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MONEY FOLLOWS THE PERSON

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

REPORTS FROM THE FIELD

Number 5 • January 2011

Money Follows the Person Demonstration Program: A Profile of Participants

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Introduction

The Money Follows the Person (MFP) Demonstration, established by Congress through the Deficit Reduction Act of 2005 (DRA), provides states with an opportunity to help Medicaid beneficiaries living in long-term care institutions for at least six months to return to the community if they so wish. As an incentive to participate, the program gives states an enhanced federal matching rate (the federal Medicaid assistance percentage) for state Medicaid spending on home and community-based services provided to MFP program enrollees. In 2007, the Centers for Medicare & Medicaid Services (CMS) awarded grants to 31 states, all but one of which began implementing MFP transition programs between October 2007 and January 2009.

This report presents a profile of MFP participants who transitioned from institutions to qualified home or community-based residences from the start of the program through June 2010. It describes their demographic characteristics, the types of institutions in which they resided before their transition, and community living arrangements. It also compares the characteristics of MFP participants to those who met program eligibility requirements in 2007 and explains what accounts for differences between the two groups.

In brief, the results indicate that, while the majority of those ***eligible*** *for MFP in 2007 were older adults living in nursing facilities, the largest group of* ***MFP participants*** *as of June 2010 has been people with physical disabilities under age 65 who had lived in nursing homes. Most other participants were equally divided between people with intellectual disabilities who lived in intermediate care facilities for the mentally retarded (ICFs-MR) and the elderly—people over age 65 who lived in nursing homes. The report discusses the reasons for discrepancies between the population eligible for the program and those who have actually enrolled so far, and recent changes that might narrow the differences in the future.*

ABOUT THE MONEY FOLLOWS THE PERSON DEMONSTRATION

The MFP demonstration, first authorized by Congress as part of the 2005 DRA 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 HCBS. Congress has now authorized up to $4 billion in federal funds to support a twofold effort by state Medicaid programs to: (1) transition people living in nursing homes and other 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. Several states launched their MFP transition programs in late 2007, and the demonstration is authorized through 2016. CMS contracted with Mathematica Policy Research to conduct a comprehensive evaluation of the MFP demonstration and report the outcomes to Congress.

Characteristics of MFP-Eligibles Prior to Program Implementation

If MFP had been implemented in 2004, the eligible population would have looked different than it did in 2007, due to changes in the long-term institutional population during those years. In 2004, about 1.3 million people received Medicaid-financed institutional care in the 31 MFP grantee states (Wenzlow and Lipson 2009), of which about one million (75 percent) were institutionalized for at least six months and would have been potentially eligible for a program like MFP. Not all of the estimated one million MFP eligibles could transition to the community if they had acute medical conditions that could not be accommodated in the community, but this could not be determined from the data (see Data, Methods, and Limitations box). At that time, about 9 out of 10 people who were MFP-eligible resided in nursing homes, and just over 3 in 4 were age 65 or older.

By 2007, the number of people eligible for MFP—those who lived in institutions for at least six months and qualified for Medicaid—declined to 929,615, an 8 percent drop.[1] The distribution of eligible individuals across the three largest groups also changed in the three-year period before the MFP program began. Over that time, the number of eligibles age 65 or older in nursing homes declined by 4.6 percent and people residing in ICFs-MR declined by 4.8 percent. In contrast, the number of Medicaid beneficiaries *under age 65 in nursing homes* for six months or more (primarily those ages 45 to 64) increased by more than 2 percent over the two-year period. Some have speculated that increases in all nursing home residents under age 65, both short and long-stay, over this period reflect an increasing proportion of short-stay residents (CMS 2009). This analysis suggests that many of those short-stay residents became longer-term residents.

As a result of these changes, when MFP began in 2007, 75 percent of MFP eligibles were older adults in nursing facilities, 15 percent were physically disabled individuals under age 65 in nursing facilities, 9 percent were people with intellectual disabilities living in ICFs-MR, and 1 percent were living in institutions for mental disease or inpatient psychiatric hospitals (Table 1).

