Report to Congress

Best Practices in the Money Follows the Person (MFP) Demonstration

As required by the Consolidated Appropriations Act, 2021 (P.L. 116-260)

Appendices

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

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Contents

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Appendix A

Methods

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Methods

I. Assessment of program performance

Performance indicators

The national MFP Best Practices evaluation included a set of program-level performance indicators developed in consultation with CMS, that were used to assess program performance and identify those MFP programs that represent model programs for each of the best practice areas (Appendix D). Two types of indicators were used to assess program performance:

- Process indicators, most of which drew on binary data (true/false or yes/no) about MFP program features or implementation.
- Quantitative indicators that assessed MFP program outputs and outcomes, such as rates of transition to the community and rates of re-institutionalization among MFP participants.

To identify the MFP programs that met either type of Best Practice indicator, the national evaluation drew on data from MFP grantees' semi-annual progress reports submitted to CMS, T-MSIS Analytic File (TAF) files, program documents, MFP program leaders' responses to a needs assessment for a MFP housing learning collaborative, and MFP program leaders' responses to a short web-based survey fielded in late 2021 (Appendix B). The analysis of progress reports, TAF files, and program documents focused on the period from 2017 through 2019, which was after the end of the earlier MFP evaluation and before COVID-19 spread to the United States, which impacted MFP program performance variably across states. The survey captured information on topics not adequately covered in other sources, such as efforts to identify and address disparities in accessing HCBS and approaches for coordinating with managed long-term services and supports (MLTSS) plans to transition eligible beneficiaries to the community.

Analytic sample

For most Best Practice areas, the analytic sample included the 34 states that were operating MFP programs in late 2021.[1] The analytic sample comprised a subset of these programs for two areas. For Best Practice 6, which focuses on delivering MFP transition services through managed care entities, the sample was states that operated both MFP programs and contracted with managed care organizations to deliver MLTSS to MFP participants.[2] For Best Practices 7 and 8, which focused on other effective transition strategies demonstrated by MFP programs, the national evaluation examined two sets of states: (1) five states that were awarded MFP Tribal Initiative grants,[3] and (2) six states that actively operated MFP programs and reported in the survey that they were making strides toward addressing disparities in MFP participation or in the broader population of Medicaid beneficiaries who receive LTSS in the state.

[1] The 34 active MFP programs include Alabama, Arkansas, California, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Washington, West Virginia, and Wisconsin.

[2] As of FY 2020, 25 states had MLTSS programs operating under various federal authorities, including section 1115 demonstrations or a combination of section 1915(a)/1915(c), 1915(b)/1915(c), or 1115/1915(c) authorities (Medicaid Long Term Services and Supports Annual Expenditures Report, FFY2017 and 2018). A subset of these states also operate MFP grant programs.

[3] The states participating in the MFP Tribal Initiative are Minnesota, North Dakota, Oklahoma, Washington, and Wisconsin.

Scoring MFP programs

After data for the performance indicators were compiled, the national evaluation calculated a composite score for each MFP program in each of the Best Practice areas. For the process-based indicators the scores, which ranged from 0 to 100, were based on how many of the total indicators each MFP program in the sample met. For example, if an MFP program met all four indicators for a given Best Practice, the state's score was "100".

For quantitative indicators (e.g., transition and re-institutionalization rates), the national evaluation constructed a score that ranged from 0 to 100 for each program, with 100 indicating the best possible performing program and 0 indicating the worst. The national evaluation defined the transition rate as the proportion of eligible institutionalizations that ended in enrollment in an MFP program and an associated transition to the community. The evaluation team defined the re-institutionalization rate as the proportion of enrolled beneficiaries who were re-institutionalized, that is, admitted to an inpatient facility such as a hospital, nursing facility, ICF/IDD, or mental health facility, within 365 days of their transition. The national evaluation then used a multilevel regression model to risk-adjust the raw values of these metrics to account for differences in beneficiary characteristics such as age, primary diagnosis, and health status. The purpose of the risk-adjustment was to make fair comparisons of program performance across states that have different beneficiary populations. The indicator-specific scores were then averaged with other process-based indicators, resulting in an overall score for each state for each Best Practice area. For each Best Practice area, the states with the six highest scores were reviewed with CMS. Two proposed state selections were changed based on CMS' input on recent program performance. The final list of state MFP programs were selected to engage in primary data collection (Appendix C). MFP program directors and partners involved in implementing the MFP program in the selected states were invited to participate in virtual focus groups and semi-structured interviews.

II. Data collection approach

Outreach strategy

CMS sent an email communication to MFP project directors in the selected states in March 2022. The communication informed them that their MFP programs were selected for the Best Practices study, explained the purpose of the study, and let them know the national evaluation team would be reaching out for assistance with identifying key informants who could provide an informed perspective on the Best Practice topic and arranging focus groups and interviews. The evaluation team then scheduled focus groups and interviews after informants' confirmed interest in participating.

Focus groups and interviews with MFP programs and partners

The national evaluation team conducted 14 virtual focus groups and 10 interviews with key informants from the selected states in early 2022. These discussions centered on understanding the specific state policies and practices, through the present day, that make the MFP programs strong on each Best Practice area (Appendix E). For Best Practices 7 and 8, which focused on other effective transition strategies demonstrated by MFP programs, the national evaluation team examined two lines of inquiry. The first relates to effective strategies implemented by the five states that were awarded MFP Tribal Initiative grants. The second line of inquiry focuses on progress making strides toward identifying and addressing disparities in MFP participation or in the broader population of Medicaid beneficiaries who receive LTSS in the state.

Interviews with MFP participants

The national evaluation team engaged a small number of MFP participants to gain their perspectives on their experiences with pre-transition planning, transitioning to the community through MFP, the services and supports they have received, and care delivery post-transition (Appendix F). These topics informed three Best Practice (BP) areas:

1. Transition strategies (BP 1 and 2),
2. Person-centered care and planning (BP3), and
3. Strategies for addressing disparities (BP8).

To identify MFP participants, the evaluation team outreached to project directors in four states (Georgia, North Carolina, Ohio, and West Virginia) that were selected for Best Practice 3 (strategies for improving person-centered planning). The email requested their assistance identifying four to six beneficiaries who recently transitioned to the community through MFP to participate in an interview. Project directors were asked to coordinate with transition specialists to identify participants across target populations that also reflected a mix of racial/ethnic backgrounds. The project directors shared participant contacts with the evaluation team which were used to arrange telephone interviews.

Given the plan to engage MFP participants in the Best Practices study, the evaluation team submitted data collection materials, including a description of the study and MFP participant interview guide, for a research ethics review by the Institutional Review Board (IRB). The study description detailed the purpose, topics of discussion, how the information would be used, and a $40 gift card the participant would receive for their participation. The IRB package also documented processes for obtaining informed consent from program participants or from a legal guardian. Before the interviews were conducted, interviewers were trained on the data collection protocols and special considerations for interviewing people with disabilities. The IRB application was approved in February 2022 (Appendix G).

