 77 and 78 percent were satisfied with their living arrangements one and two years post-transition, respectively (Figure IX.1).

²⁴ Grantee states administer the MFP Quality-of-Life survey at three points: (1) immediately before transitioning to the community; (2) one year after transitioning; and (3) two years after transitioning, one year after participation in MFP demonstration has ended. More information can be found in Appendix B.

²⁵ To assess satisfaction with living arrangements, the survey asks at pre-transition and follow-up: "Do you like where you live?"

²⁶ Here and throughout the chapter, chi-squared tests were used to compare proportions for target populations to the full population (excluding the target population of interest), and McNemar's tests were used to compare proportions across time periods. Statistical significance was determined using 2-tailed tests, $p < 0.05$.

Figure IX.1. Satisfaction with living arrangements by target population



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

B. Life satisfaction

Another important measure of success for the MFP demonstration is whether participants' life satisfaction is maintained or improved after transitioning from long-term care institutions into community living. Among all participants in the sample (17,802 respondents), we observed significant improvements in life satisfaction over time (Figure IX.2). Sixty-two percent of participants reported being satisfied with the way they lived their life while in institutional care; this increased to 78 percent of participants reporting life satisfaction one and two years after transition.²⁷

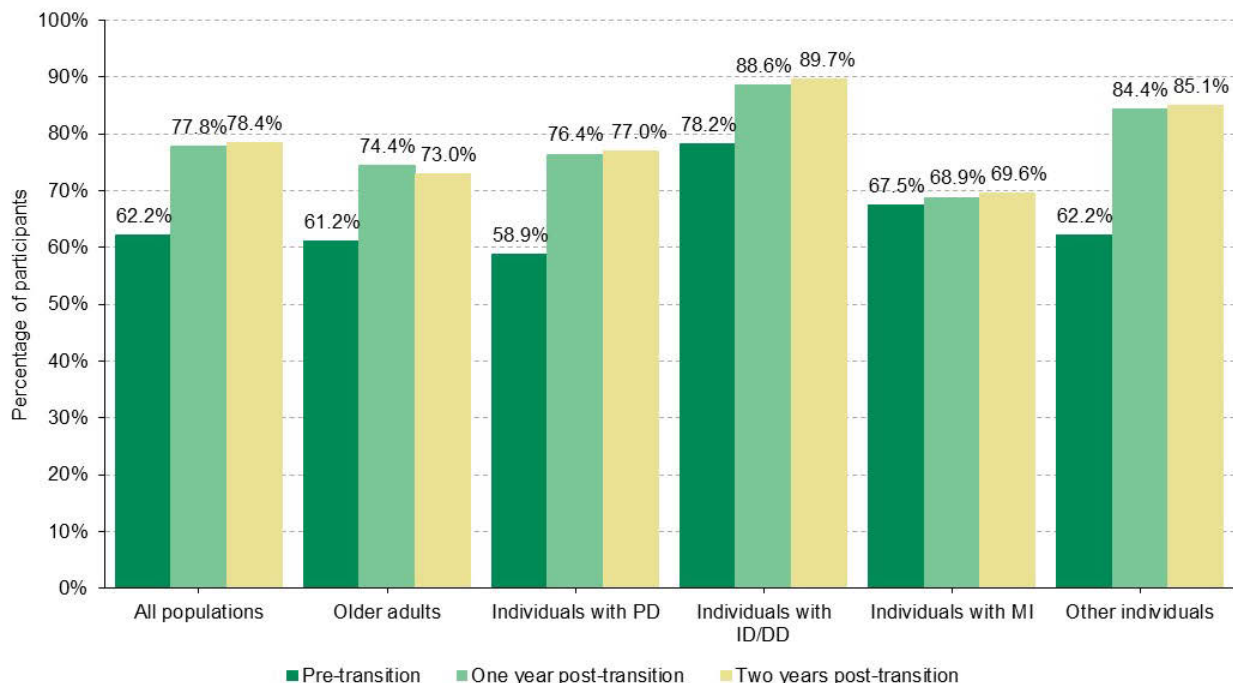
We also observed significant improvements in life satisfaction across all target populations except individuals with mental illness. The largest improvement was among participants who transitioned from "other" types of institutions (referred to as "other individuals" throughout this chapter).²⁸ Among this group, the percent of participants reporting being satisfied with the way they lived their life increased by 22 percentage points after transitioning to the community, from 62 percent while in institutional care to 84 percent one year post-transition and 85 percent two years post-transition. We also observed large improvements among participants with physical disabilities and older adults. Improvements among individuals with intellectual or developmental disabilities were smaller, but this group reported the highest levels of life satisfaction at all three time points, ranging from 78 percent pre-transition to 90 percent two years post-transition. The only group for which life satisfaction did not change upon moving to the community was the group of individuals with mental illness. Among this group, between 68 and 70 percent reported life satisfaction pre and post-transition.²⁹ These were the lowest levels of reported life satisfaction after moving to the community among all target populations. However, this group is small (122 respondents) and estimates are less precise than for other populations, so results should be interpreted with some caution (Figure IX.2).

²⁷ The survey asks at pre-transition and follow-up: "Taking everything into consideration, during the past week have you been happy or unhappy with the way you live your life?"

²⁸ For this group, administrative data is submitted with institution type categorized as "other." This group does not include individuals for whom the institution type is unknown.

²⁹ Although there is a slight increase, this difference was not statistically significant.

Figure IX.2. Overall life satisfaction by length of time in the community and target population



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

ID/DD = intellectual or developmental disabilities; MI = mental illness; PD = physical disabilities.

C. Quality of care

Moving from an institutional to a community setting changes how participants access and receive care, and ensuring that participants receive the same quality of care in the community is key to MFP’s success. The Quality-of-Life survey assesses four aspects of quality of care:

(1) satisfaction with care received;³⁰

³⁰ To assess satisfaction with care, the survey asks at pre-transition and follow-up: “Taking everything into consideration, during the past week, have you been happy or unhappy with the help you get with things around the house or getting around your community?”

(2) treatment with respect and dignity by LTSS providers;³¹ (3) unmet need for personal assistance services;³² and (4) unmet need for medical care.³³ One year after moving to the community, participants reported improvements in three of these areas: satisfaction with care, treatment with respect and dignity by LTSS providers, and unmet need for personal assistance services. These improvements were statistically significant and largely sustained two years later, consistent with past research (Irvin et al. 2017) (Figure IX.3).

The aspect of care showing the largest improvement was treatment with respect and dignity by providers. Pre-transition, 73 percent of participants reported being treated with respect and dignity; this increased to 88 percent one year after transition and 89 percent after two years in the community. A large improvement was also observed in unmet needs for personal assistance services. Overall, 18 percent of participants in the sample reported having unmet needs for personal assistance services (defined as one or more unmet needs related to eating, bathing, toileting, and medication administration) while in institutional care; this declined to 8 and 7 percent one and two years later, respectively. One year post-transition, assistance with bathing was the most frequently reported unmet need (4 percent), followed by toileting and medication administration (2 percent each), and assistance with preparing meals (1 percent) (data not shown). Overall satisfaction with care also improved upon transition, from 75 percent pre-transition to 87 percent one and two years post-transition (Figure IX.3). Taken together, these measures indicate that quality of care is not only maintained after transitioning to the community, but for many participants, improves across multiple dimensions.

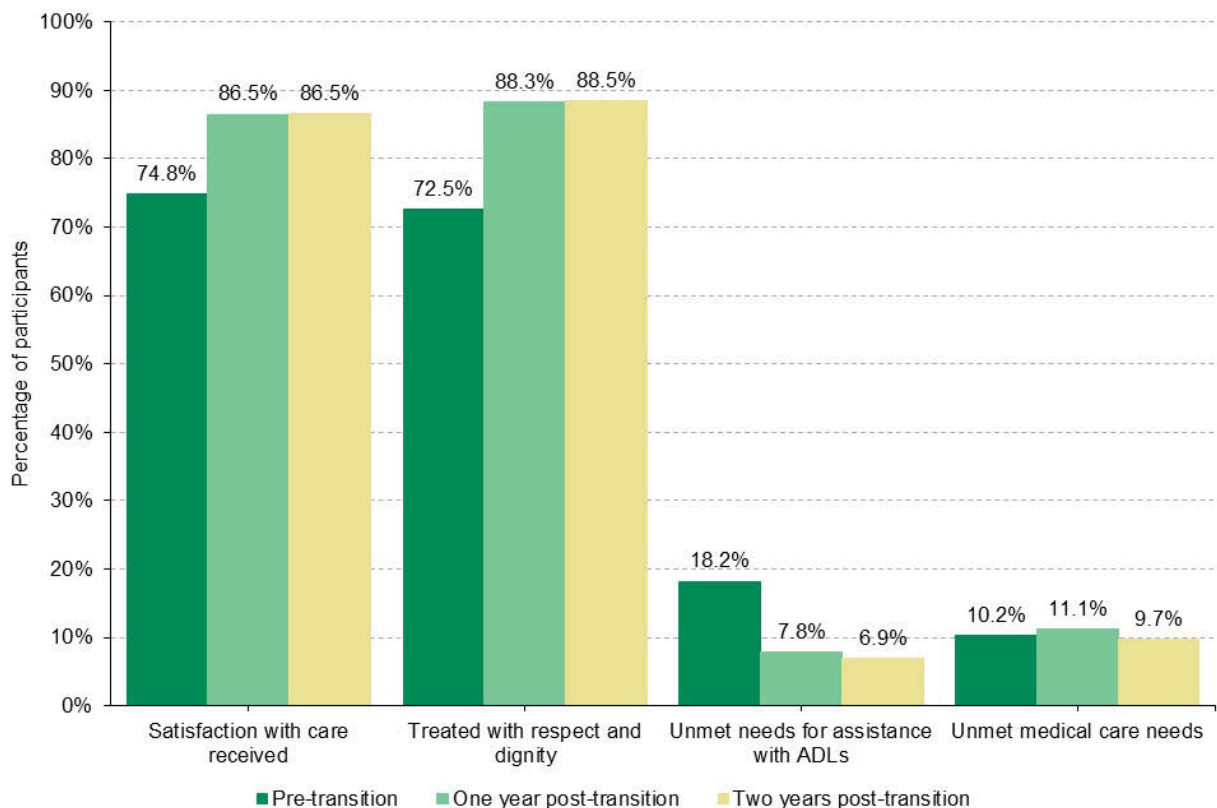
Unmet medical care needs essentially did not change for MFP participants; between 10 and 11 percent of participants reported unmet medical care needs pre- and post-transition. This lack of change suggests that unmet medical care needs may not be closely related to where someone resides and may reflect other factors that impinge on an individual's access to medical care (Figure IX.3).

³¹ Being treated with “respect and dignity” is assessed through two questions: (1) “You said that you have people who help you. Do the people who help you treat you the way you want them to?” and (2) “Do the people who help you listen carefully to what you ask them to do?” Participants who answer “yes” to both questions are identified as being treated with respect and dignity.

³² Having an “unmet need for personal assistance services” is defined as a participant who goes without needed assistance in at least one of four personal care areas (bathing, meals, medication, and/or toileting). This is assessed through a two-part question: (1) “Do you ever go without [a bath or shower/a meal/taking your medicine] when you need one?” or “Are you ever unable to use the bathroom when you need to?” and (2) “Is this because there is no one there to help you?” These two-part questions are asked separately for each of the four care needs. Participants who answer “yes” to both questions for at least one of the care needs are identified as having an unmet need for personal assistance services.

³³ Having an “unmet need for medical care” is assessed by asking, “Is there any medical care, such as a medical treatment or doctor's visits, which you have not received or could not get to within the past month?”

Figure IX.3. Quality of care by length of time in the community, all populations



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

A declining percentage indicates improvement in unmet needs for assistance with ADLs and unmet medical care needs.

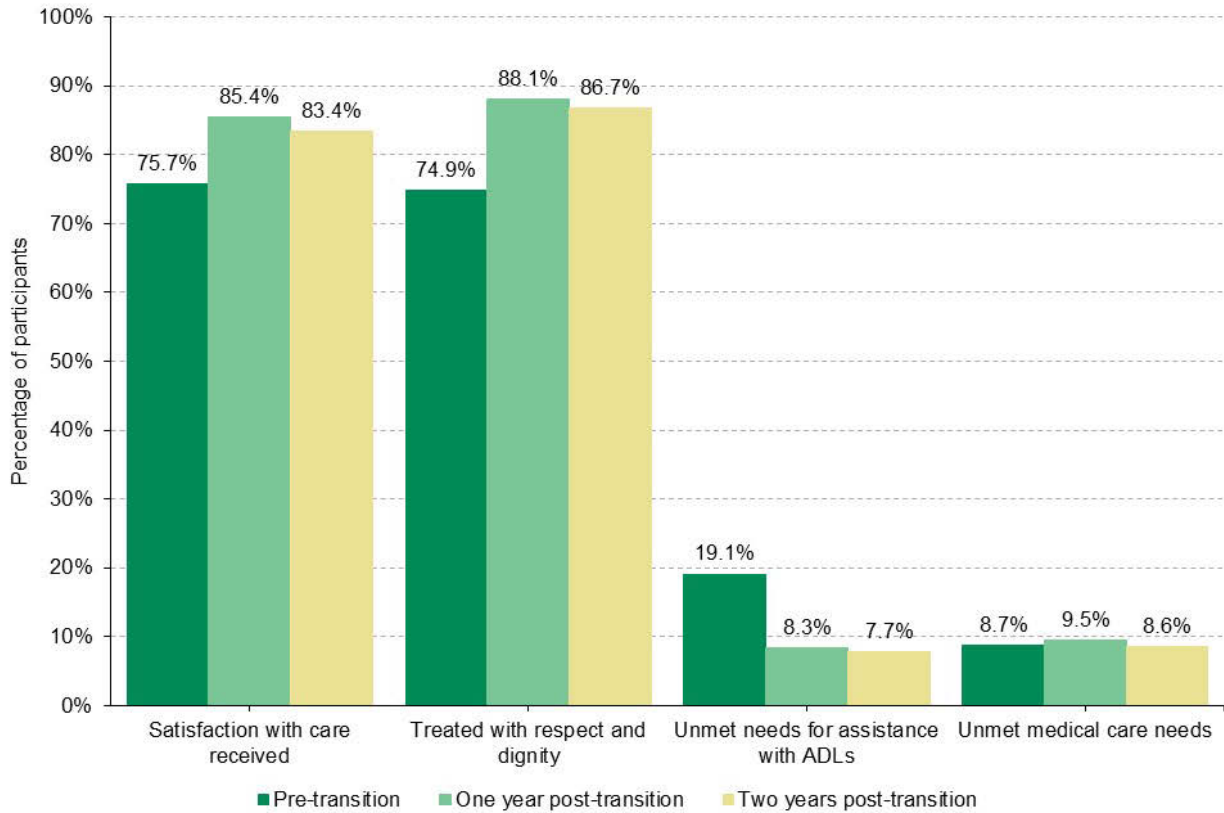
This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

ADL = activity of daily living; PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

Variation in quality of care by target population

MFP grantee states serve participants with diverse needs and, to some extent, each target population has varying needs for different types of services and supports when transitioning to the community. Understanding the distinct support needs of each population can direct targeted improvements in community-based LTSS delivery. Across all quality of care measures, older adults and individuals with physical disabilities reported similar patterns of improvement as the total population of MFP participants (Figures IX.4, IX.5). Among individuals with ID/DD, individuals with mental illness, and other individuals, there were notable differences relative to the total MFP participant sample. We discuss these differences below.

Figure IX.4. Quality of care by length of time in the community, older adults



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

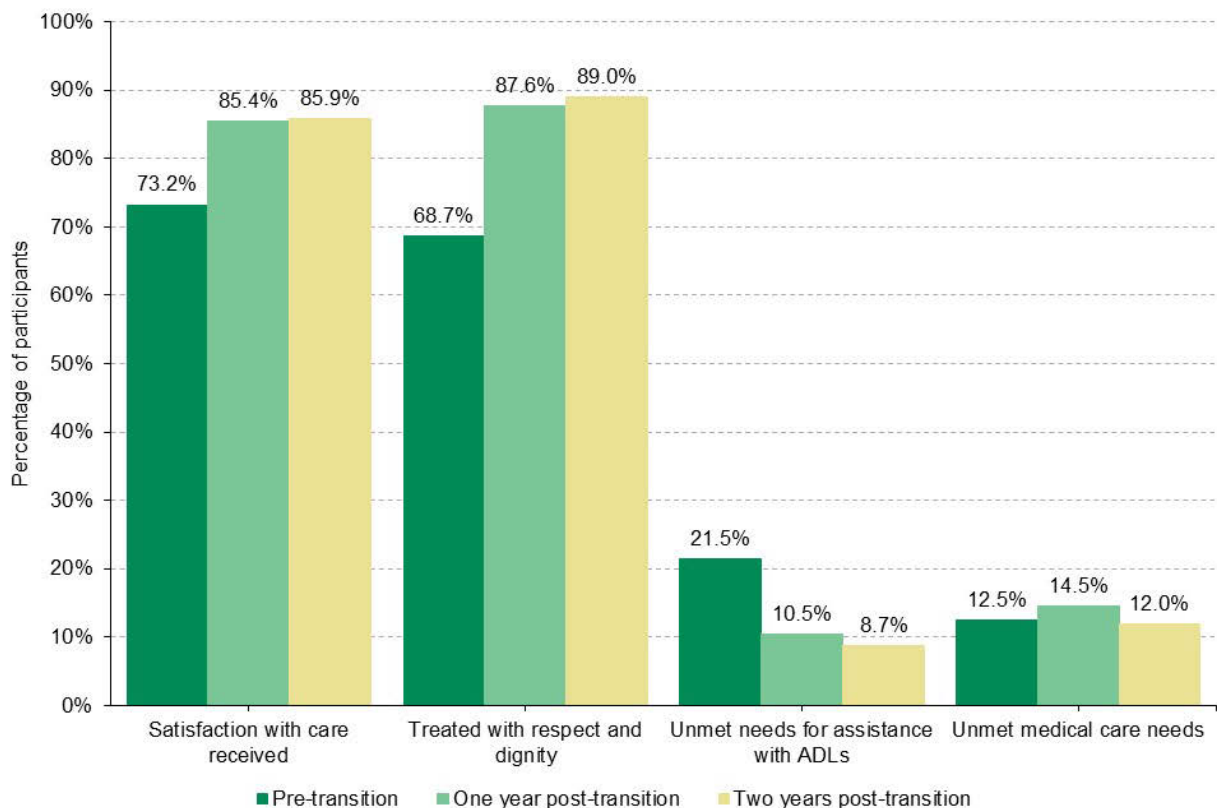
Note: Excludes data from Minnesota, South Dakota, and West Virginia.

A declining percentage indicates improvement in unmet needs for assistance with ADLs and unmet medical care needs.

This analysis is based on a sample of 5,442 survey respondents.

ADL = activity of daily living.

Figure IX.5. Quality of care by length of time in the community, individuals with physical disabilities



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

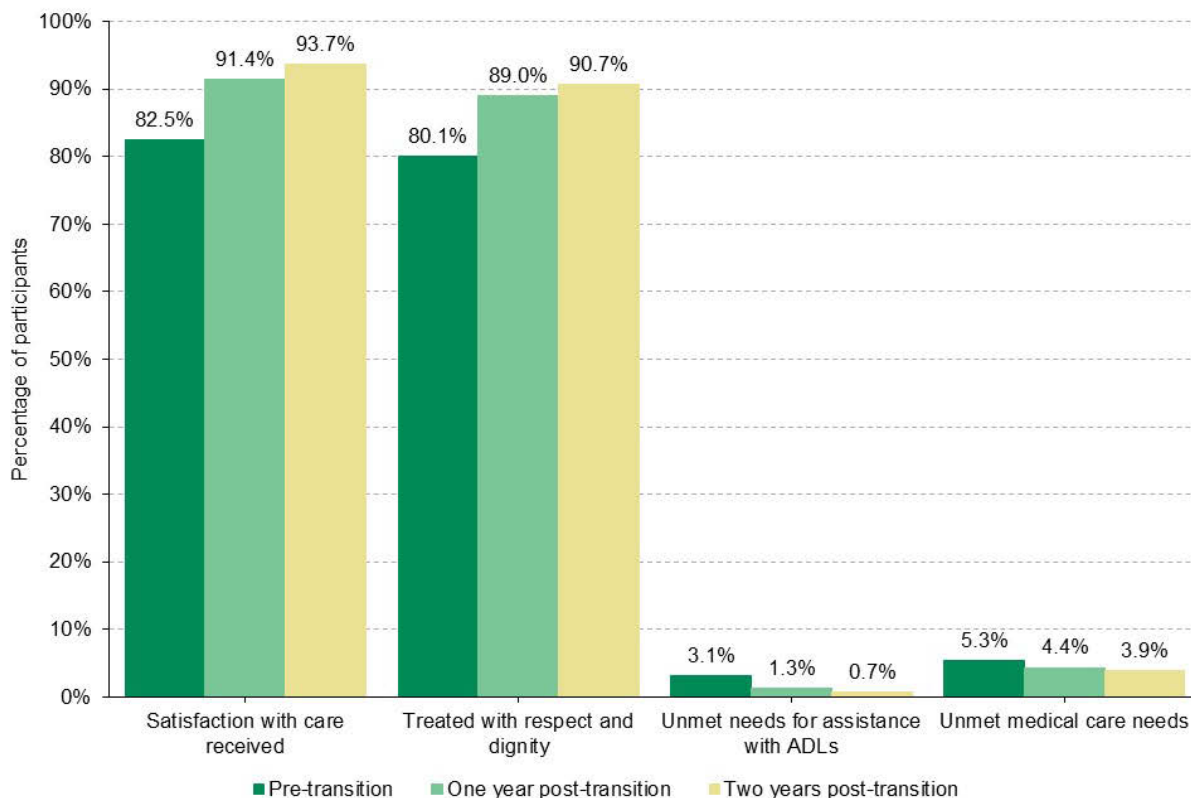
A declining percentage indicates improvement in unmet needs for assistance with ADLs and unmet medical care needs.

This analysis is based on a sample of 7,589 survey respondents.

ADL = activity of daily living.

Individuals with intellectual or developmental disabilities. At all three time points, higher proportions of participants with ID/DD reported favorable satisfaction with care received than the total population. Individuals with ID/DD reported lower levels of unmet needs for personal assistance than the total population, with just 3 percent reporting unmet needs in the institutional setting versus 1 percent in the community setting one and two years post-transition. Satisfaction with care, treatment with respect and dignity, and unmet needs for personal assistance all improved upon transitioning to the community. However, because participants with ID/DD reported high levels of quality of care pre-transition, the post-transition improvements were not as dramatic as they were for the other target populations. Improvements in unmet medical care needs were not statistically significant among individuals with ID/DD (Figure IX.6).

