



Impact of the Money Follows the Person Program

July 25, 2019

BRANDEIS UNIVERSITY

The Heller School

FOR SOCIAL POLICY AND MANAGEMENT

The Lurie Institute
for Disability Policy

Community Living Policy Center

- Aims to advance policies and practices that promote community living outcomes for individuals with disabilities of all ages through research and knowledge translation.
- The CLPC received support from the National Institute for Disability, Independent Living, and Rehabilitation Research (NIDILRR) within the Administration for Community Living, U.S. Department of Health and Human Services (Grant # 90RTCP0004). The contents of this webinar do not necessarily represent the policy of NIDILRR, ACL, or HHS, and you should not assume endorsement by the Federal Government.



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- University of California, San Francisco (UCSF)
- Association of University Centers on Disabilities (AUCD)
- Autistic Self Advocacy Network (ASAN)
- Disability Rights Education & Defense Fund (DREDF)
- Disability Policy Consortium (DPC)
- Centene Corporation
- National Association of States United for Aging and Disabilities (NASUAD)
- Mike Oxford, Topeka Independent Living Resource Center
- Henry Claypool, National Policy Expert
- Disability and Aging Collaborative



Webinar Logistics

- The power point and archived recording will be available on the Community Living Policy Center website:
 - www.communitylivingpolicy.org
- Webinar is being live captioned
- Time for questions following speakers
 - Submit questions via the Chat function

Presenters



Carol Irvin
Mathematica



Steve Kaye
University of California San Francisco



Nicole Jorwic
The Arc of the United States

The Cost Savings and Quality of Life Implications of the Money Follows the Person Demonstration

Carol V. Irvin

July 25, 2019

Money Follows the Person (MFP) Rebalancing Demonstration

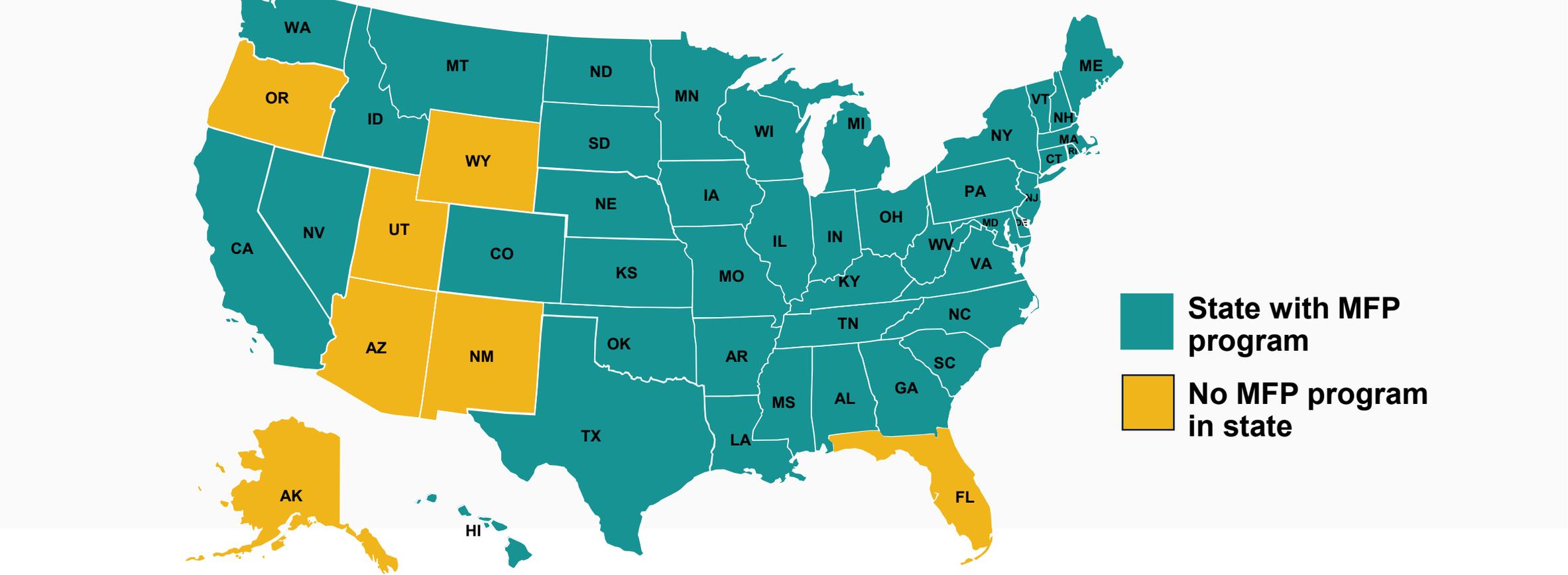


- Principal Aims
 - Reduce reliance on institutional care
 - Develop community-based long-term care opportunities
 - Enable people with disabilities to participate fully in their communities and improve their quality of life

Legislative History

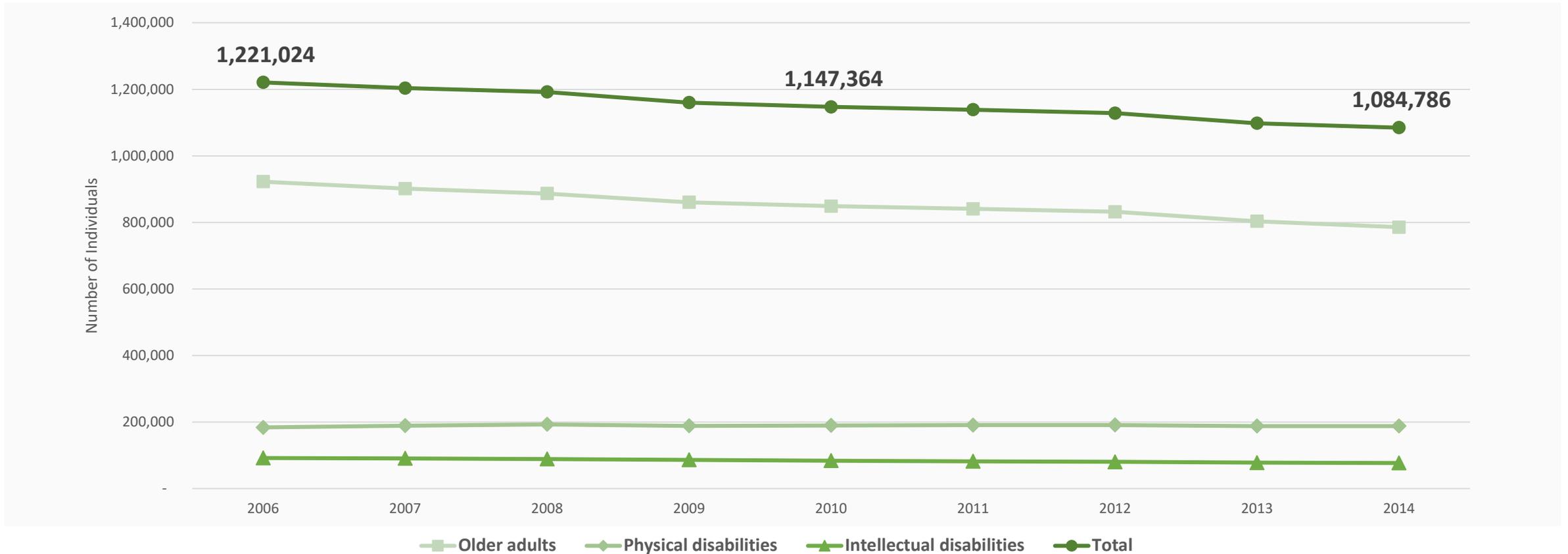
- **Established by Deficit Reduction Act of 2005**
 - 5-year demonstration and \$2 billion in grant funding for states
- **Extended and expanded by the Affordable Care Act of 2010**
 - 5-year extension and additional \$2 billion in grant funds
- **Extended by the Medicaid Extenders Act of 2019**
 - Added \$112 million for federal fiscal year 2019

A Popular Demonstration...



...Sizeable Eligible Population...

