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)

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

February 2024

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Acronyms

ADLs	activities of daily living
AI/AN	American Indians and Alaska Natives
BIP	Balancing Incentive Program
CAA, 2021	Consolidated Appropriations Act, 2021
CAHPS®	Consumer Assessment of Healthcare Providers and Services
CalAIM	California Advancing and Innovating Medi-Cal
CB	community-based
CCC	Community Care Connections
CMS	Centers for Medicare & Medicaid Services
DCHA	District of Columbia Housing Authority
EAA	environmental accessibility adaptations
ECM	enhanced case management
FFS	fee-for-service
FMAP	federal medical assistance percentage
HCBS	home and community-based services
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
I/DD	intellectual or developmental disabilities
LTSS	long-term services and supports
MCP	managed care plan
MFP	Money Follows the Person
MH/SUD	mental health or substance use disorders
MLTSS	Managed long-term services and supports
NCI®-IDD	National Core Indicators® – Intellectual and Developmental Disabilities
NCI-AD™	National Core Indicators – Aging and Disability™
NED	non-elderly disabled
NF	nursing facility
PHA	public housing authority
TAF	Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files

Key Terms

MFP grant funds: All funding awarded to states under the MFP Demonstration. States may receive funding for the following categories:

- **Qualified HCBS.** Any services available under a Medicaid home and community-based services (HCBS) state plan or waiver program under the state's Medicaid program. States receive reimbursement at an MFP-enhanced federal medical assistance percentage (FMAP) on qualified HCBS during an MFP participant's 365-day enrollment period.
- **Demonstration HCBS.** Qualified HCBS that could be provided, but are not currently provided, under the state's Medicaid program. States also receive reimbursement at the MFP-enhanced FMAP on demonstration services during an MFP participant's enrollment period.
- **Supplemental services.** Short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Services are fully covered by MFP grant funds.[1]
- **Administrative expenses.** Costs related to operationalizing the demonstration, including administrative activities and personnel. Administrative expenses are fully covered by MFP grant funds.
- **HCBS capacity building.** Planning and capacity building activities to accelerate LTSS system transformation and expand HCBS capacity. MFP grantees were eligible to submit supplemental budget requests for these activities under a funding opportunity[2] released in September 2020; states not participating in MFP were eligible to submit budget requests for capacity building under the MFP Demonstration Expansion funding opportunity[3]in March 2022.

State-equivalent funds: State funds equivalent to the amount of funds attributable to the MFP-enhanced FMAP. CMS expects states to use these state funds, commensurate with the difference between what the state receives at the MFP-enhanced FMAP rate and its regular FMAP rate, for the purposes of providing new or expanded HCBS and for initiatives to strengthen HCBS system infrastructure.

[1] Effective January 1, 2022, the description of MFP supplemental services was modified from one-time services to short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Further, the scope of MFP supplemental services was expanded to address critical barriers to transition for MFP participants, including the lack of affordable and accessible housing, food insecurity, and financial and administrative barriers to transitions. The reimbursement rate was modified from the state's FMAP rate to 100 percent (CMS 2022c).

[2] https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html

[3] https://www.grants.gov/search-results-detail/334196

Executive Summary

The Money Follows the Person (MFP) Demonstration, first authorized by Congress in the Deficit Reduction Act of 2005 (P.L. 109-171), has provided nearly $6 billion to 43 states and the District of Columbia to improve access to home and community-based services (HCBS) for Medicaid-eligible individuals who need long-term services and supports (LTSS). By the end of 2020, the MFP Demonstration had helped 107,128 long-term residents transition from institutions to the community (Peebles and Dolle 2022).

Section 204(e) of Division CC of the Consolidated Appropriations Act, 2021 (CAA, 2021) (P.L. 116-260) added a section 6071(i) to the Deficit Reduction Act of 2005, directing the Centers for Medicare & Medicaid Services (CMS) to prepare a report on MFP Demonstration best practices. This Report to Congress is organized by the eight Best Practice areas identified by the CAA, 2021, and focuses on the 34 MFP grantee states active at the time of the study, reflecting experiences through Spring 2022.[4] For each Best Practice listed below, this report identifies effective state strategies for implementing the key components of the MFP Demonstration and features case studies of distinctive state approaches. The information in this report was developed in collaboration with states, providers, and MFP participants and their family members.

State strategies and use of MFP grant funds for transitioning beneficiaries and improving health outcomes

As required by section 204(e) of Division CC of the CAA, 2021, this report describes state strategies for supporting successful transitions from institutional settings to qualified community settings, examines how these strategies vary for different types of beneficiaries, and describes how states most effectively and commonly used MFP grant funds to improve such transitions and health outcomes.

- To increase referrals from institutions, states used MFP grant funds to hire and embed local staff in long-term care institutions to provide options counseling to residents.
- To meet the diverse support needs of different populations, states used MFP grant funds to hire dedicated transition specialists—with relevant clinical expertise—to work with specific populations.
- For participants[5] with intellectual or developmental disabilities, states used MFP grant funds to also hire specialized staff, such as behavioral health specialists, to provide direct supports and capacity-building for providers.
- States used MFP grant funds to develop peer mentoring programs to build trust between their MFP programs and Medicaid beneficiaries eligible for the program as well as to provide support to those in the process of transitioning to the community.
- Most states used MFP grant funds for one-time transition costs and home accessibility modifications; states identified these services as the most valuable uses of grant funds.

[4] At the start of the study in November 2021, the 34 active MFP programs included Alabama, Arkansas, California, Colorado, Connecticut, the 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.

[5] In this report, the term "participants" refers specifically to individuals enrolled in the MFP Demonstration, while "beneficiaries" refers more broadly to Medicaid-eligible individuals.

> "A lot of the things we need in life, you don't realize how important those things are until you don't have them, or don't have the finances to get them. Every little thing I asked for, [my transition coordinator] would help me with. And it meant so much." – MFP participant

State approaches to improving person-centered care and planning

As required by section 204(e) of Division CC of the CAA, 2021, this report also describes states' most effective approaches to improving person-centered care and planning within the MFP Demonstration. States are required to use person-centered planning with MFP participants, culminating in the development of a person-centered plan that includes the goals and preferences of the participant.

- To improve person-centered planning, states invested in trainings for transition specialists on person-centered practices to build competency and ensure consistent implementation across the state.
- The transition specialists, who work with participants to develop person-centered plans, built relationships with participants and used techniques that empowered MFP participants to express their goals and preferences during the development of care plans.
- Transition specialists assisted MFP participants in making informed decisions about their care plans and continued to assess and monitor participants' needs and preferences after the transition.
- States primarily used experience of care surveys to measure the effectiveness of care plans in meeting participants' needs.

State use and impact of program, financing, and other flexibilities available under MFP

States receive an MFP-enhanced federal medical assistance percentage (FMAP) for home and community-based services furnished under the MFP Demonstration. States are expected to reinvest the amount of funds attributable to the MFP-enhanced FMAP (or "state-equivalent funds") in initiatives to expand HCBS for Medicaid beneficiaries and provide participants with services and supports above or beyond a state's current HCBS offerings. Further, MFP grant funds may cover short-term services and supports that are otherwise not allowable under Medicaid. As required by section 204(e) of the CAA, 2021, this report describes these initiatives and changes in states' financing, program structure, state service infrastructure, or other flexibilities available under MFP Demonstration projects, that are not available under the traditional Medicaid program, that directly contributed to successful transitions and better health outcomes among MFP participants.[6]

- The flexible nature of the MFP Demonstration enabled states to address, through state-specific initiatives, those barriers that preclude individuals from receiving HCBS (for example, limited accessible housing and waitlists for enrolling in a waiver program).
- States used MFP programs as a testing ground to design, implement, and evaluate service innovations as potential precursors to permanent changes in Medicaid policies and programs.

[6] Forthcoming MFP evaluation reports will examine the causal impacts of supplemental services—those not otherwise allowable under Medicaid—and other flexibilities on successful transitions and improved health outcomes. Chapter IV includes descriptive information on supplemental services used by selected study states.

- States leveraged the flexibility of the MFP Demonstration to make existing HCBS programs provided through Medicaid authorities more accessible and to offer more comprehensive services to beneficiaries that made transitions from institutional settings and improved health outcomes possible.

> "There are activities that occur in MFP that—after we assess the viability of the service as well as the efficacy of the service—might then be used to expand into other avenues such as the 1915c or 1115…. We can start off small and then [decide whether to] expand over time."
> –State Medicaid Official

State strategies for coordinating and financing housing supports

As required by section 204(e) of Division CC of the CAA, 2021, this report describes state strategies or financing mechanisms for effective provision of housing supports to MFP participants through coordination with local housing authorities and other resources. The limited availability of affordable, accessible housing has been, and continues to be, a systemic challenge for state MFP programs and necessitates intragovernmental collaboration.

- States developed strong partnerships with state executive leaders, state and local public housing agencies, landlords, and home modification programs to increase the supply of housing for MFP participants.
- States used state-equivalent funds for infrastructure improvements, including development of housing registries and capital investments in new housing.
- States used state-equivalent funds to cover enhanced pre-tenancy supports, including upfront housing costs such as rental deposits.
- Many states with active MFP programs used MFP administrative funds to employ specialized individuals to develop partnerships with state and local housing entities to increase affordable housing for MFP participants.

> "We started developing relationships with [housing] developers themselves, meeting with them, talking about MFP client needs, and being involved right from the get-go in developing accessible units – truly accessible units."
> – MFP housing specialist

State approaches for delivering transition services through managed care plans

As required by section 204(e) of the CAA, 2021, this report describes effective state approaches for providing MFP transition services in collaboration with Medicaid managed care plans. In 2021, 15 states with active MFP grants had managed LTSS (MLTSS) programs operating simultaneously.

- States used capitation payments and other financial incentives for managed care plans to increase the number of managed care enrollees in institutions that successfully transition to the community.

- States that clearly defined the roles of each party in formal cooperative agreements with managed care plans and established open lines of communication experienced more effective collaboration among state Medicaid agency staff, MFP project directors, and managed care plan case managers.
- States and managed care plans engaged in data sharing to monitor the use of health care and critical incidents, like hospitalizations, for MFP participants enrolled in managed care plans.

Other best practices and effective transition strategies: Tribal Initiative programs and addressing disparities

As required by section 204(e) of Division CC of the CAA, 2021, this report examines other best practices and effective transition strategies demonstrated by states with MFP programs. In consultation with CMS, the evaluation team chose to focus the research on investigating (1) state strategies for delivering services through MFP Tribal Initiative programs and (2) how the five states awarded funding for the Tribal Initiative in 2013 built culturally responsive HCBS for tribal communities.

- Successfully delivering services through the MFP Tribal Initiative required building close, collaborative partnerships between MFP staff, federally-recognized tribes,[7] and tribal organizations and honoring the sovereign nature of federally-recognized tribes.
- MFP Tribal Initiative programs identified opportunities to increase funding for HCBS in tribal communities and implement additional Medicaid-funded community-based services.
- Federally-recognized tribes and tribal organizations spoke of the value of services provided by tribal staff to tribal members and the need for cultural competence training for non-Native staff. Culturally responsive care can also include traditional healing practices that might not be reimbursable by Medicaid.

Second, this report describes state strategies for identifying and addressing disparities in service use and outcomes within MFP, with a focus on racial and ethnic disparities.

- States invested in data infrastructure improvements, research studies, and health information technology staff to identify and improve awareness of disparities.
- States are developing strategies to collect and analyze data on the demographic characteristics of MFP participants and HCBS users and to make these data publicly available.
- States are assessing hiring processes and providing trainings for providers to reduce unconscious bias and increase the racial, cultural, and linguistic diversity of their workforce.

Opportunities and challenges to integrating effective MFP practices into state Medicaid LTSS policies and programs

As required by section 204(e) of Division CC of the CAA, 2021, this report identifies and analyzes opportunities and challenges to integrating effective MFP practices and state strategies into the state

[7] The Indian Self-Determination and Education Assistance Act, 25 U.S.C.A. § 450b(e), defines Indian tribe as any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Medicaid program. Opportunities emphasized across states participating in MFP and receiving MFP grant funds include:

- States permanently added transition coordination services to their state plans or section 1915(c) waiver programs to expand access to HCBS.
- At least three states modified their section 1915(c) waiver programs or state plan benefits more broadly to cover one-time expenses that were necessary for institutional residents to re-establish a new home in the community.
- States operating MLTSS programs instituted features such as MFP transition services and financial incentives in managed care plan contracts to sustain promising practices developed through MFP.

States participating in MFP and receiving MFP grant funds identified several common challenges to integrating or scaling effective MFP practices into their state Medicaid programs:

- Some states have been unable to secure state funding or revise state plan benefits and waiver eligibility requirements to permanently integrate MFP Demonstration services into state plan benefits.
- Shortages within the direct-care workforce as well as a lack of affordable and accessible housing have also hindered state efforts to scale-up transition programs.

Conclusion

While states continue to improve the quality and effectiveness of their MFP programs to better serve Medicaid beneficiaries and use the MFP Demonstration to test the value of new approaches, many of the best practices highlighted in this report are not recent innovations. Rather, they reflect lessons learned by states across the country after many years of operating MFP programs. Although not all states use these practices, most have adopted effective strategies that help to expand access to HCBS, create more person-centered plans, deliver high-quality community-based care, and support beneficiaries so they may live independently in the community and achieve their care goals.

"Any way to be at home is the best. This program has given us a second chance."
– MFP participant

I. Introduction

A. Background

Overview of MFP Demonstration

The national Money Follows the Person (MFP) Demonstration program, established by section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171), has operated in 43 states and the District of Columbia since 2008.[8] The MFP Demonstration provides funding to states to support the development of services, tools, and processes to improve access to home and community-based services (HCBS) to Medicaid-eligible beneficiaries who need long-term services and supports (LTSS). From the start of the program in 2008 to the end of calendar year 2020, MFP grantees helped 107,128 Medicaid beneficiaries residing in an inpatient long-term care institution, such as a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or institutions for mental diseases transition to home and community-based settings (Peebles and Dolle 2022).

The MFP Demonstration goals are to[9]:

1. Increase the use of HCBS and reduce reliance on institutional, long-term care services.
2. Eliminate barriers or mechanisms—whether in state law, the state plan, the state budget, or otherwise—that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary LTSS in the settings of their choice.
3. Increase the ability of state Medicaid programs to provide HCBS to people who choose to transition from an institutional setting to a community setting of their choice.
4. Ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services.

Each state seeking approval to participate in the MFP Demonstration must submit an application describing a program that has (1) a transition component that identifies eligible Medicaid beneficiaries receiving care in institutional settings who wish to live in the community and helps them do so and (2) a rebalancing initiative that increases the share of Medicaid LTSS expenditures directed to community services and supports, as required by section 6071(c) of the Deficit Reduction Act of 2005. To the extent the Secretary has waived certain requirements of title XIX of the Social Security Act as authorized by section 6071(d)(3) of the Deficit Reduction Act of 2005, state Medicaid agencies are allowed to target their MFP programs to particular groups of LTSS beneficiaries, including older adults, people with physical disabilities, individuals with intellectual or developmental disabilities (I/DD), and people with mental health or substance use disorders (MH/SUD).

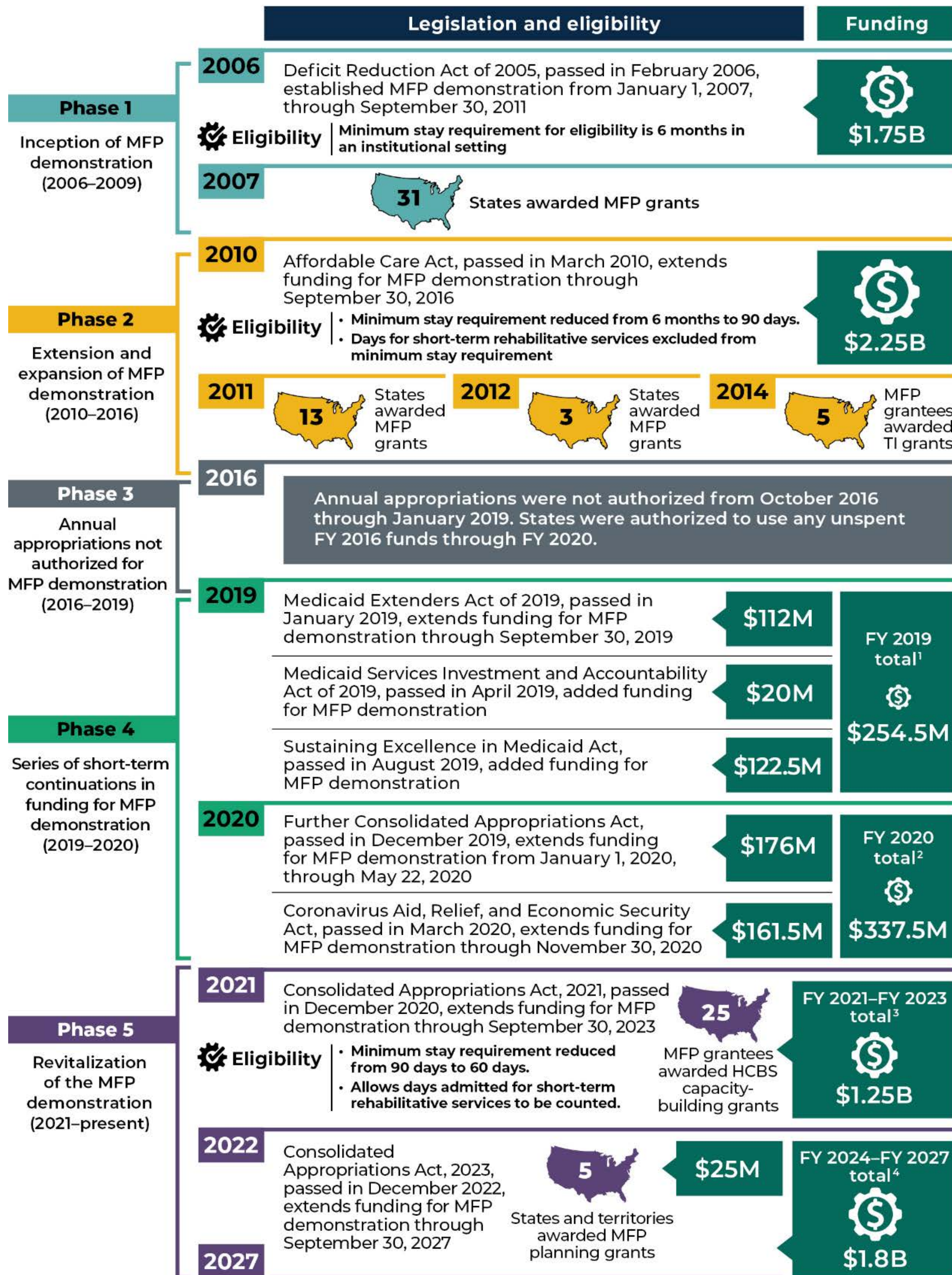
The MFP Demonstration has changed since it launched in 2007. The number of participating states increased from 31 in 2007 to 44 in 2016, and then dropped to 34 in 2020. This decline in state participation may be attributed to uncertainty in long-term funding from 2016 through 2020 when the MFP Demonstration was operating under a series of short-term funding extensions. The MFP Demonstration has evolved in five phases, each one marked by the differing landscape for the MFP Demonstration, including

[8] As of the start of this study in November 2021, 43 states and the District of Columbia had participated in the MFP Demonstration for some period of time since the program's inception in 2008. This number includes states whose participation began after 2008 as well as states no longer operating MFP programs. This number does not include states who received MFP Demonstration grants but did not operate MFP programs.

