

**THE NATIONAL EVALUATION OF THE
MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION GRANT PROGRAM**

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Toward a More Perfect Union: Creating Synergy between the Money Follows the Person and Managed Long-Term Services and Supports Programs

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EXECUTIVE SUMMARY

Money Follows the Person (MFP) Demonstration grants and Managed Long-Term Services and Support (MLTSS) programs use different strategies to shift the balance of LTSS from institutional care to home- and community-based settings. MFP helps people living in institutions to relocate to the community, while MLTSS programs use risk-based capitation payment to give health plans a financial incentive to keep people out of institutions. The relationship between the two, particularly when they serve the same population groups, determines whether or not they work in concert. As increasing numbers of state Medicaid agencies implement both programs, it is important to understand how the programs can work together to achieve their common goal.

As of January 2012, five states had MFP grants and MLTSS programs operating simultaneously: Hawaii, Massachusetts, Tennessee, Texas, and Wisconsin. This report examines how these states have structured the interface between them. It describes the eligibility rules for each program that define the extent of overlap between MFP and MLTSS enrollees; how the design of Medicaid payment rates to contracted managed care organizations (MCOs) participating in MLTSS programs can promote transitions from institutional care to home- and community-based settings; how MFP and MCO staff divide responsibility for transition planning; and how states track quality of care and MFP performance indicators for MFP participants enrolled in MLTSS plans.

The experiences of these states offer useful lessons for other states in which the two programs coexist or will soon coexist. To maximize cooperation and minimize conflicts between the programs, state Medicaid officials should:

- *Specify the roles and responsibilities of the MFP and MLTSS programs for providing transition assistance to overlapping target groups and communicate these arrangements to MFP staff, MCOs, and other organizations involved in transition assessment and care planning and monitoring*
- *Consider whether current MCO payment methods are sufficient to promote transitions or if additional financial incentives are needed to achieve MFP goals*
- *Modify MCO reporting requirements to meet federal MFP quality monitoring and reporting needs*
- *Take advantage of MFP program resources to increase MCOs' capacity and skill to plan and coordinate more challenging transitions, especially when MCOs have full responsibility for MFP transitions.*

INTRODUCTION

The Money Follows the Person (MFP) Demonstration, authorized by federal law in 2005, provides grants to state Medicaid agencies to shift the balance of long-term services and supports (LTSS) from institutional care to home- and community-based services (HCBS). MFP grants provide states with funds to help Medicaid-eligible individu-

ABOUT THE MONEY FOLLOWS THE PERSON DEMONSTRATION

The MFP Demonstration, first authorized by Congress as part of the Deficit Reduction Act of 2005 and then extended by the 2010 Patient Protection and Affordable Care Act, is designed to shift Medicaid's long-term care spending from institutional care to home and community-based services. Congress authorized up to \$4 billion in federal funds to support a twofold effort by state Medicaid programs to (1) transition people living in long-term care institutions to homes, apartments, or group homes of four or fewer residents and (2) change state policies so that Medicaid funds for long-term care services and supports can "follow the person" to the setting of his or her choice. MFP is administered by CMS, which initially awarded MFP grants to 30 states and the District of Columbia and awarded grants to another 13 states in February 2011, and 3 more states in 2012. CMS contracted with Mathematica to conduct a comprehensive evaluation of the MFP demonstration and to report the outcomes to Congress.

als who reside in institutions to move to home- and community-based settings, if that is where they wish to live and receive care. State MFP programs typically employ or contract with transition coordinators, housing specialists, and other professionals to arrange LTSS, housing, and other services individuals need to make successful transitions and become integrated into the community. MFP programs also seek to remove Medicaid policy barriers that prevent people from receiving LTSS in the settings of their choice. As of January 2012, 47 MFP grants had been awarded to 46 states and the District of Columbia, 35 of which had implemented MFP transition programs by that time.¹

State officials responsible for the design and oversight of Medicaid managed long-term services and support programs (MLTSS) share MFP's goal of shifting the balance of spending on LTSS from institutional care to HCBS. Like other managed care programs operated by state Medicaid agencies, MLTSS programs contract with managed care organizations (MCOs) to serve Medicaid beneficiaries. In the past, Medicaid managed care programs primarily served children and adults without disabilities; now, more states are also adopting managed care for beneficiaries with disabilities and chronic conditions, whose LTSS needs are addressed through such arrangements as well.

In most MLTSS programs, the state Medicaid agency pays MCOs a fixed amount each month for each enrollee—that is, a capitated rate—which MCOs use to deliver all covered services to members through an

¹ Among the 12 states with inactive MFP programs in October 2012, one (Oregon) had temporarily suspended its program and was expected to resume operations later in 2012. The other 11 received MFP grants but had not yet begun operations or had deferred program implementation.

established network of contracted providers. Under these types of risk-based contracts, MCOs assume and manage some or all of the financial risk for their members. This gives them a financial incentive to keep members healthy, to coordinate their care, and to provide care in the least costly setting so their costs do not exceed the capitation rate. For contracts that cover institutional services and HCBS, the LTSS portion of the monthly capitation rate generally is based on the average cost of both. Setting the prospective rate at a level that assumes an increasing share of LTSS will be provided in home or community settings encourages MCOs to keep people at home or in the community, because HCBS generally costs less than institutional care.