III. Analysis approach

The analysis approach relied on four data sources: (1) program-level data, (2) program documents such as semi-annual progress reports and sustainability plans submitted to CMS, (3) contextual data collected through use of live polls during the virtual focus groups, and (4) qualitative data gathered from semi-structured interviews and virtual focus groups.

The analysis proceeded in two phases: (1) within-case analysis and (2) cross-case analysis.[4] For each of the Best Practices, the national evaluation team developed a case study that summarized information across the three data sources for the selected states selected for each Best Practice. The case studies allowed the evaluation team to conduct a within-case analysis: an in-depth exploration of the effective strategies and policies that make the MFP programs in the selected states stand out as strong performers in each of the nine Best Practice areas. After data collection concluded, the evaluation team conducted a systematic cross-case analysis of the case studies within and across all nine Best Practice areas. First, case studies in each of the areas were examined to explore *how* and *why* each state's performance stood out for that particular Best Practice. Next, similarities and differences were identified across the MFP programs, using the case study template, to capture the commonalities across selected states and the features that

[4] Ayres, L., K. Kavanaugh, and K. A. Knafl. "Within-Case and Across-Case Approaches to Qualitative Data Analysis." Qualitative Health Research 13, no. 6 (July 2003), pp.: 871–83. https://doi.org/10.1177/1049732303013006008.

were unique to individual MFP programs. Finally, the evaluation team used data collected to assess program performance and contextual data to explore how characteristics of the selected states correlate with state, community, or other relevant characteristics.

IV. Limitations

There are several limitations in the analysis that include:

Sample used to select MFP programs. Across all Best Practice areas, the analysis was restricted to the 34 states that were operating MFP programs as of October 2021. At that time, there were four states (Delaware, Kansas, Massachusetts, Tennessee) that were in the process of re-activating their MFP programs and six others (Illinois, Michigan, Mississippi, Nebraska, New Hampshire, and Virginia) that had stopped operating their programs since 2017. Consequently, the analyses presented in this report do not reflect any promising strategies implemented by states no longer active in the MFP Demonstration as of October 2021.

Identification of model MFP programs. To identify the model MFP programs that participated in primary data collection, the national evaluation team assessed the performance of active MFP programs (from 2017 through 2019) on a set of indicators identified for each Best Practice area. However, these performance indicators did not attempt to capture all potential state-specific contextual factors that may influence aspects of a program's performance; for example, variability in affordable, accessible housing and HCBS workforce capacity across states.

Assessment of states' performance transitioning eligible beneficiaries through MFP. When assessing states' performance in transitioning eligible beneficiaries to the community, the evaluation team calculated risk-adjusted transition and re-institutionalization rates to account for differences in the characteristics of each MFP program's participant population (age, medical acuity, etc.). When doing so, the team assessed states efforts transitioning three populations from institutions to community-based settings: (1) older adults, (2) individuals with physical disabilities, and (3) individuals with intellectual or developmental disabilities. The national evaluation team did not assess states' performance transitioning people with mental illness from psychiatric hospitals because of challenges accurately identifying such individuals in the Medicaid claims data. Similarly, we did not assess states' performance transitioning 'other' populations, such as children, people with traumatic brain injury, or people with dual-diagnoses, because these groups represent a relatively small proportion of MFP participants, and their identification varied by state and could not be observed in the Medicaid claims data. Consequently, states' efforts transitioning these populations through their MFP programs were not taken into account when identifying model MFP programs.

Participation bias. The national evaluation team relied on MFP project directors and transition coordinators to identify MFP participants who were willing to take part in a semi-structured telephone interview. The interview respondents were a small group recommended by MFP program staff who might be more motivated to participate in an interview due to factors such as the respondent payment, availability, and experiences with MFP (both positive and negative). MFP program staff may have also selected these individuals based on their positive experiences participating in the MFP program. As a result, the MFP participants that were interviewed may differ from the broader population of MFP participants who were not invited to participate in an interview.

Potential social-acceptability bias. When interviewing MFP participants, it is possible individuals tailored their answers to say what they thought we wanted to hear or because they feared their responses

might affect their participation in the MFP demonstration. To mitigate this bias, the evaluation team emphasized in the introduction to each interview that they were not affiliated with CMS, that responses would remain anonymous, and that we were interested in hearing about the full range of their experiences participating in MFP.

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Appendix B

Survey Questions for MFP Project Directors

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Survey Questions for MFP Project Directors

Purpose

Under contract to the Centers for Medicare & Medicaid Services (CMS), Mathematica is evaluating the MFP demonstration. As part of this effort, Mathematica is taking a closer look at state systems of long-term services and supports (LTSS) for a future Report to Congress and studying:

1. factors that have contributed to effective LTSS system performance, and
2. MFP program efforts to rebalance state LTSS systems, including MFP transition programs.

This survey is intended to gather information from MFP project directors, or their designees, on key aspects of MFP program features. The national evaluation will use your input to identify MFP programs that have demonstrated strong performance across several aspects of implementation.

The survey can be accessed [hyperlink] and should take about 30 minutes to complete. You can only take the survey once, but you can edit your responses until the survey is closed end of day on **Day, Month Date.**

The survey is formatted to be fully accessible for people who use assistive technology. Please record your final responses in the survey link above. We appreciate your participation.

Background

1. Your Name:
2. Your role:
3. MFP state
4. How long have you served in this role?
   a. Under 1 year
   b. 1-3 years
   c. 4-6 years
   d. 7-9 years
   e. 10 or more years

Person-centered planning

5. Does your state's MFP program use an assessment tool that includes goals for meeting the self-reported needs and preferences of the MFP participant, and that the participant reviews and signs?
   a. Yes
   b. No
6. Is there a mechanism in place to monitor progress towards achieving the goals mutually agreed upon with the MFP participant during transition planning and post-transition?
   a. Yes
   b. No
7. If Yes, please describe:
8. Does your state include MFP program participants in the National Core Indicators (NCI)®, National Core Indicators – Aging and Disability (NCI-AD™), or the home and community-based services (HCBS) Consumer Assessment of Healthcare Providers and Services (CAHPS®) surveys?

   Note: The primary aim of NCI-AD™ is to collect valid and reliable data directly from those receiving LTSS through a publicly funded program. These data give states a broad view of how publicly-funded services impact the quality of life and outcomes of service recipients (Source: National Core Indicators: https://nci-ad.org/about). Another survey tool used to assess the experience of adults receiving LTSS is the CAHPS® HCBS Survey, developed by CMS (Source: AHRQ: https://www.ahrq.gov/cahps/index.html).

   a. Yes
   b. No
9. If Yes, please specify which surveys:

10. Are the fielded surveys limited to MFP participants? If not, are MFP participants specifically identified for inclusion in the sampling frame to support conclusions about the MFP experience?

a. Yes, the fielded surveys include MFP participants only

b. No, the fielded surveys are not limited to MFP participants, but the sampling criteria consider MFP participation

c. No, the fielded surveys are not limited to MFP participants and do not consider MFP participation

11. Please describe:

12. If MFP participants in your state are enrolled in a section 1915(c) HCBS waiver program when they transition to the community, do your state's waiver programs track outcome measures for MFP participants that focus on the successful implementation of care plans? *This may include mandated tracking through MLTSS plan contracts.*

a. Yes

b. No

13. If Yes, please describe:

Monitoring and improving health outcomes

14. At which points in the transition and post-transition process does your MFP program conduct periodic needs assessments of participants? *Select all that apply.*

a. Soon after transition

b. After a known decline in health status

c. After a participant returns to the community following a re-admission and discharge from a hospital or nursing facility

d. Other (please specify):

15. How else does your state's MFP program monitor and track the health and safety of MFP participants post transition?

MFP services and funding sources

16. Please indicate which of the following services and supports are funded with MFP grant funds. *These services and supports may be currently offered as Demonstration or Supplemental services or were previously offered as Demonstration or Supplemental services but have since been permanently added to your state's section 1915(c) waiver programs or state Medicaid plan benefit package. Select all that apply.*

– Definitions
Demonstration HCBS: Allowable services not currently available in state's HCBS offerings, or qualified HCBS above what is already available (e.g., 24-hour personal care) (eligible for enhanced FMAP).