[9] https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html. Accessed April 20, 2022.

authorizing legislation, funding amounts, and eligibility requirements. Exhibit I.1 presents a timeline highlighting changes that occurred in each phase of the MFP Demonstration in the past 17 years. These changes are described in more detail below.

Exhibit I.1. Evolution of the MFP Demonstration



HCBS = Home and community-based services; MFP = Money Follows the Person; TI = Tribal Initiative.

Exhibit I.1 (*continued*)

[1] Total amount of funding for FY 2019 accounts for funding allocated by statute for January 2019–September 2019.
[2] Total amount of funding for FY 2020 accounts for funding allocated by statute for January 2020–September 2020, and includes funds allocated for part of FY 2021 (October 1, 2020–December 18, 2020).
[3] Total amount of funding for FYs 2021–2023 accounts for funding allocated by statute for January 2021–September 2023.
[4] Total amount of funding for FYs 2024-2027 accounts for funding allocated by statute for October 2023–September 2027.

Changes to the MFP Demonstration

Over the last 17 years, Congress has made several changes to the eligibility criteria for MFP participation. At the start of the MFP Demonstration, Medicaid beneficiaries were eligible for transition services if they resided in an institution for at least 6 months (that is, 180 days). On October 1, 2011, Section 2403(b) of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) amended section 6071(b)(2) of the Deficit Reduction Act of 2005 to reduce the minimum stay requirement to not less than 90 consecutive days and to exclude days solely for short-term rehabilitative services from the minimum stay requirement. Section 204(b) of Division CC of the CAA, 2021, further reduced the minimum stay requirement to 60 days, effective January 26, 2021, and allowed states to again count days that an individual received short-term rehabilitative services when determining the length of stay. Section 204(e) of Division CC of the CAA, 2021 also extended funding for MFP through 2023 and required the Centers for Medicare & Medicaid Services (CMS) to conduct a second national evaluation and this report on best practices. Most recently, the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117-328), passed in December 2022, extended funding for the MFP Demonstration through 2027. [10]

In 2013, CMS announced the MFP Tribal Initiative and awarded nearly $1.5 million to five grantee states under this special initiative in 2014 (Minnesota, North Dakota, Oklahoma, Washington, and Wisconsin).[11] Through the MFP Tribal Initiative, federally-recognized tribes or tribal organizations can perform LTSS administrative functions on behalf of state Medicaid agencies, allowing members to access LTSS in the setting of their choice. In these five states, established MFP programs are collaborating with federally-recognized tribes and tribal organizations to increase the use of HCBS, eliminate barriers that prevent the use of Medicaid funds to support tribal members with LTSS needs, and strengthen the ability of state Medicaid programs to respond to the unique needs of tribal members. The Tribal Initiative funding also helps to develop the infrastructure required to implement HCBS for American Indians and Alaska Natives (AI/AN) using one or more Medicaid authorities.

CMS has also announced programmatic changes affecting services reimbursable under the MFP Demonstration. On March 31, 2022, CMS released a notice expanding the definition of MFP supplemental services to address critical barriers to transition for MFP participants.[12] The updated definition includes additional services that can support an individual's transition from an institution to the community, including up to 6-months of short-term rental assistance and food pantry stocking for 30 days. This definition, applicable as of January 2022, also includes payment for activities completed prior to transitioning from an institution and payment for securing a community-based home, such as apartment application fees. In this notice, CMS also announced that MFP supplemental services will be fully covered by MFP grant funds at a federal reimbursement rate of 100 percent.

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[10] All funding must be awarded to grantees by September 30, 2027. MFP funding is available to grantees for the fiscal year in which it is awarded and four additional fiscal years.

[11] https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html

[12] https://www.medicaid.gov/sites/default/files/2022-04/mfp-supplemental-services-notice.pdf.

To build the capacity and reach of the MFP Demonstration, CMS has made other supplemental funding opportunities available. From September 2020 through June 2021, CMS made capacity-building funds available to states currently operating an MFP program. Each state was eligible to receive up to $5 million in supplemental funding for planning and capacity-building activities. As of 2023, CMS awarded $149 million to 32 states to accelerate long-term care system transformation and expand HCBS capacity.

In August 2022, CMS awarded approximately $25 million to five states and territories not currently participating in the MFP Demonstration to support capacity-building and planning for implementation of MFP: American Samoa, Illinois, Kansas, New Hampshire, and Puerto Rico. These awards bring the total number of active states and territories participating in MFP to 41, as of January 2023.

Changes to the Medicaid LTSS policy landscape

The landscape in which the MFP Demonstration operates has also changed since 2007. Since Congress added section 1915(c) to the Social Security Act in 1983, giving states the option to receive a waiver of certain Medicaid rules to provide HCBS to individuals who otherwise require the level of care provided in certain institutions, the number of options available for states to provide HCBS has grown. The Deficit Reduction Act of 2005 (P.L. 109-171) afforded states flexibility to advance provision of HCBS under the MFP Demonstration as well as new state plan options for provision of HCBS under section 1915(i) of the Social Security Act and self-directed personal assistance services under section 1915(j) of the Social Security Act.[13]

The Patient Protection and Affordable Care Act of 2010 (ACA) (P.L. 111-148) added section 1915(k) Community First Choice to the Social Security Act, which expanded access to HCBS and transition supports. The ACA also extended the MFP Demonstration through September 30, 2016, and authorized the Balancing Incentive Program (BIP), which provided grants to states that spent less than 50 percent of total Medicaid LTSS expenditures on HCBS to support reforms designed to increase access to HCBS. Through BIP, states that made structural reforms to their LTSS programs received an enhanced federal medical assistance percentage (FMAP) to provide new or expanded HCBS. Thirteen of the 34 states with active MFP programs at the time of this study participated in the BIP (CMS 2022a).

Nearly half of state Medicaid agencies with active MFP programs now use managed care models to provide LTSS, rather than the fee-for-service (FFS) model, which pays providers for each service. In managed LTSS (MLTSS) programs, states contract with managed care plans and pay them a fixed per-person amount—the capitation payment —to provide all or a subset of LTSS. This model can help to shift the balance of spending from institutional care to HCBS by giving managed care plans a financial incentive to keep their enrollees in less costly home and community-based settings. Of the 34 states with active MFP programs at the time of this study, 15 operated MLTSS programs as of FY 2020 (Murray et al. 2023).

Most recently, section 9817 of the American Rescue Plan Act of 2021 (P.L. 117-2), temporarily increased the FMAP by 10 percentage points for Medicaid expenditures for certain HCBS, beginning April 1, 2021, and ending March 31, 2022. As with the MFP Demonstration and other Medicaid LTSS reforms, the aim of the American Rescue Plan Act funding is to build HCBS capacity and advance LTSS rebalancing. Based on states' FY 2023 quarter 1 spending plans, CMS estimates that states will spend over $36 billion through FY 2025 on activities to enhance, expand, or strengthen HCBS as a result of the additional funding.

[13]More information about HCBS authorities is available at: https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/index.html .

Requirements for the MFP Best Practices Report to Congress

Under section 204(e) of Division CC of the CAA, 2021 (P.L. 116-260), Congress directed CMS to submit a report that summarizes findings on best practices from state MFP programs in the following eight areas, summarized in Exhibit I.2:

> ‘‘(A) The most effective State strategies for transitioning beneficiaries from institutional to qualified community settings carried out under MFP Demonstration projects and how such strategies may vary for different types of beneficiaries, such as beneficiaries who are aged, physically disabled, intellectually or developmentally disabled, or individuals with serious mental illnesses, and other targeted waiver beneficiary populations under section 1915(c) of the Social Security Act.
>
> (B) The most common and the most effective State uses of grant funds carried out under demonstration projects for transitioning beneficiaries from institutional to qualified community settings and improving health outcomes, including differentiating funding for current initiatives that are designed for such purpose and funding for proposed initiatives that are designed for such purpose.
>
> (C) The most effective State approaches carried out under MFP Demonstration projects for improving person-centered care and planning.
>
> (D) Identification of program, financing, and other flexibilities available under MFP Demonstration projects, that are not available under the traditional Medicaid program, and which directly contributed to successful transitions and improved health outcomes under MFP Demonstration projects.
>
> (E) State strategies and financing mechanisms for effective coordination of housing financed or supported under MFP Demonstration projects with local housing authorities and other resources.
>
> (F) Effective State approaches for delivering Money Follows the Person transition services through managed care entities.
>
> (G) Other best practices and effective transition strategies demonstrated by States with approved MFP Demonstration projects, as determined by the Secretary.
>
> (H) Identification and analyses of opportunities and challenges to integrating effective Money Follows the Person practices and State strategies into the traditional Medicaid program.”

In 2021, CMS contracted with Mathematica, an independent research firm, to conduct a national evaluation of the MFP Demonstration and produce this report on MFP best practices. This report represents CMS’s response to the Congressional mandate described in the CAA, 2021. This report used the following criteria to identify best practices: (1) those supported by evidence as having met one or more MFP goals; (2) those sustained over several years or integrated into routine Medicaid policies and processes; (3) those that resulted in systemic change; (4) those that could be readily adopted in other states; and (5) as applicable, those involving strong collaboration among state agencies or between state and local partners.

Exhibit I.2. MFP Best Practice areas

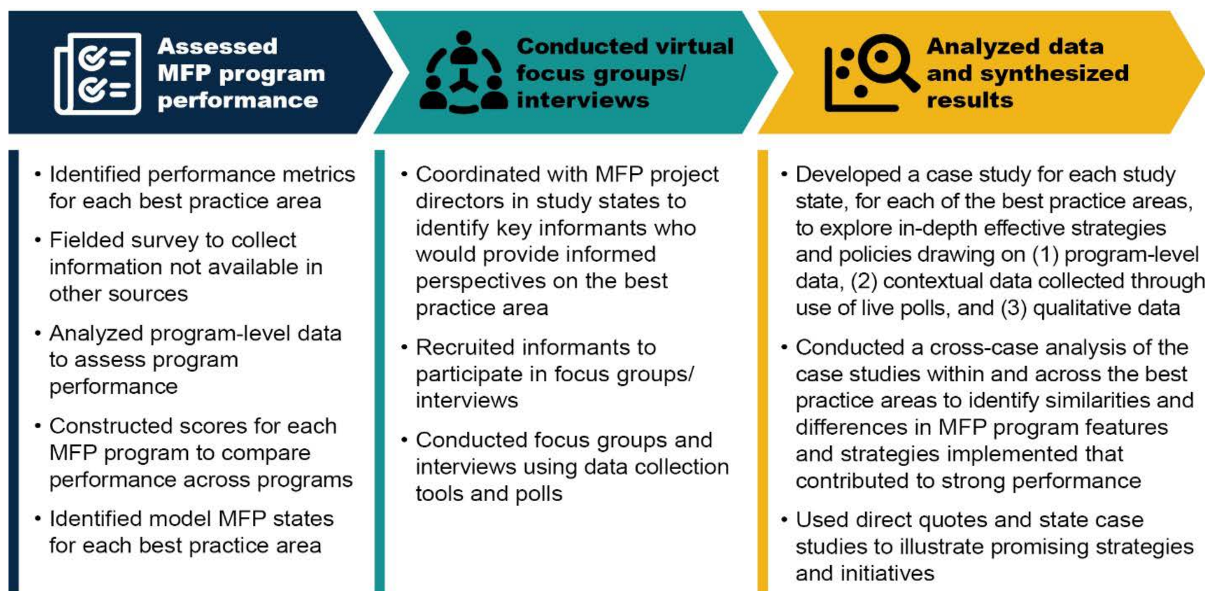
BP = best practice; MFP = Money Follows the Person.

B. Overview of study design

Methods

The national evaluation used a mixed methods approach to (1) assess MFP program performance and identify state MFP programs that performed well on indicators within each Best Practice area; (2) engage informants within the selected states in focus groups and interviews to supplement existing data sources; and (3) analyze primary and other sources of data using a case analysis approach (Exhibit I.3 and Appendix A).

Exhibit I.3 Methods used to identify effective strategies and best practices



In consultation with CMS, the evaluation team developed a set of indicators to assess MFP program performance within each Best Practice area and selected states from among the high-scoring programs in each area. The team engaged state MFP project directors, transition specialists, and others involved in MFP program implementation—including MFP participants—in virtual focus groups and interviews. These informants offered insights on the MFP program policies and practices that have been most effective in achieving MFP goals specific to each Best Practice area. Finally, the evaluation team conducted a systematic cross-case analysis of the case studies within and across all eight Best Practice areas to define and distinguish the features common to each Best Practice, and common themes across Best Practice areas (Ayres et al. 2003).

Data sources

The program-level indicators used to identify selected states for each Best Practice area drew on data from MFP programs' semi-annual progress reports submitted to CMS, T-MSIS Analytic File (TAF) files, program documents, and MFP project directors' responses to a web-based survey fielded in November and December 2021. The national evaluation fielded the web-based survey to capture information on topics of interest not adequately covered in other sources, such as efforts to identify and address disparities and approaches for coordinating with managed care plans (Appendix B). The evaluation team compiled data across the performance indicators and calculated a score for each MFP program for each Best Practice. In consultation with CMS, the team chose six of the highest-scoring MFP programs in each Best Practice area to participate in the virtual focus groups and semi-structured interviews (Appendix C). Details on the indicators and scoring methodology are available in Appendices A and D.

In early 2022, the national evaluation conducted 14 focus groups and 8 interviews with key informants from the selected states to gather detailed information on the strategies that contributed to their performance. Focus groups included informants across the six selected states to allow for a dynamic exchange of ideas; several states participated in discussions for multiple Best Practice areas. Among the informants were MFP project directors and program staff, transition specialists, officials overseeing state waiver programs, managed care plan staff, housing partners, and federally-recognized tribes or tribal organization health leaders. The evaluation team also held one-on-one discussions with MFP participants and their family members to explore topics such as effective transition strategies and person-centered planning, which are best understood by talking directly to participants with different types of disabilities and support needs. In-depth information on primary data collection, including discussion topics, is available in Appendices A through G.

Organization of the report

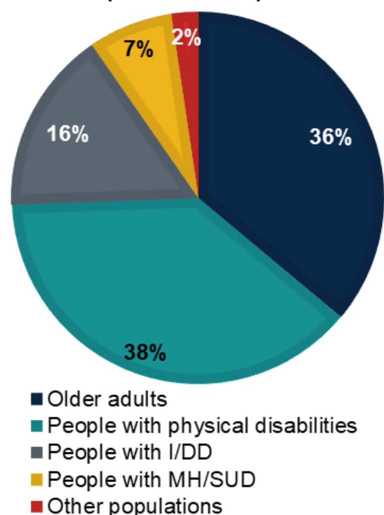
This Report to Congress has 10 chapters. After this introduction, Chapters II through IX summarize successful strategies in each of the Best Practice areas specified in the CAA, 2021. Chapter X presents a summary of overarching themes and a discussion of implications for federal and state Medicaid policy.

II. Best Practices 1 and 2. State strategies and uses of grant funds for transitioning beneficiaries to the community and improving health outcomes

A. Introduction

MFP Demonstration grants support states' efforts to help Medicaid beneficiaries living in long-term care institutions transition back to the community—if that is where they prefer to live—and receive services in their home. Through December 2020, states with MFP programs have transitioned 107,128 beneficiaries to the community, most of whom were older adults and people with physical disabilities (Exhibit II.1) (Peebles and Dolle 2022). People exiting long-term care institutions need diverse types of HCBS to relocate to a qualified setting under MFP and live independently in the community.

Exhibit II.1. Cumulative number of transitions through 2020, by population (*n* = 107,128)



Most Medicaid beneficiaries eligible for MFP have complex health and LTSS needs. They are more likely to have one or more chronic health conditions, such as hypertension, depression, diabetes, or stroke (Ross et al. 2012). All MFP-eligible individuals have functional limitations and need assistance to perform one or more activities of daily living, such as eating, bathing, toileting, and dressing, or instrumental activities of daily living, such as using transportation, preparing meals, and managing bills. MFP grantees are using the grant funds CMS made available to expand the mix of services and supports to meet people's needs during their first year in the community. Under the demonstration, grant funds can be used to cover pre-transition services and supports and up-front transition expenses, such as home modifications for accessibility purposes, to help people set up new residences in the community. States can also offer participants an enhanced set of HCBS to sustain them during their first year of community living.