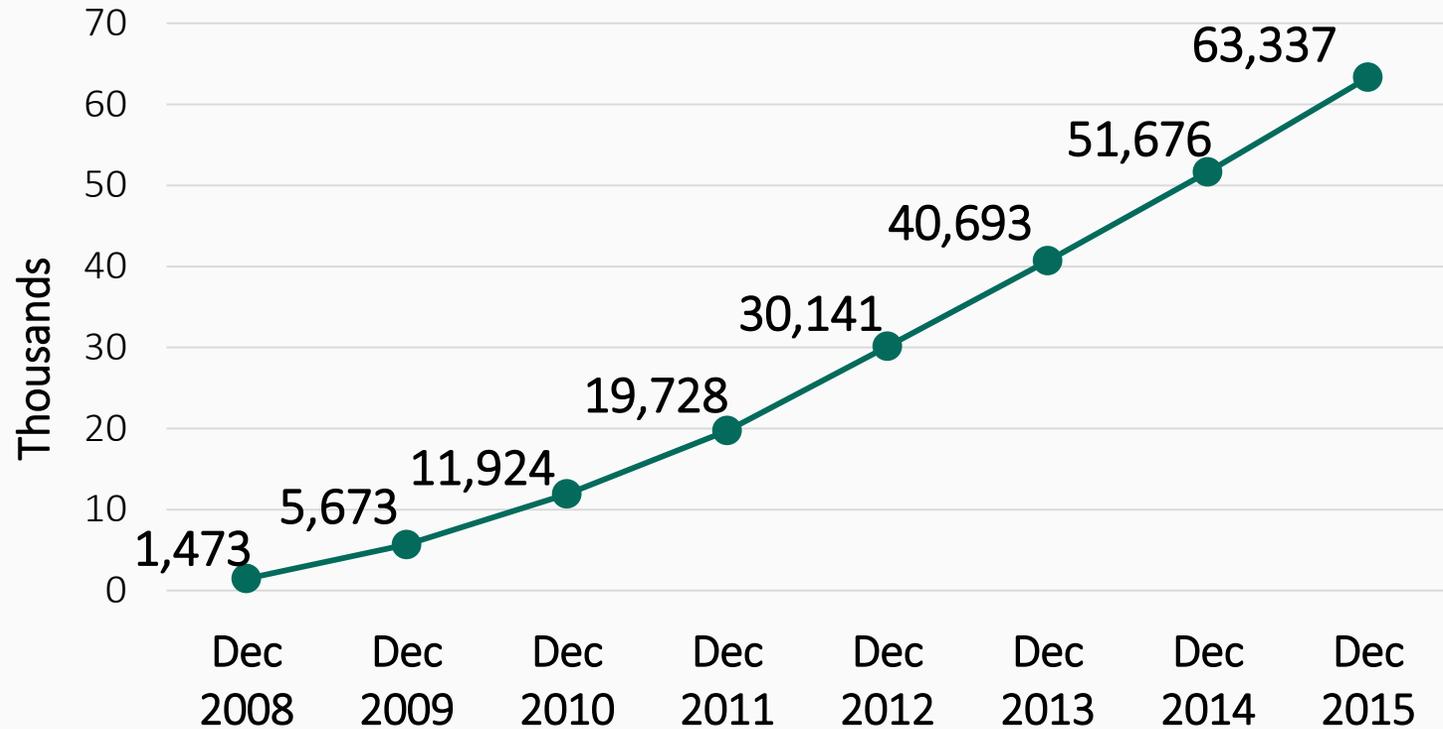
More Than One Million Eligible for MFP In Any Given Year



Source: Mathematica analysis of Medicaid Analytic eXtract (MAX) data from 2006 through 2014.

...But Not a Large Demonstration

Total cumulative number of MFP transitions grew steadily from 2008 through 2015



Source: Mathematica analysis of MFP enrollment records submitted by states to CMS.

Community-Based Services Are Less Costly than Institutional Care

Older adults

- Average per-beneficiary-per-month (PBPM) expenditures declined by \$1,840 (23 percent)

People with physical disabilities

- Average PBPM expenditures declined by \$1,730 (23 percent)

People with intellectual/developmental disabilities

- Average PBPM expenditures declined by \$4,013 (30 percent)

Savings Were Accrued by Medicaid

- MFP participants generated total savings of \$978 million in medical and LTSS costs
 - \$1 billion in savings to Medicaid
 - \$25 million increase to Medicare because of gains in Medicare coverage during the first year

Assessing Costs Extremely Difficult— Could Not Assess All Costs

- Housing – room and board
- Costs beyond the first year after the transition
 - Attempted to look at costs two years post transition, but results were inconclusive

Changes in Costs Not Unique to MFP

- The decline in costs observed among MFP participants is similar to what we see for others who transition outside the demonstration
- Did MFP transition beneficiaries who would not have transitioned otherwise?
 - Never detected a robust increase in transitions after MFP began
 - MFP participants had characteristics that suggested they had fewer connections to the community

Other Avenues for Cost Savings

- **Did MFP help beneficiaries remain longer in the community?**
 - Did MFP reduce the likelihood of someone returning to facility level care?
 - When someone returns to a facility, is the stay shorter because of MFP?
- **Did MFP provide more access to medical care?**
 - If MFP provides higher quality HCBS, are medical care costs lower as a result?

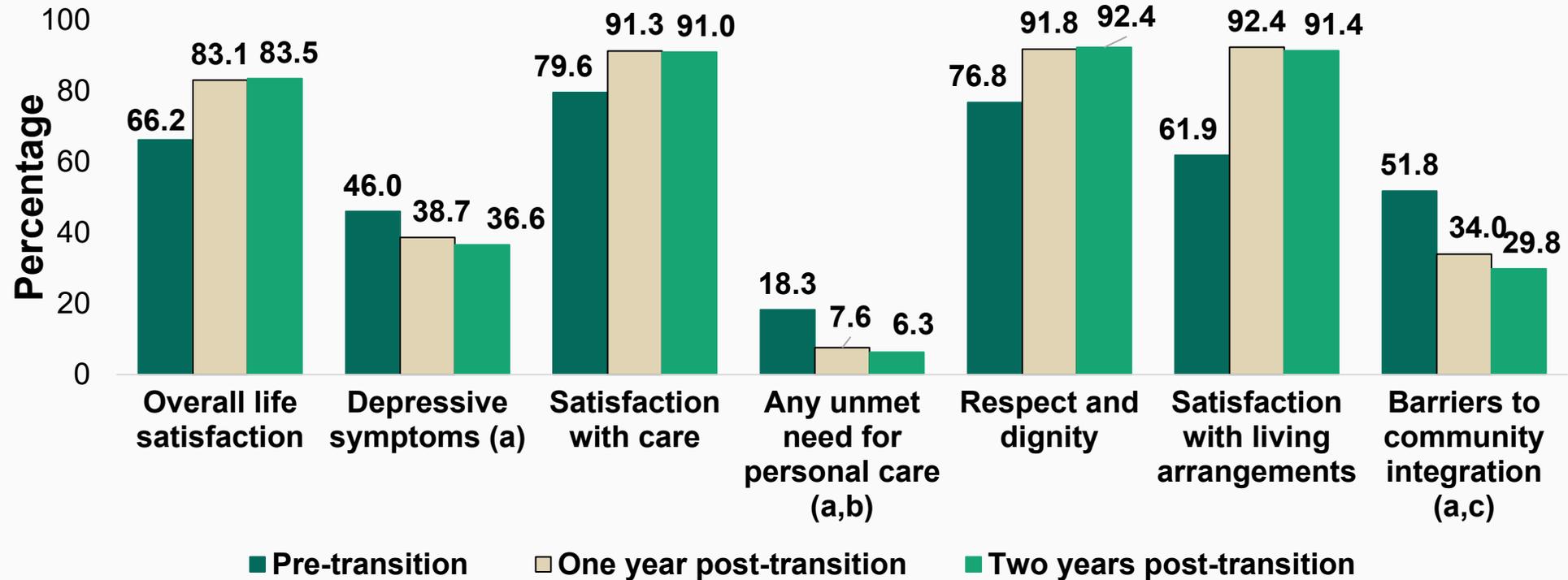
MFP Provided Other Benefits

Supported infrastructure changes

- Helped states establish formal transition programs
- Catalyst to interagency collaboration between health and housing
- Improved access to community-based LTSS

Stronger State LTSS Systems

Invaluable Quality of Life Improvements



Source: Mathematica’s analysis of MFP QoL surveys and program participation data submitted to CMS through May 2016.