As of January 2012, 15 states operated MLTSS programs, and the number is expected to increase to 28 by January 2014 (Saucier et al. 2012).² Because nearly all states (47) now have MFP grants, the two programs are more likely to intersect. Five of the 15 states with MLTSS programs in operation in January 2012 also had active MFP transition programs. Six other states had both MFP and MLTSS programs in operation at that time, but MFP participants did not or could not enroll in MLTSS programs for various reasons.³ Two states with operational MLTSS programs had not yet implemented MFP transition programs as of January 2012, and two other states with operational

² Delaware, which has an MFP program in operation, launched a new MLTSS program in April 2012.

³ For example, California contracts with MLTSS plans in some counties, but no MFP participants have enrolled in these plans yet. New York has an MLTSS program but does not offer this option to MFP participants during their one-year period of MFP enrollment. Some MFP grantee states allow MFP participants to enroll in Programs of All-Inclusive Care for the Elderly (PACE), another type of managed care program plan, but, in practice, very few do so.

TABLE 1. STATUS OF MFP GRANTS IN STATES WITH OPERATING MLTSS PROGRAMS, JANUARY 2012

MFP Transition Program Implemented	MFP Transition Program Implemented But MFP Participants are not enrolled in MLTSS Plans	MFP Grant Awarded But MFP Transition Program Not Implemented as of January 2012	No MFP Grant, or Withdrew from MFP
Hawaii	California	Florida	Arizona
Massachusetts	Michigan	Minnesota	New Mexico
Tennessee	New York		
Texas	North Carolina		
Wisconsin	Pennsylvania		
	Washington		

MLTSS programs did not have an MFP grant or withdrew from the program (Table 1).

The five states that had MLTSS and MFP programs operating simultaneously as of January 2012 and that allowed MFP participants to be enrolled in MLTSS plans were Hawaii, Massachusetts, Tennessee, Texas, and Wisconsin. This report examines how they have structured the interaction between the two programs. Even though in each case both programs are administered by the state Medicaid agency, the staff who manage them may be located in different units within Medicaid, or they may not understand enough about the federal and state policies regarding eligibility, benefits, and payment for both programs to be able to combine them effectively. The experiences of these five states in trying to find common ground and cooperation across the two programs may be instructive to other states in which MFP and MLTSS programs coexist or will soon coexist and may serve the same population.

The report first explains how eligibility rules governing MFP participation and MLTSS enrollment determine the extent to which institutional residents who wish to make a transition to a home- and community-based setting may be served by one or both programs. It then describes how the interaction between the two programs operates in practice for shared populations. The report concludes by drawing lessons on program design issues that can help other states maximize cooperation and minimize conflicts between the two programs.

The findings in this report are based on two primary data sources. One is a review of state policies related to MLTSS in MFP operational protocols. These protocols describe program policies and procedures in detail and must be approved by the Centers for Medicare & Medicaid Services (CMS) before states begin implementing MFP programs. The other comprises interviews with

state Medicaid staff responsible for MFP and MLTSS programs in the five study states. (See the Methods and Data box at the end of the report for more detail.)

OVERLAP IN TARGET POPULATIONS

MFP and MLTSS programs become linked by virtue of the populations they both serve. The potential overlap between MFP and MLTSS programs is defined by (1) which populations are served by each program and (2) whether the MLTSS program can enroll new members while they are residing in institutions. In states in which MFP and MLTSS programs serve different populations, the two complement each other but have little interaction.

However, when state MFP programs and MLTSS plans serve the same institutionalized population, the chance for duplication or poorly coordinated transition assessment and planning by the two programs is greater. Critical tasks in an individual's transition could fall through the cracks. Also missed may be opportunities for MLTSS programs to support state MFP program goals if MCOs that serve all Medicaid LTSS users lack sufficient incentive to help people living in institutions move back to the community or are not held responsible for institutional readmissions. State MFP programs must ensure that participants who are enrolled in MCOs when they return to the community are offered any extra HCBS that may be covered through the MFP demonstration, and that the MCOs are meeting MFP quality requirements, such as 24/7 backup. If MFP participants must enroll in MCO plans after they return to the community, but the MCO does not cover all HCBS or other services are carved out from the MCO benefit package, it can be more difficult to coordinate all services needed by MFP participants.

State MFP programs can serve several population groups, including older adults, adults under age 65 with physical disabilities, individuals with intellectual or

developmental disabilities (IDD), and individuals with serious mental illness. In most states, the MFP program serves all four of these groups and sometimes other populations as well, such as children with disabilities and those with traumatic brain injury. In contrast, MLTSS programs typically serve older adults and younger adults with physical disabilities and less frequently serve people with IDD and those with serious mental illness. Massachusetts has one population in common, Tennessee, and Texas have two populations in common, and Hawaii and Wisconsin have three populations in common across the two programs (Table 2).