As MFP programs have matured, they have acquired valuable knowledge about what it takes to help older adults and people with disabilities make successful transitions to the community. This chapter examines state strategies for facilitating successful transitions, how those strategies vary for participants with different disabilities and support needs, and how states have used MFP grant funds to improve transitions and participants' health outcomes in the community.

States that were identified as those using best practices to transition MFP participants from institutions to the community were selected based on their MFP program's performance on the following indicators from 2017 to 2019[14]: (1) had the highest rates of MFP transitions per 1,000 eligible adult Medicaid beneficiaries in institutions for 90 days or longer, by target population; (2) achieved 75 percent or more of their annual transition goals for each target population; (3) had low rates of re-institutionalizations among participants who transitioned to the community; (4) directed MFP grant funds or state funds equivalent to the MFP-enhanced match toward increasing the state's capacity to transition more Medicaid beneficiaries to the community; and (5) had systems in place to monitor and track the status of MFP participants' health

[14] Analyses focused on this period to examine program performance before the COVID-19 public health emergency.

outcomes after they transitioned to a qualified residence in the community. The states that performed better relative to other states on these indicators were Iowa, Louisiana, Maryland, New Jersey, North Carolina, and Washington.

Best Practices 1 and 2: "The most effective State strategies for transitioning beneficiaries from institutional to qualified community settings … and how such strategies may vary for different types of beneficiaries" and "the most common and the most effective State uses of grant funds … for transitioning beneficiaries from institutional to qualified community settings and improving health outcomes…" (P.L. 116-260).

Research questions:

- What are the most effective state strategies for transitioning beneficiaries from institutional to qualified community settings carried out under MFP?
- How did state transition strategies vary for different types of beneficiaries?
- What are the most common and most effective state uses of MFP grant funds for transitioning beneficiaries from institutional to qualified community settings and for improving health outcomes?

Selected states: Iowa, Louisiana, Maryland, New Jersey, North Carolina, and Washington.

Informants and mode: Virtual focus group with MFP project leaders (including project directors, program managers, or other senior staff), focus group with transition specialists supporting older adults and people with physical disabilities transitioning from nursing facilities, focus group with transition specialists supporting people with I/DD, and interviews with MFP participants.

B. Strategies for transitioning MFP participants from institutional to community settings

Selected states implemented a myriad of strategies to help MFP participants make successful transitions, from educating institutional residents early about HCBS options to supporting individuals after they returned home to the community.

States hired and embedded local staff in long-term care institutions to provide options counseling to residents, which increased transitions to the community. According to MFP project leaders in selected states, providing personalized education about home and community-based options, such as section 1915(c) waiver programs, and support with application assistance, was the catalyst that spurred more transitions to the community. For example, Maryland established a memorandum of understanding with local centers of independent living and used MFP administrative funds to deploy to nursing facilities peers who had personal experience transitioning from an institution to the community. These peers shared personal experiences, informed residents about HCBS waiver programs, and provided referrals to options counseling. Additionally, Maryland located several MFP staff directly in institutions before the COVID-19 public health emergency; for example, one community placement specialist operated out of a state residential treatment center for individuals with MH/SUD. New Jersey partnered with the long-term care ombudsman's office to dedicate four ombudsman staff members, funded with MFP administrative funds, to provide education to residents on their options and advocate for those who wanted to transition but encountered barriers to doing so.

In response to Olmstead settlement agreements and other state priorities,[15] several states have closed ICF/IIDs so residents have more opportunities to participate fully in community life. Maryland embedded community placement specialists within ICF/IIDs who worked hand in hand with case managers to locate small group homes and set-up HCBS for those who transitioned from the ICF/IIDs before they closed. Several ICF/IIDs in Iowa have either announced closures—including one of two state resource centers for individuals with I/DD—or are changing their licensure to provide HCBS. An informant from Iowa noted that transition specialists met with staff in these ICF/IDDs to help those residents successfully transition to community settings.

States utilized different approaches to deploy transition specialists that best suited the local context and HCBS service model. Nearly all of the selected states (Iowa, Louisiana, New Jersey, North Carolina, Washington) hired transition specialists who were dedicated to serving people in particular geographic locales. Hiring staff who know the local context helped MFP programs build relationships with staff at institutions and apply their knowledge of the provider network and area resources. In many of the selected states (Louisiana, New Jersey, Washington), transition specialists are state employees, not contracted employees. In addition to supporting transitions, these staff report directly to MFP leadership about barriers to transition, the adequacy of the provider network, process improvements, and changes in area nursing facilities. According to MFP project leaders, hiring transition specialists as state employees fostered strong buy-in among staff and gave MFP leaders sight lines into the challenges staff faced when supporting residents of institutions in their transition to the community.

"I needed someone [a transition specialist] in every public health region of our state…reporting directly on what was going on in the field as far as waiver operations and providers.… [It was important] to see what was broken, what barriers with current policies and procedures were causing people not to be able to transition easily, and to streamline those processes."

– MFP project leader

High quality standards were reinforced during transition coordination and post-transition. Selected state MFP programs implemented robust quality strategies for MFP programs that mirrored the quality monitoring systems used for section 1915(c) HCBS waiver programs. Two states (New Jersey and Washington) developed benchmarks to guide transition coordination and service delivery. For example, to ensure that residents of institutions had access to the assistance and support that is available under the demonstration, Washington State established job standards for transition specialists, such as providing options counseling to residents in institutions within 10 days upon admission, among others. The state also strived to have 94 percent or more of those transitioning from institutions remain in the community after 11 months. According to a project leader, setting these benchmarks reinforced high quality standards in transition coordination. Ongoing progress toward these metrics is communicated to leadership quarterly.

"We are trying to be as transparent as possible about quality metrics. We amended our position description forms and our workload expectations [to include quality standards and metrics]. We set a benchmark that we wanted it [overall recidivism] to be 94% or more of individuals who remain in the community [within first 30 days]."

–MFP project leader

[15] The 1999 U.S. Supreme Court ruling in *Olmstead v. L.C.* held that the Americans with Disabilities Act prohibits the unnecessary institutionalization of people with disabilities. Since the ruling, the Department of Justice has prioritized enforcing the *Olmstead* decision and established settlements with states documenting their plans to eliminate unnecessary segregation of people with disabilities, and ensure such individuals receive services in the most integrated setting appropriate to their needs (DOJ 2011).

C. How state transition strategies varied to support the diverse needs of participants

States have used the flexibility of MFP grant funding to address barriers that prevent institutional residents from returning to the community. States that performed better on performance metrics made good use of this flexibility to ensure that all participants received appropriate and timely supports in the community. This section describes the strategies selected states employed to meet the diverse support needs of MFP participants.

Dedicated transition specialists served specific populations to build their expertise. People transitioning from nursing facilities reportedly have different supports needs compared to people transitioning from ICF/IIDs. For example, people moving home following discharge from a nursing facility are more likely to benefit from personal care services, medical equipment, or home modifications to help them live independently, whereas those transitioning from an ICF/IID are more likely to benefit from behavioral supports, especially soon after moving back to the community (Denny-Brown et al. 2015). Both of these populations also interact with the HCBS system in different ways; they are supported by distinct types of providers and the services they deliver are often administered by different state agencies. Several selected states designated transition specialists to support a specific population, which helped staff build deep knowledge of the provider networks and particular support needs of each group. For example, in New Jersey, transition staff supporting nursing facility residents who will receive MLTSS upon transition are employed by the Division of Aging and have clinical expertise as registered nurses, whereas transition staff who support individuals with I/DD are employed by the Division of Developmental Disabilities and have expertise in the area of I/DD. This specialization aids transition staff in identifying individual's full support needs and connecting them to appropriate resources in the community.

Specialized staff were hired to provide intensive supports to people with complex needs. Several of the selected states have been responsive in meeting the diverse support needs of individuals with I/DD transitioning from ICF/IIDs to the community, such as New Jersey's medical and behavioral health supports tailored to this population. As of December 2021, New Jersey had transitioned a total of 3,602 participants to the community through MFP, 30 percent of whom were people with I/DD exiting one of several ICF/IIDs that operate in the state. New Jersey used MFP administrative funds to develop staff capacity to provide intensive supports to people with I/DD during their first 90 days in the community. Specifically, New Jersey established clinically trained resource teams that provide rich wraparound services for MFP participants and build provider capacity to manage participants' physical, nutritional, and/or behavioral health and well-being. For example, resource teams may provide additional supervision or training for providers on behavioral strategies to support the participant in the community. Since 2019, New Jersey has sustained these teams with state dollars. Iowa hired a dedicated behavior specialist to engage in capacity building efforts such as delivering trainings to providers statewide on de-escalation techniques and positive behavioral supports, in addition to providing direct services.

HCBS were customized to meet participants' needs, which contributed to successful transitions. Transition specialists from selected states described employing strategies to meet the full needs of participants identified in their person-centered service plan. According to one informant from Washington State, many individuals with I/DD exiting ICF/IIDs in their state identify a need for intensive behavioral supports during their transition planning, such as 24-hour in-home supports or day programs. Transition specialists strived to reproduce in the community those supports, both behavioral and physical, that stabilized the individuals while in the institution. Washington State offered supported living services, which help eligible people to live in their own homes with one to three others and receive instruction and support

from contracted service providers.[16] Prior to transition, Iowa facilitated cross-training between the facility staff and the community-based staff that will support each individual so there is a formal transfer of knowledge about effective strategies for supporting each person's needs. Louisiana's MFP program closely collaborated with hospital discharge planners and staff at community clinics to ensure each child's full support needs were met in the short and the long-term following discharge. Most MFP participants who were interviewed for this study expressed high levels of satisfaction with the services and supports they received through the MFP program.

Spotlight on State Strategy: Family Mentor program

Washington's Family Mentor program, launched in 2011, supports families and guardians through the process of moving a family member from an institution to the community through the MFP program. Mentors have personal experience with transitioning family members from an institution and provide guidance about community-based service options, share strategies for making a successful transition, and help families understand what day-to-day life looks like in the community. Mentors also share a checklist of considerations when exploring community living options. The program is funded with MFP state-equivalent dollars.

These short videos capture MFP participants' transition stories and experiences with the Family Mentor Program:
https://www.youtube.com/watch?v=2JpRnMmAJBg
https://www.youtube.com/watch?v=1SpIlwPwAKQ

Peer mentoring programs were established to address barriers to transitioning institutional residents to the community. Some of the selected states encountered resistance to transitions from family members, especially from caregivers of individuals with I/DD. According to transition specialists in one state, caregivers are afraid their family members may not be able to live safely and independently in the community. Many individuals were reportedly in crisis when they were admitted to the institution, and their family members were opposed to a return to the community out of concern that community providers could not provide adequate support to address their complex needs. In another state, some family members have questioned whether the MFP program's goal is to reduce the steep cost of institutional care, instead of promoting choice and community living. To build trust and awareness of community living options, many of the selected states

> **"If you've ever tried to use paratransit, it is not what the brochure says. To have somebody who actually uses the para-transit system who can say, 'Well if you [use para-transit] on a Monday, good luck. Better try it Wednesday.' Nuances like that are really the meat and potatoes of the peer [mentoring] program."**
> ***– MFP project director***

[16] Eligible individuals are those who qualify for services provided by the Developmental Disabilities Administration, are 18 years or older, are receiving or approved for the Home and Community Based Services Core waiver and are determined by staff to need this level of support in their person-centered service plan (Washington 2022).

(Maryland, Iowa, New York, and Washington) established peer mentoring programs (highlighted in the state spotlight above). Through these programs, people who have already transitioned educate individuals and their caregivers about available supports in the community and share their experiences to aid individuals in making informed decisions about transitioning.

D. Use of MFP grant funds to transition individuals to community settings and improve health outcomes

MFP services are classified into one of three categories: (1) qualified HCBS, (2) demonstration HCBS, and (3) supplemental services (Exhibit II.2). Qualified HCBS are any Medicaid home and community-based state plan and waiver program services available under the state's Medicaid program, such as personal assistance services available through a section 1915(c) waiver program or the state plan. Demonstration HCBS are qualified HCBS that could be provided, but are not currently provided, under the state's Medicaid program. This might include allowable Medicaid services not currently included in the state's array of HCBS (such as assistive technologies) or services above the amount that would be available to non-MFP Medicaid beneficiaries (such as 24-hour personal care). Demonstration HCBS tend to be services designed to help people adjust to community living and may be helpful to states that do not have comprehensive transition services included in certain section 1915(c) waiver programs. MFP requires that states maintain qualified HCBS after participants leave the MFP program as long as they maintain Medicaid eligibility and meet the requirements for the receipt of HCBS. States can also provide supplemental services, which are short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program, such as a trial visit to the proposed community residence.[17] In addition, states receive MFP grant funds for administrative expenses, which are costs related to operationalizing the demonstration such as administrative activities and personnel.

Exhibit II.2. MFP service categories and federal reimbursement

Money Follows the Person service categories	Grant Funding Rate	Requirement for continuity when MFP ends
Qualified HCBS. Services available to Medicaid beneficiaries under the state plan or a waiver program.	MFP-enhanced FMAP rate	Must be continued through the qualified HCBS program in operation in the state
Demonstration HCBS. Allowable services not currently in the state's HCBS offerings or qualified HCBS above what is already available (e.g., 24-hour personal care).	MFP-enhanced FMAP rate	No requirement to continue
Supplemental services. Short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program.	100 percent[18]	Not expected to continue

Source: Congressional Research Service 2021 and CMS 2022c.

The MFP Demonstration provides states with savings via an MFP-enhanced matching rate for all HCBS used during MFP participants' first 365 days in the community following discharge from an institution.[19]

[17] Effective January 1, 2022, the description of supplemental services was modified from one-time services to short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Further, the description was expanded to address critical barriers to transition for MFP participants, including the lack of affordable and accessible housing, food insecurity, and financial and administrative barriers to transitions (CMS 2022c).

[18] Effective January 1, 2022, the reimbursement rate was modified from the state's FMAP rate to 100 percent (CMS 2022c).

[19] At the end of the 365-day participation period, MFP grantees must continue to provide participants with any needed HCBS available through the state's HCBS programs, which may include section 1915(c) waiver programs, section 1115(a) demonstrations, and state plan HCBS.

MFP grantees are expected to reinvest the amount of funds attributable to the MFP-enhanced FMAP ("state-equivalent funds") for the purposes of providing new or expanded HCBS and for initiatives to strengthen HCBS system infrastructure. In addition to these state-equivalent funds, MFP grantees were also eligible to submit budget requests for capacity building activities to accelerate LTSS system transformation and expand HCBS capacity under a funding opportunity released in September 2020. This section examines how states used grant funds and state-equivalent funds to effectively support populations with complex needs in the community.

States identified one-time transition costs, home accessibility modifications, and medical equipment as the most common and critical uses of MFP grant funds. Of the 32 respondents to the MFP project director survey, 26 indicated their state used MFP funding to cover one-time transition costs such as household goods, furniture, and security deposits for an apartment. Coverage of such expenses can be a critical lifeline for residents in institutions, who need to re-establish a home in the community after a long-term stay in an institutional setting. Home accessibility modifications represented the second most common use of funds (reported by 23 of 32 responding states); this service allows those with functional needs to access and navigate their new home safely and more independently. Medical supplies, medical equipment, and housing support services[20] were the next most common uses of grant funds (each reported by 19 of 32 responding states). Informants were asked during the focus groups to explain which of these services and supports were the *most critical* to helping participants transition to the community. These informants cited these same services (one-time transition costs, home and vehicular modifications, and medical equipment and supplies beyond what is covered under the state's HCBS programs) as the most critical, in addition to specialized services to meet participants' behavioral and medical needs.

Among selected states, flexible use of grant funds facilitated transition planning and addressed gaps in support needs soon after transition. During the COVID-19 public health emergency, Washington State used MFP grant funds to provide computer tablets to residents planning to transition from nursing facilities to facilitate virtual transition planning sessions between residents and the care planning team. Louisiana's MFP program targets medically fragile children transitioning home to their families from institutions, a priority identified under the state's Systems Transformation Grant. One informant from Louisiana reported that MFP grant funds are used to purchase necessary equipment for this population, such as a large stroller that can transport both the child and their medical equipment, and portable generators for use in the event of a power outage. Louisiana's MFP program also offered wraparound supports as a demonstration service and includes training for caregivers on how to operate medical equipment, such as a ventilator, before their child is discharged home.

Personalized supports were developed to maximize participants' safety and well-being in the community. Many institution residents who wish to receive HCBS lack informal supports—relatives, friends, and neighbors who supplement the services provided by paid providers—which can compromise their ability to transition to the community. One MFP project leader reported that when holistically assessing an individual's full needs, transition specialists identify where deficits may lie and use MFP funds to "plug those gaps." Community Choice Guides, a demonstration service funded by Washington State, are contracted providers who partner with the individual and their case management team to support community integration. The guides are very "hands-on" in filling individualized needs that an informal support network typically would. According to this informant, these supports might include developing

[20] Housing support services may encompass connecting participants to resources available for home financing, home maintenance, and repair; rental counseling; accessibility consultation; low-income energy assistance evaluation; access to transitional or permanent housing; accessibility inventory design; health and safety evaluations of the property; debt or credit counseling; and homelessness and eviction prevention counseling (Peebles and Kehn 2014).

informal supports for an individual by connecting them with a faith-based organization, a peer group, or a support group. One such support might be offering them or their caregivers specialized training (e.g., behavior support or medical skills), or it might be helping the individual navigate the transportation system so they can adjust to life in the community.

One informant from North Carolina reported conducting root cause analyses to understand why some participants who were re-institutionalized were not able to remain in the community. Working from the results of the analysis, the state created stability resources, funded as a demonstration service, to ensure that participants have a stable first year in the community. Under this service, the program began offering transition candidates trial visits in the community to see how they would fare in that setting and what other types of supports could maximize their safety and well-being in the community.