Characteristics of MFP Participants

The 30 states that implemented MFP grants reported a total of 8,517 cumulative MFP transitions by the end of June 2010 through the MFP grantee web-based progress reporting system. At the time of this report, states submitted individual enrollment records for 7,729 of these individuals (91 percent of all MFP participants ever enrolled by that date) to Mathematica and the statistics presented in this report are based on this group of enrollees.[2]

Distribution by target group. Federal MFP rules specify five MFP population groups: (1) elderly people over age 65, (2) people with disabilities under age 65,

[1] South Carolina, which received an MFP grant award in 2007, had an estimated 16,432 people eligible for MFP in 2004, and they were included in the 2004 estimate of about one million total MFP eligibles in the 31 states awarded MFP grants. Because the state decided not to implement the MFP program yet (though it may still do so), its MFP-eligible population was excluded from the 2007 estimate of total eligibles.

[2] The difference between the two numbers is due to some states not submitting MFP Program Participation Data files in time for this analysis (see notes in Tables 2 – 4).

TABLE 1. MFP-ELIGIBLE POPULATION BY INSTITUTIONAL RESIDENCE AND AGE, 2007

Measure	2007 MFP Eligibles	
	Number	Percentage
Totals	**929,615**	**100**
By type of institution and age		
Nursing home, ages 65+	697,354	75.0
Nursing home, ages <65	141,092	15.2
ICF-MR	80,502	8.7
Inpatient psychiatric hospital, ages < 22	7,215	0.8
Mental hospital, ages 65+	3,452	0.4

Source: Mathematica calculations of Medicaid Analytic eXtract (MAX) files, 2007.

(3) people with intellectual disabilities, (4) people with serious mental illness, and (5) others, such as people with two or more primary diagnoses and those who do not fit into one of the other four groups. To compare MFP enrollees with those eligible for the program in 2007, we analyzed the MFP Program Participation Data files submitted by states on a quarterly basis and assigned each person represented in the files to one of these five population groups. Rules for assigning participants to one of the MFP categories are described in the Data and Methods box at the end of this report.

The monthly number of *current* MFP participants—those who were still enrolled in the program after having transitioned to the community, did not complete one year of community living, or did not leave the program for any other reason—increased rapidly in 2008 as more states began program operations, and continued to rise steadily to 4,362 in June 2010 (see Figure 1). Enrollment of the elderly and nonelderly with disabilities increased at a fairly constant rate over the two years, while enrollment of beneficiaries with intellectual disabilities reached a plateau in mid-2009. At that time, the nonelderly with disabilities became the largest group of MFP participants. Few people with mental illness as a primary diagnosis were enrolled over the two-year period.

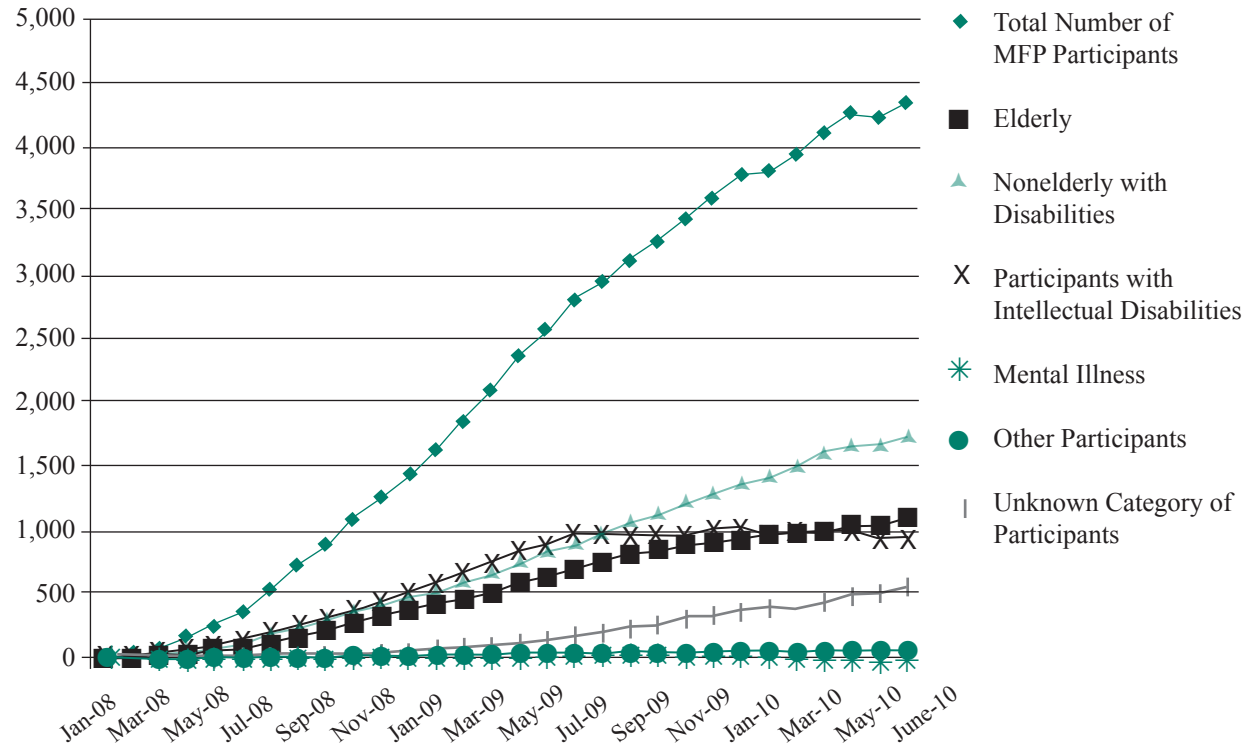
By the end of June 2010, 36 percent of those ever enrolled in the program were people under age 65 with physical disabilities, about 26 percent of MFP participants were elderly, 25 percent were people with intellectual disabilities, 2 percent were in other categories, and 10 percent were unknown because the state files did not provide all the information needed to classify the participant into one of the five groups (Table 2 and Figure 2a).