State Medicaid MLTSS program enrollment policies also determine whether someone living in an institution is eligible for transition assistance from the MFP program or an MCO before leaving the institution. In Tennessee and Hawaii, for example, all Medicaid-eligible institutional residents must be enrolled in an MCO, so the MCO is responsible for providing transition assistance and enrolling the individual into the MFP program. In states without this requirement, MFP program staff or contractors generally provide transition assistance to such individuals. In Massachusetts, and in Wisconsin counties that have MLTSS, MFP

participants can voluntarily enroll in MCOs while in an institution or upon their return to the community. In all states but Texas, MCOs are also responsible for transitions among current MCO members who are admitted to an institution after initial enrollment. If any member has an institutional stay lasting for 90 days or more, the MCO can enroll the member in MFP, as long as he or she qualifies for MFP and chooses to move to a qualified community residence. Other factors, such as an individual's status as a Medicare-Medicaid dual eligible, or the regions in which state MLTSS programs operate, may also determine whether an individual living in an institution receives transition assistance from the MFP program or an MCO, and whether the MCO or a traditional HCBS waiver program is responsible for post-institutional HCBS (see Box 1).

The manner in which each state MLTSS program requires MCOs to assist institutional residents in making the transition to the community is described below.

- **Hawaii QUEST Expanded Access Program (QExA).** All nursing home residents must be enrolled in the state's MLTSS program. The state assigns responsibility to MCOs for offering

TABLE 2. POPULATION GROUPS SERVED BY MFP AND MLTSS PROGRAMS, BY STATE, JANUARY 2012					
	HI	MA	TN	TX	WI
Older adults age 65 and above					
MFP	√	√	√	√	√
MLTSS	√	√	√	√	√
Adults under age 65 with physical disabilities					
MFP	√	x	√	√	√
MLTSS	√		√	√	√
Individuals under age 65 with intellectual or developmental disabilities (IDD)					
MFP	x	x	x	x	√
MLTSS					√
People with serious mental illness without co-occurring conditions					
MFP		x			
MLTSS					
Other groups					
MFP	√	x People with acquired brain injury			X Children
MLTSS	Children			X Children	
Number of population groups served by both MFP and MLTSS	3	1	2	2	3

Note: A check (√) signifies overlap in populations served by MFP and MLTSS programs in each state. MLTSS programs do not operate in all regions of the state in Massachusetts, Texas and Wisconsin.

BOX 1 OTHER FACTORS AFFECTING THE OVERLAP IN MFP AND MLTSS TARGET GROUPS

In addition to covered populations and whether people residing in institutions are subject to MLTSS program enrollment, other factors can determine whether an individual living in an institution receives transition assistance from MFP or an MCO and whether the MCO or a traditional HCBS waiver program is responsible for post-institutional HCBS.

Service carve-outs. In some states, MLTSS programs operate as part of a comprehensive managed care program that integrates medical services with LTSS. In others, the MLTSS program is a stand-alone plan, covering LTSS provided in institutions or in home and community settings, but not medical services. In four of the states featured in this report (Hawaii, Massachusetts, Tennessee, and Texas), the MLTSS program is part of a comprehensive managed care program, while in Wisconsin, the Family Care program covers only LTSS. When an MLTSS program operates as a stand-alone plan, coordinating all of the services used by an individual is more difficult. Coordination also becomes a challenge when a comprehensive managed care program that covers LTSS carves out or excludes certain services from its benefit package. For example, Hawaii, which enrolls people with IDD in MLTSS programs, requires them to obtain medical services through MCOs. However, both institutional care and HCBS waiver services for this population (including transition assistance and case management services) are carved out and provided on an FFS basis by providers that have traditionally served this population.

Dual enrollees. About 60 percent of MFP participants are dually eligible for Medicare and Medicaid (Irvin et al. 2012). Dual enrollees are generally excluded from mandatory MLTSS enrollment, although they may voluntarily enroll in MLTSS plans. Consequently, in most states, most dual enrollees residing in institutions for at least 90 days would receive transition assistance from MFP programs, rather than MCOs, if they wish to move to the community. It should be noted that among the states studied, Hawaii and Tennessee currently require all dual beneficiaries to enroll in managed care, and all five states are pursuing federal dual demonstrations that would include such individuals in MLTSS programs in the future. If enrollment is required, MCOs may become responsible for serving more MFP-eligible individuals.

Level of care. While the federal statute authorizing MFP requires all participants to meet institutional level of care (LOC) criteria, states have flexibility to select the LOC needed to qualify for participation in MLTSS programs. About half of current state MLTSS programs require enrollees to be eligible for institutional LOC, but the five state MLTSS programs examined in this report serve people who meet institutional LOC as well as people with lower LTSS needs. Where MLTSS programs serve only those meeting an institutional LOC, the share of members who are eligible for MFP will be higher than in programs serving people with any level of need for LTSS.

Statewide versus regional coverage. Hawaii's and Tennessee's MLTSS programs are statewide, and Massachusetts's program is nearly statewide. Although Texas and Wisconsin both have plans to extend their MLTSS programs statewide as well, as of January 2012 their programs did not reach into all counties. To fill the void, the MFP program in Texas provides transition assistance to many rural residents not yet served by MLTSS programs, while HCBS waiver programs provide assistance to MFP participants in Wisconsin counties not yet served.

these members assistance in relocating back to the community. MCO care coordinators are responsible for assessing members' interest in and potential for making the transition, developing transition plans based on individual needs and wishes, and continuing to provide care coordination after relocation. The state MFP program, called "Going Home Plus," is run by the Medicaid agency that also oversees the MCO plans serving MFP participants. In addition, it facilitates transition assistance to individuals with IDD residing in intermediate care facilities (ICFs).

