

Money Follows the Person: Impediments to Implementation

A Fact Sheet on Program Start up, Capacity and Access

Authorized by Section 6071 of the Deficit Reduction Act of 2005 (DRA), the Money Follows the Person Rebalancing Demonstration Program (MFP) was designed to assist states in rebalancing their long-term care systems, and to help Medicaid beneficiaries transition from institutions to the community. Since its inception, MFP has faced many barriers to implementation, most of which have resulted in the program transitioning fewer individuals than originally anticipated. In efforts to clarify the origin and impact of these early problems and ongoing capacity and access challenges, NASUAD prepared this fact sheet, outlining some of the most commonly-reported programmatic complications, such as the unanticipated consequences of statutory compliance and a lack of accessible, affordable housing for MFP participants.

Notably, in the time since the first MFP grants were awarded in 2007, many of the problematic protocols and operational standards that slowed the program's growth have been clarified by the Centers for Medicare & Medicaid Services (CMS), the federal agency with administrative responsibility for MFP, facilitating the ability of grantees to provide program participants with home and community based care. By reducing the timeframe for institutional stays from six months to 90 days, and by extending funds for the program into 2016, the Patient Protection and Affordable Care Act (ACA) built upon this process of recognizing and alleviating barriers to the MFP program's success. In the coming years, as MFP continues to grow, and as challenges to optimal transitions continue to be identified and addressed, it is critical that MFP receive adequate funding, as well as local, state,

A History of MFP Funding

The DRA established MFP as a five-year demonstration program, and provided \$350 million for each of fiscal years 2007-2011, for a total of \$1.75 billion.

In 2010, the ACA extended the MFP program for an additional five years, through September 30, 2016, and appropriated \$450 million for each of fiscal years 2012 to 2016, totaling \$2.25 billion for this time period.

To date, Congress has assigned \$4 billion to MFP.

and federal support, to ensure that the program is a sustainable mechanism for states to rebalance their long-term services and supports systems while successfully transitioning individuals back into the community.

Background

Under MFP, grantee states design programs to transition Medicaid beneficiaries from institutional settings into the community. Upon transition, the state provides the MFP participant with home and community based care services (HCBS) for up to one year, after which the MFP participant becomes a regular Medicaid beneficiary. States receive enhanced federal matching funds (FMAP) from their grant allotments for providing certain HCBS services during the year-long transition period, and the state then reinvests a portion of these funds to finance rebalancing initiatives within their long-term care systems.

Though the first MFP-facilitated transitions from institutional to community based care began in October 2007, that number did not begin to accelerate until the second half of 2008. By the end of December 2008, 23 states had transitioned 1,482 people, and the growth in the number of MFP transitions continued throughout the next year; in December of 2009, 30 grantee states had transitioned a total of 5,673 Medicaid beneficiaries. The program continues to grow, and as of December 31, 2010, the cumulative number of transitions to the community through the MFP program reached 11,924, more than double the number from the previous year.

Impediments to Implementation: Program Start up

CMS began awarding MFP demonstration grants in January 2007, when 17 states received funds. Analysis from the early implementation stages of the demonstration indicates that the majority of state grantees were slow to launch their MFP programs, in part resulting from unanticipated barriers caused by initial program startup, as well as problematic statutory requirements. Some of these challenges also arose due to the varying levels of transitional program experience and existing capacity among states participating in the program. That is, before they could initiate transitions, grantee states had to meet certain infrastructure targets set by CMS, which necessitated several states to undertake different degrees of capacity building. For example, in order to meet CMS's standards, some MFP states needed to make significant programmatic adjustments, such as modifying existing waiver programs or establishing new ones, while other states needed to comply with

program reporting requirements, and still others needed to develop relationships with agencies and organizations involved in the transitions and service delivery processes.

Delayed Start Date – In 2008, the first full year of program operations, about two-thirds of the grantee states began MFP transitions later than anticipated because of problems or delays related to federal planning and data reporting requirements. MFP states were required to prepare and submit program design documents, known as Operational Protocols (OP), that explain the policies and procedures that would impact the program in their state to CMS by June 30, 2008, and before grantees could begin any actual program implementation, the OP's had to be reviewed and approved by CMS. Two-thirds of all MFP grantees did not submit their initial or revised OP's to CMS until May or June of 2008, which delayed program implementation in these states pending CMS's approval. An additional eight states could not begin program implementation until late 2008 due to bureaucratic delays in negotiating and securing contracts with transition specialists or case management contractors. These delayed start dates, though a one-time impediment associated with program startup, nevertheless contributed to grantees falling short of their transition goals.