"We [transition specialists] really try to make attempts with family, with friends, with faith communities [to identify informal supports]. But it really depends on the severity and acuity of [participant's] needs because…people are not going to get that involved…and neighbors are a little bit different than they were maybe 20 to 30 years ago. They're not willing to get hands-on."
– Transition specialist

MFP funds were used to provide participants with timely services and supports. Nearly all the selected states reported challenges putting timely supports in place for some participants because of certain state Medicaid restrictions or managed care plan policies. For example, one informant said they could not order certain medications or a hospital bed while the individual is still in the nursing facility, which creates barriers during transition planning. These items require prior authorization, which cannot be requested until the individual is discharged; the process can reportedly take up to six weeks to be approved. The informant noted that the MFP program gave them the flexibility to cover these expenses until the prior authorization was approved; MFP also covered these expenses in the event the transition was not completed, mitigating the risk for providers. An informant from another state reported that consultative services to develop a behavior support plan cannot be ordered until the person is enrolled in the waiver program, which does not happen until the day of transition. To overcome this obstacle, the MFP program covered the services of a psychologist to develop the behavior support plan and train direct care workers on the plan before the person's transition.

III. Best Practice 3. State approaches to improving person-centered care and planning

A. Introduction

At the heart of HCBS lies person-centered planning, an approach that honors an individual's autonomy to direct their care. Person-centered planning focuses on identifying services and supports that not only optimize health but also further an individual's goals, independence, and quality of life (CMS 2020).

CMS defined requirements for person-centered planning in its 2014 final rule for the provision of HCBS under sections 1915(c) and (i) of the Social Security Act (79 Fed. Reg. 2,948, Jan. 16, 2014). These requirements state that person-centered planning must result in a person-centered service plan with individually identified goals and preferences. At its most basic, a service plan identifies a participant's medical and personal-care needs, type and frequency of HCBS, and treatment goals and outcomes. Person-centered planning goes further to identify and integrate the participants' strengths, values, preferences, and goals for the future. Within MFP, transition specialists help participants develop a person-centered plan that meets their care needs while aligning with their goals and preferences; for example, living in a neighborhood of their choice, keeping to a preferred daily schedule, or securing medical equipment that allows them more independence.

To explore this area, states' MFP program performance was assessed based on (1) use of a comprehensive assessment process that includes individually identified goals and preferences for the person with long-term support needs, which the person reviews and signs; (2) use of mechanisms to monitor progress toward achieving identified goals and preferences; (3) having measurable outcomes that focus on the successful implementation of service plans; and (4) inclusion of MFP participants in surveys that assess the quality and outcomes of LTSS.[21] This chapter examines state strategies for improving the implementation of person-centered care and planning in MFP programs. These include strategies for making sure participants' voices are prioritized in the development of person-centered plans, encouraging informed decision-making, monitoring participants after their transition, and measuring outcomes of person-centered practices.

Best Practice 3: "The most effective state approaches carried out under MFP Demonstration projects for improving person-centered care and planning" (P.L. 116-260).

Research questions:

- What effective strategies did MFP programs carry out for implementing person-centered care and planning?
- What approaches did MFP programs use for monitoring the implementation and outcomes of person-centered care and planning?

Selected states: Alabama, Georgia, New York, North Carolina, Ohio, and West Virginia

Informants and mode: Virtual focus groups with MFP transition specialists and interviews with MFP participants.

[21] These surveys include the National Core Indicators® – Intellectual and Developmental Disabilities (NCI-IDD®), National Core Indicators – Aging and Disability™ (NCI-AD™), and the HCBS Consumer Assessment of Healthcare Providers and Services (CAHPS®) surveys.

B. Strategies for developing person-centered service plans

Developing effective person-centered plans requires a holistic understanding of participants' needs, preferences, and desired outcomes. However, transition specialists observed that participants may be unaccustomed to asserting their voices after being in the structured environment of a nursing facility or other institution. This section examines strategies implemented in the selected states to increase the centricity of participant's voices in the person-centered planning process.

Information sharing enabled transition specialists to focus on understanding participants' goals and preferences and improved their experience of care.[22] Transition specialists from four selected states noted the value of having access to the systems used by the entities that complete eligibility determinations for the Medicaid institutional level of care in their state. Reviewing the information in eligibility assessments on participants' functional, medical, behavioral, and financial status—along with materials from institutions, social workers who initiated the referrals, and physicians—enables transition specialists to focus on person-centered planning during early conversations with participants. In addition, these linkages allowed transition specialists to proactively monitor participants' eligibility status and avoid delays, which MFP participants noted was critical to their experience of care.

"It's about relationship building. A lot of people in nursing facilities are fragile. They often feel alienated and alone. [Interactions with] teams [beyond] direct caregivers make a big difference."
– Transition specialist

Transition specialists shared techniques they use during conversations with participants to help them be present and active in person-centered planning discussions. Across selected states, three elements stood out as best practices:

- **Prioritizing relationship building and desired outcomes upfront.** Holding unstructured, relationship-building conversations at the outset of service planning helped transition specialists build trust and genuine understanding with participants, which led to a stronger transition to the community. Several transition specialists emphasized that they began service planning by identifying the participants' values and desires: what is on their wish list, what are they excited for, and what would make them comfortable? For example, one MFP participant interviewed for this study described how he prefers to wake up early, so his transition specialist helped identify a home care agency that could send staff early in the morning. Another MFP participant who was interviewed said that during the transition planning process, the transition specialist asked about his lifestyle before he became disabled, areas of his life where he could benefit from some supports, and the types of services and supports he believed he would need while living in the community. The participant expressed appreciation for the careful planning that enhanced his independence, including equipping his new home with smart devices to make daily tasks more manageable. MFP participants affirmed that their transition specialists prioritized asking them what services were

"At first, I didn't have certain preferences. [My transition specialist] asked me about furniture preferences and the paint colors that I would like… [She] gave me a home."
– MFP participant

[22] We note that each state is responsible for ensuring compliance with applicable federal and state laws and regulations governing the confidentiality of applicants' and beneficiaries' information, including, but not limited to: section 1902(a)(7) of the Social Security Act and its implementing regulations at 42 C.F.R. part 431, subpart F; the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191) and its implementing regulations at 45 C.F.R. parts 160, 162 and 164; and 42 C.F.R part 2 (governing confidentiality of substance use disorder patient records).

important to them before turning to a discussion on what services may be important for their health and safety.

- **Including family members, caregivers, and other supports.** Transition specialists emphasized that participants should determine which family members and caregivers to include in conversations, and equally important, whether there are individuals they do *not* want included. Beyond family and caregivers, transition specialists can help participants identify other informal supports in the community that may play a role in their transition—for example, friends, neighbors, religious groups, or other networks of support.
- **Creating space for participants' voices.** Transition specialists used several strategies to raise-up MFP participants' input during the planning process. During transition planning meetings, transition specialists advocated for participants to make their own decisions and may intervene and redirect focus to participants if family members or other staff are speaking on the participants' behalf. One transition specialist ensured participants' voices were included by holding initial service planning conversations with participants and family members only, before inviting social workers or other staff. Another transition specialist noted that participants are more likely to speak up when meetings are held face-to-face—or using video, if remote—in a setting where the participant is most comfortable.

MFP programs conducted trainings to build providers' capacity in person-centered practices. In focus groups and sustainability plans, five states highlighted investments in trainings to build skills and capacity in person-centered practices. North Carolina hosted an intensive annual training for professionals involved in transitions, described in the state spotlight below. Alabama implemented a person-centered training for transition specialists; the training covered person-centered techniques to use during service planning, such as motivational interviewing and conversational skills. Louisiana invested MFP administrative funds in training contracted transition specialists to build competency in person-centered practices for developing service plans, with the intent of implementing these strategies consistently statewide. Tennessee created a person-centered planning training program for managed care plans (MCPs), direct service providers, and their contractors. MCPs received intensive monthly trainings followed by debriefing sessions, while trainings for direct-service providers focused on implementing person-centered plans. New York's Department of Health offered several no-cost training opportunities for HCBS providers

Spotlight on State Strategy: North Carolina's Community Transitions Institute

North Carolina hosts an annual training called the Community Transitions Institute for professionals who support individuals transitioning to a home and community-based setting. The nine-day training builds providers' knowledge and use of person-centered practices in the context of transitions. The Institute's core sessions cover community-based resources important to a successful transition and person-centered thinking and communication skills. The Institute offers additional two-day intensive sessions on Motivational Interviewing and Person-Centered Thinking. Professionals attending the Institute have opportunities to collaborate with professionals in diverse roles, such as transition specialists, case managers, peer supports, ombudsmen, and options counsellors.

through their Person-Centered Planning Statewide Training Initiative and maintains a Person-Centered Planning and Practice Resource Library for providers and beneficiaries.

C. Strategies for encouraging informed decision-making

In person-centered planning, participants make the ultimate choice about whether they will participate in the MFP program, which services they will receive, and what service providers they will use. This section summarizes effective practices from transition specialists' experiences guiding participants to make informed decisions.

Ensuring participants have a clear understanding of their own health and abilities, as well as what the MFP program can and cannot offer them, is a critical part of informed decision-making. Transition specialists in selected states found that participants may benefit from assistance evaluating their capabilities to live independently and complete various activities and instrumental activities of daily living, given the level of support offered by the MFP program. Honest conversations about the program's possibilities and limitations—as well as the individual's health status—can empower participants to make decisions and take action to prepare for the realities of community living. To ensure participants understand their physical abilities, transition specialists included physical and occupational therapists in service planning conversations, when possible. Transition specialists also helped participants envision the scenarios and risks they might encounter in a community setting—for example, asking a participant how they will get to the bathroom and make meals when their aide is not available. Then, transition specialists developed risk mitigation plans with participants for goals and scenarios that can be proactively addressed.

Transition specialists in all selected states strategically assigned MFP participants responsibilities as part of their transition planning. Assuming responsibility for tasks not only improved participants' engagement in decision-making, but transition specialists also reported that this helped them assess participants' motivation and barriers to success in the community. Examples of participants' tasks included calling landlords to inquire about available housing or to set up tours, obtaining necessary documents from providers or other state agencies, and contacting care agencies to inquire about staff availability and assess compatibility. Transition specialists noted that tasks should be tailored to participants' abilities in order to build their confidence and skills for living independently. In one study state (Alabama), case managers taught participants and their families to use "learning logs" to track their progress in meeting their goals.

> **"The more that we can have an individual taking responsibility for their own care, the more that the services end up being person-centered."**
> ***– Transition specialist***

Transition specialists assisted participants in narrowing the wide range of service options and providers and made suggestions to help participants further their goals. Transition specialists emphasized the balance between providing the participant with all options available to them and avoiding overwhelming them with too many choices. After providing participants with a comprehensive list of all the resources and services available under MFP, transition specialists asked participants what they need and help them translate this into a service plan. The legal guardian of one MFP participant with an intellectual disability noted that her daughter's transition specialist started by asking her what she felt her daughter wanted and needed, and then helped her identify the most important services.

In some cases, transition specialists suggested additional services based on the participant's goals and functional limitations or use motivational interviewing to encourage participants to make choices that would further their goals and independence such as accessing mental health services or expanding which neighborhoods they will consider for housing. Three MFP participants noted that their transition specialists

suggested services or options that participants did not identify on their own or may have initially resisted, such as using a hospital bed in their home; ultimately, the participants made the final decision.

D. Strategies for monitoring participants' service plans post-transition

States take varied approaches to monitoring participants' outcomes during their first year in the community, including—in most cases—the effective implementation of person-centered plans. According to responses to the MFP project director survey, most state MFP programs (78 percent) had a mechanism in place to monitor an MFP participant's progress toward achieving the goals identified and included in the service plan during the post-transition period. This section discusses approaches used by selected states for monitoring service plans to drive improvement during the post-transition period.

Transition specialists recommended intensive monitoring to address unexpected or unmet needs soon after transition. Frequent check-ins during the week-to-month period following transitions allowed transition specialists in selected states to provide support to participants as they adjust and address unexpected or unmet needs. Among these are physical and mental health needs, environmental challenges, and coordination with service providers. MFP participants gave examples of how their transition specialists helped in the post-transition period, such as contacting a manufacturer for repairs to their medical equipment, finding a new aide when the one they identified was no longer available, and purchasing an adaptive recliner when they found they couldn't comfortably use their sofa. Following this week- to month-long adjustment period, states required that transition specialists check in with the participant monthly or until the responsibility for monitoring their service plan is transferred to another team. All nine MFP participants interviewed for this study were satisfied with the frequency of check-ins post-transition; four explicitly commented that they felt comfortable reaching out to their transition specialist when they needed anything, and they received timely responses.

Transition specialists ensured a "warm handoff" to the new care manager in cases where transition specialists were not responsible for monitoring participants' care after discharge from an institution. When a transfer of care takes place, warm handoffs—direct introductions made between care team members, with the participant present—can improve participant safety and engagement. The logistics of monitoring service plans by transition specialists or other entities varied by state, and even within some states. For example, transition specialists in North Carolina transferred responsibility for monitoring to a managed care plan care specialist post-transition, whereas in New York, the frequency of contact by the MFP transition specialist depended on which HCBS waiver program the individual was enrolled in, and on the level of support provided by the waiver case manager or service specialist. In these cases, a warm handoff between MFP transition specialists and the entity or program that is responsible for ongoing monitoring improved care coordination. A warm handoff might consist of a joint meeting between the participant, the MFP transition specialist, and the new care manager to facilitate introductions, transfer knowledge, and answer the participant's questions.

E. Strategies for measuring outcomes of person-centered practices

Measuring the effectiveness of service planning can track whether care managers improve their use of person-centered practices.

States used experience of care surveys to capture feedback from Medicaid beneficiaries, including MFP participants, and to monitor person-reported outcomes. States used different tools and sampling strategies, conducting these surveys primarily with the broader HCBS population. Twelve of 32 states responding to the MFP project director survey (38 percent) used the National Core Indicators® for

Intellectual and Developmental Disabilities (NCI®-IDD), National Core Indicators for Aging and Disability™ (NCI-AD™), or the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey instruments to collect experience of care feedback from the HCBS population.[23] Two states, Connecticut and Indiana, sampled 100 percent of MFP participants in their surveys. Several states reported using alternate or state-specific experience of care tools to collect feedback from the MFP population. Four of the six transition specialists noted that their states used experience of care surveys both before and after the transition period, with two noting that aggregate findings from these surveys are shared with the transition specialists in some way.

Additional efforts are underway by CMS and states to develop and adopt quality measures around person-centered planning. For example, the Functional Assessment Standardized Items are a set of reliable and valid functional assessment items states and providers may adopt and incorporate into their assessment processes for individuals applying for or receiving HCBS. States with managed care LTSS have begun to require plans to report on comprehensive assessment and service planning measures, several of which are included in the HCBS Quality Measure Set from CMS (CMS 2022d).

[23] The NCI and HCBS CAHPS surveys measure beneficiary experience in several domains, among them choice over providers and life decisions, satisfaction with services, dignity and respect in treatment, community integration, and unmet needs. More information on surveys for measuring person-reported outcomes is available in this brief: https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-2-person-reported-outcome.pdf.

IV. Best Practice 4. Program, financing, and other flexibilities available under MFP which contributed to successful transitions and improved health outcomes

A. Introduction

On the day MFP participants transition to the community, they begin receiving a package of HCBS. These services are jointly financed by the federal government—through MFP grant funds—and the state. As described in Chapter II, MFP grantees receive an MFP-enhanced FMAP when they provide either qualified or demonstration HCBS to MFP participants during the first year of community living. Following 365 days of coverage through the MFP Demonstration, participants continue to receive the HCBS they need through the Medicaid state plan or an HCBS waiver program.

States are expected to reinvest the amount of funds attributable to the MFP-enhanced FMAP ("state-equivalent funds) for the purposes of providing new or expanded HCBS and for initiatives to strengthen HCBS system infrastructure. In addition to state-equivalent funds, states may also use MFP administrative and capacity-building grant funds to cover these "rebalancing initiatives." According to the MFP 2015 Annual Report, MFP grantees reported a wide range of rebalancing initiatives that were either planned or already underway by the end of 2014. These activities can be broadly classified under the following common themes:

1. Expanding or enhancing the capacity of section 1915(c) waiver programs to serve more people
2. Improving participants' access to affordable and accessible housing
3. Promoting awareness, use, or access to transition services
4. Supporting the direct care workforce and other health care professionals
5. Engaging potential participants through outreach activities
6. Supporting the development or use of tools to assess consumer needs and preferences
7. Developing or improving administrative data or tracking systems

The national evaluation updated this analysis of completed or ongoing rebalancing initiatives through 2021 and found that MFP grantees continue to fund activities in these seven categories.

This chapter examines how flexibilities available under MFP drove changes in states' financing, program structure, or service infrastructure and contributed to successful transitions and improved health outcomes among MFP participants. This chapter also presents findings on how changes to Medicaid programming or financing of services under MFP enabled states to build transition capacity.

Six study states were selected based on the following indicators: (1) invested state-equivalent funds to advance system transformation efforts to promote transitions to the community; (2) instituted flexibility in funding or pay-for-performance metrics designed to encourage transitions of residents from institutional to community settings, cover transition costs, or better support participants in the community; (3) permanently added demonstration services to the state's section 1915(c) waiver programs or state plan benefits; and (4) maintained low rates of re-institutionalization among MFP participants who transitioned to the community from 2017 through 2019.

Best Practice 4: "Program, financing, and other flexibilities available under MFP Demonstration projects, that are not available under the traditional Medicaid program, and which directly contributed to successful transitions and improved health outcomes" (P.L. 116-260).

Research question: What program, financing, and other flexibilities are available under MFP, and which contributed to successful transitions and improved outcomes?

Selected states: Alabama, District of Columbia, Louisiana, New Jersey, New York, and Ohio.

Informants and mode: Joint telephone interviews with the MFP project director and a Medicaid official in each study state who oversees provision of LTSS.