Comparing MFP participants by category to those who would have been eligible before the program began, disproportionately more participants were under age 65 with physical or intellectual disabilities (36 and 25 percent respectively, Figure 2a) than their share of MFP-eligibles in 2007 (15 and 9 percent respectively, Figure 2b). The variance is even greater for the elderly, who comprise 27 percent of MFP participants compared to 75 percent of those eligible in 2007. When we excluded individuals for whom data were missing to determine their MFP participation group, these results did not change significantly.[3]

Community residence type. The Deficit Reduction Act of 2005 defined the types of community residences in which MFP participants can live as homes, apartments, and small group homes with four or fewer unrelated individuals. This has generally excluded assisted living facilities from the choice of community residences, although CMS has advised states that under certain circumstances, assisted living facilities can qualify as MFP community residences. As shown in Table 2, the two most common types of qualified residences used for MFP transitions are homes and group homes of four or fewer unrelated indi-

[3]As noted elsewhere, data were also missing from one state for the entire period (Virginia) and from five states for recent periods. Based on data reported by states in the semi-annual progress reports regarding MFP transitions by enrollee group, MFP participants from the states with missing data would not substantially change these results.

Figure 1. Number of Current MFP Enrollees by Month, January 2008 to June 2010



Source: Mathematica analysis of MFP Program Participation Files, 2008-2010.

TABLE 2. COMMUNITY LIVING ARRANGEMENTS OF MFP PARTICIPANTS EVER ENROLLED THROUGH JUNE 2010, BY TARGETED POPULATION

Characteristic	All MFP Participants (number)	Targeted Population (percentages)				
		Elderly	PD	ID	Other	Unknown
Totals	**7,729**	**26.7**	**36.1**	**25.1**	**2.5**	**9.6**
Type of Qualified Residence						
Home	2,048	47.7	32.4	3.0	7.3	12.9
Apartment	1,870	18.9	34.0	10.6	6.8	29.7
Assisted living	680	14.1	10.4	5.0	4.2	3.1
Group home	2,010	8.4	8.9	75.0	7.8	16.7
Unknown	1,121	11.0	14.2	6.4	74.0	37.6
Lives with a Family Member						
Yes	688	15.2	10.4	1.3	7.3	5.9
No	3,316	33.3	47.5	46.6	17.7	49.4
Unknown	3,725	51.5	42.1	52.1	75.0	44.7

Source: Mathematica analysis of MFP Program Participation Data files.
PD = individuals under age 65 with physical disabilities.
ID = individuals with intellectual disabilities.
NOTE: Virginia was not included in the data because it had not submitted any MFP Program Participation Data files when these analyses were conducted. In addition, data were available only through September 2009 for Michigan and North Carolina, through December 2009 for the District of Columbia, and through March 2010 for New Hampshire and Wisconsin.