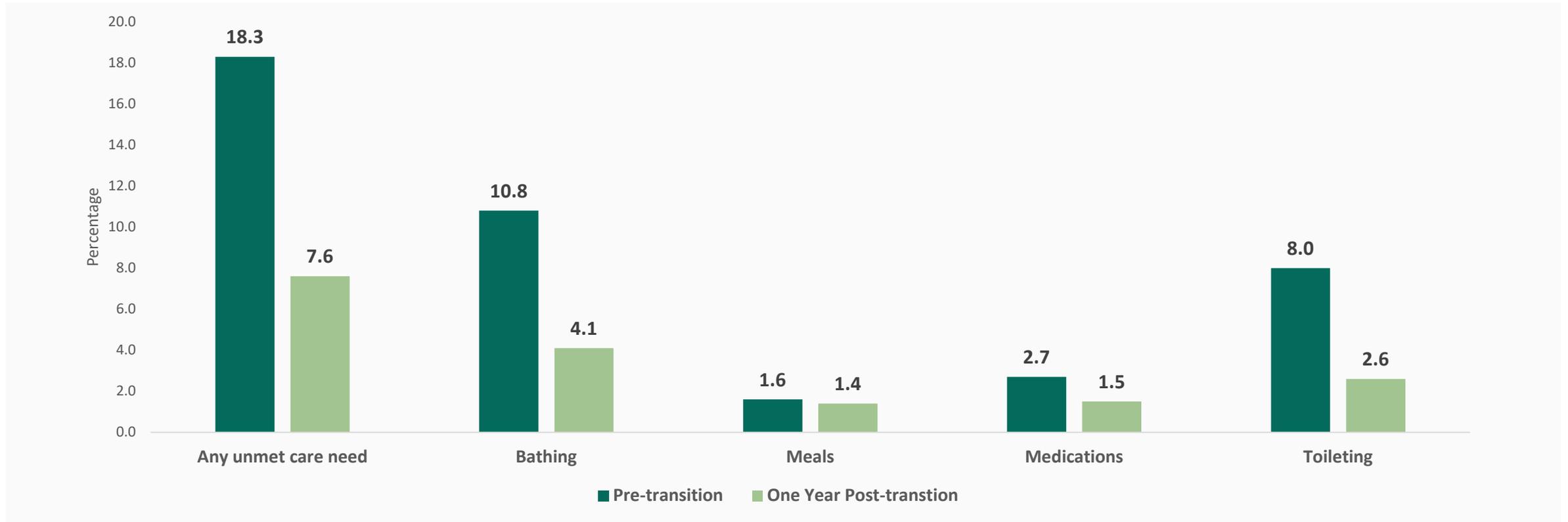
Note: The analyses are based on surveys from 13,795 MFP participants. All post-transition results were statistically different from pre-transition results at the .01 level, two-tailed test.

^aA declining percentage indicates improvement in depressive symptoms, or fewer unmet needs, or fewer barriers to community integration.

^bMeasured as “Any unmet need for personal assistance services” in bathing, eating, medication management, and toileting.

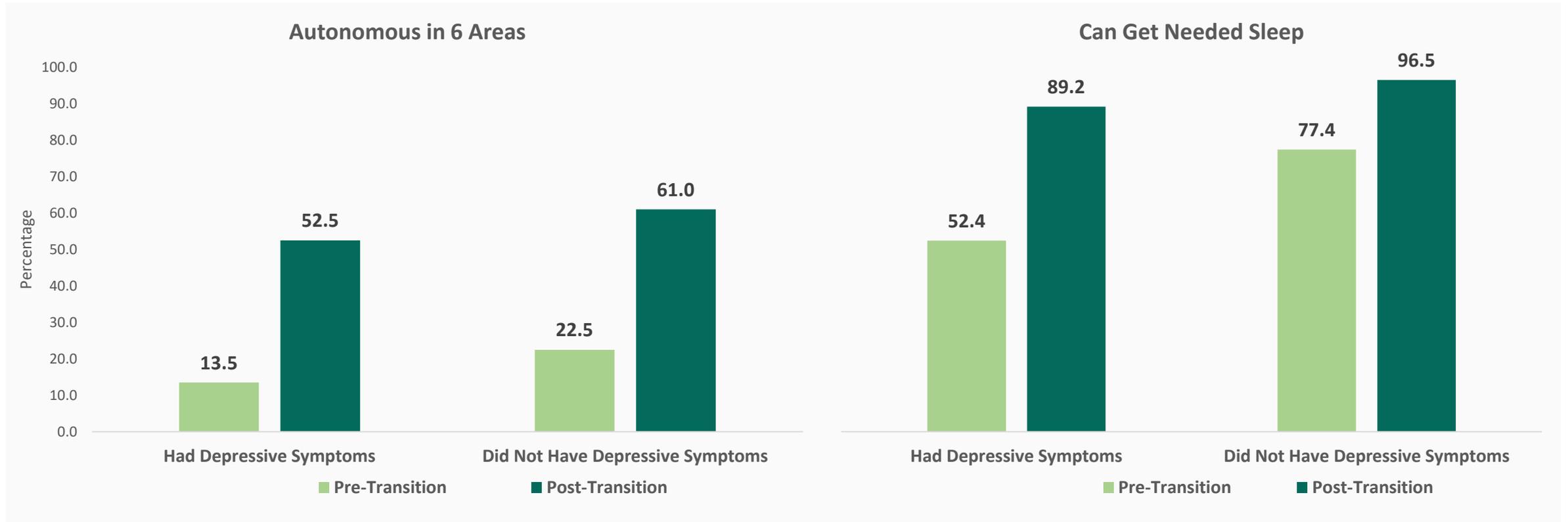
^cMeasured as affirmative responses to the question: “Is there anything you want to do outside [the facility/your home] that you cannot do now?”

Unmet Needs Declined Post Transition



Source: Mathematica's analysis of MFP QoL surveys and program participation data submitted to CMS through May 2016.
Note: The analyses are based on surveys from 13,795 MFP participants.

Unmet Needs Declined Post Transition



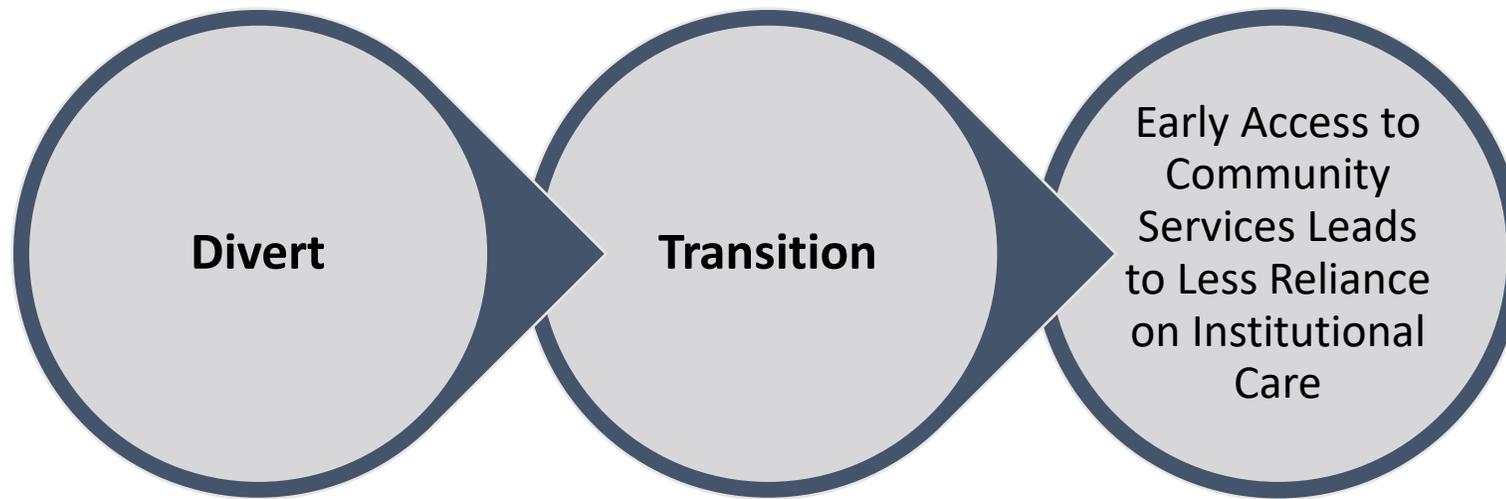
Source: Mathematica’s analysis of MFP QoL surveys and program participation data submitted to CMS through May 2016.

