

Evidence for the Impact of the Money Follows the Person Program

H. Stephen Kaye, Ph.D.
University of California San Francisco

Created in the Deficit Reduction Act of 2005 and renewed and expanded in the Affordable Care Act of 2010, the Money Follows the Person (MFP) program was designed to fund states to transition people receiving Medicaid-funded long-term services and supports (LTSS) in institutional settings back into community settings. The first MFP transitions occurred in late 2007. As of June 2018, 91,540 institutional residents had transitioned in 44 states and the District of Columbia. Some 14,856 of these were people with Intellectual or Developmental Disabilities (I/DD), who moved from either institutions for people with intellectual disabilities or nursing homes into community settings, such as their own home, a family home, or a small group setting. The remaining 76,684 had physical, mental health, or adult-onset cognitive disabilities and were primarily transitioned out of nursing homes. In each year from 2012 to 2017, MFP transitioned more than 10,000 people back to the community.

Studies have demonstrated the impacts of the MFP program on transitioned individuals: After returning to the community, they are less likely to experience unmet LTSS needs and more likely to be treated with respect and dignity by LTSS providers, and they experience greater control over their lives and are better integrated into community life (Coughlin et al., 2017; Robison, Porter, Shugrue, Kleppinger, & Lambert, 2015). In one state, MFP was found to have resulted in a net reduction in LTSS expenditures (Xing, Mancuso, & Felver, 2017).

In an effort to further explore the impact of the MFP program nationally, this report examines state-by-state trends in institutional residents

Key Points

- State MFP programs have transitioned more than 90,000 institutional residents back to the community.
- The top states transition 2% or more of their institutional population annually.
- Prior studies show that MFP improved the lives of the individuals transitioned and reduced LTSS spending.
- States with robust MFP programs reduced utilization of institutional LTSS more rapidly than other states.
- These states reduced the number nursing home residents likely to remain permanently institutionalized.
- Nursing home occupancy rates declined more in states with robust MFP.
- Robust MFP states reduced Institutional spending and “rebalanced” their LTSS systems faster than other states.

receiving LTSS and in Medicaid LTSS expenditures.

Data Sources

The analysis uses the following data sources:

- MFP transition data come from the annual grantee progress reports published by Mathematica Policy Research (Coughlin et al., 2017; and prior reports in the series), as well as other Mathematica reports (Denny-Brown & Lipson, 2009; Irvin et al., 2015). Cumulative totals through June 2018 were

July, 2019

supplied by the Centers for Medicare and Medicaid Services (CMS) via email; to estimate the number of transitions in 2017, the difference between these numbers and the 2016 cumulative total was multiplied by 2/3.

- Data on LTSS institutional residents in each state come from three distinct sources:
 - CMS’s CASPER database of nursing home resident characteristics and other data, along with its precursor, OSCAR; tabulations of resident numbers and selected characteristics are obtained from the Kaiser Family Foundation (Harrington, Carrillo, Garfield, Musumeci, & Squires, 2018; Kaiser Family Foundation, 2019) and the University of California San Francisco (Harrington, Carrillo, Dowdell, Tang, & Woleslagle Blank, 2011).
 - CMS tabulations of nursing home resident characteristics from the Minimal Data Set (MDS) National Repository (Centers for Medicare & Medicaid Services, 2019b).
 - Data on residents in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) obtained from the Residential Information Systems Project (RISP) at the University of Minnesota (Larson et al., 2018; and prior reports in the series; additional data from the RISP team).
- LTSS expenditure data come from:
 - Annual reports from IBM Watson Health and its predecessor, Truven (Eiken, Sredl, Burwell, & Amos, 2018; and prior reports in the series).
 - Data from CMS’s Medicaid Budget and Expenditure System (MBES) on bulk “supplemental payments” paid to states apart from reimbursements for institutional services delivered (Centers for Medicare & Medicaid Services, 2019a). These data are available for fiscal years beginning in 2010. For states that bill CMS for these supplemental payments, these are included as part of reported nursing home or ICF/IID expenditures, but do not reflect the costs of actual services.

Occasionally, state data on residents and LTSS expenditures is reported incompletely or inconsistently from year to year, or missing during certain years. This analysis substitutes interpolated, extrapolated, or trend-smoothed values for missing data, data known to be incomplete, or data reflecting unreasonably large year-to-year variations.

