

REPORT

FINAL REPORT

Money Follows the Person 2013 Annual Evaluation Report—Executive Summary

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EXECUTIVE SUMMARY

The Money Follows the Person (MFP) demonstration program represents a major federal initiative to give people needing long-term services and supports (LTSS) more choice about where they live and receive care, and to increase the capacity of state long-term care systems to serve people in community settings. Calendar year 2013 marked the sixth full year of implementation of the national MFP demonstration. Cumulative MFP enrollment climbed to more than 40,000 transitions by the end of December 2013, a 35 percent growth over the total number at the same point in 2012. As of December 31, 2013, 47 states had received MFP grants; Florida and New Mexico were awarded MFP grants in 2011 but later rescinded them in 2012. Among the 45 participating states, two (Montana and South Dakota) were in the program-planning phase throughout 2013, and one original grantee (Oregon) continued as a suspended program while it redesigned its operations. During 2013, 42 states were actively transitioning participants through their MFP programs; five of these states (Alabama, Colorado, Minnesota, South Carolina, and West Virginia) began transitioning people to the community for the first time during the year.

By the end of calendar year 2013, MFP programs had cumulatively transitioned 40,693 individuals.

A. Purpose of the Report

This is the fifth in a series of annual reports from the national evaluation of the MFP rebalancing demonstration. It presents three broad sets of analyses that report on the overall progress and effects of the MFP demonstration: (1) progress grantees are making on their statutory transition and expenditure goals, (2) the extent to which states are rebalancing their LTSS systems, and (3) how expenditures patterns and utilization of select services change after someone transitions from institutional to community-based LTSS. To the extent possible, the analyses cover the program from its inception through December 2013.

B. Overview of Findings

Grantee Progress on Statutory Goals

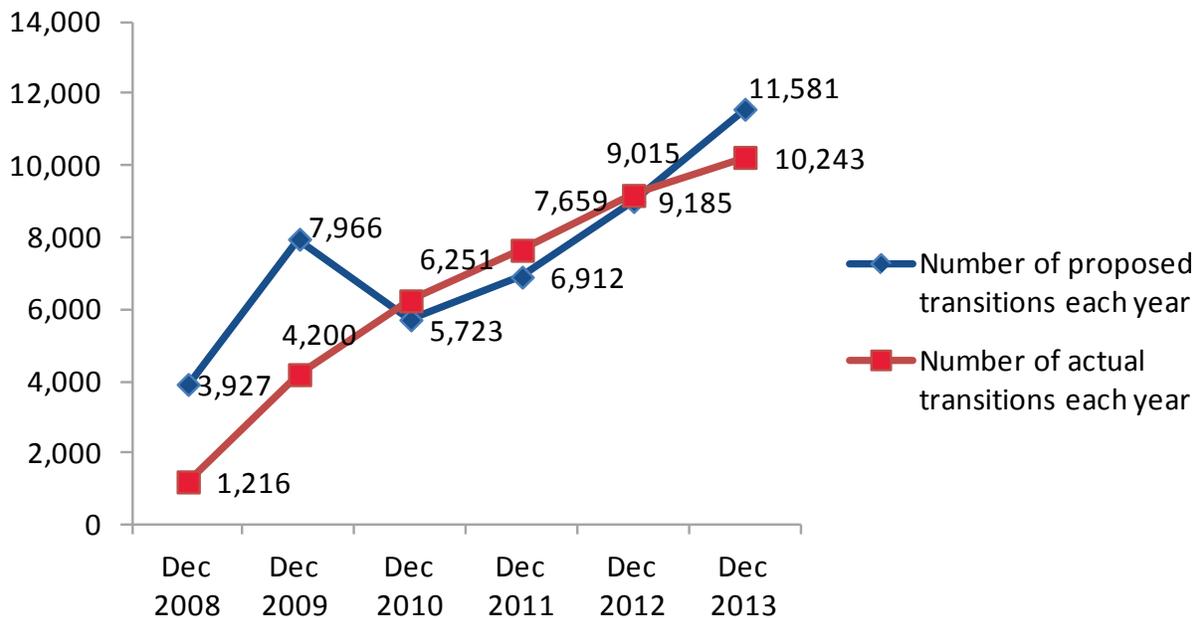
The Deficit Reduction Act of 2005, which authorized the MFP program, requires state grant applications to project the number of transitions their MFP demonstrations would achieve each year and by targeted population [DRA, §6071(c)(5)]. CMS allows states to modify these goals on an annual basis. The federal statute that created the MFP demonstration also requires grantee states to track and report their total qualified home- and community-based service (HCBS) expenditures each year.