Figure 2a. Percentage of Total MFP Participants by Group, June 2010

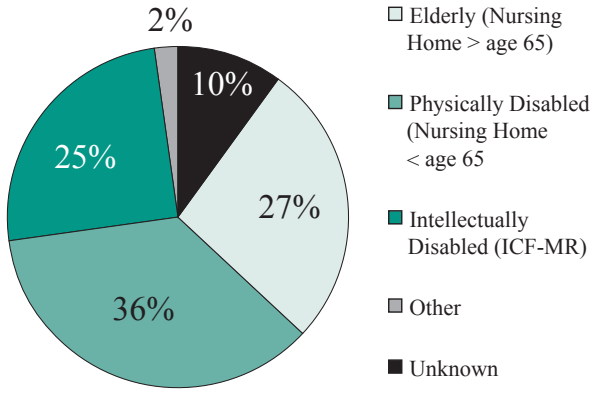
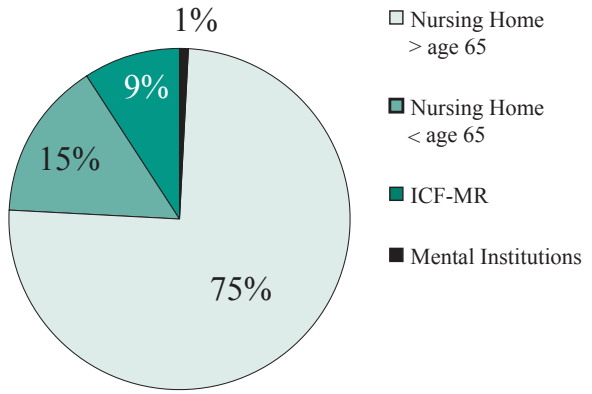


Figure 2b. Percentage of Total MFP Eligibles by Group, 2007



Source: Mathematica analysis of (1) the 2007 Medicaid Analytic eXtract (MAX) files for 30 MFP grantee states, and (2) the MFP Program Participation Data files.

viduals, with slightly more than 2,000 participants living in each type of residence. Apartments were reported as the third most common type of residence (1,870 participants), followed by assisted living facilities (680 participants). Just under half of the elderly participants relocated to homes (48 percent), while 75 percent of people with intellectual disabilities transferred to group homes. For the physically disabled population under age 65, 32 percent and 34 percent moved to homes and apartments, respectively.

Living alone or with family. Individuals who move from an institution back to the community may live by themselves, with unrelated people in a small group home, or with family. At the time they transitioned, 688 MFP participants moved to a living arrangement with another family member, while more than 3,300 participants lived alone or in a small group home. However, information on whether they lived alone or with family members was missing for almost half of all MFP participants, so the data are not necessarily representative of all participants. If the data reported by states are representative of all participants, it appears that the elderly and people under age 65 with physical disabilities were more likely to live with family members than individuals with intellectual disability (see Table 2). Excluding individuals for whom these data were missing, about a third of the elderly and about one in six individuals under age 65 with physical disabilities lived with family members, but only 3 percent of individuals with intellectual disabilities moved in with family members.

Age and gender. By June 2010, state MFP programs enrolled disproportionate numbers of working-age adults (MFP participants under age 65) relative to their share of the population eligible for the program in 2007 (Table 3). Although the elderly comprised 75 percent of those eligible for MFP, they make up about a third (33 percent) of MFP participants. Working-age adults enrolled in MFP between the ages of 21 and 64 represent two to three times their share of the population eligible for MFP.

Overall, the gender distribution of MFP participants is almost equally divided between men and women; among MFP eligibles in 2007, two-thirds were women and one-third were men. The gender distribution of MFP participants varies by target population (Table 4). Within the elderly group, two-thirds are women and one-third men. This distribution is reversed for MFP participants with intellectual disabilities—one-third are women and two-thirds are men. Individuals under age 65 with physical disabilities include slightly more men than women.

What Explains Differences Between MFP-Eligibles and MFP Participants?

Differences in the profiles of the population eligible for MFP and those who enrolled in the program by mid-2010 are attributable to several factors, including (1) state Medicaid agencies' targeting decisions, (2) states' approaches to implementing the program, and (3) the

TABLE 3. CHARACTERISTICS OF MEDICAID MFP ELIGIBLES IN 2007 AND MFP PARTICIPANTS EVER ENROLLED THROUGH JUNE 2010

	2007 MFP Eligibles		MFP Participants Through June 2010	
Measure	**Number**	**Percentage**	**Number**	**Percentage**
Totals	**929,615**	**100**	**7,729**	**100**
Age Distribution				
<21	14,959	1.6	278	3.6
21-44	57,617	6.2	1,543	20.0
45-64	157,453	16.9	3,380	43.7
65+	699,586	75.3	2,514	32.5
Unknown	NA	NA	14	0.2
Gender				
Female	650,482	66.8	3,761	48.7
Male	309,133	33.3	3,956	51.2
Unknown	NA	NA	12	0.2

Source: Mathematica analysis of (1) the 2007 Medicaid Analytic eXtract (MAX) files for 30 MFP grantee states, and (2) the MFP Program Participation Data files.