- **Massachusetts Senior Care Options (SCO).**

The SCO program serves adults ages 65 and older (including those with IDD). The state's MFP program has designated several agencies to provide

transition assistance to people living in institutions who wish to live in the community. These include Aging Services Access Points (ASAPs) for people in nursing homes, the Department of Mental Health for people living in psychiatric facilities, the Department of Developmental Services for people in ICFs, and the University of Massachusetts Medical School for people with acquired brain injury. Individuals in facilities have the option of enrolling in Senior Care Options while residing there. MFP was still in the early implementation stage at the time of this report and had only a small number of participants enrolled in Senior Care Options. The MFP program is working on developing guidelines on how MFP transition coordinators and SCO care managers will

coordinate care planning activities. The ongoing care management remains the responsibility of the SCO care manager.

- **TennCare CHOICES.** In Tennessee, MFP and the MLTSS program are overseen by the same division within the Medicaid agency, called TennCare CHOICES. TennCare CHOICES is an integrated, mandatory Medicaid managed long-term care program that serves adults age 21 or over with physical disabilities and the elderly, age 65 or older, who are eligible for LTSS. The TennCare CHOICES MLTSS program serves three groups. CHOICES Group 1 is for people who receive nursing home care, while Group 2 is for people who qualify for nursing facility level of care (NF LOC) but live at home or in community residences and receive HCBS. Group 3 is for people who do not meet NF LOC but are at risk of placement in a nursing facility if they do not receive HCBS. Since 2010, all nursing home residents have been required to enroll in managed care plans. MCO care coordinators are responsible for assessing nursing home residents' interest in and potential for making a transition to the community, developing transition plans based on individual needs and preferences, enrolling those eligible for MFP into the program, and continuing to provide care coordination after relocation. Tennessee also operates an MFP transition assistance program for people with IDD who would be enrolled in a fee-for-service (FFS) HCBS waiver program upon returning to the community. These individuals are in managed care to obtain physical and behavioral health services but receive LTSS, including MFP services, outside the managed care program.
- **Texas Star+Plus.** Texas's MLTSS program serves older adults and people under age 65 with physical disabilities who reside in counties served by the Texas Star+Plus program. MCOs do not enroll individuals living in nursing facilities and are therefore not responsible for transition planning and coordination, although they are responsible for developing care plans and setting up HCBS. Since people with IDD are not currently served by Star+Plus MCOs, transition services for all populations are provided by state MFP relocation contractors, such as Centers for Independent Living (CILs), Area Agencies on Aging (AAAs), and other community organizations. If an individual makes the transition to the community and

enrolls in an MCO, the MFP relocation contractor remains involved for the first three months, working with the MCO service coordinator to transfer gradually some of the relocation contractor's responsibilities. After three months, the MCO service coordinator takes sole responsibility for monitoring the individual's care plan, and HCBS are provided through Star+Plus MCOs. Individuals with IDD receive HCBS through FFS waiver programs.

- **Wisconsin Family Care.** The Wisconsin Family Care program provides managed LTSS to older adults and people under age 65 with physical disabilities or IDD living in select counties. (Another program, Family Care Partnership, provides integrated health care and LTSS to people in selected regions of the state who are Medicaid-only or Medicare-Medicaid enrollees; the Partnership program is not discussed in this report.) Family Care allows enrollment into MCOs by individuals who are currently institutionalized. Wisconsin officials report that most people in nursing homes who voluntarily enroll in an MCO do so because MCOs have sole responsibility for transition planning and coordination in Family Care counties, and the Family Care program is the only way people who wish to return to the community, including those eligible for MFP, can obtain transition assistance in the counties that offer this program. In counties that do not currently offer Family Care, transition assistance is the responsibility of FFS HCBS waiver program. The state is planning to hire community living specialists to work in certain counties to address barriers faced by long-term institutional residents in returning to the community.

AT THE INTERFACE: HOW MFP AND MLTSS PROGRAMS WORK TOGETHER WHEN THEY SERVE THE SAME POPULATIONS

MCO Financial Incentives for MFP Transitions

The way in which states set the monthly capitation rate, which is a fixed per member per month amount for all members needing LTSS, affects the strength of the incentives to MCOs to increase the use of HCBS and reduce nursing facility care (Gore and Klebonis 2012). State-established capitation rates for the LTSS portion of the rate usually represent a blend of average institutional care costs and average HCBS costs, and assume a specified

mix or ratio between the two. MCOs can achieve savings by serving more members in lower cost HCBS or by reducing admissions to expensive institutional care than the assumptions built into the rate. Other aspects of the rate-setting and payment methodologies that can increase or decrease the incentive to serve more members in home and community settings include the following:

- **Financial risk for institutional care.** When the institutional portion of the rate covers all institutional care, regardless of the length of stay, it strengthens the financial incentive to MCOs to serve beneficiaries in home and community settings. Rates that limit MCO liability for institutional care to a certain period of time (for example, four to six months) or exclude institutional care costs entirely reduce the MCOs' financial incentive to provide HCBS.
- **Incentives to increase HCBS.** Average capitation rates that assume an increasing ratio of members using less costly HCBS to those using more expensive institutional care can strengthen MCO incentives to serve beneficiaries in home or community settings.
- **Transition incentives.** Payment policies that offer MCOs a bonus for moving enrollees out of institutions give them an incentive to identify institutional residents who can be safely served in the community and assist them in the transition process. If capitation rates vary by the setting in which an enrollee is served, maintaining the lower community rate for a certain period after an enrollee is admitted to an institution gives the MCO an incentive to shorten the stay or discourage stays altogether. Even if the rates exclude institutional services, payment can be structured to reward plans that keep institutional use below specified levels.