B. Strategies for using MFP as a testing ground for enhancing Medicaid programs

The success of the MFP Demonstration depends on MFP grantees' ability to provide the right combination of services to each participant at the right time to support their ability to live safely and independently in the community and avoid re-institutionalization. As described in Chapter II, MFP grant funds can be used to cover an expanded range of services and expenses typically not covered under Medicaid state plan services or HCBS waiver program benefit packages. Many MFP programs have used MFP state-equivalent funds, supplemental services, capacity-building and administrative funds, and programmatic flexibilities to test service innovations on a small scale to help more people leave institutional settings and successfully reside in the community.

> **"There are activities that occur in MFP that—after we assess the viability of the service as well as the efficacy of the service—might then be used to expand into other avenues such as the 1915c or 1115…. We can start off small and then [decide whether to] expand over time."**
> ***–State Medicaid Official***

Selected states used MFP to pilot service innovations to determine whether they should be permanently added to state Medicaid benefits. New York leveraged MFP grant funds, including state-equivalent funds, to implement novel, small-scale initiatives to expand HCBS that are critical in helping individuals remain in the community. Through one MFP-funded pilot program, New York offered community-based neighbors small stipends to act as informal supports to MFP participants who do not have family members or close friends nearby. With the added informal support provided by the Good Neighbor Program, MFP participants in New York can, in some cases, transition out of the nursing facility sooner than they might have otherwise. By testing this service on a trial basis through MFP, an informant from New York stated that they can determine whether to integrate this service through other avenues. As of early 2022, New York was still refining and evaluating the Good Neighbor Program. Furthermore, as Ohio planned for the end of MFP funding, community transition services were added to all of the HCBS waivers, indicating the state's commitment to sustaining a transition program long-term.

States used flexible MFP grant funds to cover specialized HCBS for participants with I/DD to improve health outcomes. Many individuals with I/DD experience co-occurring mental health conditions, including depression, anxiety, bipolar disorder, psychotic disorders, and impulse control disorders. Because of symptoms associated with these co-occurring conditions and with the disabilities themselves, treatment is often offered through mental and behavioral health providers (Pinals et al 2021). Even within mental health services and systems, individuals with I/DD often encounter mental health professionals with limited experience in serving individuals with I/DD and who are unfamiliar with the population's relevant options

for treatment and support. To address the shortage of behavioral health services for individuals with I/DD moving from institutions to the community, New York added a new rehabilitation service to HCBS waiver programs called "Crisis Services for Individuals with I/DD." Informants conveyed that these intensive crisis services have helped prevent re-institutionalizations by stabilizing those with acute behavioral health needs and improving the chances of their successful transition into the community. As noted in Ch. II, New Jersey used MFP administrative funds to establish clinically trained resource teams for MFP participants with I/DD. The resource teams, which have been sustained with state dollars since 2019, provide rich wraparound services for MFP participants and build provider capacity to manage participants' physical, nutritional, and/or behavioral health well-being.

C. Strategies for increasing the number of beneficiaries who can benefit from HCBS waiver services

Although existing HCBS state plan authorities do not have enrollment caps, most services are provided through section 1915(c) waiver programs that do allow states to cap enrollment (Murray et al. 2023). When HCBS waiver programs cannot accommodate all those eligible for waiver services, they often establish waiting lists (Sowers et al. 2016). States can use MFP funding to increase the number of beneficiaries who can benefit from HCBS waiver services and support efforts to decrease the size of waiting lists.

Selected states changed section 1915(c) HCBS waiver program requirements to enable more participants to receive HCBS. States instituted a variety of changes to HCBS waiver eligibility requirements. For example, in Alabama, the section 1915(c) HCBS waiver program had a 60-day stay requirement before an individual in a nursing facility could qualify for enrollment. After Alabama launched its MFP program, the state removed this requirement to help more beneficiaries transition to the community sooner. Louisiana added a spend-down option which allows more people to qualify for the HCBS waiver program. Normally, monthly income limits are $2,523 for an individual and $5,046 for a couple (when both spouses need long-term care). Through the Louisiana MFP "Waiver Spend-down" option, people with income above these limits could qualify if the monthly cost of services reduces their income below these levels. Louisiana also reported reducing its waitlist for the Community Choices waiver from approximately 30,000 people in 2017 to less than 6,700 by March 2022 by giving waiver enrollment priority to long-stay nursing facility residents who moved from the waiting list to the waiver after the policy went into effect.

> **"We removed the [minimum length of] stay requirement [in the section 1915(c) waiver program] because it didn't seem productive to make somebody stay in the nursing facility this many days so they can qualify for the waiver. If they're in the nursing facility, they're going to enter our system anyway… we didn't see a negative to [engaging and transitioning] these people earlier than what MFP requires. And, our waiver allowed it."**
>
> ***–MFP project director***

Alabama applied state-equivalent funds to expand the number of HCBS waiver slots. Alabama reinvested its state-equivalent funds to transition other eligible individuals to the community. One informant from Alabama reported, "Any savings in FMAP we get for somebody's 12 months [of participation in MFP] allows us to apply that savings to somebody else [another eligible Medicaid beneficiary]. So, we directly reinvest [state savings] back into HCBS." The informant also reported that—separate from state savings due to the enhanced FMAP—the MFP program saves roughly $30,000 a year for every beneficiary who safely transitions to the community, based on the decreased cost of HCBS versus institutional care.

D. Strategies for addressing gaps in transition services

As individuals move from institutions to home and community-based settings, transition services are essential in preventing gaps in care that might compromise the success of an individual's transition. States used MFP grant funds to cover the costs of both pre- and post-transition services that may not be otherwise available through the existing set of HCBS offered to Medicaid beneficiaries under the state plan or through section 1915(c) HCBS waiver programs. This section describes the services and supports that helped MFP participants make successful transitions.

Most of the selected states used flexibilities in MFP funds to fill gaps identified during transition planning. Highlighted below are notable strategies from four selected states.

> **"I would definitely say…it [MFP program] helped us because we don't have to guess about eligibility [for a particular service or support that a person may need]. We have the assurance that we can get the authorization for services for people."**
> ***–MFP project director***

- **The District of Columbia** implemented transition program codes that allowed eligibility determination for the Elderly and Persons with Disabilities Waiver before individuals are discharged from a nursing facility. The transition program code established eligibility early in the facility stay and allowed the case manager to begin securing transition services for the participant during the transition planning period. Once authorized, services could be offered on the day of the discharge, ensuring continuity of care. The District also dedicated state-equivalent funds to address gaps in transition-related expenses for nursing facility residents who do not meet MFP eligibility requirements; these expenses include one-time costs such as home furnishings, rental unit application fees and security deposits, and copies or replacement of vital records, such as birth certificates and social security cards.
- **Louisiana** used MFP state-equivalent funds to cover the cost of services that exceed the regular community transition budget to cover one-time purchases (e.g., shower widening, door widening, installation of ramps for the home, etc.) that are necessary for an individual to transition to a new home in the community.
- **New York's** MFP program partnered with the state's Technology Related Assistance for Individuals with Disabilities Program to provide loans for assistive technology, such as hearing aids, communication devices, wheelchairs, and home or vehicle modifications. State equivalent funds were used to purchase assistive technology and equipment for short-term loans to bridge the gap between transition and approval for long-term equipment provided through another source. New York's MFP program also contracted with the New York Association for Independent Living to connect individuals to their local independent living centers for additional transition assistance. This assistance may include education and training for staff regarding Section Q referrals[24] and options for receiving HCBS in the community, peer support for individuals before transition and up to 60 days after transition, and phones for nursing facility residents.
- **Ohio** implemented the Ohio Temporary Ramp Project, initially funded with state equivalent funds, to cover the cost of a temporary ramp for those with an immediate need for this assistance, and who would not receive a ramp or home modification under available waiver options. The program's success at facilitating transitions led the state to sustain the program, independent of MFP, by incorporating it into the state's section 1915(c) HCBS waiver program.

[24] Section Q is a required section in the Minimum Data Set (MDS), part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. Section Q includes a question where every resident is asked if they would like to discuss the possibility of leaving their institution and returning to live and receive services in the community.

Another state (New Jersey) took a slightly different approach and invested its state-equivalent funds into efforts to increase the supply of housing in the state (refer to Chapter V).

Spotlight on State Strategy: New York's Community Care Connections

New York's Community Care Connections (CCC) began as a pilot program with support from MFP rebalancing funds. In 2015, the pilot set out to determine if integrating traditional community-based aging services with medical systems of care positively affects the Triple Aim (cost, quality, and beneficiary experience). Through CCC, social workers and licensed practical nurses work with physicians to connect older adults with community-based programs for help with daily living, health care, and social needs. As of 2019, comprehensive evaluation of the program demonstrated a reduction in health care utilization (hospitalizations, emergency department visits, observation stays) among beneficiaries enrolled in CCC, compared to a matched-control group of beneficiaries (Lifespan of Greater Rochester, Inc. 2019). As a result of this demonstrated success, the program received funding through three contracts (an insurer, federally qualified health centers, and Accountable Care Organizations) and three foundation grants to establish a sustainable payment model through 2023.

V. Best Practice 5. State strategies and financing mechanisms for coordinating housing supports for MFP participants

A. Introduction

The shortage of available, accessible, and affordable housing presents a significant barrier to transitioning Medicaid beneficiaries back into their communities after stays in long-term care institutions (Robison et al. 2020, Bernacet et al. 2021). Many institutional residents who wish to receive HCBS have to re-establish a new home in the community, but in most areas across the country, available housing stock is old, inaccessible for people with disabilities, and—as a result—presents safety risks to MFP participants. Additionally, the steep cost of rental housing, especially in urban areas, makes rental housing subsidies necessary to transition many MFP participants to the community.[25] While rural areas may have more affordable housing available, these areas may not have sufficient HCBS service provider capacity for beneficiaries to receive the services they need at home (Siconolfi 2019). According to data MFP project directors self-reported for the MFP Housing Learning Collaborative, 93 percent of respondents (n = 26) reported that challenges identifying affordable, accessible housing substantially (n = 12) or moderately (n = 14) impacted the delivery of HCBS in their state (Exhibit V.1).

Exhibit V.1. MFP housing-related barriers

Source: Housing Needs Assessment survey conducted with MFP project directors, 2022.

As described in Chapter II, MFP grantees can use demonstration services funded with grant dollars to provide participants with Medicaid-coverable services or supports to secure housing above or beyond what is currently in states' HCBS offerings. For example, most MFP grantees offer a mix of housing-related supports covered by grant funds, which include home accessibility modifications, one-time community transition costs, pre-transition housing supports (such as assistance in identifying housing), housing sustaining supports (such as case management), and purchase of household goods and furniture. States may also offer short-term supplemental services to support transitions, which include supports—such as pantry stocking and trial visits to new residences—otherwise not allowable under the Medicaid program. Together, these services address housing barriers, facilitate a smooth transition, and help participants maintain their residence in the community.

This chapter examines state strategies for effectively coordinating and financing housing supports for MFP participants. It describes how states established partnerships with local housing organizations and how those partnerships improved housing options for Medicaid beneficiaries. Additionally, this chapter highlights how states used MFP grant dollars and state funds attributable to the MFP-enhanced FMAP (or

[25] Housing subsidies help low-income families, the elderly, and those with disabilities to afford decent, safe, and sanitary housing through funding from a government or nonprofit, religious, or charity organization. A common form of housing subsidy, referred to as a housing voucher, is a direct payment provided to landlords in the private housing market. For example, through the Section 8 housing choice voucher program, public housing authorities receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher.

"state-equivalent funds") to improve access to available housing or fund housing supports to move MFP participants to qualified housing[26] in the community.

States were selected on the basis of their MFP program's performance on these indicators: (1) obtained priority status or set-asides for MFP participants in publicly subsidized housing programs; (2) partnered with housing organizations, which led to greater housing options for institutional residents who wished to receive LTSS in a home or community-based setting; (3) created special licensing categories for small group homes serving people with disabilities with specialized needs; and (4) hired housing coordinators and/or housing specialists to improve housing options for MFP participants.

Best Practice 5: "State strategies and financing mechanisms for effective coordination of housing financed or supported under MFP Demonstration projects with local housing authorities and other resources" (P.L. 116-260).

Research questions:

- What housing-related barriers have MFP programs encountered when helping MFP participants move to qualified housing in the community?
- What state strategies were used to effectively coordinate with local housing authorities or other partners to increase the supply of affordable, accessible housing?
- What financing strategies were used to provide housing supports to MFP participants (supported under MFP Demonstration projects)?

Selected states: Colorado, Connecticut, the District of Columbia, Ohio, New Jersey, and Washington

Respondents and mode: Virtual focus groups with MFP project directors, housing coordinators, and housing specialists.

B. Strategies for establishing partnerships with housing partners

Many state and local organizations, such as public housing authorities (PHAs), state housing and health agencies, and aging and disability networks partnered to collectively address housing barriers and improve housing options for older adults and people with disabilities. According to the MFP project director survey, 16 of 32 states established partnerships with local PHAs, and 26 partnered with state housing finance agencies. Twelve of 32 respondents reported partnerships with housing developers. Nearly three-quarters (23) indicated that these partnerships led to an increase in affordable and accessible housing for MFP participants. This section shares learnings from selected states on establishing these partnerships.

Strong partnerships with landlords and MFP programs resulted in increased housing options. Washington State's Aging and Long-Term Support Administration (ALTSA) contracted with a Spokane Housing Authority to provide an ALTSA "Bridge" subsidy statewide for individuals transitioning from nursing facilities. This subsidy, modeled on HUD's Section 8 Housing Choice Voucher, allowed the state to approve rental amounts beyond fair market rent if a participant's needs were more complex. This subsidy created opportunities to partner with landlords who typically rent at higher prices. Washington's ALTSA subsidy program also provided bridge funding to compensate landlords while they wait for the MFP program to inspect and approve the suitability of the units for MFP participants. Other study states focused

[26] An MFP qualified residence is defined, by statute, as (1) a home owned or leased by the individual or the individual's family member; (2) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and (3) a residence, in a community-based residential setting in which no more than four unrelated individuals reside (CMS 2009).

on building relationships with landlords, which helped to pinpoint and address landlords' concerns about leasing to individuals they perceive as high-risk tenants. Housing coordinators in the states served as liaisons with landlords to mitigate housing challenges that may arise soon after transition. In Connecticut, housing coordinators established open lines of communication with landlords to provide early identification and intervention to avoid situations that may jeopardize housing. For example, if the participant was late paying rent, the landlord notified the MFP program. The housing coordinator then explained the payment delay (e.g., a hospital or emergency department admission) and intervened to resolve the issue quickly. In Colorado, the housing coordinator served as a liaison with landlords, which has increased the number who are willing to lease to MFP participants.

MFP partnerships with state and local PHAs increased access to accessible and affordable housing. The District of Columbia noted how their strong working relationship with the District of Columbia Housing Authority (DCHA) has increased housing opportunities for MFP participants. For example, DCHA contacted the MFP program when units in new properties were available so MFP participants had early access. Similarly, the Connecticut State Department of Housing notified the MFP program when openings are available in their Section 811 Project Rental Assistance program, which offers rental assistance for low-income, non-elderly persons with disabilities. Additionally, some states partnered with local PHAs to manage their housing voucher programs, particularly non-elderly disabled (NED) vouchers. Category 1 NED vouchers enable non-elderly persons or families with disabilities to access affordable housing, while Category 2 are specifically for non-elderly persons with disabilities currently residing in healthcare institutions. Ohio partnered with three different PHAs throughout the state to manage its NED vouchers, which work to fill and maintain these housing slots. Similarly, Washington partnered with various local housing authorities to allocate NED vouchers or emergency housing vouchers.

"We started developing relationships with [housing] developers themselves, meeting with them, talking about MFP client needs, and being involved right from the get-go in developing accessible units – *truly* accessible units. [Through these relationships] we have first choice once they [the new housing units] do open and being their first in line to apply for these vacancies."

– MFP housing specialist

Obtaining buy-in from state leadership advanced MFP program housing strategies and funding streams. Connecticut secured state-funded rental housing subsidies by presenting a cost-benefit analysis to the state leadership documenting how providing rental housing subsidies and behavioral health supports to individuals with mental health needs transitioning from an institution to the community resulted in savings to the state Medicaid program. When conducting the cost-benefit analysis, the Medicaid HCBS cost of each person who moved to the community plus the added cost of the housing voucher (if applicable) was compared to the Medicaid rate of the nursing facility the beneficiary lived in. As a result of the projected cost savings—in combination with the success of the existing supportive housing program—the state authorized funding for 340 additional state-funded rental assistance housing vouchers. The state also proposed a new Medicaid benefit under section 1915(i) State Plan HCBS that provides mental health and substance use services to eligible individuals moving out of institutions. This new Medicaid benefit went into effect in August 2021; as of February 2023, 132 beneficiaries had benefitted from these services and supports. Also, Colorado's MFP program worked closely with the state Division of Housing through an interagency agreement that provides coordination of state rental assistance housing vouchers. The interagency agreement formally supported discussions to develop legislative requests to expand the amount and type of resources available for increasing state-wide affordable and accessible housing.

MFP programs leveraged additional funds available through home modification programs to improve accessibility of housing. The District of Columbia's Department of Aging and Community Living Safe at Home program provided safety modifications in and around the homes of qualifying older adults and adults with disabilities, including MFP participants. Through this program, case managers worked with general contractors specializing in home modifications, along with occupational therapists and/or physical therapists who conduct pre- and post-assessments of an individual to identify their functional and accessibility needs. The program installed grab bars, ramps, unit security cameras, and other items to meet participants' needs in their homes.[27] For some MFP participants, the Safe at Home program covered costs beyond what is allowable through the MFP program. Connecticut's Community First Choice program offered funding over the course of five years for those who need modifications to move to and live safely within the community. The allotted budget varied for individuals based on their housing-related needs, with an overall budget cap of $15,000 – comparatively larger than the $10,100 home modification budget offered to qualifying residents through the state's Home Care Program for Elders. MFP participants may have made use of one of these programs' funds, if qualified, to cover additional home modification costs.

C. Strategies for leveraging grant funds to increase housing options

MFP programs have access to a variety of funding streams, and programs vary in how they choose to utilize these funds to best benefit MFP participants in need of housing supports. This section describes how several selected states have used state-equivalent funds and MFP grant funds—including administrative and capacity building funds—to increase access to affordable and accessible housing.