Figure IX.6. Quality of care by length of time in the community, individuals with intellectual or developmental disabilities



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

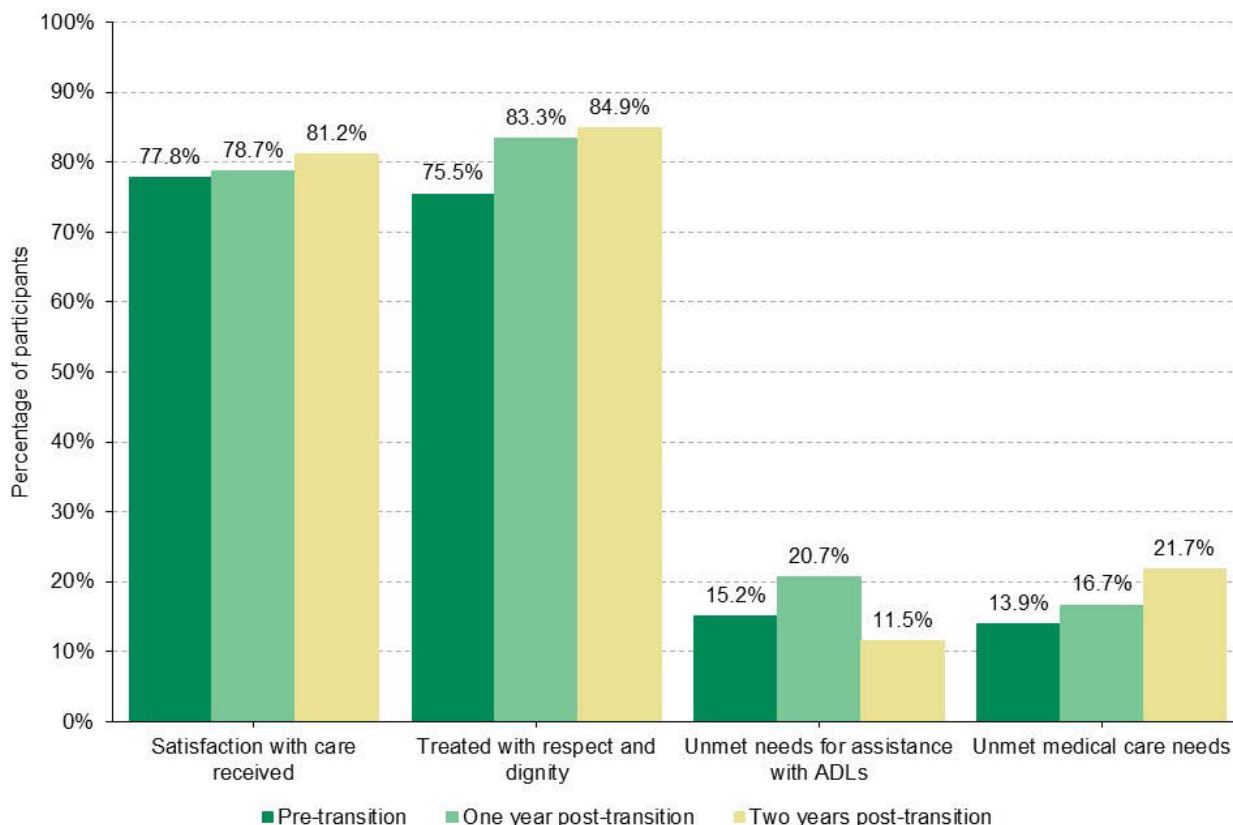
A declining percentage indicates improvement in unmet needs for assistance with ADLs and unmet medical care needs.

This analysis is based on a sample of 2,270 survey respondents.

ADL = activity of daily living.

Individuals with mental illness. Among individuals with mental illness, we observed less change in quality of care measures between pre- and post-transition than we did in the total population. Post-transition, individuals with mental illness reported lower levels of satisfaction with care compared to the total population, with no significant improvement over time (Figure IX.7). The proportion of participants in this group reporting unmet needs for personal assistance was 6 percentage points higher at one year post-transition than it was at pre-transition, although this increase was not statistically significant given the small sample size. The proportion reporting unmet medical care needs increased slightly over time, from 14 percent pre-transition to 17 percent one year after transitioning and 22 percent two years after transitioning. Although this increase over time was not statistically significant, the trend is different from the rest of the population and individuals with mental illness reported the highest levels of unmet medical care needs compared to the total population at one and two years post-transition. These data suggest

Figure IX.7. Quality of care by length of time in the community, individuals with mental illness



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

A declining percentage indicates improvement in unmet needs for assistance with ADLs and unmet medical care needs.

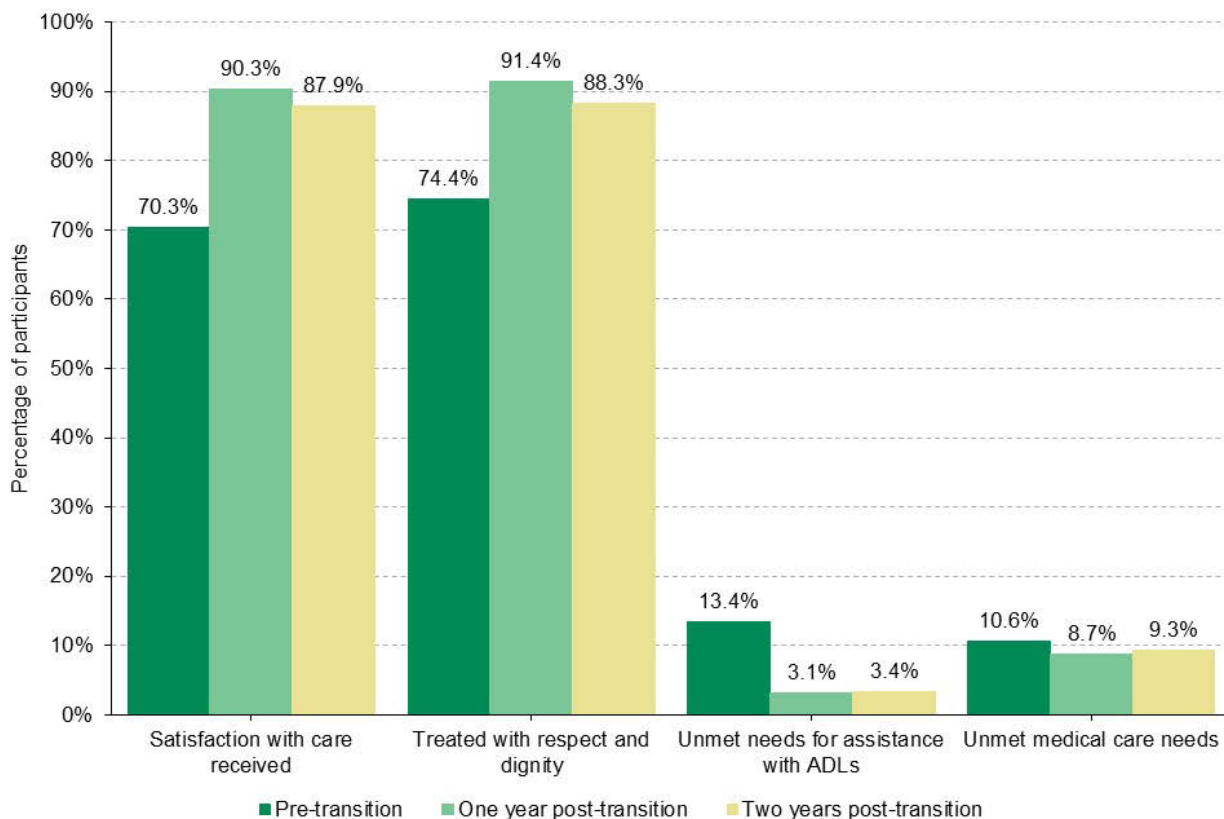
This analysis is based on a sample of 122 survey respondents.

ADL = activity of daily living.

that individuals with mental illness may need greater supports with assistance in personal care needs and with obtaining medical care while living independently in the community than they received.

Other individuals. Among individuals in the “other” category, the care measure that improved the most upon transition was satisfaction with care received, which increased by 20 percentage points between pre-transition and one-year post-transition (Figure IX.8). This is different from the full population and other target populations, which tended to report the largest improvement in the proportion of participants reporting treatment with respect and dignity by providers. The remaining measures were similar to the total population; individuals in the “other” category reported notable improvements in treatment by LTSS providers and unmet needs for personal assistance and no significant change over time in levels of unmet medical care

Figure IX.8. Quality of care by length of time in the community, other individuals



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

A declining percentage indicates improvement in unmet needs for assistance with ADLs and unmet medical care needs.

This analysis is based on a sample of 763 survey respondents.

ADL = activity of daily living.

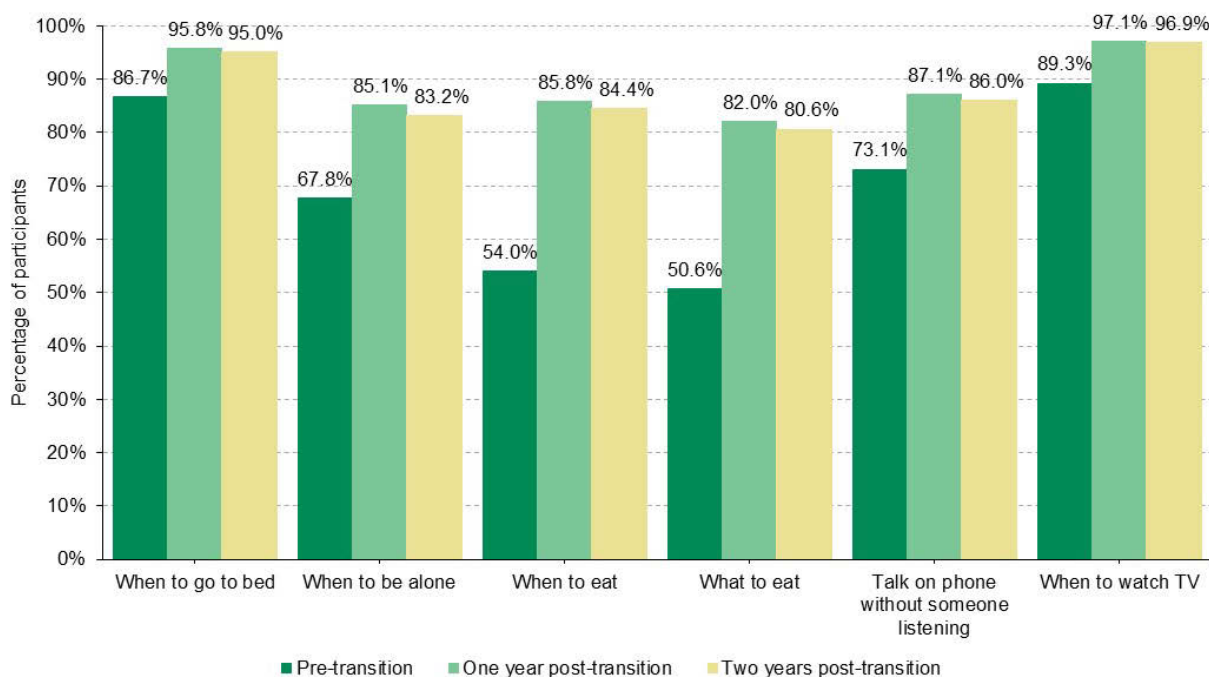
needs. These data suggest that although this group experienced a notable increase in their satisfaction with care, they may still need help reducing unmet medical care needs.

D. Choice and control of daily activities

Transitioning out of institutional settings and into the community should increase participant autonomy in their daily lives. The Quality-of-Life survey asked participants about their choice and control over six daily activities: when to go to bed, when to be alone, when to eat, what they

eat, if they can talk on the phone without someone listening, and when to watch TV.³⁴ Pre-transition, participants were least likely to report control over when and what they ate (54 and 51 percent, respectively) and most likely to report control over when they watched TV (89 percent). The proportion of respondents reporting choice and control increased for all six areas after they moved to the community, with more than 80 percent of respondents reporting choice and control for each area. Increases were highest for when and what participants ate (32 and 31 percentage points, respectively) and smallest for when to watch TV and when to go to bed. In the second year post-transition, improvements in choice and control were sustained at nearly the same levels for all six areas (Figure IX.9).

Figure IX.9. Areas of choice and control



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

³⁴ The survey asks at pre-transition and follow-up: (1) “Can you go to bed when you want?” (2) “Can you be by yourself when you want to?” (3) “When you are at home, can you eat what you want to?” (4) “Can you choose the foods that you eat?” (5) “Can you talk on the telephone without someone listening in?” and (6) “Can you watch TV when you want to?”

Consistent with the increase in the proportion of participants reporting choice and control for each area, upon transitioning to the community there was also an increase in the average number of areas of choice and control reported by participants.^{35,36} Pre-transition, participants reported having choice and control over an average of 4.4 of 6 areas. This increased to 5.3 one and two years post-transition. This increase was consistent across all target populations. At all three time points, individuals with intellectual or developmental disabilities reported slightly lower average areas of choice and control than other populations, a statistically significant difference. This difference may reflect the small group home environment that is typically the housing option for this population and involves more daily supervision and group activities (Figure IX.10).

E. Sleep quality

The final quality-of-life measure we report in this chapter is sleep quality. Sleep quality has a substantial impact on quality of life, affecting mental and physical wellbeing as well as contributing to an individual's risk for poor health outcomes. The Quality-of-Life survey asked participants if they were able to get the sleep they needed without noises or other disturbances where they live. MFP participants reported substantial improvements in sleep quality upon transitioning to the community (Figure IX.11). Pre-transition, 60 percent of all participants reported that they could get the sleep they needed.³⁷ One year post-transition, this increased by nearly 28 percentage points to 88 percent. Individuals with physical disabilities reported the largest improvement in sleep, which increased by 30 percentage points between pre-transition and one year post-transition. There was no significant improvement in sleep quality for individuals with mental illness one year after transitioning to the community.³⁸ However, this group reported a significant improvement in sleep quality two years after transitioning, when 87 percent reported that they could get the sleep they needed. The sample for individuals with mental illness is small, and these estimates may not be as robust as those for the other target populations.

The quality-of-life measures discussed in this chapter affirm MFP's basic premise that when given the option, people prefer to reside in the community. After transitioning to the community, there were significant and sustained increases in the proportion of participants reporting satisfaction with living arrangements, life satisfaction, quality of care, choice and control over

³⁵ The number of areas of autonomy could range from 0 to 6, and each area received equal weight in this measure. Autonomy was assessed by asking participants if they had choice and control over: (1) when to go to bed, (2) when to be alone, (3) when to eat, (4) what to eat, (5) talking on the phone privately, and (6) when to watch TV.

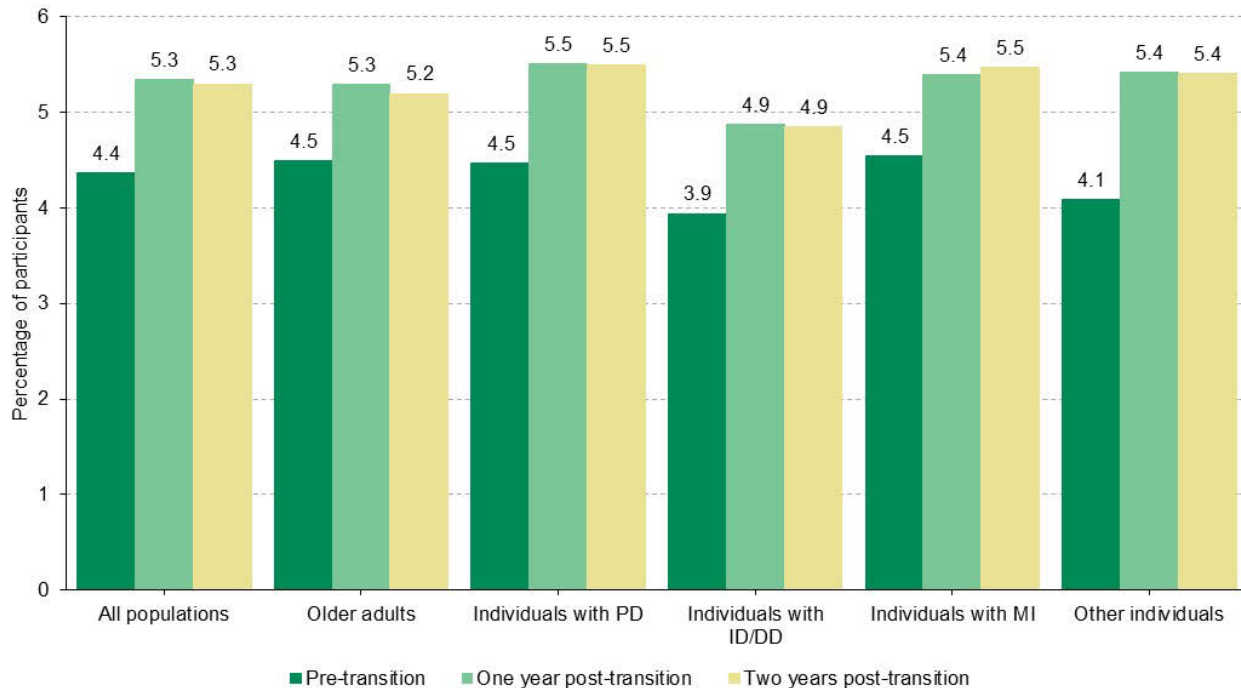
³⁶ Independent samples t-tests were used to compare target populations to the full population (excluding the target population of interest), and paired samples t-tests were used to compare means across time periods. Statistical significance was determined using 2-tailed tests, $p < 0.05$.

³⁷ Answered "yes" to "Can you get the sleep you need without noises or other disturbances where you live?"

³⁸ The increase of 5 percent between pre-transition and one year post-transition was not statistically significant.

daily activities, and the ability to get the sleep they needed. Taken together, these measures reflect the strong impact the MFP demonstration has on participants’ lives.

Figure IX.10. Mean number of areas of choice and control by target population



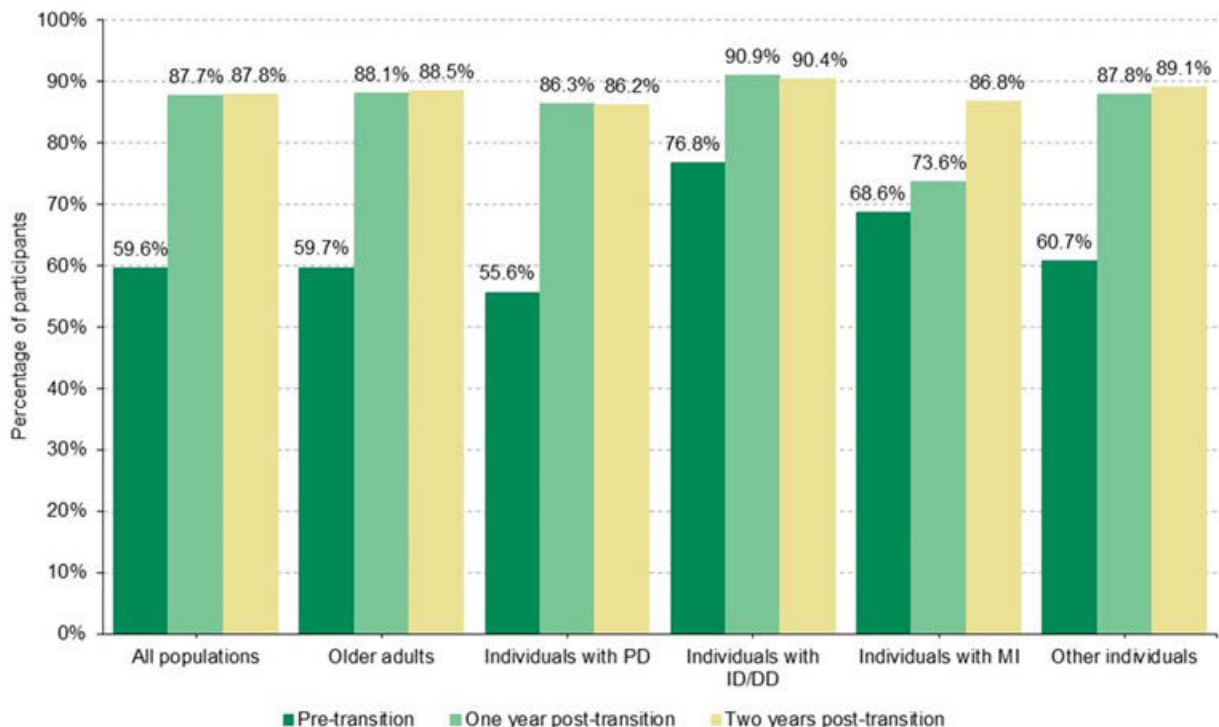
Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

Figure IX.11. Percentage of participants reporting they can get needed sleep by target population



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

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X. PARTICIPANTS' EXPERIENCE WITH COMMUNITY LIVING

Upon transitioning out of institutional settings, it is assumed that most MFP participants will have increased opportunities to take part in their communities, build social networks, and ultimately experience improved quality of life as they establish their lives in their new environment. However, challenges related to transportation, social support, and inclusion may prevent participants from fully engaging in their communities. MFP grantees offer a variety of services and supports to facilitate community living, such as employment support and self-direction programs. This chapter draws on Quality-of-Life survey data to examine changes in several different aspects of life associated with community living: community integration, volunteering, informal support, employment, and depressive symptoms.³⁹

A. Community integration

Community integration is a primary goal of many who participate in the MFP demonstration. While in institutional care, individuals have round-the-clock supports provided in a structured congregate setting. When individuals transition to the community, they may be prone to isolation due to limited access to transportation or weak informal supports, and their care and well-being may suffer as a result. For transitions to community living to be successful, participants need to be able to take part in the community in which they live.

