

Findings from the National Evaluation of the Money Follows the Person Rebalancing Demonstration

2017 HCBS Conference

August 31, 2017

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Road Map

- **Overview of the Money Follows the Person (MFP) Rebalancing Demonstration**
- **Transition program outcomes**
- **Rebalancing program outcomes**
- **Cost implications of the MFP demonstration**
- **Quality of life of MFP participants**

Overview

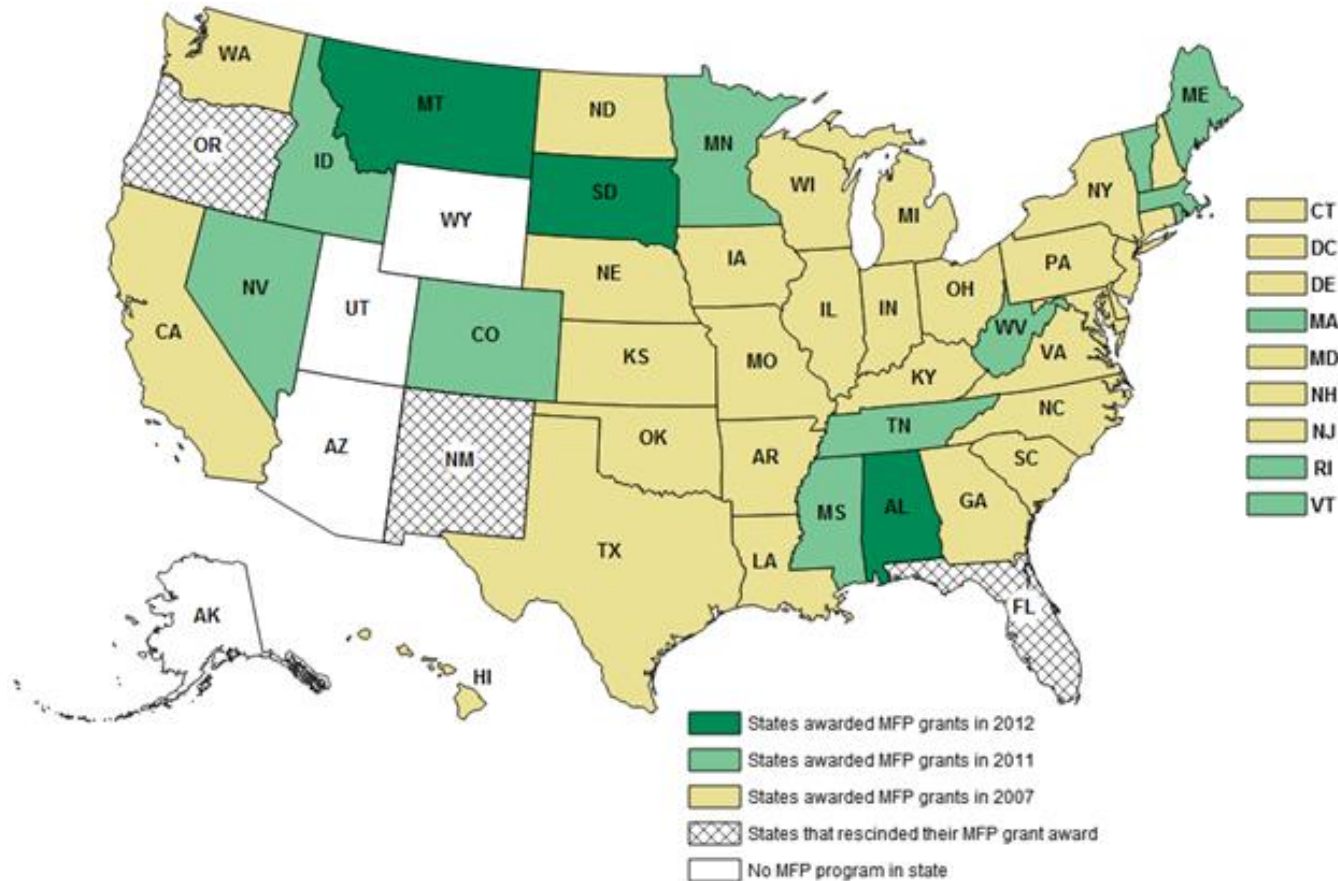
Money Follows the Person (MFP) Rebalancing Demonstration

Principal Aims

- Reduce reliance on institutional care
- Develop community-based long-term care opportunities
- Enable people with disabilities to participate fully in their communities and improve their quality of life