Note: The analyses are based on surveys from 6,688 MFP participants. Depressive symptoms are defined by affirmative responses to either of two questions: During the past week have you felt sad or blue? And During the past week have you felt irritable?. The autonomy measure is the percentage who answered “Yes” to all the following: (1) Can you go to bed when you want?, (2) Can you be by yourself when you want to?, (3) When you are at home, can you eat when you want to?, (4) Can you choose the foods that you eat?, (5) Can you talk on the telephone without someone listening in?, and (6) Can you watch TV when you want to?. The quality of sleep question was Can you get the sleep you need without noises or other disturbances where you live?

Next Steps?

- **Demonstrations are temporary**
 - Either end or adopted permanently
- **Community-based beneficiaries are less costly and have a higher quality of life than those residing in facilities**
 - Divert beneficiaries from facility-based care
 - Focus on the transition when a facility admission occurs

Make Community-Based LTSS Available As Early As Possible



- Decrease the likelihood of a long institutional stay

- Increase the likelihood of returning to the community and community-based services when an institutional stay occurs

For More Information

MFP webpage

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

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**Community
Living**
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Evidence for the Impact of Money Follows the Person

Steve Kaye

CLPC Webinar

7/25/19

Money Follows the Person transitions



Source: Mathematica, CMS

- State programs
 - 2007: 30 states + DC
 - 2011–12: 14 more states
 - 6 states never participated
 - 1 (OR) dropped out
- Cumulative total 9/07–6/18: 91,540 transitions
 - I/DD: 14,856
 - Non-I/DD: 76,684
- Some states transition >2% of institutional pop per year

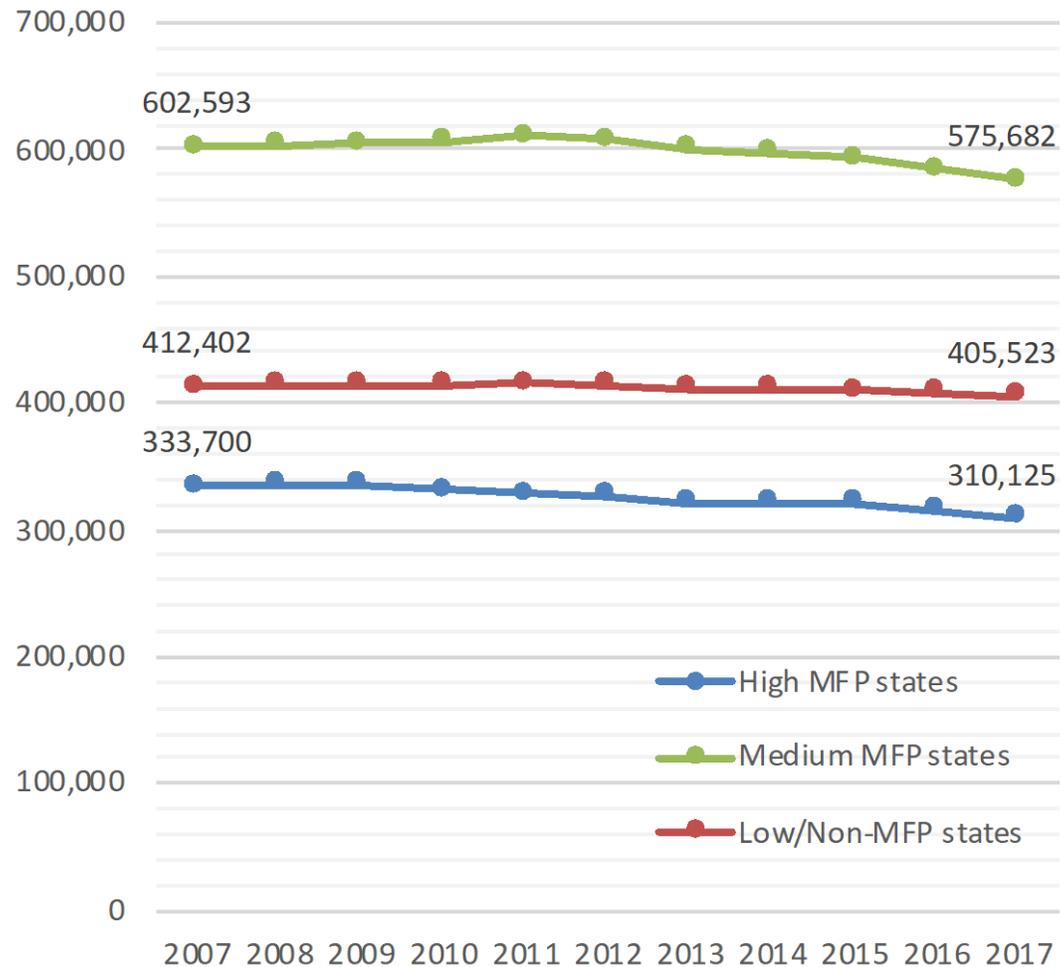
Data sources

- MFP Transitions: Mathematica Policy Research reports & CMS
- Institutional utilization
 - ▶ Nursing home residents & occupancy: Federal CASPER & OSCAR databases, from UCSF & Kaiser Family Foundation reports, with adjustments
 - ▶ Nursing home residents: CMS tabulations from Minimum Data Set (MDS)
 - ▶ ICF/IID population: Residential Information Systems Project (RISP) reports from U. Minnesota, updated by RISP team
- LTSS expenditures
 - ▶ Truven/IBM Watson Health reports w/ adjustments
 - ▶ CMS Medicaid Budget & Expenditure System (MBES) for bulk “supplemental payments”

Analysis, Part I: Non-I/DD population

- States classified as High, Medium, or Low/Non-MFP States
 - ▶ Based on 2012-17 ave. annual number of MFP transitions, relative to the state population
 - ▶ High MFP: CT, DE, DC, GA, HI, ID, KS, LA, MD, MA, NE, ND, OH, RI, TN, VT, WA
 - ▶ Low/Non-MFP states:
 - No MFP program: AK, AZ, FL, NM, UT, WY + OR (early dropout)
 - Few non-I/DD transitions: AL, CA, CO, IA, KY, MN, NC, OK, SC, VA
- Institutional population: NH residents without ID (~98%)
- LTSS expenditures: Non-I/DD-specific HCBS + nursing homes
 - Home health not counted as HCBS
 - “Supplemental payments” excluded from NH expenditures

