Money Follows the Person Demonstration: Overview of State Grantee Progress, July-December 2010

May 2011

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EXECUTIVE SUMMARY

The Money Follows the Person (MFP) Demonstration, established by Congress through the Deficit Reduction Act of 2005 (DRA), provides state Medicaid programs the opportunity to help Medicaid beneficiaries living in long-term care institutions transition back to the community. The Centers for Medicare & Medicaid Services (CMS) awarded MFP demonstration grants to 17 states in January 2007 and to 14 more states in May 2007. In February 2011, CMS awarded 13 MFP grants to another 13 states for a total of 44 grants.

Each state participating in the MFP demonstration must establish a program that has two components: (1) a transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and helps them do so and (2) a rebalancing initiative designed to restructure state Medicaid long-term care systems so they rely less on costly institutional care and individuals have a choice of where they live and receive services.

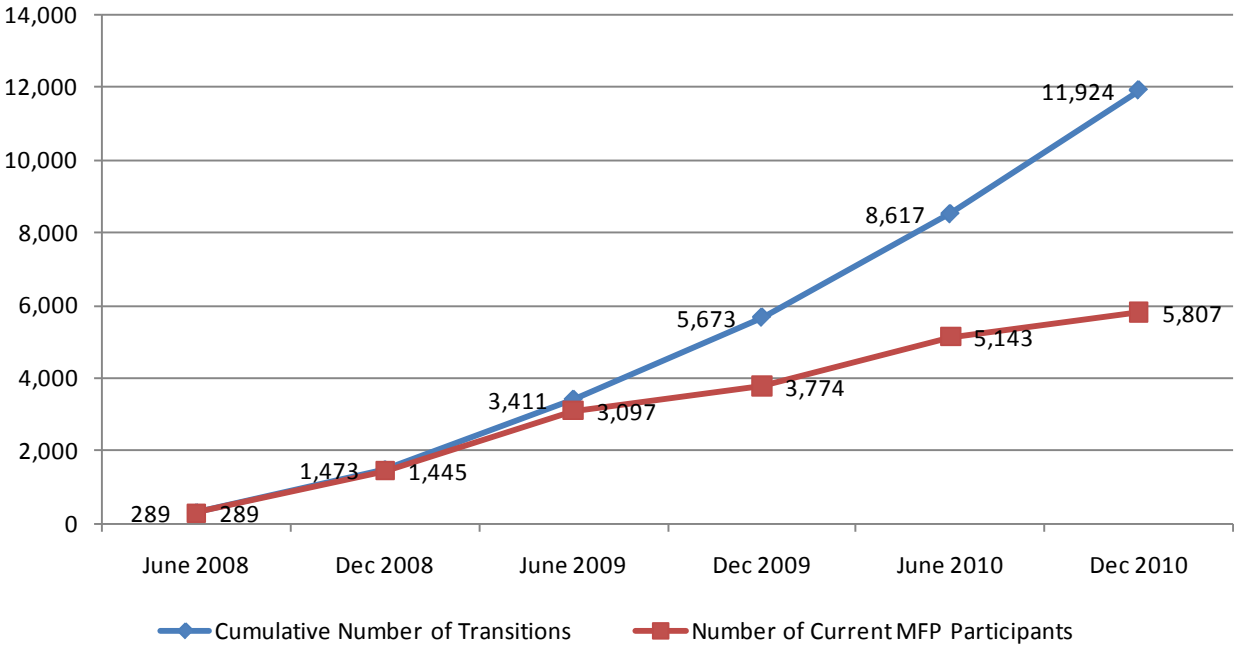
This report summarizes the implementation progress of 30 MFP Demonstration grantee states (29 states and the District of Columbia) awarded grants in 2007 for the six-month period from July 1 to December 31, 2010 (referred to as "this reporting period").[1] This summary is based on data and information reported by state grantees in their 2010 end-of-year progress reports, which were submitted at the end of February 2011 or early March 2011.

Enrollment in MFP grew steadily throughout 2010, the third full year of program operations, continuing a trend of steady growth over the past two years. The cumulative number of transitions to the community through the MFP program as of December 31, 2010, was 11,924, a 40 percent increase since June 30, 2010 six months before (see Figure 1). Overall, states reported 3,407 transitions during the six-month period from July through December 2010, 20 percent more than the number transitioned in the previous six-month period (2,844). The number of MFP transitions for the entire calendar year 2010 (6,251) exceeded state grantees' total transition goal (5,723) by nearly 10 percent.

This report summarizes state MFP grantee progress in three areas. Section I describes states' progress on key program performance indicators related to MFP transitions, including number of people in each population group transitioned during the six-month period, transitions relative to targets, cumulative number of transitions since the start of the program, number of individuals assessed, and reinstitutionalizations. Section II summarizes state grantees' achievement of goals established for qualified Medicaid home and community-based services (HCBS) spending through 2010. Section III discusses state grantees' major accomplishments and challenges in implementing the MFP demonstration during the six-month period.

[1] One of the initial 2007 grantee states received a grant but has not yet implemented its program.

Figure 1. MFP Transitions and Current MFP Participants, June 2008 to December 2010



I. KEY PERFORMANCE INDICATORS—MFP TRANSITIONS AND ENROLLEES

A. Number of New and Cumulative Transitions (Table 1)

From July to December 2010, state MFP grantees reported enrolling 3,407 new MFP participants, those who transitioned to the community for the first time, a 19.8 percent increase from the number transitioned during the previous reporting period (2,844). For all of 2010, 6,251 individuals transitioned to the community through MFP, and the cumulative number of transitions stood at 11,924 as of December 31, 2010.

The volume of new transitions during this reporting period varied by state, ranging from 811 in Texas (about a quarter of the total) to only 7 each in Delaware and the District of Columbia (Table 1). Among those who transitioned during this period, 39.1 percent were individuals with physical disabilities, 36.7 percent were elders, 17.8 percent were individuals with developmental disabilities, 3.6 percent were individuals with mental illness, and 2.8 percent were "Other" individuals. Of the number of individuals who enrolled in MFP and transitioned to the community during the period, 6.4 percent (219 individuals reported by nine states) had institutional stays between 90 and 180 days.[2] However, the actual number transitioned with shorter institutional stays, between 90 and 180 days, is likely to be higher because many states are not yet able to collect and report transitions by length of time in institutional care.

Cumulative transitions as of December 31, 2010, totaled 11,924, more than double the number from the previous year (5,673 transitions as of December 31, 2009). Of those who have transitioned to the community to date, 35.9 percent were individuals with physical disabilities, 34.3 percent were elders, 25.8 percent were individuals with developmental disabilities, 2.2 percent were individuals with mental illness, and 1.8 percent were "other" individuals. There is considerable state variation in the number of cumulative transitions, ranging from 38 in Delaware to 3,579 in Texas, which accounts for 30 percent of the total number transitioned to date. Five states together comprised 32 percent of total transitions: Washington, Ohio, Maryland, Michigan, and Pennsylvania (listed in rank order). The remaining 24 states contributed the other 38 percent of total cumulative transitions to date. Variation in program size reflects, among other things, the length of program operation, the size of the eligible population in each state, and state capacity and experience in operating transition programs of this type.

Parallel Transition Programs. Table 1 also shows the number of people who transitioned from institutions to home or community-based settings through programs *other than MFP*, which we call "parallel transition programs." Individuals who transitioned through these programs were generally ineligible for MFP for one of several reasons: (1) they were not eligible for Medicaid, as in Delaware, Georgia, and Pennsylvania; (2) did not meet MFP's minimum

[2] In March 2010, the federal Patient Protection and Affordable Care Act changed MFP eligibility rules by lowering the minimum residency period in an institution from six months to 90 days, not counting days for Medicare-covered rehabilitation. Starting with the progress report for the January to June 2010 period, grantees were asked to report data separately on the number of MFP participants who met the new Affordable Care Act requirements.

residency period of six months (now 90 days); or (3) chose to move to a type of community residence that does not qualify for MFP.