NOTE: Virginia was not included in the data because it had not submitted any MFP Program Participation Data files when these analyses were conducted. In addition, data were available only through September 2009 for Michigan and North Carolina, through December 2009 for the District of Columbia, and through March 2010 for New Hampshire and Wisconsin.

NA = not available.

TABLE 4. DEMOGRAPHIC CHARACTERISTICS OF MFP PARTICIPANTS EVER ENROLLED THROUGH JUNE 2010 (PERCENTAGES UNLESS OTHERWISE INDICATED)

		Target Population				
Characteristic	**All MFP Participants**	**Elderly**	**PD**	**ID**	**Other**	**Unknown**
Number of Participants	**7,729**	**2,061**	**2,794**	**1,939**	**192**	**743**
Age						
<21	3.6	0.0	0.9	9.1	8.4	7.9
21-44	20.0	0.0	20.2	41.1	17.7	19.9
45-64	43.7	0.0	78.5	41.6	43.2	40.0
65+	32.5	100.0	0.0	8.0	30.7	32.2
Unknown	0.2	0.0	0.4	0.2	0.0	0.0
Gender						
Female	48.7	65.3	45.5	35.5	46.4	49.4
Male	51.2	34.7	54.3	64.3	53.6	50.6
Unknown	0.2	0.0	0.3	0.2	0.0	0.0

Source: Mathematica analysis of the MFP Program Participation Data files.

PD = individuals under age 65 with physical disabilities.

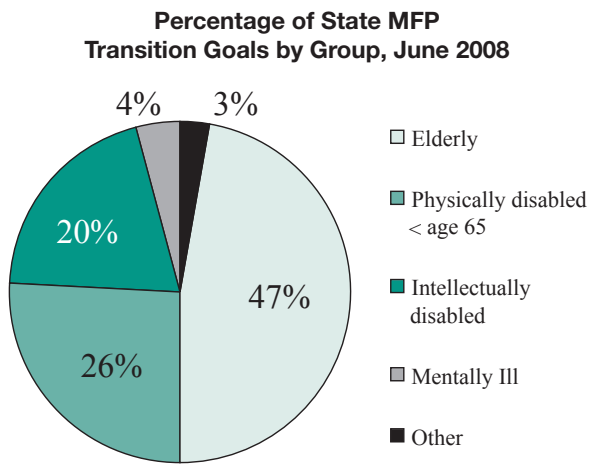
ID = individuals with intellectual disabilities.

NOTE: Virginia was not included in the data because it had not submitted any MFP Program Participation Data files when these analyses were conducted. In addition, data were available only through September 2009 for Michigan and North Carolina, through December 2009 for the District of Columbia, and through March 2010 for New Hampshire and Wisconsin.

types of available, affordable housing options that qualify as MFP community residences.

Targeting decisions. Because federal MFP rules give states the flexibility to target their MFP programs to the five different groups, the distribution of MFP participants reflects state choices regarding the target groups. In June 2008, when all state MFP programs received federal approval to begin implementing their transition programs, states planned to transition 35,380 individuals over the course of the demonstration. About 47 percent or almost half were elderly (disproportionately fewer than the 75 percent who were eligible), 26 percent of planned transitions were individuals under age 65 with physical disabilities, 20 percent were individuals with intellectual disabilities, and the rest fell into the remaining two categories (Figure 3). Some states planned to transition only certain groups; for example, Indiana and Michigan planned to transition elderly people and those under age 65 with physical disabilities, and Iowa serves only people with intellectual disabilities. In some states, these choices were driven by which agencies or waiver programs serving different populations agreed to partner with the Medicaid agency in operating the MFP transition program, while other states made these choices based on legal or political mandates to give priority to the de-institutionalization of certain groups. Despite their intentions and projections, states were able to transition only about half of the elderly individuals they had planned, and more people under age 65 with physical or intellectual disabilities as explained above.

