Contract No.: HHSM-500-2005-00025I (0002)
MPR Reference No.: 6352-500

MATHEMATICA
Policy Research, Inc.

Research Design Report for the Evaluation of the Money Follows the Person (MFP) Grant Program

Final Report

October 3, 2008

Randall Brown
Carol Irvin
Debra Lipson
Sam Simon
Audra Wenzlow

Submitted to:

Centers for Medicare & Medicaid Services
Division of Advocacy and Special Initiatives
Disabled and Elderly Health Programs
7500 Security Blvd.
Baltimore, MD 21244-1850

Project Officer:
MaryBeth Ribar

Submitted by:

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
Telephone: (609) 799-3535
Facsimile: (609) 799-0005

Project Director:
Carol Irvin

CONTENTS

Chapter **Page**

II *(continued)*

Chapter **Page**

IV *(continued)*

Chapter **Page**

TABLES

Table **Page**

Table **Page**

Table **Page**

FIGURES

Figure **Page**

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

EXECUTIVE SUMMARY

The Money Follows the Person (MFP) program is a combination of two programs: (1) a transition program to enable long-term institutional residents to move back to the community, and (2) a rebalancing initiative in which states use enhanced matching funds generated by these transitions to improve the long-term care systems and options for beneficiaries who need long-term care assistance and wish to remain in the community. The evaluation of the MFP is designed to assess the effects of both program components, as illustrated in Figures ES.1 and ES.2.

Each state designs both components to fit state-specific goals. For the transition program, states determine which populations to target, how they will inform eligibles about the MFP program option and identify enrollees who wish to transition, the number of beneficiaries they expect to transition, the types and amount of enhanced home- and community-based services (HCBS) and other benefits that will be available to MFP participants, and how they will assure that MFP participants are safe and receive appropriate care. Some states may need to institute system changes prior to implementing the MFP program, such as amending a waiver program to create more waiver capacity or alter budget authority so that funds previously used for institutional care more easily flow to community care when someone transitions.[1] States will be assessed in part by their success in meeting their targeted number of transitions, and by the aggressiveness of the target compared to pre-MFP transition rates.

Once living in the community, each MFP participant receives HCBS according to his or her needs, and for many of these services (the qualified HCBS and the demonstration services) the states will receive an enhanced federal match (known as the Federal Medical Assistance Percentage or FMAP).[2] States are required to reinvest the enhanced FMAP funds in their long-term care system, so they must determine how these funds will be used and have their plans approved by CMS before implementation.

A. THE EVALUATION APPROACH

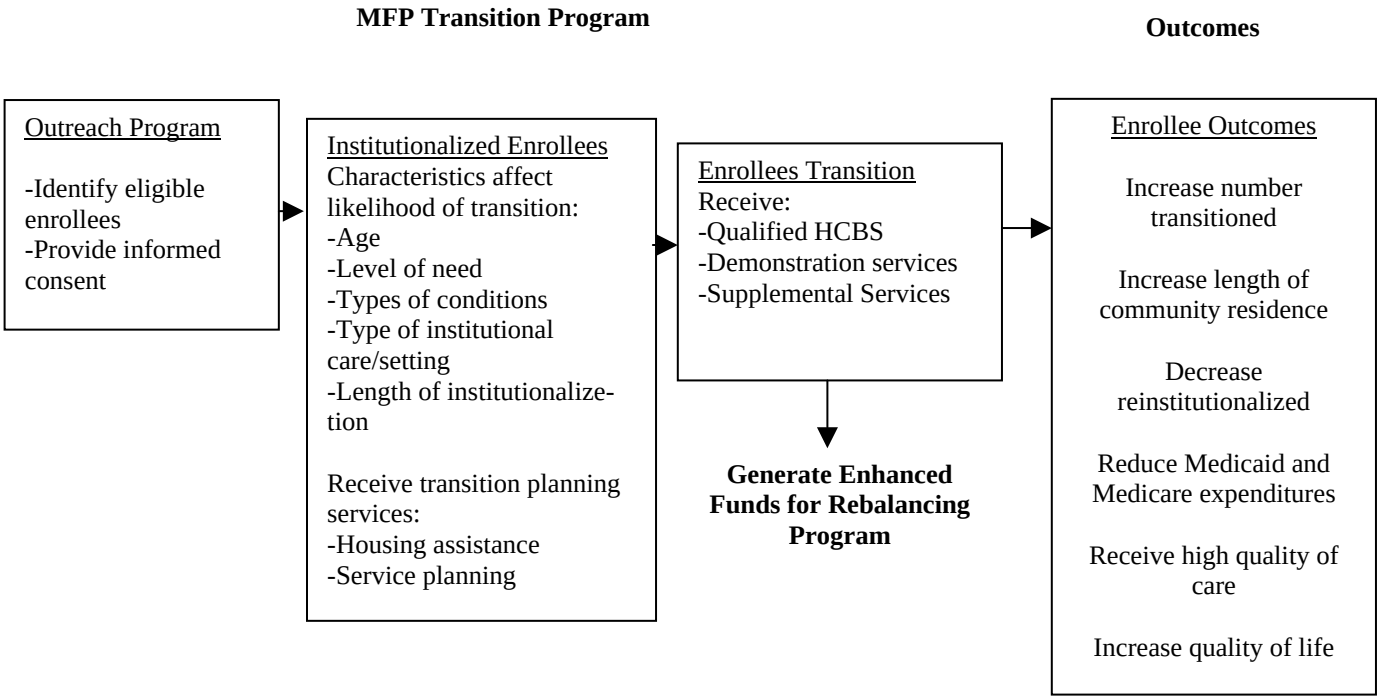
The national evaluation of the MFP program will seek to understand whether the program met its goals to (1) increase the number and proportion of institutionalized Medicaid enrollees who can live successfully in the community, and (2) facilitate state rebalancing of long-term care systems. We anticipate MFP programs will have an array of effects on enrollees with long-term care needs, including increases in the likelihood and number of transitions from institutional to community settings and greater increases in HCBS use and expenditures than in institutional care.

[1] Grantees that move MFP participants into waiver programs with waiting lists must have a process in place for determining when MFP participants move to the top of the list.

[2] States typically are reimbursed by CMS for a portion of their Medicaid costs, typically 50 to 60 percent. Under MFP, the matching rate is increased to 75 to 90 percent for qualified and demonstration services provided to MFP participants.

FIGURE ES.1

LOGIC MODEL FOR MFP TRANSITION PROGRAMS

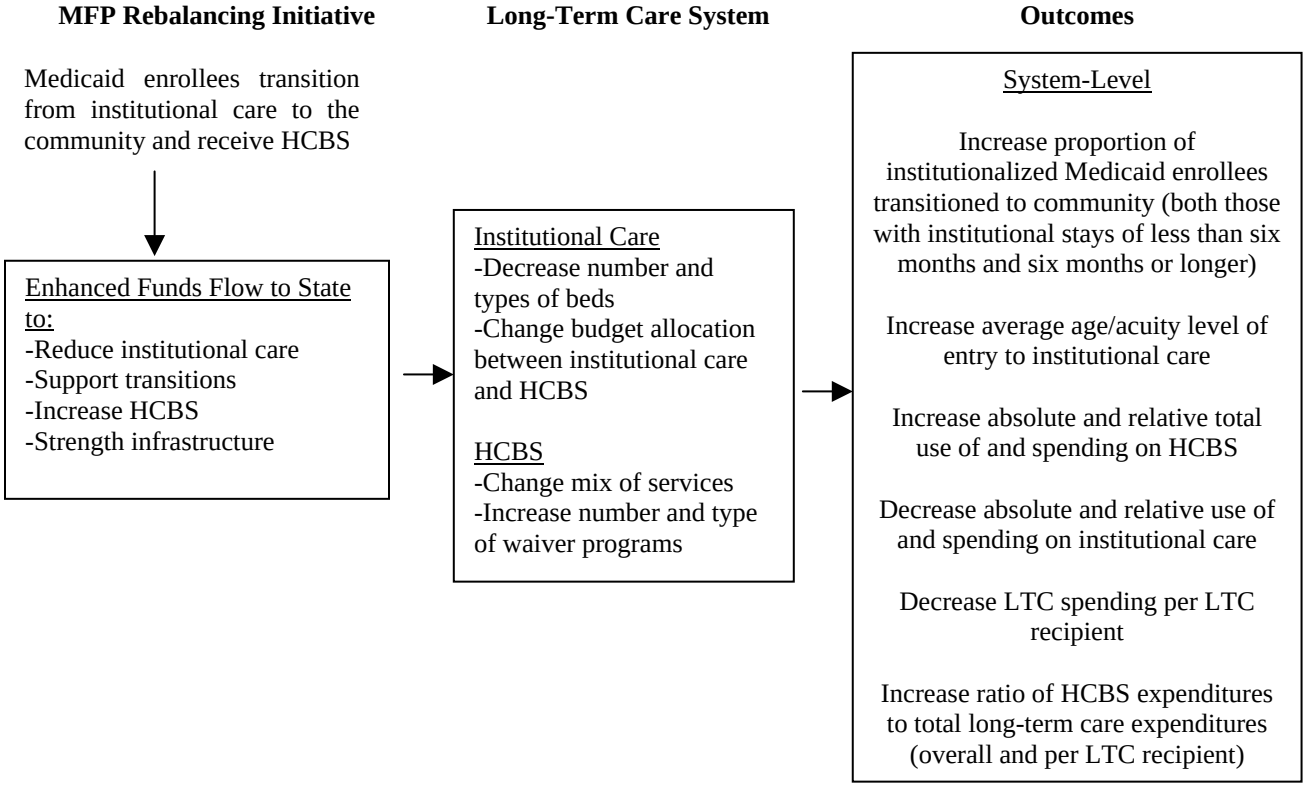


Other enrollee outcomes of interest are those that reflect the cost effectiveness of MFP programs. Success in transitioning institutionalized enrollees to the community will be jeopardized if participants cannot live in the community on a long-term basis or the costs of the transition program and participants' overall health care services are higher than if they had remained in institutional care. Outcomes related to cost effectiveness issues include (1) how long MFP participants remain living in the community (the length of community residence and likelihood of reinstitutionalization), and (2) whether their needs for Medicaid and Medicare services differ from what they would have been had they remained in the institutional setting (use and expenditures for acute an subacute care and incidence of adverse outcomes potentially related to the quality of HCBS care).

Lastly, because populations targeted by each MFP program are highly vulnerable and dependent on the receipt of adequate care, their quality of life after the transition will be a critical determinant of program success.

FIGURE ES.2

LOGIC MODEL FOR THE MFP REBALANCING INITIATIVES



1. Primary Research Questions

The two fundamental questions guiding the evaluation are:

1. How was the MFP program implemented?
2. What effects did the MFP program have on participants and the long-term care system more generally?

The first question is critical because of state variability in program implementation. States are starting at different points and tailoring their MFP programs to their state systems and needs. This state variability in program implementation highlights the importance for the national evaluation of conducting a comprehensive implementation analysis that describes each program along key program characteristics such as those suggested in the logic models above. The evaluation will document this variation to help explain state variation in program outcomes.

The second fundamental question requires analyses of impacts and outcomes at both the individual and system levels. This question looks at whether the MFP program had the intended effects, including effects on institutionalized Medicaid enrollees, MFP participants, HCBS

expenditures, and the long-term care system more generally. The evaluation will also estimate the net savings that MFP generates for Medicaid, whether MFP participants were able to remain living in the community, the program's effects on acute and subacute care services relative to what they would have been otherwise, and whether their quality of life in the community improved compared to what it was while residing in the institution. Most importantly, the evaluation will attempt to identify the type of participant and program characteristics that are most strongly associated with favorable outcomes on each of these dimensions.

2. Implementation Analyses

The implementation analysis will provide (1) a detailed description of the MFP program and the goals set by individual states, (2) an assessment of the strategies states use to affect system change, and (3) analyses of whether each state met the goals they specified. Table ES.1 displays the key questions to be addressed and the data sources. The first two components of the implementation analysis will rely on states' operational protocols (OPs), which describe state programs and benchmark measures in detail, and semi-annual progress reports. The progress reports are designed to capture information on all aspects of MFP programs, their achievements and system improvements and their challenges and how states address them.

A trend analysis will measure performance toward states' transition and rebalancing goals. This analysis will rely on data reported by the states, such as the semi-annual progress reports and MFP Services file, and analysis of Medicaid eligibility and claims records from the Medicaid Statistical Information System (MSIS) and the Medicaid Analytic Extract (MAX) system.

3. Impact on the MFP Eligible Population and on MFP Participants

The evaluation will estimate program impacts on (1) the overall population of long-term institutionalized Medicaid beneficiaries, and (2) the subset of those individuals who participate in MFP. The first impact analyses will estimate changes in the probability of transitioning to the community among Medicaid beneficiaries who reside in institutions at least six months. The second impact analyses will estimate the impacts of the MFP program on expenditures, service use, quality of care, and mortality of MFP participants. Table ES.2 summarizes the research questions, data, and methodology.

The true impact of the MFP program on a particular outcome is the difference between the average actual outcome for the target population compared to what the average outcome would have been in the absence of the program. Impacts are best estimated using a randomized design, or failing that, a well-matched, contemporaneous comparison group; neither is possible for the MFP evaluation. To identify impacts we will compare trends for the target population in key outcomes before MFP to trends after MFP is implemented, using state reported data and MSIS and MAX data.

To estimate MFP program impacts on the probability of transition from institutional care to community care, we will estimate the change between the pre-MFP and post-MFP period in this probability using regression analyses to control for any changes in the characteristics of the eligible population. For example, we will estimate models of the probability of transition from

TABLE ES.1

SUMMARY OF IMPLEMENTATION ANALYSES TO BE CONDUCTED

Research Question	Outcome Measure	Data Source		
		Web Report	MSIS/Medicare Claims	Other Data[a]
What were the MFP programs. Goals and Interventions				
What were the programs' transition goals?	- Program transition goals			✓
Which populations did grantees target for transition? What was their level of care? How did the size of the targeted population compare to total number of Medicaid beneficiaries institutionalized?	- Basis of eligibility - Distribution of MFP participants by level of care - Ratio of projected number of transitions to number eligible		✓	✓
How did grantees identify individuals to target for transition? How was the program promoted to beneficiaries?	- Categories of recruitment and outreach activities - State agencies that conducted these activities - Types of challenges to recruitment and outreach and descriptions of how states addressed the challenges	✓		✓
What services not covered normally by the Medicaid program did grantees make available to MFP participants? What types of demonstration and supplemental services were offered?	- Types of services provided by grant - Whether program offered an enriched service package or filled gaps in service - Use of managed long-term care	✓		✓
To what extent did grantees involve consumers, family members, providers, and other stakeholders when designing and implementing the MFP program? How successful were they in these efforts?	- Assessment of consumer and family involvement in MFP program design - Assessment of consumer and family involvement in ongoing program operations	✓		✓
How did MFP programs ensure or promote consumer choice of residential setting? To what extent did MFP participants choose to self-direct services?	- Approach to housing (active versus passive strategies) - Percent enrolled in self-direction programs	✓		✓
What other changes in state Medicaid policies or programs did grantees make to (1) transition MFP participants and (2) help them remain in the community?	- Assessment of categories of changes (e.g., amendments to existing HCBS 1915(c) waivers, establishment of new waivers, modification of budget policies)	✓		✓

TABLE ES.1(*continued*)

Research Question	Outcome Measure	Data Source		
		Web Report	MSIS/Medicare Claims	Other Data[a]
Did the MFP programs accomplish their transitioning and rebalancing goals? - Program Performance Indicators				
What benchmarks did the grantees set? To what extent did the grantees achieve their benchmarks? Which states were more effective in achieving their benchmarks? How ambitious were the benchmarks?	- Ratio of actual results to benchmark - Ratio of benchmark to pre-MFP values - Year-to-year trend in ratio of HCBS spending to total long-term care spending - Year-to-year trend in institutional spending - Year-to-year trend in HCBS spending	✓	✓	
What factors were associated with greater success in achieving benchmarks?	- Correlation of program characteristics with success indicators, controlling for pre-MFP levels	✓	✓	
What were the most common challenges to achieving the targeted number of transitions? What challenges did grantees encounter in trying to achieve their benchmarks? How did they try to overcome these challenges?	- Grantee-reported challenges	✓		
What processes and system changes were implemented to rebalance Medicaid long-term care spending? – Systems Change				
How much did states get in enhanced FMAP grant funds to rebalance their LTC systems? How were these enhanced funds used to rebalance LTC systems?	- Total enhanced funding received overall and as a percent of total HCBS spending and as a percent of total spending on long-term care services - Types of rebalancing benchmarks ratio of benchmarks to pre-MFP levels or transition services and infrastructure, institutional capacity reduction, or investments in HCBS systems) or by type of targeted group (MFP participants only or all users of long-term care services)	✓		✓
Are the changes made by grantees sustainable? Will they have lasting impact on state LTC systems beyond the MFP demonstration period?	- Assessment of changes made by grantees	✓		
Has collaboration among state agencies increased or improved as a result of MFP rebalancing and system change efforts?	- New collaborations - Enhancement of ongoing collaborations	✓		

[a]Other data include documents such as the MFP application and operational protocol, state financial reports, administrative files that have information on qualified residences, the MFP Quality of Life file, NF-MDS, OSCAR, and OASIS.

FMAP = Federal Medical Assistance Percentage; HCBS = home- and community-based services; LTC = long-term care; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum dataset; OASIS = Outcomes and Assessment Information Set; OSCAR = Online Survey, Certification, and Reporting database.

TABLE ES.2

SUMMARY OF IMPACT ANALYSES TO BE CONDUCTED

		Data Source			Design	
Research Question	Outcome Measure	Web Report	MSIS/Medicare Claims	Other Data[a]	Descriptive Analysis	Pre-MFP Comparison Group
How does MFP affect the probability of transition? What types of people are most likely to be transitioned?	- Probability of transition to the community - Subgroup analyses		✓	✓		✓
Which types of MFP participants are most likely to transition successfully? What program types/features are associated with maintenance in the community?	- Probability of reinstitutionalization during the MFP demonstration period and the year after the demonstration period ended - Length of time until readmission - Reasons for readmission - Status 1 and 2 years after transitioning	✓	✓	✓	✓	✓
What were the most/least successful settings for beneficiaries?	- Re-institutionalization rates by qualified housing, beneficiary characteristics, types of HCBS and other services provided (transitional, qualified, demonstration, and supplemental)		✓	✓	✓	
How does MFP affect health care utilization?	- Rates of hospitalization and hospital days - ER use, SNF use, home health visits, and personal care services		✓	✓		✓
How does MFP affect the costs of care?	- Medicaid expenditures (total, subtotal for LTC, by type of LTC services) - Medicare expenditures by type of service		✓	✓		✓

TABLE ES.2 (*continued*)

Research Question	Outcome Measure	Data Source			Design	
		Web Report	MSIS/Medicare Claims	Other Data[a]	Descriptive Analysis	Pre-MFP Comparison Group
How does MFP affect quality of care?	- Treatment for falls, fractures, urinary tract infections, etc. - Preventable hospitalizations - Death		✓	✓		✓
What are the impacts of MFP on the state's long term care costs?	- LTC costs per LTC recipient per month - Ratio of HCBS to total LTC costs		✓	✓	✓	✓
What are the impacts of MFP on other Medicaid LTC recipients?	- Probability of receiving institutional care vs. HCBS or. state plan LTC services - Days of institutional care - Volume of community-based care		✓	✓		✓

[a]Other data include documents such as the MFP application and operational protocol, state financial reports, administrative files that have information on qualified residences, the MFP Quality-of-Life file, NF-MDS, OSCAR, and OASIS.

HCBS = home- and community-based services; LTC = long-term care; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum dataset; OASIS = Outcomes and Assessment Information Set; OSCAR = Online Survey, Certification, and Reporting database.

institution to the community during a given year, as a function of whether the year was before or after MFP startup, the length of time in the institution at the start of the year, and the beneficiaries' characteristics at that point. The model will be estimated over all beneficiaries who met the eligibility criteria (in an institution for at least 6 months) at some point during the year. Tests of the statistical significance on the indicator for the MFP period will be evidence that the transition rate during the MFP period exceeds the projected rate based on the three years preceding the program.

In estimating MFP effects on annual service use and costs we will use two different comparison groups, yielding upper- and lower-bound impact estimates. One comparison group will be comprised of beneficiaries in the pre-MFP period who transitioned out of institutional care. Comparison to the pre-MFP transitioners yields a lower bound estimate of the favorable impact on outcomes, under the assumption that MFP does not increase the transition rate at all. The second comparison group will be comprised of institutionalized individuals in the pre-MFP period who did not transition out, but who are matched to MFP participants, based on having similar predicted probabilities (obtained from our models) of transitioning had MFP been available to them. Comparison to this "would-have-transitioned" group yields an upper-bound estimate of the impact, based on the assumption that none of the MFP participants would have transitioned had the program not existed. For both comparisons, the pre-transition to post-transition change in the outcome (such as expenditures for acute care) for MFP participants will be compared to the same changes over time for the comparison group.[3] A weighted average of upper- and lower-bound estimates will be calculated to provide our best estimates of impacts, with the weights dependent on our estimate of MFP's effect on institutionalized beneficiaries' probability of transitioning to the community.

Our approach to estimating impacts on quality-of-care indicators and mortality will be similar to the approach described above for estimating effects on costs and service use. We will construct measures from claims data for the MFP participants and the pre-MFP comparison group, and estimate models that test the equivalence of the mean values for the two groups. Quality-of-care indicators will include measures such as preventable hospitalizations (for conditions such as falls, infections, and decubiti) and indicators of whether certain preventive care is received (such as flu shots, annual physical examinations, and routine disease-specific care visits). For all outcomes, impacts will be estimated separately for participant's first and second years after transitioning to the community, to ascertain the differences in impacts while receiving MFP benefits and during the year after those benefits end.

4. Quality-of-Life Analyses

The administrative data available for the national evaluation do not allow for a credible comparison group methodology for assessing the effect of MFP on participants' quality of life. Even if a credible comparison group could be defined, quality of life information is not available in the administrative data, and primary data collection from a comparison group will not be

[3] Because the second comparison group does not actually transition, comparison group members will be assigned the same time to transition as the MFP participant to whom they are matched, so that comparable periods can be established.

feasible. Therefore, our analysis of participants' quality of life and how it changes over time will rely on a pre/post methodology, using primary data collected by the states.[4] States will collect quality of life data from MFP participants shortly before the transition to the community and approximately one and two years after the transition. We will measure changes in well-being and quality of life on seven different dimensions and assess the relationship between these changes and participant and program characteristics. Table ES.3 identifies the key hypotheses and methodology for this analysis.

5. MFP Impacts on Rebalancing

We will also measure changes that occur in the overall balance of state long-term care spending between institutional and community-based care. Unlike the implementation analysis, which will assess whether states achieve their individual rebalancing benchmarks and how they spend their enhanced match funds, the analyses of impacts on rebalancing will examine the effects of MFP on measures of the proportion of total state Medicaid long-term care spending that goes toward home- and community-based services (HCBS). It will include analyses of system-wide measures such as changes in the percentage of expenditures that are for community-based services and the ratio of institutional to community-based expenditures per user. These analyses will be done for each state, using aggregate data, separately for each year of MFP operations. To the extent possible, we will examine the causes of the changes (for example, changes in the proportion of long-term care recipients in institutional care or changes in long-term care recipients' ratio of Medicaid expenditures for community-based services to their total Medicaid long-term care expenditures).

B. CHALLENGES FOR THE EVALUATION

The evaluation faces several noteworthy challenges. We highlight four data quality issues:

1. Underreporting of claims
2. Incomplete claims data for states with Medicaid managed care
3. Potential problems with new data on MFP-covered services
4. Different definitions of specific HCBS.

Underreporting. For some states, the total expenditures for waiver services based on MSIS claims records are substantially less than the expenditures in state financial reports they submit to CMS. For states showing large disparities between their aggregate and individual-level data, we

[4] It may be possible, for some subset of overlapping measures, to compare changes over time in outcome measures for MFP participants to changes over the same time frame for those who do not transition, using data from the nursing facility minimum data set (NF-MDS) for individuals in institutions.

TABLE ES.3

SUMMARY OF QUALITY-OF-LIFE ANALYSES TO BE CONDUCTED

Research Question	Outcome Measure	Data Source			Design		
		Web Report	MSIS/ Medicare Claims	Other Data[a]	Descriptive Analysis	Pre-MFP Comparison Group	Pre/Post MFP Participants
How did the MFP program affect the quality of life and satisfaction of MFP participants? (Quality-of-Life Analyses)							
How do MFP participants fare living in the community? How does quality of life compare to what it was in the institution? Which types of MFP participants appear to have the greatest improvement in quality of life? Is improvement in quality of life associated with key program characteristics?	- Based on self-reported information to questions on: - Access to personal care - Choice and control - Respect and dignity - Community inclusion - Satisfaction - Percent employed			✓	✓		✓

[a]Other data include documents such as the MFP application and operational protocol, state financial reports, administrative files that have information on qualified residences, the MFP Quality-of-Life file, NF-MDS, OSCAR, and OASIS.

MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum dataset; OASIS = Outcomes and Assessment Information Set; OSCAR = Online Survey, Certification, and Reporting database.

will discuss possible reasons for the discrepancies with the state and assess how best to reconcile them and the potential biases.

Managed Care. Managed care service systems impact whether a state submits claims for all services provided. Historically, states have experienced significant difficulties getting managed care plans to submit service use claims for services they provide to their members, and most states that have Medicaid enrollees in managed care are not able to submit a complete history of claims information for their managed care enrollees. These reporting issues are likely to affect those states that enroll MFP participants in managed long-term care. Managed long-term care systems range from those that only manage HCBS, such as Wisconsin's Family Care plan, to the Program of All-Inclusive Care for the Elderly (PACE), which manages the full array of services. Full PACE programs receive capitated payments for both Medicaid and Medicare services.

In general, we will restrict our analyses of expenditures and utilization to those enrollees who never enroll in a managed care plan during the study period. Until we examine MAX and MSIS data and obtain the enrollment and service use records financed with MFP grant funds, we will not know to what extent MFP participants are receiving any of their preventive, acute, or long-term care through managed care plans.

MFP Services. Claims for MFP-financed HCBS will not be included in the regular MSIS files; states will submit MFP-financed services in a separate MFP Services file. States have been asked to submit service claims for all services financed with MFP grant funds, regardless of whether the services are provided through fee-for-service or managed care. MPR will work with the states that provide MFP services through managed long-term care plans to ensure the records for MFP services are complete. If complete data on key outcomes cannot be obtained for a particular state for a large portion of MFP participants, that state will be eliminated from any analysis that requires the data that are missing.

Differing Definitions of HCBS. Finally, another challenge to using Medicaid administrative data is presented by the different definitions states use for specific types of HCBS, such as case management or habilitation. Such differences obviously have no effect on the state-specific analyses, but they could lead to measurement biases in our comparisons across states. To address this concern, MPR has requested that each state submit a description of how the service codes that appear on their HCBS claims map to different categories of HCBS, such as case management or personal care services. Changes in definitions within a state over the time period covered by the evaluation create even greater problems because they lead to biases in the estimates of impacts of the state, so we will work closely with the states to identify such changes.

I. INTRODUCTION AND BACKGROUND

A. BACKGROUND

Since the early 1980s, states have been striving to improve their long-term care systems and to increase the capacity of these systems to serve people in the community rather than in institutions. States have made progress in the provision of home- and community-based long-term care services by establishing an array of Section 1915(c) Medicaid waiver programs for populations such as the elderly, children with special health care needs, and people with physical disabilities, developmental disabilities, mental illness, HIV/AIDS, or traumatic brain or spinal cord injuries. Between 1999 and 2002, the number of home- and community-based service (HCBS) waiver participants grew by more than 25 percent (Kitchener et al. 2007), and, between 1992 and 2005, Medicaid HCBS spending grew by 15 percent annually, more than double the rate of all Medicaid long-term care services (Burwell et al. 2005).

Progress in the provision of home- and community-based long-term care services accelerated after the 1999 Olmstead decision, which established the necessity of providing Medicaid services to people with disabilities in the setting that would best meet their needs. An array of federal grant programs have made it easier for states to comply with this legal ruling. For example, in 2001, the federal government started the Real Choice System Change (RCSC) grant program to support state efforts to move people from institutions into the community. The RCSC grant program alone has awarded more than $270 million through 332 grants, 18 of which have been Comprehensive Systems Transformation grants to improve long-term care systems. States have used RCSC funds to plan and implement new management and fiscal policies designed to either divert people from institutional- to community-based care or transition people from institutions to the community (Anderson et al. 2006).

1. Money Follows the Person (MFP) Initiative

The MFP initiative—the newest component of the President's New Freedom Initiative—represents the largest demonstration grant program of its kind and the next major step in developing community-based long-term care programs. Enacted by the Deficit Reduction Act (DRA) of 2005, the MFP program is based on the premise that many Medicaid beneficiaries currently residing in institutions want to live in the community and could do so if they had adequate support, and that it would cost less than Medicaid currently spends for institutional care.[1]

A program such as MFP is needed because Medicaid programs are not structured as well as they might be for supporting transitions from institutional care to the community. Several factors continue to pose challenges to transitioning more institutionalized people to the community:

- One-time supports that are not long-term care in nature, but are critical to help transition someone into a home or community setting (for example, rental or utility deposits, basic furnishings, vehicle modification, or other help with transportation or housing), may not always be reliably available if a state's Medicaid program or other social programs do not adequately cover these services.
- Housing options are frequently limited, particularly if a beneficiary's home was sold after entering the institution or modifications are needed to make available housing accessible.
- Existing HCB waiver services are frequently capped and some programs have long waiting lists that deny some beneficiaries timely access to necessary HCBS.
- The range of long-term care services covered by a state's optional benefit or waiver program is often limited.
- Regulations typically restrict the hours of care per week that a Medicaid beneficiary can receive and may not be enough for the beneficiary, especially when first transitioning from an institution to the community.

[1] In addition to the MFP demonstration, the DRA of 2005 included initiatives designed to help Medicaid programs rebalance their long-term care systems. For example, it gave states the option to provide HCBS as a state plan benefit and the authority to allow people to self-direct personal care services.

The MFP program is designed to help states address these barriers by providing grant funding to states to (1) support the design and implementation of a transition program for long-term institutionalized Medicaid enrollees (the transition program), and (2) provide additional funds for restructuring state long-term care systems (the rebalancing program). Each state that receives an MFP demonstration grant must use MFP grant funds to establish a transition program for Medicaid enrollees in long-term institutional care. Enrollees transitioned to the community by the MFP program are eligible for a package of HCBS financed with MFP grant funds. Eligibility for these services lasts for one year from the day of transition (365 days). For many, but not all, of the HCBS provided during this one year of eligibility, each state will receive an enhanced federal match, which will come from its allotment of MFP grant funds. States must design and implement a strategy for using these enhanced funds to reinvest in and restructure their long-term care systems; this is known as "rebalancing" the long-term care system.

2. Basic Features of the MFP Program

Each MFP program will be tailored to state needs and is therefore unique, but each must incorporate some key basic features. The long-term care system in each state is highly idiosyncratic, and these systems exhibit tremendous variability across states. In addition, some states designed and implemented transition and nursing home diversion programs before the advent of the MFP demonstration. Because of this level of variability in long-term care systems and prior experience implementing programs similar to MFP, every state participating in the demonstration is starting its MFP program at a different stage of development, and design features of each MFP program will vary considerably across states.

Transition Programs. By statute, the MFP program is for people institutionalized for a minimum of six months in nursing homes, hospitals, intermediate care facilities for the mentally

retarded (ICFs-MR), or institutions for mental diseases (IMDs).[2] These individuals must be eligible for full Medicaid benefits for at least the month before transition to the community. MFP participants begin receiving a package of HCBS financed by the state's MFP grant funds the day they transition to the community and can continue to receive these services for up to one year, or 365 days, after the date of transition. After exhausting their 365 days of eligibility for MFP-financed HCBS, MFP participants become regular Medicaid enrollees and receive HCBS through the state plan and/or a waiver program, depending on the participant's eligibility status. In general, MFP transition programs are designed to provide a richer mix of community services for a limited time to help make the transition to the community successful. The underlying assumption is that people need additional services to transition and adjust to community living, but these additional services are not needed long term.

States may enroll MFP participants in an HCBS waiver program during their one year of eligibility for MFP. If states exercise this option, MFP participants must also meet eligibility requirements for the waiver program. As MFP participants use HCBS during the 365 days of MFP eligibility, states may receive an enhanced federal match (known as the Federal Medical Assistance Percentage, or FMAP), which is drawn from their MFP grant funds.[3] The MFP-enhanced FMAP is also available for demonstration services, which are either Medicaid services not included in the state's array of HCBS for regular Medicaid enrollees or qualified HCBS above what MFP participants would have received as a typical Medicaid enrollee. In addition, states may offer MFP participants supplemental services, which are services not typically

[2] States may set the minimum length of institutionalization between 6 and 24 months for MFP participants, but all have selected 6 months as the minimum requirement.

[3] The MFP-enhanced FMAP is set in statute and the MFP-enhanced FMAP = (state's regular FMAP + [1 - state's regular FMAP]*.5). The MFP-enhanced FMAP cannot exceed 90 percent. In federal fiscal year 2008, MFP-enhanced FMAPs will range from 75.00 to 86.47 percent.

reimbursable under the Medicaid program but that make the transition to a community setting easier (such as a home computer or trial visit to the proposed community residence). States receive the regular FMAP from their MFP grant allotment when they provide supplemental services. Therefore, MFP participants can receive up to three categories of HCBS during their 365 days of MFP eligibility: (1) qualified HCBS, (2) demonstration services, and (3) supplemental services. For the first two categories, the state receives enhance federal matching funds from the state's MFP grant funds. For the third category of HCBS, the state receives its regular federal match, which will also come from its MFP grant funds.

Rebalancing Programs. MFP rebalancing programs have fewer basic requirements than the transition program. States must use the enhanced matching funds they receive when MFP participants use qualified HCBS or demonstration services to support changes in their long-term care systems. The goal of the MFP rebalancing program is to enhance the state's ability to serve enrollees with long-term care needs in the community and reduce the use of institutional care.

There are no formal requirements for how these funds are used or reinvested. States may use the enhanced funds in a variety of ways, including (1) reducing the use of institutional care (such as supporting the costs of closing beds or facilities), (2) supporting transitions of people not eligible for MFP, (3) expanding the availability of HCBS programs (such as increasing HCBS waiver slots or adding a self-direction program), or (4) improving the infrastructure (such as expanding the availability of affordable and accessible housing). Each state sets specific benchmarks for measuring the success of the rebalancing strategy, and the type of benchmarks selected should reflect the design of the rebalancing program.

3. MFP Grant Awards

MFP demonstration grants totaling nearly $1.3 billion were awarded to 30 states and the District of Columbia. State-level data presented by Burwell, Sredl, and Eiken (2008) suggest

that the 31 MFP states spent nearly $34 billion on HCBS in federal fiscal year 2007. This means that the federal funding alone represents approximately a 4 percent increase in HCBS spending across the MFP states. The percentage increase in spending will be greater when state funding is factored into the calculation.

The awards were staggered, with 17 awards made in January 2007 and 14 in May 2007. Table I.1 lists the states, the number of people states proposed to transition in their approved program design documents (known as operational protocols), and the federal grant amounts (overall and per MFP participant). Across the 30 states and the District of Columbia, states proposed to transition 35,572 people. Delaware proposed to transition 100 people, while Illinois proposed to transition 3,100 people (approximately 9 percent of the total number of proposed transitions across all states). Only the District of Columbia and Iowa did not propose to transition the elderly.[4] Nearly all states (27) will transition people with developmental disabilities, and 8 will transition people with mental illness.

As described above, states will use the federal grant funds to design their transition and rebalancing programs and to support the general administrative costs of implementing and managing these programs.[5] The funds will also be used for the FMAP for the HCBS used by MFP participants during their one year of MFP eligibility. The data in Table I.1 clearly demonstrated that federal grant amounts vary across states. The per-participant federal amount may be misleading because it does not include what states will spend for this program. Ideally, the table would present the per-participant costs of HCBS received during the 365 days of MFP eligibility. At the time of this report, we did not have the information necessary to separate

[4] The District of Columbia intends to expand their MFP program to include the elderly and possibly other groups.

funds for program administration from those for services for all states. The evaluation will include an assessment of per-participation spending to understand program costs.

Several reasons explain variability in expenditures per person transitioned, including:

1. different starting points—some states have established transition programs that they will expand, and others will develop new programs that may require greater start-up costs
2. different types of populations transitioned—some states will transition greater proportions of enrollees with developmental disabilities, a population that typically uses a more costly array of services
3. different packages of services relative to what a regular HCBS user would receive—some states may offer a richer array of services to MFP participants.

Our implementation analyses, described in Chapter II, are designed to describe the variability in state long-term care systems and MFP program design and implementation. This information will help us understand the state-level variability in per-person program costs. Our initial work included summarizing the programs based on the descriptions states provided in their grant applications (Lipson et al. 2007).

(continued)

[5] Each state must have a full-time project manager administering the MFP program, and grant funds cover this person's salary and benefits.

TABLE I.1

MFP DEMONSTRATION GRANTS:
PROPOSED NUMBER OF TRANSITIONS AND FEDERAL GRANT AMOUNTS, BY STATE

State	Number of Transitions Proposed	Elderly	PD	MR/DD	MI	Other	Five-Year Federal Commitment	Per-Participant Federal Spending
Arkansas	305	92	146	60	7	0	$20,923,775	$68,603
California	2,000	419	897	316	183	185	$117,805,229	$58,903
Connecticut	700	267	175	68	141	49	$30,651,724	$43,788
Delaware	100	32	28	20	20	0	$5,298,282	$52,983
District of Columbia	400	0	0	400	0	0	$37,498,726	$93,747
Georgia	1,312	375	375	562	0	0	$44,034,960	$33,563
Hawaii	415	175	190	50	0	0	$10,531,860	$25,378
Illinois	3,457	1,517	1,000	255	685	0	$69,727,420	$20,170
Indiana	1,039	793	246	0	0	0	$21,047,402	$20,257
Iowa	528	0	0	475	0	53	$51,383,613	$97,317
Kansas	963	242	356	315	0	50	$41,655,861	$43,256
Kentucky	546	215	90	197	0	44	$49,174,209	$90,063
Louisiana	355	259	76	20	0	0	$13,742,646	$38,712
Maryland	1,994	1,361	371	250	0	12	$71,043,160	$35,628
Michigan	3,100	2,325	775	0	0	0	$54,375,943	$17,541
Missouri	250	48	52	125	0	25	$5,125,352	$20,501
Nebraska	900	400	200	200	0	100	$27,686,808	$30,763
New Hampshire	354	87	200	5	0	62	$15,829,191	$44,715
New Jersey	587	173	89	325	0	0	$36,277,687	$61,802
New York	2,000	850	850	0	0	300	$61,498,857	$30,749
North Carolina	304	22	202	80	0	0	$3,360,352	$11,054
North Dakota	110	42	34	30	0	4	$8,434,036	$76,673
Ohio	2,231	1,428	345	373	85	0	$105,645,125	$47,353
Oklahoma	2,007	1,575	282	150	0	0	$39,189,885	$19,527
Oregon	1,000	260	500	200	0	40	$77,163,797	$77,164
Pennsylvania	2,667	1,878	537	87	165	0	$73,329,961	$27,495
South Carolina	192	160	32	0	0	0	$5,814,422	$30,283
Texas	2,999	800	600	1,599	0	0	$88,112,393	$29,381
Virginia	1,041	325	358	358	0	0	$18,835,906	$18,094
Washington	660	348	172	80	60	0	$21,109,770	$31,985
Wisconsin	1,056	448	189	247	0	172	$37,125,825	$35,157
Totals	35,572	16,916	9,367	6,847	1,346	1,096	$1,263,434,176	$35,518
Percent of Total	100	47.6	26.3	19.2	3.8	3.1	n.a.	n.a.