To gauge the number of people that cannot enroll in MFP because they do not meet its eligibility criteria, grantees are asked to provide an approximate number of individuals who transitioned through these programs. Seventeen grantees reported having parallel nursing home transition programs in their states, 12 of which estimated that a total of 4,130 individuals transitioned to the community through these programs; more than half (53.8 percent) were from one state (Washington). Twelve states reported having a parallel transition program for individuals residing in intermediate care facilities for the mentally retarded (ICFs-MR), six of which estimated that 134 individuals with developmental disabilities transitioned to the community during this period through these other programs. These totals are likely to underestimate the number of people that transitioned through parallel transition programs, because many states do not keep accurate track of these numbers or do not report this information through the MFP progress reporting system.

B. Achievement of Annual Transition Benchmark Goals (Table 2)

As of December 31, 2010, MFP grantee states exceeded their aggregate transition goal for 2010 by nearly 10 percent (6,251 transitions of 5,723 planned, which is 109.2 percent of the total annual goal).

States' achievement of the annual transition goal was markedly improved over the previous year, when MFP grantees realized only 52.7 percent of the 2009 annual aggregate transition goal. At least some of this improvement can be attributed to a revision in CMS policy, which will begin to hold states accountable for meeting their transition goals. Starting in 2011, CMS can withhold the disbursement of MFP grant funds for those states falling far short of their goals. As a result, many states reduced their annual transition goals for 2010 and subsequent years.

States varied in the degree to which they reached their 2010 transition goals (Table 2). Seventeen states met or exceeded their total transition goals for 2010, two of which (Texas and Virginia) exceeded their annual goals by the middle of 2010. Five states (California, Illinois, Iowa, Kentucky, and Michigan) achieved between 50 and 99 percent of their 2010 goals.

The remaining eight states (Delaware, District of Columbia, Hawaii, Louisiana, Nebraska, North Carolina, Oregon, and Wisconsin) achieved less than 50 percent of their 2010 transition goals, three of which (District of Columbia, Nebraska, and Wisconsin) achieved less than 25 percent of the 2010 goal. Oregon achieved 41 percent of its 2010 goal, partly because they suspended enrollment in their program in the fall after key management staff resigned; the state is reassessing its program and it is not yet known when they plan to resume operations. In the other seven states, the gap between goals and actual transitions suggests they need to (1) increase transition volume significantly by investing substantially more resources or adjusting the program design; or (2) reduce transition goals for subsequent years through amendments to their operational protocols, so as not to jeopardize their ability to continue receiving MFP grant funds.

Largely because the Affordable Care Act extended the MFP Demonstration program for another five years to 2016, more than two-thirds (23) of all state MFP grantees reported that they intend to change their transition goals in 2011 or subsequent years (several more notified CMS of plans to change transition goals since submitting progress reports). Ten states (District of

Columbia, Louisiana, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, and Virginia) said they had already or might increase their transition goals, overall or for certain populations. The increase in transition goals is spurred by (1) additional capacity supported through federal administrative funds, (2) plans to add new target populations; (3) increased outreach and marketing efforts, (4) increased referrals from nursing home implementation of new Minimum Data Set (MDS) 3.0 Section Q responses, or (5) ICF-MR closures. Seven states (District of Columbia, Hawaii, Iowa, Kansas, Maryland, Oklahoma, and Wisconsin) might reduce their transition goals overall or for specific populations. Five states (Kentucky, Michigan, North Carolina, New Hampshire, and Virginia) intend to extend the time frame for meeting their original transition goals (to 2013 or beyond) or have added transitions beyond calendar year 2011. Four states (Arkansas, Delaware, Oregon, and Texas) had not yet decided whether or how they would revise transition goals.

Despite overall success in reaching transition goals, more than half (17) of all states reported difficulty reaching their transition goals during this period due to several factors (in rank order): (1) complex needs of the target population; (2) shortages of affordable and accessible qualified housing; (3) statutory restrictions on the types of residences that qualify for MFP; and (4) shortages of qualified community-based providers. These issues are discussed in more depth in Section III.

C. Number of Current MFP Participants (Table 3)

Current monthly MFP enrollment at the end of December 2010 stood at 5,807 (Figure 1 and Table 3), 12.9 percent more than the number of MFP participants enrolled at the end of the last reporting period (5,143) on June 2010, and an increase of 53.9 percent relative to the number enrolled at the same time last year (December 2009).

Current participants include everyone eligible for MFP-financed HCBS as of December 2010. This count excludes those who completed the 365-day period of eligibility, died after transitioning, were reinstitutionalized for 30 days or more, or withdrew from the program for other reasons. As shown in Table 3, there is a wide range across states in the number of current monthly participants—from a low of 12 in Delaware to 1,654 in Texas. A total of 1,670 MFP participants completed the 365-day transition period during the reporting period.

D. Number of Individuals Assessed (Table 4)

MFP grantee states reported a total of 6,229 individuals assessed during the reporting period, of which 67.6 percent were in the transition planning process and expected to transition to the community in the future, though not all of them will enroll in the MFP program.

The number of individuals assessed varied widely by state, ranging from 8 in the District of Columbia to 1,132 in Michigan, which alone accounted for 18.2 percent of all assessments during the reporting period.[3] Of the number of individuals assessed during this period, 7.2

[3] Due to differences in how states define and track assessments, the numbers are not comparable across states. In some states, an assessment counts anyone who is initially screened and determined to meet Medicaid eligibility and who signs an MFP informed consent form, but other states use broader criteria. The reported number of

percent (450 individuals reported by eight states) had shorter institutional stays -- between 90 and 180 days. However, the actual number assessed with institutional stays less than 180 days is likely to be higher because many states have not established mechanisms to collect and report the length of time in institutional care.

Among those assessed for MFP, nearly half (45.4 percent), or 2,831 individuals, were *unable* to enroll in MFP for various reasons. The most commonly cited reason (940) was "other," which encompasses a wide range of factors.[4] The second most cited reason (823) was that the individuals *did* transition to the community but did not enroll in MFP because they were ineligible or chose not to enroll. The third most cited reason for not being able to transition to the community was that the individual's physical health, mental health, or other service needs or estimated costs were greater than what could be accommodated in a community-based setting, accounting for 776 individuals. Of the individuals who could not be accommodated in the community, more than one-third (38.8 percent) were reported by one state (Connecticut).

E. Reinstitutionalizations (Table 5)

About 12 percent (677) of current MFP participants were reinstitutionalized for any length of time from July to December 2010. Of those, 272 (40.2 percent of all who were admitted to an institution) were reinstitutionalized for more than 30 days, more than half of whom were elders (141). During this reporting period, 84 people who had at any point been reinstitutionalized for more than 30 days were reenrolled in the MFP program.

As defined in the progress reporting system, reinstitutionalization means any admission to a hospital, nursing home, ICF-MR, or institution for mental disease, regardless of length of stay.[5] The incidence of reinstitutionalization is higher among elders, relative to individuals with physical disabilities and developmental disabilities. Of the total number of individuals reinstitutionalized for any length of time, 44.0 percent (298) were elders, greater than their share (33.5 percent) of current participants, and 38.6 percent (261) were individuals with physical disabilities, about the same as their share (37.0 percent) of current participants. In addition, 8.0 percent (54) of those reinstitutionalized for any length of time were individuals with mental illness, who make up 2.9 percent of total current participants; 7.2 percent (49) were individuals with developmental disabilities, who make up 24.2 percent of current participants; and 2.2 percent (15) were "other" individuals. Consequently, reinstitutionalization appears to be

(continued)

assessments in Texas equals the cumulative number of participants enrolled in the federal MFP program because the state cannot track MFP assessments separately from those assessed through a parallel transition program.

[4] "Other" was the largest single category of reasons for not transitioning through the MFP program. Based on grantees' notes, these other reasons include: waiting for HCBS waiver approval, did not submit documentation required for eligibility determination, withdrew MFP application before transition, moved out of state, refused to pay cost-share for waiver services, died in the facility before being able to transition, moved to a nonqualified residence, left the facility without leaving contact information, and did not meet the MFP institutional length-of-stay requirement due to Medicare rehabilitative covered care.

[5] At the time grantees were completing their progress reports, if an MFP participant was admitted for more than 30 days, CMS required that person to be disenrolled from MFP. These individuals may re-enroll in MFP without meeting the minimum institutional residency requirement.

disproportionately high among those with mental illness and the elderly, and disproportionately low among those with developmental disabilities.