The five states examined in this study use different combinations of these rate-setting techniques, some of which are linked to MFP goals (see Table 3). In Hawaii, Tennessee, and Wisconsin, for example, MCOs receive the same blended monthly capitated payment regardless of whether members—including MFP participants—reside in nursing homes or in the community. Since in most situations the cost of institutional care is significantly higher than that of supporting an individual in a community setting, MCOs have a strong incentive to minimize the time members spend in nursing facilities or ICFs and to help those who do need institutional care to return to the community and remain there for as long as

possible. States may adjust monthly capitation rates paid to individual MCOs to reflect the acuity and service needs of their enrollees. Wisconsin, for example, uses the data from uniform assessment tools on health conditions and need for functional assistance to adjust rates. But none of the five states' MLTSS programs pays monthly capitated rates for MFP participants that differ from rates for other MCO enrollees with similar characteristics and needs.

Massachusetts, which holds SCOs liable for institutional care, sets different rates depending on whether a member is in the community or in an institution. To give MCOs an incentive to minimize institutional lengths of stay, Massachusetts pays the SCOs the community capitation rate for the first 90 days of an institutional stay, after which they receive the higher institutional rate. Massachusetts also has incentives for SCO plans to help people living in institutions make the transition to the community, although these are not tied to MFP benchmarks. SCOs receive the higher nursing facility capitation rate for the first three months after a member returns to the community.

Tennessee offers bonus payments to MCOs, financed by MFP grant funds, to encourage them to make transitions a priority. An MCO can receive \$1,000 for each institutional resident who moves to the community and enrolls in MFP, up to the state's annual MFP transition benchmark, and \$2,000 for each MFP participant over the annual benchmark. The plan can receive an additional one-time payment of \$5,000 if a participant remains in the community for 365 consecutive days (excluding short-term rehabilitation covered by Medicare). The bonuses are small relative to the capitation rate, which averaged \$4,105 per month in fiscal year 2012, or nearly \$50,000 per year (Vieira et al. 2012). But the state regards these incentives as sufficient to motivate the plans to increase transitions, while defraying costs associated with MFP reporting requirements and training.⁴ Tennessee also offers incremental incentive payments up to a maximum, one-time payment per year of \$100,000 per MCO to encourage the MCOs to meet established accelerated annual program benchmarks. To receive these bonuses, the MCOs must work together to meet statewide goals related to increased consumer direction, community-based residential alternatives, and raising the ratio of members living in the community to those residing in institutions.

⁴ None of the five states' MFP programs pays MCOs an additional fee for submitting reports that may be required for MFP participants.

TABLE 3. MLTSS CAPITATION PAYMENTS AND COVERED SERVICES

Feature	Hawaii QUEST Expanded Access	Massachusetts Senior Care Options	Tennessee TennCare CHOICES	Texas Star+Plus	Wisconsin Family Care ^a
MLTSS capitation payment method					
MCO financial risk for institutional care	Full	Full	Full	None	Full
Capitation rate-setting method	Blended rate paid to each plan, comprising the weighted average of medical and LTSS costs based on the Hawaiian island of residence, gender, and age	Weighted average of medical and LTSS costs; separate rate cells for enrollees in nursing facilities and in community settings	Blended rates comprising weighted average of medical and LTSS costs, adjusted by target change in ratio of HCBS to institutional care use	LTSS portion of rate based on HCBS waiver costs	For members at nursing home level of care, regression model adjusts for functional status and service need for three target groups.
HCBS incentives	-	Plans paid at lower community rate for first three months of a nursing home admission	-	Penalties for plans with nursing home occupancy rates significantly higher than previous year	-
Transition incentive payments	-	Plans paid at higher nursing home rate for first three months in the community when members with a nursing home admission of at least three months return to the community	\$1,000 for each transition up to the annual MFP goal; \$2,000 for each transition over the goal; \$5,000 each time a member is transitioned and remains in the community for 365 days	-	-
Services covered in MCO capitation rate					
Acute and primary care	X	X	X	X	-
Behavioral health services	X	X	X	X	X ^b
Nursing home care	X	X	X	-	X ^c
HCBS	X	X	X	X	X
Extra MFP demonstration or supplemental services not covered in the capitation rate	-	Transition Assistance Services ^d		MFP Behavioral Health Pilot ^e	
Transition services covered in the MCO capitation rate					
Transition assessment	X	X	X	-	X
Develop care plans	X	X	X	X	X
Arrange for services	X	X	X	X	X
One-time transition costs	X	-	X		X

^a Wisconsin Family Care provides managed LTSS only. Family Care Partnership and PACE provide managed primary and acute care and LTSS.

^b Wisconsin Family Care includes counseling and therapeutic services to treat personal, social, behavioral, emotional, cognitive, mental, or alcohol or drug abuse disorders. These services may include assistance in adjusting to aging and/or disabilities or with interpersonal relationships, as well as recreational therapies, music therapy, nutritional counseling, medical and legal counseling, and grief counseling. Other mental health and substance abuse treatment services are provided on an FFS basis.