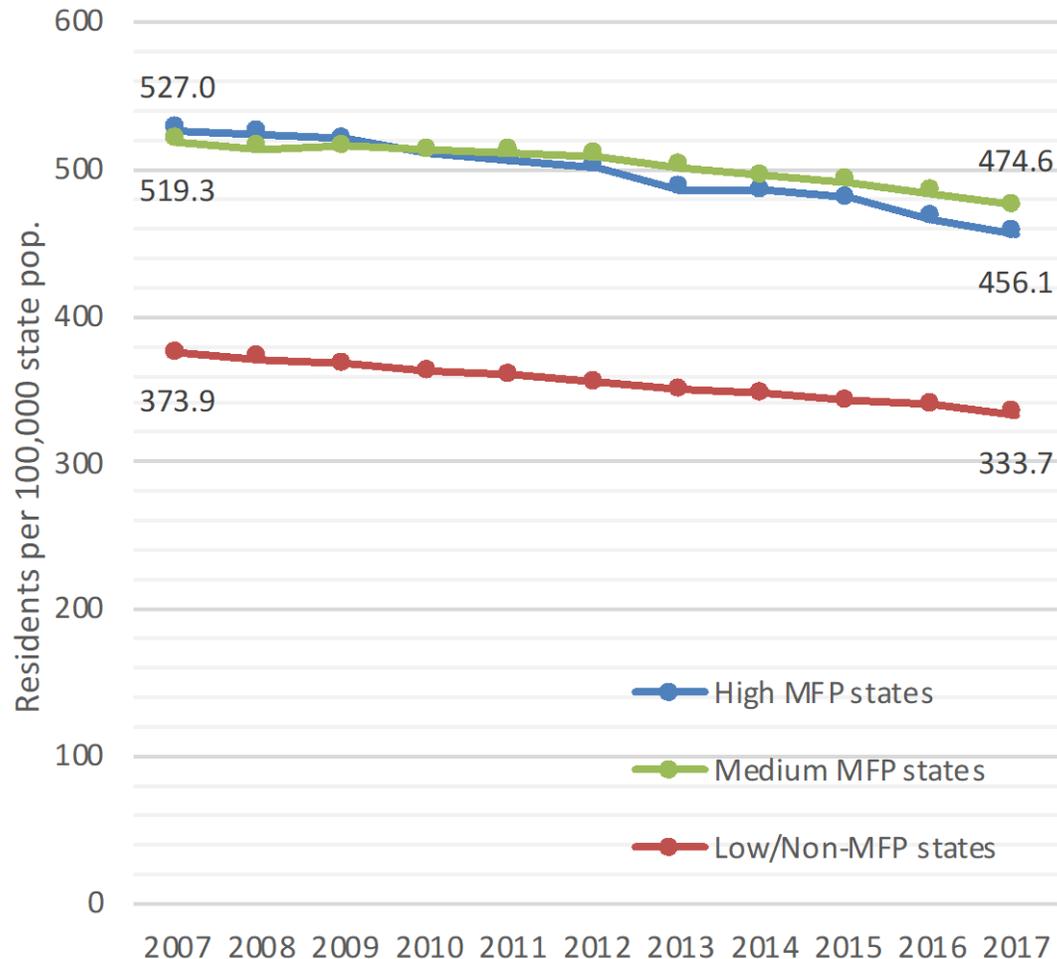
Nursing home population declined in High & Medium MFP states



- Change 2007-17
 - High -7.1%
 - Medium -4.5%
 - Low -1.7%

Source: CASPER/OSCAR tabulations from KFF & UCSF

Proportion of state pop in nursing homes: High MFP states had largest decline

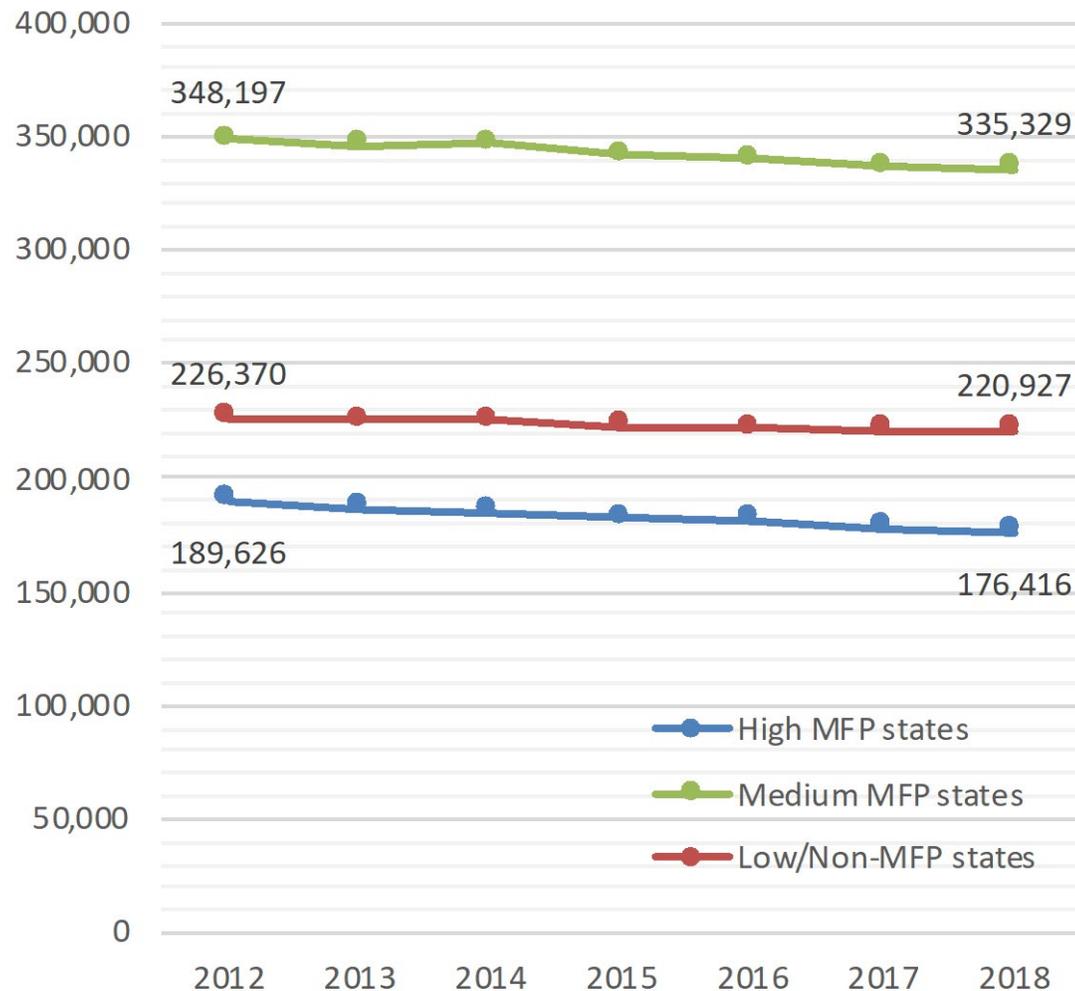


- Change 2007-17
(# per 100,000 pop,
averaged across states)