Analysis

Separate analyses were conducted for people with and without I/DD. For each population, states were classified into three groups of 17 states (including DC) labeled as High, Medium, and Low/Non-MFP states. The classification was based on the annual number of MFP transitions divided by the state population, averaged over the years 2012 through 2017. The High and Medium MFP states can together be considered as having robust MFP programs.

In the non-I/DD analysis, the institutional population comprises nursing home residents not identified as having intellectual disabilities (ID). Total nursing home expenditures were analyzed (it is not possible to distinguish expenditures by target group within nursing homes), and the analysis of the percentage of LTSS expenditures going to home and community-based services (HCBS) includes all HCBS programs not specifically targeted to people with I/DD. Expenditures on home health programs are often included as HCBS, but this analyses excludes home health.

For the I/DD analysis, the institutional population combines people living in ICF/IID with the small fraction of nursing home residents identified as having ID. The analysis of institutional expenditures focuses solely on ICF/IID. HCBS is limited to programs specifically targeting people with I/DD, mostly 1915(c) waivers.

For both populations, bulk “supplemental payments” were subtracted from reported institutional expenditures, because they reflect creative accounting on the part of the states rather than actual LTSS provided. These supplemental payments represented 2.0 percent of reported nursing home expenditures in 2010, increasing to 5.4 percent by 2016.

Table 1. Total number transitioned, average annual transitions per 100,000 population, and state rank and classification, for transitions of people without and with I/DD

State	Transitions	Transitions for people w/o I/DD				Transitions for people with I/DD			
		#	Rate*	Rank	Group†	#	Rate*	Rank	Group†
Alabama	162	162	0.5	42	Low/Non	0	0.00	38‡	Low/Non
Alaska	0	0	0.0	45‡	Low/Non	0	0.00	38‡	Low/Non
Arizona	0	0	0.0	45‡	Low/Non	0	0.00	38‡	Low/Non
Arkansas	899	440	2.2	28	Medium	459	2.04	2	High
California	4,132	3,050	0.9	38	Low/Non	1,082	0.18	30	Medium
Colorado	367	319	0.8	39	Low/Non	48	0.13	33	Medium
Connecticut	4,538	4,289	15.4	1	High	249	1.01	10	High
Delaware	328	299	4.3	14	High	29	0.16	31	Medium
District of Columbia	319	213	4.3	13	High	106	0.36	23	Medium
Florida	0	0	0.0	45‡	Low/Non	0	0.00	38‡	Low/Non
Georgia	3,991	3,359	3.9	17	High	632	0.39	21	Medium
Hawaii	612	597	5.1	9	High	15	0.10	35	Low/Non
Idaho	524	446	4.0	15	High	78	0.79	13	High
Illinois	3,177	2,853	3.1	22	Medium	324	0.51	17	High
Indiana	2,128	2,017	3.7	18	Medium	111	0.28	26	Medium
Iowa	611	62	0.3	44	Low/Non	549	1.97	3	High
Kansas	1,728	1,454	5.9	6	High	274	0.79	12	High
Kentucky	731	528	1.2	35	Low/Non	203	0.30	25	Medium
Louisiana	2,635	2,199	6.5	5	High	436	1.10	8	High
Maine	124	124	1.4	34	Medium	0	0.00	38‡	Low/Non
Maryland	3,098	2,777	4.6	12	High	321	0.39	22	Medium
Massachusetts	2,151	2,097	5.0	10	High	54	0.11	34	Medium
Michigan	3,256	3,256	3.5	21	Medium	0	0.00	38‡	Low/Non
Minnesota	452	413	1.0	37	Low/Non	39	0.09	37	Low/Non
Mississippi	551	311	1.6	31	Medium	240	1.32	5	High
Missouri	1,680	1,293	2.6	24	Medium	387	0.60	16	High
Montana	151	128	1.9	29	Medium	23	0.36	24	Medium
Nebraska	640	559	3.9	16	High	81	0.24	29	Medium
Nevada	366	339	1.8	30	Medium	27	0.15	32	Medium
New Hampshire	308	293	2.4	25	Medium	15	0.09	36	Low/Non
New Jersey	2,482	1,633	2.4	27	Medium	849	1.25	6	High
New Mexico	0	0	0.0	45‡	Low/Non	0	0.00	38‡	Low/Non
New York	3,166	2,598	1.5	33	Medium	568	0.44	19	Medium
North Carolina	905	548	0.7	40	Low/Non	357	0.44	20	Medium
North Dakota	422	284	5.3	7	High	138	2.16	1	High
Ohio	13,070	11,150	12.6	2	High	1,920	1.73	4	High
Oklahoma	778	465	1.1	36	Low/Non	313	1.03	9	High
Oregon	306	256	0.0	45‡	Low/Non	50	0.00	38‡	Low/Non
Pennsylvania	3,370	3,054	2.4	26	Medium	316	0.28	27	Medium
Rhode Island	350	350	5.0	11	High	0	0.00	38‡	Low/Non
South Carolina	117	117	0.3	43	Low/Non	0	0.00	38‡	Low/Non
South Dakota	145	96	1.5	32	Medium	49	0.83	11	High
Tennessee	2,381	2,271	5.2	8	High	110	0.27	28	Medium
Texas	12,533	9,708	3.5	20	Medium	2,825	0.65	15	High
Utah	0	0	0.0	45‡	Low/Non	0	0.00	38‡	Low/Non
Vermont	367	367	8.9	4	High	0	0.00	38‡	Low/Non
Virginia	1,404	532	0.6	41	Low/Non	872	1.23	7	High
Washington	7,889	7,407	12.5	3	High	482	0.77	14	High
West Virginia	340	340	2.7	23	Medium	0	0.00	38‡	Low/Non
Wisconsin	1,856	1,631	3.7	19	Medium	225	0.50	18	Medium
Wyoming	0	0	0.0	45‡	Low/Non	0	0.00	38‡	Low/Non
United States	91,540	76,684	2.9			14,856	0.48		