State-equivalent funds were essential in funding new housing developments. Two selected states (New Jersey and Ohio) used state-equivalent funds to cover capital investments for the development of new housing. New Jersey used MFP state-equivalent funds to cover capital costs, such as housing acquisition and/or rehabilitation to develop four-bedroom group homes for people with I/DD transitioning from ICF/IIDs. Capital funding was allocated to qualified providers in 2013 through a competitive bidding process. According to state officials, up to $250,000 per four-bedroom home was made available through this process (Denny-Brown et al. 2015). At least 12 new residential group homes were created housing more than 50 individuals, contributing to the program's success in serving individuals with complex medical and behavioral needs who wished to move from ICF/IIDs to the community.

> **"Finding affordable and particularly accessible units has been and continues to be our greatest struggle. That's where we've centered some of our investment of our MFP [state-equivalent] funds, to create more bricks and mortar housing…. Medicaid is embarking on a $100 million initiative now in the state to build new housing [for older adults transitioning from nursing facilities]…and we laid the groundwork through MFP."**
>
> ***– MFP housing specialist***

Many states used MFP administrative funds to hire dedicated housing staff to improve housing options for Medicaid beneficiaries. Nineteen states with active MFP programs employed specialized individuals to manage and coordinate housing-related supports.[28] However, state programs defined these roles differently. In many of the selected

[27] The program is available to District residents, ages 60 and over, or adults with disabilities, ages 18 and over, who are homeowners or renters of a property used as a primary residence, with an annual household income at or below 80 percent of area median income.

[28] CMS analysis of MFP grantees' housing infrastructure activities, provided October 2021.

states, dedicated housing coordinators networked with developers and landlords, identified appropriate housing units, and coordinated housing supports to meet the individualized needs of MFP participants. Housing specialists worked with PHAs, state Medicaid and housing agency staff, and community-based organizations to advance the state's housing strategy to increase the availability of community-based affordable housing. For example, New Jersey's MFP program employed a statewide housing coordinator who works with local PHAs to create subsidy opportunities targeted to Medicaid beneficiaries transitioning from institutional settings. The MFP housing coordinator also worked closely with housing specialists employed by New Jersey's managed care plans, which were responsible for helping their members transition to the community. Before 2016, MFP transition coordinators in Ohio were responsible for finding housing, but because they lacked expertise in housing issues, the state started a pilot program in 2016 to employ specialized housing navigators. These staff searched for housing based on each member's preferences and needs. They also built relationships with landlords to increase awareness of the MFP program, the needs of people with disabilities and the aging population, and how the MFP program supports the person after the transition.

All states used MFP funds to cover critical one-time community transition costs, such as rental deposits, moving expenses, and home modifications. The District of Columbia used state-equivalent funds to pay for rental costs before the MFP participant moved or before the participant received MFP funds for transition-related housing expenses. Ohio supported the provision of housing-related transition goods and services by covering up to $2,000 in Community Transition Services to help participants with security deposits, the first month's rent, purchase of furniture and household goods, and other supports needed to help the participant transition to independent living. Connecticut also provided a budget of $2,000 to help participants furnish their apartments. Maryland's MFP program similarly used flexible grant funds for up to $700 for moving expenses and other items not covered by Medicaid, such as initial pantry stocking.

Spotlight on State Strategy: Ohio Housing Locator

The Ohio Housing Locator is a state-wide registry for affordable and accessible rental housing. The housing locator – which replaced several housing directories concurrently in use by various agencies – was developed using MFP supplemental funds in partnership with Ohio's Housing Finance Agency and the Department of Health. The public website allows landlords to post properties and individuals searching for housing to filter these properties by characteristics, including:

- Available accessibility features, such as doorway clearances, roll-in or walk-in showers, grab-bars, and accessible parking;
- Whether the landlord accepts Section 8 Vouchers and is familiar with the requirements, as well as the landlord's spoken languages; and
- Requirement for a credit and criminal check on application.

MFP programs employed other strategies, such as building state housing infrastructure, to increase access to affordable and accessible housing. Many states (n = 15) utilized housing registries to locate and track housing options specifically for MFP participants**.** Ohio has used MFP funds to develop housing registries to help with the identification of affordable and accessible housing. Created in collaboration with the Housing Finance Agency and the Department of Health, this registry compiled several pre-existing housing locator systems in the state into a single tool to consolidate the housing search process (see state spotlight above).

VI. Best Practice 6. State approaches for effectively delivering MFP transition services through managed care plans

A. Introduction

A growing number of states deliver LTSS through MLTSS programs. In state MLTSS programs, states pay managed care plans risk-based capitation payments to provide care to Medicaid enrollees for LTSS. States may employ strategies through MLTSS programs to shift the balance of LTSS from institutional care to home and community-based settings.

As of FY 2020, among the 25 states that operated MLTSS programs, 15 had active MFP grants and MLTSS programs operating simultaneously (Murray et al. 2023).[29] The relationship between the two programs varies by state, depending on whether they serve the same LTSS population groups. When they serve the same populations, it is important to understand how the programs work together to achieve their common goals (Lipson and Stone Valenzano 2013; Libersky et al. 2015).

This chapter examines strategies for providing MFP transition services in collaboration with managed care plans that contract with state Medicaid agencies to serve people with disabilities who need LTSS. It features effective state policies and practices that give financial incentives to managed care plans to reward them for helping enrollees residing in institutions make successful transitions to community settings; ensure effective collaboration and communication among state agencies, managed care plans, and other entities involved in managing MFP transitions; and closely monitor the status and outcomes of MFP participants enrolled in managed care plans.

Among states that operated MFP grants and MLTSS programs simultaneously in 2021, the ones highlighted for this report had implemented two or more of the following practices: (1) they set MLTSS capitation payments using blended rates—which cover the cost of all LTSS, whether provided in institutions or the community—or other capitation rate approaches; (2) they utilize other financial incentives with managed care plans to promote transitions from institutions to community settings, such as an additional payment to the managed care plans that transition enrollees from long-term care institutions into other settings; and (3) they have a formal cooperative agreement in place with the managed care plans to document roles and responsibilities for transition coordination services for institutional residents who are eligible for and are interested in transitioning to HCBS.

[29] States with active MFP grants and an MLTSS program are Arkansas, California, Hawaii, Idaho, Iowa, Minnesota, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, and Wisconsin.

Best Practice 6: "Effective state approaches for delivering Money Follows the Person transition services through managed care entities" (P.L. 116-260).[30]

Research question:

- What are effective approaches for delivering MFP transition services through managed care plans?

Selected states: Hawaii, Idaho, Minnesota, New Jersey, Rhode Island, and Wisconsin

Informants and mode: Virtual focus groups with Medicaid agency staff that oversee MLTSS programs, MFP project directors, and care managers from managed care plans.

B. Strategies for using financial incentives to encourage managed care to transition enrollees to community settings

State Medicaid agencies have several options to give managed care plans financial incentives to achieve various performance targets. This section highlights financial incentives state Medicaid agencies use to encourage managed care plans to help their enrollees transition to the community. The online survey completed by MFP project directors asked whether respondents from states with active MFP grants and MLTSS programs operating simultaneously used either (1) a blended rate to set monthly capitation payments or (2) other approaches for capitation payments designed to encourage plans to help their enrollees transition to the community. Six of 15 states indicated they used one of these financial incentives. Three of 15 states indicated in the survey they provide other financial incentives to managed care plans, paid separately from capitation payments, for enrollees who make a successful transition to a home or community setting.

States may use strategies in risk-based capitation payment rates developed to motivate managed care plans to help enrollees in institutions make successful transitions to the community. Medicaid agencies in three of the selected states (Idaho, New Jersey, and Rhode Island) reported using blended capitation payment rates. A blended capitation strategy may cover the cost of all LTSS benefits regardless of whether they are delivered in an institutional setting or the community. This strategy may also average the costs of institutional and HCBS, potentially giving greater weight to the HCBS portion. This could incentivize managed care plans to provide care in less costly home and community-based settings. New Jersey indicated it has used blended rates since 2016 for all managed care plan enrollees who qualify for LTSS (excluding recipients in special care nursing facilities). Medicaid officials in that state believe the blended rates have contributed to a trend toward greater use of HCBS over time. The state also indicated it gives managed care plans an incentive to increase the share of members receiving HCBS by re-blending the rates based on the case mix only at the beginning of each quarter, allowing the plans that improve their case mix to receive the higher calculated blended rate for an additional three months. Rhode Island, which indicated it also uses a blended capitation payment rate for LTSS benefits, initially set the HCBS share of the rate based on each plan's experience. Over time, the state modified the blended rate based on assumptions about the plan's ability to shift the locus of care to the community.

Minnesota indicated it uses a transitional rate approach for its MLTSS capitation payments. In that state, managed care plans are required to cover the first 180 days of nursing facility care, after which point the state covers nursing facility care on a FFS basis. When a person who needs LTSS resided in the

[30] Note that while the statute refers to "managed care entities", we use the term "managed care plans" throughout to be inclusive of additional arrangement types.

community, Minnesota indicated that the plan received a basic care capitation rate to cover the cost of medical services, as well as HCBS waiver add-on and nursing facility add-on capitation rates. If an enrollee is admitted or readmitted to a nursing facility, the HCBS waiver and nursing facility add-on capitation rates were removed and the plan became liable for the cost of institutional care up to 180 days, which provided an incentive for managed care plans to minimize the length of stay in nursing facilities.

Financial incentives also motivated plans to help their enrollees transition to the community. According to the online survey of MFP project directors, three states (New Jersey, North Carolina, and Wisconsin) indicated they use other financial incentives, such as incentive arrangements (which are paid separately from capitation payments) to managed care plans for each enrollee residing in an institution who makes a successful transition to a home or community setting. For example, Wisconsin paid a one-time $1,000 payment through an incentive arrangement, funded by MFP state-equivalent funds, to managed care plans for each eligible MFP transition; one informant indicated this financial incentive had been very successful, contributing to the state exceeding its annual transition goals. In addition to its blended rates, New Jersey also created an incentive arrangement for MLTSS performance that rewards managed care plans that score the highest on identified performance goals. These incentive arrangements applied to all members of the plan, not just MFP participants.

C. Collaboration strategies among state Medicaid agency staff, MFP program managers, and managed care plan case managers in facilitating transitions

Medicaid agency staff, MFP program managers, and managed care plans all must communicate and collaborate efficiently to coordinate multiple moving pieces and potentially overlapping roles in the transition process. This section highlights strategies from selected states, identified through focus groups, to facilitate collaboration across all organizations responsible for transitioning participants enrolled in managed care plans from institutions to the community.

"There needs to be [open] lines of communication and education, because MFP staff who don't work in the managed care area don't always understand what [managed care plans] do, what they have to offer, or how to talk with them…. It's important to have a relationship and collaboration embedded into your program for it to be successful."

– Medicaid agency staff and MFP service coordinator

Defining the roles of each party and establishing clear lines of communication ensured effective collaboration among state Medicaid agency staff, MFP program managers, and managed care plan case managers. Although states divided responsibilities for MFP transition activities between Medicaid agency staff and managed care plans in different ways, the common threads were clear role definitions and assigning responsibility for each step in the process to the groups with the right skills and the right capabilities. In three selected states (Hawaii, New Jersey, and Rhode Island), state Medicaid or MFP program staff identified individuals interested in participating in the MFP program (sometimes in cooperation with the managed care plans) and referred them to the managed care plans in which they were enrolled. After the initial referral, care managers from each plan took over transition planning and coordination. In Minnesota and Idaho, state-approved third-party contractors served as transition coordinators and worked closely with the state and managed care plans to coordinate an individual's transition to the community. Minnesota indicated that even though involving a third party adds another entity to the mix, the contractors added value because their organization and staff have built expertise in navigating MFP transition policies and processes, as well as housing options. Similarly, Idaho believed that contracting with third parties to handle MFP transitions

benefited the state because Medicaid program staff specialize only in Medicaid services; effective MFP transitions required knowledge, skills, and relationships across community service providers.

Other state and local agencies played important roles in facilitating collaboration, which led to successful MFP transitions. New Jersey's Long-Term Care Ombudsman's office played a key role in resolving barriers to transition. As an influential advocate for residents within nursing facilities, the Ombudsman's office could intervene on behalf of residents if the facility or a managed care plan does not fully cooperate in efforts to help individuals transition to the community. In Wisconsin, if a nursing facility closed, staff at the local Aging and Disability Resource Center, which is overseen by the Department of Health Services, referred residents to a managed care plan to help them transition to the community.

Clear and regular communication among all parties involved in MFP transitions led to smooth and successful transitions. At the onset of its MFP program, Minnesota assigned responsibility to someone in the Medicaid agency's managed care unit to serve as the MFP point person, which made communication and collaboration between these two groups easier. In states with many managed care plans, the Medicaid agency often assigns an MFP liaison to each managed care plan to provide information about MFP policies and procedures and explain MFP's advantages relative to other transition programs that may operate in parallel. In New Jersey, it is the reverse: each managed care plan must have appointed an MFP liaison to stay updated on MFP policy and procedures and resolve any issues.

Regular meetings between managed care plans and MFP staff supported open lines of communication about successes and challenges. In New Jersey, the state convened bi-monthly meetings for housing specialists from managed care plans to share support and guidance and offer presentations from housing experts. In Hawaii, managed care plans attended quarterly meetings with MFP program staff to discuss challenges and brainstorm solutions together.

D. Strategies to track data for MFP participants enrolled in managed care plans

The MFP Demonstration requires states to report semi-annually on transitions by target population, quality monitoring metrics, use of state-equivalent funds, and other benchmarks related to total annual spending on Medicaid HCBS (federal and state funds) for all Medicaid recipients. Based on information from focus groups, this section highlights how MFP programs and managed care plans worked together to track and monitor data for MFP participants enrolled in managed care plans.

States and managed care plans worked in concert to monitor the use of health care and LTSS by MFP participants enrolled in managed care plans. All six selected states closely tracked MFP transitions and monitored key indicators of MFP participants enrolled in managed care plans, such as nursing facility and hospital admissions, emergency department visits, and critical incidents (see state spotlight below). For example, New Jersey and Wisconsin used an Access database containing an individual record for each MFP participant. In Wisconsin, this database allowed MFP program managers to track MFP participants' service use and critical incidents in detail. For example, Wisconsin required managed care plans to record every status change, including hospital admissions, relocations, disenrollments, and deaths, for all MFP participants. These managed care plans then submitted this information to the state, and state staff entered these data into a database to generate monthly reports on MFP participants in aggregate and for each managed care plan.

The six state MFP programs, with between 30 and 175 enrollees at the time of the study, used manual data systems, which contained more detailed information than would be available in state Medicaid data systems. For example, some states also entered sociodemographic information for each MFP participant in

the database, which allowed them to track key indicators by race, ethnicity, and tribal membership. These manual data systems reportedly allowed MFP program managers to monitor managed care plan performance closely. However, states recognized that this would not be feasible if the state had many MFP participants.

Spotlight on state strategy: New Jersey's managed care plan accountability reviews

New Jersey's Medicaid agency monitored managed care plan performance through extensive accountability reviews. Once a month, state Medicaid program managers assembled data on a comprehensive set of performance metrics for each managed care plan, including MLTSS-specific metrics. After examining trends over several performance periods, the Medicaid agency can identify the managed care plan's strengths and weaknesses, how each plan performs relative to other plans, and the extent to which the plan meets contract requirements. The process created a structure for holding plans accountable for their performance which, according to Medicaid agency staff, did not exist previously. Staff noted that nursing facility transitions have been a re-occurring topic in accountability reviews, leading to improved managed care plan performance in the number and success of transitions.

VII. Best Practice 7. Strategies for delivering services through MFP Tribal Initiative programs

A. Introduction

In 2013, CMS awarded funding for the MFP Tribal Initiative to five states: Minnesota, Oklahoma, North Dakota, Washington, and Wisconsin. The MFP Tribal Initiative offered existing MFP grantees and tribal partners resources to build sustainable HCBS infrastructure for tribal communities. The funds are subject to all the terms and conditions of the MFP Demonstration. As originally conceived, Tribal Initiative funding was intended to support the planning and development of:

- An in-state Medicaid HCBS program (as an alternative to institutional care) tailored for American Indian and Alaska Native (AI/AN) people who receive LTSS in an institution; and
- A service delivery structure with administration delegated by the state Medicaid agency so federally-recognized tribes or tribal organizations can (1) design an effective program or package of Medicaid HCBS and (2) operate day-to-day functions pertaining to LTSS programs (CMS 2022b).

However, early feedback from states and their tribal partners emphasized the need to build HCBS infrastructure in tribal communities prior to transitioning AI/AN people receiving LTSS in institutions to community settings. This led CMS to reconceptualize the program, over several years, to focus primarily on the second aim: building service capacity to deliver HCBS in tribal communities. The current goals of the MFP Tribal Initiative are to increase the use of culturally responsive HCBS programming and reduce the use of institutionally based services; eliminate barriers that prevent tribal members from accessing LTSS in the setting of their choice; strengthen the ability of state Medicaid programs to provide HCBS to tribal members currently in institutions; and provide quality assurance and improvement of HCBS.

The MFP Tribal Initiative aims to strengthen service capacity and address health disparities. The federally-recognized tribes and tribal organizations engaged in the MFP Tribal Initiative reported that they are grappling with severe health disparities, including significantly lower life expectancies for AI/AN people and higher rates of chronic disease (Commission on Civil Rights 2018). In addition, federally-recognized tribes and tribal organizations emphasized that historical traumas and marginalization of tribal members in receiving health care have exacerbated the crisis and led to community-internalized distrust of health care, especially among tribal elders. Federally-recognized tribes and tribal organizations participating in MFP also report that they contend with health care system capacity and service gaps—which vary across facilities and communities—leading to unmet needs for some tribal members. They report that, through the approaches highlighted in this chapter, the MFP Tribal Initiative has addressed factors contributing to health disparities in tribal communities and provided critical resources to help cover LTSS service gaps for Medicaid-eligible tribal members.