^c Wisconsin also includes the cost of intermediate care facilities for people with intellectual and developmental disabilities.

^d Massachusetts' Transition Assistance Services may include one-time moving expenses, environmental adaptations, adaptive equipment, assistive technology, pre-discharge assessment, peer support and companion services, needs assessment, service animals, family support/training, community reintegration, 24-hour on-call services, housing locator/roommate matching, telehealth monitoring or reminders, substance abuse treatment, and cognitive adaptive training.

^e MFP Behavioral Health Pilot is available in eight counties and covers cognitive adaptive training and substance abuse treatment for up to 50 MFP participants.

In Texas, where nursing home stays are carved out of the capitation rate, plans face financial penalties if their members have a nursing home occupancy rate significantly higher than that of the previous year. As a result, Star+Plus plans have reduced nursing facility utilization over time, according to state officials, although they did not cite specific numbers. MCOs are also required to check on institutionalized members every 30 days for the first four months of an institutional stay to assess their ability to return to the community. To strengthen incentives for MCOs to keep people out of institutions, the state will consider legislative changes in 2013 that would hold the MCOs liable for the first four months of a nursing home stay.

Payment to MLTSS MCOs for Transition Assistance and Extra HCBS

In three of the five states – Hawaii, Tennessee and Wisconsin -- the costs for all transition assistance services are included in the capitation rate, including transition planning, one-time moving and household set-up expenses, and home modifications. Neither do these three states offer any extra HCBS to MFP participants enrolled in MLTSS programs, since state-established capitation rates are designed to reflect the cost of all HCBS. The lack of any additional payment to MCOs for MFP participants can, however, hinder efforts to enroll them in MLTSS programs. For example, Wisconsin officials say MCOs that participate in the state's Family Care program do not see the benefit of MFP because it involves more work for them, such as conducting MFP quality of life surveys, submitting special data reports, and reporting member movement, but offers no additional benefits to the MCO or its members. Consequently, Family Care MCOs do help members in institutions move back to the community but, in many cases, without enrolling them into MFP. Wisconsin officials believe this has hindered the state's efforts to reach its MFP transition goals.

Two of the five states offer extra MFP demonstration or supplemental services to MFP participants enrolled in MCOs, and the state pays for these services separately so the MCO is not responsible for the cost. For example, in Massachusetts, SCO members can access MFP demonstration services through the MFP regional coordinating office for certain costs associated with moving to the community, such as one-time moving, household set-up, and home modification expenses. Texas operates two pilot programs that offer special behavioral health services and overnight companion services to MFP partici-

pants located in certain regions; these services are carved out of the capitation rate and paid on an FFS basis.

Respective Roles of MFP Transition Coordinators and MLTSS Care Managers

Each MFP program and MCO plan has had to define clearly the roles and responsibilities of staff involved in transition planning for and post-transition monitoring of MFP participants. Hawaii, Tennessee, and Wisconsin rely on MCO care managers to handle the entire transition planning process, establish the care plan, arrange for all HCBS, and continue monitoring participants' care after their move to the community. Individuals residing in institutions who are not yet enrolled in an MLTSS plan (such as those who have not yet spent down their assets to qualify for Medicaid after they entered the institution) may have to wait to begin transition planning until they are officially enrolled, although Hawaii and Tennessee officials say nursing home social workers do help with initial planning. According to Wisconsin officials, MLTSS case managers sometimes start transition planning for people whose enrollment is pending, even though they will not be reimbursed.

When, as in Texas and Massachusetts, MFP programs are responsible for transition planning and MCOs are responsible for post-transition HCBS, ensuring a smooth handoff is important. Texas is unique among the studied states in its use of non-MCO transition planners because its MCOs are not at risk for any institutional care. Instead, Texas contracts with nine regional relocation agencies to carry out transition planning. These relocation specialists identify MFP participants' living and housing needs, help locate housing, and set up households. They also begin working with the MCO service coordinator who will serve the participants once they have moved to the community. Prior to the transitions, the MCO service coordinators create service plans and arrange for the HCBS to be provided. After the transitions occur, the relocation specialists follow up with participants for the first three months to ensure their needs are being met and to address any problems. If none arise after three months, MCO service coordinators become solely responsible for backup and monitoring. Massachusetts's MFP program, which began in 2011, has had only one participant who was enrolled in SCO after returning to the community, so the program continues to develop strategies for MFP-SCO transition planning and coordination.

MFP representatives believe it is important for state officials to establish the rules and procedures for coor-

dination between MFP and MCOs. Officials need to explain the extra MFP quality monitoring requirements and clarify MCO responsibilities and procedures for transitions, managing care, and reporting data on MFP participants. In Hawaii, the state asked each MCO plan to designate one person to oversee coordination between MFP and MCO care managers. Wisconsin, in response to some misunderstanding by MCOs about the MFP program, recently hired someone to provide ongoing liaison with them. MFP program officials in Hawaii, Tennessee, Texas, and Wisconsin meet regularly with MCO care managers and staff to discuss specific challenges encountered by the plans in conducting transitions or serving MFP participants. These challenges have included behavioral health issues, guardianship problems, shortages of affordable housing, and risks of reinstitutionalization, among others. In Hawaii, the MFP program also facilitates communication between nursing facilities and MCOs by referring to the MCOs all people interested in making a transition out of an institution.