*2012–17 average # transitioned per 100,000 state pop. †Classification based on MFP transition rate. ‡Tie.

Per capita expenditures were obtained by subtracting the supplemental payments from total reported expenditures, and then dividing by the state population, obtained from the Census Bureau. These figures were then adjusted for inflation in the cost of medical care services, using data from the Bureau of Labor Statistics.

Results

The number of transitions in each population category (non-I/DD versus I/DD), the number per 100,000 population (averaged over 2012–17), and the state’s rank and classification are shown in Table 1. The Low/Non-MFP category includes the 6 states that never implemented an MFP program (AK, AZ, FL, NM, UT, and WY), plus Oregon, which had an early MFP program but then discontinued it; for I/DD, this category also includes 7 states (AL, ME, MI, RI, SC, VT, WV) that operated programs but reported zero transitions of people with I/DD. Also included are the lowest-ranking states reporting a non-zero number of transitions in each population group.

Note that there are substantial differences in state rankings and classifications for non-I/DD versus I/DD transitions, depending on how the state’s MFP program was focused. Iowa, for

example, ranks 44th in non-I/DD transitions and third in I/DD transitions. In contrast, Vermont ranks fourth in non-I/DD transitions but is tied for last place in I/DD transitions (none).

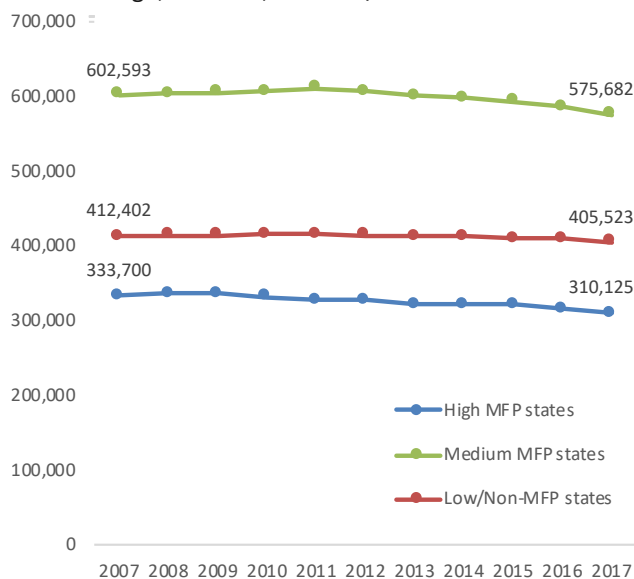
Connecticut, Ohio, and Washington rank highest in terms of non-I/DD transitions, each with greater than 12 transitions per 100,000 state population per year; this figure translates to more than 2 percent of each state’s nursing home population per year. In terms of I/DD transitions, North Dakota, Arkansas, and Iowa rank highest, at roughly 2 transitions per 100,000 population per year, amounting to more than 2 percent of the institutionalized I/DD population annually.