Source: State MFP operational protocols.
Note: This information is from the MFP operational protocols approved between September 2007 and July 1, 2008. States may revise the transition numbers as they implement their programs.

MI = people with mental illness; MR/DD = people with mental retardation/developmental disabilities; n.a. = not available; PD = people with physical disabilities.

Before each MFP program could be implemented, the grantee had to obtain approval of its Operational Protocol (OP), which describes the program in detail, from the Centers for Medicare & Medicaid Services (CMS). Among other things, each state's OP specifies (1) how outreach and enrollment will be conducted, (2) the services participants will receive, (3) how quality will be assured, and (4) the strategies that will be used to involve stakeholders and secure housing for participants. Each state must also specify program benchmarks in its OP. Grantees must provide benchmarks for the number of transitions and total HCBS expenditures; they must also develop at least three additional benchmarks to track the rebalancing of their long-term care system.

B. OVERVIEW OF THE EVALUATION DESIGN

The national evaluation will assess the transition programs and the rebalancing initiatives. Our analyses will describe these programs and assess their effects on institutionalized enrollees and MFP participants, as well as their effects on the long-term care system and how the system is balanced between institutional care and HCBS.

The national evaluation is guided by two basic logic models, one for the transition programs and the other for the rebalancing initiatives. Figure I.1 illustrates the model for MFP transition programs. States determine which populations to target, how they will identify enrollees for transition, the types and amount of HCBS that will be available to MFP participants, and how they will ensure that MFP participants are safe and receive appropriate care. Some states may need to make system changes before implementing the MFP program (for example, amending a waiver program to create more waiver capacity or altering budget authority so that funds for institutional care more easily flow to community care when someone transitions). Once living in the community, each MFP participant receives HCBS according to his or her needs. For many of these services (the qualified HCBS and the demonstration services), the states will receive enhanced FMAP funds from their grant allotments, which are reinvested with the purpose of

rebalancing their long-term care system. The availability of enhanced FMAP funds gives states an incentive to transition high-need Medicaid enrollees: the more MFP participants use qualified HCBS and demonstration services, the more funds the state has to reinvest in rebalancing initiatives. However, the state does incur costs for its share of the new services provided.

FIGURE I.1

LOGIC MODEL FOR MFP TRANSITION PROGRAMS

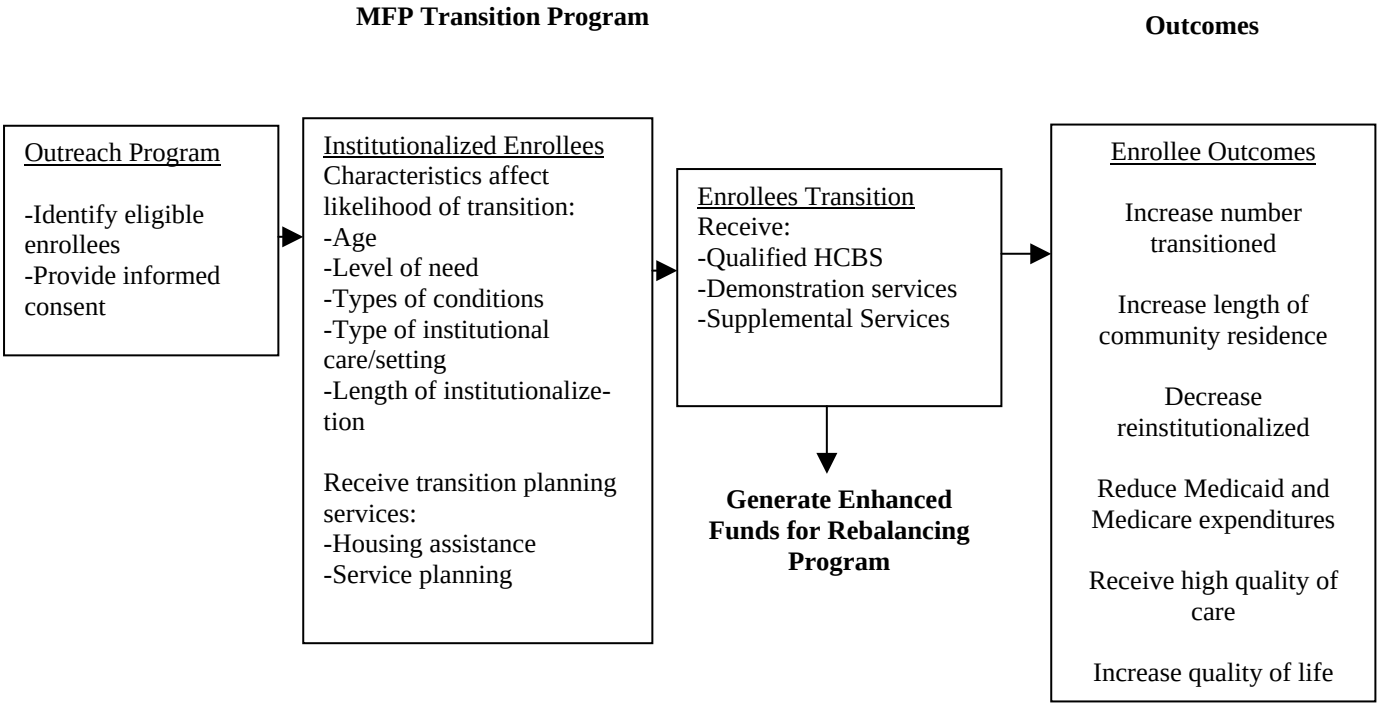
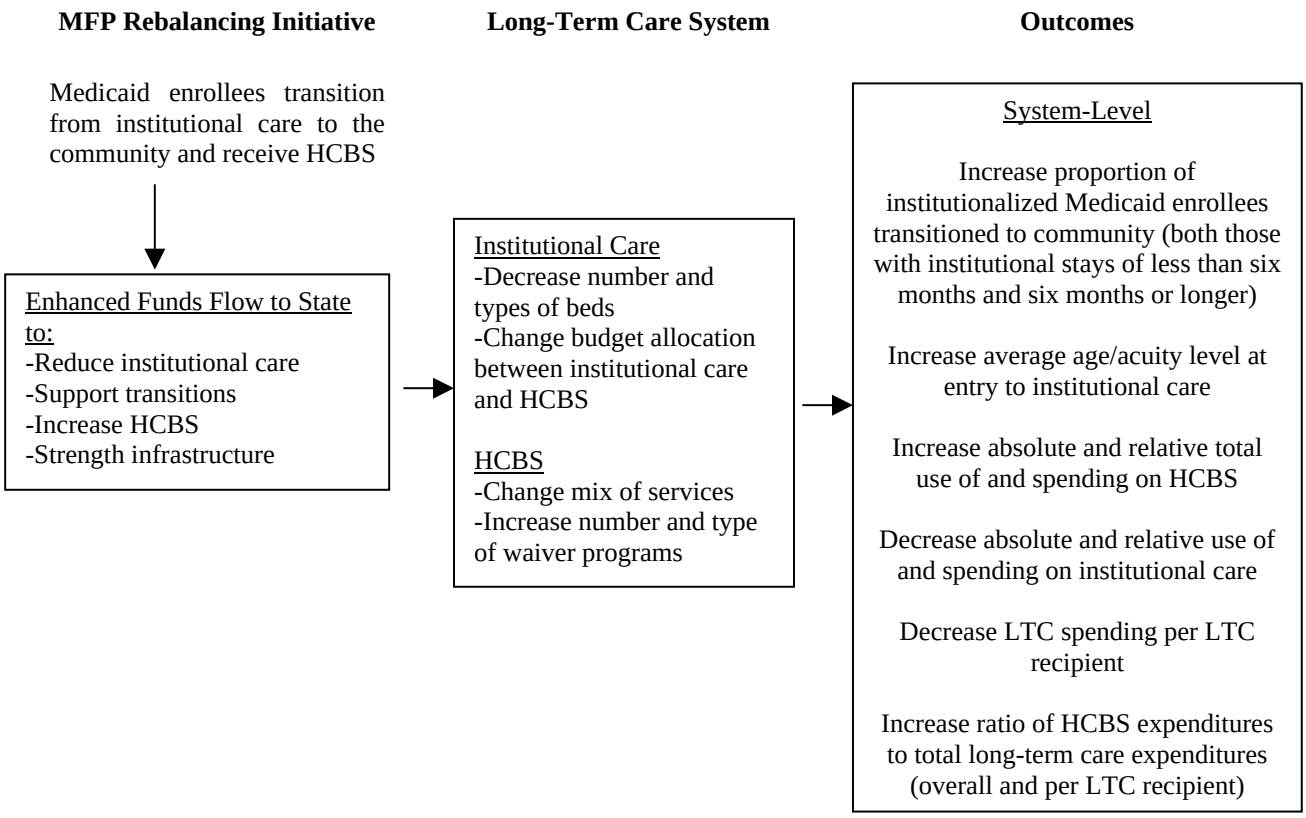


Figure I.2 illustrates MFP rebalancing initiatives. Some states plan to use the enhanced FMAP funds to reduce the use of, and spending on, institutional care by providing an enriched set of transition services or expanding subsidized housing options or downsizing institutions. Other states plan to target the funds to increase the use of, and spending on, HCBS by expanding HCBS waiver capacity or strengthening the HCBS workforce. Within each category, some states are investing in services for MFP participants, while other states are investing in the general long-term care system and enrollees who do not qualify for MFP. Regardless of how

states use the enhanced funding, the rebalancing of the enhanced FMAP funds is expected to further state goals to create system change and rebalance the long-term care system.

FIGURE I.2

LOGIC MODEL FOR THE MFP REBALANCING INITIATIVES



The national evaluation of the MFP program will seek to understand whether the program met its goals to (1) increase the number and proportion of long-term institutionalized Medicaid enrollees who can live successfully in the community, and (2) facilitate state rebalancing of long-term care systems. We anticipate MFP programs will have an array of effects on enrollees with long-term care needs, including increases in the likelihood and number of transitions from institutional to community settings and greater increases in HCBS use and expenditures than in institutional care.

1. Primary Research Questions

The two fundamental questions guiding the evaluation are:

1. How was the MFP program implemented?
2. What effects did the MFP program have on participants and the long-term care system more generally?

State variability in program implementation requires the evaluation to answer the first question in detail. As suggested above, grantees are starting at different points and tailoring their MFP programs to their state systems and needs. All states must establish annual targets (called benchmarks in the MFP program) for the number of transitions and total HCBS expenditures, but they must also establish at least three state-specific benchmarks. Table I.1 illustrates some of the state variability in program size and types of populations targeted. State variability in program design and implementation highlights the need for the national evaluation to conduct a comprehensive analysis that describes and classifies each program along several different program characteristics. The evaluation will document this variation to help explain cross-state variation in program outcomes.

The second fundamental question requires analyses of impacts and outcomes at both the individual and system levels. This question looks at whether the MFP program had the intended effects, including effects on institutionalized Medicaid enrollees, MFP participants, HCBS expenditures, and the long-term care system more generally. Enrollee outcomes of interest are those that reflect the cost-effectiveness of MFP programs. MFP programs may be successful at transitioning institutionalized enrollees to the community, but this success will be jeopardized if participants cannot live in the community on a long-term basis or the costs of the transition program and participants' overall health care services are higher than if they had remained in institutional care. Outcomes related to cost-effectiveness issues include whether MFP

participants can (1) remain living in the community beyond the one-year MFP period (the length of community residence and likelihood of reinstitutionalization); and (2) obtain health care and long-term care services and supports of a quality and type equivalent to what they would have received had they remained in the institutional setting (the program's effects on the use of acute or subacute care services relative to what they would have been otherwise, the quality of HCBS care, and the incidence of adverse health events). Finally, because populations targeted by each MFP program are highly vulnerable and dependent on the receipt of personal assistance, their quality of life after the transition will be a critical determinant of program success. Most important, the evaluation will attempt to identify the types of participant and program characteristics that are most strongly associated with favorable outcomes on each of these dimensions. The system-level analyses will focus on whether the MFP programs affect the overall balance between institutional long-term care and HCBS.

The implementation, impact, and outcomes analyses are briefly described below. More complete descriptions of these analyses are provided in Chapters II, II, and IV, respectively. Table I.2 summarizes these analyses by presenting an overview of the data sources and methods that will be used to answer the evaluation's key research questions.

TABLE I.2

MFP RESEARCH DESIGN SUMMARY TABLE

Research Question	Outcome Measure	Data Source			Design		
		Web Report	MSIS/ Medicare Claims	Other Data[a]	Descriptive Analysis	Pre-MFP Comparison Group	Pre/Post MFP Participants
How was the program implemented? (Implementation Analysis)							
What was the MFP program? - Program Description							
What were the programs' transition goals?	- Program transition goals			✓	✓		
Which populations did grantees target for transition? What was their level of care? How did the size of the targeted population compare to total number of people institutionalized in the state at the start of the program?	- Basis of eligibility - Percent of MFP participants by level of care - Ratio of projected and/or actual number transitioned to number institutionalized		✓	✓	✓		
How did grantees identify people to target for transition? How was the program promoted to beneficiaries?	- Categories of recruitment and outreach activities - State agencies that conducted these activities - Types of challenges to recruitment and outreach and descriptions of how states addressed the challenges	✓		✓	✓		
What services did grantees make available to MFP participants not normally covered by the Medicaid program? What types of demonstration and supplemental services were offered?	- Types of services provided by grant - Whether program offered an enriched service package or filled gaps in service - Use of managed long-term care	✓		✓	✓		

TABLE I.2 (*continued*)

Research Question	Outcome Measure	Data Source			Design		
		Web Report	MSIS/ Medicare Claims	Other Data[a]	Descriptive Analysis	Pre-MFP Comparison Group	Pre/Post MFP Participants
To what extent did grantees involve consumers, family members, providers, and other stakeholders when designing and implementing the MFP program? How successful were they in these efforts?	- Assessment of consumer and family involvement in MFP program design - Assessment of consumer and family involvement in ongoing program operations	✓		✓	✓		
How did MFP programs ensure or promote consumer choice of residential setting, and to what extent did MFP participants choose to self-direct services?	- Approach to housing (active versus passive strategies) - Percent enrolled in self-direction programs	✓		✓	✓		
What other changes in state Medicaid policies or programs did grantees make to (1) transition MFP participants, and (2) help them remain in the community?	- Assessment of categories of changes (e.g., amendments to existing HCBS 1915(c) waivers, establishment of new waivers, modification of budget policies)	✓		✓	✓		
Did the MFP programs accomplish their transitioning and rebalancing goals? - Program Performance Indicators							
To what extent did the grantees achieve their benchmarks? Which states were more effective in achieving their benchmarks? How ambitious were the benchmarks?	- Ratio of actual results to benchmark - Ratio of benchmark to pre-MFP values - Year-to-year trend in ratio of HCBS spending to total long-term care spending - Year-to-year trend in institutional spending - Year-to-year trend in HCBS spending	✓	✓		✓		

TABLE I.2 (*continued*)

Research Question	Outcome Measure	Data Source			Design		
		Web Report	MSIS/ Medicare Claims	Other Data[a]	Descriptive Analysis	Pre-MFP Comparison Group	Pre/Post MFP Participants
What factors were associated with greater success in achieving benchmarks?	- Correlation of program characteristics with success indicators	✓	✓		✓		
What were the most common challenges to achieving the targeted number of transitions? What challenges did grantees encounter in trying to achieve their benchmarks? How did they try to overcome these challenges?	- Assessment of grantee-reported challenges	✓					
What processes and system changes were implemented to rebalance Medicaid long-term care spending? – Systems Change							
How much did states get in enhanced FMAP grant funds to rebalance their LTC systems? How were these enhanced funds used to rebalance LTC systems?	- Total enhanced funding received overall and as a percent of total HCBS spending and as a percent of total spending on long-term care services						
	- Types of rebalancing benchmarks (level of ambitiousness or transition services and infrastructure, institutional capacity reduction, or investments in HCBS systems) or by type of targeted group (MFP participants only or all users of long-term care services)	✓		✓	✓		
Are the changes made by grantees sustainable? Will they have lasting impact on state LTC systems beyond the MFP demonstration period?	- Assessment of changes made by grantees	✓			✓		

TABLE I.2 (*continued*)

Research Question	Outcome Measure	Data Source			Design		
		Web Report	MSIS/ Medicare Claims	Other Data[a]	Descriptive Analysis	Pre-MFP Comparison Group	Pre/Post MFP Participants
Has collaboration among state agencies increased or improved as a result of MFP rebalancing and system change efforts?	- New collaborations - Enhancement of ongoing collaborations	✓			✓		
What effects did the MFP program have on institutionalized Medicaid enrollees and MFP participants? (Impact Analysis)							
How does MFP affect the probability of transition? What types of people are most likely to be transitioned?	- Probability of transition to the community - Subgroup analyses		✓	✓		✓	
Which types of MFP participants are most likely to transition successfully? What program types/features are associated with maintenance in the community?	- Probability of reinstitutionalization during the MFP demonstration period and the year after the demonstration period ended - Length of time until readmission - Reasons for readmission - Status 1 and 2 years after transitioning	✓	✓	✓	✓	✓	
What were the most/least successful settings for beneficiaries?	- Reinstitutionalization rates by qualified housing, beneficiary characteristics, types of transitional, qualified, demonstration, and supplemental HCBS and other services provided		✓	✓	✓		
How does MFP affect health care utilization?	- Rates of hospitalization and hospital days - ER use, SNF use, home health visits, and personal care services		✓	✓		✓	

TABLE I.2 (*continued*)

Research Question	Outcome Measure	Data Source			Design		
		Web Report	MSIS/ Medicare Claims	Other Data[a]	Descriptive Analysis	Pre-MFP Comparison Group	Pre/Post MFP Participants
How does MFP affect the costs of care?	- Medicaid expenditures (total, subtotal for LTC, by type of LTC services) - Medicare expenditures, by type of service		✓	✓		✓	
How does MFP affect quality of care?	- Treatment for falls, fractures, urinary tract infections, etc. - Preventable hospitalizations - Death		✓	✓		✓	
What are the impacts of MFP on the state's long term care costs?	- LTC costs per LTC recipient per month - Ratio of HCBS to total LTC costs		✓	✓	✓	✓	
What are the impacts of MFP on other Medicaid LTC recipients?	- Probability of receiving institutional care versus HCBS versus state plan LTC services - Days of institutional care - Volume of community-based care		✓	✓		✓	

TABLE I.2 (*continued*)

Research Question	Outcome Measure	Data Source			Design		
		Web Report	MSIS/ Medicare Claims	Other Data[a]	Descriptive Analysis	Pre-MFP Comparison Group	Pre/Post MFP Participants
How did the MFP program affect the quality of life and satisfaction of MFP participants? (Quality-of-Life Analysis)							
How do MFP participants fare living in the community? How does quality of life compare to what it was in the institution? Which types of MFP participants appear to have the greatest improvement in quality of life? Is improvement in quality of life associated with key program characteristics?	- Based on self-reported information to questions on: - Access to personal care - Choice and control - Respect and dignity - Community inclusion - Satisfaction - Percent employed			✓	✓		✓

[a]Other data include documents such as the MFP application and operational protocol, state financial reports, administrative files that have information on qualified residences, the MFP Quality of Life file, NF-MDS, OSCAR, and OASIS

ER = emergency room; FMAP = Federal Medical Assistance percentage; HCBS = home- and community-based services; LTC = long-term care; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set; OASIS = Outcomes and Assessment Information Set; OSCAR = Online Survey, Certification, and Reporting database; SNF = skilled nursing facility.

2. Implementation Analyses

The implementation analyses will provide (1) a detailed description of the MFP program and the goals set by individual grantees, (2) an assessment of the strategies states use to affect system change, and (3) analyses of whether each grantee met the benchmark targets it specified for this programs (see Chapter II). The first two components of the implementation analyses will rely on states' OPs, which describe their programs and benchmark measures in detail, and semi-annual progress reports. The progress reports are designed to capture information on all aspects of MFP programs; their achievements and system improvements, as well as their challenges and how grantees address them. The analysis of state progress in meeting benchmarks targets will include an assessment of the level of change represented by the benchmarks relative to past trends and levels. This analysis will rely on data reported by the grantees and analysis of Medicaid eligibility and claims records.

3. Impact Analyses

The evaluation will include two types of impact analyses: (1) impacts on the overall population of long-term institutionalized Medicaid beneficiaries, and (2) impacts on MFP participants (see Chapter III for more details). The first impact analysis will estimate changes in the probability of transitioning to the community among Medicaid beneficiaries who live in institutions at least six months. The second impact analysis will estimate the impacts of the MFP program on expenditures, service use, quality of care, and mortality of MFP participants.

Our approach to identifying impacts involves capitalizing on the longitudinal nature of the MSIS and MAX data available for the study. For the first analysis, which will assess outcomes that typically only occur once for each person during the analysis period (such as a transition from a long-term institutional stay to the community during a given year), we will examine changes between pre-MFP and post-MFP trends in outcomes to determine whether the program

has shifted the trends. For the second analysis, which will assess outcomes that can be measured both while someone is in an institution and in the community (such as annual service use and costs), our approach includes the development of multiple comparison groups (what we call "counterfactual" groups), which allows us to create a range of impact estimates. For example, the change in expenditures for acute care will be estimated before and after the transition to the community, and these changes will be compared to similar changes for two different counterfactual groups. Multiple counterfactual groups will provide multiple estimates of what would have happened to the participants and Medicaid costs if the MFP program had not been implemented. The multiple estimates will be combined using various assumptions about the proportion of MFP participants who would not have been able to transition without the benefit of MFP.

4. Quality-of-Life Analyses

The administrative data available for the national evaluation do not allow for a credible comparison group methodology for assessing the effect of MFP on participants' quality of life. Even if a credible comparison group could be defined, quality-of-life information is not available in the administrative data, and primary data collection from a comparison group will not be feasible. Therefore, our analysis of participant quality of life, and how quality of life changes, will rely on a pre/post methodology and primary data collected by the states.[6] Grantees will collect quality-of-life data from MFP participants shortly before the transition to the community and approximately one and two years after the transition. We will measure changes in well-being and quality of life on seven dimensions and assess the relationship between these changes

[6] It may be possible, for some subset of overlapping measures, to compare changes in outcome measures to data from the nursing facility minimum data set (NF-MDS) for people in institutions to changes over the same time frame for those who do not transition.

and participant and program characteristics to identify the characteristics most strongly associated with increases in quality of life.

5. System Change and Rebalancing of Long-Term Care Systems

In addition to the analyses described above, we will assess changes that occur in the overall balance of state long-term care systems (see Chapter V). Unlike what is planned for the implementation analysis, which is an assessment of state achievement of individual program benchmarks, this analysis will examine the effects of MFP on the balance of state Medicaid long-term care systems more generally. It will include analyses of system-wide measures (such as changes in the percentage of expenditures that are for community-based services and the ratio of institutional to community-based expenditures per user). These analyses will be done at the state level across all the states with MFP grants. To the extent possible, we will examine the causes of the changes (for example, changes in the proportion of long-term care recipients in institutional care or changes in the costs of community-based services relative to institutional services).

C. CHALLENGES FOR THE EVALUATION

The evaluation faces several challenges, including no resources to conduct site visits, which typically allow us to collect rich detail about program implementation. The evaluation also faces the challenge of developing comparison strategies that enable us to calculate valid and reliable estimates of program impacts. Finally, the quality of the Medicaid data available for the evaluation is known to vary across states. Next, we describe each issue and our strategy to minimize its influence on the final results of the evaluation.

1. Lack of Site Visits

Most implementation analyses include site visits that are designed to obtain in-depth information about how the program is implemented and rich contextual details about the

environment in which the program operates. Nevertheless, the national evaluation does not provide for site visits. The evaluation addresses this challenge in four ways.

1. MPR, Thomson Reuters, and CMS have designed a detailed progress report that grantees must submit on a semi-annual basis. This report asks grantees to report on all aspects of program operations including outreach, enrollment, informed consent and guardianship, stakeholder involvement, benefits and services, consumer supports, self-direction programs, quality management systems, and housing for participants. In addition, the grantees will report progress toward their benchmarks (specified in their OPs) and will identify organizational and statewide issues that either enhance the MFP program's ability to meet its goals or create additional challenges for the program. Throughout the report, grantees are asked to discuss and describe their successes and challenges.

2. We propose to add questions to the semiannual progress report starting in the second half of 2010 that ask about the sustainability of MFP-related activities and whether their programs have created permanent changes to the long-term care system in their state. These questions are likely to include inquiries about the perceived effectiveness of the rebalancing program and the enhanced matching funds, changes in funding that support the continuation of rebalancing activities, and other policy changes that will sustain the transition program when the MFP demonstration grant ends.

3. CMS will be conducting site visits, and we will explore the possibility with CMS of collecting some limited amount of information during their visits to grantees. Either the site visitors will collect select information during the visits, or MPR will join the site visit team for a select number of grantees.

4. When feasible, MPR will contact states by telephone and conduct interviews to help us obtain the level of detail necessary to understand program implementation and results.

2. Defining a Credible Comparison Group for Impact Analyses

Random assignment is not feasible for the national evaluation of the MFP program, and the national evaluation must develop a strategy for identifying a comparison or counterfactual group that will allow us to develop estimates of program impacts on participants. A methodology based on a comparison group design allows us to develop a measured set of outcomes that plausibly would have occurred for participants if MFP had not been implemented.

When constructing a comparison group, we will want to identify a group that is as similar as possible to MFP participants. Administrative data from the Medicaid Statistical Information

System (MSIS) and the NF-MDS will be used to identify people for these groups. Because these data sources do not provide complete information about each person, any comparison group we identify is likely to differ from MFP participants along some key characteristic not captured in the data. Nonetheless, by drawing the comparison group from the same state and the same data in the pre-MFP period, we hope to "net out" most such differences.

We propose to create two comparison groups and then combine them to yield an overall estimate of program impacts. We will first create one comparison group that includes Medicaid enrollees during a previous period who appear to meet the MFP eligibility criteria and transitioned from institutional to community-based care. This group will represent people who are similar to MFP participants, but were able to transition without the benefit of the MFP program. Comparison of outcomes for MFP participants to outcomes for this comparison group will be considered lower-bound estimates, because it assumes that everyone who transitions under MFP would have done so even in the absence of the program. The other comparison group will include institutionalized Medicaid enrollees in the pre-MFP period who have the same set of observable characteristics as MFP participants, but did not transition to the community. Estimates based on this comparison group will be considered upper-bound estimates, because this comparison assumes that everyone who transitions under MFP could not have done so had the program not existed. The lower- and upper-bound estimates provide a range of estimates of use and costs within which the true impacts are likely to fall. We will also provide a point estimate equal to a weighted average of the two bounds, with weights that reflects our best estimate of the proportion of transitioning institutional residents who would not have been transitioned without MFP. Our analysis will also account for the possibility that some beneficiaries may be discharged from institutional care a few months later than would have occurred in the absence of the program, due to the incentive states have to obtain the enhanced

federal match rate if the beneficiary receives qualified HCBS or demonstration services after discharge from institutional care.

3. Data Quality

Because this evaluation will rely heavily on administrative data and MFP participants will be Medicaid enrollees, understanding quality issues that affect Medicaid administrative data will be paramount. We will obtain Medicaid data from MSIS and the Medicaid Analytic Extract (MAX) system. MAX data are derived from MSIS data, and whenever possible we will use MAX data because they have undergone additional data quality checks and, unlike MSIS, include final claims records. However, MAX data typically become available approximately three years after an enrollee receives a service. When MAX data are not available, we will use MSIS data.

Based on our years of experience working with MSIS and MAX data, we know that the quality of the data varies across states. Some states have devoted more resources or have a better capacity to create these files than other states. MPR conducts quality reviews of each MSIS and MAX data file before it is approved for research use. Some data quality checks we conduct focus on the completeness of the data and others focus on the accuracy of the data. We know that in earlier years (before 2003), many states were submitting MSIS claims files that had far fewer claims for home- and community-based waiver services than what their financial reports suggested. Over the years, the reporting of these claims has improved greatly. Nevertheless, we still identify states where the total expenditures for waiver services based on MSIS claims records are substantially less than the expenditures in state financial reports they submit to CMS. In our analyses of HCBS, particularly the impact analyses, we will not use data before calendar year 2004 to minimize the effect of incomplete HCBS records.

Managed care service systems affect whether a state submits claims for all services provided. Historically, states have had great difficulty getting managed care plans to submit service use claims for services they provide to their members, and most states that have Medicaid enrollees in managed care are not able to submit a complete history of claims information for their managed care enrollees. These reporting issues are likely to affect the evaluation to the extent MFP participants and members of the comparison groups are enrolled in managed long-term care. Managed long-term care systems range from those that only manage HCBS, such as Wisconsin's Family Care plan, to the Program of All-Inclusive Care for the Elderly (PACE), which manages the full array of services. Full PACE programs receive capitated payments for both Medicaid and Medicare services. We anticipate the issue of managed long-term care will have more of an impact on the most recent claims records we use than on the oldest claims records.

Few options are available to the national evaluation if the regular MSIS files do not include all claims records for enrollees in managed care. We usually work around this problem by restricting our analyses of expenditures and utilization to those enrollees who never enroll in a managed care plan during the study period. Until we examine MAX and MSIS data and obtain the enrollment and service use records financed with MFP grant funds, we will not know to what extent MFP participants are receiving any of their preventive, acute, or long-term care through managed care plans.

Claims for MFP-financed HCBS will not be included in the regular MSIS files, and grantees will submit MFP-financed services in a separate file, known as the MFP Services file. States have been told to submit service claims for all services financed with MFP grant funds, whether or not the services are provided through fee-for-service or managed care. MPR will work with the states that provide MFP services through managed long-term care plans to ensure the records

for MFP services are as complete as possible. If the data for a particular state are incomplete in some important way for a large portion of MFP participants, that state will be eliminated from any analysis that requires the data that are missing.

Another challenge to using Medicaid administrative data for the evaluation of the MFP program is presented by the different definitions states use for HCBS. States define types of HCBS, such as case management or habilitation care, differently. We will minimize this issue by conducting all analyses separately for each state. However, this issue does limit our ability to compare across states. To address this concern, MPR has requested that each state submit a description of how the service codes that appear on HCBS claims map to different categories of HCBS, such as case management or personal care services, to help the evaluation identify when and to what extent state definitions of specific HCBS differ. Changes in definitions within a state over the time period covered by the evaluation will create even more difficult problems and we will work closely with the states to identify such changes.

The national evaluation will also use data from the NF-MDS. These data provide a rich source of information on health and functional status for nursing home residents and people in select ICFs-MR. While these data are extremely useful for determining level of need of institutionalized enrollees, they are not available for most people in ICFs-MR and other facilities and hospitals that provide long-term institutional care. In addition, at least one state with an MFP demonstration grant has told us that the NF-MDS data for enrollees not eligible for Medicare (Medicaid-only enrollees) are incomplete and unreliable. This data issue creates a challenge for the evaluation because we will not have equivalent information on all institutionalized enrollees and MFP participants. We will conduct separate analyses for the different targeted populations. Whenever possible, we will build alternative measures of need

based on information available in claims data, such as diagnostic codes, types of prescribed medications, and service utilization patterns.

D. PURPOSE AND ORGANIZATION OF THE RESEARCH DESIGN REPORT

This report describes in detail MPR's approach to evaluating the MFP program. Chapter II describes the implementation analysis in detail. The impact and outcomes analyses are described in Chapters III and IV respectively. Each chapter sets forth the research questions the analysis will address, and the data and methods that will be used. We also include draft table shells to illustrate how the results of the evaluation will be presented. Chapter V discusses how we will track and measure state rebalancing efforts, both qualitatively and quantitatively. Chapter VI presents how we will synthesize our analyses across the 31 programs. The final chapter provides information about the interim and final reports the evaluation will produce.

This report will serve as a roadmap for the evaluation. We anticipate that the analyses described in this report will be updated and revised as the MFP programs mature and we learn more about program implementation issues. In addition, we anticipate that some unforeseen factors will arise and require us to adjust the design of specific components of the evaluation. The final reports will fully document the procedures used and how (and why) they differ from the planned analyses described in this document.

II. IMPLEMENTATION ANALYSES

The outcomes and impacts of the national MFP demonstration program depend on how states design their programs and their success in implementing those programs. The aim of the implementation analysis is to describe each state grantee's MFP program features and identify the similarities and differences in their approaches to transitioning long-term institutionalized residents and to long-term care system rebalancing. Based on these commonalities and differences, the implementation analysis will produce a typology of MFP models that can be used in the impacts analysis to examine the association of each model with varying types or levels of impacts.

The evaluation of MFP program implementation will address the following research questions:

- What are the key differences in transition target groups across state MFP programs, in relative size and level of need?
- What are major differences in states' transition program features?
- How do states propose to rebalance long-term care systems, and how do they invest revenues from the enhanced Federal Medical Assistance Percentage (FMAP) in long-term care system rebalancing?
- What are the major barriers to, and facilitators of, successful transitions and long-term care system rebalancing? Why are some states more successful than others in implementing an MFP program?
- To what extent do grantees achieve their targets for number of transitions, and increases in Medicaid home- and community-based services (HCBS) spending, annually and over the four-year grant period?
- Are transition programs, Medicaid policy changes, or long-term care system changes made under the MFP grant program likely to be sustainable beyond the demonstration period?

Much of the data for this part of the evaluation will come from information supplied by grantees in MFP grant applications, approved Operational Protocols (OPs), and semiannual

progress reports. The OPs reflect each grantee's CMS-approved objectives (called "benchmarks"), and grantees must report on their progress toward these benchmarks semiannually. Self-reported information has some drawbacks, such as a tendency to overstate progress or minimize challenges. However, the web-based progress reports have been designed to obtain information on a regular basis about challenges in achieving goals or implementing specific program components, and how grantees have addressed them. This chapter describes how we plan to conduct the six components of the implementation analysis identified above.[1] In addition, it proposes a preliminary typology of state approaches to transition.

A. MFP TRANSITION TARGET POPULATIONS

Differences in the target populations that MFP states seek to transition may influence the ease or difficulty involved in achieving transition targets and maintaining people in home- or community-based settings during and after the one-year transition period. Therefore, we will compare state grantee transition groups by (1) distribution across target group categories, (2) size of transition target group relative to total number of institutional residents, and (3) level of need of those who are actually transitioned.

1. Distribution Across Target Groups

Although there are common eligibility requirements for MFP transition participants, each state grant program has leeway to select target populations. These populations fall into five categories: (1) adults age 65 and older; (2) people under age 65 with physical disabilities; (3) people with mental retardation or developmental disability; (4) people with chronic mental illness; and (5) other (for example, people with more than one diagnosis or condition, such as

[1] Because state grantees can modify MFP policies and procedures over the demonstration period, the specific approach to analyzing MFP implementation may be adjusted in response to MFP program changes.

physically disabled people who are also substance abusers). All MFP transition participants must (1) have resided in a qualifying institution (nursing home, intermediate care facility for the mentally retarded [ICF-MR], or psychiatric facility) for at least six months; (2) be eligible for Medicaid for at least one month before leaving the institution; and (3) move into a qualified residence, defined as a home, apartment, or group home of four or fewer residents. Within these confines, states can select the number and distribution of people to transition in the five target groups.

The analysis will present descriptive statistics about the number and proportion of each of these target groups in each state's total MFP transition population at four points (Table II.1): (1) in the original application (fall 2006), (2) in the approved OP (dates range from October 2007 to July 2008), (3) midway in the MFP program (end of 2009), and (4) toward the end of the MFP demonstration period (end of 2011). If information about how the targets were developed and the reasons for changes in transition targets is available in state OPs or semiannual reports, we will explain how the targets emerged and why any changes occurred.

TABLE II. 1

TRANSITION TARGETS AT KEY POINTS IN THE MFP PROGRAM

	Proposed				Actual			
	MFP Application October 2006		Approved OP (October 2007–July 2008)		Midpoint in Demonstration (December 2009)		End of Demonstration (Fall 2011)	
State/Target Population	Number	Percent of State Total	Number	Percent of State Total	Number	Percent of State Total	Number	Percent of State Total
State A • Elderly • PD • MR/DD • MI • Other								
State B • Elderly • PD								
State C • MR/DD								
State D • Elderly • PD • Other								

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

2. Size of Transition Groups

To assess the relative size of each state's transition program, the analysis will compare the number of people that each state proposes to transition as a proportion of total long-stay (more than six months) residents of institutions. For example, two states both proposing to transition 600 elderly residents of nursing facilities represent different degrees of effort, and different potential for long-term care system rebalancing, if in one state this number represents 1 percent of all nursing home residents, and in the other 20 percent. We will calculate the average number of people to be transitioned per year under MFP as a percent of all long-stay institutional residents before the MFP began (2006), derived from Medicaid Statistical Information System (MSIS) and/or Medicaid Analytic Extract (MAX) Medicaid nursing home, psychiatric facility,

and ICFs-MR claims records. We will also compare the average number of transitions per year proposed over the five-year MFP period (2007-2011) to the average number of people who transitioned per year for the previous three years (2004-2006) among those staying six months or longer.

The denominators for these two measures—all Medicaid long-stay residents, and Medicaid long-stay residents who transitioned before the MFP program—could include people who would not qualify for MFP (for example, because they are not Medicaid eligible for an entire month before leaving, or, for various reasons, could not move out of an institution). However, the measures help compare the magnitude of state MFP transition targets relative to each other. Table II.2 shows how the results will be presented, and we may show the results by the proportion with stays of 6 to 11 months, and 12 months or more, if we find significant differences in these proportions across states from baseline data analysis. We will also produce a table showing proposed transitions relative to residents of psychiatric facilities younger than age 21 and older than age 65.