– Supplemental Services: Services to facilitate a transition that are not HCBS or otherwise reimbursable (e.g., security deposit, utility set up) (eligible for the state's regular FMAP).

- □ Behavioral health supports
- □ Caregiver and client training
- □ Case management services
- □ Companion supports
- □ Employment supports
- □ Financial management services
- □ Health promotion and diseases prevention
- □ Homemaker and chore services
- □ Home health services
- □ Home repairs and accessibility modifications
- □ Home safety assessment
- □ Home-delivered meals
- □ Housing/tenancy support
- □ Hospice care
- □ Information and referral services
- □ Legal services
- □ Medical supplies, equipment and assistive technologies (wheelchairs, walkers, speech recognition software, etc.)
- □ Medical transportation
- □ Non-medical transportation
- □ One-time transition costs
- □ Personal care services
- □ Personal Emergency Response Systems (PERS)
- □ Pre-tenancy services
- □ Other (please specify):

17. Please reference your selections in Question 16. In your view, which of these services and supports are most critical to transitioning a participant to the community? *Select up to three.*

- □ Behavioral health supports
- □ Caregiver and client training
- □ Case management services
- □ Companion supports
- □ Employment supports
- □ Financial management services
- □ Health promotion and diseases prevention
- □ Homemaker and chore services
- □ Home health services
- □ Home repairs and accessibility modifications
- □ Home safety assessment
- □ Home-delivered meals
- □ Housing/tenancy support
- □ Hospice care
- □ Information and referral services
- □ Legal services
- □ Medical supplies, equipment and assistive technologies (wheelchairs, walkers, speech recognition software, etc.)
- □ Medical transportation
- □ Non-medical transportation
- □ One-time transition costs
- □ Personal care services
- □ Personal Emergency Response Systems (PERS)
- □ Pre-tenancy services
- □ Other (please specify):

18. *Please* explain *your selections:*

19. Please reference your selections in Question 16. In your view, which of these services and supports are most critical to helping people live independently? *Select up to three.*

- □ Behavioral health supports
- □ Caregiver and client training
- □ Case management services
- □ Companion supports
- □ Employment supports
- □ Financial management services
- □ Health promotion and diseases prevention
- □ Homemaker and chore services
- □ Home health services
- □ Home repairs and accessibility modifications
- □ Home safety assessment
- □ Home-delivered meals
- □ Housing/tenancy support
- □ Hospice care
- □ Information and referral services
- □ Legal services
- □ Medical supplies, equipment and assistive technologies (wheelchairs, walkers, speech recognition software, etc.)
- □ Medical transportation
- □ Non-medical transportation
- □ One-time transition costs
- □ Personal care services
- □ Personal Emergency Response Systems (PERS)
- □ Pre-tenancy services
- □ Other (please specify):

20. Please *explain your selections:*

Improving housing options

21. Did your state's MFP program obtain housing voucher priority status or set-asides for MFP participants in existing housing programs? *Priority status might mean that MFP participants are able to move up on the housing authority wait lists. Set-asides may refer to a certain percentage of units being designated specifically for MFP participants.*

a. Yes

b. No

22. If Yes, please describe:

23. Does your state have special housing licensing categories for small group homes serving people with disabilities with specialized needs? *This might include a home for people with dementia, intellectual or developmental disabilities, or a traumatic brain injury.*

a. Yes

b. No

24. If Yes, please describe:

25. Did your state's MFP program partner with state or local housing organizations that led to an increase in affordable and accessible housing for MFP participants?

a. Yes

b. No

26. If Yes, please describe:

27. Which state or local partners does your MFP program currently partner with to improve housing options for Medicaid beneficiaries? *Select all that apply.*

a. Local public housing authorities (please specific in Q28)

b. State housing finance agency

c. Unites States Department of Agriculture field offices

d. Low-income housing developers

e. Other (please specify):

f. None of the above

28. If applicable, please indicate which public housing authorities your MFP program partners with.

29. How (if at all) does your MFP program actively collaborate with housing partners to increase affordable, accessible housing for low-income people with disabilities.

Coordination with MLTSS

Questions 30-35 apply to states in which the Medicaid agency contracts with managed care plans to deliver managed long term services and supports (MLTSS) to Medicaid beneficiaries. If your state does not currently operate a MLTSS program, please select "Not applicable."

30. Does your MLTSS program use a blended rate to set monthly capitation rates, or use other capitation rate setting methods to encourage plans to help MFP participants transition to the community? *Blended capitation rates average the costs of institutional and HCBS and give greater weight to the HCBS portion.*

a. Yes

b. No

c. Not applicable

31. If Yes, please describe:

32. Does your MLTSS program use other financial incentives, outside the capitation rate, to encourage plans to help MFP participants residing in institutions transition to community settings?

a. Yes

b. No

c. Not applicable

33. If Yes, please describe:

34. Does your MFP program have a formal cooperative agreement in place with MLTSS plans either through a provision in the managed care plan contract, or separate from the contract? *Formal cooperative agreements may document roles and responsibilities for transition planning, service coordination, and supporting participants' needs after they transition to HCBS setting.*

a. Yes, via a contract provision

b. Yes, separate from the contract

c. No

d. Not applicable

35. If Yes, please describe the main components of the agreement.

Integrating MFP strategies into Medicaid programs

36. Has your state instituted flexible funding policies that make it easy to move funds from institutional to HCBS or other changes in program infrastructure that contributed to successful transitions?

Note: These funding approaches introduce flexibility in the financing of LTSS to encourage greater use of HCBS among people with disabilities to facilitate rebalancing of the long-term care system.

a. Yes

b. No

37. If Yes, please describe:

38. Please describe your state's progress with integrating MFP transition practices and strategies into regular (non-MFP) Medicaid and HCBS programs.

39. Please describe the major barriers to integrating MFP practices and program features into regular (non-MFP) Medicaid and HCBS programs).

Identifying disparities in the MFP program

40. Has your MFP program examined disparities in MFP participation or in the broader population of beneficiaries who received HCBS?