Analysis of non-I/DD transitions, institutional population, and expenditures

Nursing home utilization

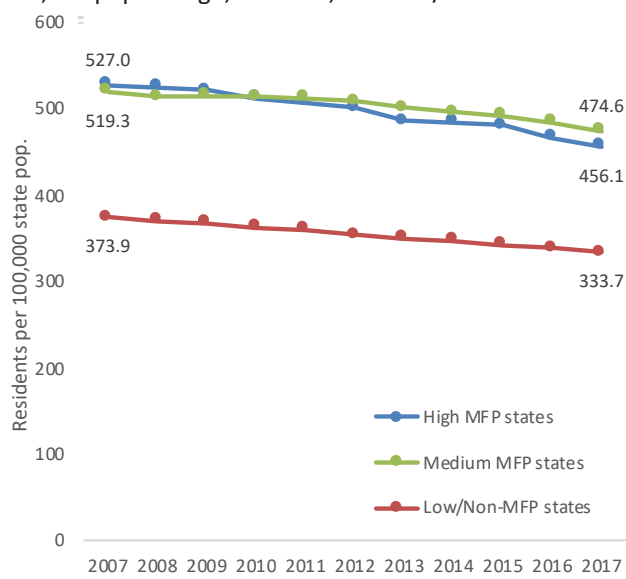
The analysis of the impact of non-I/DD transitions focuses first on nursing home utilization. Figure 1 shows a substantial decline in the total number of nursing home residents between 2007 and 2017, in both High and Medium MFP states (down 7.1 and 4.5 percent, respectively), in contrast to only a modest reduction in the Low/Non-MFP states (down 1.7 percent).

Figure 1. Nursing home residents (excl. ID pop.) in High, Medium, and Low/Non-MFP states



Source: CASPER/OSCAR tabulations from KFF & UCSF

Figure 2. Nursing home residents (excl. ID pop.) per 100,000 pop. in High, Medium, and Low/Non-MFP states



Source: CASPER/OSCAR tabulations from KFF & UCSF

Figure 3. “Permanent stay” nursing home residents in High, Medium, and Low/Non-MFP States

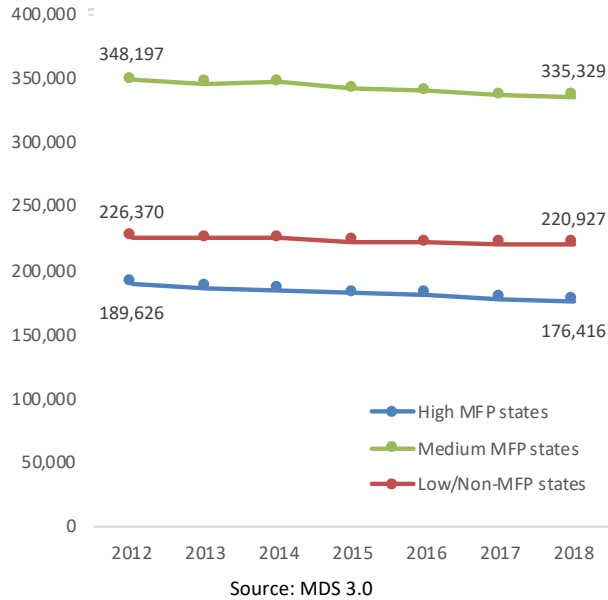
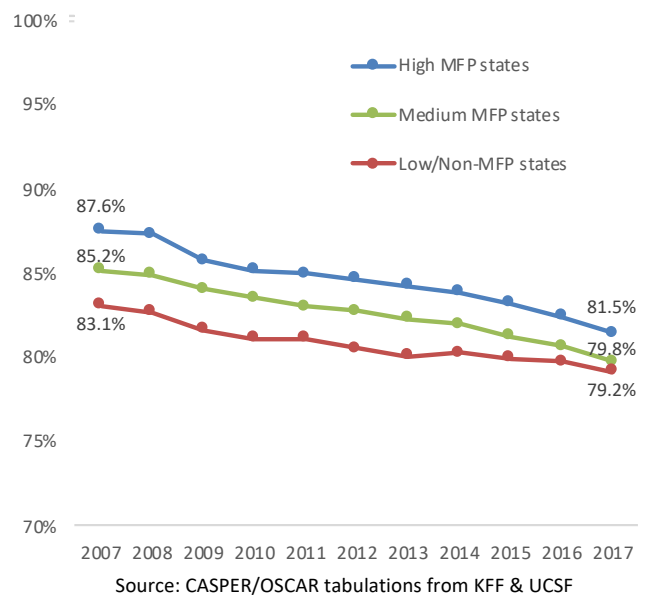