The 42 MFP grantees actively transitioning participants in 2013 achieved 88 percent of the transition goal for 2013, transitioning 10,243 people of the 11,581 transitions projected for the year. As in the earlier years of the MFP demonstration, states may have set overly ambitious transition goals for 2013 (Figure ES.1). Several states were still in the early phases of their programs in 2013 and most MFP programs have fewer than

In 2013, MFP grantees transitioned 10,243 individuals which represents a 14 percent increase in the number of transitions from the previous year.

expected transitions during the start-up phase when procedures and systems are not fully implemented.

Figure ES.1. MFP grantees' progress toward annual transition goals, 2008–2013



Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2008–2013.

Note: N = 30 states in 2009 and 2010; 34 states in 2011; 37 states in 2012; and 42 states in 2013.

The grantee states track and report their total qualified HCBS expenditures each year. These total expenditures include not just all HCBS spending on MFP participants, but all federal and state Medicaid spending on 1915(c) waiver services and home health, personal care, and other optional state-plan HCBS provided for all Medicaid beneficiaries.¹ By statute, states in the MFP program are required to set annual HCBS expenditure goals which, as with their transition goals, they can alter over time as the context in states change.

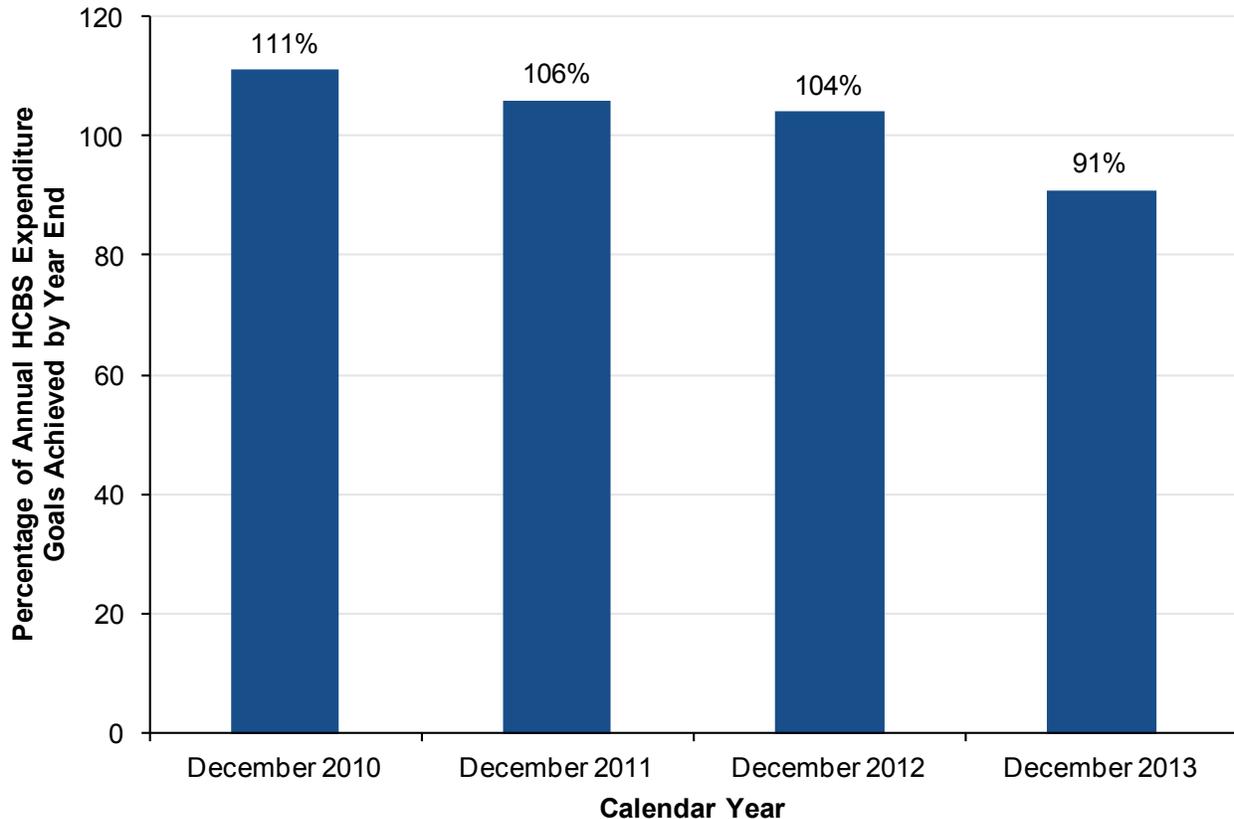
The 42 grantee states that actively transitioned participants during 2013 reported \$63 billion in qualified HCBS expenditures that year, achieving 91 percent of their annual total qualified HCBS expenditures goal (\$69,171,219,875). However, 2013

During calendar year 2013, MFP programs incurred at least \$63 billion in qualified HCBS expenditures. This figure will increase when several states with incomplete data update their expenditure amounts for the year.