For all populations, community integration—defined as participation in community activities—increased between pre-transition and one year post-transition, and this increase was sustained two years post-transition (Figure X.1).⁴⁰ Participants reported a decrease in barriers to community integration⁴¹ (decreasing from 51 percent pre-transition to 35 percent one year post-transition) and an increase in their ability to do fun things in the community (increasing from 57 percent pre-transition to 68 percent one year post-transition). Access to transportation did not appear to be an increased barrier upon transitioning to the community and, in fact, improved upon transitioning. High proportions of participants reported that they were able to get to places they need to go pre-transition (85 percent), and this increased to 93 percent both one and two years post-transition. Additionally, after moving to the community greater proportions of participants reported not missing events because they were unable to get around easily: 54 percent did not miss events due to transportation pre-transition, and this increased to 62 percent one year post-transition and 64 percent two years post-transition. The ability to see family and friends when participants wanted was high at all three time points and did not change upon

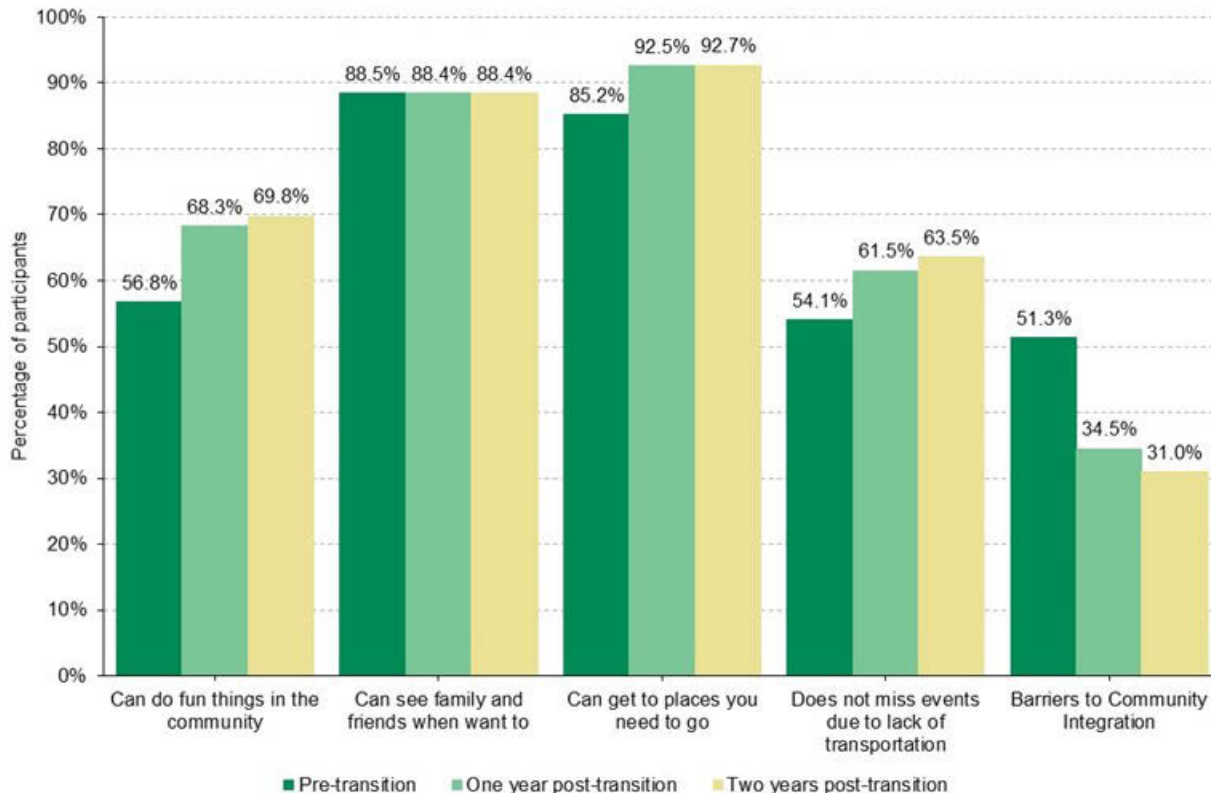
³⁹ Previous reports have examined participant quality of life and observed improvements across all domains upon transitioning to the community (Simon and Hodges 2011; Irvin et al. 2011, 2012, 2013, 2015, 2017).

⁴⁰ Here and throughout the chapter, chi-squared tests were used to compare proportions for target populations to the full population (excluding the target population of interest), and McNemar's tests were used to compare proportions across time periods. Statistical significance was determined using 2-tailed tests, $p < 0.05$.

⁴¹ Measured by asking, "Is there anything you want to do outside [the facility/your home] that you can't do now?"

transitioning to the community (89 percent of participants could see family and friends when they wanted to pre-transition; this decreased slightly to 88 percent two years post-transition).

Figure X.1. Community integration components by length of time in community, all populations



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

A declining percentage indicates improvement in barriers to community integration.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

Generally, we observed similar patterns across all target populations (Table X.1). However, compared to other groups, higher proportions of participants with intellectual and developmental disabilities reported being able to do fun things in the community pre-transition (91 percent), which increased to 95 percent two years post-transition. After transitioning, participants in this target population reported large increases in not missing events due to transportation (increasing from 63 percent pre-transition to 83 percent one year post-transition) and large decreases in barriers to community integration (45 percent reported barriers pre-transition, and reports of this

barrier decreased to 23 percent one year post-transition). This population also reported a notable increase in the ability to see family and friends when they want to, increasing from 79 pre-transition to 88 percent two years post-transition.

Table X.1. Community integration components by length of time in community and target population

Target population	Pre-transition	One year post-transition	Two years post-transition
All populations			
Can do fun things in the community	57%	68%	70%
Can see family and friends when want to	88%	88%	88%
Can get to places you need to go	85%	93%	93%
Does not miss events due to lack of transportation	54%	62%	64%
Barriers to participating in the community	51%	34%	31%
Community integration index	3.17	3.64	3.70
Older adults			
Can do fun things in the community	45%	56%	56%
Can see family and friends when want to	91%	88%	88%
Can get to places you need to go	83%	90%	90%
Does not miss events due to lack of transportation	59%	64%	65%
Barriers to participating in the community	46%	34%	31%
Community integration index	3.16	3.50	3.50
Individuals with physical disabilities			
Can do fun things in the community	56%	70%	71%
Can see family and friends when want to	89%	89%	89%
Can get to places you need to go	84%	92%	92%
Does not miss events due to lack of transportation	48%	53%	54%
Barriers to participating in the community	56%	38%	35%
Community integration index	3.09	3.57	3.63
Individuals with intellectual or developmental disabilities			
Can do fun things in the community	91%	94%	95%
Can see family and friends when want to	79%	86%	88%
Can get to places you need to go	96%	98%	98%
Does not miss events due to lack of transportation	63%	83%	80%
Barriers to participating in the community	45%	23%	22%
Community integration index	3.52	4.17	4.20

Target population	Pre-transition	One year post-transition	Two years post-transition
Individuals with mental illness			
Can do fun things in the community	57%	62%	66%
Can see family and friends when want to	88%	88%	86%
Can get to places you need to go	81%	90%	84%
Does not miss events due to lack of transportation	53%	45%	66%
Barriers to participating in the community	58%	47%	39%
Community integration index	3.13	3.35	3.57
Other individuals			
Can do fun things in the community	68%	79%	73%
Can see family and friends when want to	83%	85%	83%
Can get to places you need to go	88%	94%	94%
Does not miss events due to lack of transportation	52%	68%	75%
Barriers to participating in the community	62%	34%	27%
Community integration index	3.04	3.80	3.87

Source: Mathematica's analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

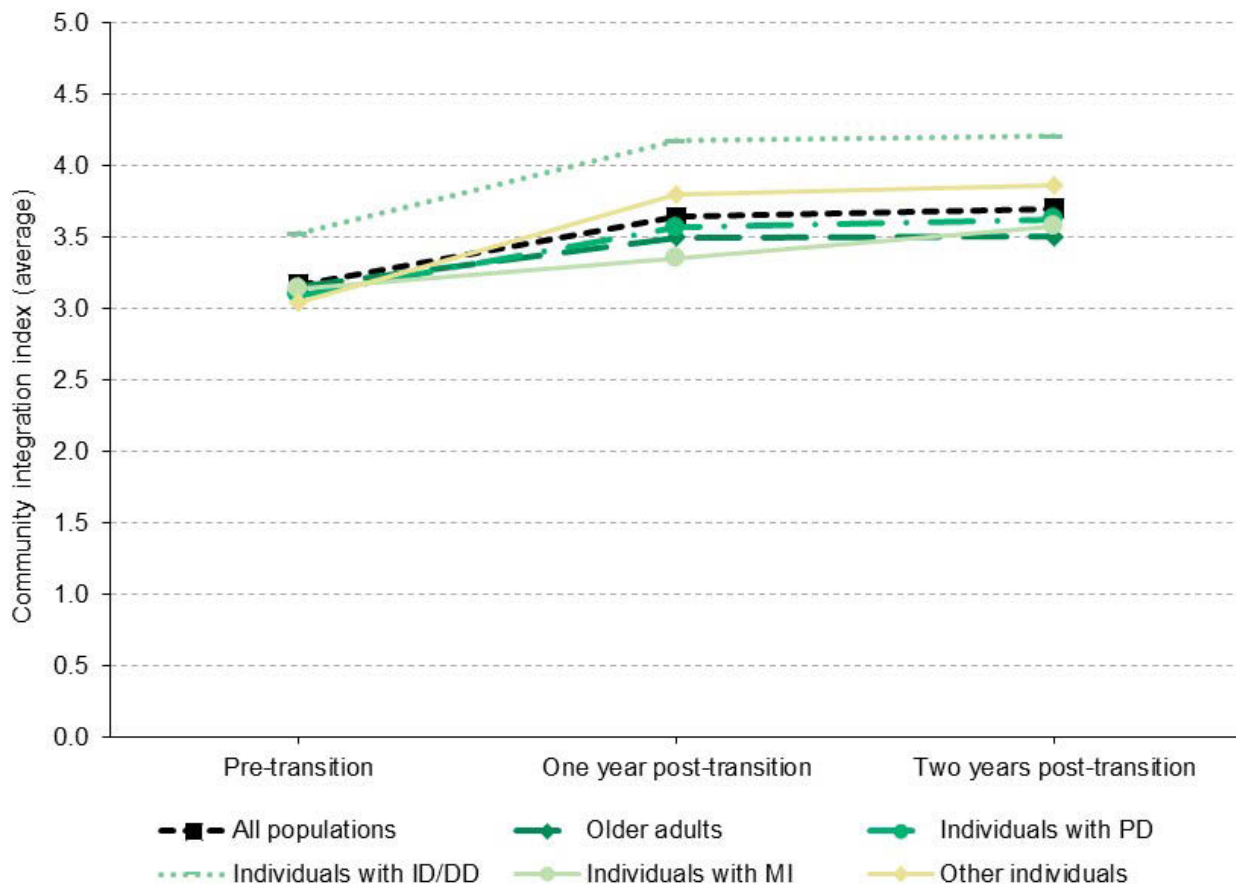
The five community living measures described above are summarized in the community integration index, a composite score summing positive responses to five Quality-of-Life survey questions.⁴² This index ranges from 0 to 5, with 5 representing high community integration. MFP participants report high levels of community integration. For all target populations, community integration increased upon moving to the community and remained high two years post-transition (Figure X.2).⁴³ At all three time periods, before and after transition, community integration was highest among individuals with intellectual or developmental disabilities. Community integration levels were similar among the remaining four target populations (Figure X.2).

Taken together, these results confirm that community integration increased in meaningful ways for MFP participants when they moved into the community. Fewer participants reported barriers to integrating into the community, and more participants were able to get outside the home and do fun things. Fewer participants reported missing things due to transportation, and more participants were able to get to places they need to go. Finally, the ability to see family and friends when wanted remained high and did not change. Importantly, these changes were sustained and in some cases continued to improve two years after transitioning. The extent of community integration and specific measures most affected varied by target population, but all groups reported increased and sustained integration after moving to the community.

⁴² These questions are: (1) “Can you see your friends and family when you want to see them?” (2) “Can you get to the places you need to go, like work, shopping, or the doctor’s office?” (3) “Do you go out to do fun things in your community?” (4) “Do you miss things or have to change plans because you don’t have a way to get around easily?” and (5) Is there anything you want to do outside [the facility/your home] that you can’t do now?”

⁴³ Independent samples t-tests were used to compare community integration indexes for target populations to the full population (excluding the target population of interest), and paired samples t-tests were used to compare indexes across time periods. Statistical significance was determined using 2-tailed tests, $p < 0.05$.

Figure X.2. Community integration by length of time in community and target population



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

Community integration was measured using the community integration index, a composite score summing positive responses to five QoL survey questions. The index ranges from 0 to 5, with 5 representing high community integration. The five component questions of the index are: (1) “Can you see your friends and family when you want to see them?” (2) “Can you get to the places you need to go, like work, shopping, or the doctor’s office?” (3) “Do you go out to do fun things in your community?” (4) “Do you miss things or have to change plans because you don’t have a way to get around easily?” and (5) “Is there anything you want to do outside [the facility/your home] that you can’t do now?”

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

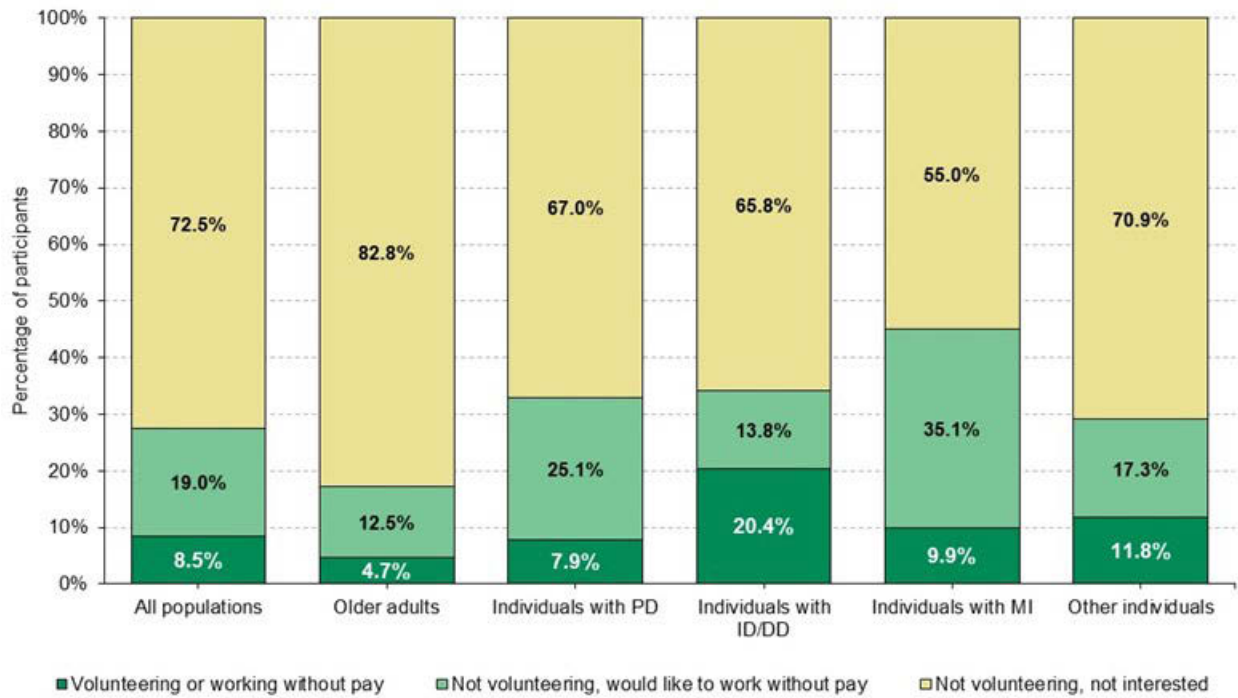
ID/DD = intellectual or developmental disabilities; MI = mental illness; PD = physical disabilities.

B. Volunteering

Volunteering provides participants with an opportunity to interact with the community and different individuals than they might otherwise encounter. Participants who express an interest in volunteering are making an effort to actively become involved with their community. One year after transitioning to the community, 9 percent of participants were volunteering, and an additional 19 percent was not currently volunteering but interested in doing so (Figure X.3).⁴⁴ This pattern was similar among most target populations. Rates of volunteering were higher among individuals with intellectual and developmental disabilities; 20 percent of this population reported volunteering, and this was the only population where a higher proportion reported volunteering than reported not volunteering but interested in doing so. Of note, the percentage of participants who reported that they were not volunteering but would like to may represent an opportunity for MFP grantees to engage participants and increase their involvement with the community. Relatively high proportions of individuals with physical disabilities and individuals with mental illness reported not volunteering but wanting to (25 percent and 35 percent, respectively).

⁴⁴ Participants were asked, “Are you doing volunteer work or working without getting paid?” Participants who answered no were then asked, “Would you like to do volunteer work or work without getting paid?” These questions were only asked after participants transitioned to the community.

Figure X.3. Volunteering by target population, one year post-transition



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

C. Informal support

Informal support, in the form of help around the house from family and friends, is an important contributor to the quality of life among MFP participants. This support reflects participants' connection to family and friends in the community and what help is available to them outside of the formal services they receive. One year after transitioning to the community, approximately 42 percent of participants reported receiving informal support from family and friends.⁴⁵ One year later, two years after transitioning and a year after leaving the MFP demonstration, this declined slightly to 38 percent (Figure X.4). On average, MFP participants reported receiving 6 hours of informal support per day both one and two years post-transition. Individuals with mental illness were the only group to report a marked change between one and two years post-transition; this group reported receiving 6.6 hours of informal support one year post-transition and 4.2 hours two years post-transition (data not shown).⁴⁶ The decline in the proportion of participants reporting informal support between one and two years post-transition was small but generally consistent across all target populations. It could reflect less contact with family and friends, but it may also indicate that participants rely less on family and friends for help around the house as they become more established in the community.

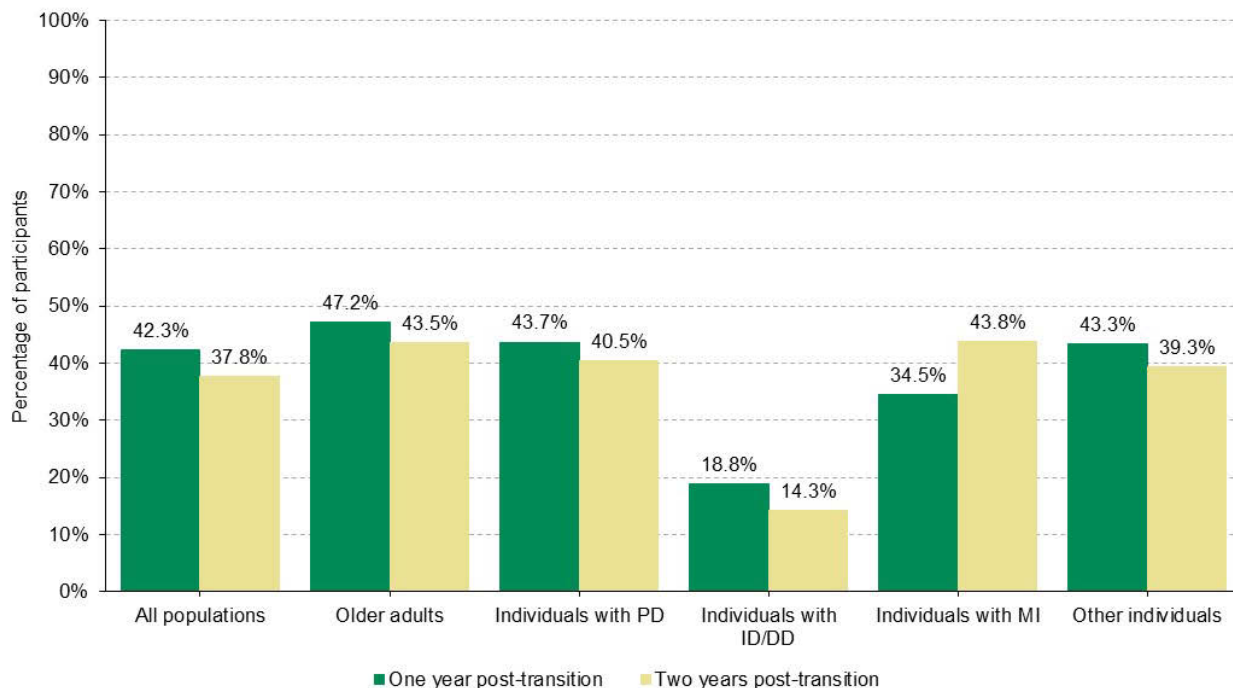
The only group to report an increase in the proportion of participants receiving informal support between one and two years post-transition was individuals with mental illness; this group reported an increase from 35 percent receiving informal support one year post-transition to 44 percent two years post-transition. Interestingly, this is also the only group that reported a decrease in the number of hours of informal support received each day. These results are based on a small sample and not statistically significant, so this should be interpreted with caution. Further research is warranted to understand the type and amount of informal support individuals with mental illness receive upon transitioning to the community and one year later, and whether this population has unmet needs for support after leaving the MFP demonstration.

The proportion of participants reporting informal support was similar across target populations, with the exception of individuals with intellectual and developmental disabilities. Smaller proportions of participants in the target population reported receiving informal support both one and two years post-transition, 19 and 14 percent respectively (Figure X.4). As described earlier in the chapter, individuals with intellectual and developmental disabilities reported the highest levels of community integration. Low levels of informal support reported by this group may reflect less need for informal support or an increased reliance on community supports relative to support from family and friends.

⁴⁵ Measured as a positive response to "During the last week, did any family member or friends help you with things around the house?" This question is only asked after participants transition to the community.

⁴⁶ Independent samples t-tests were used to compare the average hours of informal support for target populations to the full population (excluding the target population of interest), and paired samples t-tests were used to compare averages across time periods. Statistical significance was determined using 2-tailed tests, $p < 0.05$.

Figure X.4. Receipt of informal support by length of time in the community and target population



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

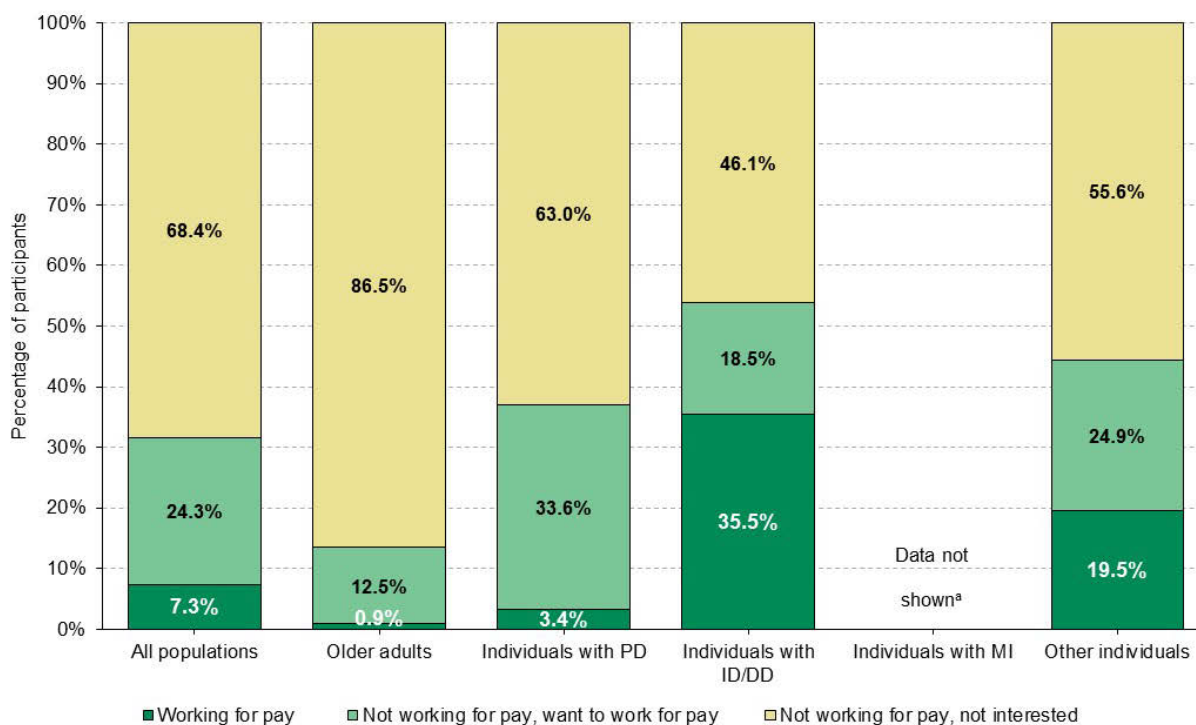
D. Employment Supports and Services

Employment is an important component of community living. Opportunities to work can increase an MFP participant’s integration in the community and sense of autonomy and self-confidence, in addition to their financial independence and well-being. After one year of living in the community, 7 percent of MFP participants were working for pay and an additional 24 percent were not working for pay but wanted to do so (Figure X.5).⁴⁷ These numbers remained relatively constant after two years in the community, with slightly more participants working for pay (9 percent) and slightly fewer not working for pay but wanting to (21 percent) (data not shown).