Figure 4. Nursing home occupancy rates in High, Medium, and Low/Non-MFP states



The story is somewhat different when population growth is taken into account. Even in the Low/Non-MFP states, there has been a reduction in nursing home utilization relative to state population (Figure 2). However, the reduction has been much more rapid in High MFP states (decline of 71.0 per 100,000 population, compared to 40.2 in the Low/Non-MFP states). These figures represent averages across the states in each group.

Residents expecting permanent stay

If MFP programs do indeed help states reduce their nursing home utilization, are they, as intended, transitioning people who would otherwise have remained stuck in institutions, or are they merely speeding up the return home of people who would have transitioned eventually even without MFP? Figure 3 focuses on “permanent stay” nursing home residents: those whose expectation on admission or readmission was that they would not be returning to the community. This group would seem to be unlikely to leave the institution without substantial support.

Between 2012 and 2018, Medium (3.7 percent reduction) and especially High MFP states (7.0 percent) saw greater reductions in “permanent

stay” nursing home residents than did the Low/Non-MFP states (2.4 percent).

Nursing home occupancy

When a nursing home bed is vacated by a resident who transitions to the community, does that bed quickly get filled by someone else? Nursing home occupancy rates should shed light on that question. As Figure 4 shows, occupancy rates declined for all three groups of states, but the decline was larger in High and Medium MFP states (down 6.1 and 5.4 percentage points, respectively) than in Low/non-MFP states (4.0).

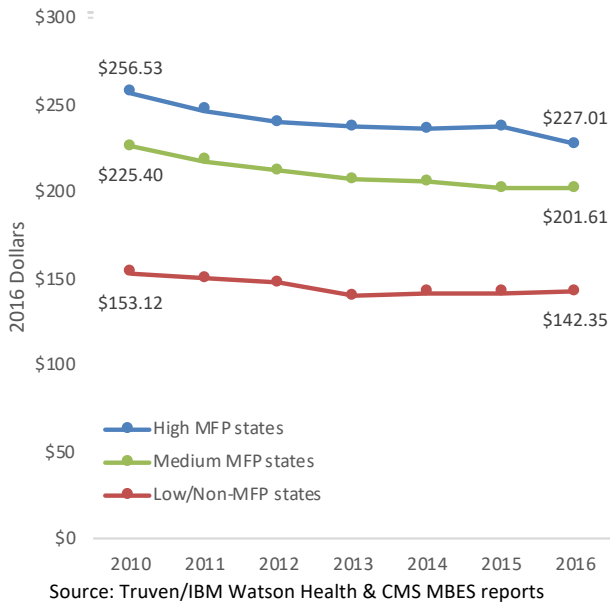
Nursing home expenditures

Findings on declines in the nursing home population are confirmed by examining inflation-adjusted expenditures (Figure 5). While spending in Low/non-MFP states declined only modestly between 2010 and 2016 (down \$10.77 per capita, averaged across states), the decline was more than twice as large in High and Medium MFP states (\$29.52 and \$23.72, respectively).

HCBS percentage of LTSS spending

The so-called rebalancing percentage, or the proportion of Medicaid LTSS spending devoted

Figure 5. Per capita, inflation-adjusted nursing home expenditures in High, Medium, and Low/Non-MFP states



to HCBS, is shown in Figure 6. Between 2010 and 2016, all three groups of states, on average, increased the share of non-I/DD LTSS expenditures going to HCBS. The shift from institutional spending to HCBS occurred more rapidly in both High and Medium MFP states (up 7.6 and 7.3 percentage points, respectively) than in the Low/non-MFP states (4.0 percentage points).

Analysis of I/DD transitions, institutional population, and expenditures

Data on people living in institutions specifically for people with intellectual disabilities (ICF/IID) is not as extensive as for nursing homes. In this section, the classification of states as High, Medium, or Low/non-MFP shifts to that shown in the right-hand columns of Table 1.