Figure 3. Distribution of State Transitions Goals by Group, June 2008



Source: Mathematica analysis of MFP Operational Protocols approved by CMS as of June 2008.

Program implementation. All of the state MFP transition programs have conducted outreach and marketing to recruit those who are eligible and potentially interested in moving to the community. Early MFP enrollment patterns may reflect the success of program outreach. They may also indicate which types of institutions have been most cooperative in identifying MFP candidates and which types of state and local agencies the Medicaid program has developed partnerships with. For example, some state MFP programs have put more effort into making contacts at nursing homes, while others have focused more attention on institutions for people with intellectual disabilities, which may have biased enrollment toward certain groups. The agencies that state Medicaid agencies were able to partner with in conducting initial assessments for eligibility and education may have also affected which groups enrolled. Some states contract with Area Agencies on Aging and Centers for Independent Living, which have historically served the elderly and younger individuals with physical disabilities, respectively, and tend to have better relationships with nursing homes than with institutions for people with intellectual disabilities. In contrast, states that built relationships with state and local agencies that serve people with mental illness or intellectual disabilities are more likely to identify people in institutions with these conditions and have a better understanding of the community service systems that can support them. Illinois' MFP program, for example, has benefited from good cooperation with the state mental health department, which has boosted the number of people with mental illness enrolled in MFP.

Community housing options available. The availability of affordable, accessible housing options is an essential ingredient for a successful transition, but the supply is frequently limited and many states are not able to find suitable housing for all individuals wishing to transition. Older adults who live alone are twice as likely to enter nursing homes as those who live with others, and those who do not own their home have greater odds of nursing home admission than those who do (Gaugler et al. 2007). Because older adults may not have a home or apartment to return to after a stay of six months or more in a nursing home, and because there are more assisted living facilities than small group homes serving

older adults, it has been harder for programs to find affordable, accessible housing for elderly beneficiaries that qualifies for MFP. Some states, such as Oregon and Washington, have a greater supply of small group homes that serve older adults than other states, but in general, small group homes are more commonly found for people with intellectual disabilities, which may make it easier to help individuals in that group transition to the community. In addition, since elderly individuals are more likely to live with family members than those in other MFP population groups, it may be that older adults do not have family members with whom they can live or that there are too few assisted living facilities that meet CMS criteria for MFP.

Implications of the Current Profile of MFP Participants and Prospects for Change

The current profile of MFP participants includes more individuals of working age than would be expected by the age profile of those eligible for the program. This suggests different needs for community supports than originally expected, such as employment services. Working-age adults who want to be employed may be more selective about finding a place to live that is near employment and social opportunities, and public transportation may be critical to their ability to live successfully in the community. In addition, since younger people with disabilities are likely to live longer in the community than older adults, this group will need supports and services in the community for a long time to come. Will the Medicaid waiver programs in which most MFP participants enroll after they transition to the community have the capacity and flexibility to grow and adapt to their changing needs over time?

Conversely, the disproportionate share of younger individuals in the program may indicate that there are significant barriers to community living for older adults in nursing homes, who comprise the majority of long-term institutional residents eligible for MFP. Barriers that states cite include: a shortage of affordable, accessible housing that meets MFP criteria as qualified housing for all individuals but especially for older adults, a lack of home and community-based services for these individuals, and difficulty arranging for support from family members or other informal caregivers. Older adults may also have more intensive medical needs that prevent them from returning to the community, or they may prefer to stay in a nursing home if they are satisfied with their care and have built relationships with those who live and work there.

Recent changes in federal rules and policies may affect the profile of MFP participants in the future. First, the Patient Protection and Affordable Care Act of 2010 made a number of changes to the MFP program. It increased total funding from $1.75 billion to $4 billion, extended MFP for another four years, and reduced the minimum period of institutional residence needed to qualify for the program from six months to 90 days.[4] The change in eligibility criteria will increase the number of people eligible for the program by as much as 12 percent, or about 112,000 individuals each year (Irvin et al. 2010). The shorter period of institutionalization needed to qualify for MFP could make it easier for older adults to transition to the community and enroll in the program if it allows them to maintain their home. At the same time, it could also increase the number of adults under age 65 who become eligible, since they tend to be in institutions for shorter periods of time and may have more motivation to transition or greater support from spouses or family members.