Most States Participate in the MFP Demonstration

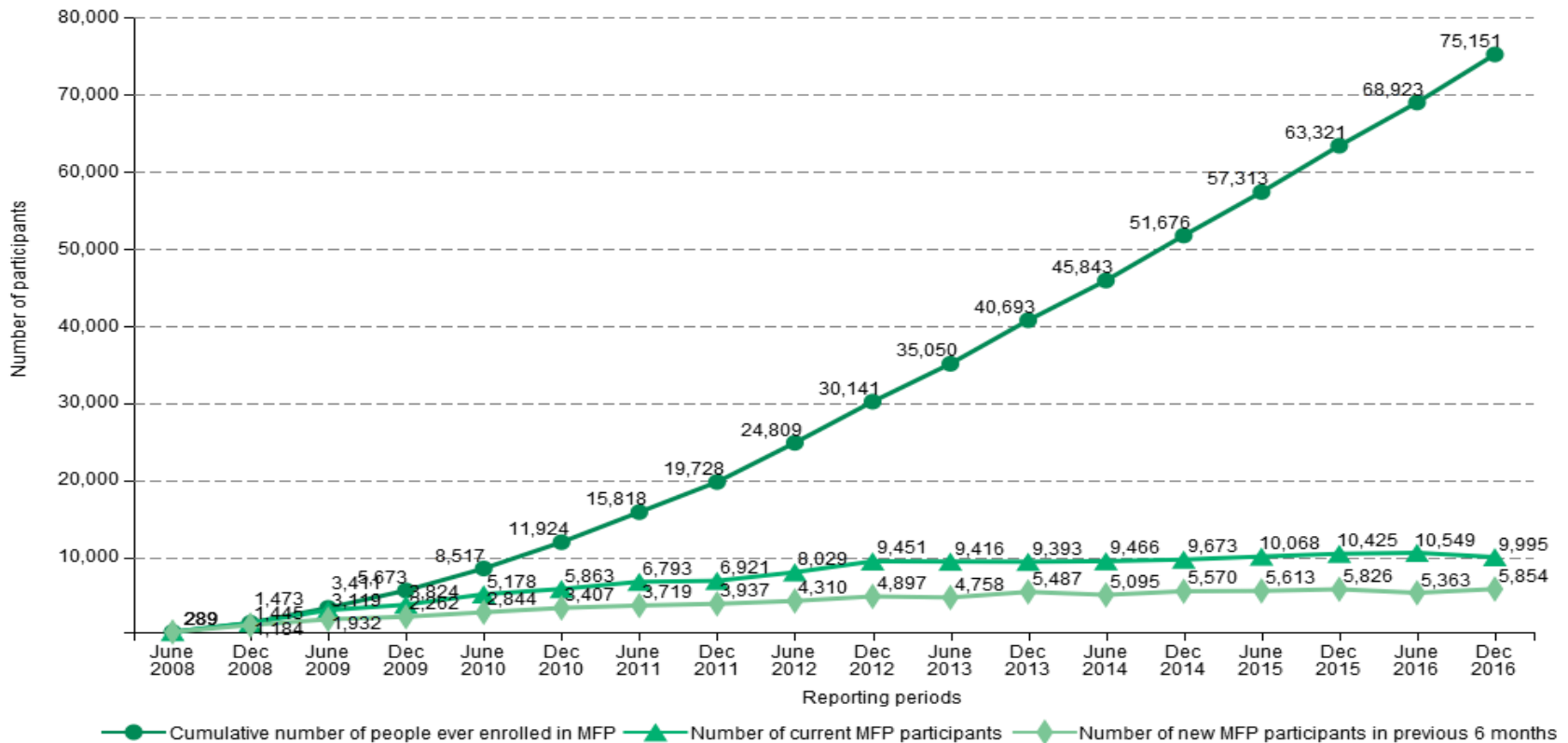


Note: New Mexico and Florida received MFP grant awards in 2011. New Mexico withdrew from the program in 2012, Florida withdrew in 2013, and Oregon withdrew in 2014.

Transition Program Outcomes

More than 75,000 Transitions by the End of 2016

Cumulative Total Number of MFP Transitions, June 2008 to December 2016



Source: Mathematica analysis of State MFP Grantee Seminannual Progress Reports, 2008-2016.

Putting the Volume of MFP Transitions in Perspective

- **Since 2010, annual MFP transitions represent about 1 percent of the people eligible for the demonstration during the year**
 - May be a conservative estimate
- **Volume of transitions reflects funding level**
 - \$4 billion \approx < 1 percent of total HCBS spending in 2007
 - **Funding spread across several years**
 - Funding allotments started in 2007 and ended in 2016 – 10 years
 - States have until 2020 to spend their allotments – 14 years
 - **Funding spread across a large number of grantees**
 - 44 states and the District of Columbia, plus Oregon

How Do MFP Participants Compare to the Eligible Population?

- MFP older adult participants are more likely to be younger, minorities, men, and Medicaid-only beneficiaries; less functionally impaired; some years more likely to have a mental health condition and other years less likely
- MFP participants with physical disabilities are very similar to the eligible population, but with fewer limitations in activities and less likely to be cognitively impaired; some years more likely to have a mental health condition and other years less likely
- MFP participants with intellectual and developmental disabilities are more likely to be younger, minorities, men, and Medicaid-only beneficiaries; more likely to live in a rural area

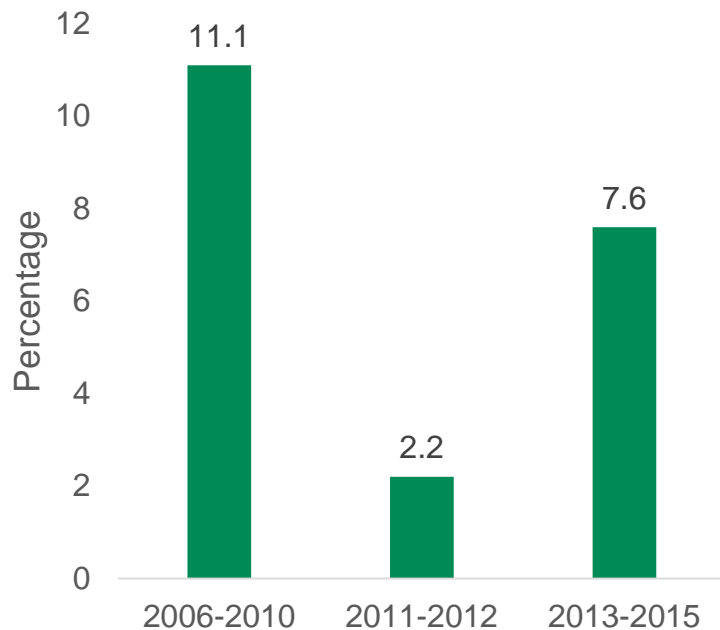
How Do MFP Participants Compare to Other Transitioners?

- **MFP participants**
 - Less likely to use hospice services near the time of transition
 - More likely to have longer institutional stays (stays of 6 months or longer)
 - Have fewer functional limitations (based on nursing home assessment data)