TABLE II.2

SIZE OF STATE MFP TRANSITION TARGET POPULATIONS

	MFP Transition Targets (2007-2011) Relative to:			
	Total Number of Long-Stay Institutional Residents in 2006		Average Number Transitioned Before MFP (2004-2006)	
State	Nursing Facilities	ICFs-MR	Nursing Facilities	ICFs-MR
Kentucky				
Michigan				
Missouri				
Nebraska				
North Dakota				

ICFs-MR = intermediate care facilities for the mentally retarded.

3. Level of Need of Transition Target Groups

States vary in the proportion of their institutionalized residents who can be defined as "low-care," broadly defined as not needing physical assistance with any of the four late-loss activities of daily living (ADLs)—bed mobility, transferring, using the toilet, and eating—and not classified in either the "special rehab" or "clinically complex" Resource Utilization Group (RUG-III) (Mor et al. 2007). By this definition, an estimated 11.8 percent of all long-stay (at least 90 days) nursing facility residents in the United States in 2005 were classified as low-care, ranging from 1.8 to 21.5 percent among the 50 states.

Whether or not state transition programs deliberately target people who are harder to serve (high-care) or easier to serve (low-care), they may find it easier to develop transition plans for people with low-care needs.[2] This may be especially true in states that have not previously tried to transition residents. Such states may be more successful in transitioning more people out of institutions and reaching their transition benchmark targets. In contrast, in states that have

[2] People with low-care needs may be long-term institutional residents if, when they were admitted to the facility, they lacked affordable housing or certain home- and community-based support services. If these resources have become more available since their admission, such people could now be good candidates for transition.

operated transition programs in the past, or have well-developed diversion programs that prevent admissions among relatively low-care people, a greater proportion of those who live in institutions may be "high-care," making it harder to find appropriate placements for them in the community.

To compare the level of need among transition target groups across states, we will calculate the proportion of all long-stay (six-month or more) nursing facility residents who left the institution who were low-care before MFP began, in 2006, in 2008 and 2010, based on Minimum Data Set (MDS) scores from the most recent MDS assessment before they leave the institution, using a methodology similar to that of Mor et al. 2007.[3] We will then compare that proportion to the proportion of MFP transition participants' level of need in corresponding years of the demonstration. The results of this analysis will be displayed for nursing facility residents above and below age 65, before the MFP demonstration began, for each year of the demonstration, and the average over the entire demonstration period. Table II.3 shows sample results.[4] The analysis will aid in the interpretation of successful implementation. For example, states serving higher percentages of low-care MFP participants relative to all nursing facility residents may be more successful in meeting their transition targets, serving them in the community at lower cost, and having lower rates of reinstitutionalization than states with higher percentages of high-care MFP participants.

[3] Because of the lack of a standardized assessment instrument to assess level of care for residents of ICFs-MR, this analysis can only be done for nursing facility residents, for whom MDS information is available.

[4] Separate tables will be created for NF residents 65 and older, and adults, ages 64 and younger.

TABLE II.3

PERCENT OF MFP-ELIGIBLE NURSING FACILITY POPULATION BEFORE MFP, AND MFP PARTICIPANTS WITH LOW-CARE NEEDS [a]

	Percent with Low-Care Needs				Percent with Low-Care Needs		
State	Long-Stay Residents Who Transitioned (2006)	MFP Participants (2008)	All NF Residents (2008)	Ratio of Low-Care MFP Participants to All Low-Care NF Residents (2008)	MFP Participants (2010)	All NF Residents (2010)	Ratio of Low-Care MFP Participants to All Low-Care NF Resident (2010)
Kentucky							
Michigan							
Missouri							
Nebraska							
North Dakota							

[a] Separate tables will be created for nursing facility residents 65 and older, and adults age 64 and younger.

NF = Nursing facility.

B. MFP TRANSITION PROGRAM FEATURES

In addition to the characteristics of target populations, MFP transition programs are expected to differ in a number of ways. This part of the implementation analysis will describe and compare transition program features and identify differences across states and target groups. Baseline information on program features will be collected from grantees' approved OPs and categorized according to major differences. Changes in program features will be monitored through grantees' semiannual progress reports, and the information will be updated in each interim report.

For the first interim report, we will decide how best to categorize key differences across grantees and target groups for the following nine program features:[5]

1. Methods and tools used to ***identify eligible MFP participants*** and assess the feasibility of transition given the availability of community services

[5] The MFP program sets uniform, minimum standards for grantees to ensure, monitor, and improve the quality of care received by MFP participants. Therefore, we will not categorize grantee approaches to quality management.

2. ***Outreach and education strategies*** aimed at professionals and consumers/families
3. ***Types of agencies providing transition coordination and support services,*** and whether they are delivered via private relocation agencies or state personnel
4. The ***range and type of services available to MFP participants*** in the three MFP service categories—qualified HCBS, home- and community-based demonstration services, and supplemental services—that are not otherwise covered by each state's Medicaid program
5. ***Changes to state Medicaid policies or programs*** to accommodate the needs of MFP participants either during or after the 12-month transition period
6. Strategies to locate and secure housing that meets MFP requirements, and to increase the availability of ***affordable, accessible housing*** for people transitioning from institutions
7. Level and nature of ***stakeholder involvement*** by consumers, family members, providers, and other groups in MFP program design and implementation
8. Whether and how MFP programs expand opportunities for some or all MFP participants to ***self-direct*** HCBS
9. Whether MFP programs allow or encourage MFP participants to enroll in ***managed long-term care*** plans

Separate tables will be developed for each of the program features identified above. To illustrate this analysis, Table II.4, column A shows differences in how grantees may choose to provide *transition coordination* (number 3 above). Some states plan to use state personnel, while other states, especially larger ones such as California and Texas, plan to contract with local private agencies to perform these services. We also will try to categorize the *types of services covered in MFP HCBS demonstration and supplemental service categories* (Table II.4. column B, number 4 above), which are not covered by the state's current Medicaid HCBS programs. Based on our initial assessment of MFP applications, some states intend to offer intensive services not covered by the state's Medicaid program (such as long-term behavioral therapy or overnight personal care attendants) to help transition clients with more than one condition. Other

states plan to fill gaps in HCBS coverage (for example, by allowing MFP participants to obtain more personal care assistance hours than the current maximum allowed per month or per week).[6]

Variations in grantee approaches to increase *housing* options (column C) may be proactive approaches (such as securing dedicated subsidy vouchers or commitments from public housing authorities to reserve slots for people leaving institutions) or less intensive approaches (such as online registries of housing units suitable for people with disabilities).

TABLE II.4

MFP TRANSITION PROGRAM FEATURES

	A		B		C		D	E
	Transition Coordination		Home- and Community-Based Demonstration and Supplemental Services		Approach to Housing		MFP Participants Can Enroll in Managed LTC Plans	Self-Direction Options Available to Some or All MFP Participants
State	State Staff	Contract Agencies	Enriched Service Package	Gap-Filling	Active (e.g., Vouchers)	Passive (e.g., Registries)		
Arkansas								
California								
Connecticut								
Delaware								
District of Columbia								
Etc.								

LTC = long-term care.

We will also examine differences in grantee approaches to the use of alternative service systems such as *managed long-term care* (Table II.4, column D), because this may affect transition outcomes. For example, states that are expanding managed long-term care plan enrollment, such as Texas and Wisconsin, plan to make this option available to a large

[6] Some states' Medicaid plans or waiver programs were generous or flexible enough to meet individuals' home care needs before MFP, so the state did not need to add MFP-specific demonstration and supplemental services. We will present the maximum number of personal care hours allowed per week or per month for all waiver participants, and separately for MFP participants if different.

proportion of MFP participants, while other states will make little or no use of such systems. Higher percentages of MFP participants enrolled in managed long-term care plans might result in fewer reinstitutionalizations if the case management by such plans is more aggressive (because of financial risk) than that provided by independent case managers. We will categorize states based on whether they plan to allow MFP participants to enroll in managed long-term care plans; in our analysis of program impacts (Chapter VI, "Synthesis Analyses"), we will assess whether managed care enrollment has an effect on program costs, quality, and participant satisfaction.

Similarly, people who choose to *self-direct* services in the community (Table II.4, column E) may have different long-term outcomes than those using agency-directed services. Most MFP grantee states indicated in their applications that they planned to increase self-directed options in HCBS waiver programs, or through state plan amendments (for example, the new 1915i option). We will categorize the extent to which MFP programs make available self-direction, according to target groups covered, types of self-direction available, and proportion of MFP participants choosing self-directed options.

In addition, we will classify the type of *Medicaid policy or program changes* that grantees make to support MFP participants during the one-year transition period. The focus will be on those changes that are more permanent and likely to be sustained after the conclusion of the MFP demonstration. State MFP proposals indicated the types of changes that grantees might pursue. These include (1) amending HCBS Section 1915c waivers to expand capacity or slots to serve MFP transition participants, (2) adding or expanding self-direction options, (3) modifying benefits covered, and (4) consolidating waiver programs. A few grantees indicated they planned to develop a new waiver program or modify Medicaid budget policies to permit more flexible use of long-term care funds. About half of the grantees indicated they would need legislative approval for their proposed changes. After all final OPs have been approved and received by

MPR, we will compile states' proposed Medicaid long-term care policy changes (similar to Table 10 in MPR's report, "Summary of State MFP Program Applications, September 2007") and track their progress in making these changes through grantee web-based progress reports.

Preliminary Typology of MFP Transition Programs. To characterize grantee approaches to implementing transition programs, and to associate program characteristics with program impacts and outcomes (as described in the synthesis analysis in Chapter VI), we will attempt to classify MFP transition programs. This could be challenging in a demonstration lasting five years, because grantee approaches may change over this period in response to lessons learned from initial experiences or based on what grantees learn from other states. Grantees may also emphasize certain program features (such as outreach and screening of potential MFP participants) in the beginning and concentrate on other strategies (such as efforts to increase the supply of housing options for people moving out of institutions) in subsequent years. Therefore, we need to develop a typology of MFP transition programs that portrays changes in state programs over time to reflect the dynamic nature of MFP programs, and identify features that have greater importance at each stage of the program.

Until state OPs are finalized, we will not know which program features are most appropriate for classifying MFP programs. At this preliminary stage, some of the most important appear to be (1) the characteristics of the populations targeted by the grantee, with some states trying to transition people with more complex needs or who require more care, and others targeting relatively low-care patients; (2) whether the state began the MFP program with prior experience and service capacity to transition institutional residents; (3) whether states have already instituted strict criteria for institutional admission, which may reduce the number of low-care individuals who can be easily transitioned; and (4) the type of changes to state Medicaid policies and the state's long-term care delivery system (whether the policy or delivery changes are permanent and

will benefit the broader Medicaid population, or are time-limited changes that apply only to MFP participants during the one-year transition period).

At least four types of MFP programs emerge from this classification system (Table II.5), and more may become apparent after closer analysis. Among states targeting high-care individuals, some may expand the availability of affordable housing units and add new optional benefits to their state plan or waiver programs to accommodate their needs over the long term (labeled "Trailblazers"). Other states may target high-care individuals, offering limited demonstration and supplemental services during the one-year transition period only (labeled "Gap-Filling"). States targeting low-care individuals can be differentiated from those proposing significant, permanent changes (labeled "Leap-Frog") and from those providing services only during the one-year period (labeled "Laying the Foundation"). Once MFP OPs are approved, we will revise or refine this preliminary typology and update it as programs evolve.

TABLE II.5

POSSIBLE TYPOLOGY OF MFP TRANSITION PROGRAMS

	High-Care Target Population	**Low-Care Target Population**
System-wide changes in long-term care supports, services and delivery, building on previous transition experience	"Trailblazers" Proactive housing development strategies and enriched service packages added permanently to waiver and state plan packages to transition difficult-to-serve MFP participants and other institutionalized residents	"Leap-frog" Major changes in Medicaid policies to facilitate institutional transitions (e.g., added services, self-direction options, expanded waiver capacity, MFP budgeting in states that did not already have them)
Temporary or minor Medicaid and system program changes to develop state capacity to transition institutional residents	"Gap-filling" Limited MFP demonstration and supplemental services available to temporarily fill gaps in existing waiver or state plan packages for high-need MFP participants	"Laying the Foundation" MFP transition services and minor service enhancements provided in geographic areas with greater supply of existing housing options

C. MFP REBALANCING PROGRAM FEATURES

A major goal of the MFP demonstration program is to permanently rebalance state long-term care systems. MFP grantees are expected to use the transition program, as well as other strategies, to remove barriers to receiving long-term services and supports in home- and community-based settings, and to using Medicaid funds for such services. CMS's guidance to state grantees requires that they set objectives, or benchmarks, for long-term care rebalancing that: ". . . should be measures of the progress made by the State to direct savings from the enhanced FMAP (Federal Medical Assistance Percentage) provided by this project toward the development of system improvements, enhancing ways in which money can follow the person (see Appendix A of the grant solicitation)."[7] States have considerable scope in selecting their rebalancing benchmarks.

As part of the implementation analysis, MPR will determine how states put this guidance into practice. This will involve (1) calculating the amount of "rebalancing funds" each state gains under the demonstration (defined as the net gain to the state from enhanced FMAP rates), and (2) describing states' use of the rebalancing fund—(for example, using the money to provide additional or more intensive services to MFP transition participants, or to operate programs and services for non-MFP participants).

1. Long-Term Care System Rebalancing Funds

The amount of revenue generated from the enhanced FMAP above the state's regular FMAP rate is called the "rebalancing fund."[8] We will present state grantees' estimates of extra funds

[7] CMS, CMSO, DEHPG. "Money Follows the Person (MFP) Rebalancing Demonstration, Operational Protocol Instruction Guide," January 2007.

[8] Two sets of MFP services qualify for enhanced FMAP rates: (1) qualified HCBS, and (2) home- and community-based demonstration services. The enhanced match rate equals 50 percent more than the state's regular FMAP, up to 90 percent maximum. MFP "supplemental services" qualify for the state's regular FMAP.

they anticipate receiving over the life of the program, at the time their OP is approved (Table II.6).[9] To place this amount in context, we also will calculate the percentage of revenue received through the enhanced FMAP rate to total Medicaid HCBS spending and to total Medicaid long-term care spending in the state (1) for each year of the demonstration; and (2) over the life of the demonstration, using data from MFP grantee financial reports and web-based progress reports (Table II.6).

TABLE II.6

STATE REBALANCING FUNDS AS A PERCENT OF MEDICAID LONG-TERM CARE SPENDING

State	Projected Amount of Additional Revenues from Enhanced FMAP	Revenue from Rebalancing Funds Received			Percent of Rebalancing Funds to Total Medicaid HCBS Expenditures			Percent of Rebalancing Funds to Total Medicaid LTC Expenditures		
		Y1	Y2	Etc.	Y1	Y2	Etc.	Y1	Y2	Etc.
Arakansas										
California										
Connecticut										
Delaware										
District of Columbia										
Georgia										

FMAP = Federal Medical Assistance Percentage; HCBS = home- and community-based services; LTC = long-term care.

2. Long-Term Care System Rebalancing Activities and Benchmarks

The extent to which revenue received from the enhanced FMAP rate contributes to overall long-term care system changes depends on how states invest it. We will categorize MFP grantees' rebalancing activities and associated benchmarks using information from OPs, semiannual progress reports, and the financial reports the states will submit.

[9] The net gain to the state from the MFP enhanced FMAP rate depends on the actual number of MFP participants transitioned and claims submitted for MFP-qualified and home- and community-based demonstration services.

LTC Rebalancing Activities. Nearly all system rebalancing activities can be categorized as attempts to either reduce the use of institutional care or increase the use of home- and community-based care, or both. For example, in the OPs submitted so far, MFP states plan to rebalance long-term care systems by (1) reimbursing some of the costs of closing institutional beds or facilities; (2) offering transition and HCBS services to non-MFP-eligible Medicaid long-term care beneficiaries (for example, those who choose nonqualified residences or live in an institution less than six months); (3) expanding the capacity of Medicaid HCBS waiver programs; or (4) investing in broader long-term care system infrastructure changes, such as creating greater capacity to divert people needing long-term care from entering institutions; increasing the supply of affordable, accessible housing for people with disabilities; expanding Aging and Disability Resource Centers (ADRCs) and other programs that provide long-term care counseling and information; and increasing the availability of trained long-term care professionals and direct-care workers.

For the first annual interim report, we will describe state long-term care rebalancing activities and sort grantee strategies into common categories (for example, as in Table II.7). In the second interim report, we will revise the categories as necessary to capture distinctions among states, according to how their programs invest rebalancing funds.

TABLE II.7

MFP GRANTEE REBALANCING ACTIVITIES

	Reduce Institutional Care		Increase HCBS		Strengthen Home- and Community-Based System Infrastructure (e.g., Diversion Programs, Housing Subsidies, ADRCs)
State	Support Costs of Closing Institutional Beds or Facilities	Support Transitions of non-MFP-Eligibles	Expand HCBS Waiver Capacity to Non-MFP Participants	Add HCBS or Self-Direction Options to State Plan or Waivers	
State A	X				
State B		X	X		
State C					X
State D			X		
State E				X	X
Etc.					

ADRCs = Aging and Disability Resource Centers; HCBS = home- and community-based services.

Grantee LTC Rebalancing Benchmarks. Because states have discretion to establish their long-term care rebalancing benchmarks, grantees have a diverse array of rebalancing goals. For example, state benchmarks proposed in OPs submitted to date include:

- Increase the proportion of long-term care beneficiaries, long-term care service days, or long-term care expenditures devoted to HCBS relative to institutional care (MD, NH)
- Increase the availability of affordable housing options for people with disabilities (MD, MO, NH, TX)
- Increase the acuity/level of need, service use rates, or per-capita costs among all HCBS beneficiaries as medically complex or dual diagnosis MFP participants transition from institutions and remain in the community in post-demonstration years (NH, WA)
- Reduce the number of large (9+ bed) ICFs-MR licensed by the state (TX), or reduced proportion of Medicaid expenditures on ICF-MR relative to home- and community-based waiver services for people with MR-DD (MO)
- Expand the number of Section 1915(c) waiver slots (WI, CA)
- Provide training, outreach, and education about the MFP program, transition options in general, or a specific topic, such as “person-centered planning” (MD, NH, NY, SC)
- Secure or increase funding for equipment loans and grants (NY)

- Reduce the reinstitutionalization rate among MFP participants (NH, DC)
- Increase the number or proportion of people choosing self-direction (MO)

Even when state benchmarks have similar aims (such as increased availability of housing for people with disabilities), the indicators to measure progress can vary greatly by state. For example, state benchmarks related to housing include (1) a specific number of visits or workshops for public housing authorities each year, (2) a task force report with recommendations, (3) a web-based housing inventory, and (4) a specific number of housing vouchers for MFP participants. In training and outreach, state benchmarks range from developing and distributing informational brochures, to training a specified number of professionals (discharge planners, nursing facility surveyors, ombudsmen), to having outreach workers meet with a specified number of institutionalized residents each year. This variation suggests that direct comparisons of grantees' rebalancing benchmarks are neither feasible nor informative; rather, the value of this analysis is cataloguing what grantees set as goals and measuring the extent to which those goals are achieved.

We will focus our analysis on grantees with rebalancing benchmarks that aim to increase HCBS beneficiaries, service days, or expenditures as a proportion of total Medicaid long-term care beneficiaries, services, or spending, by measuring and comparing the relative magnitude of changes proposed. For example, we will compare the pre-MFP community to institutional rate or ratio to the target and calculate the difference. We will use the results to classify state benchmarks according to whether they represent large, moderate, or small changes.

D. BARRIERS AND FACILITATORS TO PROGRAM IMPLEMENTATION

How successful MFP grantees are in achieving their transition targets, increasing Medicaid HCBS expenditures, and rebalancing their long-term care systems depends on the degree to which they implement key program components. Therefore, an important part of the

implementation analysis is to examine the barriers to, and facilitators of, program implementation.

We expect data on barriers to program implementation to be more complete than those for facilitators because the primary data source—semiannual progress reports—asks state program staff to identify "significant challenges"[10] for most demonstration policies and procedures (for example, participant recruitment and enrollment; outreach; involvement of consumers and other stakeholders; assuring availability of affordable, accessible housing; and making supports and services available to enable individuals to live in the community). While grantees are also asked if they made progress in implementing each demonstration component, the semiannual progress reports do not ask specifically about which factors made implementation possible or easier.

We will produce counts of (1) the number of grantees reporting challenges in each program component, to identify which program components posed the greatest or least challenge; and (2) whether the challenges were resolved and how long it took to do so (using the number of times grantees report that the resolution to a problem is still "in progress") (Table II.8). We will also report the number of calls for emergency backup, as an indicator of how frequently the program's emergency response system is tested.

[10] Significant challenges are defined as those factors that affect the program's ability to transition as many people as proposed in the state's annual and total transition benchmarks.

TABLE II.8

DEMONSTRATION COMPONENTS POSING IMPLEMENTATION CHALLENGES

	Number of Grantees Reporting Challenges in Implementing Transition Program Components				Number of Grantees Reporting That Challenges Were Resolved			
Program Component*	DY1	DY2	DY3	DY4	Within Same Reporting Period	More than One Reporting Period	More than Two Reporting Periods	Not Resolved
Recruiting and Enrolling Eligible MFP Participants								
Obtaining Informed Consent								
Conducting Outreach and Marketing								
Involving Consumers and Other Stakeholders								
Making Medicaid Policy Changes to Increase Access to HCBS **During** the Transition Period								
Etc.								

DY = demonstration year; HCBS = home-and community-based services.

**Additional tables may be created for specific types of challenges within these components.*

In the analysis of factors that pose barriers to, or facilitate, program implementation, we will qualitatively analyze grantees' responses to the question in the semiannual reports asking *how* the challenge was resolved to describe the strategies grantees use to overcome common barriers or challenges to program implementation. In interpreting the results, we will take into consideration each state's experience in transitioning long-term institutionalized residents, because states building on preexisting transition programs may be able to resolve certain challenges more quickly than states establishing new ones. They may also face different challenges as they attempt to further develop or expand existing programs.

If feasible, we will also categorize barriers and facilitators based on whether they are internal or external to state government. This can help explain how easy or difficult it was for the MFP program to resolve the challenges it encountered. For example, states reporting challenges in ensuring enough local capacity to conduct transitions (a critical implementation step) may take longer to resolve the problem if it is internal (for example, a freeze on hiring new staff, if state personnel perform this function) than if it is external (for example, contract negotiations with local public or private agencies are delayed). On the other hand, states reporting challenges external to the MFP program (for example, shortages in the supply of direct-care/direct-support workers, or in the availability of affordable, accessible housing, or a downturn in the state's economy that causes HCBS budget cuts) could take longer to resolve these challenges than an internal challenge (for example, needing to replace MFP program staff). In addition to identifying the barriers and facilitators to MFP program implementation based on whether they are internal or external to state agencies, we will try to assess their magnitude as major or minor (Table II.9). Based on the results, we will determine whether there is any strong trend or pattern suggesting that the distinction between internal and external challenges and facilitators, and whether they are considered to have major or minor effects on program implementation, should be taken into consideration in examining whether they are associated with program impacts.

TABLE II.9

BARRIERS AND FACILITATORS TO MFP PROGRAM IMPLEMENTATION

	Barriers				Facilitators			
	Internal to State		External to State		Internal to State		External to State	
State	Major	Minor	Major	Minor	Major	Minor	Major	Minor
New Hampshire								
New Jersey								
New York								
North Carolina								
North Dakota								

E. PROGRAM PERFORMANCE MEASUREMENT

Another element of the implementation analysis will examine grantee performance in achieving MFP benchmarks. We will concentrate on measuring state MFP grantee progress toward meeting the two required benchmarks—transitions and change in total state Medicaid spending on HCBS—on an annual basis, and for the entire four-year demonstration period. Because of the wide variation in states' additional benchmarks (three at minimum, with the type and level at state discretion), we will limit our analysis of grantee performance to those most commonly associated with long-term care rebalancing: increases in the proportion of HCBS to total Medicaid long-term care beneficiaries, service days, and spending.[11]

To measure grantees' performance on the two required benchmarks, we will use three data sources: (1) grantee-reported data from MFP semiannual progress reports on the number of transitions by target group, and spending on HCBS; (2) Medicaid MSIS eligibility data to verify grantee-reported numbers of MFP participants transitioning each year[12]; and (3) expenditure data

[11] We also discuss our approach to measuring change in Medicaid HCBS expenditures as a proportion of total Medicaid long-term care spending in Chapter V, which describes our plan for analyzing various rebalancing outcomes.

[12] We will analyze MSIS records for flagged MFP participants to verify that they do not have institutional stays/claims longer than 30 days in the subsequent year.

from CMS 64 reports to verify grantee-reported data on HCBS spending. When discrepancies exist between grantee-reported data and MSIS or CMS 64 data, we will try to reconcile these estimates and explain reasons for the differences. We will tabulate and present data on:

- ***Transitions (Table II.10).*** The number of people transitioned by state and by target population, annually and for the entire demonstration period. The annual tabulation will show grantee performance expressed by the ratio of transitions to the transition target benchmarks.
- ***HCBS Expenditures (Table II.11).*** Total Medicaid spending on HCBS by state, annually and for the entire demonstration period. The annual tabulation will also show grantee performance in meeting HCBS spending benchmarks, absolutely, and as a percent of the target. (We may examine the annual change in HCBS expenditures by target population, though grantees are not required to set population-specific spending benchmarks.)

We will compile and display aggregated grantee trends on benchmark attainment for each year of the demonstration (Table II.12). Depending on the distribution of states' performance after the first year or two of operation, we may sort states by (1) *normative* performance levels (for example, at least 100 percent of benchmark; 80 to 99 percent of benchmark; 60 to 79 percent; less than 60 percent of benchmark) or (2) *relative* performance levels based on the distribution of states' actual benchmark attainment rates (for example, if most states attain no more than 80 percent of their targets, we will compare their performance to each other based on the actual range of performance levels.

TABLE II.10

MFP TRANSITIONS, BY STATE AND YEAR

State	Year 1		Year 2		Overall	
	Number of Individuals Transitioned	Percent of Benchmark	Number of Individuals Transitioned	Percent of Benchmark	Number of Individuals Transitioned	Percent of Benchmark
Iowa						
MR/DD						
Nebraska						
Elderly						
PD						
MR/DD						
MI						
New Jersey						
Elderly						
PD						
MR/DD						
Other						

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

TABLE II.11

HCBS EXPENDITURES, BY STATE AND BY YEAR

	Year 1		Year 2		Year 3		Overall	
State	Annual Change in Medicaid HCBS Expenditures	Percent of HCBS Expenditure Benchmark Attained	Annual Change in Medicaid HCBS Expenditures	Percent of HCBS Expenditure Benchmark Attained	Annual Change in Medicaid HCBS Expenditures	Percent of HCBS Expenditure Benchmark Attained	Annual Change in Medicaid HCBS Expenditures	Percent of HCBS Expenditure Benchmark Attained
Ohio								
Oklahoma								
Oregon								
Pennsylvania								

HCBS = home- and community-based services.

TABLE II.12

PERCENTAGE OF GRANTEES MEETING REQUIRED MFP BENCHMARKS, BY YEAR

Demonstration Year	Percentage of Grantees Meeting **Transition** Benchmarks (By Target Population)[a]				Percentage of Grantees Meeting All **Transition** Benchmarks (All Target Populations)	Percentage of Grantees Meeting Medicaid HCBS **Spending** Benchmark	Percentage of Grantees Meeting All Required Benchmarks
	Elderly	PD	MR/DD	MI			
Year 1 (2007)							
Year 2 (2008)							
Year 3 (2009)							
Year 4 (2010)							
Year 5 (2011)							

Source: MSIS claims data and MFP semiannual progress reports.

[a] Percentage is calculated only for those states with targets relevant to specific subpopulations. Due to the few states selecting "other" populations for transition, as well as diversity across states in the characteristics of the groups, this category is not included in the assessment of program performance.

HCBS = home- and community-based services; MI = people with mental illness; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System; PD = people with physical disabilities.

While measuring the extent to which grantees achieve their required benchmarks is straightforward, comparing performance across states is more difficult. Because grantees are allowed to establish the targets, there are substantial differences in the level of ambition that each state's benchmarks represent. For example, some grantees propose to transition substantially more people than they did under previous pilot programs, or propose large increases in transition numbers in the third or fourth year of the program. Other states set easily attainable transition targets throughout the MFP demonstration period, due in part to CMS's intention to make annual supplemental grant awards contingent on meeting annual benchmark measures.

To account for variation in the level of change represented by benchmark targets, we propose to adjust states' degree or level of performance using different methods for each of the two required benchmarks. For the transition benchmark, we will adjust for the size of the transition target population relative to the overall number of institutionalized residents in the

state, using the results of the transition target population analysis described in Section A. We also will compare the number transitioned each year to the average number of long-term residents (more than six months) who transitioned during the three years preceding MFP (2004-2006).

For the HCBS spending benchmark, we will adjust for the proposed increase relative to previous years' trends by computing the ratio of its annual increase in HCBS spending to the average percent increase for three years before MFP implementation. For example, in two states, HCBS expenditures increased by an average of 8 percent for the three years before MFP (2004-2006), but State A had a benchmark target of 5 percent increase in annual HCBS expenditures, and State B had an 8 percent target increase. State B's performance would be adjusted so that it gets additional credit relative to the former even if both states attained their benchmarks, as illustrated in Table II.13.

While such adjustments will help compare states' performance in attaining benchmarks to each other, they cannot account for a variety of other factors that influence performance levels. Therefore, we will interpret the performance results in light of the barriers to, and facilitators of, program implementation. For example, if states fail to meet Medicaid HCBS spending increase targets, this may be due to economic downturns that reduce state revenues, leading to across-the-board Medicaid budget cuts.

TABLE II.13

STATE PERFORMANCE ON TWO REQUIRED BENCHMARKS,
ADJUSTED FOR LEVEL OF CHANGE

	Transitions			HCBS Spending Increases			
State	Performance: Ratio of Actual Transitions to Benchmark Target	Performance, Adjusted for Size of MFP Target Relative to Total MFP Eligible	Performance, Adjusted for Average Percent MFP-Eligible Who Transitioned 2004-2006	Benchmark Target (Average Annual Increase in HCBS Spending)	Performance: Ratio of Actual to Target	Average Percent Increase 2004-2006	Performance, Adjusted for Target Proposed Relative to 2004-2006 Increase
State 1	120%			5%	6% Actual 6%/5%=120%	8%	6%/8% = 75% .75 X 120% **=90%**
State 2	90- 100%			8%	8% 8%/8%=100%	8%	8%/8%=100% 1 X 100%=**100%**
State 3	75%			5%	2.5% 2.5%/5%=50%	4%	4%/5%=80% .8 x 50% = **40%**

HCBS = home- and community-based services.

In assessing grantee performance in meeting additional benchmarks, we will focus on the subset of benchmarks that aim to increase HCBS beneficiaries, service days, or expenditures as a proportion of total Medicaid long-term care beneficiaries, services, or spending. We will use the classification of the level of change described earlier in this chapter (Section II.C, p. 45) as large, moderate, or small to assign a measure of significance to state progress in achieving rebalancing goals. For example, states meeting only 50 percent of a benchmark that would have a major impact on system rebalancing might have accomplished more meaningful change than a state meeting 100 percent of a benchmark representing smaller changes in long-term care rebalancing (Table II.14).

TABLE II.14

STATE PERFORMANCE ON ADDITIONAL BENCHMARKS AIMED AT LONG-TERM CARE SYSTEM REBALANCING, ADJUSTED FOR LEVEL OF CHANGE

State	Target: Percentage Point Increase in HCBS:Total LTC Beneficiaries, Service Days, or Spending (All Years)	Performance: Percentage of Target Attained (All Years)	Level of Change Represented by Target (Large, Moderate, Small)	Performance Adjusted by Level of Change
State A				
State B				
State C				
State D				
State E				

HCBS = home- and community-based services; LTC = long-term care.

F. SUSTAINABILITY

A final measure of states' progress in implementing their programs is whether they can sustain the transition programs and long-term care rebalancing strategies carried out under MFP auspices beyond the end of the demonstration program. We will analyze two indicators of sustainability: (1) policy or program changes that ensure MFP participants can continue to be served *after* the one-year transition period; and (2) systemwide changes that reduce institutional care use and spending, or increase HCBS use and spending for all Medicaid beneficiaries in the long term.

1. Medicaid Policy Changes to Serve MFP Participants After the One-Year Transition Period

The federal statute authorizing MFP specifically identified "continuity of service" [DRA, Sec 6071(a)(3)] as one of the four objectives of the program, and CMS requires states to describe their plans for "post-demonstration continuity of care" in MFP OPs. State MFP applications suggested the types of policy changes that might be necessary. For example, some states need to amend HCBS waivers to increase the number of slots in HCBS waiver programs. Other states

may need to modify the types of services that can be provided under waiver programs, to mirror the additional services provided in the 12-month transition period. Some states, for example, are testing the effectiveness of new services to maintain people in the community and may decide to permanently amend their state Medicaid plan or HCBS waiver programs to include such services if they prove to be essential to successful community living.

We will monitor grantee progress in making these or other Medicaid policy changes needed to ensure MFP participants can continue to be served *after* the one-year transition period. Based on information obtained largely from grantees' semiannual progress reports, we will describe states' policy changes and report on how successful the states were in implementing them. For example, we will explain what states needed to do to ensure that a waiver slot is available, and, if a person needs extensive HCBS, how that affects the state's ability to meet waiver budget neutrality requirements. We may supplement grantee progress reports with information from CMS about HCBS waiver amendments in MFP states, and on state plan amendments affecting HCBS services. Results will be displayed as illustrated in Table II.15.

TABLE II.15

MEDICAID POLICY CHANGES TO ASSURE CONTINUITY OF SERVICE TO MFP PARTICIPANTS AFTER THE ONE-YEAR TRANSITION PERIOD

State	Proposed Policy Changes	Policy Changes to Serve MFP Participants Post-One-Year Transition Period Adopted?
Ohio		
Oklahoma		
Oregon		
Etc.		

2. Continuation of Long-Term Care System Change Beyond MFP Grant Program

A second indicator of sustainability is evidence that broader long-term care system changes, not limited to MFP participants, will continue beyond the MFP demonstration period. While

making such predictions is subject to great uncertainty, grantee semiannual progress reports on policy and budget changes in the last 18 months of the demonstration will contain questions regarding continuation of program activities. For example, grantees will be asked whether (1) reinvestment of rebalancing funds resulted in permanent changes to the long-term care system, (2) funds to support the continuation of rebalancing activities or strategies are incorporated into regular agency budget proposals, (3) greater interagency collaboration has produced greater efficiency in use of state funds, and (4) other policy changes have been made that will sustain transition programs beyond the MFP demonstration period. In addition, if budgetary resources allow, we may conduct short telephone interviews, or email surveys, with two or three key policymakers in each MFP grantee state to obtain their views on the likelihood that Medicaid long-term care policy or program changes adopted under MFP auspices will continue.

Because of the highly subjective nature of the data, the results will be presented in a descriptive, qualitative manner that assigns a greater likelihood of sustainability to those states that can demonstrate tangible evidence of program continuation, expansion, or funding. For example, the likelihood of sustainability will be higher if state policy changes have been made through permanent authorizing legislation, or if funds have been allocated to support activities after MFP grant funds are terminated. States will be grouped into categories that correspond to high, medium, or low likelihood of sustainability.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

III. IMPACT ANALYSES

A key element of the evaluation is to assess whether the MFP demonstration program achieved its goals. As described in the DRA legislation of 2005, two stated goals of the demonstration are to (1) transition from institutions those individuals who would like to live in the community, and (2) assure continuity and quality of service.[1] To determine how successfully the demonstration achieved these goals, the impact analyses for the evaluation will assess the effects of MFP on (1) successful transitions of institutionalized enrollees to the community; and (2) MFP participant outcomes, including health care expenditures, service use, quality of care, and mortality.

The impact analysis design must address several challenges:

- **Limitations of available administrative data** affect the scope and validity of the evaluation. Medicaid administrative files (Medicaid analytic Extract [MAX] and Medicaid Statistical Information system [MSIS]), the primary data sources used to assess demonstration impacts, must be evaluated for accuracy and completeness. The lack of baseline information about health and functioning for some people, particularly those institutionalized in intermediate care facilities for the mentally retarded (ICFs-MR), psychiatric facilities, and hospitals, will affect our ability to control for these factors when assessing program impacts on the affected groups.
- **Identifying comparison groups** in the absence of random assignment requires sensitivity tests to assess the validity of the estimates.
- **The need for separate impact estimates for each grantee,** along with considerable variation in size and character of grantee programs and existing long-term care systems, requires standardized analysis plans that can be tailored to the grantee.

We have developed several robust approaches to address these challenges. Table III.1 summarizes the two impact analyses described in this chapter, along with the key outcome

[1] Another goal of MFP is to rebalance the structure of Medicaid long-term care services from institutions toward community care. In Chapter V, we summarize our approach to evaluating the links between MFP and the balance between institutional services and home- and community-based services (HCBS).

measures that will be analyzed, data sources, and methodological approaches. As the table suggests, our strategy for estimating impacts will capitalize on the longitudinal nature of our analysis files and will rely heavily on changes in observed outcomes pre- and post-MFP. For analyses of transitions to the community and mortality, we will estimate impacts by measuring shifts in the trends of outcome measures when MFP was implemented. For analyses of impacts on participant expenditures, utilization, and quality of care, we will compute changes in outcomes before and after transitioning to the community for MFP participants and compare them to changes for comparison groups matched on pre-MFP characteristics.

The rest of this chapter describes in more detail our approach to assessing the impact of MFP on the two sets of outcomes: (1) transitions to the community; and 92) participants' service use, expenditures, and quality of care. We first describe the database we will develop for these analyses. Then, for each analysis, we describe key research questions, summarize the outcome measures of interest, describe our statistical methodology and analysis plan, and discuss how we will address problems we may encounter in estimating the impacts of the demonstration. The description of our methodological approaches focuses on our development of regression-adjusted estimates of program impacts. The description is highly detailed and specific. We present this level of detail for readers who are interested in the technical details of our approach and estimation strategies.

A. DEVELOPMENT OF THE IMPACT ANALYSES DATABASE

Information about enrollee characteristics, mortality, and patterns of health service use and expenditures is critical for a successful evaluation of the impacts of MFP on transitions to the community and participant outcomes. These data are needed not only for the MFP program and its participants, but also for comparison groups, whose outcomes will be used to estimate what would have been observed for MFP participants had the program not been implemented. Our

impact analyses database will include a broad array of longitudinal data capturing health status, health service use, and health expenditures for MFP participants and for all Medicaid enrollees living in institutions in participating states during the three years before MFP was implemented. These data, which will be drawn from the MAX and MSIS data systems, MFP service files, nursing facility minimum data set (NF-MDS), and Medicare files, will reflect service use both before and after the demonstration was implemented.