⁴⁷ Participants were asked, “Are you working for pay right now?” Participants who answered no were then asked, “Do you want to work for pay?” These questions were only asked after participants transitioned to the community.

After one year of community living there was substantial variation in employment status by target population. Individuals with intellectual disabilities had the highest employment rates, with 36 percent working for pay. Because the survey question was extremely broad, we do not know to what extent MFP participants are engaged in competitive employment. The lowest employment rates were among individuals with physical disabilities (3 percent) and older adults (1 percent). There was also wide variation in the percentages of each population not working for pay but wanting to work for pay, ranging from 39 percent among individuals with mental illness to 13 percent among older adults. These high percentages of participants expressing an interest in working suggest that an increased focus on employment opportunities and support is an area that needs more attention to increase community engagement, autonomy, and quality of life among participants after they transition to the community.

Figure X.5. Employment by target population, one year post-transition



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

^a Data are suppressed because the count is less than 11.

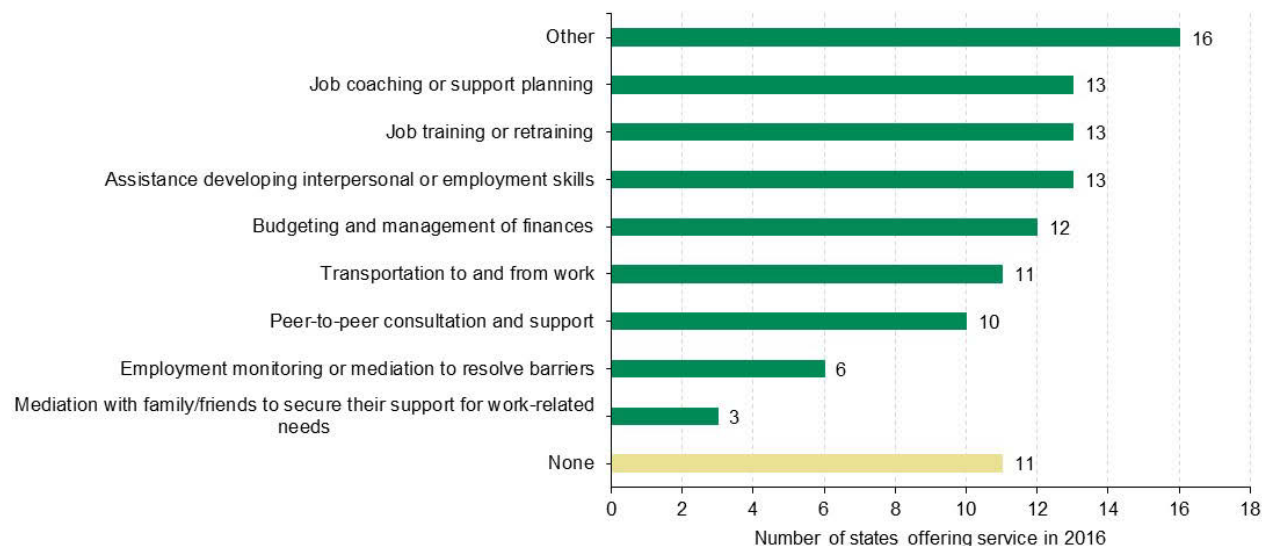
PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

Employment supports and services provided by grantee states. CMS encourages MFP grantee states to implement initiatives that promote employment for MFP participants, and MFP grantees offer a range of employment services and supports as part of the diverse set of community-based LTSS that individuals can access after transitioning to community living.⁴⁸ The 2016 State MFP Grantee Semiannual Progress Reports describe the types of employment services and supports offered by grantee states. In 2016, 33 states provided at least one kind of employment service or support. The most common category of services, offered by 16 states, was the collective “other” category. This category included vocational rehabilitation, individualized assessments and support, referrals to other departments, and application assistance, among others. The next most common services were job coaching, job training or retraining, and assistance developing interpersonal or employment skills, each offered by 13 states. Assistance with budgeting and management of personal finances was the next most common service, offered by 12 states in 2016. Ten states offered peer-to-peer consultation and support. Eleven states did not offer any employment supports or services in 2016 (Figure X.6).

Despite the wide range of services and supports offered by grantee states, there was no detectable impact on the rate of employment among participants. Figure X.7 shows employment rates among the 33 states that offered any service or support in 2016 compared with the 11 states that did not offer an employment service or support in 2016. Among states that offered employment support, 7 percent of participants reported working for pay. Among states that did not offer employment support, 11 percent of participants were working for pay. However, this finding should be interpreted with caution: Quality-of-Life surveys were administered between 2008 and 2016, and the group of states offering employment supports or services in 2016 may be different from the group offering supports or services in earlier years. Additionally, among states offering employment services and supports, a greater proportion of participants reported not being interested in working for pay (69 percent), compared to states not offering employment supports and services (66 percent). The availability of employment supports and services may not be relevant for individuals who are not interested in working. However, both groups of states had approximately the same proportion of participants who were not working but wanted to (24 and 23 percent). As noted above, the significant share of participants who wish to work represents an opportunity for all states to increase participants’ integration into the community. States currently offering employment services and supports may wish to focus on identifying participants interested in employment and targeting services to that group.

⁴⁸ Employment services available to MFP participants through a community-based LTSS 1915(c) waiver or the optional state plan most often supplement core services funded by other systems, such as vocational rehabilitation, state agencies serving individuals with intellectual disabilities, and one-stop career centers, which are supported by the Workforce Investment Act.

Figure X.6. Employment services and supports offered by states to MFP participants, by type of support, January to December 2016



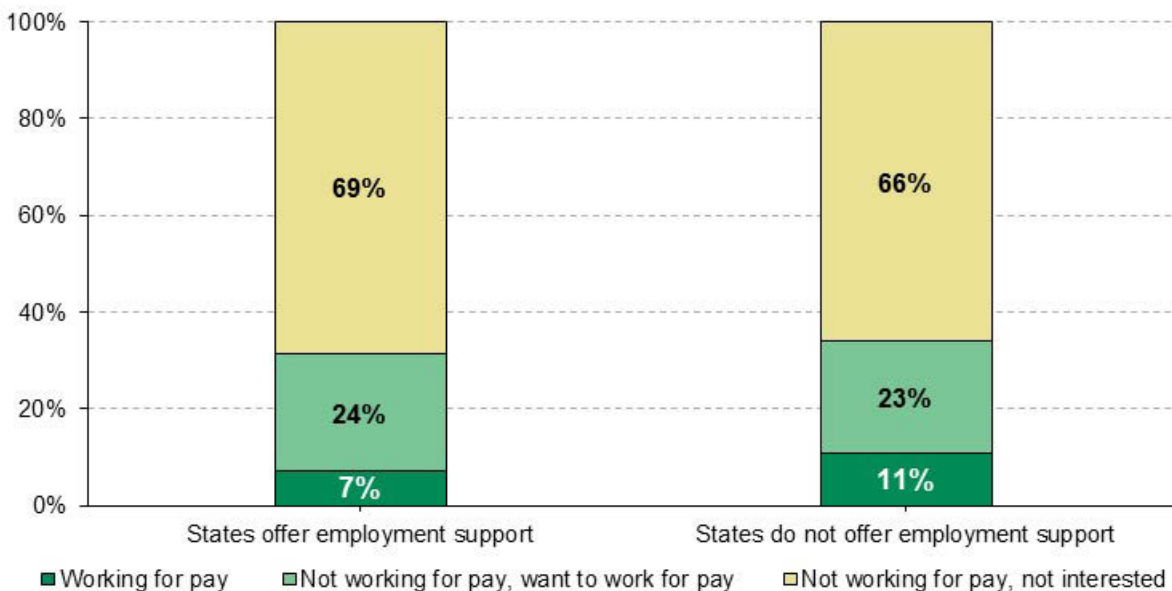
Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Note: Grantee states may select more than one type of employment service/support. Each service may be offered to one or more target population.

“Other” services include vocational rehabilitation, individualized assessments and support, referrals to other departments, and application assistance, among others.

N = 44 grantee states.

Figure X.7. Employment rates one year post-transition, by state offering of employment services and supports



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016 and Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

Note: States included in the “States offer employment support” category are Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Tennessee, Texas, Virginia, Washington, and Wisconsin.

States included in the “States do not offer employment support” category are Alabama, California, Colorado, Indiana, Maryland, New Hampshire, Oklahoma, Rhode Island, South Carolina, and Vermont.

This analysis is based on a sample of 14,416 survey respondents: 13,140 living in states that offer employment supports and 1,276 living in states that do not offer employment supports.

E. Depressive symptoms

Several factors place MFP participants at risk for depression, such as having multiple chronic conditions and reduced mobility. Other factors may include cognitive impairment, poor health status, social isolation, lack of autonomy, or unmet care needs resulting from reduced supervision in the community (Guthrie et al. 2015; Fiske et al. 2009; Cacioppo et al. 2006; Charney et al. 2003; Cole and Dendukuri 2003). Improved quality of life and increased community integration upon transitioning to the community may mitigate some of these risks.

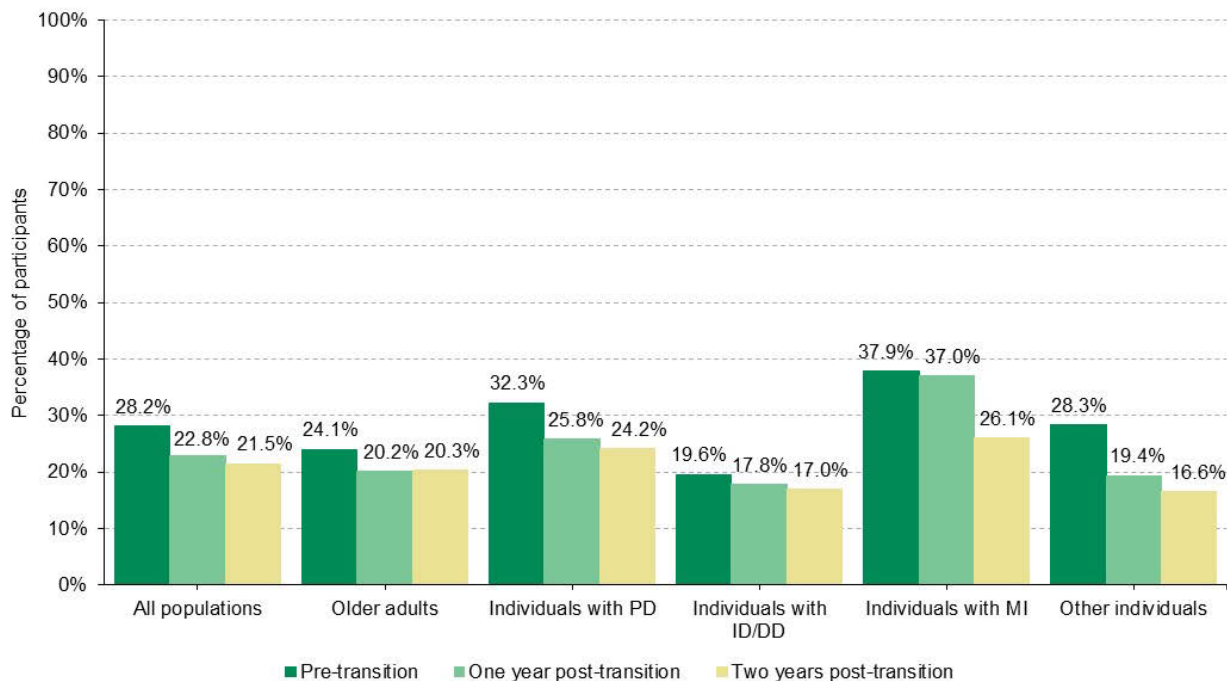
Across all target populations, and consistent with earlier reports (Simon and Hodges 2011; Irvin et al. 2011, 2012, 2013, 2015, 2017), fewer participants reported depressive symptoms one

year after transitioning to the community, as compared to before transitioning.⁴⁹ The proportion remained stable or continued to decline two years after transitioning (Figure X.8). Individuals with mental illness were most likely to report depressive symptoms pre-transition (38 percent) but also showed the greatest improvement over time. Although their reports of depressive symptoms remained approximately stable one year post-transition (37 percent reporting depressive symptoms), 26 percent reported depressive symptoms two years post-transition, a decline of 12 percentage points from the pre-transition period (Figure X.8). However, these results are based on a very small sample, are not statistically significant, and should be interpreted with caution. Individuals with intellectual and developmental disabilities were least likely to report depressive symptoms, and the prevalence of these symptoms declined only slightly post-transition, with 20 percent reporting depressive symptoms before transitioning and 18 and 17 percent reporting depressive symptoms one and two years post-transition.

The reduction in depressive symptoms is consistent with the increased community involvement MFP participants report when they transition out of facilities and into the community. A previous analysis of Quality-of-Life survey data found that community integration was higher among participants without depressive symptoms and that, upon moving to the community, participants whose mood status improved were also more likely to report increased community integration (Irvin et al. 2017). Across target populations, MFP participants report an increase in their ability to do fun things in the community and get to places they need to go, as well as a reduction in missing events due to a lack of transportation. Fewer respondents report that there are things they want to do outside the home that they are unable to do. However, as has been noted in earlier reports (Irvin et al. 2017; Simon and Hodges 2011), despite the decline in participants who report depressive symptoms upon moving to the community, the number of participants reporting depressive symptoms post-transition warrants attention: as of 2016, one in five MFP participants experienced depressive symptoms in the past week. Significant proportions of MFP participants were not currently volunteering or working for pay but expressed an interest in doing so, which is an area grantees could target to increase community involvement. These and other efforts to increase participants' involvement with the community may have additional benefits by decreasing depressive symptoms and increasing the chance that a participant's transition out of institutional living and into the community will be a success.

⁴⁹ Participants were identified as having depressive symptoms if they answered "yes" to two questions: "During the past week have you felt sad or blue?" and "During the past week have you felt irritable?" Note that this measure does not identify participants who are depressed, only those who report depressive symptoms.

Figure X.8. Depressive symptoms by length of time in the community and target population



Source: Mathematica’s analysis of MFP Quality-of-Life surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: Excludes data from Minnesota, South Dakota, and West Virginia.

This analysis is based on a sample of 17,802 survey respondents: 5,442 older adults; 7,589 individuals with PD; 2,270 individuals with ID/DD; 122 individuals with MI; and 763 other individuals.

PD = physical disabilities; ID/DD = intellectual or developmental disabilities; MI = mental illness.

XI. TRIBAL INITIATIVES

In 2014, five states (Minnesota, North Dakota, Oklahoma, Washington, and Wisconsin) launched efforts to improve access to community-based long-term services and supports for eligible tribal members, known as the MFP Tribal Initiative (TI). Through the TI, tribes or tribal organizations can serve as a waiver provider or perform LTSS administrative functions on behalf of state Medicaid agencies, allowing members to access long-term care in the setting of their choice. The MFP Tribal Initiative has four distinct phases: (I) Concept Paper, (II) Operational Protocol: Detailed Timeline and Activities, (III) Execution of Operational Protocol and Program Submittal, and (IV) Program Implementation.⁵⁰ Each phase must be approved by CMS before advancing to the next. As of 2016, only one individual had ever transitioned through the TI, out of 4,445 participants transitioned through MFP by these five states between 2014 and 2016. Grantee reports described MFP TI activities in 2016, indicating achievements—and challenges—developing their MFP TI programs.

In 2016, TI grantees faced several challenges in establishing the MFP TI and transitioning individuals to the community. Some of these challenges were related to the nature of the partnership between the grantee and the tribal entity, such as time required to build relationships and establish buy-in, leadership turnover, and sensitivity around sharing data about high-risk tribal members. Other challenges were centered in Medicaid processes, such as inadequate data fields in state information systems for capturing race and ethnicity; limited availability, accessibility, and affordability of qualified housing in rural tribal areas; and limited access to culturally competent services in tribal lands. For example, one grantee noted a lack of LTSS models that support family cohesiveness, which is valued by many tribal communities. Finally, grantees reported challenges related to Medicaid enrollment and infrastructure, such as the need to clarify the value of Medicaid enrollment and align Medicaid and tribal infrastructures. One grantee reported that the Medicaid system needs to be “adjusted to create firm pathways for tribes/tribal organizations to enter and provide LTSS.”

Despite these challenges, grantees continued to make progress in 2016 by building relationships with tribal partners, developing operational protocols, identifying service needs, and promoting the MFP TI program. For example, all TI grantees presented the program to tribes and tribal organizations in a variety of settings. In Minnesota, MFP staff attended quarterly meetings of the tribal health directors to share progress and request input on the design, implementation, and administration of the project. The Minnesota MFP staff also attended tribal health fairs and met individually with many tribes in the state to ask about their specific needs and priorities. Oklahoma developed an operational protocol for six participating tribes and continued developing the infrastructure needed to participate in the initiative. MFP staff in Oklahoma also conducted technical assistance activities, visited with tribes, and collaborated with the tribal relations division to plan Medicaid recruitment activities. North Dakota continued developing its operational protocol and began developing a home health agency with three participating tribes. Washington continued working with tribal organizations on the goals for a concept paper, offered grant writing technical assistance to tribal organizations, worked to hire

⁵⁰ Detailed information about the requirements of the four phases is available at <https://www.medicaid.gov/state-resource-center/downloads/mfp-foa.pdf>.

culturally competent community health workers and increase the number of American Indian/Alaska Native caregivers, developed protocols to address inconsistency in Medicaid eligibility determination, and identified housing needs. During the second half of 2016, Washington's governor approved funding for a kinship navigator program. This program helps elders and relatives obtain self-care and resources they need to live in the community. Finally, Wisconsin continued to work on its operational protocol and share information during TI technical assistance meetings and at the Tribal LTC Study Group. Staff attended the American Indian and Alaska Native 2016 LTSS Conference and continued to work with all 11 Wisconsin tribes to determine how best to provide community-based LTSS.

Among all five TI programs, current and future efforts are focused on increased access to services and providing culturally-relevant services. For example, one tribe in Minnesota is increasing its mental health and case management services and pursuing the idea of becoming a non-emergency medical transportation (NEMT) service provider. Tribes in North Dakota have already become NEMT and qualified service transportation providers or are in the process of applying. Some of the tribes in Wisconsin are pursuing the idea of joining provider networks for managed care systems to increase the number of people they are able to serve. In Washington, in-home aide certification is now required to include the Savvy Caregiver curriculum, which focuses on American Indian culture. Tribal nations in Oklahoma will begin training non-Native providers in the provision of culturally-appropriate services. The TI program and tribal nations in Wisconsin are considering the creation of tribally-run home health agencies or adult day care programs.

In the coming years, MFP TI grantees will continue working with tribal populations to identify priorities for delivering culturally appropriate community-based LTSS, identify and resolve policy issues that affect the availability of community-based LTSS for the American Indian/Alaska Native populations, identify tribal members eligible for Medicaid, and continue progressing through the TI phases with the ultimate goal of transitioning eligible individuals to the community.

XII. CONCLUSIONS

Calendar year 2016 marked the ninth year of the MFP demonstration and the final year of the evaluation. When reflecting on the original goals of the demonstration, the data presented in this chartbook show steady progress toward attaining the main objectives of the MFP demonstration over the past nine years—to expand Medicaid enrollees’ access to community-based LTSS and shift the balance of their Medicaid LTSS systems from institutional to community-based care.⁵¹

After nearly a decade of implementation, state MFP programs have transitioned more than 75,000 individuals into the community through 2016; in 2016, the vast majority of participants (95 percent) remained in the community without being reinstitutionalized for more than 30 days. Successful long stays in the community indicate that MFP participants are receiving adequate services and supports outside of institutional settings to live safely in the community. In addition, over the course of the demonstration, spending on qualified community-based LTSS steadily increased from \$37 billion in 2008 to \$84 billion in 2016, reflecting both an increase in the number of participating states and greater spending on LTSS. States also achieved 109 percent of the goal set for LTSS spending in 2016, reflecting strong efforts to shift state Medicaid dollars from institutional care to community-based LTSS. State spending of MFP rebalancing funds also increased sharply over the same period, from \$10 million in 2009 to \$337 million in 2015. In 2015, 33 states reported spending on rebalancing efforts, an increase from 28 in 2014. These states used these funds to expand access to community-based LTSS, reflecting further efforts to achieve the goals of the MFP demonstration.

Underlying the MFP demonstration is the premise that many people in institutional care prefer to live and receive services in the community. Our findings support this. Participants reported an increase in overall life satisfaction after moving to the community, from 62 percent before transitioning to 78 percent one and two years after transitioning. One and two years after moving to the community, MFP participants reported improvements across three care domains: increased satisfaction with the care they received, increased reports of being treated with respect and dignity by LTSS providers, and decreased unmet needs for personal assistance services.

Despite these successes, states continued to report several challenges that impede program growth, most notably insufficient affordable and accessible housing and rental vouchers. The data in this chartbook suggest that participants are underutilizing some of the services and supports available to them, such as employment services and the option to self-direct services. Compiling data from across the life of the evaluation, approximately 24 percent of participants

⁵¹ The original goals of the demonstration are to (1) increase the use of community-based LTSS and reduce the use of institutional services, (2) eliminate barriers that restrict the use of Medicaid funds to provide LTSS in settings chosen by Medicaid-eligible individuals, (3) improve state Medicaid programs’ ability to provide continued community-based LTSS after individuals transition to the community, and (4) establish and/or strengthen procedures to provide quality assurance and continuous quality improvement for community-based LTSS . For more information, see <https://www.gpo.gov/fdsys/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf>.

reported not currently working but being interested in doing so, indicating the importance of more attention to this issue to help participants integrate more fully into community life.

Finally, the infrastructure, services, and supports grantee states developed through the MFP demonstration are fundamentally changing the lives of the participants they transition. Participants reported consistent and sustained improvements in their quality of life upon moving to the community. Across all target populations, upon transitioning to the community greater proportions of participants reported satisfaction with their living arrangements and autonomy over how they lived their lives. Fewer reported experiencing depressive symptoms in the past week. Finally, more participants reported being integrated into the communities in which they lived, including the ability to do fun things in the community, not missing events due to lack of transportation, and being able to do the things they wanted to do outside of the facility/home. These changes were sustained two years after participants transitioned, one year after the end of their participation in the MFP demonstration.

In the coming years, as the demonstration draws to a close, grantees will focus on sustaining their efforts to transition more individuals to community living and rebalancing their long-term care systems.⁵² States are increasingly moving from fee-for-service delivery to managed LTSS, which will further shape the future directions of state Medicaid programs. Our findings in this final chartbook suggest that MFP programs are well-positioned to continue transitioning participants from institutional care to community-based LTSS. We expect that in the coming years MFP grantee states will sustain their progress in strengthening LTSS service systems to meet the diverse needs and growing numbers of people interested in and requiring community-based LTSS.

⁵² Although the demonstration will end after calendar year 2016, many states will continue to provide services through 2020 through no-cost extensions of their grant award.