Another change in federal rules, which took effect October 1, 2010, requires all nursing home residents' health and functional needs to be assessed using a new version of the Minimum Data Set (MDS 3.0). The new version has a revised question (in Section Q) that asks residents directly if they want to talk to someone about returning to the community. If they wish to do so and the nursing home does not have the resources to help the individual move out, the nursing home assessor must refer the individual to a "local contact agency." This new requirement may produce more referrals to MFP programs, especially if the local contact agencies work in tandem with MFP; in at least 10 states, the MFP grant project director is also the state point of contact for MDS 3.0 Section Q referrals. However, it is unclear whether this will shift current enrollment patterns in MFP across population groups.

A third development that could boost MFP transitions for younger people with disabilities emerged when the U.S. Department of Housing and Urban Development (HUD) announced in April 2010 the availability of housing vouchers for people with disabilities under age 65.[5] HUD has made available about $40 million

[4] Any days spent in an institution solely for Medicare-reimbursed rehabilitation therapy are excluded from the 90-day minimum stay requirement.

[5] "HHS, HUD Partner to Allow Rental Assistance to Support Independent Living for Non-Elderly Persons with Disabilities." CMS and HUD joint press release, April 7, 2010.

to public housing authorities across the country to fund 5,000 Housing Choice Vouchers for nonelderly persons with disabilities. Up to 1,000 vouchers are specifically targeted for nonelderly individuals with disabilities currently living in institutions, many of whom are MFP-eligible and could move to the community with assistance. According to MFP progress reports in mid-2010, at least 19 of the 30 state MFP grantees reported working with local public housing authorities to apply for these HUD vouchers. Many of the grantees indicated that some would be reserved for MFP participants.

CONCLUSION

This analysis highlights differences between the characteristics of the initial set of MFP participants and those of the MFP-eligible population before the program began. State MFP programs have enrolled disproportionate shares of men and individuals under age 65, compared to the most common type of individuals eligible for MFP – elderly women.

Some of the difference can be attributed to state decisions about which population groups to target for transition assistance. But it also appears to reflect the strengths and capacity of the *current* long-term care system, including: (1) the fact that states have more experience with transitioning individuals in ICFs-MR than those in nursing homes, (2) the availability of more housing options for individuals under age 65, and (3) relationships between Medicaid and other state and local agencies that facilitate the transition of individuals with physical or intellectual disabilities. This raises the question about whether states can make changes to the system so that long-term supports and services in the community are equally available to older adults residing in nursing homes.

At the same time, the profile of MFP participants enrolled since the start of the program reflects the program's rules and other policies in effect until March 23, 2010. The change in federal MFP eligibility rules adopted in the Affordable Care Act of 2010, which relaxed the institutional stay requirement from six months to 90 days, as well as the revised MDS assessment question that asks about interest in moving back to the community, may help improve the odds for older adults who wish to transition out of institutions. For example, states may now have more opportunity and incentives to start planning for older individuals' transition to the community during a nursing home stay that is expected to last for another 90 days beyond a short-term post-acute rehabilitation stay. This would mean changing the focus from finding a new home to ensuring that people do not lose their current housing upon entering institutional care.

Changes in federal and state policy besides those directly affecting MFP and individuals currently residing in institutions may also have consequences for the number and perhaps the profile of individuals who enroll in MFP. For example, the Affordable Care Act offers state Medicaid programs new options, and in some cases financial incentives, for expanding the availability of home and community-based services. The law offers certain states a higher federal match rate for creating single-entry access points and standardized assessment instruments. It also gives state Medicaid programs the ability to offer community-based attendant services as a state plan benefit without having to meet budget neutrality requirements, and increases funds for Aging and Disability Resource Centers. To the extent that states take advantage of these new options and additional federal financing to expand available long-term services and supports, and consumers and their families become confident that all of the community services they need will be provided and long-lasting, MFP may be able to help more frail and disabled individuals living in institutions return to the community.

REFERENCES

Centers for Medicare & Medicaid Services (CMS). "Nursing Home Data Compendium 2009 Edition." U.S. Department of Health and Human Services, CMS, 2009.

Gaugler, Joseph E., Sue Duval, Keith A. Anderson, and Robert L. Kane. "Predicting Nursing Home Admission in the U.S.: A Meta-Analysis." *BMC Geriatrics,* vol. 7, no. 13, 2007.