¹ Other optional state-plan HCBS include services such as adult day care, private duty nursing, and residential care.

spending is likely underestimated because the 2013 expenditure information for several states was incomplete. The completeness of the data may partially explain why 2013 marks the first time in recent years the state grantees did not exceed their aggregate expenditure goal (Figure ES.2).

Figure ES.2. MFP grantees’ progress toward annual HCBS expenditure goals, December 2010 to December 2013



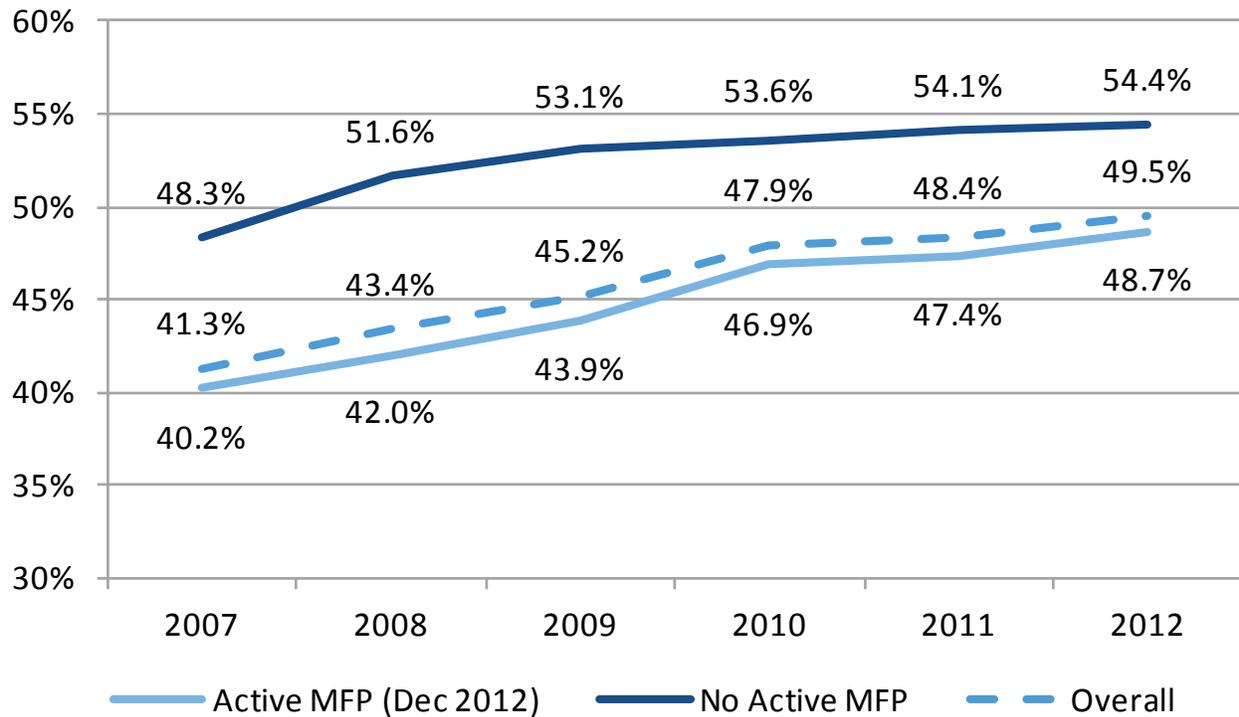
Source: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2010 to 2013.

Note: N = 29 states in 2010; 33 states in 2011; 35 states in 2012; 42 states in 2013.

Rebalancing Long-Term Services and Supports

Annual summary expenditure data published by Truven Health Analytics indicate that historically many states have spent more on institutional-based care than HCBS, but this balance has been changing (Eiken et al. 2014) (Figure ES.3). When Truven’s data are disaggregated, we find that the 37 states with an active MFP program as of December 2012 had increased the proportion of their LTSS spending accounted for by HCBS more rapidly than states without an active MFP program. Although states without an active MFP program have higher HCBS expenditures as a share of overall LTSS spending, their rate of increase appears to be slowing, while states with an active MFP program appear to be catching up.