This chapter examines state strategies for implementing MFP Tribal Initiative programs. It discusses best practices in three areas: establishing partnerships with federally-recognized tribes or tribal organizations, building workforce and service capacity in Tribal communities, and providing culturally responsive services.

Best Practice 7: "Other best practices and effective transition strategies demonstrated by States with approved MFP Demonstration projects…" (P.L. 116-260): state strategies for delivering services through the MFP Tribal Initiative program.

Research questions:

- What strategies were effective in establishing partnerships with federally-recognized tribes and tribal organizations?
- What strategies were effective in building service capacity and developing the HCBS workforce in tribal communities?
- What strategies were effective in delivering culturally appropriate LTSS to tribal members?

Selected states: Minnesota, North Dakota, Oklahoma, Washington, Wisconsin

Contributors and mode: Two virtual focus groups: One with MFP Tribal Initiative project managers and the other with MFP Tribal Initiative project managers, tribal health leaders, tribal health staff, and public health staff. Telephone interviews were also held with two tribal health staff members who were unable to attend the focus groups.

B. Establishing and maintaining partnerships with federally-recognized tribes and tribal organizations

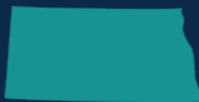
States with MFP Tribal Initiative funding partnered with federally-recognized tribes and tribal organizations to build sustainable HCBS infrastructure in tribal communities. These partnerships are intended to support implementation of the initiative and enhance the role of federally-recognized tribes and tribal organizations in the design and operations of Medicaid LTSS programs. This section describes strategies to establish effective partnerships through the MFP Tribal Initiative, as well as the challenges encountered.

To establish and maintain partnerships, states built on existing delegations, meetings, and trusted relationships to engage with federally-recognized tribes and tribal organizations around the MFP Tribal Initiative. Contributors from all five MFP Tribal Initiative programs reinforced the importance of identifying and engaging tribal leadership early in the planning process and leveraging existing relationships to build trust. Two state contributors noted that their teams leaned on the expertise of staff who had nurtured strong, long-term partnerships between state agencies and federally-recognized tribes or tribal organizations to facilitate connections and ensure they were taking the most effective approach in their outreach. States also had success raising the MFP Tribal Initiative funding opportunity for discussion during established periodic meetings between state staff and delegates from federally-recognized tribes or tribal organizations.

States found several strategies effective to support and maintain close partnerships, particularly during leadership transitions. MFP staff found that consistent, recurring in-person meetings and in-person visits to tribal communities helped some MFP staff nurture partnerships over time (see North Dakota in the state spotlight below). Other contributors noted the importance of engaging in active listening and addressing and learning from feedback provided by federally-recognized tribes or tribal organizations. Contributors in four states (Minnesota, North Dakota, Washington, and Wisconsin) said it could be difficult to sustain partnerships because of high staff turnover within state agencies, federally-recognized tribes or tribal organizations, and counties. Wisconsin's Tribal Affairs Department worked to mitigate this problem by ensuring staffing changes within state government are shared with tribal partners and circulating

updated contact lists for tribal partners within their department. To maintain partnerships during leadership transitions, one contributor recommended other states adopt Washington's Department of Social and Health Services' policy to include representatives from federally-recognized tribes or tribal organizations on employee interview panels for state government positions that work in conjunction with federally-recognized tribes and tribal organizations.

Many contributors recommended steps that state and federal governments could take to recognize the sovereign nature of federally-recognized tribes and honor each community's identity. Federally-recognized tribes have a government-to-government relationship with the federal government and determine their own governance structures. Contributors discussed the importance of characterizing federally-recognized tribes as sovereign nations in communications to build trust in this mutual recognition. Additionally, contributors also noted that many federally-recognized tribes have layered governance structures, just as state and federal agencies do, and state and federal government agencies should allow adequate time for multiple tribal councils or committees to review and approve materials. In addition to varied governance structures, each tribal community has its own history, culture, and traditions; consequently, one contributor highlighted that approaches that work with one tribe may not necessarily work for others.



Spotlight on State Strategy: North Dakota's MFP Tribal Initiative Meetings with Federally-Recognized Tribes

The North Dakota MFP Tribal Initiative program began to host regular meetings with all federally-recognized tribes participating in the MFP Tribal Initiative. In this group environment, tribal staff discussed common barriers to services and success stories. This format also promoted collaboration among federally-recognized tribes and with the MFP Tribal Initiative, as attendees often discuss solutions to challenges, such as strategies for improving access to services for their communities. During one of these meetings, MFP Tribal Initiative staff reviewed the Medicaid eligibility application with the federally-recognized tribes and found that much of the information in the Medicaid document was worded in a way that would not be interpreted as the state intended. As a result, the document was modified to be more culturally aligned based on recommendations from tribal members.

C. Strategies to build service and workforce capacity in tribal communities

Workforce challenges in the health care sector—such as shortages of trained home health care workers—have stressed many communities across the United States but are especially acute among tribal communities. Tribal communities are often located in rural areas, which have fewer medical and LTSS providers than urban areas and involve long travel distances to obtain needed care (CMS 2013). Contributors reported that challenges also exist in service capacity, as federally-recognized tribes and tribal organizations often serve as the safety net for tribal members and deliver services irrespective of the level of available reimbursement. This section describes strategies MFP Tribal Initiative programs employed to build HCBS service capacity and sustainability and increase awareness of these services in tribal communities.

Washington's MFP Tribal Initiative program developed training programs and proposed legislative reforms to increase HCBS workforce supply. In addition to the state's Home Care Aide Training program (highlighted in the state spotlight below), Washington developed localized HCBS services delivered via employee-owned, tribal co-ops. These co-ops allow tribal members to start independent businesses to provide culturally responsive caregiver services to tribal elders. In 2021, Washington passed House Bill 1411 to expand the pool of long-term care workers, particularly in tribal communities. This bill supported both individuals who sought to become paid caregivers for a loved one and the ability of tribal members to hire a trusted person of their choice to provide care.

Spotlight on State Strategy: Washington's Health Professional Training Program

Washington State developed a Home Care Aide Training program to prepare high school students in tribal communities to care for individuals requesting services in their homes or other appropriate community settings as home care aides. The program aims to train a pool of certified caregivers helping to relieve workforce shortages in home care and support provision of HCBS. The Washington MFP Tribal Initiative program promotes this program within tribal communities in the hopes of creating a pipeline of tribal home care aides to increase workforce and service capacity. The state is also working to create additional career pathways in this program for licensed practical nurse and registered nurse apprenticeships.

Three MFP Tribal Initiative programs (North Dakota, Washington, and Wisconsin) noted the importance of conducting a needs assessment to identify opportunities to increase funding for HCBS in tribal communities. Contributors suggested that as part of a needs assessment, MFP Tribal Initiative programs and federally-recognized tribes or tribal organizations first review services currently provided to tribal members, then determine which of those services are reimbursable through Medicaid and whether they are currently submitted for reimbursement. One focus group contributor reported federally-recognized tribes paying for services out of tribal funds due to a lack of knowledge around Medicaid billing processes. Providing training for federally-recognized tribes and tribal organizations to better understand billing processes and available funding would help build the infrastructure needed to increase the resources available to provide and sustain HCBS for their members. Two MFP Tribal Initiative programs described inadequate state funding and regulatory issues as barriers to optimizing available funding. For example, contributors in Minnesota and Washington noted a lack of funding to repair and develop homes in tribal communities, or regulations about ownership of the land that impact access to repair funds.

Tribal Initiative projects can support HCBS capacity building efforts by identifying which Medicaid-funded community-based services have not been sufficiently implemented in tribal communities. After identifying funding for services currently provided to tribal members, MFP Tribal Initiative programs can identify additional services reimbursable through Medicaid or MFP grant funds. MFP Tribal Initiative programs may review these services in collaboration with the federally-recognized tribes or tribal organizations to determine if they address a service gap and if the services should be implemented. Addressing these service gaps can improve the health disparities that exist among tribal members relative to

the general population. For example, one MFP Tribal Initiative project manager reported working with program staff to review HCBS waiver program contracts and to adapt the language to respect sovereignty and treaty rights. Then, MFP Tribal Initiative staff met with federally-recognized tribes and discussed whether the federally-recognized tribes were already providing the services identified in HCBS waiver program contracts and if not, whether elders could benefit from these services.

MFP Tribal Initiative programs highlighted the importance of ensuring tribal members are aware of and make use of new and expanded HCBS. In one state, the MFP Tribal Initiative project manager reported that they held meetings with tribal partners to educate them about available services and connect tribal members with county-level resources. In Minnesota, a contributor from a federally-recognized tribe reported hiring a benefits coordinator who conducts outreach and informs tribal members about services and programs for which they may be eligible. North Dakota developed a similar program to inform tribal members about services and hired a tribal staff member as a case manager, rather than relying on county or state staff to fill this role. Individual tribal members may be uncomfortable sharing personal information with someone they do not know—especially non-tribal individuals—and may overstate their ability to care for themselves and underreport their needs. This is particularly true if they fear their autonomy may be in jeopardy if they express an inability to care for themselves independently.

"[There is] a lot of under-reporting of actual need for supports in the community.… There's still a certain amount of distrust among tribal members when they have unfamiliar people coming to speak with them and evaluate things [to fully identify their needs]. There seems to be a perception that the workers are there to take away their ability to do things for themselves."

– Tribal health leader

D. Strategies for delivering culturally responsive HCBS to tribal members

MFP Tribal Initiatives made strides towards the program's goal of increasing the use of culturally responsive HCBS in tribal communities. Delivering culturally responsive care requires understanding both the individual's needs and their cultural context (Nahian and Jouk 2022). Tribal members are embedded within a community or communities that teach and protect their cultural and traditional ways. As such, program staff must ensure that services offered are culturally competent and support the sovereignty of federally-recognized tribes. This section explores strategies for delivering culturally responsive HCBS to tribal members.

Several contributors spoke of the high value placed on services provided by tribal staff to tribal members, but services provided by non-tribal staff may be better received after they engage in cultural competence training tailored to federally-recognized tribes' traditions and needs. Contributors noted that from birth, tribal members are raised in and taught the culture and traditional ways of their federally-recognized tribe(s). As a result, contributors asserted that the best way to ensure services are culturally responsive is to have them delivered by tribal members. Because non-tribal staff can reportedly struggle to identify how the health and cultural needs of tribal people are connected, emphasis must be placed on building trust, promoting relationship building, and improving and enhancing service delivery through regular cultural competence

"I think there needs to be cultural competency [training] on a regular basis, with all of the different agencies that provide these kinds of services to learn how to build trust with our Elders…we have people who have had a bad experience and so they're less likely to seek the care that they need to address their health issues because they don't have the trust."

– Tribal health leader

training. For example, the early stage of transition and care planning involves collecting sensitive information about an individual's health, habits, or home life, and tribal Elders are reportedly reticent to share that information with someone they do not trust. According to one contributor, developing a positive relationship with the family of an Elder receiving care is one way to build trust in the community. The Washington MFP Tribal Initiative program provides training to the county Area Agency on Aging Services and contracted providers on cultural appropriateness, tribal customs, and the ways in which federally-recognized tribes differ from one another; the training also stresses that federally-recognized tribes are sovereign entities. Contributors in Washington and Minnesota reinforced that trainings should be offered continuously, especially given staff turnover.

Culturally responsive HCBS for tribal members may include services that are not always reimbursable by Medicaid. One example given by contributors was traditional healing provided by tribal practitioners. Traditional healing practices can include the use of traditional foods, medicine, and ceremonies; these practices involve the individual, family, and community in the healing process, promoting overall wellness across the full range of physical, emotional, mental, and spiritual health. These long-standing practices are not always covered by Medicaid or recognized by non-tribal staff, but contributors noted these practices can be essential to the health and well-being of tribal members. Tribal health leaders noted it is critical for non-tribal staff to be aware of these services when delivering HCBS to tribal members. As an example, a tribal health leader in one state described how a retired physician in the community had immersed himself in tribal culture and would refer patients to spiritual healers.

"Our spiritual medicine people, they're not certified… so they're not considered 'health care [professionals who can be reimbursed for services]' but to Native people, it's a really important part of our lives…People seek that [support]…These spiritual leaders, they do it as a calling and out of the kindness of their hearts but it's often not reimbursable in the medical [U.S. healthcare] realm."

– Tribal health leader

VIII. Best Practice 8. State approaches to measuring and addressing disparities

A. Introduction

The U.S. health sector has seen a renewed focus on advancing health equity in recent years. In 2022, CMS released its updated Framework for Health Equity, newly incorporating Medicaid into its comprehensive 10-year approach to address avoidable inequities and to eliminate health and health care disparities (OMH 2022). The Framework for Health Equity builds on the Healthy People 2000 Framework released in 1990—which first articulated health equity as a guiding objective for HHS—along with other CMS initiatives to address disparities. Similarly, some state Medicaid programs have launched efforts to review their policies for cultural and racial bias, examine disparities in access and outcomes, and develop action plans to improve equity (Tripoli et al. 2021).

The earlier evaluation of the MFP Demonstration that concluded in 2017 identified demographic differences between MFP participants and the broader MFP-eligible population. Medicaid data from 2012 indicate that, compared to the eligible population, MFP participants are younger (mean age, 60 years old compared to 76 years old), disproportionately Black and Hispanic/Latino (32 percent compared to 24 percent) and male (47 percent compared to 34 percent) (Irvin et al. 2017). The earlier evaluation examined outcomes, including participants' quality of life, rates of re-institutionalization, and other measures by state and by target population and disability type (i.e., older adults, people with physical disabilities, developmental disabilities, or mental illness), but the evaluation did not stratify these outcomes by participants' race/ethnicity. Although previous studies have examined disparities by age, sex, and disability type, few studies have examined racial disparities among beneficiaries who transition from receiving LTSS in institutions to home and community-based settings, due in part to insufficient or unreliable data on race and ethnicity. One study of Connecticut's MFP program indicated racial disparities in outcomes such as housing access and choice (Fabius et al. 2020).

This chapter highlights strategies states use to identify and address disparities in service engagement and use within MFP or broader LTSS programs. These findings emphasize racial/ethnic disparities but also note several efforts around linguistic, cultural, and geographic disparities. Two key themes discussed are (1) leveraging data to identify and improve awareness of disparities and (2) enhancing the ability of the workforce to address the unique needs of different communities. States were selected on the basis of self-reported survey data from MFP project directors on whether they have examined disparities in MFP participation or in the broader population of HCBS beneficiaries, and whether they are working to reduce such disparities and inequities. Notably, very few respondents to the survey indicated that efforts were underway in their state to examine or reduce program disparities. All six selected states indicated that MFP program efforts to address disparities are connected to broader state or health department efforts to contend with racial inequity and disparities and improve equity in service access.

Best Practice 8: "Other best practices and effective transition strategies demonstrated by States with approved MFP Demonstration projects…" (P.L. 116-260): state strategies for addressing health equity.

Research questions:

- How have states examined disparities in access or outcomes within their MFP programs?
- What promising strategies are states using to address disparities in access or outcomes within their MFP programs?

Selected states: Connecticut, the District of Columbia, Louisiana, Minnesota, Rhode Island, and Vermont.

Informants and mode: Virtual focus groups with MFP project directors and transition specialists in each study state.

B. Strategies to leverage data for identifying and improving awareness of disparities

To effectively identify and understand racial and other program disparities, states require both accurate and complete demographic data and advanced data analytic capabilities. However, most state Medicaid agencies grapple with incomplete or inaccurate demographic data on beneficiaries within the MFP program and for the broader Medicaid population. Federal guidelines prohibit state Medicaid agencies from requiring participants to self-report race and ethnicity data during Medicaid eligibility determinations, which limits the availability and accuracy of these data. Similarly, states are not required to collect or record MFP participants' race and ethnicity in case notes or other documentation during eligibility determinations or transitions. However, in calendar year 2021, race and ethnicity data were included in Medicaid data files for 83 percent of beneficiaries served by MFP programs nationwide; this varied widely by state, from 0 to 100 percent.[31] The next section discusses strategies selected states used to overcome this data challenge.

"We have a team available to analyze data, but we don't have anything to analyze… on the issue of race, that's been a problem for us."
–MFP project director

We note that each state is responsible for ensuring compliance with applicable federal and state laws and regulations governing the confidentiality of applicants' and beneficiaries' information, including, but not limited to: section 1902(a)(7) of the Social Security Act and its implementing regulations at 42 C.F.R. part 431, subpart F; the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191) and its implementing regulations at 45 C.F.R. parts 160, 162 and 164; and 42 C.F.R part 2 (governing confidentiality of substance use disorder patient records).

States invested in data infrastructure improvements to identify disparities among enrolled MFP participants or the broader HCBS populations. Selected states reported using varied data sources and linkages for identifying the demographic characteristics of MFP participants and LTSS users. Many of these approaches were happening at a broader programmatic level (e.g., for all HCBS waivers) within state Medicaid programs. These data infrastructure improvements and any resulting strategic initiatives are described below.

[31] Mathematica analysis of Beneficiary Summary T-MSIS Analytic File (TAF) data on December 8, 2021.

- **The District of Columbia** used beneficiaries' wards, zip codes, and quadrants in Medicaid claims data to supplement information on beneficiaries' race/ethnicity from Medicaid enrollment data, given racial and socio-economic segregation across the District's neighborhoods. The District used this data to identify disparities in utilization of services, noting that neighborhoods with a majority of nonwhite residents often lack sufficient HCBS. The District has begun to address this disparity through new LTSS options in these neighborhoods, like the Program of All-inclusive Care for the Elderly (PACE) programs.
- The District of Columbia previously established a data-sharing partnership with the Department of Behavioral Health to identify nursing facility residents without a permanent address who had received Department of Behavioral Health services in the community. This enabled the District to target and tailor HCBS to individuals in insecure housing situations.
- **Rhode Island** used the Minimum Data Set resident assessment instrument, which contains information on all nursing facility residents, to supplement race and ethnicity data received through MFP program referrals. Program staff used these data to better understand the demographic composition of the broader nursing facility population and whether the MFP program is serving the intended population.
- **Connecticut** integrated demographic data gathered from LTSS users as part of its universal assessment form and is investing in data cleaning for existing race and ethnicity data.