TABLE III.1

OVERVIEW OF MFP DEMONSTRATION IMPACT ANALYSES

Evaluation Objective	Key Outcomes	Primary Data Sources	Methodology
Assess effects on successful transitions of enrollees from institutions to the community	Transition from institution to the community Length of time in the community Reinstitutionalization	Outcomes: MAX/MSIS, NF-MDS Explanatory Variables: MAX/MSIS, Medicare files, NF-MDS[a]	Pre- and post-MFP analysis of trends in successful transitions to the community
Assess effects on MFP participant outcomes	Reinstitutionalization Health care expenditures Health service use Quality of care Mortality	Outcomes: MAX/MSIS, NF-MDS, Medicare files, MFP service file Explanatory Variables: MAX/MSIS, Medicare files, NF-MDS[a]	Comparison of pre- to post-transition changes in outcomes for MFP participants to changes for two pre-MFP matched comparison groups

[a] NF-MDS data will not be available for all people institutionalized, primarily those in ICFs-MR, psychiatric facilities, and hospitals.

ICF-MR = intermediate care facility for the mentally retarded; MAX = Medicaid Analytic Extract; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set.

In this section, we describe the development of our impact analyses database, whose contents limit and shape the types of analyses we can conduct. The database consists of a person-level research file containing information about all institutionalized Medicaid enrollees in MFP grantee states between 2004 and 2010.

Medicaid enrollees living in institutions—in a nursing home, ICF-MR, institution for mental diseases (IMD), or psychiatric hospital—make up the population of interest for our impact analyses. All MFP participants must have been institutionalized for at least six months to be eligible for program benefits. Our comparison groups will be enrollees who also were institutionalized for at least six months during the years that preceded the implementation of MFP. Our data file of institutionalized enrollees must include longitudinal information about their use of Medicaid services. It must indicate (1) whether and when an enrollee transitions from institutional care to the community, and (2) more general information about the enrollee's patterns of service use before and after the transition to the community. The data must also identify enrollees' membership in targeted populations and potential explanatory variables, such as age and gender.

MAX and MSIS for calendar years 2004 through 2010 will be the primary data sources for our person-level research file of institutionalized enrollees. The MAX and MSIS eligibility and claims files provide Medicaid data in a uniform format across all states and include demographic and eligibility characteristics, Medicaid service use, and Medicaid expenditures for each enrollee in the nation. These features enable us to construct the same outcome measures and explanatory variables for each person enrolled in Medicaid in every grantee state. Because we can obtain several years of MAX and MSIS files, we can compare MFP participants to Medicaid enrollees who were institutionalized before the start of the MFP program.

Supplemental data from the MFP Services files, NF-MDS (when available), and Medicare files will be used to overcome several limitations of MAX and MSIS. Because MSIS will not include claims for MFP-financed services, we will supplement our MAX and MSIS data with claims from the **MFP Services files**, which were designed to look like MSIS ambulatory claims files (known as the MSIS Other Claims file). For those in nursing facilities, the **NF-MDS** will be used to obtain information about functioning and level of service need, which is not available in MAX and MSIS. Finally, **Medicare files** will be used to supplement acute care service utilization in MAX and MSIS for people dually enrolled in Medicare and Medicaid. Nearly all aged Medicaid enrollees, and may with physical disabilities, are covered by Medicare for acute hospital care, associated skilled nursing facility and home health care, other acute care services, and some durable medical equipment. Utilization of, and expenditures for, Medicare-covered services will be compiled and combined with Medicaid service utilization and expenditure data in our analysis file. Next, we describe in more detail the variables we will use to identify targeted populations, capture patterns of long-term care use, and measure other dependent and explanatory variables in our impact analyses.

Identification of the Targeted Populations. For the impact analyses, we will determine membership of institutionalized enrollees in five targeted populations: (1) elderly (age 65 and older), (2) enrollees with physical disabilities, (3) enrollees with mental retardation/developmental disabilities (MR/DD), (4) enrollees with mental illness, and (5) enrollees with other types of disabling conditions. Ideally, we will follow the same classification strategies that the states use. We will capitalize on demographic, enrollment, diagnostic, and utilization information available in the source files described above to identify membership in these targeted populations. Because an enrollee can belong to more than one target population, we will use a hierarchical approach to construct five mutually exclusive groups: (1) people with

developmental disabilities, (2) people with physical disabilities, (3) people with chronic mental illness, (4) the elderly, and (4) all other institutionalized enrollees.

Enrollees with developmental disabilities will be identified first, as those (1) using an ICF-MR service, (2) having an MR/DD diagnosis recorded in either MAX or MSIS or the NF-MDS, or (3) enrolled in an MR/DD waiver.[2] Those with chronic mental illness will be identified second, using a combination of (1) psychiatric hospital service utilization, (2) disabling condition codes in the NF-MDS, and (3) waiver enrollment.

The elderly and enrollees with physical disabilities will be identified third, through (1) claims for nursing home care, (2) diagnostic codes on claims during the first six months of observed institutionalization, (3) condition indicators in the NF-MDS, and (4) type of waiver enrollment. The elderly will be those enrollees age 65 or older, and those with evidence of a physical disability based on diagnostic codes and condition indicators will be under age 65. Any institutionalized person who does not fall into one of the preceding four categories and is under age 65 will be in the remaining "other" category.

As discussed above, we will use condition information in the NF-MDS whenever it is available to refine membership in a targeted population. Condition information in NF-MDS for observable illnesses will be particularly helpful, because this information includes only active diagnoses that relate to current "ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death" (CMS 2002). Therefore, this information captures conditions associated with the need for institutional care.

Operational Definition of Long-Term Care. Because Medicaid files do not include indicators that flag enrollees who use long-term care services, we need to develop an approach to

[2] MR/DD waiver enrollment information will only be available in MAX/MSIS years 2005 and later.

identifying such users and expenditures for long-term care. This approach requires a clear definition of who is a user of long-term care services and which health care expenditures will be considered long-term care expenditures. Although grantees will report claims for MFP-financed services, the types of services identified as long-term care services during baseline years (2004 through 2007) and for people not enrolled in MFP during demonstration years can be somewhat arbitrary. Use of institutional care—in a nursing home, ICF-MR, IMD, or psychiatric hospital—will be identified by Type of Service (TOS) codes found in MAX or MSIS claims records. Use of community-based long-term care services under Section 1915(c) waivers and state programs will be identified using a combination of MAX or MSIS TOS codes and Program Type codes. Table III.2 lists the services we propose to use to identify long-term care users and their expenditures in MAX and MSIS files.

The information in Table III.2 indicates whether a service will identify the beneficiary as a long-term care service user, whether the associated expenditures will be considered long-term care expenditures, and any restrictions a claim must satisfy for inclusion in our definition of long-term care. For example, all enrollees with personal care claims will be considered HCBS users, and all personal care claims will be included in HCBS expenditures. On the other hand, if a person has *only* rehabilitation claims (or targeted case management, or durable medical equipment, or transportation claims) and no other claims for services listed in Table III.2, then that person is not considered an HCBS user, because use of this service alone may indicate rehabilitation for an acute condition rather than a long-term or chronic one. However, if a person has a rehabilitation claim and a personal care claim (or any other type of claim we will use to identify a long-term care user), then that person will be considered a long-term care user, and his or her HCBS expenditures will include all the rehabilitation and personal care claims in the files. We will consider exceptions to this approach to improve our ability to identify

enrollees with mental illness or developmental disabilities who use only state plan HCBS. The evaluation will explore the possibility of using combinations of services to identify these users. For example, if feasible and appropriate, we will identify additional HCBS users who receive rehabilitation and targeted case management through the state plan, but have no prior inpatient stay.[3]

We will use MAX TOS codes to identify the services listed in Table III.2, unless otherwise noted in the table's footnote. If time and resources permit, we may use procedure codes to further refine the TOS categories and to identify any claims for HCBS that are coded as "Other" TOS in the files.

[3] We have also explored the feasibility of using claims for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services to identify adolescent and young adult HCBS users. However, EPSDT claims are known to be poorly reported in MSIS and research based on these claims is not possible at the time of this report.

TABLE III.2

LONG-TERM CARE SERVICE TYPE

Service	Identifies LTC User	Included in Expenditures for LTC Users	Restriction
Institutional Long-Term Care (ILTC)			
Nursing home	X	X	
ICF-MR	X	X	
Mental hospital services for the aged	X	X	
Inpatient psychiatric services for enrollees under age 21	X	X	
Home- and Community-Based Long-Term Care (HCBS)			
MFP services[a]	X	X	
Section 1915(c) waiver services[b]	X	X	
Non-waiver services			
Personal care	X	X	
Residential care[c]	X	X	
Adult day care[c]	X	X	
Home health	X	X	Identifies LTC user when service used for three months or more
Hospice care	X	X	When place of service is the home
Private-duty nursing	X	X	When place of service is the home
Rehabilitation[d]		X	
Targeted case management[d]		X	
Durable medical equipment[c]		X	
Transportation		X	
Managed Care			
PACE[e]	X	X	Included in overall LTC measures only[d]
Other LTC managed care programs[e]	X	X	Included in overall LTC measures only[d]

[a]All claims in the MFP Services file will be identified as HCBS services.

[b]We will identify claims coded as MAX Program Types 6 and 7 as Section 1915(c) claims. Program Types 6 and 7 reflect Section 1915(d) and Section 1915(c) waivers, respectively, but in practice are used interchangeably to identify Section 1915(c) claims.

[c]Residential care, adult day care, and durable medical equipment services are separately identified in MAX but not MSIS. Whenever possible, we will implement the algorithm used in MAX on MSIS files to identify records for these services.

[d]To improve the identification of HCBS users with mental illness and developmental disabilities, we will explore the possibility of including enrollees who use a combination of state plane rehabilitation and targeted case management services, but have no prior inpatient stay.

[e]We will use enrollment in PACE or other long-term care managed care programs to identify LTC users and include capitated claims for these programs in total LTC expenditures. PACE and LTC managed care plans may include services for both ILTC and HCBS. Therefore, LTC managed care services will only be incorporated in utilization measures of LTC by type when encounter claims are reported by states and identified as such by MAX TOS codes.

HCBS = home- and community-based services; ICF-MR = intermediate care facility for the mentally retarded; ILTC = institutional long-term care; LTC = long-term care; PACE = Program of All-Inclusive Care for the Elderly; TOS = Type of Service.

Creation of Monthly Indicators of Long-Term Care Use. To examine transitions in long-term care service use, the duration of institutional or HCBS care, and type of long-term care service used after the demonstration begins, the person-level analysis file will include an historical record that identifies the type and place of long-term care services used in each month starting with January 2004 and ending with the last month of available data. Codes indicating hospital use, Medicaid eligibility status, and death during the month will enable us to identify other transitions as well.

The service dates found in MAX and MSIS claims files can be somewhat unreliable. We know that the admission date in the institutional claims in MAX and MSIS from many states is missing. Missing admission dates makes it difficult to measure the length of institutionalization with precision, particularly if an enrollee only became eligible for Medicaid coverage during the period of institutionalization. For those in nursing homes and some ICFs-MR, data from the NF-MDS files will help identify the begin date of institutional stays. When NF-MDS data are not available, we may also use earlier years of MAX (years 2002 through 2003) to extend our knowledge of duration of institutionalization under the Medicaid program. Despite these efforts, we will have imprecise information about length of institutionalization for enrollees with no NF-MDS data and whose institutionalization started before Medicaid coverage began.

We will work around unreliable service dates in part by creating monthly indicators of service use. Enrollees with a paid claim for a long-term care service used for at least one day in a given calendar month will be coded as having used that service during the month. A “spell” of institutional care will be defined as a period of continuous months of service use. Breaks in institutional care that span two entire calendar months will identify transitions out of institutional care. Transitions to HCBS use will be identified when the break in institutional care is followed by HCBS use in either the same month or the next month. We will test these identification

methods by comparing the length of breaks in spells and time to the start of HCBS use between MFP program participants and non-participants.

It will be more difficult to address missing HCBS data in Medicaid administrative files. Services provided by managed long-term care programs or the Program of All-Inclusive Care for the Elderly (PACE) are documented in "encounter records" in MAX and MSIS, and these records are often unreliable and incomplete. Because of concerns about the quality of the information, we will frequently have to acknowledge that we do not have adequate information about HCBS when these services are provided by a managed care plan. States have been told to submit claims records for MFP-financed services that are provided by managed care plans in the MFP Services file, and we anticipate these records will be relatively complete. However, we may still have incomplete information about HCBS use among members of the comparison groups, and we may underidentify the number of transitions from institutional care to HCBS among members of the comparison groups.

In addition to underreporting of services provided by managed care plans, HCBS claims can be excluded from MAX and MSIS claims records when waiver services are paid collectively and reported as service-tracking claims rather than individual payments.[4] Finally, non-waiver HCBS may be unidentifiable if reported as non-specified "Other" services when submitted by the state. To partly address this concern of incomplete information about HCBS use, we will focus our analysis on examining the likelihood of transition to the community and present only summary information about type of long-term care service used post-transition. We will also compare aggregate MAX and MSIS HCBS data to summary measures reported in CMS Form 64 by

[4] Service-tracking claims represent services that cannot be linked to specific enrollees. These services are frequently paid in bulk, and providers are not required to bill on a person-level basis. Examples include transportation services or HCBS managed by another agency.

service type to identify and flag states with potentially incomplete HCBS data in MAX and MSIS.

Other Variables in the Analysis Database. Our person-level file will contain other variables that will allow us to measure impacts of MFP on service utilization and expenditures more generally (non-long-term care services), and mortality. These measures, along with enrollee demographic characteristics and other explanatory variables, will also be included.

Like long-term care information, monthly information about acute care and other health service utilization and expenditures will be included to measure impacts on quality and costs. Dates of death in Medicaid enrollment files are unreliable, so we will rely on the date of death available from the Medicare Enrollment Database (EDB) for those dually eligible for Medicaid and Medicare. This limitation will restrict our analysis of impacts of MFP on mortality to the dually eligible.

Demographic characteristics available in MAX and MSIS that will be used as explanatory variables include age, race, gender, and location of residence. In addition, when available, NF-MDS measures of physical function (activities of daily living [ADL] index), cognitive function (a 7-point scale), social engagement (a 7-point scale), and pain level (3-point scale) will serve as potential explanatory variables in our analysis of transitions and participant impacts and will also be included in our person-level analysis file. More detail about the specific outcome variables, explanatory variables, and their source data files is provided later in this chapter in our description of each set of impact analyses.

B. ESTIMATING IMPACTS OF MFP ON INSTITUTIONALIZED ENROLLEES

MFP is designed to help people transition from institutions to the community, as well as to support broad-based long-term care system changes. The first component of the impact analysis will assess the effects of MFP on the probability of transitioning from an institution (nursing

home, ICF-MR, or psychiatric hospital) to the community and the extent to which the transitions are successful and those who transition remain in the community. Specifically, we will examine three key research questions in this component of the analysis:

1. To what extent does MFP increase the percentage of Medicaid enrollees who transition to the community? How does the impact of MFP on transitions differ by length of institutionalization (for example, 6 to 12 months, compared to 13 to 24 months or 25 months or more)?
2. Does MFP affect the probability of (and length of time until) reinstitutionalization for those who transition?
3. Are the effects of MFP on the likelihood of transition and reinstitutionalization different for different types of enrollees?

We will explore the first two questions by comparing regression-adjusted trends in transition and reinstitutionalization outcomes before and after MFP implementation. We will address the third question by looking at how the relationship between the probability of transition and personal characteristics of institutionalized beneficiaries (for example, target population, age, gender) differs before and after MFP implementation.

1. Outcome Measures

The analysis of MFP impacts on transitions out of institutions will consist of (1) an analysis of impacts on transitions from institutions to the community; and (2) an analysis of impacts on reinstitutionalization, including the length of time spent in the community.

Transitions from Institutions to the Community. We will first measure impacts of MFP on the likelihood that institutionalized enrollees transition to the community. The analysis will examine both all institutionalized enrollees and the subset targeted by the MFP demonstration. We include institutionalized enrollees who do not participate in MFP because the broad set of MFP program features may increase transitions from institutions among non-participants. For

example, programs with aggressive outreach activities may result in people moving from nursing homes to assisted-living facilities, and such enrollees may not be eligible for MFP services if they live in state where assisted-living facilities are not qualified residences. In this case, the effects of MFP on transitions may be larger than the number of MFP participants indicates.

The MFP program may also induce some unintended behavior by states and enrollees that could result in biased estimates of MFP's effects. Of particular concern would be a decrease in transitions among those in institutions for four or five months, combined with an increase in transition among those institutionalized for at least six months and thus eligible for MFP services. This might occur if enrollees delay their transition to the community to become eligible for MFP services or are encouraged to remain in the institution until eligible. While the main portion of our analysis will focus on the population targeted by MFP—people institutionalized for at least six months—a key component of our transition analysis will be an examination of whether any increase in transitions among those institutionalized for six months is offset by fewer transitions among those institutionalized for only four or five months.

Reinstitutionalization. Transitions to the community followed by returns to institutionalization may be costly and inefficient, as well as disheartening and disorienting for the enrollee. Consequently, the success of a transition must take into account how long enrollees remained in the community and whether the transition resulted in reinstitutionalization. We will use the following measures to evaluate the success of a transition:

- Months residing in the community
- Reinstitutionalization within 12 and 24 months after transition

Stays in the community that do not result in reinstitutionalization will indicate successful transitions. We use 12 and 24 months post-transition to measure reinstitutionalization because

MFP participants are eligible for MFP benefits for a year, and we want to determine whether program participation continues to affect the success of community living after MFP benefits end. Data permitting, we will examine months residing in the community by type of transition (continued community residence, reinstitutionalized, moved out of state, or disenrolled from Medicaid, deceased) and reason for reinstitutionalization, to better understand the factors associated with success. Reasons for reinstitutionalization may include acute condition onset, deteriorating health, or lack of sufficient community-based services.

Interpreting and identifying the reinstitutionalization of working-age adults (ages 21 to 65) with mental illness poses a particular challenge for our analyses. By federal law, Medicaid programs are prohibited from paying for services that an IMD provides to working-age adults (although these services are covered for children [ages 21 and younger] and the elderly [ages 65 and older]). This prohibition means our person-level data files will not include IMD claims for working-age adults ages 21 to 65.[5] Use of IMD services may cause some working-age adults with mental illness to lose Medicaid eligibility and, therefore, MFP eligibility. When working-age adults enter an IMD for care, they will typically lose Medicaid eligibility if the stay is prolonged (more than 30 days).[6] In addition, adults with mental illness are more likely than other MFP populations to have contact with the law and become incarcerated and lose their Medicaid eligibility, which is another important indicator of their ability to live in the community. Because we will not be able to identify all institutional care for working-age adults with mental illness, measured impacts for this subgroup will need to be interpreted with caution,

[5] Obtaining these records is not feasible, because a central database of claims is not available and acquiring them from individual states will require considerable resources to address privacy concerns.

[6] Most states operationalize the IMD exclusion for working-age adults by disenrolling them when the agency responsible for managing the Medicaid eligibility determination process learns that the person is living in an IMD. However, IMD stays are frequently short (a week or less), and the Medicaid program may never know a short stay in an IMD has occurred.

and we it will be important that we identify to the extent possible the presence of mental illness conditions among all working-age adults in our data files.

2. Methods

Three key design features for ensuring valid estimates of demonstration impacts are (1) a comparison group strategy that enables us to generate valid estimates of outcomes that would have occurred in the absence of the intervention; (2) a statistical modeling approach that controls for pre-existing differences between the treatment and comparison groups to yield unbiased estimates of program effects; and (3) sample sizes large enough to ensure that we can identify true effects of a specified, policy-relevant size, while limiting the potential for concluding that there are such effects when they do not exist.

Comparison Group Strategy. It will be challenging to obtain valid estimates of the effects of MFP on transitions to the community. This is because random assignment to the demonstration was not feasible, and our evaluation must rely on comparison groups to establish what would have happened in the absence of the demonstration. A commonly used comparison group strategy—identifying people from non-demonstration states to serve as comparison groups—is not appropriate because so many states are involved in the demonstration. In addition, Medicaid programs and populations in the 31 grantee states vary significantly from those in the non-MFP states in both measured and unmeasured characteristics.

Our strategy for identifying program impacts will rely on comparisons between pre- and post-demonstration enrollees who are institutionalized for six months or more. The person-level database described above will include information about patterns of service use for each person enrolled in Medicaid and institutionalized at any time between 2004 and 2010. This time frame captures about four years (2004, 2005, 2006, and 2007) of pre-MFP Medicaid enrollment and service use and about three years (2008, 2009, and 2010) of data after program implementation.

Modeling Approach. We will use a three-stage approach to detecting program impacts on transitions among institutionalized enrollees. Our analyses will range from estimating unadjusted transition rates to using more sophisticated models that examine the length of time until transition or reinstitutionalization and address observation censoring due to death or disenrollment from Medicaid.

We will begin by tabulating the number and percent of institutionalized Medicaid enrollees who transition to the community (and other transitions) each program year, by length of time institutionalized. This initial analysis will indicate potential MFP impacts on transitions. More important, it will enable us to gauge subgroup sample sizes and determine the extent to which we must pool data. It will also provide an initial indication as to whether an increase in transitions among enrollees institutionalized for six months or more is offset by reduced transitions among those institutionalized for only four to five months. Provided we find no indication of such a bias, our primary analysis will focus on enrollees institutionalized for six months or more, and we will examine short stayers who are not eligible for MFP in sensitivity analyses only. Finally, in this initial summary analysis, to gauge the scope of the program is each states, we will determine what percentage of transitioning enrollees are MFP participants.

In the second stage of modeling, we will develop regression-adjusted estimates of program impacts. We will estimate logit models to assess program impacts on the probability of transitioning to the community (or reinstitutionalization) within a specified time period. An estimation strategy that measures impacts as differences in probabilities of transitioning (and reinstitutionalization) before and during the demonstration period would be biased by any other policy changes or trends in available services or people served during the two periods. For example, growth in community-based long-term care services more generally would be captured by such estimates. We propose a slightly stronger design in which impacts of MFP are measured

by *shifts in the trends* at the time of program implementation. That is, if movement from institutions to the community has been growing, we will use the increase or decrease in that growth to measure program effects. In sum, our approach involves:

- Modeling the probability of transition from institution to the community (or the probability of reinstitutionalization)
- Controlling for target population, age, race, gender, urban/rural residence, time in institution, physical and cognitive function, prior Medicare and Medicaid use of inpatient, emergency room, and other services
- Estimating any trend shift in the probability of transitioning to the community before and after the implementation of MFP

Table III.3 lists the key outcome measures and potential explanatory variables we propose for the two impact analyses of transitions—(1) transitions to the community, and (2) success of transition—along with each measure's data source.

TABLE III.3

PLAN FOR ESTIMATING IMPACTS ON SUCCESSFUL TRANSITIONS TO THE COMMUNITY

Measure	Analysis: Transition to Community	Analysis: Reinstitutional-ization	Data Source
Outcome Measures			
Transition to the community	X		MAX/MSIS
Success of transition			
Length of time until reinstitutionalization		X	MAX/MSIS NF-MDS
Whether reinstitutionalized within 12 months, within 24 months		X	MAX/MSIS NF-MDS
Explanatory Variables			
Time Trend			
Year indicators	X	X	MAX/MSIS
Demographic and Eligibility Characteristics			
Age	X	X	MAX/MSIS
Race	X	X	MAX/MSIS
Gender	X	X	MAX/MSIS
Urban/rural residence	X	X	MAX/MSIS
Dual status	X	X	MAX Medicare files
Institutionalization History			
Months in institution	X	X	MAX/MSIS NF-MDS
Months in community post institutionalization[a]		X	MAX/MSIS NF-MDS
Health Status			
Physical function (ADL index)	X	X	NF-MDS
Cognitive function	X	X	NF-MDS
Social engagement	X	X	NF-MDS
Pain level	X	X	NF-MDS
Composite service need score	X	X	NF-MDS
Prior inpatient, emergency room, and other acute care service use	X	X	MAX/MSIS Medicare files

Note: Impacts will be estimated separately by grantee and by target population.

[a] This variable will only be included in the third stage of estimating program effects when hazard models are estimated.

ADL = activity of daily living; MAX = Medicaid Analytic Extract; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set.

The specific regression models we estimate will use the basic standard logit model. For beneficiary i, we will set $Y_i = 1$ if the beneficiary transitioned during a given program year; and $Y_i = 0$ otherwise. Given an array of explanatory variables $X_{ji} = 1$, the probability that $Y_i = 1$ is:

$$P(Y_i = 1 \mid X_{ji}) = exp(a_0 + \sum a_j X_{ji})/[1 + exp(a_0 + \sum a_j X_{ji})].$$

To compute MFP impacts, we will use the estimated coefficients for each binary year indicator in the model. Our final models will include binary year indicators for 2004, 2005, 2006, 2008, 2009, and 2010, with 2007 as the reference year. When we exponentiate the estimated coefficient on the 2008 binary indicator (or any year indicator in the model), we obtain an estimate of the odds of transitioning in 2008 to the odds of transitioning in the reference year, which is essentially the proportionate change in the probability of transitioning between the two years. Thus, the odds ratio for each binary year indicator estimates the effect of MFP on the odds of transitioning out of an institution in that year, relative to the year MFP began. To estimated the effect on trends in the probability, we will compare the 2008 rate to:

- The trend in transition rates over the three years preceding MFP (and/or two years)
- The average transition rate over the pre-MFP period

An analogous process will be used to calculate MFP impacts during the second and third years of MFP operations by using the estimated coefficients for the 2009 and 2010 binary indicators.

While our estimation strategy does not require the assumption that transition probabilities are stable over time, it does require the assumption that any change in the trend during MFP implementation is due to the MFP demonstration alone. Many other Medicaid programs and demonstrations have focused on promoting HCBS use in recent years, and distinguishing the

effects of the MFP demonstration from these programs will be difficult. For example, 18 of the 31 MFP grantees received Nursing Facility Transition (NFT) grants sometime after 2001, many of which were intended to develop the infrastructure to support transitions to the community. In these states, it may not be possible to distinguish effects of MFP from lagged effects of NFT grant programs. When we present effect estimates for each grantee state, we will identify states with nursing home transition programs to gauge the extent of such biases. The association between estimated program effects and such grant programs will be investigated further in our synthesis analysis described in Chapter VI.

Throughout the analysis, impacts will be estimated separately for each grantee because the demonstration program, population composition, service areas, and long-term care systems differ across states. They will also be estimated separately by target population, although sample sizes may limit our ability to estimate impacts for smaller groups. Measuring impacts by subgroups is important because (1) estimates of the average program impact over all enrollees could mask important impacts on subsets of the target population, and (2) our findings could suggest more efficient targeting strategies than the demonstration grantees are practicing. Other key subgroups include those defined by duration of institutionalization and level of health service need or illness severity at the time of transition. When possible, separate impact estimates will be calculated for these subgroups.

In the third stage of modeling, we will use event-history, or "hazard," models to control for our inability to always observe the ending of an event such as an institutional stay. Hazard models assume that the likelihood of transition at any point in time may be affected by the length of time institutionalized (for example, the longer someone remains in institutional care, the less likely he or she will transition to the community) or how long someone remains living in the community (for example, the longer the elderly live in the community, the more likely they may

be to transition to institutional care). These models also allow us to control for censoring, which occurs when we cannot observe an institutional stay or community residence for 12 or 24 months. Our observation of an institutional stay or community residence can be censored for a variety of reasons, including death, enrollment in an HMO, disenrollment from the Medicaid program, or the observation period ending before a transition occurs. Thus, hazard models ensure that differences between the pre- and post-MFP periods in any of these sources of censoring do not bias the impact estimates.

We will use a flexible transition probability modeling strategy that enables us to (1) characterize how duration in an institution is associated with the probability of transition, and (2) estimate separate MFP effects by the number of months institutionalized. To estimate transition probabilities, we will use:

$$log\ h_i(t, X(t)) = \sum a_j X_{ji} + g(t, a_k X_{ki}(t)) \ ,$$

where the function g specifies the form of the dependence in the likelihood of a transition, a_j and a_k are parameters to be estimated, X_{ji} are explanatory variables that do not vary over time, and X_{ki} are time-varying covariates all measured at the level of person i. The variable t is a measure of time (for example, number of months between the observation month and entry into an institution).[7] The time-varying covariates X_k will capture subgroup effects of the MFP program by duration institutionalized. We will use various functional forms for g and select the one that

[7] The data we use to estimate the transition model will consist of *one observation per individual per month*. For example, in the analysis of transitions from institutions to the community, the dependent variable will be a binary variable that equals zero in months when an enrollee is still living in an institution, and that equals one in the month when the enrollee transitions to the community. For a person who was institutionalized for 11 months who then transitions to the community, this enrollee would contribute 12 observations to the data file (11 observations with the dependent variable equal to zero and 1 observation with the dependent variable equal to 1). A person who lived in an institution for 11 months, but then disenrolled from Medicaid or died, would contribute 11 observations with the dependent variable equal to zero for each month.

best captures the relationship between time in an institution and transition, which may be nonlinear. We will pay special attention to capturing possible MFP-induced shifts in the relationship between four or five months after institutionalization and six or more months.

The model estimates can be used to derive an estimated proportionate effect of MFP on the time until a transition (or the length of institutionalization), and statistical tests of the coefficients will enable us to assess whether the estimated changes in transition rates were larger than might be likely to occur by chance (and therefore are evidence that MFP increased transitions). Generating estimated rates of transition with and without MFP will require simulated estimates based on the model's estimated coefficients. To measure whether the MFP program affected the probability of successful transitions, we will multiply the estimated probability of transition by the estimated probability of reinstitutionalization within one year (and two years). To estimate impacts on the trend in the likelihood of transition, we will need to simulate transition probabilities by program year and to examine trends. To do this, we will simulate outcomes for prototypical individuals of median age and other general or average characteristics of MFP participants. We describe the results to be simulated in more detail below.

Sample Sizes. Although sample size is not an issue for population means, sufficient sample sizes will be critical for detecting impacts at the grantee level and sample size issues will affect our regression-adjusted estimates of program impacts. The size of the nursing home population ensures that sample sizes in the aged target population will be large enough to estimate overall impacts for this subgroup for many grantees. Nevertheless, our ability to detect significant differences by length of stay and for other subgroups will depend on the distribution of length of stays and the number of institutionalized enrollees in each subgroup. If sample sizes permit, we will estimate impacts for the MR/DD, chronically mentally ill, and physically disabled populations overall and by length of stay. We anticipate that in small states, we will not have

sufficient power to detect impacts by length of stay, and in some cases, overall. For example, analyses of MAX data from 2002 suggest that the population in ICFs-MR is quite small for a handful of grantee states—Delaware, Hawaii, Michigan, New Hampshire, Oregon, and Washington. Subgroup effect estimates for enrollees with MR/DD will not be possible for such grantees. We are not aware of currently available statistics indicating sample sizes for chronically mentally ill or physically disabled institutionalized populations. After the impact analyses database is prepared, we will conduct power analyses by target population to determine which analyses are feasible. When limited sample sizes severely restrict our ability to estimate our models, we will present results for pooled states and potentially pooled target population subgroups.

3. Analysis Plan

We will first summarize the unadjusted number and probability of institutionalized enrollees transitioning to the community for each grantee by program year and present MFP effects on these transitions. Table III.4 illustrates how we will present unadjusted probabilities of transition from institutional care to the community by target population. The table shows our intention to include all grantees in each table, regardless of the population subgroups targeted for the demonstration. While Michigan and New Hampshire, for example, did not target enrollees with MR/DD in their MFP demonstrations, these states appear in the table that presents outcomes for MR/DD only. Any estimated effect sizes for states not targeting a specific population may indicate broader effects of the MFP program or external biases.

TABLE III.4

PERCENTAGE OF MEDICAID ENROLLEES INSTITUTIONALIZED FOR SIX MONTHS OR MORE WHO TRANSITIONED TO THE COMMUNITY: POPULATION SUBGROUP (E.G., MR/DD)

	Baseline Period				MFP Program Period		
States	2004	2005	2006	2007	2008	2009	2010
Target MR/DD							
Maryland							
Missouri							
Nebraska							
Etc.							
Do not target MR/DD							
Michigan							
New Hampshire							
Etc.							

Source: MAX and MSIS data, 4005-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

MR/DD = people with mental retardation/developmental disabilities.

Tables III.5 and III.6 present examples of how we will display regression-adjusted estimated effects for a given targeted population. These estimated effects will be based on the logit regression models described above. Table III.5 illustrates how we will display estimates at the level of the target population across all states. Table III.6 illustrates how we will present information about how the overall estimates vary by person-level characteristics.[8]

The goal of the impact analyses is not only to assess whether the program was successful, but also to identify population subgroups for which the demonstration was particularly effective. The data presented in Table III.6 will help us identify such subgroups defined by demographic and health characteristics. In addition to this type of table, we will present effect estimates (estimated percent changes between pre- and post-MFP periods) based on our model predictions for other key population subgroups, including hazard model simulations for subgroups defined

[8] The estimates in Table III.6 will present percentages transitioning based on model predictions for prototypical institutionalized Medicaid enrollees of median age, race, gender, urban/rural residence, time in institution, physical function, cognitive function, and prior Medicaid and Medicare service use.

by duration of time in an institution (Table III.7). These estimates will enable us to identify whether the estimates for short stayers (those institutionalized for four or five months), are negative and suggest that any program effects for long-term stayers were offset by reduced probability of transition among short stayers.

Another key analysis will be to establish the extent to which people who transition receive HCBS and whether the likelihood of HCBS receipt among those who transition changes after the implementation of MFP. Table III.8 provides an example of how we will display the results of this type of analysis.

Finally, we will present predictions for subsets of the population identified as experiencing the largests impacts. Table III.9 presents an example based on enollees under age 75 and with fewer limitations in ADLs than the population average.

TABLE III.5

AVERAGE ANNUAL TREND IN PERCENTAGE OF MEDICAID ENROLLEES INSTITUTIONALIZED FOR SIX MONTHS OR MORE WHO TRANSITIONED TO THE COMMUNITY BEFORE AND AFTER MFP (MODEL PREDICTIONS) AND ESTIMATES OF MFP PROGRAM EFFECTS ON TRANSITIONS

	Target Population											
	Elderly			People with Mental Retardation/Developmental Disabilities			People with Physical Disabilities			People with Chronic Mental Illness		
State	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)
Arkansas[a]												
California[a]												
Connecticut[a]												
Delaware[a]												
District of Columbia												
Etc.												

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

Note: Percentages transitioning are model predictions for prototypical institutionalized Medicaid enrollees of median age, race, gender, urban/rural residence, time in institution, physical function, cognitive function, and prior Medicaid and Medicare service use for each target population.

[a]The state had a nursing facility transition program in place before MFP.

MAX = Medicaid Analytic Extract; MSIS = Medicaid Statistical Information System; and NF-MDS = nursing facility minimum data set.

*Significantly different from zero at the .05 level, two-tailed test.
**Significantly different from zero at the .01 level, two-tailed test.

TABLE III.6

AVERAGE ANNUAL TREND IN PERCENTAGE OF MEDICAID ENROLLEES INSTITUTIONALIZED FOR SIX MONTHS OR MORE WHO TRANSITIONED TO THE COMMUNITY BEFORE AND AFTER MFP (MODEL PREDICTIONS) AND ESTIMATES OF MFP PROGRAM EFFECTS ON TRANSITIONS : BY TARGET POPULATION AND BY CHARACTERISTIC

	Target Population											
	Elderly			People with Mental Retardation/Developmental Disabilities			People with Physical Disabilities			People with Chronic Mental Illness		
State	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)
Number of Enrollees												
Age (Percentage)												
Under 21												
21 to 64												
65 to 74												
75 to 84												
85 or older												
Percentage Female												
Number of Months Institutionalized (Percentage)												
6 to 8 months												
9 to 11 months												
12 to 17 months												
18 to 24 months												
25 months or more												
Average Number of ADLs												
Average Cognitive Function Score												

TABLE III.6 *(continued)*

	Target Population											
	Elderly			People with Mental Retardation/Developmental Disabilities			People with Physical Disabilities			People with Chronic Mental Illness		
State	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)
Percentage with Medicare or Medicaid Inpatient Services Use During Year Before Transition												

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

Note: Percentages transitioning are model predictions for prototypical institutionalized Medicaid enrollees of median age, race, gender, urban/rural residence, time in institution, physical function, cognitive function, and prior Medicaid and Medicare service use for each target population.

ADL = activity of daily living; MAX = Medicaid Analytic Extract; MSIS = Medicaid Statistical Information System; and NF-MDS = nursing facility minimum data set.

*Significantly different from zero at the .05 level, two-tailed test.
**Significantly different from zero at the .01 level, two-tailed test.

TABLE III.7

ESTIMATED MFP PROGRAM IMPACTS ON TRANSITIONS FROM INSTITUTIONS TO THE COMMUNITY BY MONTHS INSTITUTIONALIZED: POPULATION SUBGROUP (E.G., MR/DD)

		Months Institutionalized				
State	Overall	4-5 Months	6-8 Months	9-11 Months	12-23 Months	24+ Months
Arkansas[a]						
California[a]						
Connecticut[a]						
Delaware[a]						
District of Columbia						
Etc.						

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

Note: Data presented will be estimated percent change between pre- and post-MFP periods. Estimates will be based on hazard models that control for censoring of the data and our inability to observe the end of institutional stays for some people.

[a]The state had a nursing facility transition program in place before MFP.

MAX = Medicaid Analytic Extract; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set.

*Significantly different from zero at the .05 level, two-tailed test.
**Significantly different from zero at the .01 level, two-tailed test.

TABLE III.8

ESTIMATED MFP PROGRAM IMPACTS ON TRANSITIONS FROM INSTITUTIONS TO THE COMMUNITY, BY TRANSITION STATUS: BY POPULATION SUBGROUP (E.G., MR/DD)

	Transition Status											
	Overall			Remained in Institution Until Year End or Death			Transitioned to Community With HCBS			Transitioned to Community Without HCBS		
State	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)
Arkansas[a]												
California[a]												
Connecticut[a]												
Delaware[a]												
District of Columbia												
Etc.												

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

[a]The state had a nursing facility transition program in place before MFP.

HCBS = home- and community-based services; MAX = Medicaid Analytic Extract; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set.

*Significantly different from zero at the .05 level, two-tailed test.
**Significantly different from zero at the .01 level, two-tailed test.

TABLE III.9

EFFECT OF MFP ON TRANSITIONS TO THE COMMUNITY FOR ENROLLEES UNDER AGE 75 WITH LESS THAN TWO ADLS: PREDICTED CHANGE IN YEARLY TREND PRE- AND POST-MFP

	Target Populations			
State	Elderly	People with Mental Retardation/Developmental Disabilities	People with Physical Disabilities	People with Chronic Mental Illness
Arkansas				
California				
Connecticut				
Delaware				
District of Columbia				
Etc.				