Figure ES.3. Percentage of long-term services and supports expenditures accounted for by HCBS, by MFP status, 2007–2012



Source: Mathematica analysis of Truven Health Analytics data (Eiken et al. 2014).

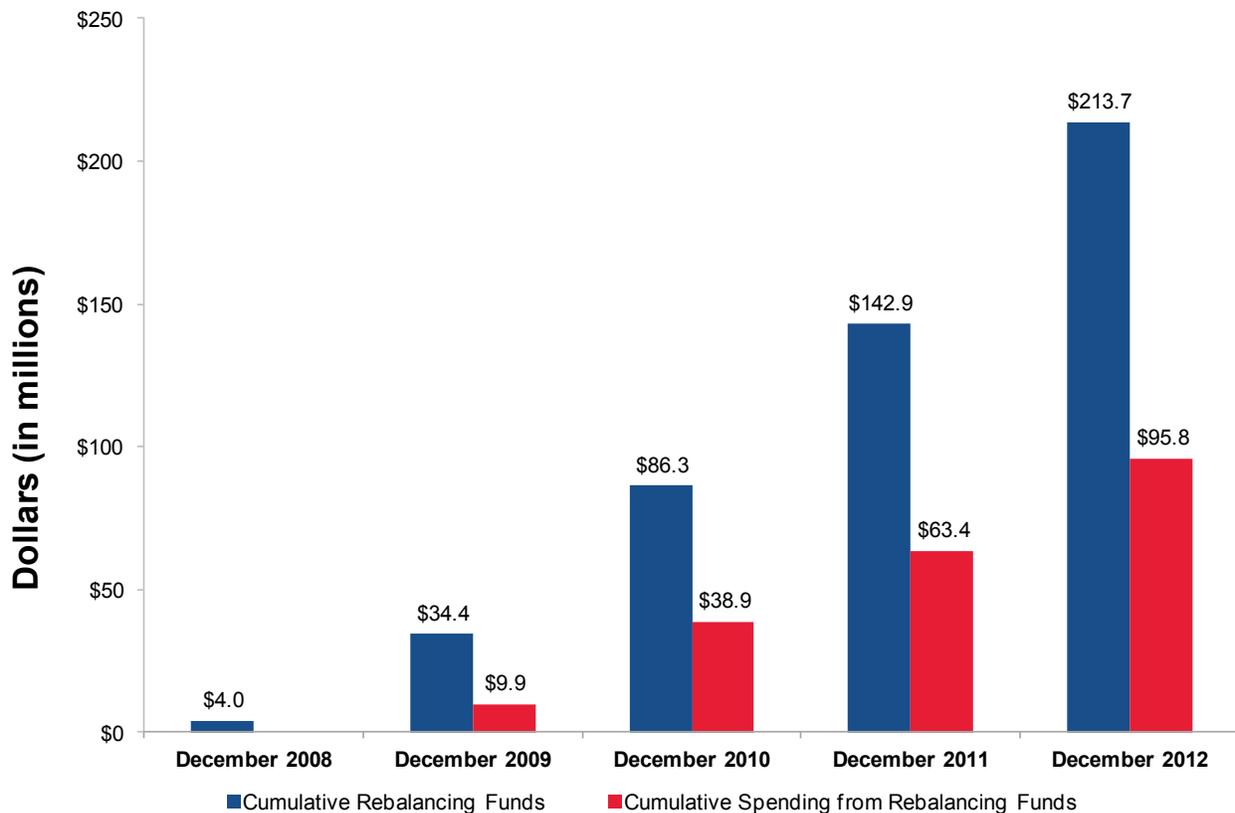
State MFP rebalancing funds have grown from nearly \$4 million at the end of calendar year 2008 to nearly \$214 million across 30 states by the end of calendar year 2012 (Figure ES.4). The rate at which states spend these funds has been slower than their accumulation rate. By the end of 2012, the most recent data available, states had spent slightly more than \$95.8 million, or about 45 percent of the amount accrued. However, spending might be higher than these estimates suggest, because several states have not been able to report on their rebalancing fund spending (California, Georgia, New Hampshire, and Wisconsin) or have inconsistently reported this spending (Arkansas, Delaware, Hawaii, and Kansas).

States have been steadily accumulating MFP rebalancing funds. However, among states with available data, states have been slow to expend the funds, spending about 45 percent of the amount accrued by the end of 2012.