Grantees reported that a decline in the individual's physical or mental health status was the most common factor contributing to reinstitutionalization. Other reasons included short-term hospitalization (which may or may not have been followed by a subsequent nursing home admission) attributable to acute events such as stroke, infections, inability to manage medications, falls, pneumonia, or severe flu; participants' or families' requests to return to institutional care; participants' noncompliance with a safety plan or inability to maintain safety due to inadequate supports; lack of family or other informal supports in the community; inability to manage behavioral issues; and loss of subsidized housing in the community.

F. Self-Direction (Table 6)

Sixteen of the 24 MFP grantee states that offered self-direction options during the reporting period[6] had participants who chose to self-direct their care. Among the 5,807 current participants as of December 2010, 17.7 percent (1,029) were reported to be self-directing at least one type of HCBS.

Louisiana was the only state that added a self-direction option this reporting period as a pilot test in one region, and it has plans to expand statewide in spring 2011. Of the 1,029 participants who self-directed services during the reporting period, 48.7 percent hired or supervised their own personal care assistants and 47.8 percent managed their own allowance or budget (the two categories are not mutually exclusive). For the remaining 3.5 percent, states did not indicate which of the two types of self-direction participants chose. Thirty-six MFP participants in four states withdrew from a self-direction program during the reporting period. Reasons for withdrawal included an end to MFP eligibility, death, opting out of self-direction, returning to a nursing facility, problems with workers, and moving out of state or to a different type of living situation. The number of individuals self-directing is not comparable across states because of differences in what counts as self-direction. For example, Ohio's 425 self-directing participants accounted for 41.3 percent of the total for all states, but this number includes anyone managing the use of the one-time community transition services budget (an MFP supplemental service of up to $2,000 per participant), for rental deposits, home furnishings, and other expenses that arise at the time of transition to the community. Washington defines self-directing participants as those who hire individual providers or are enrolled in the New Freedom 1915(c) waiver program, which allows participants to direct a service budget.

G. Type of Qualified Residence (Table 6)

Among the 3,407 MFP participants who transitioned to the community during this period, 33.7 percent (1,147 individuals) moved to a home, 33.6 percent (1,145) moved to an apartment, and 19.9 percent (678) moved to a small group home. The type of residence for the remaining 12.8 percent, or 437 individuals, was unavailable at the time of this report.

[6] Two additional states reported that they planned to make a consumer-directed option available to MFP participants in the future. Oklahoma plans to contract with a fiscal management service in 2011. New Jersey is discussing how to make the state's two existing self-direction programs available to MFP participants.

Grantees report the type of residence to which participants moved upon transitioning to the community, rather than where they resided at the end of the reporting period. Grantees are not required to report living arrangement by population subgroup in the semiannual progress reports, but that information is available from other grantee data, which indicates that just under half of the elderly (48 percent) relocated to homes, and 75 percent of individuals with intellectual disabilities moved to small group homes. Among individuals under age 65 with physical disabilities, about a third moved to homes and another third to apartments. [7]

[7] Data derived from MFP Program Participation Files as reported in Lipson, Debra J., and Susan R. Williams. "Money Follows the Person Demonstration Program: A Profile of Participants." MFP Report from the Field #5, Princeton, NJ: Mathematica Policy Research, January 2011.

II. ACHIEVEMENT OF QUALIFIED HCBS EXPENDITURES GOALS (TABLE 7)

CMS defines qualified HCBS expenditures as **total** Medicaid HCBS expenditures (federal and state funds) for all Medicaid recipients, including expenditures for all 1915(c) waiver programs, home health services, and personal care if provided as a state plan optional service.[8] In addition, total qualified HCBS expenditures include all HCBS spending on MFP participants (qualified, demonstration, and supplemental services).[9]

Twenty-nine state grantees reported qualified HCBS expenditures for 2010 totaling approximately $46.6 billion (Table 7). Among the reporting states, actual 2010 spending as a percentage of 2010 benchmark targets ranged from 75 percent (Delaware and Georgia) to 418 percent (Connecticut). Eight states (California, Delaware, Georgia, Hawaii, Maryland, New Hampshire, Oklahoma, and Wisconsin) spent between 75 and 100 percent of 2010 HCBS spending targets. Twenty-one states reported HCBS spending that represented 100 percent or more of their 2010 targets; of these 21 states, 9 states (Arkansas, Indiana, Kansas, Michigan, Nebraska, New Jersey, New York, Pennsylvania, and Washington) spent between 100 and 110 percent of 2010 HCBS spending targets, and the remaining 12 states (Connecticut, Illinois, Iowa, Kentucky, Louisiana, Missouri, North Carolina, North Dakota, Ohio, Oregon, Texas, and Virginia) achieved more than 110 percent of HCBS spending targets. Fourteen states modified actual qualified HCBS expenditures that were reported in 2009 either to correct previously reported data or to reflect additional claims that were processed since the submission of an earlier report.

Eight states (Delaware, Louisiana, Maryland, Missouri, North Carolina, New Hampshire, New Jersey, and Oklahoma) indicated for different reasons that they plan to revise their annual benchmarks for qualified HCBS expenditures in subsequent years. The District of Columbia reported that these data were not available at the time its report was submitted.

Four states reported provisional or incomplete data on qualified HCBS spending. Two of these states (Maryland and Wisconsin) noted that reported expenditures are subject to change due to lags in claims reporting. Hawaii reported that it began using encounter data from its QUEST Expanded Access (QExA) Medicaid managed care program last year, and revisions are needed because the encounter data do not match the reporting structure for the MFP web-based progress report. North Carolina reported that PACE services are excluded from the qualified HCBS expenditures because it does not have the ability to extract the HCBS portion from the total capitated rate paid for participants in that program.

[8] Total HCBS expenditures also include spending on HCBS by capitated managed care plans that provide long-term care services when the state can identify HCBS-related expenditures separately from total capitated payments.

[9] Grantees are instructed to report total annual qualified HCBS expenditures once each year, on a calendar-year basis; 29 grantees reported qualified HCBS expenditures in their end-of-year reports.

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III. PROGRESS AND CHALLENGES, BY PROGRAM COMPONENT

During the second half of 2010, MFP grantees reported more accomplishments than challenges in most dimensions of the program. The types of accomplishments and challenges vary by state and are driven by differences in state capacity to transition individuals to the community, the needs of the target populations, and community-based service delivery systems. Despite reported progress, MFP grantee states continue to encounter systemic challenges related to state budget cuts; shortages of home and community-based services or providers; scarcity of affordable housing; and weaknesses in quality management systems. Key themes that emerged from their semiannual progress reports are described next.

A. State Budget Cuts

Slightly more than half of MFP grantee states (16) reported that the effects of the economic downturn on state budgets have adversely affected MFP programs. Although the economic climate has begun to improve in some states, many state grantees continue to be adversely affected by budget shortfalls, which in some states have led to across-the-board cuts to all state government programs, including Medicaid. Tightened budgets have caused staffing restrictions, cuts to HCBS funding, and reduced provider reimbursement rates that impair MFP progress.

Eight states reported hiring freezes, furloughs, lay-offs, and an early retirement program that have strained available staff resources and in some cases limited the MFP program's ability to make timely transitions or achieve its benchmarks (Connecticut, Hawaii, Iowa, Kentucky, Missouri, New Hampshire, Washington, and Wisconsin). Staffing restrictions did not always directly affect the staffing of the MFP program, but two states (Hawaii and Iowa) reported that staffing shortages caused lengthy delays or errors in determining Medicaid eligibility; another state (Wisconsin) reported that care management staffing restrictions at the county level have hindered nursing home transition efforts. Iowa reported that staff shortages at its state resource centers for people with intellectual disabilities caused delays in referrals to the MFP program.

Additional federal administrative funds offered some relief to offset the effects of state budget cuts. For example, one state (Washington) reported an easing of staffing challenges after it obtained approval to hire additional MFP-dedicated staff with 100 percent federal administrative funds. States also took advantage of federal administrative funds to improve MFP participant access to HCBS, and hire transition coordinators and housing specialists, as explained below.