XIII. TECHNICAL NOTES

This report draws on two data sources: state MFP grantee semiannual progress reports and the MFP Quality-of-Life survey. Of note, analyses using state MFP grantee semiannual progress report data use transition and target population counts reported by grantee states in their semiannual progress reports. The Quality-of-Life analysis derives transition and target population counts from the matched administrative records, submitted quarterly by grantee states throughout the life of the evaluation. In this analysis, target populations are identified by the institution from which individuals transitioned.⁵³ In both data sources, individuals with mental illness can include individuals with substance abuse disorders. We describe each data source in detail below.

A. State MFP Grantee Semiannual Progress Reports

1. Source data

This report derives data from each MFP grantee's web-based semiannual progress report for the periods January to June 2016 and July to December 2016.⁵⁴ Data were self-reported by MFP grantees in August 2016 and February 2017 and represent a point in time. These 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 community-based LTSS. The reports also capture information on the progress and challenges the states encountered in all dimensions of the program.

MFP programs differ in program design, infrastructure, and service capacity, as well as experience implementing transition programs for populations with disabling impairments. MFP programs are also at various stages of maturation, a result of differences in the year in which states received MFP grant awards and began transitioning participants to the community. For these reasons, variations across MFP grantee states' progress toward the key performance indicators can be explained by multiple factors.

2. Annualizing data

Grantee states report the number of current participants enrolled in the MFP program at the end of each reporting period (June 30 and December 31) of each year. Throughout this report, when we calculated an annual percentage of enrolled participants in a given state, we divided the numerator of interest by the number of current participants at the end of each reporting period

⁵³ Target populations are defined by the institution from which individuals transitioned, as follows: Older adults, adults aged 65 years and older who transitioned from nursing homes; Physical disabilities, individuals under 65 years who transitioned from nursing homes; Intellectual disabilities, individuals who transitioned from intermediate care facilities for individuals with intellectual disabilities; Psychiatric conditions: individuals who transitioned from institutions for mental diseases; and Other, individuals who transitioned from some other type of institution. Individuals for whom the institution is unknown are not included in the analyses.

⁵⁴ Several MFP grantees provided corrected data after submitting their initial reports; this chartbook presents state-reported data submitted by March 30, 2017.

and averaged the numbers. For example, to calculate the percentage of participants reinstitutionalized among all states in 2016, we divided the sum of all participants reinstitutionalized in the first reporting period by the total number of current participants as of the end of the first reporting period. We then performed the same calculation for the second reporting period and averaged the results to calculate the annual reinstitutionalization rate.

3. Data limitations

Some states do not report on all data elements each period, and some data are reported more consistently than others. We have indicated throughout this report—by the use of color coding on the maps and explanatory footnotes—which states have not reported a particular data element, thus excluding it from aggregate MFP program totals or MFP state averages. In addition to missing data, variations in reporting practices may explain some of the observed differences in data across states. For example, wide variation in the rate of reinstitutionalization for more than 30 days across states is likely due to actual differences in the rates as well as differences in states' data collection and reporting methods. Within each chapter, we have indicated when differences in state reporting practices may have contributed to differences in rates. We note that some states occasionally submit corrections to their data that are not reflected in the data in this report because they were received after the date of publication.

B. MFP Quality-of-Life Survey

1. Survey administration

Since the beginning of the MFP demonstration, grantee states have been administering the MFP Quality-of-Life survey to their participants at three points: (1) immediately before transitioning to the community; (2) one year after transitioning; and (3) two years after transitioning, when participation in MFP has ended and they are regular Medicaid beneficiaries. The instrument is based largely on the Participant Experience Survey, although a few items are drawn from other instruments (Sloan and Irvin 2007). The QoL instrument captures three areas of participant quality of life: (1) overall life satisfaction, (2) quality of care, and (3) community life. Past research has used these survey data to examine different aspects of participants' quality-of-life outcomes after they relocate to the community.⁵⁵

⁵⁵ Simon and Hodges (2011) addressed details concerning grantee responsibility for the survey and the timing of its administration relative to participant transition. Irvin et al. (2012) examined the relationship between the level of care needs and the change in quality of life, as well as work status and its association with the quality of life one year after returning to community living. Irvin et al. (2013) further explored these findings two years after participants returned to the community, one year after leaving MFP. Irvin et al. (2015) examined associations between unmet care needs and adverse care outcomes and the use of health care services one-year post-transition. This work also examined associations between community integration and depressive symptoms, and community integration and reinstitutionalizations in the first year post-transition. In the most recent research, Irvin et al. (2017) explored variations in the need for personal care assistance across different levels of care needs and diagnostic groups. Irvin et al. (2017) also examined associations between depressive symptoms and quality-of-life domains.

2. Data

The primary data source for the analyses presented in this chapter includes QoL survey data submitted by grantees through December 2016. When constructing the sample used in the analyses, we restricted it to include only completed surveys that matched to MFP administrative and program participation data submitted by grantees through December 2016. Overall, data for 42 states, of the 45 that have operated an MFP program at some point in the past, are included in the analyses of participants' quality-of-life outcomes presented in this chapter (Appendix B).⁵⁶ Data for 5 states (Connecticut, Ohio, Tennessee, Texas, and Washington) comprise more than half of all participants included in the main analytic sample. When constructing the samples, we imposed the following restrictions: (1) participants must have completed a survey prior to transitioning (baseline) and one year after transitioning, (2) the completed one-year follow-up survey must have been conducted within 6–18 months of transitioning, and (3) the completed two-year follow-up survey must have been conducted within 18–30 months after transitioning from a qualified institution.

3. Analytic samples

The analytic sample used in this report consists of 17,802 MFP participants who had both a completed baseline and one-year post-transition QoL survey, and both surveys could be matched to the administrative data grantees submitted to CMS through December 2016. This sample represents 29 percent of the 61,047 participants who transitioned through December 2015.

A total of 33,478 participants had a completed pre-transition QoL survey that matched to administrative records (which represents 45 percent of the 75,151 people who transitioned by the end of December 2016).⁵⁷ Of these, 17,802 participants had completed a survey at pre-transition and one year post-transition within the designated time frame.⁵⁸ A considerable proportion of MFP participants are excluded from the analyses because (1) the QoL surveys were not conducted or (2) the QoL surveys were conducted, but they could not be matched to the administrative data. Therefore, it is not clear that these data can be used to generalize the results to the entire MFP population. Table XIII.1 presents information that identifies key characteristics of our sample and how it compares to the overall population of MFP participants. We compared our sample of participants with completed baseline and year-one follow-up surveys to the population of MFP participants who transitioned through December 2015, which represents the last possible transition date in the sample for the one year post-transition surveys. Based on how this sample is distributed across the target populations and age groups, the study sample is reasonably representative of the MFP population. The study sample underrepresents participants younger than 21 years, which is not surprising since the QoL survey was not designed

⁵⁶ The three state grantees not included in the analyses are Minnesota, South Dakota, and West Virginia.

⁵⁷ Surveys with incomplete or missing identifiers could not be matched with administrative data and were not included in this analysis.

⁵⁸ This sample includes participants with a year-one QoL survey completed within 6–18 months of transition; 2,610 participants had a pre-transition survey, a year-one survey, and matched to administrative records, but they were excluded because the year-one survey was completed outside the designated range.

specifically for children, and grantees are not required to administer the QoL survey when the participant is a child. The study sample also has a much lower proportion of cases missing race/ethnicity than the overall population, making it difficult to assess the extent to which the two samples are similar on race and ethnicity.

Table XIII.1. Demographic characteristics of analytic samples, by survey status

Characteristics	Participants with pre-transition and one-year post-transition surveys ^a	All MFP participants who transitioned through December 2015
Total (N)	17,802	61,047
Target population (%)		
Older adults	30.6	31.1
Physical disabilities	42.6	40.0
Intellectual disabilities	12.8	13.9
Psychiatric conditions	0.7	1.3
Other	4.3	3.9
Race/ethnicity (%)		
White	58.5	30.3
Black or African American	17.3	11.9
Asian	1.2	0.6
Hispanic or Latino	2.5	3.0
American Indian or Alaska Native	0.7	0.4
Other/unknown	1.2	0.1
Missing	18.6	53.7
Age group^b (%)		
< 21	1.6	5.1
21–44	15.8	14.2
45–64	46.6	43.8
65–84	29.6	29.9
≥ 85	6.4	7.0
Gender (%)		
Female	50.1	50.3
Male	49.9	49.6

Source: Mathematica's analysis of MFP QoL surveys and program participation data submitted to Centers for Medicare & Medicaid Services through December 2016.

^a This sample includes participants who transitioned to the community sometime between 2008 and 2015. Data from Minnesota, South Dakota, and West Virginia were excluded because they could not be matched to administrative data or did not submit completed QoL survey data.

^b The first two age group categories are slightly different between the QoL survey data and the program participation data: QoL survey data are categorized as < 21 and 21–44 years, and program participation data are categorized as ≤ 21 and 22–24 years. This table presents data using the QoL survey categories.

4. Limitations

Several limitations of our analyses warrant consideration when interpreting the findings presented in Chapters IX and X. First, the findings should be viewed with caution because our analytic sample represents 29 percent of the 61,047 people who had transitioned by the end of 2015, when the last cohort of participants in our sample completed their pre-transition (baseline) QoL survey. Compared to all people who had transitioned through the MFP demonstration by the end of 2015, the current analytic sample may be disproportionately white, and the experiences of participants under the age of 21 appear to be underrepresented.

Second, program administration will always vary by state, affecting the method, timing, and quality of survey administration. Each grantee has established a unique set of goals for transitioning target populations—such as which beneficiaries will be the focus of their program and how many in each target population will be transitioned—and other related objectives. When transition coordinators or case managers administer the survey, participants may emphasize reports of satisfaction or conflate feelings of satisfaction with their living arrangement with feelings about the demonstration or services in general. Although there is no evidence that this occurred, it cannot be ruled out as a potential bias in the data.

Third, we have not controlled for unmeasured program- and individual-level factors likely to affect a participant's reported quality of life and changes to it. Unmeasured factors include participants' health status, pre-transition conditions, community-level factors (such as access to public transportation and proximity to medical care settings, providers, and unpaid caregivers), program maturation, and state policy and economic climates. These unmeasured factors might affect our analyses of participants' quality of life and bias the results. Additionally, we did not control for demographic differences among target populations. These differences may explain some of the variation we observed in quality of life among target populations.

Finally, because the QoL survey can be administered with assistance or even by a proxy respondent, data reported may not always accurately capture the perceptions and experiences of participants. At pre-transition, proxy respondents and survey assisters provided information on QoL for 8 and 23 percent, respectively, of all participants.⁵⁹ The proportion of respondents using a proxy or survey assister increased to 15 and 32 percent, respectively, at one year post-transition and 19 and 34 percent at two years post-transition. At all three time points, the use of proxies or survey assisters varied widely by target population and the sample used in the analysis. Among people participating in all three survey rounds, rates of proxy use were substantially higher among those with intellectual disabilities, where proxies completed 35 and 38 percent of all interviews for this target population at one and two years post-transition, respectively. Proxy use was considerably lower among individuals with mental illness, ranging between 3 and 5 percent at all three time points. Proxy use was also lower among individuals with physical disabilities, ranging between 5 and 9 percent. Rates of survey assistance followed the same pattern as proxy use: highest among those with intellectual disabilities (72 and 73 percent) and lowest among

⁵⁹ A *proxy respondent* is defined as someone who responds to survey questions on behalf of a participant. A *survey assister* is defined as someone who assists the participant in interpreting and providing responses to survey questions and may serve as a proxy respondent for some questions.

individuals with mental illness (11 percent) at one and two years post-transition. Participants using proxy respondents reported slightly lower levels of life and care satisfaction at all three time points, although their responses followed the same pattern of increase between pre- and one and two years post-transition, and the proportions reporting each were very close post-transition. The difference in care satisfaction at two years post-transition was not statistically significant.⁶⁰ Some researchers question the validity of proxy responses for subjective questions, such as quality of life (Elliott et al. 2008). Future analyses could further explore the effect of proxy responses on our findings.

⁶⁰ Before transitioning to the community, 56 percent of respondents using proxies reported satisfaction with the way they lived their life and 67 percent reported satisfaction with the care they received, compared to 61 and 74 percent of respondents not using proxies, respectively. One and two years after transitioning, life satisfaction among respondents using proxies increased to 75 and 77 percent and care satisfaction increased to 85 and 87 percent. Among respondents not using proxies, life satisfaction increased to 79 and 80 percent, and care satisfaction increased to 87 percent.

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APPENDIX A

DATA TABLES

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Table A.1. Cumulative number of MFP grant transitions, start of program through December 31, 2016

State	Cumulative total	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Alabama	104	56	48	0	0	0
Arkansas	899	165	274	459	1	0
California	3,191	960	1,224	872	49	86
Colorado	214	17	75	44	32	46
Connecticut	3,934	1,832	1,587	218	297	0
Delaware	305	114	155	29	7	0
District of Columbia	251	93	53	105	0	0
Georgia	2,468	683	962	611	191	21
Hawaii	511	285	213	13	0	0
Idaho	416	118	208	65	25	0
Illinois	2,731	696	854	313	868	0
Indiana	1,892	1,045	543	111	193	0
Iowa	572	0	0	519	0	53
Kansas	1,658	397	926	279	0	56
Kentucky	680	180	207	203	10	80
Louisiana	1,911	811	729	371	0	0
Maine	92	30	44	0	0	18
Maryland	2,698	1,242	1,084	295	0	77
Massachusetts	2,101	990	930	53	128	0
Michigan	3,015	1,634	1,381	0	0	0
Minnesota	223	22	47	9	39	106
Mississippi	451	71	149	230	1	0
Missouri	1,487	372	707	370	0	38
Montana ^a	124	43	41	20	17	3

TABLE A.1. (continued)

State	Cumulative total	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Nebraska	536	235	205	76	0	20
Nevada	283	96	166	21	0	0
New Hampshire	308	125	121	15	3	44
New Jersey	1,958	640	559	759	0	0
New York	2,400	636	645	478	0	641
North Carolina	774	224	242	308	0	0
North Dakota	359	84	142	120	0	13
Ohio	9,310	1,655	3,263	1,037	3,355	0
Oklahoma	734	140	281	313	0	0
Oregon ^b	306	105	144	50	0	7
Pennsylvania	2,948	1,670	910	283	0	85
Rhode Island	273	172	101	0	0	0
South Carolina	68	38	30	0	0	0
South Dakota ^a	75	14	32	29	0	0
Tennessee	1,869	951	816	102	0	0
Texas	11,433	4,362	4,406	2,665	0	0
Vermont	280	192	88	0	0	0
Virginia	1,165	195	237	733	0	0
Washington	6,444	3,290	2,705	329	120	0
West Virginia	214	90	124	0	0	0
Wisconsin	1,486	581	685	219	1	0
TOTAL	75,151	27,351	28,343	12,726	5,337	1,394

Source: State MFP Grantee Semiannual Progress Reports, 2016.

^a Montana and South Dakota started transitioning individuals during 2014.

^b Oregon suspended program operations in 2010 and later rescinded its grant award.

Table A.2. Number of institutional residents who transitioned under MFP during the reporting period, January 1 to December 31, 2016

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Alabama	55	34	21	0	0	0
Arkansas	126	22	49	55	0	0
California	408	174	179	47	8	0
Colorado	78	4	31	6	2	35
Connecticut	757	328	332	64	33	0
Delaware	38	7	30	1	0	0
District of Columbia	40	26	14	0	0	0
Georgia	207	80	102	1	24	0
Hawaii	67	40	26	1	0	0
Idaho	88	21	48	11	8	0
Illinois	374	103	119	17	135	0
Indiana	70	42	22	1	5	0
Iowa	65	0	0	48	0	17
Kansas	182	52	90	37	0	3
Kentucky	35	13	17	0	0	5
Louisiana	438	205	163	70	0	0
Maine	33	15	13	0	0	5
Maryland	267	97	138	23	0	9
Massachusetts	572	195	332	9	36	0
Michigan	375	208	167	0	0	0
Minnesota	114	16	18	5	3	72
Mississippi	101	25	51	24	1	0
Missouri	225	65	135	24	0	1

TABLE A.2. (continued)

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Montana ^a	56	21	16	11	8	0
Nebraska	65	30	34	1	0	0
Nevada	73	26	42	5	0	0
New Hampshire	21	7	13	1	0	0
New Jersey	330	113	150	67	0	0
New York	423	128	117	93	0	85
North Carolina	144	29	58	57	0	0
North Dakota	59	12	26	17	0	4
Ohio	1,804	236	560	238	770	0
Oklahoma	20	5	15	0	0	0
Pennsylvania	503	252	183	50	0	18
Rhode Island	49	28	21	0	0	0
South Carolina	13	6	7	0	0	0
South Dakota ^a	32	8	13	11	0	0
Tennessee	458	230	212	16	0	0
Texas	937	382	393	162	0	0
Vermont	62	41	21	0	0	0
Virginia	164	25	42	97	0	0
Washington	963	551	334	60	18	0
West Virginia	78	32	46	0	0	0
Wisconsin	248	108	125	15	0	0
TOTAL	11,217	4,042	4,525	1,345	1,051	254

Source: State MFP Grantee Semiannual Progress Reports for January 1 to December 31, 2016.

^a Montana and South Dakota started transitioning individuals during 2014.

Table A.3. Current MFP participation, June 30, 2015 through December 31, 2016

State	As of December 2016	As of June 2016	As of December 2015	As of June 2015
Alabama	70	37	32	4
Arkansas	110	111	113	111
California	171	406	202	126
Colorado	72	76	77	72
Connecticut	679	641	612	602
Delaware	56	45	69	11
District of Columbia	35	31	34	38
Georgia	93	99	178	268
Hawaii	65	59	66	83
Idaho	85	66	69	78
Illinois	357	420	590	549
Indiana	69	141	628	584
Iowa	63	74	142	133
Kansas	232	238	238	232
Kentucky	21	28	33	45
Louisiana	598	482	508	403
Maine	27	27	17	14
Maryland	223	216	251	250
Massachusetts	288	739	432	374
Michigan	234	455	497	466
Minnesota	109	70	67	63
Mississippi	91	98	92	92
Missouri	333	302	320	252
Montana ^b	50	75	43	22
Nebraska	43	62	59	53
Nevada	66	57	50	63
New Hampshire	20	36	33	33
New Jersey	290	282	243	202
New York	367	350	239	241
North Carolina	127	124	113	166

TABLE A.3. (continued)

State	As of December 2016	As of June 2016	As of December 2015	As of June 2015
North Dakota	51	57	57	44
Ohio	1,711	1,609	1458	1342
Oklahoma	18	11	30	76
Pennsylvania	397	407	310	273
Rhode Island	43	37	42	40
South Carolina	11	9	11	15
South Dakota ^a	45	42	31	28
Tennessee	441	387	324	275
Texas	987	846	916	980
Vermont	46	50	58	55
Virginia	172	174	169	170
Washington	719	756	702	803
West Virginia	70	50	37	51
Wisconsin	240	267	233	286
TOTAL	9,995	10,549	10,425	10,068

Source: State MFP Grantee Semiannual Progress Reports for January 1 to June 30, 2014; July 1 to December 31, 2014; January 1 to June 30, 2015; July 1 to December 31, 2015; January 1 to June 30, 2016; and July 1 to December 31, 2016.

Note: Current MFP enrollees are counted on the last day of each six-month reporting period and include MFP participants who transitioned in the current or any previous period and were living in the community and receiving community-based LTSS on that day. It excludes MFP participants who (1) completed the full 365 days of MFP eligibility, (2) were reinstitutionalized for 30 days or more, (3) died, or (4) withdrew from the program or became ineligible for other reasons before the end of 365 days of program eligibility.

^a South Dakota implemented its MFP transition program during the reporting period from July 1 to December 21, 2014.

^b Montana implemented its MFP transition program during the reporting period from January 1 to June 30, 2014.

LTSS = long term services and supports; n.a. = not applicable.

Table A.4. MFP states' progress toward yearly transition goals, 2016 and 2015

State	January to December 2016 MFP transition activity			January to December 2015 MFP transition activity		
	Percentage of 2016 transition target achieved as of December 2016	Total 2016 transition goals	Total number of transitions in 2016	Percentage of 2015 transition goal achieved as of December 2015	Total 2015 transition goals	Total number of transitions in 2015
Tennessee	202.7%	226	458	82.2%	437	359
Maine	183.3%	18	33	73.1%	26	19
New Hampshire	161.5%	13	21	81.6%	49	40
Ohio	143.2%	1,260	1,804	133.0%	1,247	1,658
New Jersey	137.5%	240	330	89.9%	287	258
Washington	133.0%	724	963	133.1%	724	964
Louisiana	125.1%	350	438	116.6%	326	380
Dist. of Columbia	121.2%	33	40	80.0%	45	36
Michigan	121.0%	310	375	142.0%	300	426
New York	120.9%	350	423	89.3%	364	325
Pennsylvania	117.8%	427	503	62.8%	562	353
Connecticut	108.1%	700	757	107.1%	700	750
Mississippi	106.3%	95	101	104.2%	95	99
Montana ^c	105.7%	53	56	112.8%	47	53
Missouri	104.7%	215	225	114.2%	218	249

TABLE A.4 (continued)

State	January to December 2016 MFP transition activity			January to December 2015 MFP transition activity		
	Percentage of 2016 transition target achieved as of December 2016	Total 2016 transition goals	Total number of transitions in 2016	Percentage of 2015 transition goal achieved as of December 2015	Total 2015 transition goals	Total number of transitions in 2015
Massachusetts	103.6%	552	572	89.4%	614	549
South Dakota ^b	100.0%	32	32	110.0%	30	33
Wisconsin	99.6%	249	248	82.7%	300	248
Hawaii	98.5%	68	67	122.1%	68	83
West Virginia ^a	97.5%	80	78	41.8%	110	46
Georgia	95.8%	216	207	65.1%	350	228
North Dakota	95.2%	62	59	136.2%	47	64
Vermont	93.9%	66	62	139.6%	53	74
Virginia	91.1%	180	164	104.2%	168	175
Idaho	90.7%	97	88	100.0%	81	81
Nevada	86.9%	84	73	84.6%	78	66
Iowa	86.7%	75	65	205.3%	75	154
Arkansas	86.3%	146	126	80.5%	164	132
Delaware	84.4%	45	38	63.6%	55	35
Rhode Island	81.7%	60	49	103.3%	60	62
Nebraska	80.2%	81	65	102.5%	81	83
California	75.6%	540	408	80.9%	425	344
North Carolina	74.6%	193	144	82.6%	155	128
Maryland	73.2%	365	267	75.3%	365	275
Texas	69.4%	1,350	937	76.9%	1,350	1,038

TABLE A.4 (continued)

State	January to December 2016 MFP transition activity			January to December 2015 MFP transition activity		
	Percentage of 2016 transition target achieved as of December 2016	Total 2016 transition goals	Total number of transitions in 2016	Percentage of 2015 transition goal achieved as of December 2015	Total 2015 transition goals	Total number of transitions in 2015
Illinois	68.6%	545	374	111.1%	577	641
Colorado ^a	60.9%	128	78	68.8%	80	55
Kansas	58.7%	310	182	106.8%	220	235
Minnesota ^a	57.9%	197	114	40.5%	185	75
South Carolina ^a	46.4%	28	13	34.1%	44	15
Oklahoma	42.6%	47	20	51.5%	68	35
Alabama	39.9%	138	55	11.7%	205	24
Kentucky	35.0%	100	35	36.0%	100	36
Indiana	15.6%	450	70	101.3%	450	456
TOTAL	97.6%	11,498	11,217	95.4%	11,985	11,439

Source: State MFP Grantee Semiannual Progress Reports for January 1 to June 30, 2015; July 1 to December 31, 2015; January 1 to June 30, 2016; and July 1 to December 31, 2016.