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

Note: Percentages transitioning are model predictions for prototypical institutionalized Medicaid enrollees of median age, race, gender, urban/rural residence, time in institution, physical function, cognitive function, and prior Medicaid and Medicare service use for each target population.

MAX = Medicaid Analytic Extract; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set.

*Significantly different from zero at the .05 level, two-tailed test.
**Significantly different from zero at the .01 level, two-tailed test.

Our analysis of whether transitioned enrollees successfully remained in the community will use the same analytic approach as the analysis of transitions out of institutions, but will necessarily be restricted to those who did transition to the community. We will examine how the probability of reinstitutionalization differed before and after the intervention (Table III.10) and estimate effects by target population (Table III.11) and demographic and enrollment characteristics (Tables III.6 through III.9). We will also characterize the type of long-term care services that are used one year and two years after MFP implementation (Table III.12) to better understand enrollee trajectories and Medicaid costs. After estimating reinstitionalization rates using only pre-transition predictors, we will test the predictive nature of other explanatory variables. For example, we will reestimate the models to include

a variable for admission to a hospital during the first six months after transition to see if that type of service use predicts reinstitutionalization. Our analyses of reinstitutionalization will be supplemented with information we obtain from MFP grantees about the reason for reinstitutionalization. This information will only be available for MFP participants, but we will tabulate it for this population and use the tabulations to help inform the results we identify.

TABLE III.10

PERCENTAGE OF MEDICAID ENROLLEES INSTITUTIONALIZED FOR SIX MONTHS OR MORE WHO TRANSITIONED INTO THE COMMUNITY AND WERE REINSTITUTIONALIZED WITHIN 24 MONTHS (MODEL PREDICTIONS): POPULATION SUBGROUP (E.G., MR/DD)

	Baseline Period				MFP Demonstration Period		
State	2004	2005	2006	2007	2008	2009	2010
Arkansas							
California							
Connecticut							
Delaware							
District of Columbia							
Etc.							

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

Note: Percentages reinstitutionalized are model predictions for a prototypical institutionalized Medicaid enrollee of median age, race, gender, urban/rural residence, time in institution, physical function, cognitive function, and prior Medicaid and Medicare service use.

MAX = Medicaid Analytic Extract; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set.

TABLE III.11

YEARLY TREND IN PERCENTAGE OF MEDICAID ENROLLEES INSTITUTIONALIZED FOR SIX MONTHS OR MORE WHO WERE REINSTITUTIONALIZED WITHIN 12 MONTHS AFTER TRANSITIONING TO THE COMMUNITY (MODEL PREDICTIONS) AND ESTIMATES OF MFP PROGRAM EFFECTS ON TRANSITIONS

	Elderly			People with Mental Retardation/Developmental Disabilities			People with Physical Disabilities			People with Chronic Mental Illness		
State	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)	Pre-MFP	Post-MFP	Percent Change (Effect Estimate)
Arkansas												
California												
Connecticut												
Delaware												
District of Columbia												
Etc.												

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

Note: Percentages reinstitutionalized are model predictions for prototypical institutionalized Medicaid enrollees of median age, race, gender, urban/rural residence, time in institution, physical function, cognitive function, and prior Medicaid and Medicare service use for each target population.

MAX = Medicaid Analytic Extract; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set.

TABLE III.12

ESTIMATED MFP PROGRAM IMPACTS ON LONG-TERM CARE USE ONE AND TWO YEARS AFTER TRANSITION FROM INSTITUTION TO THE COMMUNITY: POPULATION SUBGROUP (E.G., MR/DD)

		Percent Change (Effect Estimate) in Residence One Year Post Transition					Percent Change (Effect Estimate) in Residence Two Years Post Transition				
State	Number Transitioned	Community with HCBS	NF	Hospital-ized	No Longer Enrolled in Medicaid	Died	Community with HCBS	NF	Hospital-ized	No Longer Enrolled in Medicaid	Died
Arkansas											
California											
Connecticut											
Delaware											
District of Columbia											
Etc.											

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

Note: Percentages reinstitutionalized are model predictions for prototypical institutionalized Medicaid enrollees of median age, race, gender, urban/rural residence, time in institution, physical function, cognitive function, and prior Medicaid and Medicare service use for each target population.

HCBS = home- and community-based services; MAX = Medicaid Analytic Extract; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System; NF = nursing facility; NF-MDS = nursing facility minimum data set.

C. ESTIMATING IMPACTS OF MFP ON PROGRAM PARTICIPANTS

The second portion of our impact analyses will examine the effects of MFP on the expenditures, health care utilization, and mortality of program participants. Unlike the analyses of transitions from institutions that were described in the previous section and that will examine institutionalized enrollees, the analyses described in this section will focus on effects of MFP on the people who were eligible for program services—those in institutions for six months or more—who transitioned to an eligible community residence. The overarching question driving these analyses is: How well did program participants fare under MFP relative to how they would have fared if the MFP program did not exist?

More specifically, the analysis will address the following research questions for program participants only:

- How does MFP affect Medicaid and Medicare expenditures?
- How does MFP affect patterns of health care utilization?
- How does MFP affect the quality of care?
- How does MFP affect mortality?
- What subgroups of MFP participants have the best outcomes?

We will analyze participant-level outcomes across three distinct periods: (1) before transition and the start of the MFP demonstration period, (2) during the 12-month demonstration period for the individual, and (3) during the first 12 months after the demonstration period ends.

A key component of our analysis of participant outcomes will analyze patterns of care and quality-of-care indicators, which can differ across target populations and will involve the identification of population-appropriate outcome measures. Table III.13 lists some population-specific outcomes we will examine and identifies their source data: (1) MAX/MSIS and Medicare files that are available for all enrollees (M); (20 the NF-MDS available for people

institutionalized in nursing facilities and some ICFs-MR (N); or (3) grantee-reported data, which will only be available for MFP participants (G).

TABLE III.13

POPULATION SPECIFIC UTILIZATION AND QUALITY-OF-CARE MEASURES AND THEIR DATA SOURCES

Measure	Elderly	MR/DD	PD	MI
Health Care Utilization				
Environmental modifications to home or apartment	G		G	
Receipt of assistive technologies and devices	G		G	
Receipt of supportive services (e.g., guide animals)			G	
Receipt of durable medical equipment	M, G		M, G	
Use of mental health services				M
Service use by type (physician, inpatient care, durable medical equipment, HCBS)	M, G	M, G	M, G	M, G
Quality of Care				
Admission to ER/hospital and/or office visits for pressure ulcer	M		M	
Admission to ER/hospital and/or office visits for infection	M		M	
Admission to ER/hospital for acute psychiatric episode				M
Admission to ER/hospital for medication administration error	M	M		M
Admission to ER/hospital related to cognitive condition (e.g., delirium)	M	M		
Admission to ER/hospital related to diabetes mismanagement	M			
Admission to ER/hospital related to a fall or injury	M		M	M
Annual physical exam		M		M
Use of community-based psychiatric services				M
Use of occupational/physical therapist services	M		M	
Isolation/social engagement	N, G	N, G	N, G	G
Medication compliance				M
Mortality	M	M	M	M

G = Data from grantees that are available for program participants only.

M = Data from MAX/MSIS and Medicare files available for all enrollees.

N = Data from the NF-MDS available for NF-MDS respondents only (people institutionalized in nursing facilities and some ICFs-MR).

ER = emergency room; HCBS = home- and community-based services; ICF-MR = intermediate care facility for the mentally retarded; MAX = Medicaid Analytic Extract; MI = people with mental illness; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set; PD = people with physical disabilities.

1. Outcome Measures

Health Expenditures. HCBS services are expected to be less costly for Medicaid than institutional care because they typically do not include the cost of housing. In addition, services

needed in institutions can be replaced by support services provided by family and other unpaid caregivers in the community. However, enrollees who transition from institutional care may have greater HCBS expenditures than other users of community-based long-term care services. They may need a broader spectrum of Medicaid-covered services or a larger volume of services than what they needed while in institutional care to make the transition to the community and to remain living there. In addition, there may be inefficiencies in providing care in a wide variety of settings, and a lack of appropriate care may result in more frequent hospitalizations or need for acute care services among those in the community than for those in more stable institutional environments. To assess the composite effect of MFP on expenditures, we will examine program impacts on participant-level total expenditures, total Medicaid expenditures, and Medicare and Medicaid expenditures (combined and by program) among enrollees dually eligible for Medicare and Medicaid benefits. We also propose to assess expenditures by service type, when feasible, including HCBS, institutional care, hospitalizations, emergency room visits, and ambulatory care, to understand how MFP affects health care costs.

Expenditures will be adjusted to reflect 2008 dollars using the Consumer Price Index for all urban consumer medical care series.

Health Service Use. Because estimates of impacts on expenditures can be sensitive to inflation adjustments, we will also examine MFP impacts on participant health service use to ensure our estimates are consistent. We will examine use of HCBS, hospitalizations, emergency room visits, and ambulatory care. If MFP reduces participants' hospitalization expenditures or emergency room expenditures, for example, we will confirm that there are similar impacts on utilization of these services. These utilization measures will also be supplemental indicators of successful transitions and improved quality of care and quality of life.

Quality of Care. We will examine several indicators of quality of care to assess the degree to which appropriate care was provided to program participants. Routine ambulatory care visits to health care professionals are a critical measure of program quality. People who transition to the community should continue to receive at least some routine care services from a primary care provider. Quality will also be measured by the incidence of hospital admissions or emergency room visits for treatment of conditions that can arise if home care is inadequate (for example, medication administration errors, delirium, infections, falls, skin wounds, fractures, depression, or exacerbation of chronic conditions such as heart failure or diabetes). Many of these measures will mirror the measures developed and used by the Agency for Healthcare Research and Quality to measure the quality of HCBS.

Our approach acknowledges that different metrics are more relevant for certain target populations than others. For example, hospitalizations or emergency room visits with a diagnosis of an acute psychiatric episode will be relevant for participants with mental illness. If possible, medication compliance will also be used to infer quality of care for this population.[9] Access to environmental modifications, personal care services, and assistive technology and devices will be particularly relevant for the elderly and people with physical disabilities. Among the MR/DD population, hospital admissions for medication administration errors will be used as an indicator for insufficient care.

[9] Measures of medication compliance can be derived from MAX drug claims. For example, given a diagnosis is observed on claim records, number of prescriptions filled by type of class of medication (for example, antipsychotics for schizophrenia) can be used to measure appropriate care. However, our ability to analyze access to services and quality of care associated with medications will depend on the availability of research-quality prescription claims. For enrollees not eligible for Medicare, MAX and MSIS drug claims will be used. These files will also be adequate for the dually eligible who use drugs not covered by Medicare Part D, such as some important classes of psychiatric medications. For the dually eligible who use drugs covered by Medicare Part D, we will attempt to establish access to Part D records when they become available to researchers.

Because the program's impact on quality of care in the community versus institutions may depend on severity of condition, subgroup analyses by level of need will be particularly important for these outcomes.

Mortality. The most fundamental measure of participant outcomes is mortality. Date of death is frequently not recorded in Medicaid eligibility files, so we will rely on date of death information we obtain from Medicare eligibility records. Therefore, for enrollees dually eligible for Medicare and Medicaid—for whom we have reliable date of death data—we will measure mortality rates and estimate program effects on mortality by population subgroup. The analysis of mortality will be particularly important for the subgroup of elderly enrollees.

2. Methods

While the outcomes of demonstration participants can be observed and measured, the principal challenge to estimating demonstration effects accurately lies in approximating the counterfactual—that is, the outcomes that would have occurred had the demonstration not been implemented. With a counterfactual, estimating the effect of the demonstration becomes a matter of appropriately comparing observed and counterfactual outcomes.

This section presents our approach to addressing four groups of questions:

1. What would participants' Medicaid and Medicare expenditures have been in the absence of the demonstration?
2. What would the service use of participants have been in the absence of the demonstration?
3. What would the quality of care have been in the absence of the demonstration?
4. What would the mortality rate have been in the absence of the demonstration?

We then describe the statistical models we will use for the analysis and sample size requirements.

Establishing the Counterfactual. We will use several steps to establish the counterfactual. This process will involve identifying two different counterfactual groups and then computing a weighted average of effects based on these two groups. Both counterfactuals will be drawn from the population of Medicaid enrollees who are observed to be institutionalized for at least six months. Within this population we will select those individuals who most closely match MFP participants on a given set of observable characteristics.

- ***First Counterfactual Group.*** The first counterfactual group will be Medicaid enrollees who were institutionalized for at least six months during calendar years 2004 and/or 2005, have characteristics similar to those of program participants, and transitioned to the community without the benefits of the MFP program during 2004 or 2005.[10] This counterfactual group and its expenditures, service use, and mortality during the two years after transition will be used to compute an heuristic *lower-bound* estimate of program effects.[11]
- ***Second Counterfactual Group.*** The second counterfactual group will be the same as the first, except these institutionalized enrollees will have remained in institutional care throughout calendar years 2004 and/or 2005. Members of this group will be randomly assigned a pseudo transition date, and the distribution of pseudo transition dates will match the distribution of transition dates of the first counterfactual group. This counterfactual group and its expenditures, service use, and mortality during the two years after its pseudo transition dates will be used to compute an heuristic *upper-bound* estimate of program effects.
- ***Combined Lower- and Upper-Bound Estimates.*** We will use both counterfactual groups to examine differences in post-transition outcomes, controlling for any differences in the characteristics of the two counterfactual groups and MFP participants. Measures of expenditures, utilization, and quality of care, both while in institutional care and in the community, will be measured for MFP participants and members of both counterfactual groups. The lower-bound, upper-bound, and weighted average estimates, along with their standard errors, will provide a range of expected program impacts on participant outcomes.

[10] Based on service dates, we will see the end of institutional services, but their Medicaid eligibility and use of other services continues.

[11] The lower-bound estimate is likely to produce "negative" impacts for some outcomes. For example, because MFP programs involve expanded access to community services, the lower-bound estimate may suggest increased expenditures among program participants relative to people who transitioned during pre-MFP periods.

The weights used to compute the weighted average will be based on the estimated proportion of MFP participants who would not have been able to transition to the community had the program not been available. The weight on the upper-bound estimate will be equal to the estimated impact on the probability of transition divided by the proportion of eligibles who did transition. The weight on the lower-bound estimate is one minus the weight on the upper-bound estimate.[12] That is, suppose that 3 percent of the eligible population participates in the MFP program, and suppose that our estimate is that the impact on the probability of transitioning out of a nursing home is 1 percentage point. In this case, one-third of the MFP participants are people who would not have transitioned to the community had the MFP program not been implemented. The weight on the upper-bound estimate then should be one-third, and the weight on the lower-bound estimate should be two-thirds.

Developing the counterfactual groups requires us to identify enrollees during the pre-MFP period who are similar to MFP participants. To identify both counterfactual groups, we will match enrollees institutionalized before MFP was implemented to program participants by length of institutionalization, institution type, target population, age, and health care needs (as measured by their level-of-need score). To do so, we will estimate a model of the probability of transitioning from institution to community during the MFP period, and use this propensity model to select the best-matched cases from the set of enrollees who transitioned from (or

[12] This approach assumes that MFP has no adverse impact on the proportion of individuals in institutions who transition out of the institution before six months. If such an impact is observed, it will be necessary to have three components to the overall impact, with appropriate weights on each. The third component in this case would be the impact on costs and services for those whose transition was delayed because of MFP's effects, occurring after six months in the institution instead of within the first six months of entry. The weight for this component would be the negative of the impact on the probability of transitioning from an institution to the community during the first six months after entry, divided by [the number who transitioned after six months in an institution during the demonstration period – (number who entered an institution during the demonstration period) * (estimated impact of MFP on probability of transitioning during first six months after entering an institution)]. This same denominator would be used to calculate the weights for the other two groups (those who would have transitioned after at least six months in an institution even without MFP and those who would not have transitioned after six months had MFP not been implemented).

remained in) institutions during the pre-demonstration period from 2004 through 2005 in the same state. Post-transition outcomes will be measured during the 12 and 24 months after the transition date (or pseudo transition date).

Conditional on health need and other characteristics, increases in the use of acute care utilization, preventable hospitalizations or emergency room visits, or mortality between the MFP and counterfactual groups would indicate that the quality of care in the community associated with MFP participation was less than what they would have received in the absence of the program. Meanwhile, if, after transitioning to the community, MFP participants use ambulatory care at higher rates, or have fewer hospitalizations and lower mortality than the counterfactual groups, that would indicate a positive impact of MFP on participant outcomes. Table III.14 lists the outcome measures and associated explanatory variables we propose to examine in our analysis of impacts on MFP participants.

TABLE III.14

PLAN FOR ESTIMATING IMPACTS ON GENERIC MFP PARTICIPANT OUTCOMES

Measure	Data Source
Outcome Measures	
Health Expenditures[a]	
Total Medicare and Medicaid	MAX/MSIS Medicare files
Medicaid	MAX/MSIS Medicare files
Medicare	MAX/MSIS Medicare files
Expenditures by service type (physician visits, inpatient hospital admissions, ER visits, HCBS)	MAX/MSIS Medicare and MFP Services files
Health Care Utilization	MAX/MSIS Medicare files
Number of physician visits	MAX/MSIS Medicare files
Hospitalized	MAX/MSIS Medicare files
Number of inpatient hospital admissions	MAX/MSIS Medicare files
Number of hospital days	MAX/MSIS Medicare files
Any ER visit	MAX/MSIS Medicare files
Number of ER visits	MAX/MSIS Medicare files
Any use of durable medical equipment	MAX/MSIS Medicare file
Number of mental health service visits	MAX/MSIS Medicare file
HCBS use by type	MAX/MSIS Medicare and MFP Services files
Quality Indicators	
Hospitalization/ER visit for accident, fall, fracture, burn/scald, or other preventable condition	MAX/MSIS Medicare files
Treatment for skin wounds	MAX/MSIS Medicare files
Annual physical exam	MAX/MSIS Medicare files
Use of community-based psychiatric services	MAX/MSIS Medicare files
Use of occupational/physical therapist services	MAX/MSIS Medicare files
Medication compliance	MAX/MSIS Medicare files
Mortality	MAX/MSIS Medicare files
Explanatory Variables	
Demographic and Eligibility Characteristics	
Age	MAX/MSIS
Race	MAX/MSIS
Gender	MAX/MSIS
Urban/rural residence	MAX/MSIS
Dual status	MAX Medicare files
Institutionalization History	
Months in institution before transition	MAX/MSIS NF-MDS
Initial Health Status	
Physical function (ADLs)	NF-MDS
Cognitive function	NF-MDS
Social engagement	NF-MDS
Pain level	NF-MDS
Composite service need score	NF-MDS
Inpatient, ER, and other acute care service use	MAX/MSIS Medicare files

TABLE III.14 *(continued)*

[a] Expenditures will be defined as expenditures per month during the year.

ADL = activity of daily living; ER = emergency room; HCBS = home- and community-based services; MAX = Medicaid Analytic Extract; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set.

Modeling Approach. We will use a range of standard regression models to examine MFP impacts on other participant outcomes. We will measure outcomes one and two years after the transition date (or pseudo-transition date). A year time frame is meaningful because MFP-covered services will be provided during the first year (365 days) of program enrollment, and it will be important to observe program effects during the year after the MFP transitional services end. As a result, we will need to address both left and right censoring in our analysis because we will not always be able to observe what occurred during the year before the transition and the first and second years after the transition. We will use weighting approaches based on cost or use per month over the period of interest and weight the observation by number of months observed to address censoring of observations during the year before transition or within the two years post-transition from institutions.

The simplest model for a continuous outcome variable can be written as:

$$Y = a + b_1 Counter_1 + b_2 Counter_2 + fX + e ,$$

where Y is the outcome measure for person i the first year after transition, $Counter_1$ = 1 for Medicaid enrollees in the first counterfactual group, $Counter_2$ = 1 for Medicaid enrollees in the second counterfactual group, X is a set of beneficiary characteristics, which will include pre-transition utilization measures, and e is an error term. The parameters b_1 and b_2 are estimates of the difference between program participants and the counterfactual groups from the pre-MFP period. Tests of whether b_1 and b_2 are significantly different from zero will provide evidence for the effect of MFP on the outcome Y during the first year after transition. This model will be

estimated twice, once for outcomes measured during the first year after transition and again for outcomes measured during the second year after transition.[13]

Robustness Testing. For key outcome measures, such as expenditures and hospitalizations, we will check the robustness of our estimates by using alternative approaches to modeling program effects. One alternative approach will be to develop difference-of-differences estimates, which will compare the difference in pre- to post-transition outcomes (such as costs) of the counterfactual groups to the pre- to post-transition outcomes of MFP participants. We will also test the sensitivity of our expenditures estimates to outliers by trimming the data and developing a second group of estimates that exclude the enrollees in the top 1 percent of expenditures.

Sample Sizes. We will estimate separate impacts for each state by target population for those target subgroups included in the MFP demonstration within the state. This might create problems in some cases, because sample sizes by subgroup may be very small. As an indication of our ability to detect significant differences given the program participant sample sizes, Table III.15 shows the minimum detectable effects (MDEs) for binary variables for each grantee (measured in percentage points) based on the assumption of 80 percent statistical power, 95 percent confidence for a two-sided test, and model R-squared of 0.3. The calculations assume that all grantees achieve their target MFP enrollments and that the number of people in each counterfactual group equals the number of program participants. If there are 300 MFP participants, each counterfactual group has 300 enrollees, for a total of 600 enrollees in both counterfactual groups.

[13] If Y is a binary variable (for example, whether hospitalized), a logit model will be estimated instead of a general linear regression model. In this case, we will compute the effect of MFP as differences in predictions of Y occurring during the first post-transition year (see Ai and Norton 2003) and during the first 24 months after transition. Thus, exp (b_1) and exp (b_2) is MFP's effect on the odds of being hospitalized.

The table suggests that the impact analyses will have a good chance of detecting only very large effects in some states and target population subgroups. In Arkansas, for example, the sample size for aged participants supports detection of impacts of about 17 percentage points for an outcome with a mean of 50 percent. For unlikely outcomes and for other states with large numbers of expected program participants—for example, the aged and people with physical disabilities subgroups in Illinois and Michigan—smaller effects will be detectable. Because program participant sample sizes vary significantly across states, we will identify states for which sample sizes are small, resulting in insufficient power to detect moderate impacts. As in the analysis of institutionalized enrollees, we will pool data across states and, if necessary, by target population. Pooling will require the assumption that the explanatory variables are associated with outcomes similarly across states.

TABLE III.15

MINIMUM DETECTABLE EFFECTS FOR BINARY PROGRAM PARTICIPANT OUTCOMES, BY TARGET POPULATION

State	Aged		Mentally Retarded/Developmentally Disabled		Physically Disabled		Chronically Mentally Ill	
	Number of Program Participants	MDE for Binary Variables	Number of Program Participants	MDE for Binary Variables	Number of Program Participants	MDE for Binary Variables	Number of Program Participants	MDE for Binary Variables
Arkansas	92	17.3	60	21.4	146	13.7	7	88.5
California	400	8.3	331	9.1	899	5.5	185	17.2
Connecticut	280	9.9	70	19.8	140	14.0	140	19.8
Delaware	32	29.3	20	37.1	28	31.3	20	52.4
District of Columbia	215	11.3	150	13.5	645	6.5	100	23.4
Georgia	175	12.5	562	7.0	375	8.6	0	n.a.
Hawaii	185	12.2	50	23.4	180	12.4	0	n.a.
Illinois	1,517	4.2	105	16.2	1,000	5.2	735	8.6
Indiana	768	6.0	71	19.7	200	11.7	0	n.a.
Iowa	0	n.a.	528	7.2	0	n.a.	0	n.a.
Kansas	242	10.7	0	n.a.	356	8.8	0	n.a.
Kentucky	218	11.2	197	11.8	131	14.5	0	n.a.
Louisiana	364	8.7	320	9.3	76	19.0	0	n.a.
Maryland	1,467	4.3	200	11.7	746	6.1	0	n.a.
Michigan[a]	1,860	3.8	0	n.a.	1,240	4.7	0	n.a.
Missouri	48	23.9	125	14.8	52	23.0	0	n.a.
Nebraska	400	8.3	200	11.7	200	11.7	0	n.a.
New Hampshire[a]	325	9.2	0	n.a	45	24.7	0	n.a.
New Jersey	174	12.6	229	11.0	87	17.7	0	n.a.
New York	1,190	4.8	140	14.0	1,190	4.8	280	14.0
North Carolina	300	9.5	225	11.0	300	9.5	520	10.3
North Dakota	46	24.4	30	30.3	34	28.4	0	n.a.
Ohio	1,428	4.4	584	6.9	158	13.2	61	30.0
Oklahoma	1,575	4.2	200	11.7	300	9.5	0	n.a.
Oregon	300	9.5	179	12.4	301	9.5	0	n.a.

TABLE III.15 *(continued)*

State	Aged		Mentally Retarded/Developmentally Disabled		Physically Disabled		Chronically Mentally Ill	
	Number of Program Participants	MDE for Binary Variables	Number of Program Participants	MDE for Binary Variables	Number of Program Participants	MDE for Binary Variables	Number of Program Participants	MDE for Binary Variables
Pennsylvania	1,317	4.6	427	8.0	563	7.0	183	17.3
South Carolina	240	10.7	0	n.a.	60	21.4	0	n.a.
Texas	780	5.9	1,216	4.7	420	8.1	160	18.5
Virginia	325	9.2	358	8.8	358	8.8	0	n.a.
Washington	348	8.9	80	18.5	172	12.7	60	30.2
Wisconsin	533	7.1	313	9.3	221	11.2	195	16.8

Note: The number of program participants is based on state applications and do not reflect the revisions states made during the approval of operational protocols. MDEs are expressed as percentage points and are based on the standard assumption of 80 percent statistical power, for a two-sided test at the .05 significance level, and model R squared of 0.3, for a binary variable with a mean of .50. Calculations assume that there will be the same number of enrollees selected for the pre-MFP comparison group in each state as the number of program participants in that state and that each grantee reaches its program participation targets.

MDE = minimum detectable effect.

Limited information about services paid in lump sum may limit our ability to use MAX/MSIS data to examine outcomes for people in certain grantee states. For example, broad managed care enrollment among duals in Kansas, Pennsylvania, and Rhode Island may limit our ability to measure use of preventive services and expenditures by type in these states. Because the use of managed care and patterns of reporting change over time, we will assess the feasibility of using each state's data for outcomes analyses as they become available. We may provide estimates only for aged enrollees, who are much less likely to enroll in managed care, or limit certain analyses to people not enrolled in comprehensive managed care plans to address MAX/MSIS limitations for outcomes analyses. Such a sample size limitation would reduce the precision of our estimates.

3. Analysis Plan

For analyses of utilization, expenditures, and quality of care, we will first present unadjusted summary statistics for program participants (Table III.16) followed by estimated program effects (Table III.17). These estimates will be reported for the first and second program years, as well as for the composite two-year average. We will include sample sizes in our effect estimate tables to indicate states for which there was insufficient power to detect small impacts.

TABLE III.16

NUMBER AND PERCENTAGE OF MFP PROGRAM PARTICIPANTS WHO WERE HOSPITALIZED BEFORE TRANSITION AND DURING FIRST YEAR AND SECOND YEAR AFTER TRANSITION: POPULATION SUBGROUP (E.G., MR/DD)

		Number of Participants			Percentage of Participants Who Were Hospitalized		
State	Total Number of Participants	Pre-Transition	Year 1 Post-Transition	Year 2 Post-Transition	Pre-Transition	Year 1 Post-Transition	Year 2 Post-Transition
Arkansas							
California							
Connecticut							
Delaware							
District of Columbia							

Source: MAX and MSIS data, 2004-2010; NF-MDS 2004-2010; Medicare claims files, 2004-2010.

MR/DD = people with mental retardation/developmental disabilities.

TABLE III.17

ESTIMATED IMPACTS OF MFP ON LIKELIHOOD OF HOSPITALIZATION: POPULATION SUBGROUP (E.G., MR/DD)

		Impacts by Year		
State	Total Number of Participants	Year 1 Impact	Year 2 Impact	Composite Year 1 and Year 2 Impact
Arkansas				
California				
Connecticut				
Delaware				
District of Columbia				

Source: MAX and MSIS data, 2004-2010; NF-MDS 2004-2010; Medicare claims files, 2004-2010.

Note: Estimates are based on a model that adjusts for age, race, gender, urban/rural residence, time in institution, physical function, cognitive function, and prior Medicaid and Medicare service use.

MR/DD = people with mental retardation/developmental disabilities.

*Significantly different from zero at the .05 level, two-tailed test.
**Significantly different from zero at the .01 level, two-tailed test.

IV. WELL-BEING, SATISFACTION, AND QUALITY OF LIFE: WHAT IS THE EXPERIENCE OF MFP PARTICIPANTS?

The welfare of participants who have transitioned from institutional settings into less restrictive community-based care is a primary concern of long-term care stakeholders, beneficiaries, and their advocates. Careful measurement of participant well-being, quality of life, and satisfaction in the community is a fundamental consideration when the implementation of flexible benefits afforded by grantees' MFP programs replaces institutional care with a less structured environment. To address this concern, substantial effort will be devoted to systematically measuring and reporting outcome measures for MFP participants related to well-being, quality of life, and satisfaction during and after the MFP demonstration period. This chapter describes (1) the research questions guiding the analysis; (2) the relevant data sources; (3) the outcome measures that will be used to infer well-being, quality of life, and satisfaction for participants; (4) the analysis methodology; and (5) analytic challenges.

Little is known about how deinstitutionalization affects the well-being, quality of life, and satisfaction of Medicaid beneficiaries. To address this concern, data on participants will be systematically obtained from participants at three points: (1) before discharge to the community, (2) 11 months after discharge to the community, and (3) 24 months after discharge to the community. These data will be collected through face-to-face interviews conducted by grantees using the MFP-Quality of Life Survey (MFP-QOLS), an instrument designed to discern change in quality of life as participants move from institutional to community-based settings. The MFP-QOLS instrument will be administered whether participants live in the community or have been reinstitutionalized at the time of follow-up. Most of the questions are based on the Participant Experience Survey (PES) (Version 1.0 of Mental Retardation/Developmental Disabilities 2003,

MEDSTAT Group, Inc.), although a few items are drawn from other instruments (ASK ME!, Cash and Counseling, National Core Indicator Survey [NCI], Quality of Life Enjoyment and Satisfaction Questionnaire—Short Form, and the Nursing Home Consumer Assessment of Health Plans Survey [NH CAHPS]). The MFP-QOLS instrument is appended to this report (see Appendix A).

The MFP-QOLS will collect information on participant welfare in the following domains: (1) satisfaction with living arrangements, (2) unmet need for personal care, (3) respect and dignity, (4) choice and control, (5) community integration and inclusion, (6) overall satisfaction with life, and (7) psychosocial health status. Some questions (for example, on employment status) are designed to be collected only after the transition has occurred. Participant welfare will be ascertained through evaluation of change in each domain. Summary performance for each domain will be captured through the calculation of summative counts of similar items, where possible. The calculation of each domain's summary measure is detailed in the outcome measures section of this chapter. Throughout this chapter, we refer to the quality-of-life domains in the MFP-QOLS collectively as "quality of life."

A. THREATS TO THE EVALUATION OF QUALITY OF LIFE

A methodological issue inherent in the evaluation design is the lack of a comparison group, a consequence of an absence of quality-of-life metrics on other Medicaid beneficiaries. Without an appropriate set of Medicaid beneficiaries for comparison, evaluation of quality-of-life outcome measures lacks a proper counterfactual. However, moving from an institution to the community is a *major* life change, so any significant changes in quality-of-life outcome

measures between baseline and followup will likely be largely attributed to this change.[1] Furthermore, our focus in this analysis is on estimating the relationship of observed changes in quality-of-life indicators to both individual and program characteristics. This will yield information about the types of participants and program features that are most associated with improved quality-of-life outcome measures as participants transition out of institutions, as well as any characteristics that are found to be associated with reduced quality-of-life.

Analysis of the results from the MFP-QOLS information will require consideration of several threats to the validity of the data. First, nonresponse to the followup surveys may yield non-representative results and reduce the statistical power to detect effects on the outcome measures. The primary sources of nonresponse are expected to be inability to find the participant, death, and refusal to complete the survey. MPR will compare the baseline characteristics of participants who did not participate at followup to those who did to identify any systematic differences between the two groups. Overall, we anticipate a high response rate from grantees at each time point; 95 percent response rate at the baseline measurement, 90 percent for the 12-month followup, and 80 percent for the 24-month followup. Thus, nonresponse bias is expected to be minimal.

A second threat to this analysis is the difference in data collection methodology across grantees, between baseline and followup, and among participants for a given grantee. Proxy interviews, which the survey protocol permits, may yield different responses than surveys conducted with MFP participants. A similar phenomenon may occur for surveys administered by telephone, which may differ from in-person surveys. The use of different interviewers at followup (for example, volunteers or staff external to the MFP program) than at baseline to

[1] Therefore, we expect that a person's baseline status is an appropriate control. However, we acknowledge that the pre-post design does not systematically control for sentinel events leading to lower ratings of quality of life.

collect data may also yield data that reflect the differences in who collects the data rather than true differences over time. MPR will examine MFP-QOLS results to determine, where possible, if such biases appear to exist, and attempt to develop creative approaches to control analytically for any systematic differences in collection methodology.

B. RESEARCH QUESTIONS

The following questions will guide our analysis of MFP participants' quality of life:

1. *What happens to participants' quality of life after transition?* To provide an overview of how MFP participants' quality-of-life experiences before discharge have changed at 11 and 24 months after discharge, we will report the percent that improved and the percent that maintained or improved quality of life for each time period, for each target population, for each grantee.
2. *Which participant characteristics are associated with the greatest improvements in quality of life?* To assess which characteristics of beneficiaries are associated with the greatest improvements in quality of life one and two years after transitioning from the institution to the community, we will define as our outcome measures three binary variables:
   - Whether the beneficiary's quality of life improved
   - Whether the beneficiary's quality of life was maintained or improved
   - Whether quality of life either improved or was at the maximum value

   For each measure, we will examine which participant characteristics have statistically significant independent association with improvement. In addition to the demographic, functional, cognitive, and clinical characteristics of participants listed in the methods section below, and the length of time in the institution before transition, we will examine the role of institutional care needs (before transition) on quality-of-life improvement. Claims data will permit examination of the role of pre-transition emergency room and hospital use, specific diagnoses (for example, chronic conditions such as diabetes or heart failure), and medication (for example, anti-depressants) on quality-of-life improvement. We will use the summary definitions of low care described by Mor and colleagues (2007).[2] We will also examine the

[2] As first described in Chapter II, Mor et al. (2007) use a "narrow" and "broad" definition of low care. The broad definition includes residents who do not require physical assistance in any of the four late-loss activities of daily living (ADLs) (bed mobility, transferring, toileting and eating) and are not classified as either "Special Rehab" or "Clinically Complex" in the RUG-III grouper. The narrow definition of low care excludes any resident who meets the broad definition but who is classified in the lowest 2 of the 44 RUG-III groups.

association between low-volume MFP service use and quality-of-life outcome measures.

3. *Does quality of life vary by key program component?* Our evaluation of the MFP program provides a unique opportunity to enhance understanding of the relationship between program structure and participant quality of life. Previous research, for example, has found that consumer-directed models of home care services provide much greater levels of satisfaction and better meet beneficiary needs than traditional Medicaid home- and community-based services (HCBS) (Carlson et al. 2007). We will examine the role that key program components, such as aggressiveness of grantee targets, transition coordination by state staff versus use of a contracted agency, and service package type (for example, targeted provision of services that fill gaps in existing waivers versus broad-based, comprehensive "stand-alone" programs) play to understand the impact of specific program design components on participant ratings of quality of life. Table IV.1 lists potential program-specific characteristics that will be explored. Where relevant, based on our findings from the program performance analysis (refer to Chapter II, Section C), we will also include other grantee-specific variables related to the environment in which the MFP program operates, such as meeting all transition or spending benchmarks.

The impact of program characteristics will be analyzed by target population to determine if there is an interaction between target population type, program component, and quality of life. Differences due to participant characteristics will be mitigated, because each person's quality-of-life is measured relative to his or her own baseline quality of life, and because the effects of participant characteristics on likelihood of improvement will be controlled for in the analysis.

Our analytic approach to link program components with participant ratings of quality of life is described in the methods section of this chapter. The overall approach will be to rank states by their quality-of-life outcome measures in a given domain and examine the characteristics of those with high rankings for evidence of patterns. For example, for states in the top quintile of performance on a composite measure of participant unmet needs, we will look for common program components that seem to be over-represented (or under-represented).

Table IV.1 illustrates examples of program characteristics with a potential for impact on participants' quality of life. Where feasible, to aid interpretation, we propose creating dichotomous indicators of program characteristics rather than measuring implementation of

characteristics along a continuum. Most program characteristics would be abstracted from grantees' Operational Protocols (OPs). The semiannual web-based progress reports are the other source of data for this information.

TABLE IV.1

EXAMPLES OF PROGRAM CHARACTERISTICS WITH POTENTIAL IMPACT ON QUALITY OF LIFE

Program Characteristics	Measurement	Source	Anticipated Findings
Grantee transition target ratio	Number in targeted population divided by number eligible for MFP	OP	Grantees with higher targets may reach goals through transitioning participants "at the margins," perhaps leading to lower quality-of-life scores at baseline or over time.
Transition coordination	Dichotomous indicator of state staff versus contracted agency	OP	State staff may be more accountable and thus do a better job of appropriately transitioning participants.
Self-directed care	Continuum of self-directedness	OP	Programs with components of self-directed care may enhance participant's control and therefore quality of life.
Enriched versus "gap-filling" service package	Dichotomous indicator	OP	More enriched service packages may yield higher ratings of quality of life through greater service connection.
Pre-existing transition initiatives	Dichotomous indicator of newly formed versus existing transition initiatives (e.g., diversion grants)	OP	Grantees with greater infrastructure in place may yield greater improvement of quality of life at baseline measurement. Alternatively, gains may be greatest in areas where no such options previously existed.
Managed LTC	Dichotomous indicator	OP	Participants with integrated services from managed LTC systems may demonstrate higher quality-of-life scores over time.
Program director turnover	High/Low	Semi-annual web reports	Grantees unable to retain high level administrative staff may translate into service inadequacy.
Shortage of care providers noted as barrier to success by grantee	Yes/No	Semi-annual web reports	Grantees who indicate a shortage of care providers may translate into sub-optimal care.
Active (e.g., use of vouchers) versus passive (e.g., use of registries) housing management	Dichotomous indicator	OP	Active coordination with housing may improve participant experience yielding higher quality-of-life scores.
Shortage of housing noted as barrier by grantee	Yes/No	Semi-annual web reports	Lack of appropriate housing created by shortage may lead to lower quality-of-life scores.
Number of populations targeted	Continuous	OP	Grantees who target more populations may not be prepared to meet needs of multiple populations, leading to lower quality-of-life scores.
Average caseload for care coordinators	Continuous	Semi-annual web reports	Higher coordinator burden may be associated with lower quality-of-life ratings.
Provision of prevocational services	Yes/No	OP	Vocational support is likely to increase reported quality-of-life for some participants.