Rebalancing Program Outcomes

State Spending on Community-Based LTSS Continues to Grow

Percentage of LTSS Spending on Community-Based LTSS

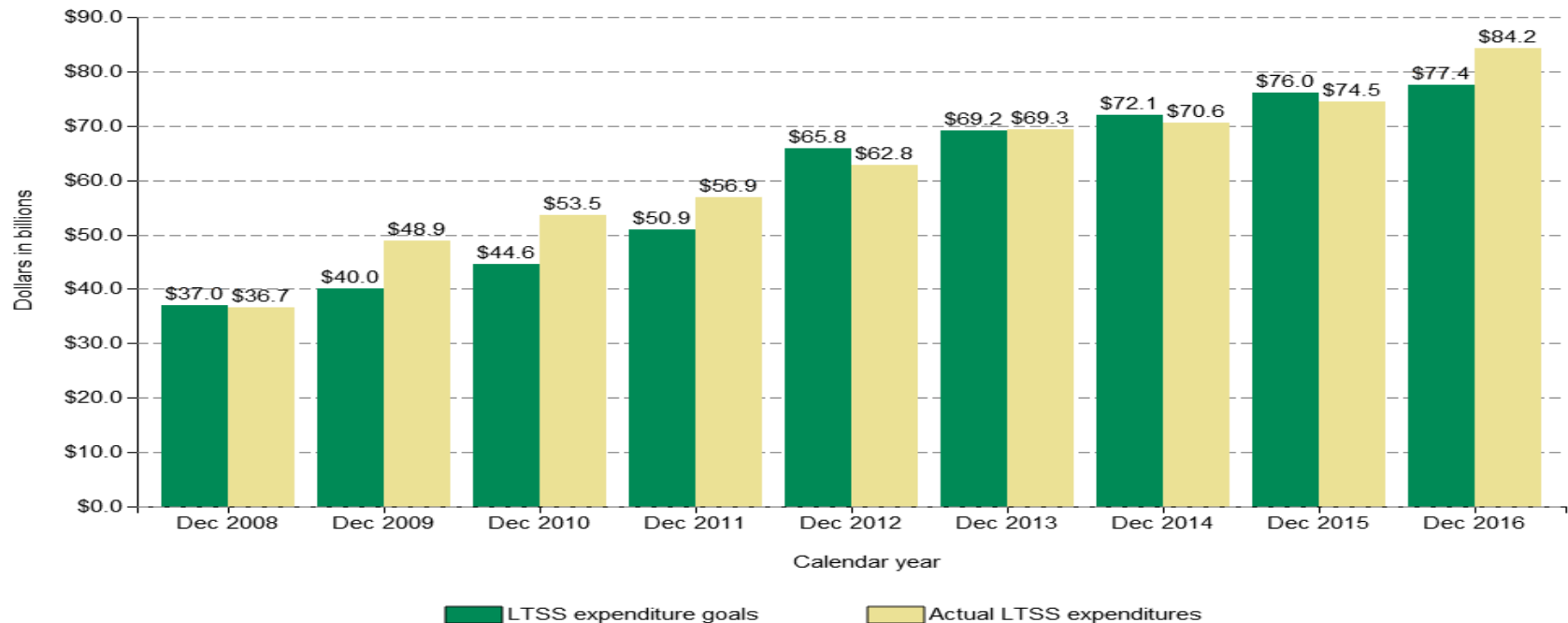


- Growth is due in part to adoption of new authorities
 - Section 1915(i)
 - Self-directed personal assistance services (Section 1915(j))
 - Community first choice (Section 1915(k))
 - Health homes (Section 1945)

Source: Eiken et al. “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in 2015.” April 2017.

Growth of LTSS Spending Also Evident Among MFP State Grantees

Projected and actual qualified community-based LTSS expenditures, December 2008 to December 2016

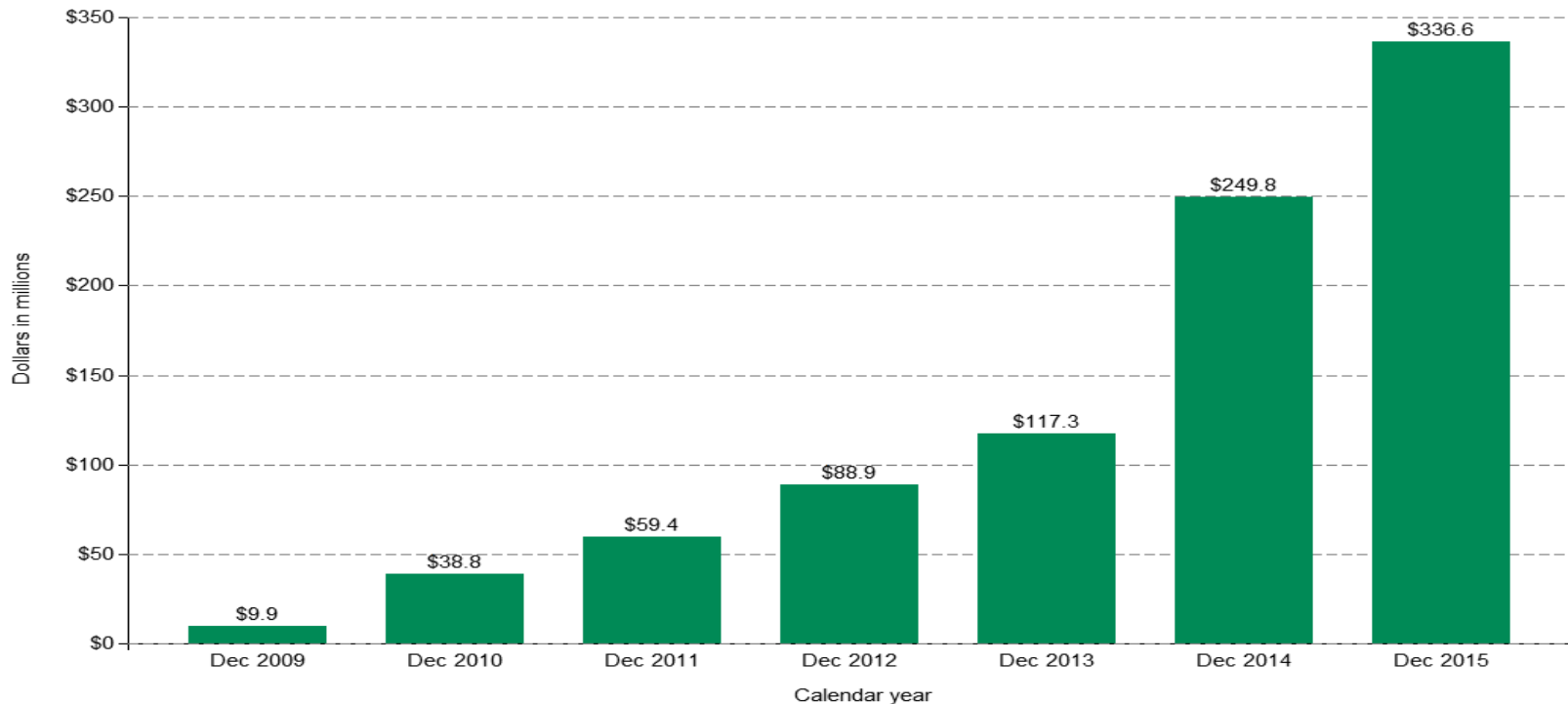


Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

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.