Investing in health information technology staff has strengthened data infrastructure efforts. For example, Vermont employed both a project director and a senior staff member focused on data, two roles previously combined in a single position. Two states noted that the lapse in MFP funding and short-term continuations posed a challenge to hiring and maintaining dedicated staff, but the MFP funding extension through 2023 allowed them to hire new staff focused on improving data quality and infrastructure.

States have supported research to understand the extent of disparities and are using these findings to inform interventions. Minnesota is using MFP state-equivalent funds to improve the MFP program's understanding of disparities in access to and use of HCBS by incorporating MFP program data into planned and ongoing research studies within the broader state health care system. An informant in Connecticut noted that an article on racial differences in choice and control among older adults in Connecticut's MFP program published in the *Journal of Aging & Social Policy* in 2020 (Fabius 2020) was influential in jump-starting their efforts to address disparities within the MFP program.

"MFP is really about supporting marginalized populations, period. That's why we exist."
– MFP project director

At least two states are maintaining dashboards on HCBS and/or transitions through waiver programs, broken out by participants' demographic characteristics. Connecticut is developing a dashboard to share data with providers who participate in their state's health information exchange; the dashboard will include demographic characteristics, such as race and ethnicity. The purpose of this strategy is to improve awareness among providers about who they are transitioning through the MFP program. Minnesota maintained a public dashboard with demographic data, capturing information on the language, race, and age of LTSS users receiving HBCS and those in institutional settings. This dashboard showed trends in the beneficiaries' demographics over time and across settings. The state also maintained a dashboard of LTSS performance measures that can be viewed by race/ethnicity and age.

Transition specialists did not report accessing or using race and ethnicity or language data to inform their work. Transition specialists from two selected states described how demographic data was used to

make programmatic decisions in their state but noted these data were used at a “higher level” and did not inform their day-to-day work. Transition specialists did not access data on the racial/ethnic makeup of their transitioned participants. One transition specialist in Connecticut, for example, noted that they received a quarterly report that compiles information on their transition benchmarks, transition challenges, readmissions, and participant outcomes—but the report did not provide race/ethnicity data or data on other potential sources of disparities.

C. Strategies to enhance the ability of MFP service providers to provide culturally and linguistically appropriate services

As discussed in Chapter III, successful transitions involve person-centered practices and trusted relationships between service providers and participants. Lack of cultural and linguistic understanding and representation within the MFP staff team—as well as unconscious bias—can pose a barrier to participant engagement and affect participants’ experience of care and outcomes. States emphasized the importance—and challenge—of building a workforce that understands and reflects the communities they serve, including transition specialists, HCBS program staff, and front-line providers. This section highlights strategies used by states to reduce unconscious bias and increase the diversity of their workforce.

Intentional hiring efforts were intended to increase linguistic, racial, and cultural concordance between staff and MFP participants. Transition specialists and project directors from four selected states noted that participants valued being able to work with staff that understand their primary language and cultural frame of reference, but transition specialists, case managers, and other providers often do not reflect the diversity of the communities they work with. Three of the four states reported recent efforts to improve the linguistic and racial/ethnic diversity of providers. For example, Vermont reviewed their job postings to reduce unintentional bias and has encouraged providers to do the same, and Rhode Island hired a Spanish-speaking staff member to reduce reliance on translation services. Cultural competency often extends beyond one’s racial/ethnic background. For example, Louisiana noted the importance of strategically assigning transition specialists to regions where they understand the culture and geography, such as the unique culture of New Orleans. In New York, one transition specialist noted the benefit of hiring staff with experience living with a disability and reported hiring a former MFP participant from their peer program as a transition specialist.

> **“At the state level, we’ve been talking about how we hire and how providers hire. Job descriptions can be unconsciously biased. We’ve been making an effort on this [which] has led to a change in who we see apply to job postings.”**
> ***–MFP project director***

States targeted training efforts to improve the provision of culturally and linguistically appropriate services. Selected states reported the following two examples:

- **Connecticut** developed a Trauma Informed Care Racial Equity Lens Initiative Training for Medicaid HCBS providers and provided incentives for providers to participate in it by including it as a component of a value-based payment program. Connecticut used state funds from the American Rescue Plan Act of 2021 to operate this program (highlighted in the state spotlight below).
- **The District of Columbia** delivered language access plan trainings to staff employed by Medicaid providers in the District and monitors providers’ implementation of language access plans, which detail how to provide services to individuals who are not English speakers or have only limited English proficiency. These actions to reduce linguistic barriers to services were previously required under the District's Olmstead Community Integration Plan (DC ODR 2017).

Spotlight on State Strategy: Connecticut's Racial Equity Training

Connecticut launched its Trauma Informed Care Racial Equity Lens Initiative Training for Medicaid HCBS providers in December 2021. The web-based training program includes courses on (1) Health Literacy and Self-Management, (2) Cultural Humility, (3) Implicit Bias, and (4) Racial Microaggressions, available in both English and Spanish. Completion of this training is a required benchmark for Connecticut's Provider Value Based Payment Initiative. Providers who completed this training and executed data-sharing agreements with Connecticut's Health Information Exchange received a one percent supplemental payment on claims. Approximately one-third of all eligible providers—such as nursing facility staff, transition coordinators, and personal care aides—completed this training in the first three months it was offered.

IX. Best Practice 9. Opportunities and challenges to integrating effective Money Follows the Person practices and state strategies into the traditional Medicaid program

A. Introduction

States have used the MFP Demonstration to test which services and supports are most important to ensure successful transitions and determine which policies and procedures are needed to expand access to HCBS for all Medicaid-eligible individuals who need LTSS. To identify opportunities and challenges to integrating effective MFP practices and strategies into regular Medicaid programs, this study analyzed (1) responses to the MFP project director survey on this topic and (2) states' sustainability plans and other MFP program documents.[32] This chapter presents findings on opportunities and challenges to integrating effective MFP practices and state strategies into ongoing state Medicaid program policies and operations.

Best Practice 9: "Opportunities and challenges to integrating effective Money Follows the Person practices and State strategies into the traditional Medicaid program" (P.L. 116-260).

Research questions:

- What are opportunities to integrating effective MFP practices and state strategies into state Medicaid programs?
- What are the challenges to integrating effective MFP practices and state strategies into state Medicaid programs?

Informants and mode: Analysis of responses to MFP project director survey, states' MFP sustainability plans and program documents, and findings from informants for Best Practices 1-7.

B. Opportunities for successfully integrating MFP policies and strategies into the state Medicaid program

States leveraged the flexibilities under MFP to test new transition services and supports and new ways to deliver them. If these new services or delivery systems produced positive results, many states integrated them into existing Medicaid HCBS programs, illustrated by the examples below.

State Medicaid agencies added transition coordination services to their state plans or section 1915(c) waiver programs to expand access to HCBS. More than half (18) of the 32 states that responded to the MFP project director survey made transition services available to individuals not eligible for MFP. Many of these states (Colorado, Connecticut, the District of Columbia, Idaho, North Carolina, North Dakota, South Dakota, and Washington) did so by permanently adding transition coordination services to the benefit package of one or more section 1915(c) waiver programs, making these supports available to all eligible Medicaid beneficiaries. Colorado permanently implemented community transition services and supports into their Medicaid state plan, including transition coordination services such as options counseling and identification of service providers.

States changed section 1915(c) HCBS waiver program requirements allowing HCBS to be authorized during pre-transition planning. Two states altered prior authorization requirements in existing section 1915(c) waiver programs to allow beneficiaries to access pre-transition planning while in the institution.

[32] Sustainability plans were developed by states and submitted to CMS with the intent to detail the state's future rebalancing efforts.

Louisiana pre-authorized intense transition support coordination into its waiver programs to allow these services to be billed for up to 6 months prior to a resident's transition from a nursing facility and enrollment in an HCBS waiver program. The District of Columbia streamlined its process for determining eligibility for the Elderly & Persons with Physical Disabilities Waiver program by adding a transition program code, which allowed nursing facility claims to be paid and community transition waiver services to be pre-authorized at the same time; this allowed transition planning to begin while an individual is still in the facility.

States used MFP grants to fund one-time costs to meet the immediate needs of individuals transitioning to the community. Several states added home modifications and one-time household set up costs—such as furnishing and initial pantry stocking—to the services covered by section 1915(c) waiver programs, after seeing their value to successful transitions under the MFP program. More than three quarters (26) of the 32 states that responded to the MFP project director survey used MFP supplemental, demonstration, or state-equivalent funds to cover one-time expenses—such as rental deposits and home modifications—that were not covered by existing state plan benefits or section 1915(c) waiver programs but were necessary for an institutional resident to re-establish a home in the community. The District of Columbia and Ohio decided to add these transition-related costs into their section 1915(c) HCBS waiver programs more broadly. Louisiana amended its Elderly Disabled Adult section 1915(c) HCBS waiver program to fund environmental accessibility adaptations (EAA) necessary to accommodate individuals' safe transition to their homes. After determining that the lifetime limit of $1,500 for EAAs did not adequately meet the needs of all individuals transitioning home, Louisiana instituted a one-time exception policy for all waiver recipients. This policy allowed individuals to go above the $1,500 budget allocation to cover EAAs integral to their transition home.

States operating MLTSS programs instituted requirements in managed care plan contracts to sustain promising practices developed through MFP. Several states with MLTSS programs have already integrated financial incentives into their programs, which motivate managed care plans to minimize their members' institutional length of stay. For example, Idaho, New Jersey, and Rhode Island Medicaid agencies use a blended rate to set monthly capitation payments, which incentivizes managed care plans to support members who need LTSS in less costly home and community settings. These states also added transition coordination functions to the roles of managed care plans' service coordinators.

In California, the California Advancing and Innovating Medi-Cal (CalAIM) Initiative which began in January 2022, includes a broad range of delivery system reforms designed to improve Medicaid beneficiary outcomes. One of the CalAIM initiatives will require managed care plans to provide enhanced case management (ECM) services, including comprehensive transitional care starting in January 2023, to institutional residents transitioning to the community. Should the state MFP program end, ECM services would sustain the states' capacity to transition institutional residents to the community once managed care plans are required to cover institutional long-term care services and the state begins to phase in mandatory enrollment of institutional residents into managed care plans. New Jersey amended its managed care contracts to require plans to employ at least one housing specialist to assist members in securing housing. Under MFP, Texas implemented a behavioral health pilot program to help adults with behavioral health conditions who wish to relocate to the community from nursing facilities. These individuals had access to two new MFP Demonstration services—cognitive adaptation training and substance use treatment services—as well as behavioral health benefits provided through the Medicaid state plan. Based on pilot program outcomes, Texas integrated these elements into the array of services offered under the managed care program.

Funding opportunities under MFP were optimized to support broader, long-term strategic rebalancing efforts. In some states, MFP funding was used to support broader strategies for rebalancing the state LTSS system. In Connecticut, for example, the State Strategic Rebalancing Plan proposed a framework for a comprehensive re-design of HCBS, covering housing, transportation, workforce development, and discharges from nursing facilities. Connecticut cited MFP funds as a critical resource to support transition services as part of its broader LTSS rebalancing effort.

C. Challenges to integrating effective MFP policies and strategies into the state Medicaid program

Although many states were successful in integrating MFP policies and strategies into their state Medicaid programs, states noted several challenges to permanently incorporating these policies into state programs.

Some states with MFP programs have not yet been able to secure funding for ongoing services or revise eligibility requirements for transition services. Some states have been unable, so far, to add MFP Demonstration services to state plan benefits or 1915(c) HCBS waiver programs because of lack of funding, challenges operationalizing payment mechanisms for pre-transition services, and eligibility requirements. For example, in Kentucky, the MFP project director reported challenges securing permanent funding to expand transitional services beyond the Supports for Community Living waiver. Five of 32 states (Louisiana, Minnesota, Nevada, North Carolina, and Vermont) reported in the project director survey that they lacked sufficient funds to expand transition services or other HCBS. Waiver eligibility requirements in Maine made it challenging for participants to obtain pre-transition services and supports while living in an institution.

Shortages of affordable and accessible housing make it difficult to expand transition services to a larger group of Medicaid beneficiaries. The shortage of appropriate housing for LTSS beneficiaries restricts state Medicaid programs from helping more people in institutions move to the community. As reported in Chapter V, 93 percent of respondents reported that challenges identifying affordable, accessible housing substantially or moderately impacted the delivery of HCBS in their state; respondents in two states (California and Wisconsin) said the shortage of available and accessible housing has impacted their efforts to expand transition services within the state Medicaid program. States have had success leveraging MFP resources to address housing challenges, as discussed in Chapter V.

Likewise, shortages in the direct care workforce hinder the expansion of transition services and HCBS. Several state MFP program directors also cited direct care workforce shortages and high turnover as a major impediment to broadening access to HCBS. In their sustainability plans, states noted that many regions were impacted by direct care worker shortages, lack of training, lack of supervision, and high turnover. In most states, the COVID-19 pandemic exacerbated these workforce challenges. Vermont reported that COVID-19 has worsened systemic workforce challenges, which hindered integration of services into their Medicaid program. Several MFP participants noted challenges identifying or retaining direct care workers as an impediment to timely transitions; one participant noted her transition was significantly sped up due to a personal connection with a staff member at a home healthcare company. The demand for direct care workers will likely continue to grow due to aging populations, increased preferences

for living in the community, and states' rebalancing initiatives (MACPAC 2022b). CMS and states continue to explore strategies for strengthening the direct care workforce to increase access to HCBS. [33]

[33] CMS has developed numerous resources pertaining to improving the recruitment, training, and retention of the direct care workforce, including information on workforce development through MFP. More information is available at: https://www.medicaid.gov/medicaid/long-term-services-supports/workforce-initiative/overviews-of-workforce-challenges-and-effective-improvement-strategies/index.html. Of note, the Direct Care Workforce Learning Collaborative Summary identifies innovative state Medicaid agency strategies for addressing common workforce challenges for HCBS.

X. Conclusion

As of 2024, the Money Follows the Person Demonstration has been operating for 17 years and is one of the longest federal demonstrations in the Medicaid program's history. During that time, Congress relaxed eligibility rules for MFP participation twice, and extended funding for MFP grant awards seven times. In December 2022, Congress authorized the eighth extension of MFP funding through the Consolidated Appropriations Act, 2023, appropriating $450 million per year through FY 2027.

Over the course of the MFP Demonstration, state MFP programs have tested and adopted new approaches to improve transitions of Medicaid-eligible institutional residents to home or community settings. As a result, the cumulative number of transitions through MFP grew from almost 1,500 in 2008 to more than 107,000 at the end of 2020. Compared with other institutional residents who transitioned to the community, MFP participants had statistically significant lower institutional care use within 180 days of transition, were less likely to be readmitted to long-term care institutions, and reported fundamental and sustained improvements in quality of life (Hargan 2017). Furthermore, previous evaluations of the MFP Demonstration show that participants' total Medicaid and Medicare costs declined in the two years following transition, contributing to state and federal cost savings (Irving et al. 2017, Li et al. 2019). State strategies have aimed to address the challenges involved in helping long-term residents of institutions find and secure affordable, accessible housing; establish a system of high-quality, coordinated long-term services and supports; and ensure that MFP participants are well integrated into the community.

This report identified a broad range of policies and procedures that illustrate best practices in state MFP program operations. States with the most successful transition outcomes apply person-centered approaches throughout the process. They inform all MFP-eligible individuals who reside in institutions about their option to move to the community and explain the potential benefits and challenges of doing so. They develop transition plans that are tailored to each person's unique needs and care goals, and they ensure ongoing service coordination and monitoring to assess whether and how well the services and supports meet each person's needs.

States with high-performing MFP programs also maximize the use of MFP grant funds to cover transition costs and pay for a wide range of HCBS, or more intensive HCBS, than Medicaid programs normally would. These states have also made concerted efforts to strengthen the HCBS infrastructure by investing in the direct care workforce and collaborating with public housing authorities.

By using the MFP Demonstration to test the value of new approaches, many states have adopted Medicaid policies and benefit packages into their ongoing HCBS program operations in order to ensure that all institutional residents, including those that do not qualify for MFP, can choose to live in community-based residences. For example, more than half of states with active MFP programs now cover transition services in their section 1915(c) HCBS waiver programs, and several have added specialized services, such as enhanced behavioral health supports, to better support beneficiaries with complex needs. Although some states have yet to incorporate MFP transition services and supports into existing HCBS programs, most have integrated continuous quality improvement approaches into ongoing HCBS program operations that could extend beyond MFP grant funding.

State participation in the MFP Demonstration has fluctuated over time; almost a dozen states ended or suspended their MFP programs from 2016 through 2020 when the MFP Demonstration was operating under a series of short-term funding extensions. During this period, some states integrated transition services comparable to MFP into state plans or waivers.

The revitalization of funding opportunities for MFP grantees in recent years has enabled states to further expand access to HCBS through Medicaid. In September 2020, CMS announced the availability of supplemental funds to support capacity-building initiatives for states that operate MFP-funded transition programs. CMS awarded $149 million to 32 states to accelerate long-term care system transformation and expand HCBS capacity. For example, California is using this funding to conduct a gap analysis of their HCBS and MLTSS networks, and Rhode Island is using the funding to develop new accessible housing and expand effective supportive housing models.

Recent funding opportunities have also enabled states *not* active in the MFP Demonstration to launch new programs or rejoin the demonstration. In August 2022, CMS awarded approximately $25 million through a funding opportunity to expand access to HCBS through the MFP Demonstration. The grants were made to five states and territories to support the initial planning and implementation of their programs and HCBS capacity-building: American Samoa, Illinois, Kansas, New Hampshire, and Puerto Rico. These awards bring the total number of active states and territories participating in MFP to 41, as of February 2024.

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