LTC= long-term care; OP=Operational Protocol.

C. DATA SOURCES

Data for this analysis will be drawn from six sources; (1) the MFP QOLS, (2) the MFP Services file, (3) semiannual web-based progress reports, (4) the nursing facility minimum data set (NF-MDS) where available, (5) Medicaid and Medicare claims data, and (6) state OPs.

The MFP Quality of Life file, containing survey data elements collected by grantees, will be the source for the quality-of-life data used for this analysis. The quality-of-life survey administered by the grantees is designed to reflect the current quality of life for participants, including (1) satisfaction with their housing, (2) access to care and unmet needs, (3) feelings about whether they are treated with adequate respect and dignity, (4) freedom of choice and control over their lives, (5) ability to engage in and enjoy community activities, (6) satisfaction with their care and life in general, and (7) health status.

Quality-of-life data from the MFP-QOLS instrument will be collected before transition and at two time points after transition. A baseline measurement is obtained once participants have been accepted into the MFP program and before they have been discharged from the institution. The second assessment of quality of life is to be completed 11 months after discharge from the institution. The third assessment is to be completed 24 months after discharge. Assessments are completed irrespective of current placement—that is, if a participant is 11 months post discharge and has returned to an institution, that person is still assessed, even though he or she is no longer participating in MFP. This design allows our evaluation to consider quality-of-life effects for all MFP participants, regardless of institutionalized status.

Baseline surveys will be administered to all MFP participants in each target population in each state during the first three years of operation, until the number of participants in each state exceeds 700. After 700 participants have been surveyed, MPR will discuss with the state and CMS whether to continue collecting data on all participants or to limit the survey to a sample of

the future participants. If sampling is used, we will use sampling weights to obtain unbiased parameter estimates for the target population.

The MFP Services file will be used primarily to identify the type and volume of HCBS provided to participants. The MFP Services file will include all HCBS that MFP participants receive during their MFP demonstration period. This file will be used to ascertain the use of qualified, demonstration, and supplemental services. This information will be used primarily to classify participants into high- or low-volume users of MFP services and to test for differences between the two groups in quality-of-life improvement. It will also indicate which type of services is most strongly predictive of improved quality-of-life.

The NF-MDS will be used to ascertain baseline (pre-transition) conditions to be used as predictors of participant improvement in well-being, quality of life, and satisfaction. Validated and reliable scales have been developed for cognition, pain, mood symptoms, social engagement and physical function. These conditions will be assessed to determine which factors are associated with improvement in participant quality of life for those participants whose information is captured in NF-MDS data.

Demographic characteristics, such as participant age and sex, will be obtained from the MSIS files. Data on beneficiaries' chronic illness and recent use of acute care will be abstracted from Medicare claims data for dual eligibles and from Medicaid claims data for non-dually eligible participants.

Analysis of grantee OPs will be used to ascertain most program characteristics. OPs will likely first be used to develop typologies of MFP programs as described in Chapter II. The analysis of grantee programs described in Chapter II will be used to determine the prevalence and relevance of program characteristics in terms of their potential impact on quality of life.

Therefore, the program characteristics listed in Table IV.1, will change based on our evaluation of grantee OPs.

The semi-annual web-based progress reports will also be used to measure program characteristics illustrated in Table IV.1, such as program director turnover rate, implementation barriers encountered, and degree of collaboration with state agencies outside of the traditional long term-care service delivery systems (for example, housing, transportation). Operational data will enrich the analysis of which program-level characteristics affect participants' quality-of-life.

D. OUTCOME MEASURES

Questions contained in the MFP-QOLS have been adapted from validated and reliable instruments such as the PES, and will be administered by the grantees. Each domain is described below. The MFP-QOLS is appended to this report for reference (see Appendix A).

1. Domain Summary Measures

For every measurement period (baseline, year 1, year 2), each domain will contain a summary measure combining all quantitative elements contained in the domain. For example, the living arrangement domain consists of four questions inferring satisfaction with living arrangement. A summary measure would be computed where a count of "1" is added for each positive answer provided to the following questions:

1. Do you like where you live?
2. Did you help pick this place to live?
3. Do you feel safe living here?
4. Can you get the sleep you need without noises or other disturbances where you live?

Where feasible, performance will be assessed using a summary measure consisting of a count of related items with consistent coding in each domain. A count of each "yes" response

can be used to summarize overall choice and control results for each participant. Table IV.2 lists the domains and number of items for each summary measure proposed.[3]

TABLE IV.2

PROPOSED SUMMARY QUALITY-OF-LIFE OUTCOME MEASURES

Quality-of-Life Domain	Number of Constructs Represented in Summary Measure
Living arrangement	4
Unmet need for personal care	4
Respect and dignity	2 - 5[a]
Choice and control	6
Community integration/inclusion	8
Satisfaction	2
Health status	3

[a] Depending on grantee's data collection policy, some optional items may be included in the summary measure.

The psychometric properties of domain summary measures will be evaluated to ensure that measures are internally consistent and externally valid. First, we will perform confirmatory factor analysis (CFA) of items from the MFP-QOLS to confirm the composition of each domain summary. CFA is a statistical technique used to verify the factor structure of a set of observed variables. CFA can be used to test whether a relationship between observed variables and their underlying latent constructs exists. For example, we would expect that each item from the living arrangement domain to "load," or correlate, very high (correlation >.50) onto a single factor representative of the living arrangement domain. Items that do not have a high correlation with a priori factors may be removed from the domain summary. To assess internal consistency of domain summary scales, we will measure each measure's Chronbach's alpha. Where

[3] Table IV.2 illustrates the unique number of constructs contained in each domain summary. Each domain in the MFP-QOLS often contains multiple questions per construct. Therefore, the total number of questions in each domain is often considerably higher than the number of constructs represented in the summary measure.

Chronbach's alpha is <.70, we will consider a measure to have less evidence of internal consistency and will either revise the measure to enhance internal consistency, or not use the measure for reporting.

In addition to combining individual measures into summary measures, we will report change for individual measures that are particularly illuminating or helpful for our evaluation.

Living Arrangement. Four items from the MFP-QOLS relate to participants' satisfaction with their current living arrangement. These items will be summarized as a count, in addition to being reported individually.

Unmet Need for, and Access to, Personal Care. A prominent feature of institutional care is direct access to assistance with ADLs and instrumental activities of daily living (IADLs). While community residence offers more freedom, a notable shortcoming of community-based care is the inconsistent availability of paid and unpaid caregivers who provide essential assistance with ADLs and IADLs. A single measure will summarize whether participants have any unmet ADL/IADL needs in (1) bathing, (2) meal preparation, (3) medication management, or (4) toileting. All items will be reported separately, as well as being included in the summary measure. Other conditions captured in this domain include unmet need for cooking/cleaning (measured after transition only), and need for special equipment.

Respect/Dignity. Institutional settings have structured systems designed to maintain and enhance the respect and dignity of residents. Once transitioned to the community, MFP participants lose these institutionally based safeguards. On the other hand, some institutional residents may not feel they are treated with respect and hope to achieve that respect by managing their own care in their own home. Thus, it is important to assess how participants rate their feelings about how they are treated once they are living in the community.

For participants who receive help from a caregiver, a summary measure of respect/dignity will be computed consisting of two items to infer the presence or absence of respect and dignity issues. This measure will summarize whether participants are treated how they wish to be treated and are listened to. For states that collect optional measures regarding abuse, these items will be included in the summary count. Depending on a grantee's policy on reporting suspected incidents of abuse and neglect, an optional set of questions will be asked to address physical and verbal abuse.

Choice and Control. A significant advantage to community based care is the potential for enhanced choice and control for participants. Six questions address participants' overall choice and control of their living arrangement. Responses to these questions will be summed to yield an overall summary measure as well as being reported individually.

Community Integration and Inclusion. Community integration is a critical goal of de-institutionalization. A summary count will include eight general questions related to community integration relevant to all target populations. Two additional questions relating to employment (assessed only after transition) will be assessed at each follow-up assessment.

Satisfaction. Participant satisfaction is a fundamental concern for all MFP stakeholders. The MFP-QOLS assesses overall satisfaction through two broad measures of general satisfaction. Each question has a probe to illuminate degree of satisfaction/lack of satisfaction. In addition to being analyzed separately, the two satisfaction questions will be summed for each participant to create a single measure of overall satisfaction.

Health and Emotional Status. Three questions assess the presence of key health and emotional factors affecting one's quality of life: sadness, irritability, and aches/pains. Each will be reported separately and as a summed index.

2. Single Item Indicators

In addition to reporting outcome measures by domain summary measures, we will report improvement for key individual indicators of quality of life contained in the MFP-QOLS that warrant special attention. In general, these special indicators are not captured at baseline, as they are not relevant to institutional life. We will measure effects on these outcome measures for those individuals who expressed an interest in having such options.

- Receipt of equipment or modifications, for those who said they consulted with case manager or support coordinator about special equipment or changes to home to make life easier
- Whether currently working for pay, among those who are working or expressed an interest in working
- Whether doing volunteer/unpaid work, among those who are doing such work or expressed an interest in volunteer/unpaid work

E. METHODS

Participant quality of life will be tracked as people move from institutional to community-based settings. Analyses will focus on whether participants have maintained or improved their quality of life after making the transition to the community. We will evaluate this question using raw reported rates of satisfaction, as well as regression models to identify the effects of demographic and care needs on changes in well-being. Finally, this investigation will explore what program characteristics appear to be associated with improvements in participant ratings of quality of life and satisfaction.

Our approach to estimating the models to identify which beneficiary and state characteristics are associated with improvements in quality of life will be to pool the data for all grantees and estimate separate models for each targeted population, with binary variables identifying the state in which the beneficiary lives. States may well differ substantially in how these characteristics relate to quality-of-life improvements. However, the cell sizes for many states will be too small

to estimate the model separately for each. Furthermore, analyzing the relationships separately for each state will make it difficult to draw generalizable inferences about the effects of MFP on quality-of-life. This approach is different from what we proposed for claims-based data. Because we are relying on primary data collection, rather than claims data, to assess quality-of-life improvement, we expect to have smaller cell sizes than the claims-based data. Therefore, to maintain statistical power and enhance our ability to draw inferences, we plan to pool quality-of-life data across states.

We believe it is important to analyze the different target populations separately, because there may be major differences among them in the beneficiary characteristics that predict improvements in quality-of-life. After estimating the models separately by target population, we will test for whether the coefficients on the various characteristics are equal; if so, we will pool all target populations and run a single regression for each analysis, with binary variables for target population, as well as for state of residence. The coefficients on the binary state variables will indicate the difference between that state and the reference state in the odds that a beneficiary shows improvement. The estimated models will be used to generate predicted probabilities for each state, holding all other covariates constant. For states with few MFP participants in a given targeted population, the estimates of the state effect will have large variance. Observations from states with very few (for example, 10 or fewer) participants in a given targeted population will be excluded or grouped together with the reference state.

As an alternative, we will also estimate a model in which indicators of program characteristics are entered in the model instead of the state binary variables. However, these variables are likely to be highly collinear, given that there are many such variables and only 31 states, so this analysis will be exploratory.

1. Analysis of Quality-of-Life Improvement and/or Maintenance

The primary analysis will be to identify the factors associated with improvement in quality of life. Three types of measures will be used: (1) whether beneficiaries quality of life improved, (2) whether they maintained or improved, and (3) whether they either improved or were at the maximum quality-of-life value at follow-up. For models predicting improvement (model 1), we will need to remove from the regression analysis participants who at baseline have the maximum quality-of-life measures, as these participants, by definition, cannot improve. Similarly, for models predicting maintenance or improvement (model 2), participants with the minimum quality-of-life measure at the baseline survey will be removed as they cannot fail to maintain their baseline value. The models predicting improvement or maximum quality of life at follow-up (model 3) can keep all participants in the model and, therefore, have the most statistical power. For this reason, we will use model 3 to report main results and will put the findings from models 1 and 2 in appendixes, noting any marked discrepancies between the alternative model findings.

Logistic regression, specified below, will be used to estimate the effect of various personal characteristics on the probability of quality-of-life improvement or maintenance. Examples of individual-level covariates measured at enrollment include:

- Age
- Sex
- Race/ethnicity
- Enrollment in self-directed program (for example, Cash and Counseling)
- Health status (for example, physical impairment, cognitive impairment, pain status)
- Medical complexities (for example, pressure ulcers, infections, fractures, incontinence)
- Social engagement

- Mood status
- Length of time in the institution before transition
- Survey administration mode (telephone/proxy)
- Survey administrator (whether administrator at baseline and follow-up are different staff types, for example, MFP staff, contracted agency, volunteer)

In addition to the predictors listed, we will test for differences across grantees by including binary variables indicating the state in which the participant lives. This model allows us to test whether quality of life, or probability of improvement/maintenance, differed across state, controlling for differences in participant characteristics at baseline. Separate models will be estimated for each target population. We will also test for whether quality of life improves more for some target populations than others by comparing predicted values for each target population at the overall point of means for the independent variables.

2. Analysis of Change Over Time

Logit models will be used to estimate binary dependent variables reflecting changes in quality-of-life over time for individual MFP-QOLS items and domain summary measures. For any two observations of a given quality-of-life measure for person i, we will set $Y_i = 1$ if the measure improved for the person between the two time points and $Y_i = 0$ otherwise. We will define a separate binary variable indicating whether the measure was sustained or improved. We assume there exists a continuous latent variable Y_i^* that measures the propensity that a person has a change in quality-of-life measure over time, conditional on observable characteristics X_{ji} and unobservable factors e_i. As described in Chapter III, when this propensity exceeds a threshold, the enrollee is observed to have $Y_i = 1$.

To assess change, we will compute change scores from y_0 to y_1, y_1 to y_2 and y_0 to y_2, where

- y_0 is the baseline measurement
- y_1 is the 11 month assessment
- y_2 is the 24 month assessment

and then convert these changes to binary indicators of (1) whether the outcome measure improved, (2) whether it was maintained, and (3) whether it was improved or already at its maximum value.

Next, we detail each major analysis to address the research questions.

3. Analysis of How Participants Fare in the Community

The first analysis of participant rating of quality of life will be a descriptive report containing means and distributions of domain summary and selected individual measures at baseline and each follow-up period for each target population across all grantees. This descriptive analysis will provide an overview for each target population to answer the question: How does each MFP target population fare living in the community? In addition to displaying means and distributions of individual and domain summary measures, Table IV.3 shows an example of an overview table that will be generated for each target population, summarizing information on improvement on each domain for each state. Similar tables will be generated using the alternative measures of improvement (maintained or improved, and improved or at the maximum value). Tables will be generated for improvement between baseline and 11 months, baseline and 24 months, and between 11 and 24 months. Each set of tables will be constructed separately for each target population.

TABLE IV.3

PERCENT OF PARTICIPANTS WHO IMPROVED ON SUMMARY DOMAIN MEASURES BETWEEN BASELINE AND 11 MONTHS: ELDERLY

	Living Arrangement		Unmet Need for Personal Care		Respect/Dignity		Choice and Control		Community Integration and Inclusion		Satisfaction		Health Status	
State	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Arkansas														
California														
Connecticut														
Delaware														

Source: MFP-QOLS.

Note: This table will be repeated for each target population, and for three periods (baseline to 11 months, baseline to 24 months, and 11 to 24 months). It will also be repeated for two alternative measures of improvement (whether maintained or improved, and whether improved or at the maximum value).

This set of tables will not inform the discussion of which types of states had the largest percentage improvement in quality-of-life outcome measures, as this requires regression adjustment to take into account differences in the transitioned populations across states. Our approach to this issue is described below.

TABLE IV.4.

DOMAIN SUMMARY: REGRESSION ADJUSTED ESTIMATED QUALITY-OF-LIFE IMPROVEMENT OVER ONE YEAR

Target Population	Living Arrangement	Unmet Need for Personal Care	Respect/Dignity	Choice and Control	Community Integration and Inclusion	Satisfaction	Health Status
Elderly							
PD							
MR/DD							
MI							
Other							
ALL							

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

Table IV.4 aggregates grantee data and permits demonstration-wide comparison across target populations. This table will be generated from regression adjusted estimates, as described in the methods section above. Table IV.5 provides more detail on the components of the quality-of-life summary measures, by domain and target population from all grantees combined.

TABLE IV.5

AGGREGATED OUTCOMES AT FIRST FOLLOW-UP, BY TARGET POPULATION

	Target Population					
	Elderly	PD	MR/DD	MI	Other	Total
N at Baseline						
N at 11 Month Followup						
Living Arrangement						
Summary measure						
Followup						
Baseline						
Difference						
Participant likes where he or she lives						
Followup						
Baseline						
Difference						
Participant feels safe						
Followup						
Baseline						
Difference						
Choice and Control						
Summary measure						
Followup						
Summary measure						
Baseline						
Summary measure						
Difference						
Participant can go to bed when he or she wants						
Followup						
Baseline						
Difference						

Note: This table will be generated for the second followup as well. Table will include all items from each domain.

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

4. Which Types of MFP Participants Appear to Have the Greatest Improvements in Quality of Life?

As explained above, the findings from the pooled regression analysis of quality-of-life improvement and maintenance will be used to infer the association of participant clinical, service-level, and demographic characteristics with improved and maintained quality-of-life. Table IV.6 illustrates how the association of various participant characteristics would be

summarized for a particular domain across all target populations. Table IV.6 would only display significant estimates, representing the independent association between the characteristic and the likelihood of improvement. Complete tables showing estimates for all characteristics and the associated p-values will be reported in an appendix to each report. Table IV.6 would be replicated for each domain summary measure for improvement and maintenance models.

TABLE IV.6

EFFECTS OF PARTICIPANT CHARACTERISTICS ON IMPROVEMENT IN SATISFACTION WITH LIVING ARRANGEMENT, BY TARGET POPULATION (IN PERCENTAGE POINTS)

	Target Population					
Participant Characteristic	Elderly	PD	MR/DD	MI	Other	All
Demographic Characteristics						
Age (>84)						
Race (Non-white)						
Rural residence						
Health Status						
Depression (Yes)[a]						
Pain (Yes)[a]						
Social engagement (low)[a]						
Cognitive impairment(Yes)[a]						
Physical impairment (High)[a]						
Low Care(Yes)[a]						

Source: MFP-QOLS, MSIS, and NF-MDS.

Note: Overall mean percent improved is the reference point. This table will be generated for each quality-of-life domain.

[a] Measured at baseline using NF-MDS.

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

5. What Is the Association Between Program Characteristics and Participant Quality of Life?

The final quality-of-life analysis will evaluate the relationship between program characteristics and improvement in quality-of-life. Due to the limited number of programs and

their characteristics, we will not use multilevel, hierarchical, or mixed-effects models because none of these approaches could compensate for the small number of enrollees at the grantee level. Furthermore, it will be useful to identify states that are particularly successful or unsuccessful in improving quality-of-life, so that plausible explanations can be identified for these differences and lessons learned about how to improve. Therefore, we will use a combination of a standard regression approach to estimate the association between program characteristics and changes in quality of life and a qualitative assessment of common program elements and designs to draw conclusions about the role of program design on participant quality of life.

Our approach to assessing program characteristics and quality-of-life is to use the regression coefficients generated from our analysis of quality-of-life improvement and to generate predicted probabilities of improvement for each state for each domain summary measure, evaluated at the point of means for the full population of all MFP participants in a given target population across all states. Table IV.7 shows how we will list, for each state, the predicted probability of improvement for a given domain, along with key characteristics of grantees, to see what patterns of association emerge. The states will be listed in order, from highest to lowest predicted value. Tests will be conducted to identify states that had predicted values that are significantly different from the mean for all states, and states that are significantly higher or lower than the overall mean will be identified. We will also calculate rank order correlations of predicted probabilities for one domain with each of the others and with program characteristics. This analysis will enable us to determine if states that have favorable effects tend to have such effects in other domains or whether positive effects tend to be limited to particular domains in particular states. (As noted, we will also attempt to estimate models in which we replace the binary state variables with indicators of grantee features.)

The program design features shown in Table IV.7 are illustrative only. This table would be produced for each target population and each domain summary measure. Visual examination of the table will reveal any obvious patterns. However, because there would be at least 28 such tables (four to five target populations by seven domains) and some patterns that are not obvious, we will produce a table that summarizes the findings from the separate tables. For binary characteristics, the summary tables will show the mean probability of improvement across states exhibiting the characteristic and those that do not have the characteristic (Table IV.8). For continuous measures of program characteristics, we will calculate the correlation between the states' regression-adjusted predicted probability of improvement and the program characteristic, rather than means, and display the results in a table similar to Table IV.8.

TABLE IV.7

PROBABILITY OF IMPROVEMENT IN LIVING ARRANGEMENT DOMAIN SUMMARY, ELDERLY PARTICIPANTS

	Probability of Quality-of-Life Improvement	Grantee Transition Ratio	Enriched Service Package	Pre-existing Transition Services	Transition Coordination Not Contracted
Arkansas					
California					
Connecticut					
Delaware					
Etc					

Note: Separate versions of this table will be produced for each domain for each target population. States will be ordered by probability of improvement from high to low as listed in the first column. The remaining columns will identify the presence or absence of program characteristics.

When 24-month outcome measures become available (starting in 2010), we will produce the same tables to describe change in quality of life between baseline and the 24-month assessment. We will also examine changes between the 12- and 24-month assessment to determine whether initial quality-of-life improvements during the period when enhanced MFP services are available persist when the beneficiary is forced to rely on conventionally available HCBS.

TABLE IV.8

PROPORTION OF PARTICIPANTS SHOWING IMPROVEMENT IN EACH DOMAIN, BY PROGRAM FEATURES

Program Characteristic	Living Arrangement	Unmet Need for Personal Care	Respect/ Dignity	Choice and Control	Community Integration and Inclusion	Satisfaction	Health Status
Has aggressive transition target							
Yes							
No							
Has self-directed option							
Yes							
No							
Transition coordination contracted							
Yes							
No							

Note: Estimates in this table are the means of regression-adjusted predicted probabilities of improvement for states exhibiting the characteristic. A separate version of this table will be produced for each target population.

V. REBALANCING ANALYSES

Together, the MFP program transition and reinvestment components are intended to rebalance the long-term care system by shifting many Medicaid long-term care resources from institutional care to the community. Shifting resources to the community typically involves attempts to either reduce the use of institutional care or increase the use of home- and community-based care, or both. For example, reinvestment strategies may focus on increasing use of home- and community-based services (HCBS) by expanding the HCBS covered in the state or increasing the number of people eligible for HCBS. MFP transition activities are aimed at reducing the number of people living in institutions, as well as at increasing use of HCBS. In general, use of a given service (institutional care or HCBS) depends on (1) the number of people using the service, (2) the cost of the service, and (3) the amount of service use. This chapter describes our plan for assessing how successfully and by what means MFP demonstration programs shifted long-term care from institutions to the community.

Two key research questions will drive this component of our evaluation:

1. What is the effect of MFP on use of institutional versus home- and community-based care?
2. What components of service use (number of users, expenditures per user month, length of service use) were affected most by MFP?

Because a state provides only one unit of observation, we cannot estimate the impacts of MFP on the use of institutional versus HCBS for an individual grantee. Instead, we will describe the trends in key rebalancing outcomes for each grantee before and after MFP implementation and use the change in the trend to estimate program effects. The rest of this chapter describes our selection of rebalancing measures and our methods and analysis plan.

A. OUTCOME MEASURES

Rebalancing measures should reflect a range of rebalancing characteristics (for example, shifts in number of users, shifts in length of service use), be comparable across grantees, and be feasible to compute using data collected for the evaluation. They should also capture the means by which rebalancing occurred (increased waiver slots versus decreased nursing home beds). Table V.1 lists the 16 rebalancing measures we will compute for each MFP grantee for the evaluation.

Our list of rebalancing measures includes Medicaid program or system change indicators measured at the grantee level and service utilization and expenditure measures based on individual-level Medicaid claims data. We include summary rebalancing measures (for example, increased HCBS expenditures as a percentage of total long-term care expenditures), as well as their component parts, so that we can better understand the nature of any observed changes. Table V.1 shows measures that, once adjusted for a population's age distribution and/or Consumer Price Index, could indicate the extent to which rebalancing is occurring.

1. Aggregate System Change Indicators

To evaluate effects of MFP on structural changes to grantee Medicaid long-term care systems, we will examine changes in available institutional services and HCBS services in a state program. A reduction in the number of nursing home beds per 1,000 aged Medicaid enrollees or the number of intermediate care facilities for the mentally retarded (ICF-MR) beds licensed by the state would indicate rebalancing away from institutional care. An increase in the number of Section 1915(c) waiver slots available for potential HCBS users would indicate rebalancing toward HCBS care. We will use data from OSCAR on the number of available nursing home beds, survey data from the University of Minnesota and Institute on Community Integration on number of licensed ICF-MR beds, and if possible, survey data from Kaiser and University of

California, San Francisco (UCSF) on available Section 1915(c) waiver slots in each grantee state for the 2004 through 2010 study period.

TABLE V.1

MFP REBALANCING MEASURES

Measure (Percent Change Over MFP Period Versus Percent Change Over Pre-MFP Period In):	Data Source[a]	Analysis Subgroup: State Program	All Medicaid LTC Users	New Medicaid LTC Users	Medicaid HCBS Users
Aggregate System Change Indicators					
Number of nursing home beds per 1,000 Medicaid enrollees age 65 or older	OSCAR, MAX/MSIS	X			
Number of ICF-MR beds licensed by the state	UMinn/ICI survey	X			
Number of Section 1915(c) waiver slots[b]	Kaiser/UCSF survey	X			
Individual-Level Utilization-Based Measures					
Percentage of ILTC users who transition to HCBS use, overall and by length of ILTC stay (< 6 months, 6+ months)	MAX/MSIS		X		
Percentage of ILTC users expressing interest in returning to the community who actually transition to HCBS[c]	NF-MDS/MAX/MSIS		X		
Among LTC Users					
Percentage using ILTC	NF-MDS/MAX/MSIS		X	X	X
Percentage using HCBS	MAX/MSIS		X	X	
Average person months of ILTC use	NF-MDS/MAX/MSIS		X	X	X
Average person months of HCBS use	MAX/MSIS		X	X	X
Individual-Level Expenditure-Based Measures					
LTC expenditures	MAX/MSIS/CMS-64[d]		X	X	
ILTC expenditures	MAX/MSIS/CMS-64[d]		X	X	
HCBS expenditures	MAX/MSIS/CMS-64[d]		X	X	
HCBS expenditures as a percentage of total LTC expenditures	MAX/MSIS/CMS-64[d]		X	X	
Individual-Level Utilization and Expenditure-Based Measures Combined					
LTC expenditures per user per month	MAX/MSIS		X	X	
ILTC expenditures per LTC user per month	MAX/MSIS		X	X	
HCBS expenditures per LTC user per month	MAX/MSIS		X	X	

[a] MAX and MSIS data will be supplemented by MFP Services files for MFP demonstration years.
[b] Our ability to include these rebalancing measures will depend on our ability to gain access to state-level measures collected in the Kaiser/UCSF state survey.
[c] Expected changes in the NF-MDS survey may limit our ability to include this rebalancing measure in our analyses. The relevant section of the survey will be changed in 2009 to reflect the client's perspective, rather than that of the provider. We have requested that the current measure based on the provider's perspective be maintained in the survey for continuity and validation at least one overlap year, or for each MFP demonstration year.
[d] CMS-64 data are aggregated and will include all fee-for-service LTC expenditures for Section 1915(c) services, personal care services, and home health services. Consequently, measures based on CMS-64 data will be available only for "all LTC enrollees."

HCBS = home- and community-based services; ICI = Institute on Community Integration; ICF-MR = intermediate care facility for the mentally retarded; ILTC = institutional long-term care; LTC = long-term care; MAX = Medicaid Analytic Extract; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set; OSCAR = Online Survey, Certification, and Reporting data; UCSF = University of California, San Francisco.

2. Rebalancing Measures Based on Individual-Level Claims Data

To evaluate effects of MFP on use of institutional versus home- and community-based care, we will examine changes in utilization-based, expenditure-based, combined utilization, and expenditure-based measures of institutional and home- and community-based care in a state program. This analysis will rely largely on data collected for the impact analyses. Unlike our analyses of program impacts, however, the data file constructed for the rebalancing analyses will include information about all Medicaid enrollees, not just those institutionalized and potentially eligible for MFP. We will use MAX and MSIS data for calendar years 2004 through 2010, supplemented by NF-MDS data, to construct measures of the use of, and expenditures for, Medicaid long-term care services.

Utilization-Based Measures. Use of institutional care and HCBS captures the supply of long-term care services, as well as the demand for these services. Utilization-based rebalancing indicators include changes in the rate of transition of enrollees from institutions to the community (including, but not limited to, MFP eligibles), changes in the percentage of institutionalized enrollees expressing interest in returning to the community (in NF-MDS data) who actually transition to HCBS, and the percent of Medicaid long-term care recipients whose Medicaid claims records indicate that they use HCBS or use institutional care. Because MFP may influence both the number of enrollees using certain services, as well as the length of service use, we will also examine the change in average person months using each type of long-term care service.

Expenditure-Based Measures. To evaluate effects of MFP on overall investment in community based long-term care, we will examine how the percentage of long-term care expenditures that are for community-based services has changed over time. Because shifts in the balance of expenditures can be due to changes in expenditures for HCBS, changes in

expenditures for institutional care, or changes in both types of expenditures, we will also examine changes in the component parts of long-term care expenditures.

Managed care, bulk reporting, and missing data in MAX/MSIS are likely to result in biased estimates for certain states. In MAX 2002, HCBS reporting for nine MFP grantees is thought to be incomplete. Although the reporting in many states improved, those in others became worse by 2004. We also expect that data-reporting requirements associated with MFP may result in improved HCBS expenditure reporting for post-MFP years. Therefore, we may see spurious increases in HCBS expenditures at the start of MFP that are associated with improved data reporting rather than program success. To validate our data, we will compare aggregate expenditures reported in MAX/MSIS to CMS Form 64 data. If our preliminary analysis and state reporting patterns suggest HCBS data in MAX/MSIS are not valid in a given state (for example, if waiver services are provided in the state but are measured in bulk and thus not reported in MAX/MSIS data), we will use Form 64 data to report rebalancing effects for that grantee.

Utilization and Expenditure-Based Measures Combined. Some state Medicaid programs cover a very limited set of community-based services for a large number of enrollees. Others provide extensive HCBS for a relatively small number of people living in the community. To evaluate effects of MFP on relative expenditures for care in institutional versus community settings, we will examine the effects of the MFP program on long-term care expenditures per user per month, overall and for institutional care and HCBS.

Because CMS Form 64 does not collect utilization data, we will rely solely on MAX/MSIS data to measure of expenditures per user in each grantee state. As in our expenditure analyses, our analyses of payments per user will be limited to enrollees who are not enrolled in managed care during the observation period.

3. Subgroup Analyses

To obtain a clearer indication of how long-term care spending patterns are shifting over time, we will construct claims-based rebalancing measures for *new* long-term care users, as well as for *all* long-term care users. Other analyses will focus only on HCBS users (See Table V.1). CMS and grantees hope that total spending on long-term care (overall or per person receiving Medicaid long-term care) will grow more slowly after MFP than before it, because some spending that would have gone for institutional care is being replaced by less expensive HCBS. Changes in the percentage transitioning to the community will provide some evidence that this is occurring. However, because only a small percentage of institutional residents are likely to transition back to the community even with MFP's assistance, this effect is likely to have only a limited impact on overall rebalancing. Systemwide changes that make receipt of HCBS easier could have a larger effect on rebalancing by slowing the rate of entry into institutions. To assess empirically whether this is occurring, we will compute most measures for the subset of long-term care users who are new long-term care users, and several for those already living in the community, in addition to measures calculated over all long-term care recipients.

In addition to the analysis subgroups listed in the table (state program, all long-term care users, etc.), we will compute the rebalancing measures by target population—aged, physically disabled, enrollees with mental retardation or developmental disability (MR/DD), and enrollees with mental illness—whenever possible. Comparisons across the target populations will indicate whether any change in long-term care service delivery in the MFP subgroups were simply mirroring trend changes occurring for all eligibility groups in the state or occurred only for the MFP target populations (or were substantially larger for these groups).

B. METHODS AND ANALYSIS PLAN

Our analysis of program effects on the 16 rebalancing measures has two steps. First, we will present summary information and effect estimates for each indicator. Second, we will combine the results for multiple measures to decompose changes in overall rebalancing measures into their component parts. In addition, we will report the size of the long-term care population, the number transitioning, total long-term care expenditures each year, by type, and the ratio of MFP funds to total long-term care spending for the state in our evaluation reports to provide context for interpreting these statistics.

1. MFP Effects on Rebalancing Measures

We will first summarize the trends in our outcome measures for each grantee by program year, for four years preceding and the three years following the implementation of MFP. The tables will include (1) an estimate of the rebalancing indicator in year 0—the year before the start of the program, (2) percentage change between program years, and (3) a summary measure of the change in trends associated with MFP (Table V.2). The summary trend shift effect measure will reflect the difference between the observed outcome and the expected (or projected) outcome given the pre-MFP trend. We may present the same information in plots, to illustrate any trend shift across grantees at the start of MFP.

TABLE V.2

FFS COMMUNITY LONG-TERM CARE EXPENDITURES AS A PERCENTAGE OF TOTAL FFS LONG-TERM CARE EXPENDITURES: POPULATION SUBGROUP (E.G., MR/DD)

State	HCBS Expenditures During Year 0	Percent Change Between:				Average Annual Percent Change Over the Pre-MFP Period	Average Annual Percent Change during MFP Period	Post-/Pre-MFP Trend Change (Effect Indicator)
		Years -3 and -2	Years -2 and -1	…	Years 2 and 3			
Arkansas								
California								
Connecticut								
Delaware								
District of Columbia								
Etc.								

Source: MAX and MSIS data, 2004-2010.

Note: Expenditures are adjusted using the Consumer Price Index, all urban consumers, medical care series and are in 2008 dollars.

FFS = fee-for-service; HCBS = home- and community-based services; MAX = Medicaid Analytic Extract; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System.

When we interpret our results, we will review contextual information about each grantee (for example, the size of MFP grantee funds relative to the size of total long-term care spending) to gauge whether the estimated effects are plausible and can indeed be attributed to MFP.

2. Decompositions

To determine what component parts contributed to an observed overall change in the structure of a state's long-term care service delivery, we will summarize the effect estimates in several ways. We will first present the effect estimates in one summary table (Table V.3). We will rank states by several key effect estimates to see whether patterns arise with respect to whether changes in HCBS (such as increased percentage using HCBS) or changes in institutional care (such as decreased percentage using institutional care) contributed most to overall effects. For individual claims-based measures, we will examine whether an effect is observed for all enrollees or just new enrollees or HCBS users, to determine whether MFP was more or less effective at rebalancing long-term care delivery for those not eligible for MFP. In one table, we will also summarize estimates overall and by target population, to examine whether changes in long-term care service delivery were more concentrated in some target populations than in others.

To better understand which components of the long-term care system were most effectively rebalanced, some of the rebalancing measures can be more formally decomposed into their component parts. For example, because total institutional long-term care expenditures equal the number of users of institutional care times average long-term care expenditures per user, the effect estimate for total long-term care expenditures can be decomposed into the portion of the effect that is due to changes in utilization of long-term care services and the portion that is due to changes in expenditures per user. For such decomposable measures, we will compute and present the percentage of the effect that is due to each of the measure's components (Table V.4).

TABLE V.3

SUMMARY OF ESTIMATED EFFECTS ON EXPENDITURE-BASED REBALANCING MEASURES:
POPULATION SUBGROUP (E.G., MR/DD)

				Total LTC Expenditures				LTC Expenditures for New LTC Users			
	Nursing Home Beds per 1,000 Aged Enrollees	ICF-MR Beds	Etc.	All LTC	Institutional LTC	HCBS	HCBS Expenditures as a Percent of Total LTC Expenditures	All LTC	Institutional LTC	HCBS	Etc.
Arkansas											
California											
Connecticut											
Delaware											
District of Columbia											
Etc.											

Source: MAX and MSIS data, 2004-2010.

Note: Fee-for service expenditures used to compute effect estimate are adjusted using the Consumer Price Index, all urban consumers, medical care series and are in 2008 dollars. Entries are the difference between the observed expenditure measure and the expected expenditure measure given the pre-MFP trend.

HCBS = home- and community-based services; ICF-MR = intermediate care facility for the mentally retarded; LTC = long-term care; MAX = Medicaid Analytic Extract; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System.

TABLE V.4

DECOMPOSITION OF ESTIMATED EFFECTS ON EXPENDITURE-BASED REBALANCING MEASURES: POPULATION SUBGROUP (E.G., MR/DD)

	Total LTC Expenditures			Total ILTC Expenditures			Total HCBS Expenditures		
	Effect Estimate	Percent Due to Change in Number of Users	Percent Due to Change in Expenditures per User	Effect Estimate	Percent Due to Change in Number of Users	Percent Due to Change in Expenditures per User	Effect Estimate	Percent Due to Change in Number of Users	Percent Due to Change in Expenditures per User
Arkansas									
California									
Connecticut									
Delaware									
District of Columbia									
etc.									

Source: MAX and MSIS data, 2004-2010.

Note: Fee-for-service expenditures used to compute effect estimate are adjusted using the Consumer Price Index, all urban consumers, medical care series and are in 2008 dollars. Entries are the difference between the observed expenditure measure and the expected expenditure measure given the pre-MFP trend.

HCBS = home- and community-based services; ILTC = institutional long-term care; LTC = long-term care; MAX = Medicaid Analytic Extract; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System.

These decomposition analyses, together with the measure-specific analyses, will characterize not only whether and how much, but also for which components, the long-term care system was most successfully rebalanced as a result of MFP.

VI. SYNTHESIS ANALYSES

The ultimate goal of the evaluation is to provide guidance to Medicaid programs regarding which MFP program features increase the likelihood of transitioning people from institutions to the community, change patterns of long-term care service use and expenditures, improve quality of life, and rebalance state Medicaid long-term care systems. This component of our evaluation will pull together our findings from all grantee states from the implementation, impact, and outcomes analyses to draw inferences about the most successful ways to implement MFP-type programs. Three key research questions will drive the synthesis analyses:

1. To what extent does MFP affect transitions to the community; enrollee health care expenditures, quality of care, and mortality; quality of life; and the overall balance of institutional and community long-term care?
2. What MFP program types/features are associated with positive outcomes?
3. What beneficiary characteristics are associated with positive (or negative) outcomes?