Nearly \$1 Billion in Reported Spending of Rebalancing Funds

Total annual expenditures of state rebalancing funds between December 2009 and December 2015

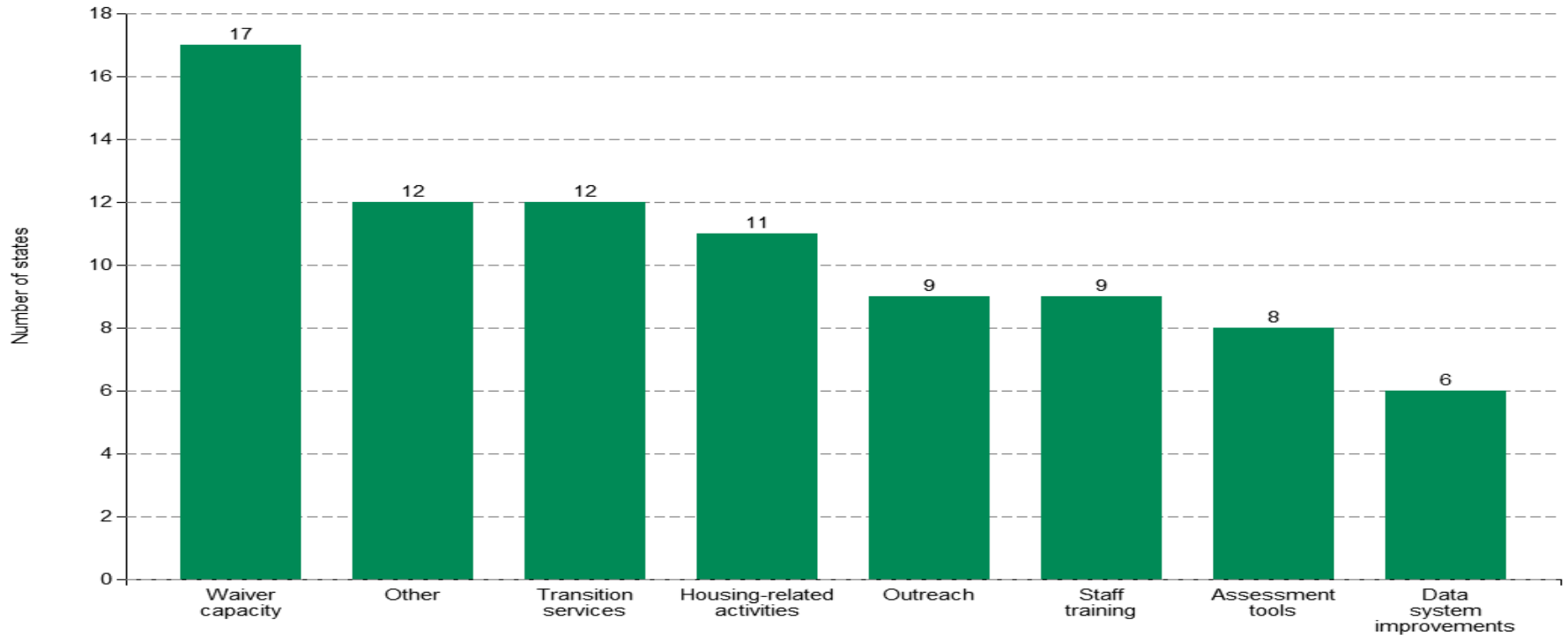


Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2016.

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.

State Approaches to Using MFP Rebalancing Funds

Types of rebalancing initiatives in 2015



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

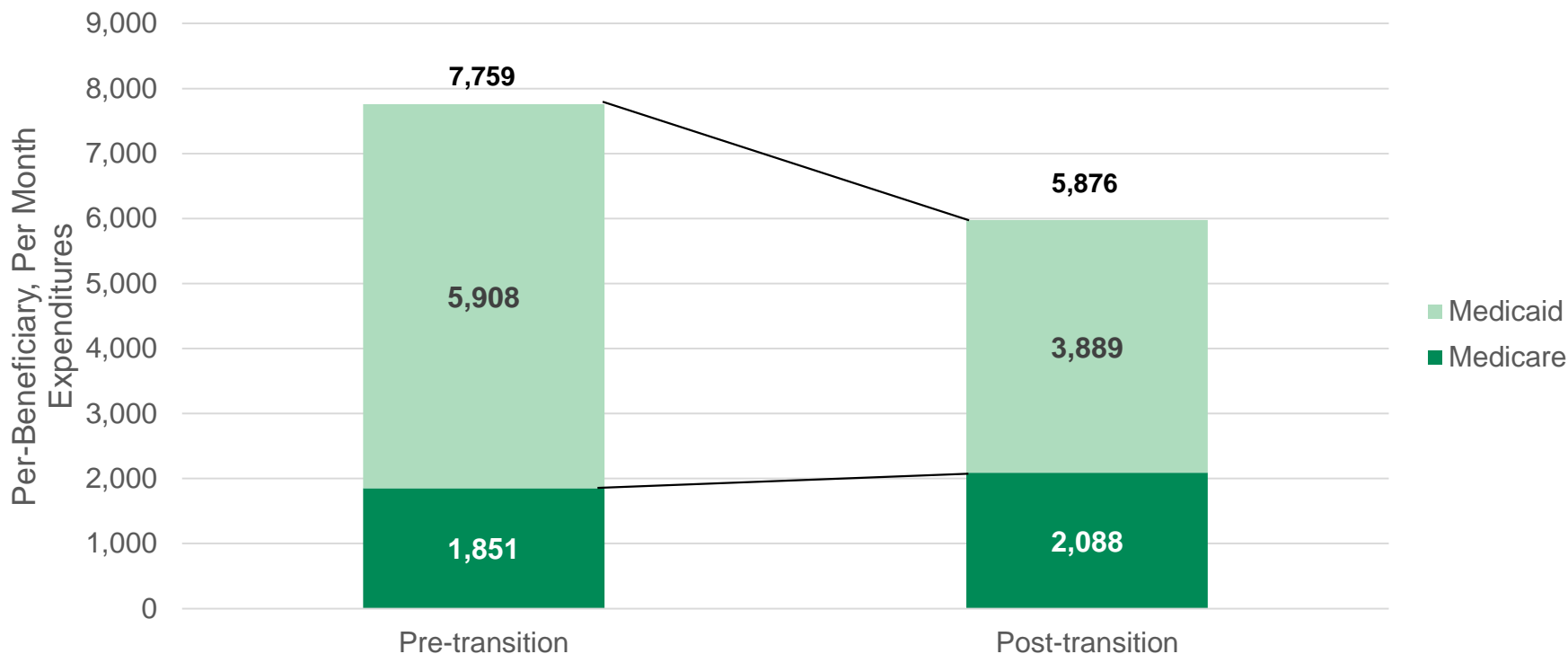
Note: States may spend rebalancing funds on multiple types of initiatives and can be counted in multiple categories.