Note: States are sorted by the percentage of 2016 transition targets achieved as of December 31, 2016.

^a Colorado, Minnesota, South Carolina, and West Virginia implemented MFP programs during the reporting period from January 1 to June 30, 2013.

^b South Dakota implemented its MFP transition program during the reporting period from July 1 to December 21, 2014.

^c Montana implemented its MFP transition program during the reporting period from January 1 to June 30, 2014.

n.a. = not applicable.

Table A.5. 2016 and 2015 qualified community-based LTSS expenditures

State	Percentage of 2016 spending target achieved as of December 2016	2016 target level of spending	Qualified LTSS expenditures as of December 2016	Percentage of 2015 spending target achieved as of December 2015	2015 target level of spending	Qualified LTSS expenditures as of December 2015
Alabama ^a	94.5%	\$714,057,086	\$674,944,811	93.6%	\$693,589,356	\$648,938,137
Arkansas	87.6%	\$395,911,851	\$346,812,303	86.3%	\$377,058,905	\$325,409,206
California	92.0%	\$11,495,019,372	\$10,571,818,005	79.8%	\$10,966,784,300	\$8,756,406,398
Colorado ^b	193.5%	\$899,860,963	\$1,741,130,405	107.3%	\$879,998,546	\$943,893,163
Connecticut	46.6%	\$4,058,355,639	\$1,891,268,415	40.5%	\$4,018,173,900	\$1,628,247,668
Delaware	73.8%	\$144,519,274	\$106,616,000	84.0%	\$137,194,160	\$115,245,992
District of Columbia	66.7%	\$886,371,554	\$591,307,525	64.5%	\$829,935,911	\$534,973,795
Georgia	83.7%	\$1,414,391,307	\$1,183,571,575	86.7%	\$1,328,066,955	\$1,151,994,007
Hawaii	103.2%	\$189,265,987	\$195,385,653	102.9%	\$187,569,867	\$192,931,797
Idaho	118.8%	\$255,195,626	\$303,146,451	182.9%	\$236,292,154	\$432,153,015
Illinois	83.9%	\$2,199,819,486	\$1,844,759,004	95.8%	\$1,999,835,896	\$1,915,873,272
Indiana	69.2%	\$1,290,000,000	\$892,699,275	71.5%	\$1,230,000,000	\$879,506,675
Iowa	109.6%	\$743,820,000	\$815,093,555	109.6%	\$736,939,093	\$808,047,005
Kansas	102.8%	\$976,310,767	\$1,003,250,345	151.8%	\$633,840,897	\$961,882,529
Kentucky	69.8%	\$1,100,600,000	\$768,361,953	77.0%	\$973,200,000	\$749,669,149
Louisiana	90.4%	\$881,564,960	\$797,045,417	98.8%	\$858,558,030	\$847,971,858
Maine	79.9%	\$492,783,537	\$393,811,120	76.0%	\$479,167,111	\$364,107,562
Maryland	97.3%	\$1,196,834,816	\$1,164,100,215	101.1%	\$1,134,447,621	\$1,147,099,433
Massachusetts	216.0%	\$2,432,000,000	\$5,253,722,481	108.6%	\$4,417,000,000	\$4,797,088,555
Michigan	111.4%	\$999,450,030	\$1,113,083,065	120.7%	\$976,080,750	\$1,178,348,149

TABLE A.5 (continued)

State	Percentage of 2016 spending target achieved as of December 2016	2016 target level of spending	Qualified LTSS expenditures as of December 2016	Percentage of 2015 spending target achieved as of December 2015	2015 target level of spending	Qualified LTSS expenditures as of December 2015
Minnesota ^b	100.7%	\$3,500,142,327	\$3,524,171,519	103.0%	\$3,221,477,903	\$3,319,272,121
Mississippi	99.3%	\$469,293,750	\$466,046,627	103.1%	\$453,774,657	\$467,902,078
Missouri	138.3%	\$1,187,078,247	\$1,641,726,950	132.8%	\$1,141,423,514	\$1,515,511,457
Montana ^c	105.4%	\$146,918,089	\$154,916,204	104.5%	\$142,638,922	\$149,042,840
Nebraska	110.6%	\$358,100,000	\$396,123,168	100.9%	\$351,100,000	\$354,182,097
Nevada	135.2%	\$181,648,210	\$245,583,461	121.4%	\$177,706,407	\$215,754,035
New Hampshire	0.2%	\$393,308,675	\$860,738	78.9%	\$369,651,010	\$291,670,948
New Jersey	269.7%	\$1,336,939,843	\$3,605,355,066	220.6%	\$1,309,124,519	\$2,887,764,243
New York	106.9%	\$14,391,887,456	\$15,381,734,405	100.7%	\$14,121,780,984	\$14,220,886,848
North Carolina ^d	99.2%	\$1,721,039,554	\$1,706,875,306	108.8%	\$1,582,507,210	\$1,721,039,554
North Dakota	138.4%	\$216,741,830	\$300,000,000	116.6%	\$203,706,386	\$237,506,401
Ohio	109.6%	\$4,403,000,000	\$4,825,877,430	73.3%	\$4,086,000,000	\$2,995,642,908
Oklahoma	76.5%	\$682,136,726	\$521,819,979	98.1%	\$615,148,224	\$603,371,259
Pennsylvania	120.2%	\$4,101,100,803	\$4,928,594,000	100.0%	\$3,868,963,022	\$3,868,963,022
Rhode Island	97.0%	\$504,024,493	\$488,773,298	98.3%	\$502,016,427	\$493,703,136
South Carolina ^b	118.2%	\$566,217,153	\$669,363,391	106.2%	\$560,950,017	\$595,578,720
South Dakota ^e	102.8%	\$133,996,567	\$137,802,909	102.8%	\$130,093,754	\$133,733,410
Tennessee	104.9%	\$1,111,073,082	\$1,165,161,489	106.1%	\$1,062,468,177	\$1,126,942,659
Texas	190.4%	\$3,378,671,461	\$6,433,853,587	157.4%	\$3,378,671,461	\$5,316,995,139
Vermont	108.9%	\$62,811,505	\$68,391,989	103.2%	\$61,579,906	\$63,529,390

TABLE A.5 (continued)

State	Percentage of 2016 spending target achieved as of December 2016	2016 target level of spending	Qualified LTSS expenditures as of December 2016	Percentage of 2015 spending target achieved as of December 2015	2015 target level of spending	Qualified LTSS expenditures as of December 2015
Virginia	86.7%	\$1,778,576,101	\$1,542,792,874	91.0%	\$1,634,172,053	\$1,487,652,130
Washington	131.5%	\$915,718,397	\$1,204,304,712	115.9%	\$906,651,878	\$1,050,827,532
West Virginia ^b	84.1%	\$711,556,901	\$598,063,233	97.3%	\$675,406,454	\$656,914,627
Wisconsin	106.4%	\$2,421,348,117	\$2,575,844,013	100.8%	\$2,351,559,388	\$2,369,616,619
TOTAL	108.8%	\$77,439,461,542	\$84,235,963,921	98.1%	\$76,002,305,725	\$74,523,790,538

Source: State MFP Grantee Semiannual Progress Reports for July 1 to December 31, 2016.

^a Alabama implemented its MFP transition program during the reporting period from July 1 to December 31, 2013.

^b Colorado, Minnesota, South Carolina, and West Virginia implemented new MFP programs during the reporting period from January 1 to June 30, 2013.

^c Montana implemented its MFP transition program during the reporting period from January 1 to June 30, 2014, and

^d North Carolina's expenditure data includes PACE and Private Duty Nursing spending.

^e South Dakota implemented its MFP transition program during the reporting period from July 1 to December 31, 2014.

n.a. = not applicable; NR = not reported; ID = intellectual or developmental disabilities; LTSS = long-term support services

Table A.6. Use of rebalancing funds through December 31, 2015

State ^a	Cumulative rebalancing expenditures as of December 2015	Cumulative rebalancing expenditures as of December 2014	Cumulative rebalancing expenditures as of December 2013	Type of activities
Arkansas	\$2,100,000	\$2,100,000	\$2,100,000	(1) Data system improvements
California ^c	\$0	\$0	NR	
Connecticut	\$14,932,000	\$12,600,000	\$9,266,750	(1) Housing; (2) Transition Services
Delaware ^c	\$0	\$0	NR	
District of Columbia ^d	\$2,339,120	\$43,811	\$1,372	(1) Transition services; (2) Waivers
Georgia ^c	\$0	\$0	NR	
Hawaii ^c	\$0	\$1	NR	(1) Housing; (2) Staff training; (3) Waivers
Idaho ^h	\$3,294,077	\$0	\$0	(1) Assessment tools
Illinois ^d	\$1,226,560	\$679,969	\$338,157	(1) Housing; (2) Transition services; (3) Outreach
Indiana	\$15,967,210	NR	\$3,417,208	(1) Waivers
Iowa	\$10,889,169	\$7,309,571	\$4,816,787	(1) Data system improvements; (2) Staff training; (3) Assessment tools; (4) Waivers
Kansas	\$11,677,973	\$9,929,647	NR	(1) Transition services
Kentucky ^c	\$0	\$0	NR	(1) Waivers

TABLE A.6 (continued)

State ^a	Cumulative rebalancing expenditures as of December 2015	Cumulative rebalancing expenditures as of December 2014	Cumulative rebalancing expenditures as of December 2013	Type of activities
Louisiana ^b	\$9,083,277	\$0	\$0	(1) Transition services; (2) Waivers
Maine ^e	\$96,784	\$64,588	\$0	(1) Housing; (2) Staff training; (3) Other
Maryland	\$19,180,085	\$16,178,056	\$14,234,333	(1) Assessment tools; (2) Housing; (3) Data system improvements; (4) Outreach; (5) Waivers; (6) Other
Massachusetts	\$1,289,771	\$1,181,111	\$0	(1) Data system improvements; (2) Waivers
Michigan	\$56,460,347	\$54,583,409	\$1,570,153	(1) Waivers
Mississippi ^e	\$35,824	\$0	\$0	(1) Housing; (2) Outreach
Missouri ^d	\$70,225,221	\$51,325,696	\$28,513,753	(1) Assessment tools; (2) Transition services; (3) Waivers; (4) Other
Montana ^g	\$157,477	\$48,638	\$0	(1) Waivers
Nebraska	\$701,663	\$150,404	\$940,709	(1) Data system improvements; (2) Waivers
Nevada	\$7,478	\$7,478	\$0	(1) Other
New Hampshire ^j	\$168,848	\$0	NR	
New Jersey	\$8,233,138	\$4,908,646	\$1,499,729	(1) Housing; (2) Staff training; (3) Transition services
New York	\$12,051,122	\$10,330,420	\$8,922,440	(1) Outreach; (2) Transition services; (3) Other

TABLE A.6 (continued)

State ^a	Cumulative rebalancing expenditures as of December 2015	Cumulative rebalancing expenditures as of December 2014	Cumulative rebalancing expenditures as of December 2013	Type of activities
North Carolina	\$164,098	\$54,584	\$32,591	(1) Outreach; (2) Other
North Dakota	\$378,392	\$316,656	\$11,275	(1) Assessment tools; (2) Other
Ohio ^d	\$5,640,463	\$4,037,264	\$3,277,049	(1) Assessment tools; (2) Housing; (3) Outreach; (4) Staff training; (5) Other
Oklahoma	\$8,060,870	\$6,456,024	\$3,720,256	(1) Waivers
Oregon ^f	\$0	\$0	n.a.	
Pennsylvania	\$21,040,403	\$14,028,377	\$9,764,731	(1) Waivers
Rhode Island ^h	\$50,208	\$8,600	\$0	(1) Housing; (2) Data system improvement; (3) Staff training
Tennessee	\$94,572	\$11,010	\$0	(1) Outreach; (2) Staff training; (3) Other
Texas ^d	\$9,688,116	\$4,702,196	\$3,566,567	(1) Assessment tools; (2) Staff training; (3) Transition services
Vermont ^{c,d}	\$0	\$5,943,704	\$5,551,945	
Virginia	\$16,957,801	\$13,925,957	\$10,901,660	(1) Waivers
Washington ^d	\$27,549,052	\$23,478,106	\$4,401,114	(1) Assessment tools; (2) Housing; (3) Staff training; (4) Transition services; (5) Waiver; (6) Outreach
West Virginia ⁱ	\$262,000	\$0	\$0	(1) Other
Wisconsin	\$6,631,223	\$5,442,401	\$417,757	(1) Outreach; (2) Waivers; (3) Other
TOTAL	\$336,634,342	\$249,846,323	\$117,266,336	--

TABLE A.6 (continued)

Source: MFP semiannual progress reports covering the reporting periods from January 1 to June 30, 2014; January 1 to June 30, 2015; and January 1 to June 30, 2016.

^a Alabama, Colorado, Minnesota, and South Carolina started transitioning participants in 2013; South Dakota started transitioning participants in 2014. These states were not included in this table because they did not have any rebalancing expenditures to report through December 2015.

^b Louisiana started transitioning participants in 2009.

^c California, Delaware, Georgia, Hawaii, Kentucky, and Vermont reported cumulative expenditures in previous reporting periods but did not reporting spending through December 2015.

^d Cumulative expenditures reported in later years were lower than what had been reported in earlier years because the state changed or corrected earlier methods of tracking.

^e Maine and Mississippi started transitioning participants in 2012.

^f Oregon suspended program operations in 2010 and later rescinded its grant award.

^g Montana started transitioning participants in 2014.

^h Idaho and Rhode Island started transitioning participants in 2011.

ⁱ West Virginia started transitioning participants in 2013.

^j New Hampshire started transitioning participants in 2008.

n.a. = not applicable; NR = not reported.

Table A.7. Number of participants reinstitutionalized for any length of stay, January 1 to June 30, 2016

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Alabama	0	0	0	0	0	0
Arkansas	11	4	4	3	0	0
California	34	10	23	0	1	0
Colorado	14	1	3	2	1	7
Connecticut	259	118	118	10	13	0
Delaware	1	1	0	0	0	0
District of Columbia	1	0	1	0	0	0
Georgia	53	51	2	0	0	0
Hawaii	6	2	4	0	0	0
Idaho	3	2	0	1	0	0
Illinois	237	49	76	6	106	0
Indiana	75	46	6	14	9	0
Iowa	3	0	0	3	0	0
Kansas	12	2	10	0	0	0
Kentucky	3	1	1	0	0	1
Louisiana	4	2	1	1	0	0
Maine	2	2	0	0	0	0
Maryland	8	7	0	1	0	0
Massachusetts	79	44	28	1	6	0
Michigan	138	68	70	0	0	0

TABLE A.7 (continued)

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Minnesota	3	0	1	0	0	2
Mississippi	5	1	2	2	0	0
Missouri	49	12	33	4	0	0
Montana ^a	5	2	2	0	1	0
Nebraska	2	2	0	0	0	0
Nevada	28	14	14	0	0	0
New Hampshire	1	0	1	0	0	0
New Jersey	16	6	6	4	0	0
New York	6	2	1	2	0	1
North Carolina	32	9	16	7	0	0
North Dakota	3	2	1	0	0	0
Ohio	351	51	107	3	190	0
Oklahoma	2	0	1	1	0	0
Pennsylvania	18	11	6	0	0	1
Rhode Island	42	17	25	0	0	0
South Carolina	6	5	1	0	0	0
South Dakota ^a	2	1	1	0	0	0
Tennessee	135	85	43	7	0	0
Texas	83	43	34	6	0	0
Vermont	27	11	16	0	0	0

TABLE A.7 (continued)

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Virginia	4	0	4	0	0	0
Washington	75	47	28	0	0	0
West Virginia	14	7	7	0	0	0
Wisconsin	56	25	29	2	0	0
TOTAL	1,908	763	726	80	327	12

Source: State MFP Grantee Semiannual Progress Reports for January 1 to June 30, 2016.

^a Montana and South Dakota started transitioning individuals during 2014.

Table A.8. Number of participants reinstitutionalized for any length of stay, July 1 to December 31, 2016

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Alabama	0	0	0	0	0	0
Arkansas	6	0	3	3	0	0
California	27	7	20	0	0	0
Colorado	31	2	11	4	0	14
Connecticut	256	119	116	11	10	0
Delaware	4	2	0	0	2	0
District of Columbia	2	2	0	0	0	0
Georgia	13	8	5	0	0	0
Hawaii	6	1	4	1	0	0
Idaho	1	0	1	0	0	0
Illinois	165	41	58	4	62	0
Indiana	36	15	9	4	8	0
Iowa	1	0	0	1	0	0
Kansas	13	3	10	0	0	0
Kentucky	1	0	1	0	0	0
Louisiana	5	0	2	3	0	0
Maine	2	2	0	0	0	0
Maryland	11	9	2	0	0	0
Massachusetts	78	39	36	0	3	0
Michigan	156	87	69	0	0	0
Minnesota	4	0	1	0	1	2
Mississippi	4	0	4	0	0	0
Missouri	104	26	70	8	0	0

TABLE A.8 (continued)

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Montana ^a	10	6	2	1	1	0
Nebraska	14	11	3	0	0	0
Nevada	22	7	15	0	0	0
New Hampshire	0	0	0	0	0	0
New Jersey	22	8	12	1	1	0
New York	24	3	1	19	0	1
North Carolina	14	6	4	4	0	0
North Dakota	3	2	0	1	0	0
Ohio	306	39	99	8	160	0
Oklahoma	1	1	0	0	0	0
Pennsylvania	28	22	6	0	0	0
Rhode Island	23	13	10	0	0	0
South Carolina	2	1	1	0	0	0
South Dakota ^a	0	0	0	0	0	0
Tennessee	192	105	82	5	0	0
Texas	94	46	40	8	0	0
Vermont	22	11	11	0	0	0
Virginia	7	1	3	3	0	0
Washington	80	54	21	3	2	0
West Virginia	15	6	9	0	0	0
Wisconsin	59	25	34	0	0	0
TOTAL	1,864	730	775	92	250	17

Source: State MFP Grantee Semiannual Progress Reports for July 1 to December 31, 2016.

^a Montana and South Dakota started transitioning individuals during 2014.

Table A.9. Number of participants reinstitutionalized for more than 30 days, January 1 to June 30, 2016

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Alabama	0	0	0	0	0	0
Arkansas	6	2	2	2	0	0
California	4	2	2	0	0	0
Colorado	5	1	0	0	1	3
Connecticut	48	29	17	0	2	0
Delaware	1	1	0	0	0	0
District of Columbia	1	0	1	0	0	0
Georgia	7	5	2	0	0	0
Hawaii	2	1	1	0	0	0
Idaho	2	1	0	1	0	0
Illinois	79	13	25	2	39	0
Indiana	43	37	3	2	1	0
Iowa	0	0	0	0	0	0
Kansas	9	2	7	0	0	0
Kentucky	1	0	0	0	0	1
Louisiana	1	0	0	1	0	0
Maine	1	1	0	0	0	0
Maryland	8	7	0	1	0	0
Massachusetts	32	19	10	0	3	0
Michigan	21	13	8	0	0	0

TABLE A.9 (continued)

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Minnesota	0	0	0	0	0	0
Mississippi	5	1	2	2	0	0
Missouri	9	4	5	0	0	0
Montana ^a	2	0	2	0	0	0
Nebraska	2	2	0	0	0	0
Nevada	8	3	5	0	0	0
New Hampshire	1	0	1	0	0	0
New Jersey	16	6	6	4	0	0
New York	3	1	1	1	0	0
North Carolina	8	2	3	3	0	0
North Dakota	3	2	1	0	0	0
Ohio	63	9	17	0	37	0
Oklahoma	2	0	1	1	0	0
Pennsylvania	5	3	2	0	0	0
Rhode Island	6	3	3	0	0	0
South Carolina	2	2	0	0	0	0
South Dakota ^a	2	1	1	0	0	0
Tennessee	41	28	11	2	0	0
Texas	55	27	23	5	0	0
Vermont	5	2	3	0	0	0

TABLE A.9 (continued)

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Virginia	1	0	1	0	0	0
Washington	41	22	19	0	0	0
West Virginia	5	3	2	0	0	0
Wisconsin	26	12	13	1	0	0
TOTAL	582	267	200	28	83	4

Source: State MFP Grantee Semiannual Progress Reports for January 1 to June 30, 2016.

^a Montana and South Dakota started transitioning individuals during 2014.

Table A.10. Number of participants reinstitutionalized for more than 30 days, July 1 to December 31, 2016

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Alabama	0	0	0	0	0	0
Arkansas	6	0	3	3	0	0
California	1	0	1	0	0	0
Colorado	5	0	3	0	0	2
Connecticut	64	39	20	2	3	0
Delaware	2	1	0	0	1	0
District of Columbia	2	2	0	0	0	0
Georgia	2	0	2	0	0	0
Hawaii	2	0	2	0	0	0
Idaho	1	0	1	0	0	0
Illinois	6	2	2	1	1	0
Indiana	20	12	5	0	3	0
Iowa	0	0	0	0	0	0
Kansas	5	2	3	0	0	0
Kentucky	1	0	1	0	0	0
Louisiana	5	0	2	3	0	0
Maine	2	2	0	0	0	0
Maryland	10	8	2	0	0	0
Massachusetts	40	15	24	0	1	0
Michigan	31	18	13	0	0	0

TABLE A.10 (continued)

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Minnesota	0	0	0	0	0	0
Mississippi	4	0	4	0	0	0
Missouri	7	1	6	0	0	0
Montana ^a	6	3	1	1	1	0
Nebraska	14	11	3	0	0	0
Nevada	2	2	0	0	0	0
New Hampshire	0	0	0	0	0	0
New Jersey	22	8	12	1	1	0
New York	5	3	1	1	0	0
North Carolina	13	5	4	4	0	0
North Dakota	3	2	0	1	0	0
Ohio	66	6	21	3	36	0
Oklahoma	1	1	0	0	0	0
Pennsylvania	11	7	4	0	0	0
Rhode Island	2	1	1	0	0	0
South Carolina	0	0	0	0	0	0
South Dakota ^a	0	0	0	0	0	0
Tennessee	33	17	15	1	0	0
Texas	58	31	22	5	0	0
Vermont	2	2	0	0	0	0

TABLE A.10 (continued)

State	Total number	Older adults	People with physical disabilities	People with intellectual or developmental disabilities	People with mental illness	Other
Virginia	3	1	0	2	0	0
Washington	70	49	19	2	0	0
West Virginia	7	4	3	0	0	0
Wisconsin	3	2	1	0	0	0
TOTAL	537	257	201	30	47	2

Source: State MFP Grantee Semiannual Progress Reports for July 1 to December 31, 2016.

^a Montana and South Dakota started transitioning individuals during 2014.