To characterize the features of the 31 grantee programs, we will capitalize on the summary measures constructed for the implementation analysis. To measure program success, we will use impact estimates and quality-of-life improvement and long-term care system rebalancing estimates described in Chapters III through V for each of the 31 grantees. If feasible and project resources permit, we will contact those states that appear to be particularly successful to get a more detailed assessment for factors behind their success. We will do the same for those states that were less successful to develop a more complete understanding of possible relationships between program design and overall success.

Our basic approach to the synthesis analysis will be to array the findings and look for correlations between program features and program impacts. Similarly, we will examine beneficiary characteristics for potential generalizations about which characteristics are most

strongly linked to favorable outcomes. The analysis will also use grantee-level historical data about long-term care Medicaid programs in each state to examine potential biases in our estimates. For example, states that had already aggressively tried to increase transitions from institutions in the years before MFP may have difficulty showing impacts on transition rates during the MFP demonstration.

Next, we describe how we will conduct these exploratory analyses. We first describe the database to be constructed and the impact estimates to be examined. We then discuss the methodology we will use for assessing associations and show how we will display the results.

A. DEVELOPMENT OF THE STATE-LEVEL ANALYSES DATABASE

A database containing state program characteristics—from MFP web-based reports, CMS Form 382, and other publicly available sources—and evaluation analysis estimates will be used to synthesize the evaluation findings and assess which factors are associated with program success. The longitudinal state-level Medicaid program file will contain characteristics of the 31 MFP grantee demonstration programs collected in the implementation analysis, as well as historical information about each grantee's long-term care systems compiled for the 2004 through 2010 observation period. These data will include waiver information obtained from CMS Form 372 (Kitchener et al. 2007) and a summary of long-term care managed care programs in place in the state (for examples, see Saucier 2005; National PACE Association 2004). The grantee-level research file will also contain compiled information about Nursing Facility Transition grants, Diversion Grants, and other related demonstration programs that are expected to affect the Medicaid long-term care systems.

B. OUTCOME MEASURES

Four types of outcomes—reflecting our two sets of impact analyses and the quality-of-life and rebalancing outcomes analyses—will be used to measure MFP program success. We will examine (1) positive impacts on transitions from institutions to the community; (2) positive impacts on program participants' expenditures, quality of care, and mortality; (3) improved quality of life; and (4) shifts in the balance of Medicaid long-term care. In addition, we will examine any outcomes for which MFP appears to have had negative impacts (for example, adverse health events could increase under MFP).

Impacts on Transitions from Institutions to the Community. Program features, population characteristics, and exogenous factors may result in variation across grantees in estimated impacts on transitions to the community. Impacts on transitions may depend on the type of staff coordinating the transitions (state staff or contracted staff), whether a housing program was implemented, the population targeted for the demonstration, and many other local factors.

Measured impacts may also depend on the characteristics of a state's enrollee population. For example, states whose institutionalized enrollees are significantly older than those of other states may be less likely to see significant impacts of MFP on transitions to the community. Our cross-state comparison of effects on transitions will use only regression-adjusted impact estimates or estimates for prototypical individuals computed in Chapter III, by target population, to control for differences in populations across states.

It will also be important to consider other state policies when comparing impacts on transitions across states. For example, the effects of MFP on transitions may be small for grantees with extensive HCBS and for transition programs that were already in place before the demonstration. As described in Chapter III, impacts on transitions will be estimated by

examining changes in transition trends. Our identification strategy does not require the assumption that transition probabilities would have been the same in the MFP period as they were before MFP. However, it does require the assumption that any change in the trend during MFP implementation relative to the pre-MFP trend is due to the MFP demonstration alone. Here, we will examine outcomes across states by exogenous state characteristics to gauge the validity of such assumptions.

Impacts on Program Participants. Success of the MFP program should also be measured by how successfully transitioned participants stayed in the community. Impacts on program participant outcomes—expenditures, service use, quality of care, and mortality—measure MFP's success in maintaining continuity and quality of care. The outcome measures we will choose to analyze will be those for which there is sufficient power to detect impacts of policy-relevant magnitude. If possible, we will analyze key outcomes for specified subgroups within states—for example, mortality among the aged and routine medical care for people with mental retardation or developmental disabilities (MR/DD)—to determine which program characteristics are associated with success. Key program features that we hypothesize may affect program participant outcomes include consumer involvement and use of managed long-term care.[1]

Like impacts on institutionalized enrollees, estimated impacts on program participants may vary by population characteristics or exogenous state factors. We will use regression-adjusted impact estimates to address differences in population characteristics. To try to distinguish MFP from exogenous state factors, we will examine the association between the size of impact estimates and both non-MFP and MFP program features in our analyses.

[1] Only limited utilization data are available for services used under managed care plans. Therefore, our examination of the links between managed care components and program outcomes will be limited to outcomes that are not based on service-specific claims (for example, total expenditures and mortality).

Improved Quality of Life. Another important aim of MFP is to provide long-term care service choices to Medicaid long-term care users to improve their quality of life. We will examine the association between MFP program and grantee characteristics and improved quality of life of MFP participants for seven quality domains examined in Chapter IV: (1) living arrangement, (2) unmet need for personal care, (3) respect and dignity, (4) choice and control, (5) community integration and inclusion, (6) overall satisfaction with life, and (7) psychosocial health status. We expect that programs with certain characteristics will be associated with larger quality-of-life improvements than programs without these characteristics. For example, grantees with an active rather than passive approach to housing may show larger quality-of-life improvements in the housing domain. To assess the links between grantee characteristics and quality-of-life improvement, we will examine regression-adjusted estimated quality-of-life improvement on each of the seven domains.

Indicators of Shifts in Grantee Long-Term Care Service Systems. While impacts on institutionalized enrollees and program participants and improved quality of life are key indicators of the success of MFP, some broader measures are needed to capture which MFP program features were successful in rebalancing grantee long-term care systems more generally. We will examine the association between MFP program characteristics and changes in key rebalancing indicators (for example, number of Section 1915(c) waiver slots, growth of Medicaid long-term care expenditures, and HCBS expenditures as a percentage of total long-term care expenditures). We will use pre- and post-MFP trend shifts measured in Chapter V as indicators of MFP effects on these aggregate measures of the balance of long-term care.

C. METHODS AND ANALYSIS PLAN

Our analysis will proceed in three stages. First, we will summarize all our grantee-level estimates from the impact and outcomes analyses to characterize potential MFP effects and their

component parts and assess consistency of findings across outcomes. Second, we will test hypotheses about whether these estimates are greater for programs with certain features or characteristics than for programs that lack these characteristics. Third, we will conduct exploratory analyses to identify combinations of factors that may be linked to success. In this portion of the analysis, we will rank order the programs by the size of estimated impacts and associations on a key outcome measure and visually examine the characteristics for evidence of relationships between the impact and combinations of characteristics. We will also compare the average characteristics of "more effective" programs to those of "less effective" programs, as described below.

Linking Results Across Analyses. The first portion of our grantee-level analyses will synthesize all the results of our impact and outcomes analyses to summarize the overall effect of MFP on grantee states. This summary will help us to draw inferences about two issues: (1) whether the MFP program appears to have had consistently favorable impacts on particular outcomes for a sizable number of states, and (2) whether some individual grantees have consistently favorable impacts across a range of key outcomes. The key component of this synthesis will be a summary table displaying all the impact and outcomes estimates (Table VI.1) on both of these dimensions, looking both across the rows and down the columns. We will compute at least two summary measures for each outcome: (1) the average impact or association across grantees, and (2) percentage of grantees with significant impacts or associations. We will use these two summary measures to characterize the scope of effects and determine whether grantee-specific estimates vary from the national average. We will flag those that are statistically significant and within one standard deviation of the overall average impact and use a second flag for those that are statistically significant and within two standard deviations.

Linking Results to Program Characteristics. If at least some of the MFP programs are significantly associated with key outcomes, we will conduct exploratory analyses to help identify the sources of differences across grantees. It will not be possible to identify which program features result in significant impacts or associations, because the study includes only 31 grantees, each with unique features, which generally implemented most aspects of their programs at one time. By summarizing information across the 31 states, however, we hope to learn how a particular program impact or association—on transitions to the community, costs and quality of patient care, mortality, quality of life, and structure of long-term care system—varies with program characteristics.

We will first identify a broad array of characteristics, based on the discussion in the implementation analysis chapter, and compare mean impacts and associations on key outcomes for programs that have a given characteristic to the mean impacts and associations for programs that lack that characteristic. We will then present tables showing how program features are associated with the mean estimated impact or association and with the proportion of plans with a statistically significant estimate in the desired direction (or the proportion with a point estimate larger than a certain level) (Table VI.2). Use of mean estimates allows us to assess whether impacts or associations tend to be larger for programs with a given feature than for those without the feature and ensures that we identify situations in which estimates are consistently larger for certain types of programs but not statistically significant. However, comparison of mean outcomes can mask important relationships if some estimates are negative or extremely large. Comparing the proportion of programs with significant effects prevents this problem but fails to capture any differences in the magnitude of the estimates. Consequently, we will report both measures. We will also calculate the correlation between program impacts and any program features that are continuous rather than categorical.

TABLE VI.1

SUMMARY OF MFP IMPACTS AND ESTIMATED ASSOCIATIONS: POPULATION SUBGROUP (E.G., MR/DD)

	Impacts on Institutionalized Enrollees			Impacts on Participant Outcomes			Improved Quality of Life			Rebalancing Indicators		
	Transitions to the Community	Time in the Community	Reinstitu-tionalization	Total Medicaid Expenditures	Mortality	Etc.	Living Arrangement	Health Status	Etc.	Section 1915(c) Waiver Slots	Percent of LTC Dollars for HCBS	Etc.
Arkansas												
California												
Connecticut												
Delaware												
District of Columbia												
Etc.												
Average Impact												
Percentage of Grantees with Significant Impact										**n.a.**		**n.a.**

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010; NF-MDS, 2004-2010.

HCBS = home- and community-based services; LTC = long-term care; MR/DD = people with mental retardation/developmental disabilities; MAX = Medicaid Analytic Extract; MSIS = Medicaid Statistical Information System; NF-MDS = nursing facility minimum data set.

n.a. = not applicable.

TABLE VI.2

PROGRAM CHARACTERISTICS AND ASSOCIATED IMPACTS: POPULATION SUBGROUP (E.G., MR/DD)

	Impact on Transitions to the Community			Impact on Reinstitutionalization			Etc.
	Number of Grantees with Program Characteristic	Average Impact	Percentage of Grantees with Significant Impact	Number of Grantees with Program Characteristic	Average Impact	Percentage of Grantees with Significant Impact	
Grantee MFP Program Characteristics							
Transition coordination							
State staff							
Contracted agencies							
Demonstration and supplemental services							
Enriched service package							
Gap-filling							
Approach to housing							
Active (e.g., vouchers)							
Passive (e.g., registries)							
Used managed long-term care							
Yes							
No							
Consumer involvement							
Above-average percentage with self-directed care							
Below-average percentage with self-directed care							
Grantee targeted							
Aged							
MR/DD							
MI							
PD							

TABLE VI.2 *(continued)*

	Impact on Transitions to the Community			Impact on Reinstitutionalization			Etc.
	Number of Grantees with Program Characteristic	Average Impact	Percentage of Grantees with Significant Impact	Number of Grantees with Program Characteristic	Average Impact	Percentage of Grantees with Significant Impact	
Implementation Success							
Attained transition benchmark as of (date)							
Yes							
No							
Attained HCBS spending benchmark as of (date)							
Yes							
No							
Exogenous Factors							
Nursing facility transition program							
Yes							
No							
Non-MFP managed long-term care program							
Yes							
No							
MFP Transition Program Typology							
Trailblazers							
Leap-frog							
Gap-filling							
Laying the Foundation							

Source: MAX and MSIS data, 2004-2010; Medicare claims files, 2004-2010.

Note: Regression models adjust for the age distribution, gender distribution, and urban-rural residence of institutionalized enrollees in the grantee state during the program year.

HCBS = home- and community-based services; MAX = Medicaid Analytic Extract; MI = people with mental illness; MR/DD = people with mental retardation/developmental disabilities; MSIS = Medicaid Statistical Information System; PD = people with physical disabilities.

We will construct similar comparison tables for each target population summarizing impacts on and associations with each of the key outcomes. These outcomes include (1) transitions to the community and reinstitutionalization among institutionalized enrollees; (2) reinstitutionalization, use of services, total expenditures, quality of care, and mortality for program participants; and (3) indicators of improved quality of life and long-term care rebalancing.

We will test the differences in mean impacts for groups of grantees defined by characteristics (and differences in the proportions of grantees with significant effects) to determine whether they are statistically significant. Because the programs and samples are independent of each other, the variance of the difference in mean impacts between (say) 13 programs that have a particular characteristic and 18 that do not have it is simply:

$$var = \frac{1}{169}\sum_{i=1}^{13} s_i^2 + \frac{1}{324}\sum_{i=14}^{31} s_i^2 ,$$

where s_i^2 is the variance of the impact estimate for the *i*th grantee. To obtain a very rough estimate of minimum detectable differences in the cross-state comparisons, we assume that variances for the grantee-specific impact estimates are equal across states.[2] This reduces the variance of the difference in means to $s^2(1/13 + 1/18) = s^2 (31/234)$, or about 13 percent of the size of the variance of an individual grantee-specific estimate. Because minimum detectable differences are proportional to the standard error of the estimate, this implies that, in comparing impacts across grantees, we should be able to detect differences that are a bit larger than a third ($\sqrt{(0.13)}$ of the minimum detectable difference of the impact at the grantee level. For example,

[2] This assumption is clearly not correct, because the standard errors for the impact estimates will be smaller in those states with more observations. Sample sizes will vary widely across states. Nonetheless, the example illustrates the approximate level of precision that we will have for comparison of impacts between subgroups of grantees defined by characteristics.

we can detect effects of 0.345σ, or 17.3 percentage points for binary outcomes with mean 0.5, in the grantee-specific estimate for Arkansas. Assuming all states had similar estimate errors, we should be able to detect (with the same 80 percent power) differences of about 6 percentage points between the average impact or association for a group of 13 grantees and the average impact or association for the other 18 grantees. Differences when the sites are more evenly split between the two categories will have smaller variances and smaller detectable differences (that is, more precision).

Identifying Combinations of Factors Linked to Success. We will conduct an exploratory analysis to identify combinations of characteristics that seem to be associated with program success (assuming that at least some of the programs are favorably associated with outcomes). There are far too many potentially important characteristics and too few grantees to determine the relative importance of each program characteristic. Instead, we will compare the characteristics of the successful and unsuccessful programs.

We will make this comparison in two ways—first, by arranging the data on program characteristics in a manner that makes visual identification of patterns easier, and then by comparing the mean characteristics of successful and unsuccessful programs. We will first order the grantees by the size of their impact on transitions to the community. We will then create a large table, in landscape format, to display all the characteristics we believe are most likely to influence program impacts. Each row of the table will represent a different grantee, and each column will represent a program characteristic. Because grantees will be listed in descending order by size of a particular impact or estimated association, program characteristics that cluster in the top portion of the table will tend to be associated with successful programs. Examining other characteristics that these programs share may enable us to distinguish patterns suggesting combinations of characteristics that are important for success for a particular outcome. For

example, we might observe that programs focusing on enriching housing services are heavily represented among the most successful programs, but that enriched housing without active housing programs (such as vouchers) are not among the successful ones, or have noticeably smaller impacts or associations. We will repeat this process with programs arranged by size of impacts on one or more key program participant outcome measures (such as expenditures or mortality) and on indicators of quality of life and the balance of long-term care service systems. Comparison of mean characteristics of programs that do and do not have significant favorable impacts will allow us to quickly identify possible associations.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

VII. REPORTING

We will present the results of the evaluation in a series of short reports, three interim reports, and a final evaluation report. The series of short reports will include semiannual state-specific data reports for dissemination to grantees. The content of the reports will vary and depend on the data available when the analyses are conducted. All reports will be designed for public dissemination and include executive summaries. Here, we describe the reporting schedule and the reports we will produce.

A. REPORTING SCHEDULE

1. Series of Short Reports

Beginning in January 2009, we will produce a series of short reports on a variety of different topics. We anticipate producing between four and six such reports each year. The schedule for these reports will be determined as data become available.

The state-specific data reports will be disseminated to grantees in February and August of each year, starting in August 2008. The schedule for these semiannual reports coincides with the timing of grantees' submissions of their semiannual progress reports. When grantees are submitting their semiannual progress reports they will receive a report on their state and MFP program from MPR. As described below, these semiannual reports will be data reports that describe the state's long-term care system and the progress of its MFP program. For each report, we will extract and use the most recent data available approximately three to four months before the reports are due (October/November for the February reports and April/May for the August reports).

2. Interim and Final Evaluation Reports

As described in Table VII.1, drafts of the three interim reports are due in August of each year, starting in 2009, and final versions are due by the end of September. The first draft of the final evaluation report is due in March 2012, approximately six months after we submit the draft of the third interim report.

This reporting schedule, combined with the natural lags in the reporting of program information and Medicaid claims, determines the study period of each report. For analyses based on grantees' semiannual progress reports and the quality-of-life data, we anticipate using information reported through the preceding February for each draft report, which will represent program activities through the calendar year of the prior year. For example, for the first interim evaluation report due in August 2009, we should have enough time to analyze the grantees' February 2009 progress reports and the quality-of-life data submitted by mid-February 2009, which will represent progress made through calendar year 2008.

TABLE VII.1

REPORTING SCHEDULE FOR THE EVALUATION OF MFP
DATA SOURCES AND STUDY PERIOD, BY REPORT

Report	Proposed Due Date for Drafts	Data Sources	Study Period
First Interim Report	August 2009	-Medicaid and Medicare Claims Data[a]	2004 through August 2008
		-MFP Finders, Program Participation, and Services Files	Through calendar year 2008[b]
		-MFP Quality-of-Life Data	Through calendar year 2008[b]
		-MFP Progress Reports	Through calendar year 2008
Second Interim Report	August 2010	-Medicaid and Medicare Claims Data[a]	2004 through August 2009
		-MFP Finders, Program Participation, and Services Files	Through calendar year 2009[b]
		-MFP Quality-of-Life Data	Through calendar year 2009[b]
		-MFP Progress Reports	Through calendar year 2009
Third Interim Report	August 2011	-Medicaid and Medicare Claims Data[a]	2004 through August 2010
		-MFP Finders, Program Participation, and Services Files	Through calendar year 2010[b]
		-MFP Quality-of-Life Data	Through calendar year 2010[b]
		-MFP Progress Reports	Through calendar year 2010
Report to Congress	March 2012	-Medicaid and Medicare Claims Data[a]	2004 through March 2011
		-MFP Finders, Program Participation, and Services Files	Through mid 2011[c]
		-MFP Quality-of-Life Data	Through mid 2011[c]
		-MFP Progress Reports	Through mid 2011[d]

Note: In addition to the data sources listed above, the evaluation of the MFP program will include data from sources such as the nursing facility minimum data set (NF-MDS) and the Online Survey, Certification, and Reporting database (OSCAR).

[a]MPR will extract these records using the identifying information in the MFP Finders Files, and on all individuals identified as receiving Medicaid-covered institutional care during the study period. The study period for these data assumes that MPR will receive reasonably complete data coverage a given calendar year by May 31 of the following year, to allow adequate time for processing and analysis.

[b]The data will come from the MFP files submitted through February of each year. If feasible, MPR will extend the data to include MFP files submitted in mid May of each year.

[c]The data will come from the MFP files submitted through mid August of 2011. If feasible, MPR will extend the data to include MFP files submitted in mid November of 2011.

[d]The last progress report MPR will use in the evaluation will be that submitted in August 2011, covering the first six months of calendar year 2011.

For our most data-intensive analyses based on Medicaid and Medicare claims records, we must start our analytical work no later than four months before a report's due date. We need this time to clean and analyze the data and draft the report. Medicaid and Medicare claims

information will have longer lags in reporting than the grantee progress reports and quality-of-life data, and the Medicaid data need to be verified and approved before they can be used for research. In addition, Medicaid and Medicare claims information require more processing time. The primary data source for our analyses of impacts will be the Medicaid Statistical Information System (MSIS). States submit MSIS claims files quarterly. CMS instructs states to submit their quarterly files within 45 days after the end of each federal fiscal quarter. States that follow these instructions submit their MSIS claims files for the federal fiscal quarter ending in September by mid-November of each year and by mid-February for the quarter ending in December. Review and approval of these files by CMS and MPR should take about a month, which means the September quarterly files become available for research by mid-December and the January files become available in mid-March. The review and approval process takes much longer than a month when a submitted file initially fails the approval process and the state has to rebuild and resubmit the file.

We will extract the most recent Medicaid claims available. For the typical state, we will extract the most recent Medicaid claims records available in March so that we have approximately four to five months to build our final analytical files and conduct our analyses. This schedule will allow us to extract Medicaid claims records through the quarterly files ending in December of the previous year. For example, we will extract claims through the MSIS quarterly file for December 2008 for the August 2009 report. The claims we extract will represent all the services with payment dates through the end of December. Because the most recent Medicaid claims records we extract may not be fully adjudicated claims, analyses based

on the most recent records must be considered preliminary.[1] This schedule will apply to those states that submit MSIS files on a timely basis and the files are approved the first time they are submitted. For those states that do not submit acceptable MSIS files within 45 days of the federal fiscal quarter ending in December, we will have to use whatever data are available.

The lags in the availability of Medicaid data mean that the results presented in the reports each August are likely to include only services rendered through the preceding August for most states. The claims files extracted in March containing all claims paid through December will be reasonably complete only for services that are actually *delivered* through the preceding August. Using data from the next quarterly extraction in June would not leave enough time for us to conduct the file construction, analyses, and writing necessary to complete a draft report by August. Thus, each report is likely to contain results for a period that concluded about one year before the date our draft is delivered.

B. CONTENT OF REPORTS

The series of short reports will be summarized in each annual interim report and the final evaluation report. In addition, we anticipate these reports will include more detailed analyses than what is possible in an issue brief or policy report. Below, we describe the types of analyses we believe will be possible during each year leading up to an interim report.

1. Analyses Prior to the First Interim Report

Leading up to the first interim report, due in August 2009, we will primarily conduct descriptive analyses. For nearly all programs, the data available during this period will only cover the initial implementation stage, and we will not be able to conduct analyses of impacts

[1] When working with MSIS claims, we typically look for correction records for six months past the original payment date on the claim, because we have found that most correction records for original claims are submitted within this time frame.

and outcomes. During this period, we anticipate conducting three types of analyses: (1) an implementation analysis, (2) an assessment of each state's long-term care system before the implementation of MFP, and (3) an assessment of baseline quality of life of the first MFP participants.

Program Implementation. In early 2009, all grantees will have at least six months of program experience, and about four or five states will have had a year or more. The implementation analyses conducted during this period will focus on summarizing state variation in program implementation (both the transition component and the rebalancing component of each state's MFP program) and developing a typology of programs, as described in Chapter II. In addition, we will be able to use information from the August 2008 and February 2009 progress reports to describe the grantee's initial experience with program operations. We will describe the first MFP participants (those who begin receiving MFP services some time in calendar year 2008). We will assess grantee progress toward achieving their benchmarks, to the extent the data (the progress reports and/or Medicaid data) can support such assessments.

State Long-Term Care Systems Before Implementation of MFP. For the first interim report, we will use Medicaid and Medicare eligibility and claims information from 2004 and 2006 to develop a statistical portrait of enrollees eligible for MFP in the baseline period and each state's long-term care systems before the implementation of MFP. The purpose of this analysis will be to describe the context in which MFP programs were implemented and the baseline information needed to understand program impacts. Key analyses will include assessments of (1) transition rates from institutional to community settings before the implementation of the MFP program, (2) reinstitutionalization rates of those who transitioned during these years, and (3) measures that reflect the balance between institutional and community-based care (see Chapter V).

MFP Participant's Qualify of Life at Baseline. Our analyses of participants' quality of life will also be limited, because only a few MFP participants will have completed their 365 days of eligibility when the quarterly quality-of-life data files are submitted in February 2009. Therefore, our analyses of quality-of-life information will focus on assessing and describing the quality of life of early MFP participants before their transition to the community.[2]

2. Analyses Prior to the Second Interim Report

Between the first and second interim reports, we will expand our analyses to include descriptions of the initial experience of MFP programs. During this period, we will assess (1) the ongoing program implementation experience and grantee progress toward program goals, (2) early state system changes that occur, (3) impacts on institutionalized beneficiaries and MFP participants during the first 12 to 18 months of program operations, and (4) initial changes in the quality of life of MFP participants.

Program Implementation and Grantee Progress. The analysis of program implementation will continue and be more detailed as we obtain more information through the semiannual web-based progress reports. Grantees that alter program features during the year will be noted (such as those who change from a passive approach to housing to a more aggressive approach), and the typology of grantees will be revised as necessary. We will also update our descriptive analyses of MFP participants to assess whether and how the characteristics of later enrollees differ from those of earlier enrollees.

The implementation analysis will also be expanded to incorporate a more complete assessment of grantee progress on their benchmarks than was possible previously. Because this

[2] In this chapter, early MFP participants are defined as participants who transitioned during the first year of program operations.

analysis will use data through early 2010, when all programs will have been operating for more than a year, the analysis will reflect interim progress and identify programs that show promising results, as well as those that are experiencing significant challenges that may affect their ability to achieve their benchmarks.

State Long-Term Care System Change. The impact analyses we conduct during thie period will include an assessment of changes in state long-term care systems. Because we will only have MSIS data from approximately the first 18 months of program implementation, this analysis will also only reflect early impacts on long-term care systems. We anticipate that, in many states, the system changes that result from the MFP program will be long term and may take at least two or more years before they are detected in the data. In addition, it will be difficult to determine whether the changes we detect are due to the MFP program rather than to other initiatives the state may be pursuing at the same time. Therefore, our analyses of state long-term care system changes conducted at this time will represent a preliminary assessment.

Impacts on Institutionalized Beneficiaries and MFP Participants. The analyses we conduct leading up to the second interim report will include the full range of analyses described in Chapter III. The data available for this report will cover the period from 2004 through August 2009 for states that submit acceptable MSIS files on a timely basis. The data will cover approximately four years before the implementation of MFP and approximately 18 months after implementation (for early implementing states, such as Missouri, New Hampshire, and Wisconsin, we will have nearly two years of data from the post-implementation period). Therefore, the impact analyses conducted during this period will reflect initial impacts on institutionalized beneficiaries and impacts on early MFP participants.

MFP Participant's Qualify of Life. The analysis of MFP participants' quality of life will provide information on how baseline quality of life is changing as the program matures. Because

we will have quality-of-life data reported through February 2010, by which time all MFP participants transitioning in 2008 will have completed their first quality-of-life follow-up interview, we will assess how the quality of life of first-year participants changed after living in the community and receiving MFP benefits for one year.[3] Where sample sizes permit, our analyses will investigate how this change is associated with participant and program characteristics.

3. Analyses Prior to the Third Interim Report

Between the second and third interim reports, we will assess (1) grantees' achievement of their benchmarks over the first three years of operation, (2) state system changes, (3) impacts on institutionalized beneficiaries and MFP participants, and (4) changes in the quality of life of MFP participants during the first and second years after transition.

Grantee Achievement of Program Goals. As needed, we will update our previous analyses of program implementation to identify those grantees that alter their programs or the types of enrollees they transition. We will also describe grantees' achievement of their benchmarks and the factors that affected their ability to achieve their benchmarks. Key elements of our analyses will be an assessment of the relationship between grantee achievements and program characteristics and the identification of sustainable program changes.

State Long-Term Care System Change. Our analyses of impacts on state long-term care systems will also be updated and expanded to include more months of data. Over time, states will have accrued more enhanced funds for rebalancing, and the reinvested funds will have had

[3] Missouri, New Hampshire, and Wisconsin, the first states to begin program operations, were the first states to begin administering the quality-of-life survey in January 2008. Early reports suggest these states are transitioning less than 10 people each month during the first few months of program operations. Therefore, we will have too few observations to assess how quality of life changes after MFP eligibility ends by due date of the second interim report.

more time to result in system changes. If MFP programs can effect system change, we should be able to detect the initial results of these system changes in the analyses we conduct during the period leading up to the third interim report.

Impacts on Institutionalized Beneficiaries and MFP Participants. The impacts analyses we conduct during this period will include more months of data and the MFP participants who entered the program since our last analysis. Because the data available during this period will cover approximately 26 months of program implementation (and nearly 30 months for a few programs), the impact estimates presented will reflect the results of more mature programs. The results will also include our first good look at claims-based outcomes for the second year after transition, because during the previous year we will only have second-year findings for those who transitioned in the first half of 2008.

MFP Participant's Qualify of Life. When we extract the data needed to conduct quality-of-life analyses during this period, early MFP participants (those transitioning in 2008) will have completed their third quality-of-life interview. For these participants, we will be able to expand our analyses and assess participants' change in their quality of life during the year after their MFP benefits ended. That is, we will be able to determine whether MFP participants can (1) maintain or improve their quality of life while receiving MFP benefits, and (2) continue to maintain or improve their quality of life when MFP services end (which include the additional demonstration and supplemental benefits provided by the programs). In addition, we will add to earlier findings on outcomes at the first followup for MFP participants who transitioned during 2009, expanding the sample size and allowing comparisons for whether program effects on quality of life are changing as grantees gain experience.

4. Final Evaluation Report

The final evaluation report will be a compilation and summary of all the short reports and the three interim reports. It will combine final analyses from the three interim reports into one comprehensive document that describes the history of the program and its final impacts and outcomes. It will draw most heavily from the reports and analyses produced during 2011, but the earlier reports will provide information about the evolution of MFP programs and program dynamics. This report will be designed as a Report to Congress, with the first draft due in March 2012 and the final version to be delivered to Congress by September 2012. The Report to Congress will focus on information policymakers need to determine the direction for future policies affecting long-term care systems.

The final analyses presented in the Report to Congress will draw on claims data for services delivered by March 2011. This means that, for beneficiaries entering MFP after March 2009, we will have fairly complete data, but the data will not cover a full two years after transition to the community. For enrollees entering after March 2010, we will have data from less than a one-year follow-up period for claims-based outcomes. Nonetheless, to meet the scheduled delivery date for the Report to Congress in September 2012, we will need to adhere to this schedule.

C. STATE-SPECIFIC REPORT SERIES

The series of semi-annual reports we develop for grantees will be data reports designed to describe their long-term care systems and MFP programs. The format and topic of each report will be the same across all grantees, and each grantee will receive a report that presents its own data and compares the grantee to the average across all MFP grantees. We anticipate producing seven reports—one in calendar year 2008, two in 2009, two in 2010, and two in 2011. Each data report will become available to grantees about the time the web-based reporting system is opened

for grantee reporting. Each grantee will log in to the reporting system and select the current MPR data report for downloading.

The topics of the reports will vary and depend on the data available. We will suggest several topics for each report about four months before its due date so that CMS can review the proposed content. Because we want these reports to be as responsive as possible to the information needs of CMS and grantees, we recommend asking the grantees to nominate several representatives to participate in the selection of topics. We anticipate the initial reports will present data on the states' long-term care systems before the implementation of the MFP program. These reports will include information about transition and reinstitutionalization rates (by length of institutional stay) and the balance of long-term care spending between institutional and community-based care. As program data become available, the reports will evolve and focus more on describing program enrollment patterns, MFP participants and their level of need, and program expenditures (overall and by type of service).

REFERENCES

Ai, C., and Edward C. Norton. "Interaction Terms in Logit and Probit Models." *Economics Letters,* vol. 80, no. 1, 2003, pp. 123–129.

Anderson, W., J. Wiener, and J. O'Keeffe. "Money Follows the Person Initiatives of the Systems Change Grantees, Final Report." Baltimore, MD: Centers for Medicare and Medicaid Services, July 2006.

Burwell, Brian, Kate Sredl, and Steve Eiken. "Medicaid Long-Term Care Expenditures in FY 2007." Cambridge, MA: Thomson Reuters, September 26, 2008. Available online at www.hcbs.org. Accessed October 1, 2008.

Burwell, Brian, Kate Sredl, and Steve Eiken. "Medicaid Long-Term Care Expenditures in FY 2005." Cambridge, MA: Medstat, July 5, 2006. Available online at www.hcbs.org/moreInfo.php/nb/doc/1636. Accessed November 2007.

Carlson B., L. Foster, S. Dale, and R. Brown. "Effects of Cash and Counseling on Personal Care and Well-Being." *Health Services Research*, vol. 42, no. 1, 2007, pp. 467–487.

Centers for Medicare & Medicaid Services. "Long-Term Care Resident Assessment Instrument User's Manual: Version 2.0." Washington, DC: CMS, 2002.

Kitchener, Martin, Terence Ng, and Charlene Harrington. "Medicaid Home and Community-Based Services for the Elderly: Trends in Programs and Policies." *Journal of Applied Gerontology*, vol. 26, no. 3, 2007, pp. 305–324.

Lipson, Debra, Cindy Gruman, et al. "Money Follows the Person Demonstration Grants: Summary of State MFP Program Applications." Washington, DC: Mathematica Policy Research, Inc., August 31, 2007.

Mor, V., J. Zinn, P. Gozalo, et al. "Prospects for Transferring Nursing Home Residents to the Community." *Health Affairs,* vol. 26, no. 6, 2007, pp. 1762–1771.

National PACE Association. "ASAP Guidebook." Alexandria, VA: National PACE Association, March 2004. Available online at www.npaonline.org/ website/article.asp?id=119. Accessed June 15, 2007.

Saucier, Paul. "Medicaid Managed Long-Term Care." AARP Public Policy Institute Issue Brief. Washington, DC: AARP Public Policy Institute, November 2005. Available online at assets.aarp.org/rgcenter/il/ib79_mmltc.pdf. Accessed June 14, 2007.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

APPENDIX A

MONEY FOLLOWS THE PERSON QUALITY-OF-LIFE SURVEY

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

MONEY FOLLOWS THE PERSON QUALITY-OF-LIFE SURVEY

The Money Follows the Person Quality of Life Survey (QoL) was designed to measure quality of life in seven domains: living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction, and health status. The target population for the survey includes people with disabilities and long-term illnesses who are transitioning from institutionalized care to a care setting in the community. The survey is to be administered to all participants at three points in time—just prior to transition, about 11 months after transition, and about 24 months after transition.

The QoL takes approximately 15 to 20 minutes to complete. A few questions are asked only before or after the transition, although most are asked at all three interviews. The survey is intended to be administered by an interviewer, in person, and in a private setting (e.g., an office in a nursing facility). Depending on the individual circumstances and the abilities of the participant, however, a proxy respondent or an assisted interview may be necessary. A proxy respondent is a person who answers the survey questions on the participant's behalf. In an assisted interview, a third person is present to help the participant answer questions. This survey also has been translated into Spanish.

The development of the QoL survey was funded by the Centers for Medicare and Medicaid Services (CMS) under contract HHSM-500-2005-00025I (0002). The majority of questions are based on the Participant Experience Survey (Version 1.0 of Mental Retardation/Developmental Disabilities 2003, MEDSTAT Group, Inc.), although a few items are drawn from other instruments (ASK ME!, Cash and Counseling, National Core Indicator Survey (NCI), Quality of Life Enjoyment and Satisfaction Questionnaire—Short Form, and the Nursing Home Consumer Assessment of Health Plans Survey (NH CAHPS)).

The survey is free and available for use by the public; no one can use the survey for monetary purposes. Users are expected to include the following citation:

Sloan, Matt, and Carol Irvin. Money Follows the Person Quality of Life Survey. Prepared for Centers for Medicare and Medicaid Services (CMS). Washington, D.C.: Mathematica Policy Research, Inc., 2007.

MFP QUALITY OF LIFE SURVEY

RESPONDENT INFORMATION

Respondent Name: _____

Respondent Street Address: _____

Respondent City: _____

Respondent State: _____

Respondent ZIP Code: _____

Medicaid ID number: _____

☐ *Check here if the Sample Member is deceased and record date of death:*

[_____] [_____] [_____] ➡ **GO TO END**
Month Day Year

Hello, my name is _____ and I am from _____. I'm here to ask for your help with an important study of Medicaid beneficiaries in the state of _____. The Quality of Life Survey, sponsored by the Centers for Medicare & Medicaid Services (CMS) and the state of _____, is an essential part of an evaluation of the Money Follows the Person Program, a program designed to help Medicaid beneficiaries transition out of institutional care into the community. I'd like to ask you some questions about your housing, access to care, community involvement, and your health and well-being. Results from the study will help CMS and the state of _____ evaluate how well its programs are meeting the needs of Medicaid beneficiaries like you.

Before we begin, let me assure you that all information collected will be kept strictly confidential and will not be reported in any way that identifies you personally. Your answers will be combined with the answers of others and reported in such a way that no single individual could ever be identified. Further, the information collected will not be used by anyone to determine your continuing eligibility for Medicaid benefits. We are collecting this information for research purposes only. However, I may be required to report any instances of abuse or neglect that you tell me about to authorities. Your participation is completely voluntary and if we come to any question you prefer not to answer, just tell me and we'll move on to the next one.

If you have any questions, please stop me and ask me. Also, please let me know if you do not understand a question or if you would like me to repeat it.

MODULE 1: LIVING SITUATION

1. I'm going to ask you a few questions about the place you live. About how long have you lived (here/in your home)?

   Probe: Your best estimate is fine.

   Interviewer: If respondent indicates less than 1 month, enter 1 month.

   [_____] [_____] ➡ **GO TO QUESTION 2**
   Years Months

   DON'T KNOW..... DK
   REFUSED..... R

   1a. Would you say you have lived here more than five years?

   Yes..... 01
   No 02
   Don't Know..... DK
   Refused..... R

2. *Interviewer: Does sample member live in a group home or nursing facility?*

   Yes..... 01
   No 02
   Don't Know ..... DK
   Refused ..... R

3. Do you like where you live?

Yes..... 01
No 02
Sometimes..... 03
DON'T KNOW..... DK
REFUSED..... R

4. Did you help pick (this/that) place to live?

Yes..... 01
No 02
DON'T KNOW..... DK
REFUSED..... R

5. Do you feel safe living (here/there)?

Yes..... 01 ➡ **GO TO QUESTION 6**
No 02
DON'T KNOW..... DK ➡ **GO TO QUESTION 6**
REFUSED..... R ➡ **GO TO QUESTION 6**

5a. How often do you feel unsafe living (here/there)?