Note: Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic -status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (Source: Healthy People 2020)

a. Yes

b. No

41. If Yes, what were some of the main findings from the analysis?

42. If Yes, how (if at all) is the MFP program in your state working to reduce disparities and inequity?

43. If Yes, how (if at all) is the MFP program in your state tracking the results of efforts to reduce disparities?

Identify participants for a Community Advisory Panel

Mathematica will assemble a Community Advisory Panel to provide input during the evaluation of MFP on the experiences of Medicaid beneficiaries. The panel will include a diverse mix of MFP participants and Medicaid beneficiaries who receive LTSS in institutional settings or transitioned to the community outside of the MFP. A stipend of $100 will be provided per each meeting attended.

44. Do you have a contract for state Stakeholder Advisory groups focused on MFP program, HCBS Waivers, or institutional long-term care?

a. Yes

b. No

45. If Yes, please share contact name and information:

End of survey

Thank you for providing input on your MFP program's features and implementation experience. Please feel free to edit your responses until the survey is closed end of day on **Day, Month Date**.

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Appendix C

MFP States Selected for Best Practice Areas

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Appendix Exhibit C1. MFP states selected for each Best Practice area

Exemplar State Rank	Best Practices 1&2 Transition strategies and use of MFP funds	Best Practice 3 Person centered planning	Best Practice 4 Flexibilities available under MFP	Best Practice 5 Effective coordination of housing and supports	Best Practice 6 Transitions through managed care entities	Best Practice 7 Strategies implemented through MFP Tribal Initiative	Best Practice 8: Making strides toward addressing disparities
1	Louisiana*	Georgia	New Jersey	Colorado	Minnesota*	Minnesota*	*Connecticut*
2	Washington*	*New York*	*New York*	District of Columbia*	New Jersey	North Dakota	Louisiana*
3	*North Carolina*	West Virginia	District of Columbia*	New Jersey	*Wisconsin*	Oklahoma	Minnesota*
4	New Jersey	*Alabama*	*Alabama*	Washington*	Idaho	Washington*	*Rhode Island*
5	Maryland	*North Carolina*	Louisiana*	Ohio*	*Rhode Island*	*Wisconsin*	Vermont
6	Iowa	Ohio*	Ohio*	*Connecticut*	Hawaii		District of Columbia*

States in *italics* have been selected as states for two Best Practice areas.
States with an asterisk (*) have been selected as states for three best practice areas.
New Jersey was selected as a state for four Best Practice areas.

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Appendix D

Performance Indicators

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Appendix Exhibit D1. Performance Indicators used to identify model MFP programs, by Best Practice area

No.	Process	Performance metric 1 (data source)	Performance metric 2 (data source)	Performance metric 3 (data source)	Performance metric 4 (data source)	Performance metric 5 (data source)
1.	**Most effective strategies for transitioning beneficiaries from institutional to qualified community settings and how such strategies may vary for different populations.**					
2.	**Most common and the most effective uses of MFP grant funds for transitioning beneficiaries from institutional to qualified settings and improving health outcomes.**					
	The national evaluation team identified states with demonstrated success in transitioning eligible beneficiaries to the community (metrics #1-3) and states that used MFP grant funds to strengthen transition capacity (#4) and track participants' health outcomes (#5). The evaluation team also identified which services were perceived to be most critical to a successful transition and good health outcomes and are not offered under the traditional Medicaid program.	States with the highest rates of MFP transitions per 1,000 eligible adult Medicaid beneficiaries from 2017 to 2019 in institutions for 90 days or longer, by target population *(TAF data)*	States that achieved 75 percent or more of their annual transition goals from 2017 to 2019 for each target population *(SA progress report data)*	MFP programs with low rates of re-institutionalizations among beneficiaries who transitioned to the community from 2017 to 2019 *(TAF data)*	States that directed rebalancing funds, Demonstration funds, or administrative funds towards increasing their capacity to transition more beneficiaries to the community (*SA progress report data and sustainability plans)*	States that are monitoring and tracking status of health outcomes post transition *(Survey with MFP program leaders)*

No.	Process	Performance metric 1 (data source)	Performance metric 2 (data source)	Performance metric 3 (data source)	Performance metric 4 (data source)
3.	**Most effective approaches for improving person-centered care and planning. This topic focused on effective approaches to measuring and implementing person-centered care.**				
	The national evaluation team identified states that are tracking implementation of person- centered care best practices.	States that use a comprehensive assessment process that includes individually identified goals/preferences for the person with long-term support needs, and which includes the person reviewing and signing the plan *(Survey with MFP program leaders)*	States that instituted a mechanism to monitor progress towards achieving identified goals/preferences *(Survey with MFP program leaders)*	States with measurable outcomes that focus on the successful implementation of care plans, evidence that the person's goals are being met, and evidence that efforts are being made to minimize difficulties during transitions between healthcare providers and across care settings. *(Survey with MFP program leaders)*	States that include MFP participants in the National Core Indicators (NCI)®, National Core Indicators – Aging and Disability (NCI-AD™), or the HCBS Consumer Assessment of Healthcare Providers and Services (CAHPS®) surveys *(Survey with MFP program leaders)*
4.	**Identification of program, financing, and other flexibilities available under MFP (that are not available under the traditional Medicaid program) which directly contributed to successful transitions and improved health outcomes. This topic identified broader changes in financing, program structure, or state service infrastructure that contributed to successful transitions.**				
	The national evaluation team assessed strategies for building transition capacity or incentivizing transitions through changes to Medicaid programming or financing of services.	Instituted flexibility in funding or pay-for-performance metrics designed to encourage transitions of residents from institutional to community settings, cover the cost of executing a transition, or better support of participants in the community *(Survey with MFP program leaders)*	MFP programs with low rates of re-institutionalizations among beneficiaries who transitioned to the community from 2016-2019 *(TAF data)*	States that invested rebalancing funds to advance system transformation efforts to promote transitions to the community. *(SA progress report data and sustainability plans)*	States that permanently added Demonstration or Supplemental services to the state's section 1915(c) waiver programs or state Medicaid plan benefit package. *(SA progress report data and survey with MFP program leaders)*

No.	Process	Performance metric 1 (data source)	Performance metric 2 (data source)	Performance metric 3 (data source)	Performance metric 4 (data source)
5.	**State strategies and financing mechanisms for effective coordination of housing financed or supported under MFP with local housing authorities. This topic identified strategies related to effective coordination of housing.**				
	The national evaluation team identified states that have 1) obtained priority status, or 2) increased the supply of housing options, and 3) have current and active partnerships, and 4) have housing coordinators and/or housing specialists with relationships with housing agencies.	States that obtained priority status or set-asides for MFP participants in existing housing programs or developed a new licensing category for small group homes for participants with specialized needs *(Survey with MFP program leaders)*	States that have partnered with state or local housing organizations that led to an increase in the supply of housing options for MFP participants and others who transition to the community from institutional settings *(Survey with MFP program leaders)*	States that have special licensing categories for small group homes serving people with disabilities with specialized needs *(Survey with MFP program leaders)*	States that have housing specialists and/or housing coordinators who built relationships and collaborations with housing agencies *(Housing inventory from CMS)*
6.	**Effective approaches for delivering MFP transition services through managed care entities.**				
	The national evaluation team identified which states operate an MFP program and have MLTSS programs in the state, as well as those that use blended rates to set their MLTSS capitation and those that instituted incentives that encourage successful transitions.	States that use a blended rate to set monthly capitation rates, or use other capitation rate setting methods to encourage plans to help MFP participants transition to the community *(Survey with MFP program leaders)*	States that use other financial incentives, outside the capitation rate, to encourage plans to help MFP participants residing in institutions transition to the community *(Survey with MFP program leaders)*	States that have a formal cooperative agreement in place with the MLTSS plans to provide transition coordination services for institutional residents interested in receiving care in an HCBS setting *(Survey with MFP program leaders)*	
7.	**Other effective transition strategies demonstrated by MFP programs.** The national evaluation team engaged MFP programs that were awarded a MFP Tribal Initiative grant to learn about their efforts.				