N = 35 grantee states.

Cost Implications of the MFP Demonstration

Total Health Care Costs Decline After the Transition

Monthly Medicare and Medicaid pre- and post-transition monthly expenditures for MFP participants with physical disabilities transitioning from nursing homes



Source: Mathematica's analysis of Medicaid and Medicare claims and enrollment data for Medicaid beneficiaries who transitioned from institutional to community-based LTSS from 2008 through 2013 in 32 states.

Cost Implications of MFP

- **Total monthly health care expenditures decline after the transition to the community**
 - Decline by 23 percent among beneficiaries who transition from nursing homes
 - Decline by 30 percent among beneficiaries who transition from intermediate care facilities for individuals with intellectual and developmental disabilities
 - **Composition of LTSS expenditures changes**
 - Sharp decline in institutional care expenditures
 - Increase in community-based expenditures
 - **Among younger adults with physical or intellectual disabilities, Medicare expenditures increase slightly as some beneficiaries gain Medicare coverage during the year**

Avenues for Cost Savings

- **Does MFP help beneficiaries stay longer in the community and avoid readmissions to institutional care?**
 - MFP participants less likely to be reinstitutionalized compared to other transitioners
- **Is MFP associated with lower medical care costs?**
 - Little evidence this avenue is a mechanism for cost savings
 - **Beneficiaries who transition from institutional care to community-based LTSS use medical care at high rates and MFP programs are not designed to focus on this aspect of care**
 - Between 46 and 50 percent of former nursing home residents have an inpatient stay after transition
 - Between 52 and 55 percent of beneficiaries who transition from an intermediate care facility for individuals with intellectual disabilities visit the emergency room after transition

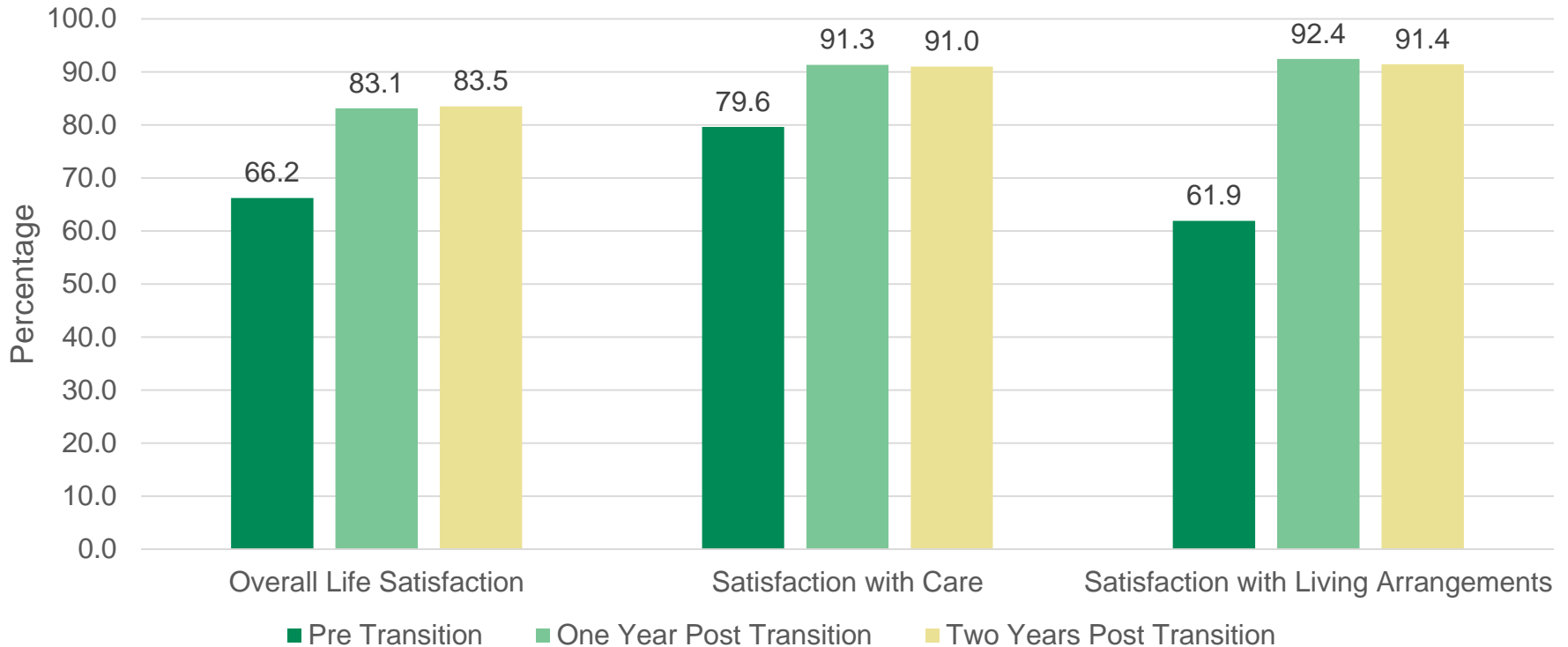
Additional Avenues for Cost Savings

- **Is MFP associated with shorter institutional stays when they occur?**
 - **Descriptive data indicate that when compared to other transitioners, MFP participants**
 - Have longer institutional stays on average before they transition
 - Were less likely to use community-based LTSS before entering institutional care