- High −71.0
- Medium −44.7
- Low −40.2

Source: CASPER/OSCAR tabulations from KFF & UCSF

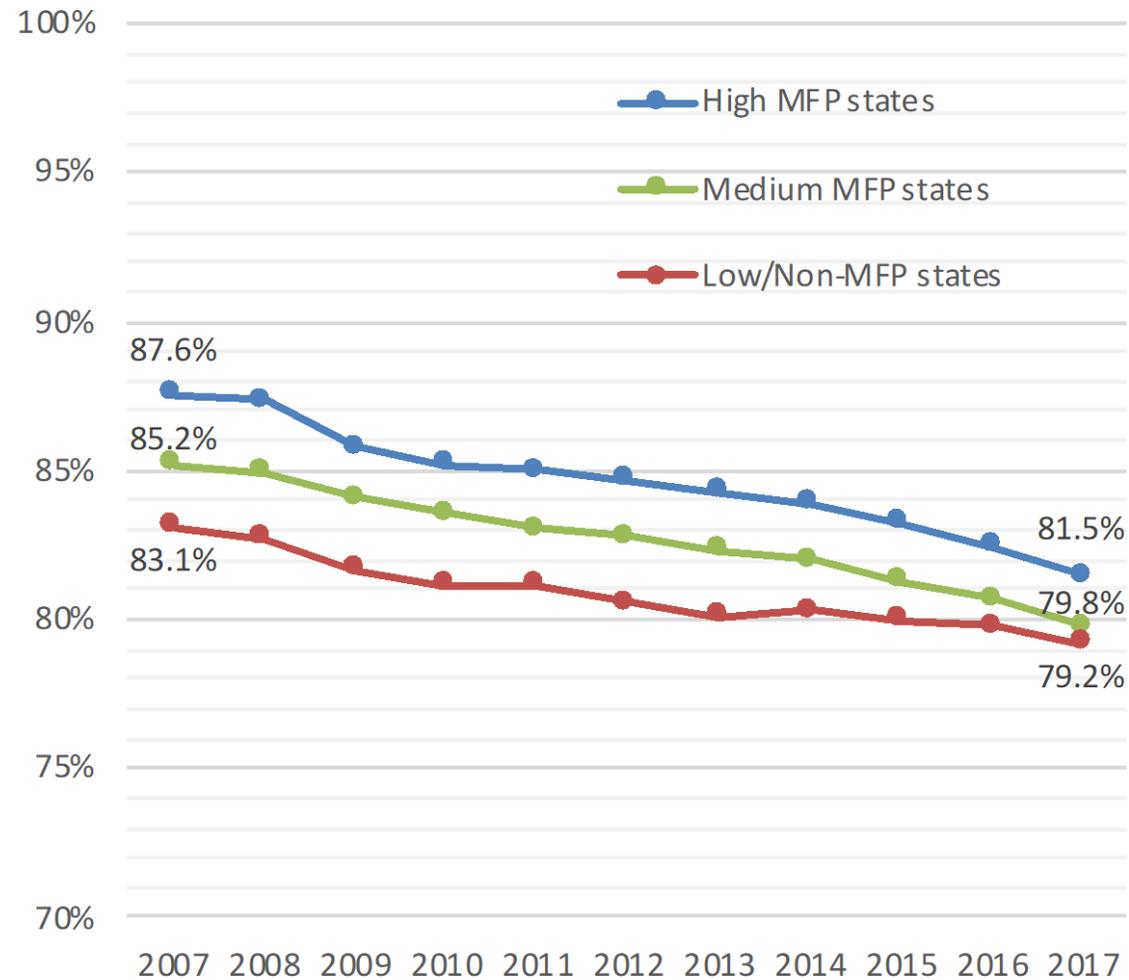
Permanent-stay nursing home residents: Reductions in High/Medium MFP states



Source: MDS 3.0

- Change 2012–18
 - High –7.0%
 - Medium –3.7%
 - Low –2.4%
- “Permanent-stay” based on residents’ expectations when admitted/readmitted

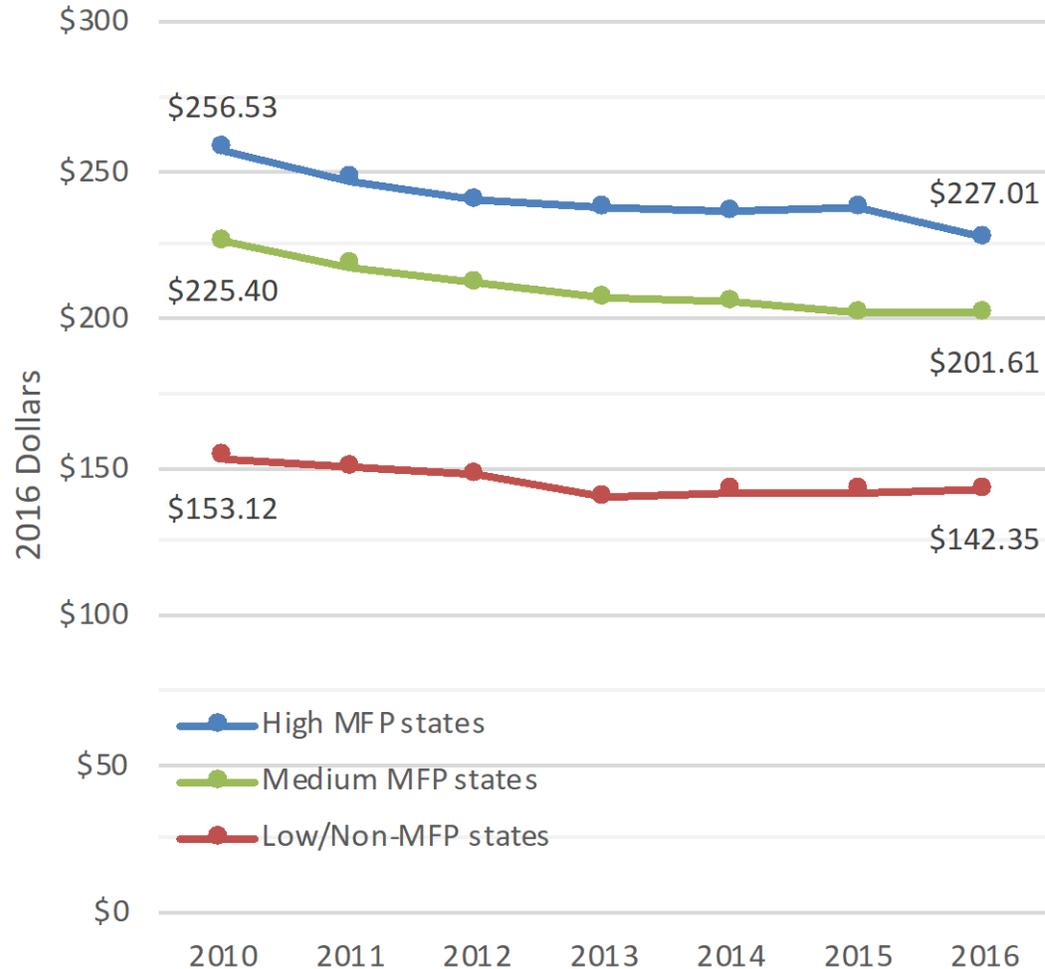
Nursing home occupancy: Greater reduction in High & Medium MFP states



Source: CASPER/OSCAR tabulations from KFF & UCSF

- Change 2007-17 (percentage points, averaged across states)
 - High -6.1
 - Medium -5.4
 - Low -4.0

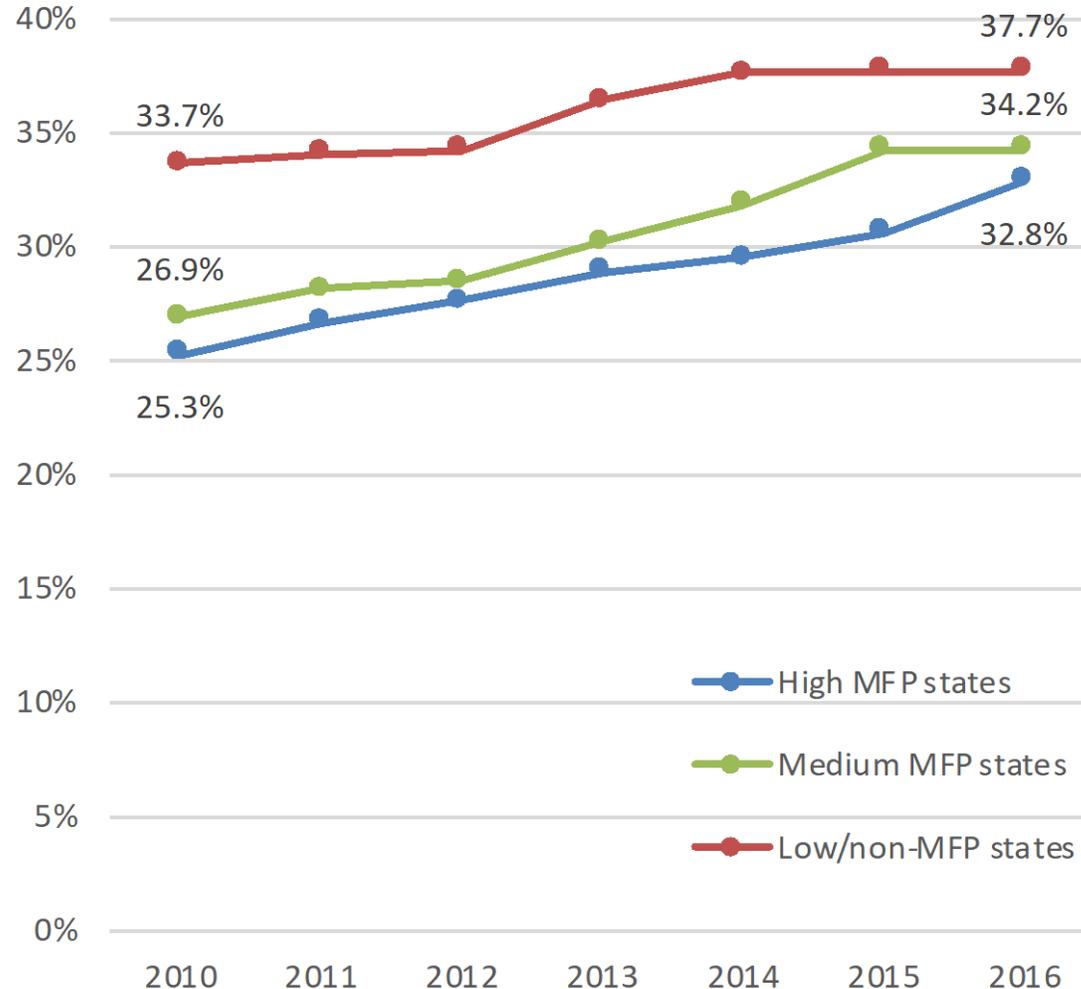
Medicaid nursing home expenditures declined more in High & Medium MFP states