A number of states indicated their MFP programs have been affected by cuts to the Medicaid HCBS budget or to HCBS provider reimbursement rates. California reported significant cuts to the Medicaid budget for HCBS. Iowa reported that providers are exempt from the mandated rate reductions for the first 365 days of MFP eligibility, but all providers are subject to these reductions when the participant transitions into the waiver at the conclusion of his or her 365 days of MFP eligibility. Louisiana reported that rate cuts have made it difficult for providers to cover up-front costs for deposits, housing, and equipment. In Virginia, the economic downturn adversely affected MFP by making community agencies reluctant to serve as MFP transition coordination agencies, due to continued cuts to provider reimbursement rates and

services throughout the HCBS long-term care system. In Hawaii, both the developmental disability HCBS waiver and the QExA plans implemented service reductions, and the worsening state budget led to the closure of two case management agencies and the merger of several others.[10] Hawaii was concerned about the probable loss of experienced MFP transitional case management services; QExA plan staff will face a learning curve to effectively manage recently relocated individuals living at home. North Carolina reported significant cuts to case management and other community-based services; case managers are authorized to bill for only three hours of service per month, including pre-transition services, which has destabilized the community support structure. In addition, New Hampshire and Washington observed faster spend-down and enrollment into Medicaid, resulting in bigger caseload growth.

B. Availability of Medicaid HCBS Waiver Capacity and State Plan HCBS Services

Eighteen states reported at least some improvement in the capacity or range of benefits available through HCBS waivers or state plan services to serve MFP participants during or after the one-year transition period; only seven states reported difficulties in this area.

Five states increased the capacity of HCBS waiver programs to serve participants during their enrollment in the MFP program (California, Connecticut, New York, North Carolina, and Oklahoma) and three states reported that HCBS waiver enrollment increased after MFP participants completed one year of participation (Kentucky, Louisiana, and Oregon). Connecticut developed a 24-hour care model to help new MFP participants with community integration and provide for additional supervision immediately following discharge from an institution. In Oregon, rebalancing funds from MFP supported new or continuing slots in the waiver for those with developmental disabilities and new options and service rates for elders and individuals with physical disabilities. Louisiana added a self-direction option to its mental retardation and other developmental disability (MR/DD) waiver that will be implemented statewide. In Oklahoma, a new waiver for people with physical disabilities who have completed their first year in a community placement was approved and began enrolling MFP participants.

Five states reported seeking or receiving legislative authority for additional funding for HCBS waiver slots (Connecticut, Georgia, Kentucky, Louisiana, and Pennsylvania). In Louisiana, the legislature funded 210 slots in the Residential Options Waiver (ROW) for individuals with developmental disabilities for the first time during the 2011 state fiscal year; many of those slots are expected to accommodate MFP participants. Other notable accomplishments include Pennsylvania's approval to allow individuals transitioning from nursing facilities into a Program of All-Inclusive Care for the Elderly (PACE) to enroll in MFP, and Indiana's approval to include assisted living as an MFP service.

Seven states reported a variety of challenges to assuring that HCBS, whether covered by Medicaid waivers or state plan benefits, were available to MFP participants in this period. In three states, the problems were caused by state budget cuts; for example, California eliminated

[10] In Hawaii, the developmental disabilities and mental retardation waiver program provides HCBS to individuals with developmental disabilities and mental retardation who would otherwise receive such services in an ICF-MR. QExA is a capitated managed care program for all covered services, including primary, acute, HCBS, and long-term care.

the Linkages Program for transitional case management; Louisiana cut funding for certain types of Medicaid HCBS benefits; and New Hampshire might not approve funds for transitional case management, which is offered as a MFP demonstration service.

Several states plan to address challenges in making HCBS services available to MFP participants by increasing staff capacity or offsetting state funding cuts with federal MFP funds. Iowa, Hawaii, New Hampshire, and North Carolina began or planned to use federal funds to hire specialized staff, such as employment specialists, behavioral health experts, housing specialists, and behavioral health transition coordinators. Louisiana used 100 percent federal administrative funding to help regional offices and providers cover up-front transition costs.

C. Participant Access to Services (Table 8)

Most states reported both accomplishments and challenges in ensuring that MFP participants can access HCBS covered by Medicaid. Twenty-two MFP grantee states reported a total of 33 accomplishments, whereas 21 MFP grantee states reported a total of 42 challenges. The total number of reported challenges has increased over the past five reporting periods, reaching a high of 45 in the January–June 2010 reporting period but dropped to 42 during this reporting period (Table 8). Total accomplishments have been stable over time.

As in previous reporting periods, MFP grantee states have reported the most progress in improving access to HCBS for MFP participants in two categories: (1) increasing the number of transition coordinators (13 states) and (2) increasing the number of HCBS providers contracting with Medicaid (five states) (Table 8). Some of the increase in transition coordinators was made possible through approval of additional federal administrative funds (District of Columbia, Maryland, North Dakota, and Texas) and implementation of the MDS 3.0 Section Q changes (Ohio, Texas, and Virginia). Indiana's MFP program hired additional transition coordinators in response to increased referrals to the program. The number of states reporting new HCBS providers contracting with Medicaid was the fewest since July–December 2008. Three states reported improved transportation options (Nebraska, New Hampshire, and New Jersey); in Nebraska, a contract was awarded to provide nonemergency transportation and recruit additional providers, particularly in rural areas.

The three most common challenges to MFP participants' access to HCBS over time have been (1) insufficient supply of HCBS provider agencies, (2) limits on amount and scope or duration of HCBS, and (3) insufficient supply of specific types of HCBS. During this period, MFP grantee states reported the third biggest challenge in this area was an insufficient supply of direct service workers.

During this reporting period, 12 states reported that an insufficient supply of HCBS providers or direct service workers made it difficult to provide MFP participants with the necessary supports they need to live in the community. Georgia, Hawaii, Indiana, and North Carolina cited too few small group homes or foster homes; most of these states continue to make efforts to encourage larger group homes (e.g. 6 to 8 beds) to reduce bed size or open foster homes for participants. Georgia contacted the Department of Housing and Urban Development (HUD) regarding the possibility of developing small group homes using HUD 811 funds. States that reported a shortage of HCBS providers and/or direct service workers are pursuing a range of

strategies to address this problem. Arkansas worked with local chambers of commerce to identify potential HCBS providers, Iowa encouraged self-direction, and Kentucky assisted in locating and interviewing direct service workers. Four more states trained staff or family members on how to work with people with challenging behaviors or complex cases.

Fewer MFP grantees reported limits on HCBS benefits or a shortage of specific types of HCBS than in previous reporting periods. Nonetheless, eight states reported an insufficient supply of HCBS and/or limits on the amount and scope or duration of HCBS. In Louisiana and Hawaii, fiscal controls have reduced the number of hours of support participants can receive, making transitions more difficult. Maryland, Missouri, and North Carolina have budget cost caps in place that prevent them from transitioning more complex cases that can require up to 24 hours of care. North Carolina is working to supplement funding with state dollars and is reexamining the budget neutrality formula to allow for more support. Most of the other states reported there is little they can do at this point to address the issue given state budget constraints. In the meantime, Hawaii is closely monitoring the service plans, complaints, and critical incidents of MFP participants to ensure potential impacts of service restrictions are identified early. Finally, the lack of adequate behavioral and mental health services has hindered progress in Maryland and North Carolina. In response, North Carolina is developing a mental health service package for MFP participants and Maryland plans to hire a behavioral health consultant to recommend services to add to the waivers or state plan.

D. Securing Housing for Participants (Table 9)

Three-quarters of state MFP grantees (23) reported challenges related to procuring housing for MFP participants during this reporting period (Table 9). The two most frequently cited difficulties were an insufficient supply of affordable and accessible housing (17 grantees) and too few rental vouchers (14 grantees). Despite such challenges, states made some progress by hiring new housing specialists, developing new partnerships, and receiving HUD housing vouchers for non-elderly persons with disabilities.

Since the end of 2008, the number of MFP grantee states' achievements in securing community-based housing options for participants has been relatively constant, but the number of challenges has risen over the same time period. The most commonly cited accomplishments since 2008 have included (1) developing local or state coalitions to identify needs and/or create housing-related initiatives (2) increasing the number of rental vouchers, and (3) developing inventories of affordable and accessible housing. Yet, states have consistently cited the two most prevalent housing-related challenges since January 2008 as an insufficient supply of both (1) affordable and accessible housing and (2) rental vouchers. Although an increase in rental vouchers is frequently cited as an achievement, states such as Texas note that the increases are small in number relative to the demand.