Irvin, Carol, Debra Lipson, Sam Simon, Audra Wenzlow, and Jeffrey Ballou. "Money Follows the Person 2009 Annual Evaluation Report." Final report submitted to Centers for Medicare & Medicaid Services. Cambridge, MA: Mathematica Policy Research, September 10, 2010.

Simon, Samuel E., Debra J. Lipson, and Christal Stone. "Mental Disorders Among Non-Elderly Nursing Home Residents," *Journal of Aging & Social Policy*, 23:1, 58–72, 2011.

Wenzlow, Audra, and Debra Lipson. "Transitioning Medicaid Enrollees from Institutions to the Community: Number of People Eligible and Number of Transitions Targeted Under MFP." National Evaluation of the Money Follows the Person Demonstration Program, Reports from the Field, No. 1. Mathematica Policy Research, January 2009.

ACKNOWLEDGMENTS

This report draws on analyses performed under Contract HHSM-500-2005-00025(0002), "Money Follows the Person Demonstration National Evaluation," funded by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. The content of this publication does not necessarily reflect the views or policies of the Department of Health and Human Services. The authors thank Audra Wenzlow and Gregory Bee for data analysis, and Carol Irvin and Valerie Cheh for their review and helpful comments.

DATA, METHODS, AND LIMITATIONS

Sources. Estimates of the number and characteristics of Medicaid beneficiaries eligible for MFP in 2007 in the 30 states that implemented MFP grants are based on 2007 Medicaid Analytic eXtract (MAX) data. The MAX data files, produced by CMS are extracted from the Medicaid Statistical Information System, a person-level data system containing eligibility, claims, and encounter information for all individuals covered by Medicaid.

Data on the characteristics and monthly counts of MFP participants are based on MFP Program Participation Data files that state grantees submit on a quarterly basis. These data include all participants enrolled in the program from inception through June 2010, with some exceptions. Virginia was not included in the data because it had not submitted any MFP Program Participation Data files when these analyses were conducted. In addition, data were available only through September 2009 for Michigan and North Carolina, through December 2009 for the District of Columbia, and through March 2010 for New Hampshire and Wisconsin. The distribution of Medicaid enrollees that states planned to target in their MFP transition programs is based on the MFP Operational Protocols that states were required to submit for the program and that were approved by CMS as of June 30, 2008.

Identification of the MFP-Eligible Population. We used service dates from Medicaid institutional care claims (nursing home, ICF-MR, or psychiatric facility) in MAX to identify Medicaid enrollees in institutional care in 2007 for at least six consecutive months. For enrollees with an institutional care claim in 2007, we used claims from 2006 and 2007 to create 24 monthly status indicators that specified whether or not an enrollee was in institutional care each calendar month from January 2006 through December 2007. Breaks in institutional care that spanned two consecutive calendar months identified transitions out of institutional care. Each enrollee found to be in institutional care for six or more consecutive months was classified by age group and by the type of institutional claim during the last observed month of the institutional admission. MAX data do not allow us to assess the medical conditions of individuals who meet the length-of-stay and Medicaid-eligible requirements for MFP eligibility; therefore, our estimates of MFP eligibles may be overstated since they include individuals who may be unable to transfer to the community because of medical conditions that are too acute or cannot be supported in the community. The number of MFP eligibles in 2007 with serious mental illness may be underestimated. Medicaid does not cover psychiatric facility services for people between the ages of 22 and 64, so technically, those with serious mental illness in this age group should not be counted as Medicaid eligible at all. However, an analysis of 2002 MAX data found that nearly 16% of Medicaid nursing home residents ages 22 to 64 with a stay of six months or more had a primary or secondary mental disorder diagnosis (Simon et al. 2010). Consequently some of these individuals may be counted among the group of physically disabled individuals under age 65 in nursing homes.

MFP Target Population Assignments. For analyses based on the MFP Program Participation Data files, we used the "Qualified Institution" and "Age" data fields as reported at the time of an individual's initial transition to the community to construct MFP target group assignments for enrollees. The "elderly" were age 65 years or older in a nursing home; the "nonelderly with disabilities" were under 65 years in a nursing home; the "participants with intellectual disabilities" were all ages in an ICF-MR; and "participants with mental illness" were all ages in an institution for mental disease. Individuals in any other type of institutional care were assigned to "other" and individuals reported without complete age and qualified institution data were categorized as "unknown." This method of constructing the target group assignments for enrollees limits any analyses or direct comparison to the MFP-eligibles target groups.

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