Table A.11. Overview of Minimum Data Set 3.0, Section Q Referrals, January to June 2016 and July to December 2016

State	Number of people referred to MFP through MDS Section Q referrals between January and June 2016	Number of people ever referred through MDS Section Q that enrolled in MFP between January and June 2016	Number of people referred to MFP through MDS Section Q referrals between July and December 2016	Number of people ever referred through MDS Section Q that enrolled in MFP between July and December 2016
Alabama	0	0	0	0
Arkansas	8	3	43	8
California	79	2	115	8
Colorado	74	4	116	13
Connecticut	23	1	25	1
Delaware	27	0	20	0
District of Columbia	3	2	65	3
Georgia	271	105	141	121
Hawaii	1	1	0	0
Idaho	0	0	0	0
Illinois	56	4	383	53
Indiana	0	0	70	0
Iowa	0	0	0	0
Kansas	0	0	0	0
Kentucky	7	3	31	2
Louisiana	146	30	205	33
Maine	0	0	3	0
Maryland	3,439	13	2,691	12
Massachusetts	82	42	37	9
Michigan	290	12	307	11

TABLE A.11 (continued)

State	Number of people referred to MFP through MDS Section Q referrals between January and June 2016	Number of people ever referred through MDS Section Q that enrolled in MFP between January and June 2016	Number of people referred to MFP through MDS Section Q referrals between July and December 2016	Number of people ever referred through MDS Section Q that enrolled in MFP between July and December 2016
Minnesota	0	0	0	0
Mississippi	2	0	4	1
Missouri	143	19	111	19
Montana	0	0	0	0
Nebraska	25	0	11	0
Nevada	3	1	0	0
New Hampshire	0	0	0	0
New Jersey	230	33	200	33
New York	559	22	679	50
North Carolina	74	11	83	18
North Dakota	3	0	2	0
Ohio	506	120	457	104
Oklahoma	0	0	0	0
Pennsylvania	248	15	931	67
Rhode Island	62	7	51	10
South Carolina	5	2	10	1
South Dakota ^a	0	0	0	0
Tennessee	0	0	0	0
Texas	593	53	497	47
Vermont	0	0	0	0

TABLE A.11 (continued)

State	Number of people referred to MFP through MDS Section Q referrals between January and June 2016	Number of people ever referred through MDS Section Q that enrolled in MFP between January and June 2016	Number of people referred to MFP through MDS Section Q referrals between July and December 2016	Number of people ever referred through MDS Section Q that enrolled in MFP between July and December 2016
Virginia	17	5	8	6
Washington	0	0	0	0
West Virginia	12	3	6	8
Wisconsin	0	0	0	0
TOTAL	6,988	513	7,302	638

Source: State MFP Grantee Semiannual Progress Reports for January 1 to June 30, 2016 and July 1 to December 31, 2016.

^a Montana and South Dakota started transitioning individuals during 2014.

MDS = Minimum Data Set

Table A.12. Total number of current MFP participants in a self-direction program, June 30, 2016 and December 31, 2016

State	Total number of current MFP participants as of June 30, 2016 that ...			Total number of current MFP participants as of December 31, 2016 that ...		
	Chose to participate in a self-direction program	Hired/supervised their own personal assistants	Managed their own allowance/budget	Chose to participate in a self-direction program	Hired/supervised their own personal assistants	Managed their own allowance/budget
Alabama	0	0	0	3	3	0
Arkansas	14	12	12	15	15	15
California	0	0	0	0	0	0
Colorado	12	12	1	24	23	1
Connecticut	254	215	215	225	225	225
Delaware	45	45	45	56	27	27
District of Columbia	0	0	0	1	1	1
Georgia	0	0	0	0	0	0
Hawaii	7	7	0	6	6	0
Idaho	2	2	2	1	1	1
Illinois	51	45	32	24	23	23
Indiana	0	0	0	0	0	0
Iowa	10	10	10	6	6	6
Kansas	10	10	10	93	93	93
Kentucky	40	40	40	13	13	13

TABLE A.12 (continued)

State	Total number of current MFP participants as of June 30, 2016 that ...			Total number of current MFP participants as of December 31, 2016 that ...		
	Chose to participate in a self-direction program	Hired/supervised their own personal assistants	Managed their own allowance/ budget	Chose to participate in a self-direction program	Hired/supervised their own personal assistants	Managed their own allowance/ budget
Louisiana	9	9	9	6	6	6
Maine	6	6	0	9	9	0
Maryland	0	0	0	0	0	0
Massachusetts	186	186	0	173	173	0
Michigan	34	34	34	35	35	35
Minnesota	0	0	0	0	0	0
Mississippi	3	3	3	4	4	4
Missouri	59	50	51	106	71	64
Montana	1	1	1	1	1	1
Nebraska	0	0	0	0	0	0
Nevada	0	0	0	0	0	0
New Hampshire	0	0	0	0	0	0
New Jersey	3	3	3	15	15	15
New York	2	2	0	31	25	8
North Carolina	13	13	13	11	11	11
North Dakota	0	0	0	0	0	0
Ohio ^a	1,609	0	1,609	1,711	0	1,711
Oklahoma	0	0	0	0	0	0
Pennsylvania	22	22	0	23	22	1
Rhode Island	0	0	0	0	0	0

TABLE A.12 (continued)

State	Total number of current MFP participants as of June 30, 2016 that ...			Total number of current MFP participants as of December 31, 2016 that ...		
	Chose to participate in a self-direction program	Hired/supervised their own personal assistants	Managed their own allowance/budget	Chose to participate in a self-direction program	Hired/supervised their own personal assistants	Managed their own allowance/budget
South Carolina	0	0	0	0	0	0
South Dakota ^b	2	2	2	0	0	0
Tennessee	21	21	0	17	17	0
Texas	28	28	28	32	32	32
Vermont	37	37	8	14	14	2
Virginia	9	9	0	23	23	0
Washington	99	127	42	104	89	55
West Virginia	12	12	12	6	6	6
Wisconsin	1	1	1	2	2	2
TOTAL	2,601	964	2,183	2,790	991	2,358

Source: State MFP Grantee Semiannual Progress Reports for January 1 to June 30, 2016 and July 1 to December 31, 2016.

^a Ohio considers all MFP participants to be self-directing because they all receive a small amount of money for one-time moving expenses to use as they wish. Delaware also considers all MFP participants to be self-directing.

^b South Dakota implemented its MFP transition program during the second half of 2014.

n.a. = not applicable.

Table A.13. Number of MFP transitions during the reporting period, by type of qualified community residence, January 1 to June 30, 2016

State	Homes	Apartments	Group homes	Apartment in qualified assisted living
Alabama	14	3	0	0
Arkansas	10	36	11	13
California	16	68	35	109
Colorado	4	27	2	0
Connecticut	84	279	11	0
Delaware	1	11	0	0
District of Columbia	4	12	0	0
Georgia	47	54	1	0
Hawaii	8	5	20	0
Idaho	6	15	18	0
Illinois	8	123	17	37
Indiana	17	0	0	0
Iowa	3	20	0	0
Kansas	16	29	2	25
Kentucky	2	14	0	0
Louisiana	114	73	0	0
Maine	9	4	4	0
Maryland	59	41	25	0
Massachusetts	76	125	74	9
Michigan	60	85	8	25
Minnesota	2	18	11	15
Mississippi	13	19	11	6
Missouri	10	68	14	0
Montana	3	9	5	25
Nebraska	12	8	0	11
Nevada	5	25	6	0
New Hampshire	2	19	0	0
New Jersey	56	71	43	0
New York	58	94	59	0
North Carolina	30	17	17	0

Table A.13 (continued)

State	Homes	Apartments	Group homes	Apartment in qualified assisted living
North Dakota	8	19	0	0
Ohio	293	491	85	7
Oklahoma	0	3	0	0
Pennsylvania	204	0	36	1
Rhode Island	4	12	0	5
South Carolina	3	2	0	0
South Dakota ^a	2	7	4	0
Tennessee	112	39	38	0
Texas	246	86	79	0
Vermont	17	9	5	0
Virginia	21	22	29	8
Washington ^b	274	37	86	104
West Virginia	16	15	0	0
Wisconsin	31	39	22	24
TOTAL	1,980	2,153	778	424

Source: State MFP Grantee Semiannual Progress Reports for January 1 to June 30, 2016.

Note: The total of participants residing in all types of MFP-qualified housing does not equal the total of new people who transitioned to the community during this period for each state, because some states reported either more or fewer transitioned people than types of residences.

^a South Dakota implemented its MFP transition program during the second half of 2014.

^b Washington ceased distinguishing between homes and apartments beginning the second half of 2014. All residents transitioning to apartments are classified as transitioning to homes.

Table A.14. Number of MFP transitions during the reporting period, by type of qualified community residence, July 1 to December 31, 2016

State	Homes	Apartments	Group homes	Apartment in qualified assisted living
Alabama	31	7	0	0
Arkansas	13	31	9	3
California	18	69	10	83
Colorado	9	28	5	3
Connecticut	99	262	12	10
Delaware	0	25	1	0
District of Columbia	5	17	0	0
Georgia	34	61	7	3
Hawaii	6	5	22	1
Idaho	14	31	4	0
Illinois	18	119	10	42
Indiana	50	1	1	1
Iowa	2	40	0	0
Kansas	29	41	11	29
Kentucky	3	15	1	0
Louisiana	160	91	0	0
Maine	6	9	1	0
Maryland	70	45	27	0
Massachusetts	63	122	92	11
Michigan	83	57	16	42
Minnesota	3	28	12	25
Mississippi	13	32	4	3
Missouri	8	52	17	0
Montana	3	3	0	1
Nebraska	8	9	1	16
Nevada	12	25	0	0
New Hampshire	0	0	0	0
New Jersey	64	76	20	0
New York	68	122	22	0
North Carolina	38	20	22	0

TABLE A.14 (continued)

State	Homes	Apartments	Group homes	Apartment in qualified assisted living
North Dakota	2	30	0	0
Ohio	263	537	111	17
Oklahoma	1	16	0	0
Pennsylvania	202	0	36	1
Rhode Island	7	15	0	3
South Carolina	6	2	0	0
South Dakota	3	12	2	2
Tennessee	167	42	60	0
Texas	332	111	79	0
Vermont	11	15	5	0
Virginia	11	36	30	7
Washington	281	32	73	76
West Virginia	24	23	0	0
Wisconsin	28	50	40	14
TOTAL	2,268	2,364	763	393

Source: State MFP Grantee Semiannual Progress Reports for July 1 to December 31, 2016.

Note: The total of participants residing in all types of MFP-qualified housing does not equal the total of new people who transitioned to the community during this period for each state, because some states reported either more or fewer transitioned people than types of residences.

Table A.15. Achievements and challenges securing appropriate housing options for participants, by reporting period, 2013–2016—number of grantee states reporting each type of achievement or challenge

Response option	July to Dec. 2013	Jan. to June 2014	July to Dec. 2014	Jan. to June 2015	July to Dec. 2015	Jan. to June 2016	July to Dec. 2016
Number of Grantees Reporting Achievement ^a	30	32	36	34	35	44	44
Developed inventory of affordable and accessible housing	12	9	9	11	11	14	11
Developed local or state coalitions to identify needs or create housing-related initiatives	15	12	16	15	12	11	10
Developed statewide housing registry	7	7	9	9	7	8	7
Implemented new home ownership initiative	0	0	1	2	0	1	0
Improved funding for developing assistive technology related to housing	2	1	2	3	2	3	3
Improved information systems about affordable and accessible housing	7	9	5	7	7	6	7
Increased number of rental vouchers	7	5	7	11	10	10	8
Increased supply of affordable and accessible housing	6	9	6	8	13	13	12
Increased supply of residences that provide or arrange for long-term services or supports	3	1	3	1	1	3	4
Increased supply of small-group homes	2	4	4	5	4	1	3
Increased or improved funding for home modifications	6	5	7	6	8	8	7
Other	7	13	17	19	20	18	14
Number of Grantees Reporting Challenge ^b	33	38	37	38	37	44	43

TABLE A.15 (continued)

Response option	July to Dec. 2013	Jan. to June 2014	July to Dec. 2014	Jan. to June 2015	July to Dec. 2015	Jan. to June 2016	July to Dec. 2016
Lack of information about affordable and accessible housing	3	5	5	4	4	6	8
Insufficient supply of affordable and accessible housing	26	32	33	30	29	32	26
Lack of affordable and accessible housing that is safe	8	9	11	7	6	7	9
Insufficient supply of rental vouchers	22	19	16	17	17	17	18
Lack of new home ownership programs	2	0	1	0	0	1	2
Lack of small-group homes	7	5	9	9	7	8	7
Lack of residences that provide or arrange for long-term services or supports	5	3	4	3	4	3	3
Insufficient funding for home modifications	7	6	3	7	8	6	6
Unsuccessful efforts in developing local or state coalitions of housing and human services organizations to identify needs or create housing-related initiatives	1	1	0	1	4	1	2
Unsuccessful efforts in developing sufficient funding or resources to develop assistive technology related to housing	1	2	1	0	0	0	1
Other	6	7	4	8	8	10	9

Source: State MFP Grantee Semiannual Progress Reports covering the reporting periods from July 1 to December 31, 2013; January 1 to June 30, 2014; July 1 to December 31, 2014; January 1 to June 30, 2015; July 1 to December 31, 2015; January 1 to June 30, 2016; and July 1 to December 31, 2016.

Notes: The progress reports were designed to capture information on states' progress and challenges encountered in all dimensions of the program. Information presented was based on self-reports and reflected the challenges encountered during the reporting period.

TABLE A.15 (continued)

^a Report asked, “What achievements in improving housing options for MFP participants did your program accomplish during the reporting period?”

^b Report asked, “What significant challenges did your program experience in securing appropriate housing options for MFP participants? Significant challenges are those that affect the program’s ability to transition as many people as planned or to keep MFP participants in the community.”

APPENDIX B

**QUALITY-OF-LIFE SURVEY OUTCOMES BY TIME PERIOD, TARGET
POPULATION, AND STATE**

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Table B.1. Quality-of-Life survey outcomes by time period, target population, and state (part 1)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
ALL STATES (N)	10,640	13,038	7,101	7,532	6,244	3,196	12,841	14,515	7,842	2,692	1,083	518
Older Adults (%)	61.2	74.4	73.0	43.1	36.4	35.4	75.7	85.4	83.4	19.1	8.3	7.7
People with PD (%)	58.9	76.4	77.0	48.9	41.3	40.0	73.2	85.4	85.9	21.5	10.5	8.7
People with ID (%)	78.2	88.6	89.7	26.0	23.5	23.5	82.5	91.4	93.7	3.1	1.3	0.7
People with MI (%)	67.5	68.9	69.6	49.6	53.3	44.9	77.8	78.7	81.2	15.2	20.7	11.5
Other (%)	62.2	84.4	85.1	41.3	32.5	29.1	70.3	90.3	87.9	13.4	3.1	3.4
Unknown (%)	59.6	77.3	80.3	47.2	39.3	36.9	71.2	87.3	86.9	22.2	5.8	8.3
Excluded participants												
No match (N)	955	1,082	256	631	455	94	1,125	1,200	277	246	94	17
Out of range (N)	1,028	519	265	883	305	142	1,287	571	291	313	63	22
ALABAMA (N)	-	-	-	-	-	-	-	-	-	-	-	.
All participants (%)	-	-	-	-	-	-	-	-	-	-	-	.
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	-	-	-	-	-	-	-	-	.	.
ARKANSAS (N)	13	17	-	-	-	-	13	15	-	-	-	-
All participants (%)	65.0	85.0	-	-	-	-	68.4	75.0	-	-	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	.	-	-	.	-	-	.	-	-	.

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
CALIFORNIA (N)	447	632	231	387	294	98	558	687	244	117	44	11
All participants (%)	54.6	77.8	81.9	47.4	36.4	35.1	68.5	85.3	86.2	16.3	6.6	4.6
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	35	14	-	36	-	-	41	13	-	14	-	-
COLORADO (N)	19	25	12	-	-	-	21	25	11	-	-	-
All participants (%)	67.9	89.3	100.0	-	-	-	75.0	92.6	91.7	-	-	-
Excluded participants												
No match (N)	.	.	.	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.	.	.	.
CONNECTICUT (N)	1,399	1,744	1,271	1,003	933	677	1,710	2,006	1,447	369	165	131
All participants (%)	59.6	74.3	75.3	42.8	39.7	40.1	73.4	86.8	86.7	19.0	8.6	9.5
Excluded participants												
No match (N)	-	-	-	-	-	-	-	-	-	-	-	-
Out of range (N)	14	25	23	23	16	18	27	28	25	-	-	-
DISTRICT OF COLUMBIA (N)	72	89	68	18	20	-	73	87	68	-	-	-
All participants (%)	80.9	93.7	93.2	19.8	20.8	-	83.0	92.6	93.2	-	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	-	-	-	-	-	-	-	-	-	-

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
DELAWARE (N)	-	15	-	-	-	-	-	16	-	-	-	-
All participants (%)	-	68.2	-	-	-	-	-	61.5	-	-	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	-	-	-	.
Out of range (N)	19	-	-	14	-	-	17	16	-	-	-	-
FLORIDA (N)	.	.	.	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.	.	.	.
Excluded participants												
No match (N)	.	.	.	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.	.	.	.
GEORGIA (N)	367	400	238	156	161	47	414	427	254	49	40	-
All participants (%)	72.1	80.6	90.2	30.6	31.8	17.8	81.7	86.3	95.5	10.3	8.4	-
Excluded participants												
No match (N)	-	-	-	11	-	-	-	14	-	-	-	-
Out of range (N)	50	-	-	33	-	-	58	13	-	-	-	-
HAWAII (N)	82	105	51	53	47	18	102	122	54	24	-	-
All participants (%)	57.3	71.9	85.0	36.8	32.9	30.0	69.9	85.9	91.5	17.3	-	-
Excluded participants												
No match (N)	-	-	-	-	-	-	-	-	-	-	-	-
Out of range (N)	18	-	-	14	-	-	22	-	-	-	-	-

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
IOWA (N)	220	235	152	84	81	54	235	242	156	11	-	-
All participants (%)	81.8	87.4	87.9	31.1	30.2	31.6	86.4	91.0	91.2	5.3	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	21	17	13	-	-	-	23	20	15	-	-	-
IDAHO (N)	44	67	21	40	40	-	60	74	21	21	-	-
All participants (%)	52.4	79.8	95.5	47.1	47.6	-	69.8	87.1	95.5	26.9	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	-	.	.	-	.	.	15	.	.	-	.	.
ILLINOIS (N)	411	619	460	252	194	99	473	625	460	60	-	-
All participants (%)	60.5	89.6	94.5	36.7	28.2	21.0	68.9	90.2	94.1	15.6	-	-
Excluded participants												
No match (N)	68	94	20	39	31	12	72	96	19	11	-	-
Out of range (N)	-	11	-	-	-	-	11	-	-	-	-	-
INDIANA (N)	41	36	-	19	15	-	45	38	-	-	-	.
All participants (%)	78.8	80.0	-	37.3	33.3	-	88.2	86.4	-	-	-	.
Excluded participants												
No match (N)	-	-	-	-	-	-	-	-	-	-	-	-
Out of range (N)	-	-	-	-	-	-	-	-	-	-	-	-

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
KANSAS (N)	81	99	-	58	48	-	85	111	11	40	-	-
All participants (%)	65.3	82.5	-	48.3	39.3	-	68.5	92.5	100.0	34.5	-	-
Excluded participants												
No match (N)	62	68	32	29	25	-	64	75	32	12	-	-
Out of range (N)	-	-	.	-	-	.	-	-	.	-	-	.
KENTUCKY (N)	147	233	110	84	51	31	171	247	117	44	-	-
All participants (%)	59.0	86.3	84.6	34.6	18.8	24.4	67.6	92.5	90.7	17.5	-	-
Excluded participants												
No match (N)	18	15	-	-	-	-	26	17	-	13	-	-
Out of range (N)	123	31	46	107	-	11	167	31	49	62	-	-
LOUISIANA (N)	-	11	-	-	-	-	-	12	-	-	-	-
All participants (%)	-	91.7	-	-	-	-	-	100.0	-	-	-	-
Excluded participants												
No match (N)	63	62	18	27	19	-	63	68	19	-	-	-
Out of range (N)	-	-	-	-	-	-	-	-	-	-	-	-
MASSACHUSETTS (N)	158	211	54	121	92	28	211	266	60	48	-	-
All participants (%)	61.7	83.7	80.6	41.7	31.7	37.8	73.5	93.0	81.1	18.5	-	-
Excluded participants												
No match (N)	-	-	-	-	-	-	-	12	-	-	-	-
Out of range (N)	.	.	.	.	.	.	.	.	.	.	.	.

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
MARYLAND (N)	115	163	29	103	69	11	143	176	31	40	-	-
All participants (%)	59.0	84.5	87.9	53.1	35.6	33.3	73.3	90.7	93.9	25.8	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	.	-	-	.	-	-	.	-	-	.
MAINE (N)	15	21	11	13	11	-	11	18	-	14	-	-
All participants (%)	55.6	75.0	84.6	50.0	39.3	-	40.7	64.3	-	51.9	-	-
Excluded participants												
No match (N)	.	.	.	.	.	.	.	.	.	.	.	.
Out of range (N)	-	-	.	-	-	.	-	-	.	-	-	.
MICHIGAN (N)	241	198	24	221	108	15	295	217	23	81	31	-
All participants (%)	56.6	76.2	75.0	50.9	42.4	55.6	68.9	81.0	69.7	19.1	13.1	-
Excluded participants												
No match (N)	167	187	14	116	92	-	199	217	15	40	24	-
Out of range (N)	110	54	-	116	33	-	150	57	-	36	-	-
MINNESOTA (N)	.	.	.	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.	.	.	.
Excluded participants												
No match (N)	.	.	.	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.	.	.	.

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
MISSOURI (N)	432	555	353	274	245	165	508	575	378	88	26	13
All participants (%)	65.4	83.3	80.8	41.1	36.7	37.8	76.0	86.1	86.5	17.3	5.2	3.8
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	35	-	-	23	-	-	46	-	-	-	-	-
MISSISSIPPI (N)	212	252	173	116	80	42	226	255	170	16	-	-
All participants (%)	72.9	92.0	93.0	40.7	29.3	22.6	77.9	93.1	91.9	6.1	-	-
Excluded participants												
No match (N)	-	-	-	-	-	-	-	-	-	-	-	-
Out of range (N)	-	.	.	-	.	.	-	.	.	-	.	.
MONTANA (N)	-	-	-	-	-	-	-	-	-	-	-	-
All participants (%)	-	-	-	-	-	-	-	-	-	-	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	.	.	.	.	.	.	.	.	.	.	.	.
NORTH CAROLINA (N)	70	82	28	47	43	-	80	94	30	-	-	-
All participants (%)	70.7	81.2	80.0	46.1	41.3	-	80.0	91.3	85.7	-	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	-	-	-	-	-	-	-	-	-	.