Source: Truven/IBM Watson Health & CMS MBES reports

- Change 2010–16 (\$ per capita, adjusted for inflation)
 - High –\$29.52
 - Medium –\$23.79
 - Low –\$10.77
- CA & NM omitted due to missing/ inconsistent data

Rebalancing: High & Medium MFP States had larger increase in HCBS % of LTSS Spending



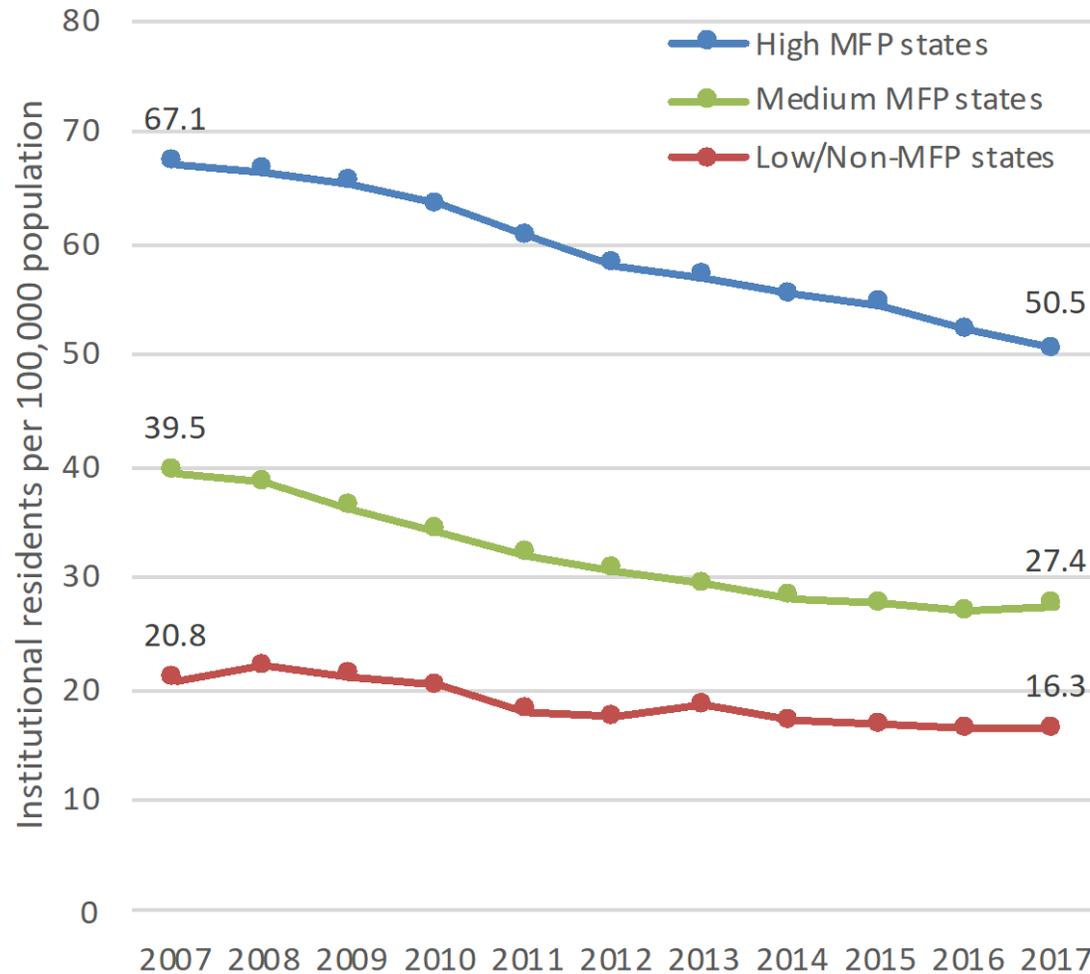
Source: Truven/IBM Watson Health reports

- Change 2010-16 (percentage points, averaged across states)
 - High +7.6
 - Medium +7.3
 - Low +4.0
- CA, FL, ID, NJ, NM omitted due to missing/inconsistent data

Analysis, Part II: I/DD population

- States classified as High, Medium, or Low/Non-MFP States
 - ▶ Based on 2012-17 ave. annual number of MFP transitions of people with I/DD, relative to the state population
 - High-MFP: AR, CT, ID, IL, IA, KS, LA, MS, MO, NJ, ND, OH, OK, SD, TX, VA, WA
 - ▶ Low/Non-MFP states:
 - No MFP program: AK, AZ, FL, NM, UT, WY + OR (early dropout)
 - No I/DD transitions: AL, ME, MI, RI, SC, VT, WV
 - Few I/DD transitions: HI, MN, NH
- Institutional population: ICF/IID pop + NH residents with ID (~2%)
- LTSS expenditures: I/DD-specific HCBS & ICF/IID
 - “Supplemental payments” excluded from ICF/IID expenditures