Quality of Life Outcomes

Large Improvements in Quality of Life

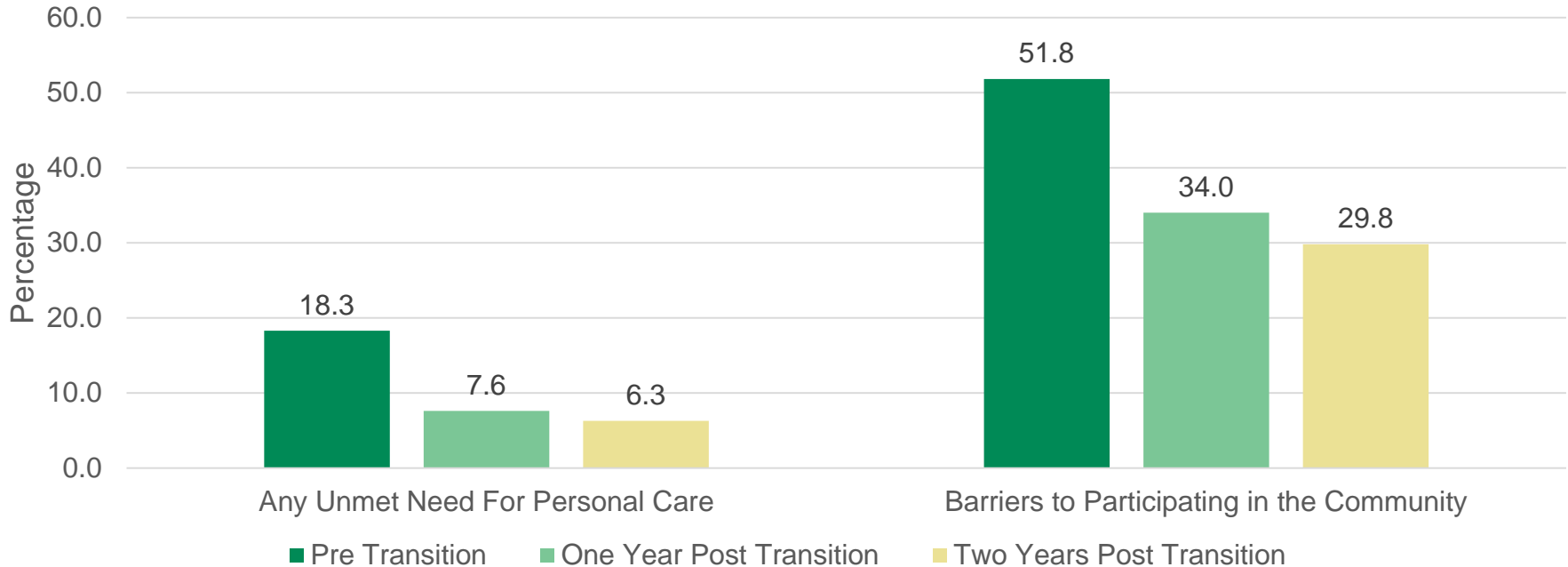
Quality of life of MFP participants pre- and post-transition



Source: Mathematica's analysis of MFP Quality-of-Life surveys and program participation data submitted to CMS through May 2016.

Large Improvements in Quality of Life

Quality of life of MFP participants pre- and post-transition



Source: Mathematica's analysis of MFP Quality-of-Life surveys and program participation data submitted to CMS through May 2016.

Note: Lower percentages indicates an improvement. Unmet care needs include bathing, eating, medication management, or toileting. Barriers to participating in the community are measured as an affirmative response to "Is there anything you want to do outside [the facility/your home] that you cannot do now?"

Summary

- The changes in the quality of life are remarkable
 - *The MFP demonstration has had positive impacts on participants' lives*
- Any dollar value placed on these improvements would not adequately reflect what it means for people with significant disabilities when they can live in and contribute to their local communities.

For More Information

– CMS MFP website

- <https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html>

– Mathematica MFP website

- <http://www.disabilitypolicyresearch.org/our-publications-and-findings/projects/research-and-evaluation-of-the-money-follows-the-person-mfp-demonstration-grants>

Maryland's Money Follows the Person Demonstration

Jennifer Y. Miles
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MFP- Office of Health Services



Money Follows the Person Overview

- Federal demonstration, offered through the Centers for Medicare and Medicaid Services (CMS) and designed to:
 - Assist states in rebalancing long-term services and supports (LTSS) systems
 - Increase the use of Home and Community Based Services (HCBS)
 - Remove barriers to receiving services in the community
- Maryland will continue transitions through December 31, 2018

MFP Overview

- To access MFP funds, states must transition “qualified individuals” receiving Medicaid services from “qualified institutions” to “qualified residences”
- MFP Eligibility-qualified individual
 - 90 days in institution (excluding Medicare rehab stays)
 - 1 day of Medicaid eligibility in the institution
 - Signed consent form
- The State receives enhanced federal matching funds for HCBS provided to demonstration participants for 365 days
- Enhanced matching funds result in “savings” to the State, which is then required to spend savings on approved rebalancing initiatives
- Savings can not:
 - Pay for services
 - Off-set ongoing state costs

Existing Waivers

Maryland currently serves MFP participants using three home and community-based waiver programs and the Increased Community Services Program.

- The Home and Community-based Options (CO) Waiver
 - Serves adults with physical disabilities 18 and older
- The Brain Injury (BI) waiver
 - Serves adults with brain injuries that are transitioning from chronic hospitals and State-owned nursing facilities
- The Community Pathways (CP) waiver
 - Serves adults with intellectual and developmental disabilities
- Increased Community Services (ICS)
 - Nursing facility residents 18 and older that have been denied CO Waiver SOLELY due to over scale income

Maryland Transition Numbers

- **2,844** transitions since program approval in 2008
 - Older Adults- 1,299
 - Adults with Physical Disabilities- 1,161
 - 2,460 NF transitions
 - Adults with Developmental Disabilities- 303
 - More than half of the transitions originate from State Residential Centers
 - Adults with Traumatic Brain Injury- 81
 - Transitions from chronic hospitals or state owned and operated NFs

Numbers from MMIS as of 8/25/17

Approved Rebalancing Initiatives 2013-2020

- *Housing activities*
- *Bridge subsidies*
- *Development of the In-home Supports Assurance System (ISAS)*
- *interRAI training and implementation costs*
- *Nursing facility options counseling*
- *Peer outreach and on-going support*
- *Tracking system development*
- *ADRC (MAP) expansion grants*
- *Toll free number for MAP*
- *MAP Website*
- *Provider Registry*
- *Training*
- *Self-Advocacy*