Institutional utilization

This analysis includes people living in ICF/IID and the subset of nursing home residents identified as having intellectual disabilities. The institutional population with ID is shown in Figure 7. Continuing a decades-long trend in the deinstitutionalization of people with ID, all three groups of states show declines in the institutional population. Between 2007 and 2017, particularly rapid deinstitutionalization is

Figure 6. HCBS percentage of non-I/DD Medicaid LTSS expenditures in High, Medium, and Low/Non-MFP states

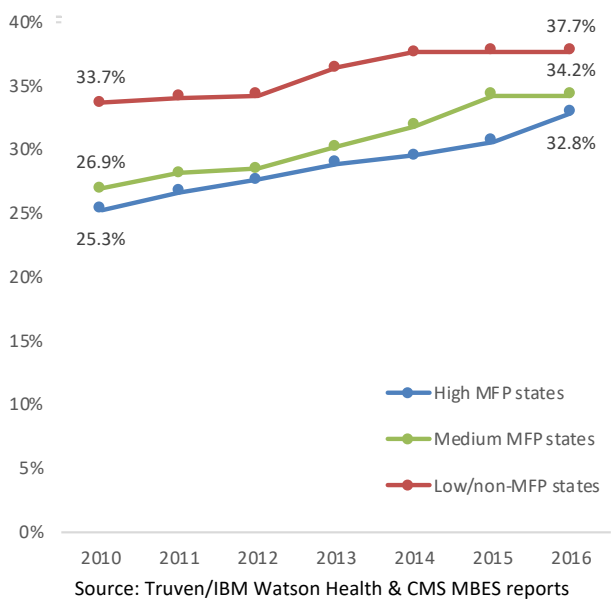
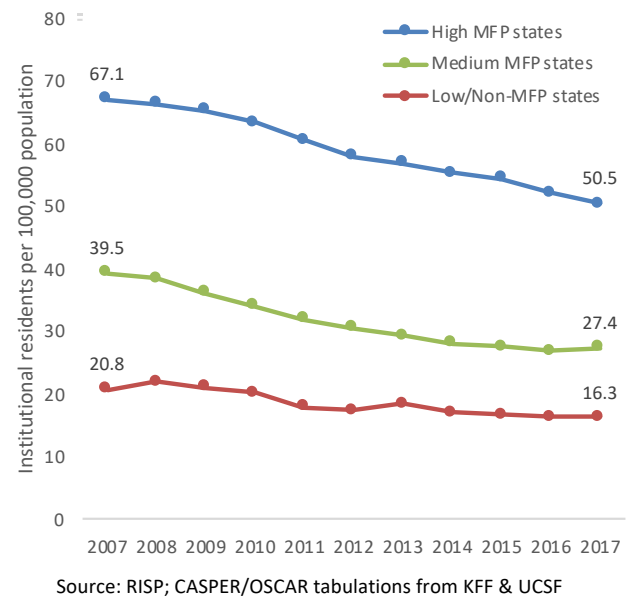
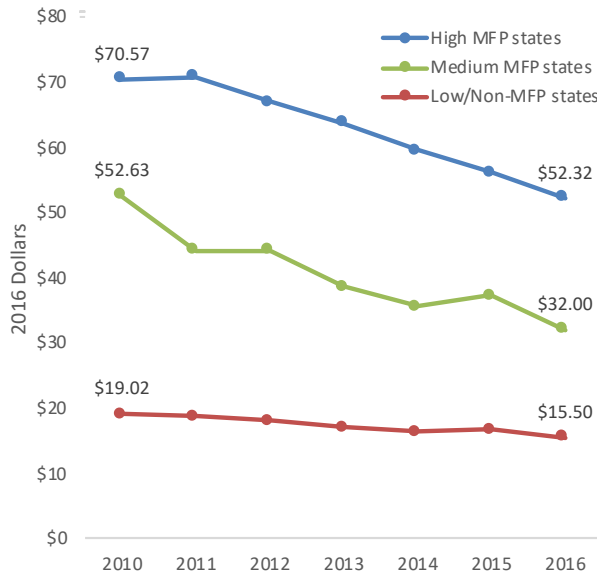


Figure 7. Institutional residents with I/DD per 100,000 pop. in High, Medium, and Low/Non-MFP states



apparent in both High MFP states, which saw an average decline of 16.6 institutionalized persons with ID per 100,000 state population, and Medium MFP states, which were down 12.0 persons per 100,000 populations over the decade. In contrast, Low/non-MFP states, whose institutional utilization was already much lower than in the other states, saw a relatively modest

Figure 8. Per capita, inflation-adjusted ICF/IID expenditures in High, Medium, and Low/Non-MFP states



Source: Truven/IBM Watson Health & CMS MBES reports

drop of 4.5 persons with ID living in institutions per 100,000 state population.