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
NORTH DAKOTA (N)	68	78	60	44	25	35	84	82	64	12	-	-
All participants (%)	70.8	84.8	85.7	45.8	27.5	50.0	87.5	91.1	91.4	14.8	-	-
Excluded participants												
No match (N)	18	16	12	-	-	-	20	18	12	-	-	-
Out of range (N)	-	.	.	-	.	.	-	.	.	-	.	.
NEBRASKA (N)	189	199	139	128	64	41	216	208	140	42	-	-
All participants (%)	63.4	90.0	89.1	43.7	29.0	27.2	73.0	92.9	90.3	15.4	-	-
Excluded participants												
No match (N)	18	21	12	16	-	-	19	24	12	-	-	-
Out of range (N)	-	-	-	-	-	-	12	-	-	-	-	-
NEW HAMPSHIRE (N)	35	50	11	19	30	-	50	52	12	-	-	-
All participants (%)	60.3	87.7	91.7	32.8	52.6	-	87.7	91.2	100.0	-	-	-
Excluded participants												
No match (N)	-	-	-	-	.	.	-	-	-	-	.	-
Out of range (N)	-	-	.	-	-	.	-	-	.	-	.	.
NEW JERSEY (N)	310	355	273	146	133	100	357	382	297	51	12	-
All participants (%)	72.4	82.8	81.3	34.1	30.8	29.8	82.6	88.4	87.6	12.6	2.9	-
Excluded participants												
No match (N)	172	196	53	95	57	21	218	212	59	53	14	-
Out of range (N)	31	20	15	23	-	-	41	20	16	-	-	-

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
NEW MEXICO (N)	.	.	.	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.	.	.	.
Excluded participants												
No match (N)	.	.	.	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.	.	.	.
NEVADA (N)	36	52	-	47	28	-	52	62	-	20	-	-
All participants (%)	43.9	78.8	-	58.0	42.4	-	65.0	92.5	-	25.6	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	.	-	-	.	-	-	.	-	-	.
NEW YORK (N)	533	849	466	458	360	210	658	909	514	122	29	14
All participants (%)	55.6	83.4	80.6	47.3	35.3	36.4	68.7	89.4	88.5	17.4	3.6	3.1
Excluded participants												
No match (N)	18	18	-	14	11	-	20	20	-	-	-	-
Out of range (N)	150	-	30	158	-	15	205	-	33	51	-	-
OHIO (N)	1,267	1,435	690	886	832	365	1,507	1,582	758	217	162	70
All participants (%)	68.3	77.2	77.6	47.3	44.4	40.8	80.8	85.0	85.5	15.4	13.6	11.4
Excluded participants												
No match (N)	-	-	-	-	-	-	-	-	-	-	-	.
Out of range (N)	15	-	-	-	-	-	14	-	-	-	-	-

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
OKLAHOMA (N)	181	209	82	63	55	26	196	216	82	-	-	-
All participants (%)	80.4	92.5	93.2	28.3	24.4	29.5	87.1	95.2	93.2	-	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	41	48	-	32	19	-	50	49	14	12	-	-
OREGON (N)	129	135	58	136	51	21	156	158	61	72	11	-
All participants (%)	51.6	84.4	85.3	54.0	31.5	30.4	62.2	96.9	88.4	29.0	6.7	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	-	.	-	-	.	-	-	.	-	-	-	-
PENNSYLVANIA (N)	97	124	36	66	50	22	106	137	36	17	-	-
All participants (%)	63.4	81.0	56.3	44.0	32.5	55.0	70.2	87.8	52.9	13.6	-	-
Excluded participants												
No match (N)	13	17	-	12	-	-	19	19	-	-	-	-
Out of range (N)	99	66	30	90	72	27	107	64	27	16	-	-
RHODE ISLAND (N)	47	53	17	28	26	13	54	58	21	-	-	-
All participants (%)	73.4	80.3	81.0	43.1	39.4	59.1	83.1	90.6	95.5	-	-	-
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	.	-	-	.	-	-	.	-	-	.

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
SOUTH CAROLINA (N)	16	21	13	13	13	-	20	26	16	-	-	-
All participants (%)	57.1	77.8	81.3	46.4	44.8	-	71.4	92.9	94.1	-	-	-
Excluded participants												
No match (N)	-	-	-	-	-	-	-	-	-	-	-	-
Out of range (N)	-	.	.	-	.	.	-	.	.	-	.	.
SOUTH DAKOTA (N)	.	.	.	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.	.	.	.
Excluded participants												
No match (N)	.	.	.	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.	.	.	.
TENNESSEE (N)	570	677	412	421	376	208	665	782	462	196	47	39
All participants (%)	65.0	77.8	79.4	48.0	43.0	40.2	75.9	89.3	89.0	22.8	5.8	8.6
Excluded participants												
No match (N)	22	24	-	15	12	-	23	25	-	-	-	-
Out of range (N)	-	-	-	-	-	-	-	-	-	-	-	-
TEXAS (N)	677	836	321	401	361	118	775	900	335	126	71	16
All participants (%)	67.4	82.4	86.3	39.8	35.4	31.6	77.0	88.2	90.1	14.7	8.4	5.0
Excluded participants												
No match (N)	135	176	20	99	73	-	164	191	22	22	-	-
Out of range (N)	45	30	-	21	21	-	45	33	11	-	-	-

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
VIRGINIA (N)	101	163	85	57	33	19	121	169	87	22	-	-
All participants (%)	55.2	92.6	93.4	31.3	18.9	20.9	65.4	96.0	95.6	12.2	-	-
Excluded participants												
No match (N)	18	23	-	-	-	-	21	23	-	-	-	-
Out of range (N)	27	38	-	11	11	-	28	38	-	-	-	-
VERMONT (N)	31	53	23	55	28	11	41	63	28	30	-	-
All participants (%)	39.2	70.7	71.9	70.5	37.3	34.4	52.6	84.0	90.3	39.5	-	-
Excluded participants												
No match (N)	.	.	.	.	.	.	.	.	.	.	.	.
Out of range (N)	-	-	.	-	-	.	-	-	.	-	-	.
WASHINGTON (N)	1,524	1,606	991	1,340	1,059	613	2,056	2,017	1,239	626	278	137
All participants (%)	56.3	61.8	63.2	49.4	40.7	39.1	75.8	77.8	79.0	24.0	11.7	9.5
Excluded participants												
No match (N)	67	65	27	74	47	17	95	82	36	34	19	-
Out of range (N)	93	70	42	80	44	20	114	86	48	41	15	-
WISCONSIN(N)	226	327	111	139	156	57	272	370	130	55	20	13
All participants (%)	62.8	78.4	74.5	38.6	37.7	39.0	76.6	89.2	88.4	16.9	5.2	9.6
Excluded participants												
No match (N)	-	-	.	-	-	.	-	-	.	-	-	.
Out of range (N)	26	-	-	16	-	-	28	12	-	-	-	-

TABLE B.1 (continued)

	Overall life satisfaction			Mood status			Satisfaction with care			Any unmet need for personal care		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
WEST VIRGINIA (N)	.	.	.	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.	.	.	.
Excluded participants												
No match (N)	17	17	.	16	12	.	22	23	.	-	-	.
Out of range (N)	.	.	.	.	.	.	.	.	.	.	.	.

Source: MFP Quality-of-Life surveys submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: ‘-’ indicates that a cell is suppressed because the count is less than 11. The tables present only the overall rates, by state, because the small population sizes in many states creates a privacy concern.

‘.’ indicates that the value is missing.

The N’s shown reflect the number of participants who answered each survey question, by state. The “All participants (%)” show the percentage of participants who answered “Yes” to each question, by state, described in more detail in the footnotes for each question.

In the “Excluded participants” rows, the “No match” counts represent the number of records in each state that were excluded because the QoL survey could not be matched to administrative data due to an issue with the Medicaid ID. The “Out of range” counts represent the number of records in each state that were excluded because the QoL survey was completed outside of the designated timeframe (year-one surveys must be conducted within 6–18 months of transition to the community; year two surveys must be conducted within 18–30 months of transition to the community).

^a The percent of participants who responded “very happy” or “a little happy” to the question: “Taking everything into consideration, during the past week, have you been happy or unhappy with the way you live your life?”

^b The percent of participants who reported feeling sad or blue in the past week.

^c The percent of participants who responded “very happy” or “a little happy” to the question: “Taking everything into consideration, during the past week have you been happy or unhappy with the help you get with things around the house or getting around your community?”

^d The percent of participants who have any unmet care need in the areas of bathing, eating, medication, and toileting.

TABLE B.1 (continued)

Pre = surveys conducted pre-transition; 1 Yr Post = surveys conducted one year post-transition; 2 Yr Post = surveys conducted two years post-transition; PD = Physical disabilities; ID = intellectual disabilities MI = serious mental illness.

Table B.2. Quality-of-Life survey outcomes by time period, target population, and state (part 2)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
ALL STATES (N)	11,452	12,706	6,811	8,732	14,471	7,740	8,025	5,402	2,603
Older Adults (%)	74.9	88.1	86.7	64.8	90.9	89.9	45.9	34.3	30.9
People with PD (%)	68.7	87.6	89.0	56.3	90.2	88.9	56.2	37.9	34.7
People with ID (%)	80.1	89.0	90.7	75.6	93.5	92.2	45.2	22.6	21.9
People with MI (%)	75.5	83.3	84.9	66.3	77.0	78.1	58.4	47.1	38.8
Other (%)	74.4	91.4	88.3	59.5	93.6	90.7	62.3	33.7	27.3
Unknown (%)	71.2	90.1	88.5	58.1	92.5	91.3	47.4	33.8	27.8
Excluded participants									
No match (N)	1,030	1,059	263	793	1,152	265	716	448	73
Out of range (N)	1,130	442	251	922	673	321	1,007	214	89
ALABAMA (N)	-	-	-	.	-	-	-	-	-
All participants (%)	-	-	-	.	-	-	-	-	-
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	-	.	-	-	-	-	-
ARKANSAS (N)	11	14	-	12	17	-	-	-	-
All participants (%)	61.1	77.8	-	66.7	94.4	-	-	-	-
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
Out of range (N)	-	-	.	-	-	.	-	-	.
CALIFORNIA (N)	516	623	223	375	686	247	374	212	76
All participants (%)	67.0	81.9	83.5	54.3	91.2	93.2	52.7	28.6	29.3
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	38	-	-	26	14	-	44	-	-
COLORADO (N)	16	23	12	-	24	11	17	11	-
All participants (%)	61.5	95.8	100.0	-	96.0	100.0	65.4	44.0	-
Excluded participants									
No match (N)	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.
CONNECTICUT (N)	1,585	1,701	1,213	765	2,005	1,377	1,317	945	629
All participants (%)	72.1	91.2	90.3	43.7	89.6	86.9	59.1	41.9	38.5
Excluded participants									
No match (N)	-	-	-	-	-	-	-	-	-
Out of range (N)	21	24	21	12	29	25	17	16	-
DISTRICT OF COLUMBIA (N)	69	80	66	55	89	67	37	25	11
All participants (%)	86.3	89.9	90.4	67.9	94.7	90.5	50.7	32.1	21.2
Excluded participants									

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	-	-	-	-	-	-	-
DELAWARE (N)	-	17	-	20	18	-	-	-	-
All participants (%)	-	81.0	-	90.9	75.0	-	-	-	-
Excluded participants									
No match (N)	-	.	.	-	-	-	-	-	-
Out of range (N)	-	-	-	107	-	-	39	17	-
FLORIDA (N)	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.
Excluded participants									
No match (N)	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.
GEORGIA (N)	399	414	236	298	445	247	247	176	73
All participants (%)	78.1	85.7	93.7	68.3	96.7	95.0	61.1	37.1	29.0
Excluded participants									
No match (N)	13	14	-	-	-	-	14	-	-
Out of range (N)	61	14	-	28	12	-	44	-	-
HAWAII (N)	108	132	56	92	133	57	60	45	21
All participants (%)	76.6	91.7	96.6	70.2	93.0	95.0	50.0	36.6	36.2
Excluded participants									

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
No match (N)	-	-	-	-	-	-	-	-	-
Out of range (N)	25	-	-	15	-	-	16	-	-
IOWA (N)	189	205	122	186	246	145	111	68	60
All participants (%)	79.7	86.1	87.1	76.2	92.1	87.3	46.6	28.6	37.7
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	17	16	13	20	21	15	16	-	-
IDAHO (N)	51	72	20	37	72	21	48	38	11
All participants (%)	60.7	88.9	100.0	55.2	91.1	95.5	63.2	50.0	52.4
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	-	.	.	-	.	.	14	.	.
ILLINOIS (N)	273	347	268	217	590	435	375	123	38
All participants (%)	64.5	90.8	95.0	46.3	94.7	97.5	61.6	18.5	8.2
Excluded participants									
No match (N)	33	54	16	27	90	18	59	36	-
Out of range (N)	-	-	-	-	12	-	-	-	-
INDIANA (N)	43	40	-	38	40	-	15	13	-
All participants (%)	93.5	90.9	-	86.4	97.6	-	29.4	31.7	-
Excluded participants									

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
No match (N)	-	-	-	-	-	-	-	-	-
Out of range (N)	-	-	-	-	-	-	-	-	-
KANSAS (N)	87	109	11	51	103	-	59	44	-
All participants (%)	73.7	91.6	100.0	54.3	92.0	-	50.9	37.6	-
Excluded participants									
No match (N)	62	67	32	51	76	32	33	19	-
Out of range (N)	-	-	.	-	-	.	-	-	.
KENTUCKY (N)	143	236	114	103	256	123	150	38	25
All participants (%)	56.5	96.3	96.6	51.8	97.0	93.9	66.7	16.0	21.6
Excluded participants									
No match (N)	22	17	-	14	17	-	22	-	-
Out of range (N)	156	31	50	88	31	48	156	-	-
LOUISIANA (N)	-	-	-	-	11	-	-	-	-
All participants (%)	-	-	-	-	100.0	-	-	-	-
Excluded participants									
No match (N)	60	64	19	45	60	17	16	18	-
Out of range (N)	-	-	-	-	-	-	-	-	-
MASSACHUSETTS (N)	207	263	63	142	259	62	161	89	21
All participants (%)	75.3	93.9	88.7	59.4	94.5	92.5	58.3	31.9	28.8

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
Excluded participants									
No match (N)	-	11	-	-	11	-	-	-	-
Out of range (N)	.	.	.	.	.	.	.	.	.
MARYLAND (N)	116	167	30	128	187	32	82	63	13
All participants (%)	75.8	92.8	96.8	66.3	97.4	97.0	42.7	33.3	39.4
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	.	-	-	.	-	-	.
MAINE (N)	18	21	-	-	17	-	18	15	-
All participants (%)	69.2	77.8	-	-	77.3	-	64.3	55.6	-
Excluded participants									
No match (N)	.	.	.	.	.	.	.	.	.
Out of range (N)	-	-	.	-	-	.	-	-	.
MICHIGAN (N)	320	185	20	281	178	16	213	122	11
All participants (%)	75.3	86.9	83.3	74.3	67.4	50.0	54.3	51.0	44.0
Excluded participants									
No match (N)	191	185	14	154	196	14	126	114	-
Out of range (N)	152	57	-	94	65	-	110	37	-
MINNESOTA (N)	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
Excluded participants									
No match (N)	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.
MISSOURI (N)	446	501	324	357	584	375	335	224	124
All participants (%)	72.8	88.7	86.6	63.6	92.7	90.8	56.6	36.8	31.7
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	36	-	-	28	11	-	30	-	-
MISSISSIPPI (N)	217	231	164	162	246	156	192	86	42
All participants (%)	82.2	93.9	91.6	65.6	93.9	92.3	70.8	32.8	23.5
Excluded participants									
No match (N)	-	-	.	-	-	-	-	-	-
Out of range (N)	-	.	.	-	.	.	-	.	.
MONTANA (N)	-	-	-	-	-	-	-	-	-
All participants (%)	-	-	-	-	-	-	-	-	-
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	.	.	.	.	.	.	.	.	.

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
NORTH CAROLINA (N)	69	90	27	55	95	30	48	50	14
All participants (%)	74.2	90.0	87.1	64.7	94.1	88.2	55.8	51.5	42.4
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	.	-	-	-	-	-	-
NORTH DAKOTA (N)	68	65	50	56	81	64	40	25	15
All participants (%)	87.2	95.6	96.2	70.9	90.0	97.0	46.0	29.8	23.4
Excluded participants									
No match (N)	17	15	12	16	19	12	-	-	-
Out of range (N)	-	.	.	-	.	.	-	-	.
NEBRASKA (N)	170	183	134	109	196	130	110	27	16
All participants (%)	60.5	87.1	88.2	51.7	93.8	90.9	50.5	14.7	12.9
Excluded participants									
No match (N)	21	20	11	12	23	11	-	-	-
Out of range (N)	-	-	-	-	-	-	-	-	-
NEW HAMPSHIRE (N)	46	54	12	31	52	11	22	17	-
All participants (%)	90.2	98.2	100.0	75.6	100.0	100.0	39.3	30.4	-
Excluded participants									
No match (N)	-	-	-	-	-	-	-	-	-

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
Out of range (N)	-	-	.	-	-	.	-	-	.
NEW JERSEY (N)	330	401	311	243	387	291	213	127	97
All participants (%)	78.9	94.8	94.2	64.8	93.5	90.9	57.1	32.2	32.7
Excluded participants									
No match (N)	213	211	62	140	208	55	158	68	21
Out of range (N)	39	21	14	33	20	15	29	-	-
NEW MEXICO (N)	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.
Excluded participants									
No match (N)	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.
NEVADA (N)	50	58	-	31	54	-	42	26	-
All participants (%)	64.9	89.2	-	47.0	85.7	-	55.3	42.6	-
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	.	-	-	.	-	-	.
NEW YORK (N)	582	765	456	303	857	489	579	330	184
All participants (%)	71.8	87.9	89.6	42.0	91.9	90.6	64.7	34.3	33.6
Excluded participants									
No match (N)	17	20	-	12	20	-	15	-	-

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
Out of range (N)	186	-	31	92	-	27	205	-	15
OHIO (N)	1,230	1,138	586	1,068	1,561	736	838	674	317
All participants (%)	74.2	89.8	89.3	69.2	88.5	88.1	48.3	37.2	36.6
Excluded participants									
No match (N)	-	-	-	-	-	-	-	-	-
Out of range (N)	15	-	-	-	-	-	12	-	-
OKLAHOMA (N)	179	207	75	145	215	78	103	47	29
All participants (%)	88.2	96.7	89.3	74.0	96.0	91.8	54.5	23.5	33.7
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	43	46	13	40	52	13	50	20	-
OREGON (N)	154	142	63	98	150	66	127	59	18
All participants (%)	62.1	87.1	91.3	50.5	98.0	97.1	57.7	37.8	26.9
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	-	-	-	-	-	-	-
PENNSYLVANIA (N)	102	140	24	65	131	52	69	47	-
All participants (%)	73.9	92.7	88.9	50.4	92.9	70.3	49.3	31.8	-
Excluded participants									
No match (N)	19	19	-	15	18	-	-	-	-

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
Out of range (N)	59	-	-	93	157	58	26	-	-
RHODE ISLAND (N)	50	58	22	41	53	22	28	25	-
All participants (%)	79.4	90.6	100.0	75.9	91.4	100.0	44.4	40.3	-
Excluded participants									
No match (N)	-	-	.	-	-	.	-	-	.
Out of range (N)	-	-	.	-	-	.	-	-	.
SOUTH CAROLINA (N)	25	28	16	15	24	14	22	16	11
All participants (%)	89.3	96.6	94.1	60.0	92.3	82.4	81.5	59.3	64.7
Excluded participants									
No match (N)	-	-	-	-	-	-	-	.	-
Out of range (N)	-	.	.	-	.	.	-	.	.
SOUTH DAKOTA (N)	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.
Excluded participants									
No match (N)	.	.	.	.	.	.	.	.	.
Out of range (N)	.	.	.	.	.	.	.	.	.
TENNESSEE (N)	624	747	416	463	771	455	343	291	143
All participants (%)	72.9	91.5	90.6	62.0	93.7	92.3	41.4	35.2	28.6
Excluded participants									

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
No match (N)	23	27	-	15	26	-	-	-	-
Out of range (N)	-	-	-	-	-	-	-	-	-
TEXAS (N)	680	788	300	644	895	332	444	329	90
All participants (%)	79.0	92.2	90.1	72.9	91.9	91.0	48.2	34.2	26.1
Excluded participants									
No match (N)	150	165	18	142	190	22	110	68	-
Out of range (N)	41	30	-	39	33	-	31	11	-
VIRGINIA (N)	124	94	47	77	160	85	89	36	17
All participants (%)	68.9	84.7	83.9	50.3	92.5	94.4	58.2	23.5	20.7
Excluded participants									
No match (N)	18	-	-	16	21	-	12	-	-
Out of range (N)	29	24	-	20	37	-	23	13	-
VERMONT (N)	45	54	21	30	69	24	49	36	13
All participants (%)	61.6	85.7	80.8	50.0	95.8	85.7	67.1	52.9	41.9
Excluded participants									
No match (N)	.	.	.	.	.	.	.	.	.
Out of range (N)	-	-	.	-	-	.	-	-	.
WASHINGTON (N)	1,839	1,955	1,171	1,737	2,171	1,337	881	757	408
All participants (%)	70.0	80.7	81.6	74.5	89.4	89.3	35.3	33.4	29.8
Excluded participants									

TABLE B.2 (continued)

	Respect and dignity			Satisfaction with living arrangements			Barriers to community integration		
	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post	Pre	1 Yr post	2 Yr post
No match (N)	87	80	32	67	86	41	53	33	-
Out of range (N)	96	83	51	99	86	59	62	28	19
WISCONSIN(N)	253	342	113	185	337	114	147	134	42
All participants (%)	72.5	86.1	80.1	61.3	87.8	87.0	45.1	34.0	29.4
Excluded participants									
No match (N)	-	-	.	.	-	.	-	-	.
Out of range (N)	28	-	-	25	12	-	18	-	-
WEST VIRGINIA (N)	.	.	.	.	.	.	.	.	.
All participants (%)	.	.	.	.	.	.	.	.	.
Excluded participants									
No match (N)	20	24	.	-	22	.	16	13	.
Out of range (N)	.	.	.	.	.	.	.	.	.

Source: MFP Quality-of-Life surveys submitted to Centers for Medicare & Medicaid Services through December 2016.

Note: ‘-’ indicates that a cell is suppressed because the count is less than 11. The tables present only the overall rates, by state, because the small population sizes in many states creates a privacy concern.

‘.’ indicates that the value is missing.

The N’s shown reflect the number of participants who answered each survey question, by state. The “All participants (%)” show the percentage of participants who answered “Yes” to each question, by state, described in more detail in the footnotes for each question.

In the “Excluded participants” rows, the “No match” counts represent the number of records in each state that were excluded because the QoL survey could not be matched to administrative data due to an issue with the Medicaid ID. The “Out of range” counts represent the number of records in each state that were excluded because the QoL survey was completed outside of the

TABLE B.2 (continued)

designated timeframe (year-one surveys must be conducted within 6–18 months of transition to the community; year-two surveys must be conducted within 18–30 months of transition to the community).

^a The percent of participants who reported being treated with respect and dignity by providers, measured by two questions: “You said that you have people who help you. Do the people who help you treat you the way you want them to?” and “Do the people who help you listen carefully to what you ask them to do?”

^b The percent of respondents who responded “yes” to “Do you like where you live?”

^c The percent of respondents who responded “yes” to “Is there anything you want to do outside [the facility/your home] that you cannot do now?”

Pre = surveys conducted pre-transition, 1 Yr Post = surveys conducted one year post-transition, 2 Yr Post = surveys conducted two years post-transition, PD = Physical disabilities, ID = intellectual disabilities, MI = serious mental illness.

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