During this reporting period, 56 percent (17) of MFP grantee states reported that shortages of affordable and accessible housing are impeding transition efforts, continuing the trend since 2008 as the most commonly reported housing-related barrier (Table 10). Maryland reported that the lack of affordable and accessible housing is the single most important barrier that prevents more MFP participants from transitioning to the community. Nearly half (14) of MFP grantee states reported a shortage of rental vouchers as a barrier to securing appropriate housing for MFP participants, and most of these states expressed concern closed or long waiting lists for public

housing, limited numbers of vouchers, and difficulty placing certain types of MFP participants. For example, Hawaii reported that the waiting lists for affordable, accessible housing and Section 8 vouchers are more than two years long. In California, transition coordinators reported difficulty finding housing that meets federal standards for people with developmental disabilities; in Michigan, there have been challenges finding wheelchair-accessible housing or placing younger adults with credit problems or criminal histories.

Public housing authorities (PHAs) in many MFP grantee states responded to HUD's Notice of Funding Availability (NOFA) in the spring of 2010 for over 5,000 nonelderly disabled (NED) housing vouchers. Awards for Category 1 vouchers were announced in October 2010 (during the June–December 2010 reporting period), and Category 2 awards, which are specifically dedicated to individuals relocating from institutions to the community, were announced in January 2011. Eight MFP grantee states (California, Maryland, New Jersey, North Carolina, Ohio, Pennsylvania, Texas, and Virginia) reported receiving Category 1 or 2 vouchers. Some states received a substantial number of vouchers; Virginia received 436 vouchers, California 135, Ohio 160, and New Jersey 100. However, public housing authorities in some MFP states—such as Indiana, Louisiana, and Missouri—that submitted applications were not awarded any vouchers. Hawaii reported that it could not apply for the HUD vouchers due to the small size of its MFP population. Although the award of these vouchers represents progress, Pennsylvania reported that because many currently available units do not meet HUD housing quality standards, MFP participants cannot use the vouchers.

In addition to increasing housing vouchers, six states (Maryland, Michigan, New Hampshire, New Jersey, Virginia, and Washington) have hired or expect to hire housing specialists, often paid for with federal administrative funding. Many MFP grantee states are also trying to strengthen partnerships with state and local PHAs. For example, Louisiana is developing relationships with state and local PHAs, including the Louisiana Housing Finance Association, by educating them about the housing needs of MFP participants. Connecticut reported a new formal partnership with a statewide association of real estate agents has already yielded 26 apartments. The District of Columbia reported weekly calls with the DC Housing Authority and a new housing partnership with NCB Capital Impact, a certified community development finance institution. In an attempt to bring all stakeholders to the table, Delaware plans to host a housing policy "Academy" to be attended by state housing authorities and other interested parties; the event is endorsed by the governor and state secretary of health and social services.

E. Quality Management and Improvement

Approximately two-thirds of MFP grantee states (21) reported improvements in their quality management systems. However, several states continue to experience difficulty obtaining the information necessary to identify needs in a timely manner and determine whether participants were receiving adequate services and support.

MFP grantee states improved quality management systems by (1) enhancing critical incident reporting and tracking systems, (2) improving intra- or inter-departmental coordination, and (3) enhancing or establishing new data collection instruments. As part of these improvements, four states (Connecticut, Indiana, Missouri, and Nebraska) enhanced their critical incident reporting and tracking systems to include new or additional information or populations. Ohio expanded

the team that monitors critical incidents to include community living administrators; in Georgia, Pennsylvania, and Texas new critical incident reporting and monitoring systems are currently under development. In Georgia, this work dovetails with the state evaluation of the MFP program and will be used to develop protocols to improve outcomes for MFP participants.

Following publicly reported quality problems in the first half of 2010, Washington convened a workgroup of state and CMS staff to identify and address gaps in its existing data and reporting systems for adult protective service reporting and critical incident reporting. The state is working to improve inter-agency communication in this area and has recently hired new staff to strengthen continuous quality improvement for all clients. Other states reporting improvements in intra- or inter-departmental cooperation include Arkansas, California, Kentucky, Louisiana, Missouri, North Carolina, and Texas. North Carolina also reported new regular meetings, inclusion of MFP staff on quality teams, or joint projects to develop new databases.

Twelve grantee states reported a number of challenges related to remediation or discovery processes. Primary issues relate to difficulty in determining whether participants were receiving adequate services and supports (California, Georgia, Illinois, Iowa, and North Carolina) and getting timely information when participants' health or welfare is at risk (California, Georgia, Illinois, Indiana, North Carolina, and North Dakota). States are addressing these challenges by conducting regular meetings with transition coordinators to discuss cases, identify risks and advise on how best to mitigate those risks. In Illinois, transition coordinators are not confident of their ability to address medical risk, so the state conducts 30-day and six-month post-transition reviews of case notes to ensure key action items are addressed. In Iowa, transition coordinators review provider plans for behavioral problem management after an incident occurs, and plans to hire a behavioral specialist and provide more training to support providers with these issues.

Several grantee states have also reported problems getting case managers or transition coordinators to document their contact with and status of participants, or to communicate with MFP staff in a timely way after an incident has occurred. States continue to educate providers, case managers, and transition coordinators about their documentation responsibilities. Georgia also included participants and families in its education and outreach efforts to remind them to contact the MFP program about problems because additional supports might be available.

IV. CONCLUSION – GAINING MOMENTUM

At the end of 2010, nearly all of the initial 30 MFP grantee states had been in operation for at least 18 months.[11] By that time, most states overcame early start-up problems and developed expanded capacity to help larger numbers of Medicaid beneficiaries with disabilities transition from institutions to home and community-based residences. As a result, by December 2010 the number of people ever enrolled in MFP stood at nearly 12,000, more than double the number of MFP participants ever enrolled one year earlier. While initial transition goals set by states in 2007 and 2008 exceeded this number, it is a testament to state program leaders that they achieved this milestone despite state budget shortfalls which made it hard to launch any new program during the last three years.

This progress reflects collaborative efforts by state and federal MFP program officials to remove barriers to transitions and target additional resources to critical gaps. At the state level, MFP program leaders worked with community partners, providers, consumers, and other state agencies to step up recruitment efforts, enlist and train more transition coordination agencies and staff, make it easier to find or secure affordable and accessible housing, and strengthen quality management and assurance systems. At the federal level, changes to MFP adopted in the Affordable Care Act of 2010 made more people eligible for the program by reducing the minimum residency period from 6 months to 90 days. CMS also made concerted efforts to provide more federal funds to states to enhance state program capacity; CMS approved requests from many states for 100 percent federal funding to pay for additional administrative staff to upgrade information system upgrades, deploy housing specialists, and provide behavioral health training and consultation among other activities. CMS also collaborated with HUD to target some new housing vouchers to MFP participants. While these efforts began to show payoffs in 2010, their full effect may not be apparent until 2011 or later.

In 2011, MFP enrollment is expected to rise again in most of the 30 current grantee states, assuming they can maintain and build on their momentum. A few established grantees like Connecticut are planning significant growth, and most states expect increased referrals to MFP due to implementation of MDS Section Q questions regarding nursing home residents' desire to return to the community. A larger number of MFP participants receiving services in the community will in turn increase the extra federal funds paid to states from the enhanced Federal Medicaid Assistance Percentage for HCBS provided during the first year after MFP participants return to the community. States are required to re-invest these extra revenues into broader long-term care system balancing initiatives. However, state fiscal problems may continue to dampen the ability of some MFP programs to ensure all long-term services and supports are available to allow individuals to remain safely in the community.

A new chapter in the MFP program will begin in 2011 with the addition of 13 states awarded new MFP grants in February 2011. This development also promises to boost MFP transitions. Some of these new states plan to begin operations by the middle of the year, although the experiences of many of the initial MFP grantees suggest it may take a while for them to put in place or scale up their capacity to transition large numbers of people.

[11] One state—Louisiana—did not start its program until the fall of 2009.