Interagency Collaboration – Due to the complex nature and broad scope of the MFP program, several agencies must work together to plan and deliver services to participants. To ensure meaningful program implementation, CMS requires MFP states to establish systems to track and share information among the state Medicaid agency, state agencies that manage HCBS waiver programs, and contracted vendors. Since each state department or service system has separate data collection and reporting systems, as well as different protocols and procedures for performing agency functions, coordinating these multiple systems slowed MFP program startup in nearly every state. During 2008, several grantees reported difficulty in gaining cooperation from other state agencies in developing, or agreeing to use, common screening, enrollment, and tracking tools; six MFP grantees spent that year establishing common screening and assessment tools; 12 developed common systems to track enrollment; and 16 enhanced systems to collect and report financial or service data in a timely manner. As states moved beyond the initial implementation stages, these problems decreased, and by 2009, only eight states reported issues in collaborating or coordinating with other agencies.

Outreach, Marketing and Recruitment – In order for MFP to be sustainable, it was necessary for states to gain the public’s support for the program at its outset, in part to establish a network for referrals. As a result, during the first several months that MFP was operational, states spent considerable time and resources marketing it to providers, individuals, families, and community leaders. Grantee states reported that these outreach efforts were often met with resistance from providers and family members, who cited concerns about the health and safety of individuals if they were to participate in MFP and leave an institutional setting. In 2008, eight states reported obtaining referrals from agencies and providers to be a significant barrier to recruitment efforts. To address these concerns, CMS required state MFP programs to adopt health and welfare protections that extend beyond the standard HCBS waiver requirements. While these protections were designed to alleviate some of the public’s initial concerns with the program, the additional infrastructure changes associated with developing these systems caused further delays in MFP implementation, contributing to a reduction in transitions relative to state goals. Currently, resistance at the community level prevails, as some states continue to report opposition from institutional providers, in part driven by fears that transitions could threaten their financial viability. During the first six months of 2009, 13 states reported increased referrals in response to direct outreach efforts and greater awareness of the program; by the end of the year, however, 14 states still reported problems generating referrals.

Quality Management and Assurance – When the program began, many states needed to establish or strengthen quality-monitoring systems to ensure that MFP participants living in the community were receiving appropriate services in a timely manner, or to capture data from all agencies involved in serving MFP participants. MFP states also needed to develop procedures to assess and mitigate potential risks to participants’ health and safety, and systems to report and track critical incidents. According to data for the last six months of 2010, 12 grantee states continue to experience difficulty obtaining the information necessary to determine whether participants are receiving adequate services and support.

Six Month Institutional Residency Requirement - The DRA restricted MFP participant eligibility to Medicaid beneficiaries who have been institutionalized for at least six months in nursing homes, hospitals, intermediate care facilities for the mentally retarded, or institutions for mental diseases. When the program became operational, some MFP grantee states reported that this six-month minimum

institutional residency requirement acted as a barrier to recruitment and enrollment efforts, because many candidates interested in transitioning to the community had not yet been institutionalized long enough to qualify, and those who did meet the residency requirement frequently had complex medical or mental health conditions that made it very difficult to serve them safely in the community. This problem was addressed by statutory changes to MFP adopted in 2010 through the ACA, which reduced the minimum length of institutional residency from six months to 90 days, excluding any rehabilitative days covered by Medicare.

Statutory Exclusion of ALFs from MFP-Qualified Community Residences -The statutory exclusion of assisted-living facilities (ALFs) from MFP-qualified community residences was another deterrent to recruitment and enrollment cited by states during the early implementation process. In 2008, grantees reported that 51 people, or five percent of the 1,038 individuals assessed for MFP participation that year, were eligible for the program, but chose not to transition, in part because these individuals preferred to reside in an assisted living facility rather than any of the MFP-qualified community settings. In July of 2009, to make it easier for people to transition to the community in states where the exclusion of assisted living facilities hindered program recruitment and enrollment, CMS issued guidance describing the criteria that must be met in order for a community residential setting, including an assisted living facility, to be considered a qualified residence under MFP statute.

Impediments to Implementation: Capacity and Access

By June 2010, the MFP program in all 30 grantee states had been in operation for at least 18 months, enough time for most states to overcome initial start up problems. As a result of states moving past the hurdles associated with the early implementation stages, the number of people enrolled in MFP increased by nearly two and half times from June 2009 to June 2010. Once states were able to move forward with operationalizing MFP, the problems they faced evolved, and many grantees cited community level barriers, such as a lack of affordable and accessible housing and inadequate HCBS system capacity, as the major forces hindering their ability to transition individuals. Further compounding shifting operational challenges is the ongoing impact of the economic downturn on state budgets. As the 2007 launch of the MFP program coincided with a weakening national economy, consistent and widespread state budget cuts have plagued the program from its outset, which has made sustaining and expanding MFP even more difficult.