No.	Process	Performance metric 1 (data source)	Performance metric 2 (data source)	Performance metric 3 (data source)	Performance metric 4 (data source)
8.	**Other effective transition strategies demonstrated by MFP programs.** The national evaluation team purposively selected six MFP grantees that self-reported in the MFP survey making strides addressing disparities among MFP participants or in the broader population of Medicaid beneficiaries accessing LTSS.				
	The national evaluation team assessed responses to the MFP survey to identify states that are working to address disparities in MFP participation or in the broader population of HCBS beneficiaries who receive LTSS.	States that have examined disparities in MFP participation or in the broader population of HCBS beneficiaries who receive LTSS *(Survey with MFP program leaders)*	States that are actively working to reduce disparities and inequity *(Survey with MFP program leaders)*	States that are tracking the results of efforts to address disparities *(Survey with MFP program leaders)*	
9.	**Analyses of opportunities and challenges to integrating effective MFP practices and state strategies into the traditional Medicaid program.** To explore opportunities and challenges to integrating effective MFP practices and state strategies into the Medicaid program, the national evaluation team conducted a cross-case analysis to identify findings about successes and perceived challenges to integrating MFP into the Medicaid program reported in survey responses, primary data collection, and sustainability plans submitted to CMS.				

CMS = Centers for Medicare & Medicaid Services; HCBS = home and community-based services; LTSS = long term services and supports; MFP = Money Follows the Person; MLTSS = managed long term services and supports; SA = semi-annual; TAF = Transformed Medicaid Statistical Information System (T-MSIS) Analytical Files

Appendix E

Discussion Topics and Modes, by Best Practice Area and Key Informant

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Exhibit E.1. Best Practices 1 and 2: Discussion topics, by research question and informant

Question/probe (Mode) FG = focus group 1:1 = telephone interviews	Other source	MFP project directors (1 FG)	Transition specialists (1 FG with transition staff for each group/care setting) • Older adults/PD • People with IDD and other populations	MFP participants
RQ for BP1: What are the most effective state strategies for transitioning beneficiaries from institutional to qualified community settings carried out under MFP? How do state strategies vary for different types of beneficiaries?				
What factors contribute to your state's strong performance transitioning [each target population] to the community?	✓	✓	✓	
What systems are in place to identify suitable transition candidates? *PROBE: How do the processes vary for each target population?*	*Operational protocols*			
What systems are in place to coordinate transition planning?			✓	
How do these systems vary for each target population?			✓	
What has helped your program/you to effectively coordinate transition planning (for each population)?		✓	✓	
What systems are in place to monitor MFP participants' well-being after they transition to the community? *PROBE: How do the systems vary for each target population?*	*Survey*			
How did your transition team include your goals, interests, and preference in your care plan, developed before you were discharged from a nursing facility or hospital? PROBE: Which, if any, of your goals or preferences were not reflected in your care plan? Why?				✓
Which supports were most critical in helping you move back to the community? Why?				✓
Which supports were most critical in monitoring your well-being after you moved back to the community? Why?				✓
What aspects of your transition back to the community went well? Not so well? Please describe.				✓

Question/probe (Mode) FG = focus group 1:1 = telephone interviews	Other source	MFP project directors (1 FG)	Transition specialists (1 FG with transition staff for each group/care setting) • Older adults/PD • People with IDD and other populations	MFP participants
How do state Medicaid agency staff responsible for the state MFP and state Medicaid MLTSS programs work together to facilitate transitions to the community for residents of institutions who are eligible for MFP? PROBE: Are the policies and processes well-coordinated? If so, what makes this coordination effective? What hinders more effective coordination?		✓		
RQ for BP2: What are the most common and the most effective state uses of MFP grant funds for transitioning beneficiaries from institutional to qualified community settings and improving health outcomes?				
What services and supports are funded with MFP grant funds?	*Survey*			
Which of these services and supports are most critical to transitioning a participant to the community?	*Survey*			
Why do you think [insert services and supports here] are most critical to transitioning a participant to the community? PROBE: How do the services/supports vary for each target population?		✓	✓	
Which of these services and supports are most critical to helping people live independently in the community?	*Survey*			
Why do you think [insert services and supports here] are most critical to helping people live independently in the community?		✓	✓	
Which, if any, of these services have been permanently added to an existing waiver to be made available to other HCBS populations?	Poll	✓		
How did your state invest MFP funds to build capacity to transition more Medicaid beneficiaries to the community?		✓		

BP = best practice; HCBS = home and community-based services; IDD = intellectual or developmental disability; MFP = Money Follows the Person; MLTSS = managed long term services and supports; PD = physical disability; RQ = research question; SMI = serious mental illness.

Italicized text denotes program-level data integrated during analysis.

Exhibit E.2. Best Practice 3: Discussion topics, by research question and informant

Question/probe (Mode) FG = focus group 1:1 = telephone interviews	Other source	Transition/support coordinators(1 FG for each population/care setting) • Older adults/PD • People with IDD and other populations	MFP participants
RQ: What are effective state approaches carried out under MFP for implementing person-centered care and planning?			
Does your state's MFP program use an assessment tool that includes goals for meeting the self-reported needs and preferences of the MFP participant, and that the participant reviews and signs?	*Survey*		
What strategies do you/your team use to promote the use of person-centered practices when: 1. Assessing participant's eligibility for services and supports? 2. Creating person-centered plans? 3. Ensuring the services in place are working?		✓	
As part of your transition to the community, MFP participants generally work with a team to identify the services and supports you need to live independently in the community. Did the service planning process take into account your needs and preferences? What went well? Not so well?			✓
How do you/your team help MFP participants fully participate in and express their goals and preferences when developing their service plan (to receive services and supports in the community)?		✓	
How did the MFP transition coordinator help you decide which services and supports could met needs and preferences for your return home to the community?			✓
To what extent does your service plan include the services and supports important to you? To what extent did the supports that you received after you moved back to the community (following discharge from a nursing facility or hospital) meet all of your needs?			✓
How do you help people make informed choices about their person- centered service plan?		✓	