Table 1. Overview of MFP Grant Transition Activity

State	Cumulative Number of Transitions from Program Start to December 31, 2010						Number of Participants Transitioned from July 1 to December 31, 2010						Estimated Number of Individuals Transitioned Through Parallel NH Transition Programs This Period	Estimated Number of Individuals Transitioned Through Parallel ICF-MR Transition Programs This Period
	Cumulative Total	Elders	People with PD	People with MR/DD	People with MI	Other	Total Number	Elders	People with PD	People with MR/DD	People with MI	Other		
Arkansas	150	25	54	71	0	0	42	4	11	27	0	0	0	0
California	401	79	161	109	12	40	215	55	97	27	8	28	66	0
Connecticut	405	144	181	6	74	0	157	51	68	2	36	0	26	3
Delaware	38	14	20	2	2	0	7	1	5	1	0	0	18	0
Dist. of Columbia	75	0	0	75	0	0	7	0	0	7	0	0	0	0
Georgia	442	104	146	192	0	0	142	36	50	56	0	0	0	80
Hawaii	70	33	34	3	0	0	25	13	12	0	0	0	0	0
Illinois[a]	233	65	42	0	126	0	101	33	15	0	53	0	0	0
Indiana	287	124	163	0	0	0	157	63	94	0	0	0	0	0
Iowa	118	0	0	118	0	0	30	0	0	30	0	0	0	0
Kansas	343	96	132	103	0	12	129	38	77	8	0	6	0	0
Kentucky	156	30	35	63	0	28	73	9	14	35	0	15	0	0
Louisiana	90	33	26	31	0	0	22	13	0	9	0	0	0	33
Maryland	799	323	320	136	0	20	187	97	73	12	0	5	58	0
Michigan	640	345	295	0	0	0	123	66	57	0	0	0	569	0
Missouri	285	45	106	124	0	10	52	9	22	19	0	2	0	0
Nebraska	102	22	27	44	0	9	27	11	11	1	0	4	128	4
New Hampshire	72	23	22	5	0	22	13	4	3	2	0	4	0	0
New Jersey	157	70	4	83	0	0	39	26	0	13	0	0	0	0
New York	256	82	109	0	0	65	91	30	32	0	0	29	18	0
North Carolina	60	12	6	42	0	0	13	4	1	8	0	0	20	10
North Dakota	43	9	13	21	0	0	12	1	3	8	0	0	0	0
Ohio	850	195	381	243	31	0	240	62	154	10	14	0	14	0
Oklahoma	152	32	62	58	0	0	78	21	45	12	0	0	0	4
Oregon	299	101	142	49	0	7	53	19	31	1	0	2	489	0
Pennsylvania	578	402	148	20	8	0	159	123	28	0	8	0	503	0
Texas	3,579	1,181	1,121	1,275	2	0	811	280	266	265	0	0	0	0
Virginia	218	36	48	134	0	0	59	11	7	41	0	0	0	0
Washington	949	444	454	45	6	0	319	160	148	9	2	0	2,221	0
Wisconsin	77	26	28	22	1	0	24	10	8	5	1	0	0	0
TOTAL	**11,924**	**4,095**	**4,280**	**3,074**	**262**	**213**	**3,407**	**1,250**	**1,332**	**608**	**122**	**95**	**4,130**	**134**

Source: MFP semiannual web-based progress reports covering the July 1–December 31, 2010 period. Submitted February 28, 2011.

[a] Illinois' progress report had not been submitted as of April 6, 2011; hence, reported figures are subject to change.

ICF-MR = intermediate care facilities for people with mental retardation; MI = mental illness; MR/DD = mental retardation/developmental disabilities; NH = nursing home; PD = physical disabilities.

Table 2. MFP States' Progress Toward Yearly Transition Goals: 2010 and 2009

	2010 MFP Transition Activity			2009 MFP Transition Activity		
State	Percentage of 2010 Transition Target Achieved as of December 2010[a]	Total 2010 Transition Goals	Total Number of Transitions in 2010	Percentage of 2009 Transition Goal Achieved as of December 2009	Total 2009 Transition Goals	Total Number of Transitions in 2009
Kansas	231.3	80	185	21.1	417	88
Texas	207.0	819	1,695	146.0	769	1,123
Virginia	195.5	66	129	22.8	320	73
New York	169.0	100	169	79.1	110	87
Ohio	166.5	269	448	49.8	687	342
Washington	162.8	360	586	110.9	293	325
Indiana	132.8	171	227	27.3	220	60
Oklahoma	129.2	96	124	70.0	40	28
Missouri	129.0	62	80	242.1	57	138
Georgia	122.5	200	245	55.4	350	194
Connecticut	120.0	230	276	96.3	134	129
North Dakota	120.0	20	24	29.2	48	14
Arkansas	116.7	66	77	81.0	63	51
Pennsylvania	116.5	243	283	29.0	873	253
New Jersey	116.1	62	72	41.1	180	74
Maryland	103.6	304	315	114.6	288	330
New Hampshire	100.0	27	27	22.1	95	21
Illinois	93.8	192	180	10.3	517	53
Michigan	88.3	300	265	95.3	300	286
California	84.0	325	273	22.9	551	126
Iowa	74.7	75	56	35.8	148	53
Kentucky	57.2	201	115	163.6	22	36
Hawaii	46.9	96	45	21.8	110	24
Oregon	41.1	331	136	33.2	394	131
Delaware	39.5	38	15	80.0	25	20
North Carolina	33.3	87	29	35.6	87	31
Louisiana	28.9	280	81	13.8	65	9
Dist. of Columbia	24.4	90	23	24.7	150	37
Wisconsin	24.3	111	27	11.4	219	25
Nebraska	10.4	422	44	9.0	434	39
TOTAL	**109.2**	**5,723**	**6,251**	**52.7**	**7,966**	**4,200**

Source: MFP semiannual web-based progress reports covering the January 1–June 30, 2009 period; the July 1–December 31, 2009 period; the January 1–June 30, 2010 period; and the July 1–December 31, 2010 period.

[a] States shown in table are sorted by the percentage of 2010 transition targets achieved as of December 31, 2010.

[b] Illinois' progress report had not been submitted as of April 6, 2011; hence, reported figures are subject to change.

Table 3. Current MFP Participation: December 31, 2009 Through December 31, 2010

State	Total Number of Current Participants as of December 2010	Total Number of Current Participants as of June 2010	Total Number of Current Participants as of December 2009	Number of MFP Participants Completing the 365-Day Transition Period from July to December 2010	Number of MFP Participants Completing the 365-Day Transition Period from January to June 2010	Number of MFP Participants Completing the 365-Day Transition Period as of December 2009
Arkansas	63	35	32	16	17	17
California	168	116	118	63	43	1
Connecticut	264	204	121	104	22	0
Delaware	12	22	19	14	8	2
Dist. of Columbia	22	35	38	15	30	15
Georgia	235	175	221	79	95	22
Hawaii	40	35	22	16	5	1
Illinois[a]	144	106	52	33	14	0
Indiana	157	132	60	16	3	0
Iowa	56	59	51	26	17	6
Kansas	212	117	88	32	24	67
Kentucky	103	62	31	18	4	0
Louisiana	81	64	9	7	0	0
Maryland	283	244	303	115	177	108
Michigan	191	188	153	69	45	57
Missouri	122	151	158	49	51	19
Nebraska	51	20	30	13	18	12
New Hampshire	38	34	28	11	6	6
New Jersey	74	52	69	35	37	13
New York	156	123	78	43	22	0
North Carolina	68	38	28	35	0	0
North Dakota	25	24	16	0	13	5
Ohio	425	646	319	138	141	67
Oklahoma	75	74	20	15	8	0
Oregon	191	199	148	55	28	15
Pennsylvania	241	202	180	74	79	49
Texas	1,654	1,340	1,025	470	405	370
Virginia	198	191	67	27	19	13
Washington	394	446	265	75	72	13
Wisconsin	64	9	25	7	11	4
TOTAL	**5,807**	**5,143**	**3,774**	**1,670**	**1,414**	**882**

Source: MFP semiannual web-based progress reports covering the July 1–December 31, 2009 period; the January 1–June 30, 2010 period; and the July 1–December 31, 2010 period.

[a] Illinois' progress report had not been submitted as of April 6, 2011; hence, reported figures are subject to change.