Housing - Upon transition to the community, MFP participants must reside in a qualified residence; since January 2008, states have consistently cited insufficient supplies of affordable, accessible housing and rental vouchers as the two most prevalent challenges to procuring housing for MFP participants. Long waiting lists for public housing, slow rental turnover among older adults in subsidized housing, the few connections the MFP participant traditionally has to the community, and the lack of housing with accommodating features that help individuals with mobility and functional disabilities maintain their independence, compound the housing problem, impeding state transition efforts. In 2008, 15 MFP states, half of all grantees, reported that an inadequate supply of either affordable, accessible housing, or of rental vouchers, reduced the number of people who could transition into the community. By the end of 2009, that number had risen to 20, and during the last six months of 2010, three-quarters of state MFP grantees, 23, reported challenges related to securing housing for MFP participants. Yet, states are making some progress in this area, in part by hiring new housing specialists, who often paid for with federal administrative funding; as well as by developing new partnerships with state and local public housing authorities (PHAs); and by utilizing new vouchers from the Department of Housing and Urban Development (HUD), which were first made available in 2010 to help facilitate the transition of non-elderly persons with disabilities from institutions to the community.

HCBS - The ability of state MFP programs to serve individuals in the community depends on the supply and availability of a range of home and community based services and supports. Increasing access to HCBS for MFP participants requires that HCBS waiver programs have sufficient funding and capacity, and that Medicaid or MFP is able to cover all of services and supports needed by the participant. While every state provides some HCBS through waiver programs and state plan benefits, most state Medicaid programs have some coverage gaps in the specialized services and supports that MFP participants need as they transition from institutional stays to the community. Therefore, when states began to implement MFP, many grantees reported the need to increase the capacity of HCBS waiver programs in their state in order to meet the anticipated demand of MFP participants. In 2008, six states gained state or federal approval for enhanced waiver authority to serve MFP participants, and in 2009, nine states received legislative or executive authority to increase funds for key waiver programs, and four states added HCBS to existing waivers or state plans. The time and resources necessary to achieve this capacity building delayed MFP implementation, both slowing program growth and reducing

the number of transitions states were able to provide during this time. These challenges are ongoing, as states seek to build the capacity of their HCBS waiver programs despite the negative impact of the economic downturn on state Medicaid and HCBS programs.

Workforce - Enhanced access to services for MFP participants also requires that providers or direct care workers are available to serve the participant in a self-directed manner. Accordingly, in addition to an insufficient supply of home and community based services, states must also deal with inadequate service capacity due, in part, to the growing shortages of direct service workers and providers. As the MFP program evolves, states strive to increase the supply of HCBS providers and direct care workers, with five states reporting progress in expanding the number and type of HCBS providers available to serve MFP participants in 2008, and 10 states reporting an increased number of HCBS providers contracting with Medicaid in 2009. However, challenges remain; in 2010, about half of all MFP states, 14, reported an inadequate supply of direct care workers in the community as a barrier to successful transitions.

Economic Downturn - Just as states began implementing the MFP program, the United States entered into a serious economic downturn, which resulted in widespread state budget shortfalls. In the last six months of 2010, more than half of all MFP grantee states, 16, reported that the impact of the economic downturn on state budgets has adversely affected the program. In efforts to mitigate the impact of the economic downturn and balance their budgets, states have had to reduce spending and cut services, often through across the board budget cuts. These reductions have made it increasingly difficult for states to secure sufficient state funding to cover Medicaid HCBS after an MFP participant completes 365 days in the community, as well as to maintain and build out their existing programs. Accordingly, the contraction in state resources has made MFP implementation even more difficult in most states, as budget shortfalls have resulted in strained state Medicaid management resources and diminished HCBS capacity, effectively reducing the number of people who can be transitioned through MFP.

Looking Ahead

States began actively transitioning individuals into community settings in the spring of 2008. Each year, the number of participants transitioning has increased as solutions to barriers were identified, and significant technical assistance is continuing to be provided to help states meet transition goals; as of December 2010, almost 12,000 individuals have returned to the community as a result of these demonstration programs. The program's extension in the ACA provides an opportunity for additional states to participate in the demonstration program, and for current grantees to continue strengthening their existing MFP initiatives. With the addition of thirteen new state grantees in February 2011, 43 states and the District of Columbia are currently implementing MFP Programs.

Sources:

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