Question/probe (Mode) FG = focus group 1:1 = telephone interviews	Other source	Transition/support coordinators(1 FG for each population/care setting) • Older adults/PD • People with IDD and other populations	MFP participants
After a person transitions home, how do you/your team monitor the service plan to make sure it meets their needs and preferences? PROBE: What strategies worked especially well?		✓	
After you transitioned home, how often did your team check with you to make sure your services and supports were meeting your needs? Do you think that frequency was adequate?			✓
RQ: What are effective state approaches carried out under MFP for measuring person-centered care and planning?			
Is there a mechanism in place to monitor progress towards achieving the goals mutually agreed upon with the MFP participant during transition planning and post-transition?	*Survey*		
Does your state include MFP program participants in the National Core Indicators (NCI)®, National Core Indicators – Aging and Disability (NCI-AD™), or the HCBS Consumer Assessment of Healthcare Providers and Services (CAHPS®) surveys?	*Survey*		
Are the fielded survey(s) limited to MFP participants? If not, *are MFP participants specifically identified for inclusion in the sampling frame to support conclusions about the MFP experience?*	*Survey*		
If MFP participants in your state are enrolled in a section 1915(c) home and community-based services (HCBS) waiver program when they transition to the community, do your state's waiver programs track outcome measures for MFP participants that focus on the successful implementation of care plans? This may include mandated tracking through MLTSS plan contracts.	*Survey*		
Please describe how measurement of person-centered practices is part of your program's quality improvement activities.		✓	

BP = best practice; IDD = intellectual and developmental disabilities; MFP = Money Follows the Person; MLTSS = managed long term services and supports; PD = physical disability; RQ = research question; SMI = serious mental illness.

Italicized text denotes program-level data integrated during analysis.

Exhibit E.3. Best Practice 4: Discussion topics, by research question and informant

Question/probe (Mode) Joint telephone interviews with the MFP Project Director and the State Medicaid official	Other source	MFP project directors and state Medicaid officials
RQ: How have states used rebalancing funds to contribute to successful transitions and improved health outcomes?		
States that invested rebalancing funds to advance system transformation efforts to promote transitions to the community.	*Sustainability plan*	
Why did your program decide to invest your rebalancing funds in building transition and HCBS system capacity in your state? *[Probe on the challenge/need this aims to address, and how this need was identified]*		✓
How and to what extent have these investments increased your state's ability to help more people transition to, and live independently, in the community? How and to what extent have these investments helped to improve health and LTSS outcomes among MFP participants?? *[Probe on whether the state tracks outcome data]*		✓
What has been helpful in using the rebalancing funds on this strategy? *[Probe on facilitators within the MFP program and within the Medicaid program]*		✓
How does your state plan to sustain these investments?		✓
What lessons learned would you share with other states implementing this work?		✓
RQ: How have states instituted flexibility in funding or pay-for-performance metrics to contribute to successful transitions?		
Has your state instituted flexible funding policies that make it easy to move funds from institutional to HCBS or made other policy or program changes that contributed to successful transitions?	*Survey*	
Can you describe the funding structure or pay-for-performance program that allows your state to transition more participants to the community or better support their needs in the community?		✓
How is this funding or P4P program authorized? Does it require annual budget approval by the state legislature? Are the funds available through a permanent authorization?		✓
What helped you establish this funding structure or pay-for-performance program?		✓
How and to what extent has the flexible funding or pay-for-performance program increased your state's capacity to help more people in institutions move to and remain in the community? *[Probe on whether the state tracks outcome data]*		✓
What lessons learned would you share with other states implementing this work?		✓

Question/probe (Mode) Joint telephone interviews with the MFP Project Director and the State Medicaid official	Other source	MFP project directors and state Medicaid officials
RQ: How has your program integrated MFP services and supports into the traditional Medicaid program to build transition capacity?		
How has your program increased the availability of HCBS (through increased capacity of HCBS waiver programs, State Plan Amendments to add or modify benefits, obtaining authority for more funds, etc.)?		✓
Why did your program decide to pursue this option to increase the availability of HCBS?		✓
How and to what extent have these changes increased your state's ability to help more people transition to, and live independently in the community?		✓
What lessons learned would you share with other states implementing this work?		✓

BP = best practice; HCBS: home and community-based services; LTSS = long term services and supports; MFP = Money Follows the Person; P4P = pay for performance; RQ = research question.

Italicized text denotes program-level data integrated during analysis.

Exhibit E.4. Best Practice 5: Discussion topics, by research question and informant

Question/probe (Mode) FG = focus group	Other source	MFP project directors (1 FG)	MFP housing specialists (1 FG)	MFP housing coordinators (1 FG)
RQ: What state strategies and financing mechanisms were used to effectively coordinate housing with local housing authorities or provide housing supports (financed or supported under MFP demonstration projects)?				
What are the biggest housing related barriers that your program encountered when helping MFP participants move to qualified housing in the community?	Poll	✓	✓	✓
What strategies did your MFP program/you employ to address each of these barriers?		✓		✓
What strategies did your MFP program/you employ to increase the supply of affordable and accessible housing in your state? *[Inquire if shortages of affordable and accessible housing was NOT reported as a barrier in earlier question]*		✓	✓	
Did your state's MFP program obtain housing voucher priority status or set-asides for MFP participants in existing housing programs?	*Survey*			
Does your state have special licensing categories for small group homes serving people with disabilities with specialized needs?	*Survey*			
Did your state's MFP program partner with state or local housing organizations that led to an increase the supply of community-based affordable and accessible housing for MFP participants?	*Survey*			
Which state or local partners does your MFP program currently partner with to improve housing options for Medicaid beneficiaries?	Survey/Poll	✓	✓	
How (if at all) does your MFP program actively collaborate with housing partners to increase affordable, accessible housing for low-income people with disabilities?	*Survey*			
How did your MFP program establish these partnerships? PROBE: What helped you/your program to establish these partnerships?		✓	✓	
How have these partnerships helped your MFP program improve housing options for Medicaid beneficiaries?		✓	✓	

Question/probe (Mode) FG = focus group	Other source	MFP project directors (1 FG)	MFP housing specialists (1 FG)	MFP housing coordinators (1 FG)
RQ: What state strategies and financing mechanisms were used to effectively coordinate housing with local housing authorities or provide housing supports (financed or supported under MFP demonstration projects)?				
Are there any types of qualified housing options requested by MFP participants that your MFP program has had more, or less success, fulfilling? *(For example, which are the most requested housing options or supports?)* PROBE: What helped your program to fulfill participant preferences?				✓
How has your program used MFP funds to improve the availability of affordable and accessible housing options for MFP participants? *(MFP funds may include administrative funds, Demonstration funds, Supplemental funds, or rebalancing funds.)*		✓		✓
How has your program used MFP funds to coordinate housing supports to move MFP participants to qualified housing in the community? *{Housing supports may include home accessibility modifications, payment of security deposits and utility activation fees, and purchasing of essential household furnishings.}* *(MFP funds may include administrative funds, Demonstration funds, Supplemental funds, or rebalancing funds.)* PROBE: Which housing supports are most critical to move participants to the community?		✓		✓

BP = best practice; MCO = managed care organization; MLTSS = managed long term services and supports; MFP = Money Follows the Person; RQ = research question.