MFP programs in three of the five study states provide training to MCO staff to strengthen their capacity to provide HCBS to individuals with special needs. Hawaii has provided trainings to MCO case managers on a variety of subjects, such as financial assistance and foster homes, while Tennessee and Wisconsin are educating MCO staff about housing resources. The Wisconsin MFP program offers technical assistance to HCBS providers working with MCOs on such issues as participants' behavioral health needs. Federal MFP grant funds are available to cover the cost of these types of administrative activities, which states might otherwise be unable to afford.

Monitoring Care Quality and Service Utilization for MFP Participants Enrolled in MCOs

Federal regulations [42 C.F.R. §438.202(a)] require each state contracting with managed care organizations to establish a strategy for assessing and improving the quality of services offered by all MCOs, developed with input from beneficiaries and other stakeholders. States must also conduct ongoing monitoring to ensure that MCOs, including MLTSS plans, comply with state quality standards. As required by federal rules, the five states in this study hold the MCOs that serve MFP participants responsible for ensuring access to and quality of all covered services, including HCBS, based on standards specified in their contracts. This includes providing assurances regarding service plans, qualified providers,

health and welfare, administrative authority, participant rights, discovery and remediation processes, and overall system improvement. MFP also has three specific quality assurance requirements that must be met including an incident report management system that provides timely reports on certain events, risk assessment and mitigation, and 24-hour emergency backup.

In all five states, MCOs are contractually obligated to ensure the quality of members' care, and, in most cases, they are also responsible for extra MFP quality assurances, such as 24-hour emergency backup. In Texas, MFP relocation contractors and the MCO care managers share responsibility for monitoring MFP participants' care plans immediately after a transition; unless problems arise, this responsibility shifts to the MCO after three months. Some MFP programs, however, do not require MCOs to provide critical incident reports for participants using MFP-defined categories. Even when the programs require such MFP-defined reports, they can face challenges in receiving them and reporting the data to federal officials in a timely fashion. Some MFP program officials are also unable to track participant outcomes systematically for those enrolled in MCOs. Wisconsin, for example, reported a two-year delay in enrolling MFP participants who were MCO members because they could not flag them in Wisconsin's Medicaid Management Information System (MMIS). Texas manually flags participants in its MMIS. Some MCOs have been unable to identify MFP participants separately in the encounter data submitted to states, or they say that doing so is burdensome because the participants make up such a small share of MCO members. Texas and Massachusetts report they do not receive encounter data for MFP participants that would enable them to monitor actual service use.

Another challenge to MFP programs that need to monitor care quality for participants enrolled in MCOs are differences between MFP quality requirements and those used by state MLTSS programs. MFP data reporting requirements entail quarterly reporting of services used by each participant, but Texas's encounter data, for example, are reported in the aggregate, so the state cannot break out data by MFP and non-MFP enrollees. Recently, Texas officials used MFP rebalancing funds to set up a "data mart" that will improve its analytical capabilities by, for instance, tracking factors leading to reinstitutionalizations among MFP participants, including those enrolled in MCOs. To ensure it can track and report MFP data, Ten-

nessee modified MCO contractual reporting requirements to capture additional information specific to MFP, such as reasons for reinstitutionalizations and types of qualified residences, as well as to flag MFP participants separately in aggregate reports to track services received, critical incidents, and consumer direction.

LESSONS ON INTEGRATING MFP WITH MLTSS PROGRAMS

As more states develop MLTSS programs, the potential for interaction between them and MFP programs grows. Ideally, planning of MFP and MLTSS programs is closely coordinated. But most states cannot design both programs in advance, as many have one or both already operating or have completed the planning process. Rather, states need to assess the overlap between the two programs and determine how they can work together in the future, which means either revising the MFP program or changing MCO responsibilities and requirements. The five states examined in this study provide lessons for others on activities or program design features that will increase coordination between the two programs.

- **Identify overlapping target groups.** For institutionalized populations eligible both for MFP and for enrollment in MLTSS programs, states should decide which organizations will be responsible for providing transition assistance to the MFP-eligible individuals.
- **Define roles and responsibilities.** State program officials in charge of MFP and the MLTSS program need to define the roles and responsibilities of the MCOs, MFP staff, and any other contracted entities, like CILs, AAAs, or Aging and Disability Resource Centers (ADRCs), in transition assessment and planning, and in follow-up care monitoring. It is important to involve all parties with responsibility for MFP outreach and assessment, such as ADRCs, nursing home discharge planners, long-term care ombudsmen, community organizations, local government entities, and consumer advocates. It is also important to understand each organization's roles and responsibilities for identifying and serving people eligible for MFP transition assistance and for MLTSS enrollment and to make any necessary changes in referral patterns and HCBS delivery systems to reach MFP transition goals collectively. Communication between MFP program staff and MCO staff must be ongoing, so they may discuss and resolve problems as they arise.
- **Consider financial incentives for transitions.** While most states have built transition-related service costs

into MLTSS capitation rates, additional financial incentives may be needed to ensure MCOs take proactive steps to reach the state's MFP transition targets. Incentives can be particularly important if transition assistance is a new or unfamiliar service for the MCO. Additional money, which may be available through MFP grant or rebalancing funds,⁵ can be used to compensate MCOs (all or in part) for the higher costs of serving members with high medical or support needs, if they require more intensive monitoring or specialized services, or if the rates are not adequately risk-adjusted to reflect their more complex conditions and needs. The availability of such funds can enhance MFP marketing and outreach and increase referrals to the MCOs, likely resulting in more transitions.