Collaborations and Partnerships

- Maryland Department of Disabilities (MDOD)
- Centers for Independent Living (CILs)
- Maryland Department of Aging (MDoA) & Local Area Agencies on Aging (AAAs)
- Local Health Departments (LHDs)
- FEI
- Maryland Department of Housing and Community Development (DHCD)
- Supports Planning Agencies (SPAs)
- Public Housing Authorities (PHA)
- Schaefer Center of Public Policy- University of Baltimore

Reasons for Collaborations and Partnerships

- Increase outreach to institutional residents
 - Peer Outreach and Supports
 - Options Counseling
- Improve Systems
 - Maryland Access Point (MAP)
 - Uniform Standardized Assessment (InterRai Home Assessment)
 - Integrated web-based tracking system (LTSS System)
- Maryland's Housing Initiatives
 - Section 811 Project Rental Assistance (PRA)
 - Weinberg Units
 - MFP Bridge Subsidy
- Quality of Life Survey
 - Continuation through the Community Options Waiver

Maryland Access Point

- Maryland's name for ADRCs is Maryland Access Point or MAP
 - Single points of entry into the LTSS system for older adults and people with disabilities
 - Coordinate existing aging and disability service systems
 - Provide information, counseling, and assistance
 - Empower people to make informed decisions about their long term supports
 - Designed to ease access to public and private LTSS resources



Toll-free
1-844-MAP-LINK
(1-844-627-5465)
TTY #711

Peer Outreach & Supports

Peers are responsible for:

- One-on-one peer support for nursing facility residents to help with understanding and navigating the complex process of exploring and engaging in the transition from nursing facilities to community based living
- Referring interested individuals to options counseling and, at the request of the individual, maintaining relationships throughout the application process for Home and Community-Based Services
- On-going peer supports can continue until the person transitions (MFP participants are eligible for peer mentoring at that point) or until the person no longer is pursuing transition to the community

NF Options Counseling

- Referrals for options counseling may come from:
 - Peers
 - Minimum Data Set (MDS) 3.0 Section Q
 - Ombudsmen
 - Nursing facility social workers, other NF staff
 - Family members or self-referrals
- MDS 3.0 Section Q:
 - Questions Q500 and Q600 relate to referral
 - If the person answers yes, a referral must be sent to the local contact agency (LCA)
 - MFP is the LCA for Maryland, the AAAs and CILs provide the options counseling
- Options counseling is an in person educational meeting to inform the person (and any family or other reps-at the individual's request) of available community programs
- The 19 local Area Agencies on Aging (AAAs) and the local Centers for Independent Living (CILs) provide options counseling to nursing facility residents that indicate an interest in community living
- If the person has Long Term Care Medical Assistance (LTC MA), options counseling can also include waiver application assistance

InterRai & Integrated Web based System

InterRai Home Care Assessment:

- The interRAI is administered by the Local Health Department (LHD) of the jurisdiction where the applicant/participant lives
- The InterRai helps determine medical eligibility for waiver services

Integrated Web based system (LTSS):

- Developed in collaboration with FEI
- Used to track applications, level of care, waiver enrollment, options counseling, reportable events, deaths, etc.

~~Maryland Partnership for Affordable Housing:~~ Housing Initiatives

- Administered through partnership between Department of Health (MDH), Department of Housing and Community Development (DHCD), and Maryland Department of Disabilities (MDOD)
 - HUD Section 811 Project Rental Assistance Demonstration (811 PRA)
 - Harry and Jeannette Weinberg Foundation's Affordable Housing Opportunities Initiative for People with Disabilities (Weinberg)
 - Money Follows the Person Bridge Subsidy Program



Quality of Life Survey

MFP participants received the Quality of Life survey through the Schaefer Center of Public Policy:

- Prior to Transition, 1 year after transition, and 2 years after transitioning to the community
- CMS no longer requires the administration of the Quality of Life survey

Due to the importance of the Quality of Life survey, the Community Options Waiver will continue to administer the survey through the Schaefer Center

In addition to the MFP Quality of Life Survey questions, the CO waiver administration has added 6 additional questions to the survey for CO waiver participants

Successes & Challenges

What Have We Learned	Challenges
1. Housing is still the number one barrier to transitioning to the community	1. The lack of affordable, accessible and safe housing
2. On going outreach is necessary	2. Turnover amongst Nursing facility social workers/staff, Supports Planners, State Agency Employees (keeping everyone up to date)
3. Collaborations/Partnerships are important	3. State Budget Silos
4. On going training/technical assistance is necessary; bi monthly calls and meetings are needed	
5. An individuals quality of life matters	
6. Keeping an open mind and communicate	

Questions?

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**Department
of Health**

Office of
Health Insurance
Programs



Money Follows the Person in New York State

Where we have Been  Where we are Going

2017 HCBS Conference
August 31, 2017
Andrea Juris, LCSW
MFP Project Director

What is MFP in New York State?

A Small Group of Dedicated Staff

A Large Network of Partnerships

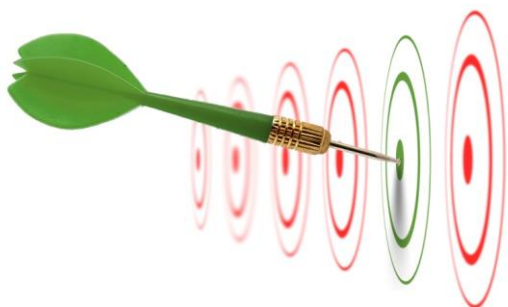
A Mission

Increase HCBS Services = Improve Quality Of Life

Decrease Institutional Services = Decrease Costs

What is MFP in New York State?

- Federal Demonstration
 - Deficit Reduction Act of 2005 and Affordable Care Act
 - First MFP transitions in New York State in 2008
 - Approved Sustainability Plan
- Rebalancing Initiative
 - Rebalance the long term care system from institutional services to home and community based services (HCBS)
 - Earn enhanced federal match and deploy funds on rebalancing activities
- Transition Assistance through ***Open Doors***
 - Transition participants from Long Term Care facilities to the community
 - Provide peer support for participants to support these transitions



What Have We Learned?

- Collaboration and Partnerships
 - Managed Long Term Care
 - Assistive Technology and the NYS Justice Center (TRAID)
 - Division of Veteran's Affairs
 - Office for People with Developmental Disabilities
 - Office of Community Transitions (PASRR)
- **Open Doors** and Enhanced Identification and Outreach thru the ILC Network
- Revised Quality of Life Survey
- Provider Education
 - Public Health Live on MFP aired February 16th, 2017
- Data
 - Section Q+
- Rebalancing Initiatives

Exceeded benchmark set for 2016 community transitions by 25%

What is Open Doors?