Larger declines in institutionalized state pop in High & Medium MFP states

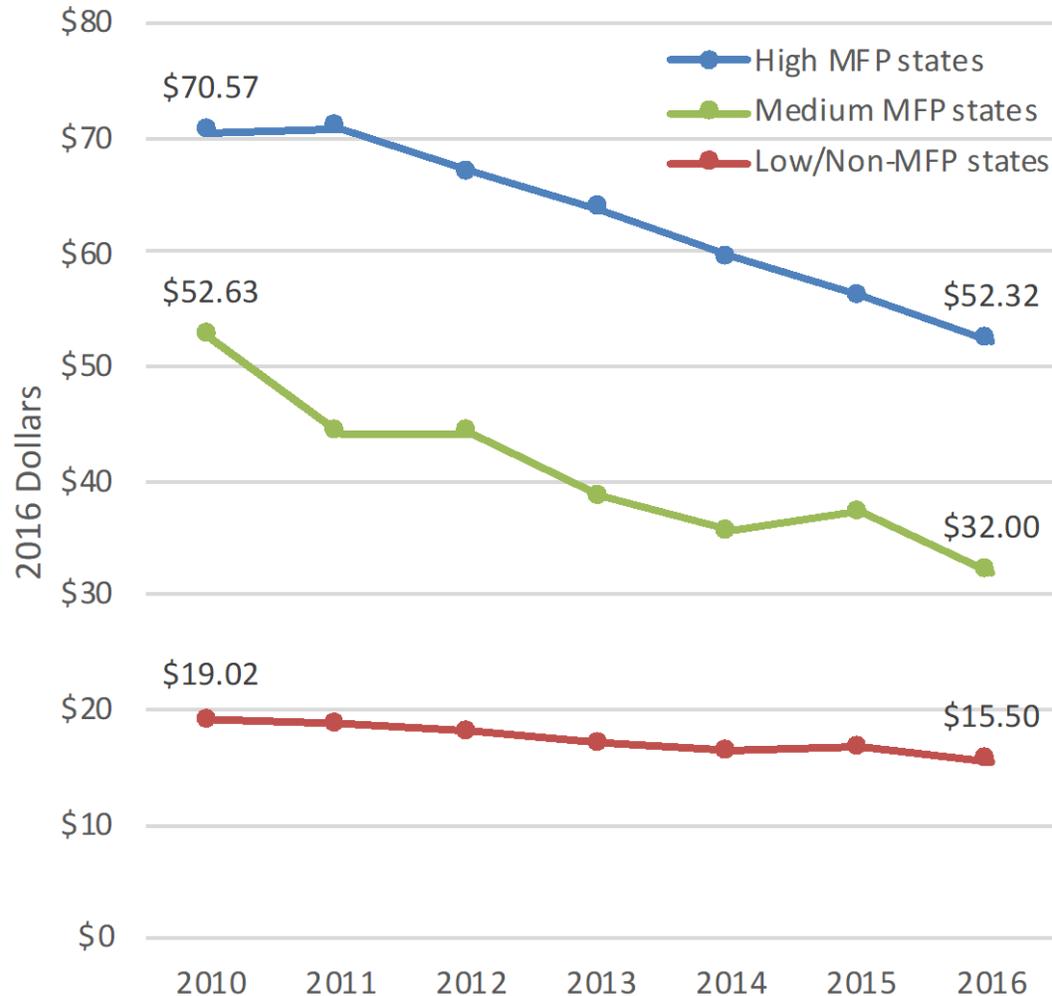


- Change 2008-17 (# per 100,000 pop, averaged across states)

- High -16.6
- Medium -12.0
- Low -4.5

Source: RISP; CASPER/OSCAR tabulations from KFF & UCSF

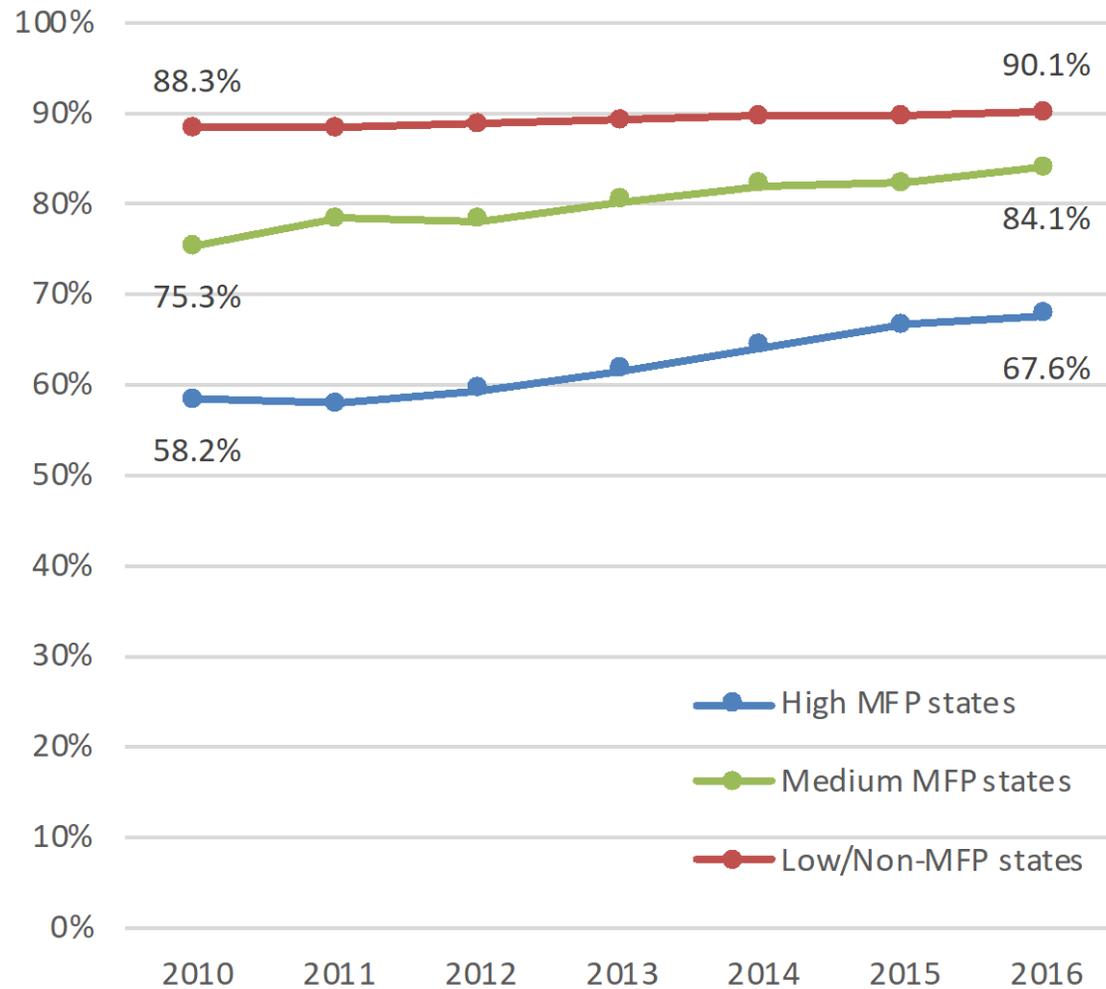
Medicaid ICF/IID expenditures declined in High & Medium MFP states



Source: Truven/IBM Watson Health & CMS MBES reports

- Change 2010–16 (\$ per capita, adjusted for inflation)
 - High –\$18.25
 - Medium –\$20.63
 - Low –\$3.53
- NC omitted due to missing data

Rebalancing: High & Medium MFP States had larger increase in HCBS % of LTSS Spending



Source: Truven/IBM Watson Health & CMS MBES reports

- Change 2010-16 (percentage points, averaged across states)
 - High +9.4
 - Medium +8.8
 - Low +1.8
- NC omitted due to missing data

Conclusions

- States with robust MFP programs substantially reduced nursing home & ICF/IID utilization relative to other states
- Reduced nursing home occupancy rates suggest that transitioned residents are not being replaced by new residents
- Reductions in “permanent-stay” NH residents are particularly important
 - Suggests that MFP targets those who would not otherwise return to community
- High & Medium MFP states rebalanced their Medicaid LTSS systems faster than Low/non-MFP states
- MFP appears to have been successful in helping states shift away from institutional services and toward HCBS
- Tiny program that works: Permanent part of Medicaid?

Money Follows the Person- EMPOWER Care Act (S. 548, H.R. 1342)

Nicole Jorwic, J.D.
Senior Director of Public Policy,
The Arc of the United States

Money Follows the Person

Money Follows the Person (MFP) gives states additional federal Medicaid funds to help transition people from institutions to the community

Congressional Intent: Rebalance the Long-Term Care system from institution to community

Mechanism: Enhanced federal match earned on HCBS for each MFP participant enrolled in HCBS program following discharge from a qualified institution

History

Federal Demonstration Project

- Originated under the Deficit Reduction Act of 2005
- Expanded by the Affordable Care Act Rebalancing Initiative

Congressional Intent: Rebalance the Long-Term Care system from institution to community **Strong Bi-Partisan support

Mechanism: Enhanced federal match earned on HCBS for each MFP participant enrolled in HCBS program following discharge from a qualified institution

Legislative History of MFP

- First became law through the The Deficit Reduction Act of 2005 (S. 1932)
- Reauthorized as part of the Affordable Care Act (H.R. 3590) (Senate passed the House version) and the
- Program expired September 30, 2016

Recent MFP Activity

There have been several short term extension bills, but the EMPOWER Care Act (S. 548, H.R. 1342) would extend and improve the MFP program through 2023

A 4.5 year extension passed the House in June now we will look to the Senate

Changes in Current Legislation

The EMPOWER Care Act improves MFP by reducing how long someone must be in a nursing home before becoming eligible to transition from 90 days to 60.

The bill also enhances the reporting and accountability of MFP funding

Requires the federal government to identify and share the most effective state strategies for transitioning beneficiaries from institutional to qualified community settings, including how such strategies vary for different types of beneficiaries.

Questions

Submit your questions via the Chat



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