Among the MFP grantees, 16 were also reporting the rebalancing funds they earned and spent through the Balancing Incentive Program, a similar rebalancing program that allows states to accumulate rebalancing funds immediately upon approval of their application and on all HCBS provided to all Medicaid beneficiaries. Of the 16 states reporting total rebalancing funds earned and spent as of the first quarter of 2014, two states—New York and Texas—reported the largest accumulation of funds, approximately \$296 million and \$104 million, respectively. New York reported spending only about 7 percent of total funds (approximately \$20 million) to date, and Texas reported spending 8 percent of total funds (approximately \$8 million). In contrast,

Missouri and Ohio reported the highest spending amounts to date among all states: approximately \$57 million and \$48 million, respectively. These two states are also the only states that reported spending 100 percent of the rebalancing funds they had accumulated through the Balancing Incentive Program. Nine of the 16 states reported spending less than 50 percent of accumulated funds, and 7 spent less than 25 percent.

Figure ES.4. Cumulative accrual and expenditure of state rebalancing funds, December 2009–December 2012



Sources: Mathematica analysis of State MFP Grantee Semiannual Progress Reports, 2010–2013, and the 2013 state budget worksheets.

Note: N = 30 states in 2008–2010; 37 states in 2011; 43 states in 2012.

MFP states used their rebalancing funds on several initiatives in 2012 to support general rebalancing goals and additional state-specific benchmarks. These activities can be broadly classified into the following categories:

- Improving pathways to HCBS
- Financing provision of services
- Expanding and supporting 1915(c) waiver programs
- Supporting providers
- Investing in strategic planning and research
- Improving information technology systems

States participating in both the MFP and Balancing Incentive Payment programs frequently braid the rebalancing funds from each. Several states are using MFP rebalancing or administrative funds to support the structural changes required under the Balancing Incentive Program while other states are using MFP funds to support implementation of the structural changes required by the Balancing Incentive Program. For example, Ohio's Balancing Incentive Program work plan indicated that the state planned to use MFP rebalancing funds almost exclusively to support the development of the structural changes the Balancing Incentive Program requires. Texas' application to the Balancing Incentive Payment program noted that although the funds would be used for Balancing Incentive Program activities, any additional or supplemental activities identified during the three-year grant period will be financed by MFP administrative funds, if approved.

The effect of the MFP demonstration on individuals' post-transition expenditures and utilization

Analyses of program outcomes focused on how medical and long-term care expenditures and use of selected potentially high-cost medical services change when Medicaid beneficiaries transition from institutional to community-based LTSS. A program such as MFP might not be considered successful unless it demonstrates that a formal transition program for long-term residents of institutions either generates savings or at least does not increase costs significantly for Medicaid programs. The analyses focused on the extent to which the changes in expenditures or use of inpatient and emergency department (ED) services that occur after someone transitions to the community can be attributed to the MFP program.

Using Medicaid and Medicare claims data from 2008 through 2010 we found the following.

- Medicaid and Medicare total expenditures decline, sometimes substantially so, during the first 12 months after someone transitions from institutional care to HCBS. MFP participants with physical disabilities or mental illness had higher post-transition total expenditures than a matched set of people who transitioned to the community outside the MFP program. The higher post-transition total expenditures are primarily attributable to higher HCBS expenditures, reflecting the design of the MFP program.
- After the transition, MFP participants have greater average HCBS expenditures compared with other transitioners with similar characteristics, but typically have lower post-transition Medicaid and Medicare medical care expenditures. Thus, MFP participants' higher HCBS expenditures are partially offset by the higher medical expenditures the other transitioners incur.
- Inpatient care and ED use, both potentially high-cost services, however, do not explain the differences in post-transition medical care expenditures between MFP participants and those who transition without the benefit of the MFP program. The likelihood of using these services after transition was not significantly different between MFP participants and other transitioners with similar characteristics.

HCBS expenditures of MFP participants

Because MFP participants have greater average HCBS expenditures compared with other transitioners, we continued to assess the HCBS MFP participants receive during their period of program eligibility.

- In line with last year's report, the majority of HCBS spending is concentrated in home-based (primarily personal assistance services) and round-the-clock services. Each category accounts for about 30 percent of all expenditures.
- Home-based and coordination and management services, as well as equipment, technology, and modifications, were provided to MFP participants in all 30 states available for analysis.
- The most commonly used HCBS was coordination and management services (73 percent of MFP participants used this service which is likely an underestimate), and more than half of MFP participants used home-based services (primarily personal assistance services) or equipment, technology, and modifications.

REFERENCE

Eiken, Steve, Kate Sredl, Lisa Gold, Jessica Kasten, Brian Burwell, and Paul Saucier. "Medicaid Expenditures for Long-Term Services and Supports in FFY 2012." Bethesda, MD: Truven Health Analytics, April 2014.

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