Italicized text denotes program-level data integrated during analysis.

Exhibit E.5 Best Practice 6: Discussion topics, by research question and informant

Question/probe (Mode) FG = focus group	Other source	MCO plan managers who oversee care managers (1 FG)	State Medicaid agency staff who oversee the MLTSS program (1 FG)
RQ: What are effective approaches for delivering MFP transition services through managed care entities?			
Does your MLTSS program use a blended rate to set monthly capitation rates, or use other capitation rate setting methods to encourage plans to help members transition to the community?	*Survey*		
Does your MLTSS program use other financial incentives, outside the capitation rate, to encourage plans to help members residing in institutions transition to community settings?	*Survey*		
Which financial incentives have you found most effective in encouraging plans to help their members who reside in institutions and qualify for MFP transition to community settings?			✓
Does your MFP program have a formal cooperative agreement in place with the MLTSS program?	*Survey*		
How do state Medicaid agency staff responsible for the state MFP and state Medicaid MLTSS programs work together to facilitate transitions to the community for residents of institutions who are eligible for MFP? PROBE: Are the policies and processes well-coordinated? If so, what makes this coordination effective? What hinders more effective coordination?			✓
How are the roles and responsibilities for managing transitions to the community for institutional residents divided between the state MFP program and managed care plans? *Discuss each in turn – which group is responsible for:* 1. Identifying MFP eligible individuals 2. Transition planning 3. Facilitating enrollment in MLTSS plans 4. Developing care plans 5. Monitoring and coordinating services for MFP participants in community settings		✓	
What strategies have worked well in the division of labor between the state MFP program and managed care plans for managing transitions to the community for MFP participants? What strategies have worked well to ensure successful transitions (i.e. no re-admissions)? PROBE: Are there any drawbacks, i.e. steps in the process where coordination breaks down?		✓	
What systems or policies have helped your plan/the state Medicaid agency track and report MFP transitions and the status of MFP participants enrolled in MLTSS plans to the state MFP program?		✓	✓

Question/probe (Mode) FG = focus group	Other source	MCO plan managers who oversee care managers (1 FG)	State Medicaid agency staff who oversee the MLTSS program (1 FG)
What lessons or advice would you give to states that operate both MFP and state Medicaid MLTSS programs to ensure successful transitions?		✓	✓

HCBS = home and community-based services; MCO = managed care organization; MLTSS = managed long term services and supports; MFP = Money Follows the Person.

Italicized text denotes program-level data integrated during analysis.

Exhibit E.6 Best Practice 7: Discussion topics, by research question and informant

Question/probes (Mode) FG = focus group	Other source	Project manager of MFP Tribal Initiative (1 FG)	Tribal health leaders (1 FG)
RQ: What are effective strategies to establishing partnerships with Tribal nations?			
How did your (MFP TI) program establish partnerships with tribes and Recognized American Indian Organizations? PROBES: What factors have helped your MFP TI program form and maintain strong partnerships (e.g., continuity of leadership, funding availability, shared goals, good communication between partners, previous good relationships)?		✓	
What were the main challenges to forming or maintaining strong partnerships? How did you overcome these? [Probe on cultural barriers, or issues of trust or power balances]	Poll	✓	✓
RQ: What are effective strategies to build service capacity/develop workforce in tribal communities?			
What strategies has your (MFP TI) program employed to build LTSS service capacity in tribal communities?		✓	✓
What strategies did you find effective in building capacity for culturally appropriate LTSS services?		✓	✓
How does your (MFP TI) program ensure efforts to expand and strengthen the LTSS workforce are equitable and honor the culture of the tribal communities? *(This might include recruiting, hiring and training Native Americans to fill these jobs; paying higher wages and providing better benefits, or other strategies.)* PROBES: What strategies were especially effective?		✓	✓
What are the major barriers to developing the workforce? How has the MFP TI tried to overcome these barriers?	Poll		✓

Question/probes (Mode) FG = focus group	Other source	Project manager of MFP Tribal Initiative (1 FG)	Tribal health leaders (1 FG)
RQ: What are effective strategies to addressing disparities in accessing LTSS among Tribal nations?			
How has your MFP TI program worked to address disparities in access to LTSS between American Indians/Alaska Natives and other Americans? PROBE: What are the effective or promising strategies for addressing disparities? What outcome measures does your program monitor as part of your efforts to address health disparities?	Poll to identify outcomes measures	✓	
RQ: What are effective strategies to delivering culturally appropriate LTSS to tribal members?			
How does your program ensure that LTSS are provided in a culturally appropriate manner? PROBE: What best practices would you recommend?		✓	✓
In your view, what are the essential elements to delivering culturally appropriate LTSS? *(For example, gathering feedback from tribal leaders about the types of services that are most needed, and how they should be provided)*			✓
What lessons learned or best practices would you share with other TI programs? PROBE: To what extent could these strategies be adopted by other states providing community-based LTSS for American Indians and Alaska Natives? What barriers have you/your program identified that should be addressed to ensure successful implementation of similar programs providing community-based LTSS for American Indians and Alaska Natives?		✓	✓

BP = best practice; LTSS = long term services and supports; MFP = Money Follows the Person; RQ = research question; TI = Tribal Initiative.

Italicized text denotes program-level data integrated during analysis.

Exhibit E.7. Best Practice 8: Discussion topics, by research question and informant

Question/probes (Mode) FG = focus group	Other source	MFP project directors (1 FG)	Transition coordinators (1 FG)	MFP participants (1 FG)
RQ: How have states examined disparities in access or outcomes within their MFP programs? What disparities exist within MFP programs?				
Please describe your MFP program's efforts examining disparities in MFP participation or in the broader population of HCBS beneficiaries who receive LTSS.	*Survey*			
Which beneficiary-level characteristics did your state consider when examining disparities? *Options: Race, Ethnicity, Gender, Urban/Rural, Language, SES, Other* PROBE: Which data sources did your state use to identify social and demographic characteristics?	WebEx poll	✓		
When assessing disparities, what outcomes did your state examine? PROBE: MFP participation rates among those eligible; Transition rates to the community through MFP; Use of specific MFP services or supports; Re-institutionalization rates among MFP participants; Health outcomes among MFP participants		✓		
What were the main findings in the examination of disparities?	*Survey*			
Have you found that beneficiaries with certain characteristics (such as race or ethnicity, primary language, socio-economic status) are more or less likely to transition to the community? What do you think explains such differences?		✓	✓	
Have you found that participants with certain characteristics are more or less likely to remain in the community after transitioning (i.e. not becoming re-institutionalized)? Why do you think that is?			✓	
To what extent did the supports that you received after you moved back to the community (following discharge from a nursing facility or hospital) meet all of your needs? Please describe.				✓

Question/probes (Mode) FG = focus group	Other source	MFP project directors (1 FG)	Transition coordinators (1 FG)	MFP participants (1 FG)
Questions to assess participants' experience with the cultural competence of HCBS providers: 1. Do your service providers communicate with you about your goals, services and supports in a way you understand? 2. Do your service providers take your personal preferences into account (for example, the foods you like and your religious practices?) 3. Do your service providers speak to you in your preferred language?				✓
RQ: What promising strategies are states using to address disparities in access or outcomes within their MFP programs?				
How is the MFP program in your state working to reduce disparities and inequity?	*Survey*			
What strategies have been effective in addressing disparities? PROBE: What approaches have been effective in increasing successful transitions in populations experiencing disparities?		✓	✓	
What challenges has your program encountered in addressing disparities?		✓		
How is the MFP program in your state tracking the results of efforts to reduce disparities?	*Survey*			
If your state has identified equity goals or benchmarks for MFP, how were these goals identified? How is does MFP program monitor progress toward the goals?		✓		

BP = best practice; HCBS = home and community-based services; LTSS = long term services and supports; MFP = Money Follows the Person; SES = socioeconomic status; RQ = research question.