Table 4. Overview of the Assessments for the MFP Program: July 1 through December 31, 2010

State	Total Number of MFP Candidates Assessed [a]	Total Number of Candidates in the Transition Planning Process	Number Assessed That Did Not Transition Through MFP	Reasons Participants Did Not Transition Through the MFP Program: Individual Transitioned but Was Not Enrolled	Too Physically Ill, Cognitively Impaired, or Service Needs Greater than What Could Be Provided in the Community	Family Member or Guardian Refused Participation or Would Not Provide Back-Up Support	Could Not Secure Affordable, Accessible Housing or Did Not Choose MFP-Qualified Residence	Individual Changed His or Her Mind, Would Not Cooperate in Care Plan Development, Had Unrealistic Expectations, or Preferred to Remain in the Institution	Other
Arkansas	64	14	4	1	1	5	5	1	630
California	580	421	64	10	14	6	6	28	0
Connecticut	295	474	494	96	301	9	45	10	33
Delaware	29	48	57	4	8	12	41	16	0
Dist. of Columbia	8	38	2	10	0	1	1	0	0
Georgia	243	405	30	3	2	2	4	16	3
Hawaii	34	4	11	1	4	0	4	1	1
Illinois	0	0	0	0	0	0	0	0	0
Indiana	182	96	48	0	31	1	1	15	0
Iowa	16	63	1	0	0	0	0	1	0
Kansas	205	71	62	9	11	3	15	14	9
Kentucky	159	236	383	7	177	2	2	195	0
Louisiana	139	123	38	3	13	2	4	16	0
Maryland	447	320	61	4	1	0	35	1	20
Michigan	1,132	338	940	594	103	23	21	105	94
Missouri	105	39	9	1	20	3	1	9	25
Nebraska	39	19	78	32	5	3	3	19	0
New Hampshire	35	9	3	0	2	1	0	0	0
New Jersey	49	76	18	0	0	0	0	0	18
New York	135	150	227	18	68	2	120	30	4
North Carolina	61	86	46	1	0	0	0	0	45
North Dakota	12	23	11	2	8	0	0	1	0
Ohio	457	592	24	0	3	1	1	7	17
Oklahoma	190	150	35	6	4	1	1	15	8
Oregon	45	0	16	6	0	0	0	1	9
Pennsylvania	223	68	20	14	0	0	0	4	2
Texas	811	NR	NR	NR	NR	NR	NR	NR	NR
Virginia	29	0	0	0	0	0	0	0	0
Washington	471	344	138	0	0	0	11	0	22
Wisconsin	34	4	11	1	0	6	2	2	0
TOTAL	**6,229**	**4,211**	**2,831**	**823**	**776**	**83**	**323**	**507**	**940**

Source: MFP semiannual web-based progress reports covering the July 1– December 31, 2010 period. Submitted February 28, 2011.

Note: The reasons participants did not transition to the community do not sum to the total number assessed that did not transition through MFP because several states cited multiple reasons for individuals, and Arkansas reported 630 individuals did not transition through MFP for 'Other'' reasons, which is likely to be incorrect because the state reportedly assessed only 64 candidates for MFP enrollment during the reporting period.

[a] The number of assessments is not comparable across states due to differences in how states define and track assessments.

[b] Illinois' reported figures are not displayed because the data on reported assessments appear to be inconsistent.

NR = not reported.

Table 5. Number of Reinstitutionalizations: July 1 Through December 31, 2010

State	Number of MFP Participants Reinstitutionalized During the Period					
	Total Number	Elders	People with PD	People with MR/DD	People with MI	Other
Arkansas	4	1	3	0	0	0
California	9	4	5	0	0	0
Connecticut	38	18	15	5	0	0
Delaware	1	1	0	0	0	0
Dist. of Columbia	0	0	0	0	0	0
Georgia	1	0	0	1	0	0
Hawaii	13	5	7	1	0	0
Illinois[a]	77	12	16	0	49	0
Indiana	32	24	8	0	0	0
Iowa	1	0	0	1	0	0
Kansas	9	6	3	0	0	0
Kentucky	29	6	12	9	0	2
Louisiana	4	2	1	1	0	0
Maryland	14	12	2	0	0	0
Michigan	51	30	21	0	0	0
Missouri	10	3	7	0	0	0
Nebraska	3	2	1	0	0	0
New Hampshire	1	1	0	0	0	0
New Jersey	1	0	0	1	0	0
New York	68	30	25	0	0	13
North Carolina	2	0	0	2	0	0
North Dakota	2	0	1	1	0	0
Ohio	92	26	60	1	5	0
Oklahoma	7	2	3	2	0	0
Oregon	8	1	6	1	0	0
Pennsylvania	17	15	2	0	0	0
Texas	112	53	37	22	0	0
Virginia	14	4	9	1	0	0
Washington	53	36	17	0	0	0
Wisconsin	4	4	0	0	0	0
TOTAL	**677**	**298**	**261**	**49**	**54**	**15**

Source: MFP semiannual web-based progress reports covering the July 1–December 31, 2010 period. Submitted February 28, 2011.

[a] Illinois' progress report had not been submitted as of April 6, 2011; hence, reported figures are subject to change.

MI = mental illness; MR/DD = mental retardation/developmental disabilities; PD = physical disabilities.

Table 6. Other Key Indicators: July 1 Through December 31, 2010

State	Self Direction			Community Residence Type		
	Number of MFP Participants Self-Directing	Number of MFP Participants That Hired/Supervised Personal Assistants	Number of MFP Participants That Managed Their Allowance/Budget	Number of MFP Participants That Transitioned to Home	Number of MFP Participants That Transitioned to Apartment	Number of MFP Participants That Transitioned to Group Home
Arkansas	42	4	9	13	14	14
California	0	0	0	11	33	11
Connecticut	128	128	0	68	87	2
Delaware	7	7	6	2	4	1
Dist. of Columbia	NA	NA	NA	0	4	3
Georgia	0	0	0	25	38	70
Hawaii	2	2	0	5	1	19
Illinois	NR	NR	NR	NR	NR	NR
Indiana	1	1	0	0	0	0
Iowa	2	2	2	0	16	0
Kansas	98	98	0	42	79	6
Kentucky	59	3	1	10	20	43
Louisiana	0	0	0	7	20	0
Maryland	0	0	0	97	67	20
Michigan	48	48	48	63	67	2
Missouri	70	70	0	3	28	21
Nebraska	NA	NA	NA	14	10	0
New Hampshire	5	5	1	8	3	3
New Jersey	0	0	0	14	12	13
New York	NA	NA	NA	27	63	1
North Carolina	0	0	0	22	0	1
North Dakota	0	0	0	1	9	0
Ohio	425	0	425	58	173	9
Oklahoma	0	0	0	19	68	10
Oregon	0	0	0	14	11	28
Pennsylvania	19	19	0	84	67	8
Texas	10	1	0	416	122	273
Virginia	33	33	0	12	18	0
Washington	80	80	0	106	102	111
Wisconsin	0	0	0	6	9	9
TOTAL	**1,029**	**501**	**492**	**1,147**	**1,145**	**678**

Source: MFP semiannual web-based progress reports covering the July 1–December 31, 2010 period. Submitted February 28, 2011.

NA = Indicates that state does not have self-direction option in place.

NR = not reported.