- **Open Doors** is:
 - Funded by MFP to provide assistance to participants to transition from Long Term Care facilities to the community, and peer support for participants to support these transitions
- **Transition Center Project:** Identify potential participants in nursing facilities and intermediate care facilities and facilitate successful transitions to one's community of choice
- **Peer Outreach and Referral Program:** Provide one-on-one peer support to individuals and families interested in transitioning to community living

Independent Living Center Network

Contract with the New York Association for Independent Living for:

- Transition Centers
 - 9 Regional Lead Independent Living Centers and 15 Auxiliaries
 - Regional Transition Coordinator/Liaison in the 9 Regions
 - Over 60 Transition Specialists statewide
- Peer Outreach and Referral
 - Available at ILCs across the State
 - Approximate the characteristics of the MFP participants (age, physical and/or developmental disability, veteran status)
 - When possible, have moved from an institution into the community

Transition Specialist Role

- Meet with participants in the facility
 - Also meet with family/guardian
- Provide objective information about services available in the community
- Help link individuals to the programs that will best meet their need
- Resolve individual barriers to transition
- Community Preparedness Education for day one in the community
 - budgeting/bill paying; medication/self administration; meal preparation; feeding self; shopping; bathroom use; dressing self
- Referral to peers who will share experiences of living with a disability in the community with participants

MFP and Managed Long Term Care: a Natural Partnership

- Managed Long Term Care (MLTC) members added to MFP as a constituent population (retroactive to 7/1/15)
- *MFP and MLTC: a Natural Collaboration*
 - Care managers may have members who express a desire to return to the community; Transition specialists can assist with the discharge process
 - Transition Specialists can provide the bridge from the facility to the community; MLTC plans can provide the services needed for people to return to the community
- *MLTC and MFP: a Value-Added Alliance*
 - MFP Expedites transition to HCBS for cost savings to MLTC plans
 - MLTC increases access to more robust HCBS services for MFP participants

A natural, mutually-beneficial relationship

Technology Related Assistance for Persons with Disabilities (TRAID)

- Memorandum of Understanding (MOU) with the NYS Justice Center
- 12 Regional TRAID Centers across NYS
- TRAID Centers purchase devices to provide:
 - ✓ Device demonstrations
 - ✓ Device loans
- TRAID Centers also provide:
 - ✓ Outreach to persons in institutions and Area Agencies on Aging (AoA)
 - ✓ Quarterly reporting on outcomes

MFP and NYS Division of Veterans' Affairs (DVA)

- Collaboration initiated in 2016
- Cross-training:
 - MFP trained Veterans Benefits Advisors
 - DVA trained Transition Specialists
- Cross-Referrals
 - Added identification of Veteran status to *Open Doors* intake process
 - DVA hired statewide Benefits Advisors specifically for Veterans in nursing homes.
- Peer Services – successful methodology for delivering Veterans services
 - Peer program recruits Veteran peers
 - Peer-matching on Veteran status
 - Veterans Outreach Video recorded by Veteran peer
- Presentations and Outreach
 - DVA presenting at bi-annual NYAIL conference and *Open Doors* training day.
 - *Open Doors* presented at successful DVA community events in July of 2016 and 2017.

The Revised Quality of Life Survey

- Initially developed by Mathematica Policy Research to evaluate effectiveness of MFP – shows people have a better quality of life in community vs. facility
- NYS MFP elected to modify and continue administration of the survey by the Transition Specialists
 - obtained input from transition specialists
 - shortened and simplified
 - clarified wording
 - maintained/improved validity and reliability of results
- Semi-annual and annual reporting of results to inform stakeholders

Provider Education Public Health Live on MFP

“**PUBLIC HEALTH LIVE** is a monthly webcast series designed to provide continuing education opportunities on public health issues. Broadcasts are free and available to all who are interested in furthering their knowledge of public health.” Public Health Live also provides free CMEs for physicians and nurse practitioners and CEUs for nurses, social workers, and health educators.

Thursday, February 16th, 2017

9-10am

The *Money Follows the Person* Program:
Facilitating Return to Community-based Settings

(<http://www.albany.edu/sph/cphce/phl.shtml>)

Provider Education and Section Q

Money Follows the Person (MFP)

- MFP funds the New York Association for Independent Living (NYAIL) “Open Doors” program.

Open Doors is the Local Contact Agency*

- Open Doors provides transition assistance to individuals who wish to transition from long term care facilities to community settings.

MDS Section Q

- If an individual responds “yes” to Question 0500 providers **MUST** refer them to the Open Doors unless there is an **ACTIVE**** discharge plan.

*https://www.health.ny.gov/professionals/nursing_home_administrator/dal_nh_16-10_mds_version_3_section_q.htm

**<https://www.hhs.gov/sites/default/files/mds-guidance-2016.pdf>



Contact Information



Referral:

- Call NYAIL/Open Doors at: **1-844-545-7108**
- Access referral form at:
<http://www.ilny.org/programs/mfp/transition-center>

Questions:

- Call NYAIL/Open Doors at: **1-844-545-7108**
- Email MFP at MFP@health.ny.gov

Resources:

- <http://ilny.org/programs/mfp>
- https://www.health.ny.gov/health_care/medicaid/redesign/nys_money_follows_person_demonstration.htm
- <https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html>

Section Q+ Index

- University of Michigan conducted a case study comparing “MDS” characteristics of successful transitions in 3 states for prioritizing nursing facility transitions
- Study defined “success” as a discharge to community.
- Study resulted in a targeting algorithm: The “Q+ Index”:
 - Identifies nursing home residents for transition to community settings
 - Deploys evidence-based criteria for identifying individuals
 - Prioritizes those individuals most likely to succeed in community settings

Rebalancing

- Enhanced match dollars
 - earned on HCBS for qualified MFP participants.
 - reinvested in the Long Term Care system.
- Rebalancing Initiatives
 - Enhanced Identification and Outreach Services
 - Access to Guardianship Project
 - Volunteer Caregiver Project
 - Housing Education and Accessible Housing Registry
 - Community Care Connections - Lifespan
 - Access to Assistive Technology and Durable Medical Equipment (TRAID)
 - Person-Centered Planning Systems Transformation Initiative

Contact Us

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