Italicized text denotes program-level data integrated during analysis.

Appendix F

MFP Participant Interview Guide

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MFP Participant Interview Guide

Date:

Mathematica Interviewer:

Participant (target population):

MFP state:

Informed Consent

Hello, May I please speak to [participant name]? I'm (NAME) from Mathematica. I got your name and contact information from [insert name of state contact who did initial outreach] and they indicated you'd be willing to speak about your experiences with the [insert state-specific name of the Money Follows the Person (MFP) program] program. Thank you for speaking with me today.

As you may know, [insert state-specific name of the Money Follows the Person (MFP) program] help people who need long-term services move out of nursing homes and other institutions to homes and community residences. Many states operate MFP programs, but states run these programs in different ways. The Centers for Medicare & Medicaid Services, the federal agency which administers the MFP program, asked our organization, Mathematica, to learn what MFP programs are doing well and what could be improved.

As part of this study, we are speaking to people—like you—who are receiving services in their homes provided through MFP programs. We want to learn about your experiences during and after your move back home and what services and supports were most important to you.

Our discussion should last about 30 minutes, and your participation is voluntary. Any information that you share with me will remain confidential—meaning your name and other identifying information will be kept as private as possible. If you choose not to participate, or to stop the interview at any time, this will not affect your participation in MFP, the current services you receive, or your eligibility for future services. If you choose to participate, you will receive a $40 Visa gift card after this phone call to thank you for your time. Would you like to proceed with this interview?

[If YES] With your permission, we would like to record this discussion to make sure our notes are complete. The notes and recording will not be shared with anyone outside of Mathematica and will be deleted at the end of our study. If you do not wish to be recorded, that is fine. Are you comfortable with this conversation being recording? [If "No" objections to recording, start recording.]

Before we begin, do you have any questions?

If you have any questions that I cannot answer, or at any time after this interview, you may contact the Mathematica project director, Jessica Ross. Her contact information was in the overview document that [State Contact] may have given you, and I'm happy to provide it to you after this interview.

Interview Protocol

1. To start, please introduce yourself and briefly tell me about your involvement with the MFP program.

   a. Roughly when did you return home following discharge from a nursing home or hospital?

I am first going to ask you a few questions about transition planning that occurred before you were discharged [from a nursing home or hospital] to your home.

Before transitioning to the community, MFP participants generally work with a team to identify the services and supports they need to live independently in the community. [If we have this information, interviewer can refer to the name of the TC who made contact with the MFP participants.]

1. When you were in a nursing home or hospital, how did the [state MFP program] transition coordinator identify the services that support you in your home?
2. Did the service planning process take into account your needs and preferences? What went well? Not so well?
    a. *How did your transition team include your goals, interests, and preferences in your service plan, developed before you were discharged from a nursing home or hospital?*
3. To what extent does your service plan include the services and supports important to you?

PROBE: Which, if any, of your goals or preferences were not reflected in your service plan? Why?

These next questions are related to the services and supports you received during and after your transition home (following discharge from a nursing home or hospital).

4. After you transitioned home, how often did your transition team check with you to make sure your services and supports were meeting your needs? Do you think that frequency was adequate?
5. Which services or supports were **most important** in helping you move back to the community? Why?
6. To what extent did the supports that you received after you moved back home (following discharge from a nursing home or hospital) meet all of your needs? Please describe.

PROBE: Were there any services or supports that you would have benefitted from after you moved back to the community that you did not receive? Please describe.

Next, I'd like to hear your perceptions of the supports that you've received from your service providers since you returned to your home.

7. Do your service providers communicate with you about your goals, services and supports in a way you understand?
    a. Do they speak to you in your preferred language?
8. On a scale of 1-5 (with 1 being 'not understood' and 5 being 'very understood'), to what extent do you feel understood and heard by your service providers?
9. Do your service providers take your personal preferences into account (for example, the foods you like and your religious practices?)
10. What aspects of your transition back to home went well? Not so well? Please describe.
    a. **[If a negative response is provided]:** How could the services that you receive be improved to improve communication? Incorporate your preferences?
11. **[If unintended consequences of participation in MFP does NOT come up in responses to other questions, ask:]** Have you experienced any negative effects since you returned home (following discharge from a nursing home or hospital)?

PROBE: Negative effects might relate to quality of life, health, access to services, or financial situation that they did not expect.

12. Is there anything that I have not asked about, but you think is important for me to know about your experience as a participant in the MFP program?

Thank you for your time and for sharing your experiences and insights. I learned a lot from our discussion.

Before we end this call, I'd like to get your full name and mailing address so that I can mail your $40 gift card, to thank you for your participation today.

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Appendix G

IRB Approval Letter

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22 February 2022

Jessica Ross, MPH
Mathematica
955 Massachusetts Avenue, Suite 801
Cambridge, MA 02139

RE: Expedited research ethics review findings for: *National Evaluation of the Money Follows the Person Demonstration (51285)* (HML IRB Review #1092MATH22)

Dear Jessica Ross,

Protocols for the protection of human subjects in the above study were assessed through an expedited research ethics review by HML Institutional Review Board on 18 – 22 February 2022.

This study's human subjects' protection protocols, as stated in the materials submitted, received **research ethics review approval** in accordance with the requirements of the US Code of Federal Regulations for the Protection of Human Subjects (45 CFR 46 & 45 CFR 46.110). You may rely on this IRB for review and continuing ethical oversight of this study.

You and your project staff remain responsible for ensuring compliance with HML IRB's determinations. Those responsibilities include, but are not limited to: 1) ensuring prompt reporting to HML IRB of proposed changes in this study's design, subject risks, informed consent, or other human protection protocols; 2) investigators will conduct the research activity in accordance with the terms of the IRB approval until any proposed changes have been reviewed and approved by the IRB, except when necessary to mitigate hazards to subjects; 3) and to promptly report any unanticipated problems involving risks to subjects or others in the course of this study.

HML IRB is authorized by the U.S. Department of Health and Human Services, Office of Human Research Protections (IRB #1211, IORG #850), and has DHHS Federal-Wide Assurance approval (FWA #1102).

Sincerely,

D. Michael Anderson, Ph.D., MPH
HML IRB Chair & Human Subjects Protections Director

cc: Patricia Rowan, Noelle Denny-Brown, Penelope A. Lantz, JD