Table 7. 2010 Qualified HCBS Expenditures

State	2010 Target Level of Spending	Qualified HCBS Expenditures as of December 2010	Percentage of 2010 Target Achieved as of December 2010	Notes
Arkansas	$308,750,922	$330,794,573	107.1	
California	$7,187,756,743	$7,025,644,308	97.7	
Connecticut	$887,891,913	$3,710,909,322	418.0	
Delaware	$144,680,086	$109,041,681	75.4	Delaware's expenditure data were not final at the time of report submission.
Dist. of Columbia	$326,558,806	NR	NR	The District of Columbia indicated that a number of HIV/AIDS waiver recipients were found to be ineligible to continue to receive waiver services, which has led to lower annual expenditures. Elderly and disabled waiver recipients need of fewer services overall in comparison to previous years.
Georgia	$946,274,550	$712,299,646	75.3	
Hawaii	$179,542,428	$178,907,664	99.7	Hawaii's HCBS spending level in CY 2010 reflects the need to reduce spending on the MR/DD waiver to remain within budget. Use of QUEST Expanded Access (QExA) HCBS encounter claims data was initiated in late 2010 and report revisions are needed.
Illinois[a]	$1,036,978,658	$1,163,731,437	112.2	
Indiana	$770,574,328	$816,411,152	105.9	
Iowa	$420,275,456	$548,049,514	130.4	
Kansas	$551,434,222	$572,729,099	103.9	Kansas' overall HCBS expenditures were lower in CY 2010 than in CY 2009 due to budget cuts and efforts to control costs within program budgets.
Kentucky	$370,004,496	$426,591,633	115.3	
Louisiana	$692,915,345	$781,604,762	112.8	
Maryland	$945,130,594	$860,882,455	91.1	Maryland expected the 2010 total spending to increase in the next reporting period due to additional claims from the 2010 calendar year that have yet to be processed. Community providers received a 1% rate cut due to the state budget deficit so it is not likely it will meet the 2011 target level of spending and will need to amend its benchmark.
Michigan	$824,589,834	$865,403,732	105.0	
Missouri	$938,176,756	$1,032,654,952	110.1	
Nebraska	$283,000,000	$285,098,564	100.7	.
New Hampshire	$261,570,975	$250,495,990	95.8	
New Jersey	$1,098,368,143	$1,160,782,863	105.7	
New York	$11,552,146,000	$11,739,610,848	101.6	
North Carolina	$631,405,849	$1,358,232,363	215.1	North Carolina determined that its 2010 target level was missing all applicable HCBS and will need to revise the targets for subsequent years. Spending excluded PACE services because the state cannot isolate the HCBS portion of the capitated rate paid to PACE.
North Dakota	$119,444,831	$131,983,929	110.5	
Ohio	$1,740,784,820	$2,059,856,510	118.3	
Oklahoma	$616,504,833	$475,757,317	77.2	Oklahoma's original estimates of HCBS expenditure growth have not been met, so it intends to lower its spending benchmarks in the future to reflect lower annual growth of HCBS expenditures.
Oregon	$771,784,690	$930,438,598	120.6	
Pennsylvania	$2,289,794,000	$2,479,462,417	108.3	
Texas	$2,735,440,000	$3,198,703,827	116.9	
Virginia	$845,412,400	$998,729,516	118.1	
Washington	$787,992,510	$834,057,056	105.9	Washington's HCBS expenditures are based on SFY (July–June) using month of service, and might not exactly equal those reported on the CMS-64 and MFP Financial Reporting Forms A and B due to different reporting structure.
Wisconsin	$1,772,204,451	$1,603,800,700	90.5	Wisconsin's CY 2010 number is an estimate based on data available at this time. It might change as a result of claims lag and reconciliation of costs.
TOTAL	**$42,037,388,639**	**$46,642,666,428**	**111.0**	

Source: MFP semiannual web-based progress reports covering the July 1–December 31, 2010 period. Submitted February 28, 2011.

[a] Illinois' progress report had not been submitted as of April 6, 2011; hence, reported figures are subject to change.

CMS = Centers for Medicare & Medicaid Services; CY = calendar year; HCBS = home and community-based services; MR/DD = mental retardation/developmental disabilities; NR = not reported; PACE = Program of All-Inclusive Care for the Elderly; SFY = state fiscal year.

Table 8. MFP Grantees' Progress and Challenges in Assuring Participants' Access to Home and Community-Based Services, by Reporting Period, 2008–2010

Response Option	July–Dec 2008	Jan–June 2009	July-Dec 2009	Jan–June 2010	July–Dec 2010[c]
Number of Grantees Self-Reporting Challenges[a]					
Insufficient Supply of HCBS Providers	7	6	7	9	9
Insufficient supply of direct service workers	5	3	4	4	6
Preauthorization requirements	1	2	3	2	3
Limits on amount and scope or duration of HCBS	3	4	4	10	7
Lack of appropriate transportation options	1	3	3	4	3
Insufficient supply of specific types of HCBS	2	5	9	8	4
Other	7	11	7	8	10
SUBTOTAL	**26**	**34**	**37**	**45**	**42**
Number of Grantees Self-Reporting Progress[b]					
Increased the number of transition coordinators	9	12	8	12	13
Increased the number of HCBS providers contracting with Medicaid	7	10	10	9	5
Increased access requirements for managed long-term care providers	0	0	0	1	1
Increased payment rates to HCBS providers	8	6	5	3	1
Increased the supply of direct service workers	0	2	1	2	1
Improved or increased transportation options	1	1	1	2	3
Added or expanded managed long-term care programs	1	1	1	2	2
Other	6	2	4	6	7
SUBTOTAL	**32**	**34**	**30**	**37**	**33**

Source: MFP semiannual web-based progress reports covering the July 1–December 31, 2008 period; the January 1–June 30, 2009 period; the July 1–December 31, 2009 period; the January 1 – June 30, 2010 period; and the July 1 – December 31, 2010 period.

Note: The progress reports are designed to capture information on states' progress and challenges encountered in all dimensions of the program. Information presented is based on self-reported information and reflects the challenges encountered during the reporting period.

[a] Report question asks, "What are MFP participants' most significant challenges to accessing home and community-based services? These are challenges that either make it difficult to transition as many people as you had planned or make it difficult for MFP participants to remain living in the community."

[b] Report question asks, "What steps did your program take during the reporting period to improve or enhance the ability of MFP participants to access home and community-based services?"

[c] Illinois did not report data on participants' access to home and community-based services.

HCBS = home and community-based services.

Table 9. MFP Grantees' Progress and Challenges Securing Appropriate Housing Options for Participants, by Reporting Period, 2008–2010

Response Option	July–Dec 2008	Jan–June 2009	July–Dec 2009	Jan–June 2010	July–Dec 2010[c]
Number of Grantees Self-Reporting Challenges[a]					
Lack of information about affordable and accessible housing	3	1	2	2	0
Insufficient supply of affordable and accessible housing	13	19	14	18	17
Lack of affordable and accessible housing that is safe	0	2	3	5	3
Insufficient supply of rental vouchers	8	15	14	16	14
Lack of new home ownership programs	0	0	0	2	0
Lack of small group homes	6	5	6	6	4
Lack of residences that provide or arrange for long-term services and/or supports	1	2	2	2	3
Insufficient funding for home modifications	1	1	1	1	2
Unsuccessful efforts in developing local or state coalitions of housing and human services organizations to identify needs and/or create housing-related initiatives	0	0	2	0	3
Unsuccessful efforts in developing sufficient funding or resources to develop assistive technology related to housing	0	0	0	0	0
SUBTOTAL	**35**	**53**	**51**	**56**	**46**
Number of Grantees Self-Reporting Progress[b]					
Developed inventory of affordable and accessible housing	6	7	2	3	3
Developed local or state coalitions to identify needs and/or create housing-related initiatives	4	8	9	5	6
Developed statewide housing registry	5	4	1	3	1
Implemented new home ownership initiative	0	1	0	1	0
Improved funding for developing assistive technology related to housing	2	2	1	1	2
Improved information systems about affordable and accessible housing	2	2	2	2	3
Increased number of rental vouchers	5	5	5	8	9
Increased supply of affordable and accessible housing	2	3	2	1	2
Increased supply of residences that provide or arrange for long-term services and/or supports	1	4	1	0	1
Increased supply of small group homes	2	3	3	4	3
Increased/improved funding for home modifications	3	5	6	1	1
Other	6	6	6	9	8
SUBTOTAL	**38**	**50**	**38**	**38**	**39**

Source: MFP semiannual web-based progress reports covering the July 1–December 31, 2008 period; the January 1–June 30, 2009 period; the July 1–December 31, 2009 period; the January 1–June 30, 2010 period; and the July 1–December 31, 2010 period.

Note: The progress reports are designed to capture information on states' progress and challenges encountered in all dimensions of the program. Information presented is based on self-reported information and reflects the challenges encountered during the reporting period.

[a] Report question asks, "What significant challenges did your program experience in securing appropriate housing options for MFP participants? Significant challenges are those that affect the program's ability to transition as many people as planned or to keep MFP participants in the community."

[b] Report question asks, "What achievements in improving housing options for MFP participants did your program accomplish during the reporting period?"

[c] Illinois did not report data on housing for participants.

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