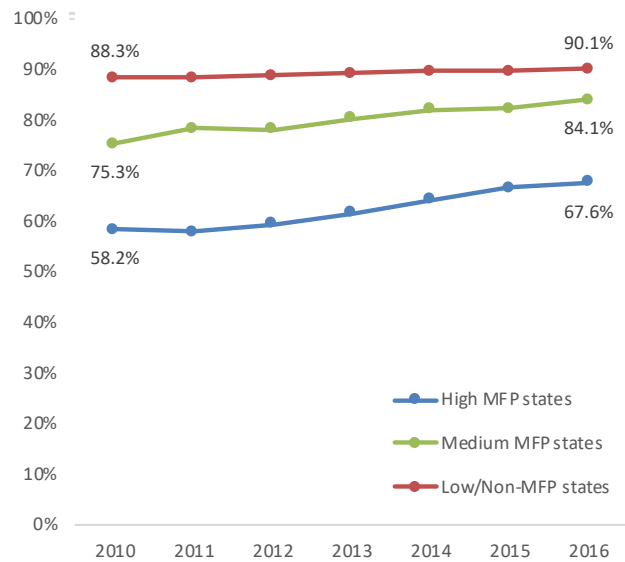
ICF/IID expenditures

A similar story is apparent in Medicaid expenditure data. Figure 8 focuses exclusively on institutions for individuals with intellectual disabilities (breakdowns of nursing home expenditures by disability type are not available). Both High and Medium MFP states saw large declines in per capita, inflation-adjusted expenditures on ICF/IID between 2010 and 2016: down by an average of \$18.25 and \$20.63 per capita, respectively. Over the same period, per capita expenditures in Low/non-MFP dropped an average of \$3.53.

HCBS percentage of LTSS spending

A look at the proportion of Medicaid LTSS expenditures that are going to HCBS, as opposed to institutional services, reveals similar trends (Figure 9). Averaged across the Low/non-MFP states, the “rebalancing percentage” increased by a modest 1.8 percentage points. In contrast, the increases in High and Medium MFP states were substantially larger, at 9.4 and 8.8 percentage points, respectively.

Figure 9. HCBS percentage of I/DD Medicaid LTSS expenditures in High, Medium, and Low/Non-MFP states



Source: Truven/IBM Watson Health & CMS MBES reports

Conclusions

Based on institutional population data from multiple sources and on LTSS expenditure data, analyzed separately for two distinct populations, this report offers evidence that states with robust Money Follows the Person programs fared better than states without MFP or with minimal MFP programs in terms of reducing institutional populations and expenditures and in rebalancing their LTSS systems. A limitation of this analysis is that it is not possible to conclude definitively that MFP was the cause of these gains, but it certainly appears that this program is a tool that states use to help them speed up the process of reducing reliance on institutional LTSS and increasing use of HCBS.

Of particular importance are findings showing declines in nursing home occupancy rates and reductions in the nursing home population expecting never to return to the community. Those skeptical of the impact of MFP have sometimes questioned whether institutions simply find other residents to fill beds vacated by those who transition back to the community, and whether the people targeted for transition really would have remained institutionalized were it not for the services provided under MFP, as opposed to eventually returning to the

community without this extra support. The findings on occupancy rates and “permanent stay” residents help to remove those doubts.

States spent \$450 million in MFP funds in fiscal year 2016, a tiny fraction—only 0.3 percent—of the \$167 billion spent on Medicaid LTSS in that year (Eiken et al., 2018). Yet, as this report

argues, the program has an outside impact not only on the lives of the individuals it serves, but also in measurably shifting LTSS recipients and expenditures away from institutional services and toward services provided in people’s homes and communities. It is a successful program that merits a permanent place in national policy.

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Acknowledgments

For advance access to data on institutional residents, thanks go to Priya Chidambaram at the Kaiser Family Foundation and Heidi Eschenbacher and colleagues at the Institute for Community Inclusion, University of Minnesota.

The contents of this report were developed under a grant from the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR grant number 90RTCP0004). NIDILRR is a Center within the Administration for Community Living (ACL), Department of Health and Human Services (HHS). The contents of this report do not necessarily represent the policy of NIDILRR, ACL, or HHS, and you should not assume endorsement by the Federal Government.