- **Harmonize monitoring and reporting requirements.** MFP and MLTSS programs both entail extensive reporting requirements related to service utilization, quality of care, and expenditures. When MFP participants enroll in MCOs, it is important to incorporate MFP tracking, reporting, and monitoring activities into MCO reporting requirements. This includes requiring MCOs to track MFP participants and their service use through the 365 days of eligibility and to document that they are meeting MFP's three quality assurance requirements (incident report management system, risk assessment and mitigation, and 24-hour emergency backup). If MCOs have primary responsibility for MFP transitions, states should consider developing data collection systems using MFP grant or rebalancing funds that can compare performance across MCOs on key MFP outcomes, such as transition and reinstitutionalization rates.
- **Create other partnerships between MFP and MLTSS programs.** MFP programs, which are staffed by or can contract with professionals who have extensive knowledge and experience in helping institutional residents return to the community, can provide technical assistance and training to increase the capacity and skills of MCO staff in transition planning. Such training can help educate MCO staff about the needs of people who, with appropriate services and supports, can successfully

⁵ MFP rebalancing funds are the "dividend," or net federal revenues, that states receive from an enhanced Federal Medical Assistance Percentage (FMAP) matching rate, above the state's regular FMAP rate, for expenditures on qualified and demonstration HCBS provided to MFP participants during their first 365 days of community living.

live in a community setting. MFP programs can also provide technical assistance to MCOs on how to find affordable, accessible housing—an area that is unfamiliar to many MCO care managers. MFP housing specialists can also help MCO care managers overcome specific housing challenges.

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REFERENCES

Center for Health Care Strategies. “Profiles of State Innovations: Roadmap for Managing Long-Term Supports and Services.” Center for Health Care Strategies, November 2010.

Gold, Marc S. “Star+Plus: Texas’ Managed Long-Term Services and Supports System.” Presentation at the MLTSS-MFP Webinar, February 8, 2012.

Gore, Suzanne, and Julie Klebonis. “Medicaid Rate-Setting Strategies to Promote Home- and Community-Based Services.” Policy brief, Center for Health Care Strategies, May 2012. Available at [http://www.chcs.org/usr_doc/Incentivizing_HCBS_in_MLTS_Programs_05_01_12.pdf].

Irvin, Carol, Debra Lipson, Samuel Simon, Matthew Hodges, Alex Bohl, Victoria Peebles, Jeremy Bary, Matthew Sweeney, Laura Ruttner, Sean Orzol, and John Schurrer. “Money Follows the Person 2011 Annual Evaluation Report.” Submitted to Centers for Medicare and Medicaid Services, Disabled and Elderly Health Programs Group. Mathematica Policy Research, October 31, 2012.

Lipson, Debra J., Jenna Libersky, Rachel Machta, Lynda Flowers, and Wendy Fox-Grage. “Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports.” AARP Public Policy Institute, July 2012.

Propsom, Gail. “Wisconsin Long Term Care System Overview.” Presentation at the MLTSS-MFP Webinar, February 8, 2012.

Saucier, Paul, Jessica Kasten, Brian Burwell, and Lisa Gold. “The Growth of Managed Long Term Services and Supports (MLTSS) Programs: A 2012 Update.” Truven Health Analytics, July 2012.

TennCare. “Bureau of TennCare Managed Care Approach to LTSS.” Presentation at the MLTSS-MFP Webinar, February 8, 2012.

Vieira, Kenneth, Michael Rasmussen, and Leo Lichtig. “Actuarial Review of the TennCare Program: Development of Fiscal Year 2012 Per Member Costs.” Aon Hewitt, January 2012. Available at [<http://www.tn.gov/tenncare/forms/actuarial12.pdf>].

Wisconsin Office of Family Care Expansion. “Money Follows the Person.” OFCE Technical Assistance Series, Memo 10-07, November 30, 2010.

METHODS AND DATA

This study examined policies and practices in five states that had MFP and MLTSS programs in operation as of January 2012. Hawaii, Texas, and Wisconsin were awarded MFP grants in 2007, and Massachusetts and Tennessee received them in 2011. We reviewed each state’s most recent MFP operational protocol, which outlines the details of the MFP program, to gather information about the way in which MFP was designed to interact with the MLTSS program. Semi-structured telephone discussions also were conducted with state officials covering six major topics: (1) MFP and MLTSS program goals; (2) eligibility requirements for MFP and MLTSS; (3) payment rates; (4) coordination of transition planning between programs; (5) tracking, reporting, and quality; and (6) lessons learned by states. MFP project directors in the five states were interviewed, and these discussions often included other state LTSS staff and/or MLTSS program managers. Additional information on MLTSS programs was collected from publications and state presentations (Center for Health Care Strategies 2010; Gold 2012; Lipson et al. 2012, Wisconsin Office of Family Care Expansion 2010; Propsom 2012; Saucier 2012; TennCare 2012).

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