Sometimes 01
Most of the Time 02
DON'T KNOW..... DK
REFUSED..... R

6. Can you get the sleep you need without noises or other disturbances where you live?

Yes..... 01
No 02
Sometimes..... 03
DON'T KNOW..... DK
REFUSED..... R

MODULE 2: CHOICE AND CONTROL

7. Can you go to bed when you want?

Yes..... 01
No 02
Sometimes..... 03
DON'T KNOW..... DK
REFUSED..... R

8. Can you be by yourself when you want to?

Yes..... 01
No 02
Sometimes..... 03
DON'T KNOW..... DK
REFUSED..... R

9. When you are at home, can you eat when you want to?

Yes..... 01
No 02
Sometimes..... 03
DON'T KNOW..... DK
REFUSED..... R

10. Can you choose the foods that you eat?

Yes..... 01
No 02
Sometimes..... 03
DON'T KNOW..... DK
REFUSED..... R

11. Can you talk on the telephone without someone listening in?

Yes..... 01
No 02
Sometimes..... 03
No access to telephone 04
DON'T KNOW..... DK
REFUSED..... R

12. Can you watch TV when you want to?

Yes..... 01
No 02
Sometimes..... 03
No access to TV..... 04
DON'T KNOW..... DK
REFUSED..... R

13. **[AFTER TRANSITION ONLY]** Some people get an allowance from the state to pay for the help or equipment they need. Do you get an allowance like this?

Yes..... 01
No ..... 02 ➡ **GO TO QUESTION 14**
DON'T KNOW..... DK ➡ **GO TO QUESTION 14**
REFUSED..... R ➡ **GO TO QUESTION 14**

13a. **[AFTER TRANSITION ONLY]** In the last 12 months, what help or equipment did you buy with this allowance?

[Code all that apply]

Modified Home 01
Modified Car 02
Special Equipment 03
Paid Help 04
Transportation 05
Household Goods 06
Security Deposit 07
Other 08
DON'T KNOW ..... DK
REFUSED ..... R

MODULE 3: ACCESS TO PERSONAL CARE

14. Now I'd like to ask you about some everyday activities, like getting dressed or taking a bath. Some people have no problem doing these things by themselves. Other people need somebody to help them. First, does anyone help you with things like bathing, dressing, or preparing meals?

Probe: Please include any help received by another person, including cueing or standby assistance.

Yes 01
No ..... 02 ➡ **GO TO QUESTION 15**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 15**
REFUSED ..... R ➡ **GO TO QUESTION 15**

14a. Do any of these people get paid to help you?

Yes 01
No ..... 02 ➡ **GO TO QUESTION 15**
Don't Know ..... DK ➡ **GO TO QUESTION 15**
Refused ..... R ➡ **GO TO QUESTION 15**

14b. Do you pick the people who are paid to help you?

Yes 01
No 02
Don't Know ..... DK
Refused ..... R

15. Do you ever go without a bath or shower when you need one?

Yes 01
No ..... 02 ➡ **GO TO QUESTION 16**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 16**
REFUSED ..... R ➡ **GO TO QUESTION 16**

15a. How often do you go without a bath or shower when you need one? Would you say only sometimes or most of the time?

Sometimes 01
Most of the time 02

DON'T KNOW ..... DK
REFUSED ..... R

15b. Is this because there is no one there to help you?

Probe: Please include any help received by another person, including cueing or standby assistance.

Yes 01
No..... 02
DON'T KNOW ..... DK
REFUSED ..... R

16. Do you ever go without a meal when you need one?

Yes..... 01
No ..... 02 ➡ **GO TO QUESTION 17**
DON'T KNOW..... DK ➡ **GO TO QUESTION 17**
REFUSED..... R ➡ **GO TO QUESTION 17**

16a. How often do you go without a meal when you need one? Would you say only sometimes or most of the time?

Sometimes 01
Most of the Time 02
DON'T KNOW ..... DK
REFUSED ..... R

16b. Is this because there is no one there to help you?

Probe: Please include any help received by another person, including cueing or standby assistance.

Yes 01
No..... 02
DON'T KNOW ..... DK
REFUSED ..... R

17. Do you ever go without taking your medicine when you need it?

Probes: Medicines are pills or liquids that are given to you by a doctor to help you feel better.

Yes..... 01
No ..... 02 ➡ **GO TO QUESTION 18**
DON'T KNOW..... DK ➡ **GO TO QUESTION 18**
REFUSED..... R ➡ **GO TO QUESTION 18**

17a. How often do you go without taking your medicine when you need it? Would you say only sometimes or most of the time?

Sometimes 01
Most of the Time 02
DON'T KNOW ..... DK
REFUSED ..... R

17b. Is this because there is no one there to help you?

Probe: Please include any help received by another person, including cueing or standby assistance.

Yes 01
No 02
DON'T KNOW ..... DK
REFUSED ..... R

18. Are you ever unable to use the bathroom when you need to?

Yes 01
No ..... 02 ➡ **GO TO QUESTION 19**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 19**
REFUSED ..... R ➡ **GO TO QUESTION 19**

18a. How often are you unable to use the bathroom when you need to? Would you say only sometimes or most of the time?

Sometimes 01
Most of the Time 02
DON'T KNOW ..... DK
REFUSED ..... R

18b. Is this because there is no one there to help you?

Probe: Please include any help received by another person, including cueing or standby assistance.

Yes 01
No 02
DON'T KNOW ..... DK
REFUSED ..... R

19. **[AFTER TRANSITION ONLY]** Have you ever talked with a case manager or support coordinator about any special equipment or changes to your home that might make your life easier?

Probe: Equipment means things like wheelchairs, canes, vans with lifts, and automatic door opener.

Yes 01
No ..... 02 ➡ **GO TO QUESTION 20**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 20**
Not Applicable ..... N/A ➡ **GO TO QUESTION 20**
REFUSED ..... R ➡ **GO TO QUESTION 20**

19a. **[AFTER TRANSITION ONLY]** What equipment or changes did you talk about?

_____

_____

_____

_____

DON'T KNOW ..... DK
REFUSED ..... R

19b. **[AFTER TRANSITION ONLY]** Did you get the equipment or make the changes you needed?

Yes 01
No 02
In Process 03
DON'T KNOW ..... DK
REFUSED ..... R

20. **[AFTER TRANSITION ONLY]** Please think about all the help you received during the last week *around the house* like cooking or cleaning. Do you need *more* help with things around the house than you are now receiving?

Yes 01
No 02
DON'T KNOW ..... DK
REFUSED ..... R

21. **[AFTER TRANSITION ONLY]** During the last week, did any family member or friends help you with things around the house?

Yes 01
No ..... 02 ➡ **GO TO QUESTION 22**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 22**
REFUSED ..... R ➡ **GO TO QUESTION 22**

21a. **[AFTER TRANSITION ONLY]** Please think about *all* the family members and friends who help you. About how many hours did they spend helping you yesterday?

Probe: Your best estimate is fine.

Interviewer: if less than one hour, enter 1 hour.

[_____]
Hours

DON'T KNOW ..... DK
REFUSED ..... R

MODULE 4: RESPECT AND DIGNITY

Note: If Q14 = No, DK or R ➡ **GO TO QUESTION 27**

Interviewer: For questions in this module, refer to your state's policy on reporting any suspected incidents of abuse and neglect. For this survey, record only reports of current abuse.

22. You said that you have people who help you. Do the people who help you treat you the way you want them to?

Yes ..... 01 ➡ **GO TO QUESTION 23**
No 02

DON'T KNOW..... DK ➡ **GO TO QUESTION 23**
REFUSED..... R ➡ **GO TO QUESTION 23**

22a. How often do they not treat you the way you want them to? Would you say only sometimes or most of the time?

Sometimes 01
Most of the Time 02
DON'T KNOW..... DK
REFUSED..... R

23. Do the people who help you listen carefully to what you ask them to do?

Yes..... 01 ➡ **GO TO QUESTION 24**
No 02
DON'T KNOW..... DK ➡ **GO TO QUESTION 24**
REFUSED..... R ➡ **GO TO QUESTION 24**

23a. How often do they not listen to you? Would you say only sometimes or most of the time?

Sometimes 01
Most of the time..... 02
DON'T KNOW..... DK
REFUSED..... R

24. **[Optional]** Have you ever been physically hurt by any of the people who help you now?

Probe: Physically hurt means someone could have pushed, kicked, or slapped you.

Yes..... 01
No ..... 02 ➡ **GO TO QUESTION 25**
DON'T KNOW..... DK ➡ **GO TO QUESTION 25**
REFUSED..... R ➡ **GO TO QUESTION 25**

24a. **[Optional]** What happened when the people who help you now physically hurt you?

_____

_____

_____

_____

DON'T KNOW..... DK
REFUSED..... R

24b. **[Optional]** How many times have you been physically hurt by the people who help you now?

Probe: Your best guess is fine.

[_____]
Times

DON'T KNOW ..... DK
REFUSED ..... R

25. **[Optional]** Are any of the people who help you now mean to you or do they yell at you?

Probe: Do they treat you in a way that makes you feel bad or do they hurt your feelings?

Yes 01
No ..... 02 ➡ **GO TO QUESTION 26**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 26**
REFUSED ..... R ➡ **GO TO QUESTION 26**

25a. **[Optional]** How often are they mean to you? Would you say only sometimes or most of the time?

Sometimes 01
Most of the Time 02
DON'T KNOW ..... DK
REFUSED ..... R

26. **[Optional]** Have any of the people who help you now ever taken your money or things without asking first?

Yes 01
No ..... 02 ➡ **GO TO QUESTION 27**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 27**
REFUSED ..... R ➡ **GO TO QUESTION 27**

26a. **[Optional]** How many times have they taken your money or things without asking first?

Probe: Your best guess is fine.

[_____]
Times

DON'T KNOW ..... DK
REFUSED ..... R

MODULE 5: COMMUNITY INTEGRATION AND INCLUSION

27. I'd like to ask you a few questions about things you do. Can you see your friends and family when you want to see them?

Interviewer: Code "yes" if respondent indicates that they have either gone to see friends or family or that friends and family have come to visit them.

Yes 01
No ..... 02 ➡ **GO TO QUESTION 28**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 28**
REFUSED ..... R ➡ **GO TO QUESTION 28**

27a. How often do you see your friends and family when you want to see them? Would you say only sometimes or most of the time?

Sometimes 01
Most of the Time 02
DON'T KNOW ..... DK
REFUSED ..... R

28. Can you get to the places you need to go, like work, shopping, or the doctor's office?

Yes 01
No ..... 02 ➡ **GO TO QUESTION 29**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 29**
REFUSED ..... R ➡ **GO TO QUESTION 29**

28a. How often do you get to the places you need to go, like work, shopping, or the doctor's office? Would you say only sometimes or most of the time?

Sometimes 01
Most of the Time 02
DON'T KNOW ..... DK
REFUSED ..... R

29. Is there anything you *want* to do outside [the facility/your home] that you can't do now?

Yes 01
No ..... 02 ➡ **GO TO QUESTION 30**
DON'T KNOW ..... DK ➡ **GO TO QUESTION 30**
REFUSED ..... R ➡ **GO TO QUESTION 30**

29a. What would you like to do that you don't do now?

_____

_____

_____

_____

DON'T KNOW ..... DK
REFUSED ..... R

29b. What do you need to do these things?

_____

_____

_____

_____

DON'T KNOW ..... DK
REFUSED ..... R

30. When you go out, can you go by yourself or do you need help?

Go out Independently..... 01 ➡ **GO TO QUESTION 31**
Need Help..... 02
DON'T KNOW..... DK ➡ **GO TO QUESTION 31**
REFUSED..... R ➡ **GO TO QUESTION 31**

30a. Please think about *all* the help you received during the last week with *getting around the community,* such as shopping and going to a doctor's appointment, do you need *more* help getting around than you are receiving?

Yes..... 01
No 02
DON'T KNOW..... DK
REFUSED..... R

31. **[AFTER TRANSITION ONLY]** Are you working for pay right now?

Probe: Do you get any money for doing work?

Yes..... 01 ➡ **GO TO QUESTION 32**
No 02
DON'T KNOW..... DK ➡ **GO TO QUESTION 32**
REFUSED..... R ➡ **GO TO QUESTION 32**

31a. **[AFTER TRANSITION ONLY]** Do you want to work for pay?

Yes..... 01
No..... 02
DON'T KNOW..... DK
REFUSED..... R

32. **[AFTER TRANSITION ONLY]** Are you doing volunteer work or working without getting paid?

Probe: Are you doing work but not getting any money for it?

Yes..... 01 ➡ **GO TO QUESTION 33**
No 02
DON'T KNOW..... DK ➡ **GO TO QUESTION 33**
REFUSED..... R ➡ **GO TO QUESTION 33**

32a. **[AFTER TRANSITION ONLY]** Would you like to do volunteer work or work without getting paid?

Probe: would you like to do work without getting paid for it?

Yes..... 01
No 02
DON'T KNOW..... DK
REFUSED..... R

33. I'd like to ask you a few questions about how you get around. Do you go out to do fun things in your community?

Probe: These are things that you enjoy such as going to church, the movies or shopping?

Yes..... 01
No 02
DON'T KNOW..... DK
REFUSED..... R

34. When you want to go somewhere, can you just go, do you have to make some arrangements, or do you have to plan many days ahead and ask people for help?

Decide and Go..... 01
Plan Some 02
Plan Many Days Ahead 03
DON'T KNOW..... DK
REFUSED..... R
N/A……NA

35. Do you miss things or have to change plans because you don't have a way to get around easily?

Probe: Do you have to miss things because it is hard for you to get there?

Yes..... 01
No 02
Sometimes..... 03
DON'T KNOW..... DK
REFUSED..... R

36. Is there any medical care, such as a medical treatment or doctor's visits, which you have not received or could not get to within the past month?

Probe: The medical care includes doctor visits or medical treatments that you may need.

Yes..... 01
No 02
DON'T KNOW..... DK
REFUSED..... R

MODULE 6: SATISFACTION

37. Taking everything into consideration, during the past week have you been happy or unhappy with the help you get with things around the house or getting around your community?

Happy ..... 01 ➡ **GO TO QUESTION 37a**
Unhappy ..... 02 ➡ **GO TO QUESTION 37b**
DON'T KNOW..... DK ➡ **GO TO QUESTION 38**
REFUSED..... R ➡ **GO TO QUESTION 38**

37a Would you say you are a little happy or very happy?

A little happy ..... 01 ➡ **GO TO QUESTION 38**
Very happy ..... 02 ➡ **GO TO QUESTION 38**
Don't Know..... DK ➡ **GO TO QUESTION 38**
Refused..... R ➡ **GO TO QUESTION 38**

37b Would you say you are a little unhappy or very unhappy?

A little unhappy 01
Very unhappy..... 02
Don't Know..... DK
Refused..... R

38. Taking everything into consideration, during the past week have you been happy or unhappy with the way you live your life?

Happy ..... 01 ➡ **GO TO QUESTION 38a**
Unhappy ..... 02 ➡ **GO TO QUESTION 38b**
DON'T KNOW..... DK ➡ **GO TO QUESTION 39**
REFUSED..... R ➡ **GO TO QUESTION 39**

38a. Would you say you are a little happy or very happy?

A little happy ..... 01 ➡ **GO TO QUESTION 39**
Very happy ..... 02 ➡ **GO TO QUESTION 39**
Don't Know..... DK ➡ **GO TO QUESTION 39**
Refused..... R ➡ **GO TO QUESTION 39**

38b. Would you say you are a little unhappy or very unhappy?

A little unhappy 01
Very unhappy..... 02
Don't Know..... DK
Refused..... R

MODULE 7: HEALTH STATUS

39. During the past week have you felt sad or blue?

Yes..... 01
No ..... 02 ➡ **GO TO QUESTION 40**
DON'T KNOW..... DK ➡ **GO TO QUESTION 40**
REFUSED..... R ➡ **GO TO QUESTION 40**

39a. How often have you felt sad and blue? Would you say only sometimes or most of the time?

Sometimes 01
Most of the Time 02
DON'T KNOW ..... DK
REFUSED ..... R

40. During the past week have you felt irritable?

Probe: Irritable means grumpy or easily upset about things in your life.

Yes..... 01
No ..... 02 ➡ **GO TO QUESTION 41**
DON'T KNOW..... DK ➡ **GO TO QUESTION 41**
REFUSED..... R ➡ **GO TO QUESTION 41**

40a. How often have you felt irritable? Would you say only sometimes or most of the time?

Probe: Irritable means grumpy or easily upset about things in your life.

Sometimes 01
Most of the Time 02
DON'T KNOW..... DK
REFUSED..... R

41. During the past week have you had aches and pains?

Yes..... 01
No ..... 02 ➡ **GO TO QUESTION 42**
DON'T KNOW..... DK ➡ **GO TO QUESTION 42**
REFUSED..... R ➡ **GO TO QUESTION 42**

41a. How often do you have aches and pain? Would you say only sometimes or most of the time?

Sometimes 01
Most of the Time 02
DON'T KNOW..... DK
REFUSED..... R

CLOSEOUT

42. Those are all the questions I have you now. We would like to talk with you in about a year or so to find out how you are doing. In case we have trouble reaching you, what is the name, address, and phone number of a close relative or friend who is not living with you and is likely to know your location in the future? For example, a mother, father, brother, sister, aunt, uncle, or close friend.

No Contact Available ..... 01 ➡ **GO TO QUESTION 43**
Contact Available..... 02

42a. Contact Name: _____

42b. Contact Street Address: _____

42c. Contact City: _____

42d. Contact State: _____

42e. Contact ZIP _____

42f. Contact Phone: _____

43. *Interviewer: Did you complete the interview with the sample member alone, the sample member who was assisted by another, or with a proxy?*

Sample Member Alone 01
Sample Member with Assistance..... 02
Proxy..... 03

44. *Interviewer: Record date the interview was completed:*

[_____] [_____] [_____]
Month Day Year

➡ **END INTERVIEW**

MFP QUALITY OF LIFE SURVEY

ENCUESTA DE LA CALIDAD DE VIDA – MFP

Spanish Version – Versión en Español

RESPONDENT INFORMATION – INFORMACIÓN (DEL/DE LA) RESPONDIENTE

Respondent Name: _____
Nombre de Respondiente

Respondent Street Address: _____
Dirección de Respondiente

Respondent City: _____
Ciudad de Respondiente

Respondent State: _____
Estado de Respondiente

Respondent ZIP Code: _____
Código Postal (ZIP) de Respondiente

Medicaid ID number: _____
Número de Medicaid de Respondiente

☐ *Check here if the Sample Member is deceased and record date of death*
Marque aquí si (el/la) Miembro de Muestra falleció, y anote la fecha de muerte:

[_____] [_____] [_____] ➡ **GO TO END / VAYA AL FIN**
Month/Mes Day/Día Year/Año

Hola. Me llamo _____ y soy de _____. Estoy aquí para pedir su ayuda con un importante estudio de beneficiarios de Medicaid en el estado de _____. La Encuesta de la Calidad de Vida, auspiciada por los Centros para los Servicios de Medicare y Medicaid ("Centers for Medicare & Medicaid Services o CMS") y el estado de _____ es una parte esencial de una evaluación del programa "Money Follows the Person – El Dinero Sigue la Persona", un programa diseñado para ayudar a beneficiarios de Medicaid a hacer la transición del cuidado institucional a la comunidad. Quiero hacerle algunas preguntas acerca de su vivienda, su acceso a servicios y cuidado, su participación en la comunidad, y su salud y bienestar. Los resultados del estudio ayudarán a CMS y el estado de _____a evaluar cómo sus programas llenan las necesidades de beneficiarios de Medicaid como usted.

Antes de comenzar, permítame asegurarle que toda la información recolectada será estrictamente confidencial y no será usada en ninguna forma que le identifique a usted personalmente. Sus respuestas estarán combinadas con las respuestas de otras personas y reportadas en tal forma que ninguna persona individual pueda ser identificada. Además, la información recolectada no será usada por nadie para determinar su continuada elegibilidad para beneficios de Medicaid. Estamos recolectando esta información solamente para los propósitos de estudio. Sin embargo, es posible que sea requerido(a) informar de cualquier caso de abuso o de negligencia que usted me diga a autoridades. Su participación es completamente voluntaria y si llegamos a alguna pregunta que usted prefiere no contestar, por favor dígame y seguiremos con la próxima.

Si usted tiene alguna pregunta, por favor páreme y pregunte. Por favor, dígame también si no entiende alguna pregunta o si quiere que yo la repita.

MODULE 1: LIVING SITUATION
MÓDULO 1: SITUACIÓN DE VIVIENDA

1. Le voy a hacer algunas preguntas acerca del lugar donde vive. ¿Más o menos por cuánto tiempo ha vivido (aquí/en su hogar)?

SONDEO: La mejor estimación que me puede dar está bien.

Interviewer: *If respondent indicates less than 1 month, enter 1 month.*
Entrevistador(a): *Si (el/la) respondiente indica menos de 1 mes, anote 1 mes.*

[_____] [_____] ➡ **GO TO QUESTION 2 / VAYA A PREGUNTA 2**
Years/Años Months/Meses

DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

1a. ¿Diría que ha vivido aquí más de cinco años?

Yes / Sí 01
No 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

2. *Entrevistador(a): ¿Vive (el/la) miembro de la muestra en un hogar de grupo o en una facilidad de enfermería o "nursing facility"?*

Yes /Sí 01
No 02
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

3. ¿Le gusta dónde vive?

Yes /Sí 01
No 02
Sometimes / A veces 03
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

4. ¿Usted ayudó a escoger (este/ese) lugar para vivir?

Yes / Sí 01
No 02
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

5. ¿Se siente usted seguro(a) viviendo (aquí/allí)?

Yes / Sí ..... 01 ➡ **GO TO QUESTION 6 / VAYA A PREGUNTA 6**
No 02
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 6 / VAYA A PREGUNTA 6**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 6 / VAYA A PREGUNTA 6**

5a. ¿Con qué frecuencia se siente inseguro(a) viviendo (aquí/allí)?

Sometimes / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

6. ¿Puede usted dormir como necesita sin ruido o disturbios, en el lugar donde vive?

Yes /Sí 01
No 02
Sometimes / A veces 03
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

MODULE 2: CHOICE AND CONTROL
MÓDULO 2: SELECCIÓN Y CONTROL

7. ¿Puede acostarse cuando usted quiere?

Yes / Sí 01
No 02
Sometimes / A veces 03
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

8. ¿Puede estar a solas cuando usted quiere?

Yes / Sí 01
No 02
Sometimes / A veces 03
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

9. Cuando está en casa, ¿puede comer cuando usted quiere?

Yes / Sí 01
No 02
Sometimes / A veces 03
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

10. ¿Puede usted seleccionar las comidas que usted come?

Yes /Sí 01
No 02
Sometimes / A veces 03
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

11. ¿Puede usted hablar por teléfono sin que alguien esté escuchando?

Yes / Sí 01
No 02
Sometimes / A veces 03
No access to telephone / No tiene
acceso a un teléfono..... 04
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

12. ¿Puede usted ver televisión cuando quiere?

Yes / Sí 01
No 02
Sometimes / A veces 03
No access to TV / No tiene acceso
a un televisor..... 04
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

13. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** Algunas personas reciben un subsidio del estado para pagar por la ayuda o el equipo que necesitan. ¿Recibe usted un subsidio como este?

Yes /Sí 01
No ..... 02 ➡ **GO TO QUESTION 14 / VAYA A PREGUNTA 14**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 14 / VAYA A PREGUNTA 14**
REFUSED/ NEGÓ DE CONTESTAR ... R ➡ **GO TO QUESTION 14 / VAYA A PREGUNTA 14**

13a. **[AFTER TRANSITION ONLY][SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** En los últimos doce meses, ¿qué ayuda o equipo compró usted con este subsidio?

[Code all that apply] / [Marque todos que sean aplicables]

Modified Home / modificaciones al hogar 01
Modified Car / modificaciones al auto 02
Special Equipment / equipo especial 03
Paid Help / ayuda pagada..... 04
Transportation / transporte..... 05
Household Goods / bienes para el hogar..... 06
Security Deposit /depósito de garantía 07
Other /otro 08
DON'T KNOW / NO SABE ..... DK
REFUSED? NEGÓ DE CONTESTAR ..... R

MODULE 3: ACCESS TO PERSONAL CARE
MÓDULO 3: ACCESO A CUIDADO PERSONAL

14. Ahora quiero preguntarle acerca de algunas actividades diarias, tales como vestirse o bañarse. Algunas personas no tienen ningún problema para hacer estas cosas por si mismos. Otras personas necesitan que alguien les ayude. Primero, ¿alguien le ayuda con cosas como bañarse, vestirse o preparar comidas?

SONDEO: Por favor incluya cualquier ayuda recibida por otra persona, incluyendo ayuda con asistencia para espera de turno o "standby".

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 15 / VAYA A PREGUNTA 15**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 15 / VAYA A PREGUNTA 15**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 15 / VAYA A PREGUNTA 15**

14a. ¿Alguna de estas personas recibe pago por ayudarle a usted?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 15 / VAYA A PREGUNTA 15**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 15 / VAYA A PREGUNTA 15**
REFUSED / NEGÓ DE CONTESTAR ..... R ➡ **GO TO QUESTION 15 / VAYA A PREGUNTA 15**

14b. ¿Usted escoge a las personas que reciben pago por ayudarle?

Yes / Sí 01
No 02
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

15. ¿Alguna vez no toma un baño o una ducha cuando lo necesita?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 16 / VAYA A PREGUNTA 16**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 16 / VAYA A PREGUNTA 16**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 16 / VAYA A PREGUNTA 16**

15a. ¿Con qué frecuencia no toma un baño o una ducha cuando lo necesita? ¿Diría que es solamente a veces o casi todo el tiempo?

Sometimes / A veces 01
Most of the time / Casi todo el tiempo..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

15b. ¿Es esto porque no hay nadie allí para ayudarle?

SONDEO: Por favor incluya cualquier ayuda recibida por otra persona, incluyendo ayuda con asistencia para espera de turno o "standby".

Yes / Sí..... 01
No..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

16. ¿Alguna vez no come una comida cuando lo necesita?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 17 / VAYA A PREGUNTA 17**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 17 / VAYA A PREGUNTA 17**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 17 / VAYA A PREGUNTA 17**

16a. ¿Con qué frecuencia no come una comida cuando lo necesita? ¿Diría que es solamente a veces o es casi todo el tiempo?

Sometimes / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

16b. ¿Es esto porque no hay nadie allí para ayudarle?

SONDEO: Por favor incluya cualquier ayuda recibida por otra persona, incluyendo ayuda con asistencia para espera de turno o "standby".

Yes / Sí..... 01
No..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

17. ¿Alguna vez no toma su medicina cuando la necesita?

SONDEO: “Medicinas” son píldoras o pastillas o líquidos que un médico le da para que usted se sienta mejor.

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 18 / VAYA A PREGUNTA 18**
DON’T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 18 / VAYA A PREGUNTA 18**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 18 / VAYA A PREGUNTA 18**

17a. ¿Con qué frecuencia no toma usted su medicina cuando la necesita? ¿Diría que es solamente a veces o es casi todo el tiempo?

Sometimes / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON’T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

17b. ¿Es esto porque no hay nadie allí para ayudarle?

SONDEO: Por favor incluya cualquier ayuda recibida por otra persona, incluyendo ayuda con asistencia para espera de turno o “standby”.

Yes / Sí..... 01
No..... 02
DON’T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

18. ¿Alguna vez no puede usar el baño cuando necesita hacerlo?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 19 / VAYA A PREGUNTA 19**
DON’T KNOW? NO SABE..... DK ➡ **GO TO QUESTION 19 / VAYA A PREGUNTA 19**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 19 / VAYA A PREGUNTA 19**

18a. ¿Con qué frecuencia usted no puede usar el baño cuando necesita hacerlo? ¿Diría que es solamente a veces o casi todo el tiempo?

Sometimes / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON’T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

18b. ¿Es esto porque no hay nadie allí para ayudarle?

SONDEO: Por favor incluya cualquier ayuda recibida por otra persona, incluyendo ayuda con asistencia para espera de turno o “standby”.

Yes / Sí..... 01
No..... 02
DON’T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

19. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** ¿Alguna vez ha hablado usted con un administrador de casos (“case manager”) o un coordinador de apoyo

("support coordinator") acerca de algún equipo especial o cambios a su hogar para hacer su vida mas fácil?

SONDEO: "Equipo" quiere decir cosas como sillas de ruedas, bastones, camionetas con ascensores, y abrepuertas automático.

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 20 / VAYA A PREGUNTA 20**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 20 / VAYA A PREGUNTA 20**
Not Applicable / No se aplica..... N/A ➡ **GO TO QUESTION 20 / VAYA A PREGUNTA 20**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 20 / VAYA A PREGUNTA 20**

19a. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** ¿De qué equipo o cambios hablaron ustedes?

_____

_____

_____

_____

DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

19b. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** ¿Consiguió el equipo o hizo los cambios que necesitaba?

Yes/ Sí 01
No 02
In Process / en proceso 03
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

20. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** Por favor piense en toda la ayuda que usted recibió durante la última semana *en la casa*, por ejemplo, para cocinar o limpiar. ¿Necesita *más* ayuda con las cosas de la casa que la ayuda que usted recibe ahora?

Yes / Sí 01
No 02
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

21. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** Durante la última semana, ¿algún miembro de la familia o alguna amistad le ayudó con cosas en la casa?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 22 / VAYA A PREGUNTA 22**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 22 / VAYA A PREGUNTA 22**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 22 / VAYA A PREGUNTA 22**

21a. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** Por favor piense en todos los miembros de la familia y amistades que le ayudan. ¿Más o menos por cuántas horas le ayudaron a usted ayer?

SONDEO: La mejor estimación que me puede dar está bien.

Interviewer: if less than one hour, enter 1 hour.
Entrevistador(a): si es menos de una hora, marque 1 hora.

[_____]
Hours / Horas

DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

MODULE 4: RESPECT AND DIGNITY
MÓDULO 4: RESPETO Y DIGNIDAD

NOTE: IF Q14 = NO, DK OR R ➡ **GO TO QUESTION 27**
NOTA: SI LA RESPUESTA A 14 ES "NO", 'DK' O 'R' **> VAYA A PREGUNTA 27**

Interviewer: For questions in this module, refer to your state's policy on reporting any suspected incidents of abuse and neglect. For this survey, record only reports of current abuse.
Entrevistador(a): Para las preguntas en este módulo, refiérase a las normas de su estado acerca de procedimientos para informar de sospechados incidente de abuso y negligencia. Para esta encuesta, anote solamente informes de abuso que está ocurriendo.

22. Usted dijo que tiene personas que le ayudan. ¿Las personas que le ayudan, le tratan a usted en la manera que usted quiere?

Yes / Sí ..... 01 ➡ **GO TO QUESTION 23 / VAYA A PREGUNTA 23**
No 02
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 23 / VAYA A PREGUNTA 23**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 23 / VAYA A PREGUNTA 23**

22a. ¿Con qué frecuencia no le tratan a usted como usted quiere? ¿Diría que es solamente a veces o casi todo el tiempo?

Sometimes / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

23. ¿Las personas que le ayudan escuchan con cuidado a lo que usted pide que hagan?

Yes / Sí ..... 01 ➡ **GO TO QUESTION 24 / VAYA A PREGUNTA 24**
No 02
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 24 / VAYA A PREGUNTA 24**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 24 / VAYA A PREGUNTA 24**

23a. ¿Con qué frecuencia no le escuchan a usted? ¿Diría que es solamente a veces o casi todo el tiempo?

Sometimos / A veces 01
Most of the time / Casi todo el tiempo 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

24. **[Optional] [Opcional]** ¿Alguna vez usted ha sido físicamente lastimado(a) por alguna de las personas que le ayudan ahora?

SONDEO: "Físicamente lastimado(a)" quiere decir que alguien pudo haberle empujado, pateado o dado una bofetada.

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 25 / VAYA A PREGUNTA 25**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 25 / VAYA A PREGUNTA 25**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 25 / VAYA A PREGUNTA 25**

24a. **[Optional] [Opcional]** ¿Qué pasó cuando las personas que le ayudan ahora le lastimaron físicamente?

_____

_____

_____

_____

DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

24b. **[Optional] [Opcional]** ¿Cuántas veces ha sido usted físicamente lastimado(a) por las personas que le ayudan ahora?

SONDEO: La mejor estimación que me puede dar está bien.

[_____]
Times/ Veces

DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

25. **[Optional] [Opcional]** ¿Alguna de las personas que le ayudan ahora le tratan mal o le gritan a usted?

SONDEO: ¿Le tratan a usted en una manera que le hace sentirse mal o que le hieren su sentimientos?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 26 / VAYA A PREGUNTA 26**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 26 / VAYA A PREGUNTA 26**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 26 / VAYA A PREGUNTA 26**

25a. **[Optional**] **[Opcional]** ¿Con qué frecuencia le tratan mal? ¿Diría que es solamente a veces o es casi todo el tiempo?

Sometimos / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

26. **[Optional] [Opcional}** ¿Alguna vez una de las personas que le ayudan ahora ha tomado su dinero o sus cosas sin pedir permiso primero?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 27 / VAYA A PREGUNTA 27**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 27 / VAYA A PREGUNTA 27**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 27 / VAYA A PREGUNTA 27**

26a. **[Optional] [Opcional]** ¿Cuántas veces han tomado su dinero o sus cosas sin pedir permiso primero?

SONDEO: La mejor estimación que me puede dar está bien.

[_____]
Times / Veces

DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

MODULE 5: COMMUNITY INTEGRATION AND INCLUSION
MÓDULO 5: INTEGRACIÓN E INCLUSIÓN EN LA COMUNIDAD

27. Ahora quiero hacerle algunas preguntas acerca de las cosas que usted hace. ¿Puede usted ver a sus amistades y familia cuando quiere verlos?

Interviewer: Code "yes" if respondent indicates that they have either gone to see friends or family or that friends and family have come to visit them.

Entrevistador(a): Marque "sí" si (el/la) respondiente indica que ha ido a visitar a sus amistades o familia o si amistades y familia han venido a visitar (al/ a la) respondiente

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 28 / VAYA A PREGUNTA 28**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 28 / VAYA A PREGUNTA 28**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 28 / VAYA A PREGUNTA 28**

27a. ¿Con qué frecuencia ve usted a sus amistades y familiares cuando usted quiere verlos? ¿Diría que es solamente a veces o es casi todo el tiempo?

Sometimes / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

28. ¿Puede ir a los lugares donde necesita ir, como al trabajo, a hacer compras o a la oficina del médico?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 29 / VAYA A PREGUNTA 29**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 29 / VAYA A PREGUNTA 29**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 29 / VAYA A PREGUNTA 29**

28a. ¿Con qué frecuencia usted puede ir a los lugares donde necesita ir, como al trabajo, hacer compras o ir a la oficina del médico? ¿Diría que es solamente a veces o es casi todo el tiempo?

Sometimes / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

29. ¿Hay alguna cosa que *quiere* hacer fuera de [la facilidad o "facility"/su hogar] y que no puede hacer ahora?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 30 / VAYA A PREGUNTA 30**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 30 / VAYA A PREGUNTA 30**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 30 / VAYA A PREGUNTA 30**

29a. ¿Qué le gustaría hacer que no hace ahora?

_____

_____

_____

_____

DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

29b. ¿Qué necesita para hacer estas cosas?

_____

_____

_____

_____

DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

30. Cuando sale, ¿puede salir solo(a) o necesita ayuda?

Go out Independently / Sale sin ayuda . 01 ➡ **GO TO QUESTION 31 / VAYA A PREGUNTA 31**
Need Help / Necesita ayuda 02
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 31 / VAYA A PREGUNTA 31**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 31 / VAYA A PREGUNTA 31**

30a. Por favor piense acerca de *toda* la ayuda que usted recibió durante la última semana para *poder movilizarse en la comunidad*, tal como ir de compras e ir a una cita médica. Para hacer esto, ¿necesita *más* ayuda de lo que ahora recibe?

Yes / Sí 01
No 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

31. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** ¿Está usted ahora trabajando por pago?

SONDEO: ¿Recibe algún dinero por trabajar?

Yes / Sí ..... 01 ➡ **GO TO QUESTION 32 / VAYA A PREGUNTA 32**
No 02
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 32 / VAYA A PREGUNTA 32**
REFUSED? NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 32 / VAYA A PREGUNTA 32**

31a. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** ¿Quiere usted trabajar por pago?

Yes /Sí..... 01
No..... 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

32. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** ¿Hace usted trabajo voluntario o trabaja sin ser pagado(a)?

SONDEO: ¿Hace trabajo pero no recibe ningún dinero por hacerlo?

Yes / Sí ..... 01 ➡ **GO TO QUESTION 33 / VAYA A PREGUNTA 33**
No 02
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 33 / VAYA A PREGUNTA 33**
REFUSED / NEGÓ DE CONTESTAR ... R ➡ **GO TO QUESTION 33 / VAYA A PREGUNTA 33**

32a. **[AFTER TRANSITION ONLY] [SOLAMENTE DESPUÉS DE LA TRANSICIÓN]** ¿Le gustaría hacer trabajo voluntario o trabajar sin ser pagado(a)?

SONDEO: ¿Le gustaría hacer trabajo sin recibir pago por hacerlo?

Yes / Sí 01
No 02
DON'T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

33. Quisiera hacerle algunas preguntas acerca de cómo usted se moviliza. ¿Sale usted para hacer cosas divertidas en su comunidad?

SONDEO: Estas son cosas que le gustan, tal como ir a la iglesia, al cine o hacer compras.

Yes / Sí 01
No 02
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

34. Cuando usted quiere ir a algún lado, ¿simplemente lo puede hacer o tiene que planificar con muchos días de antemano y pedir que personas le ayuden?

Decide and Go / decide y se va 01
Plan Some / planifica algo 02
Plan Many Days Ahead /planifica con muchos días de antemano..... 03
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R
N/A / NO SE APLICA ……NA

35. ¿No llega a hacer cosas o tiene que cambiar sus planes porque no tiene una forma fácil de movilizarse?

SONDEO: ¿Tiene que dejar de hacer o de ir a cosas porque le es difícil para usted llegar ahí?

Yes / Sí 01
No 02
Sometimes / A veces 03
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

36. Durante el último mes, ¿hay algún servicio o atención medica, como por ejemplo un tratamiento médico o una visita al doctor, que usted no ha recibido o que no podía conseguir?

SONDEO: El servicio médico incluye visitas al doctor o tratamientos médicos que usted pueda necesitar.

Yes / Sí 01
No 02
DON'T KNOW / NO SABE..... DK
REFUSED / NEGÓ DE CONTESTAR .. R

MODULE 6: SATISFACTION
MÓDULO 6: SATISFACCIÓN

37. Tomando todo en consideración, durante la última semana ¿ha estado usted feliz o no ha estado feliz con la ayuda que usted ha recibido para hacer cosas en la casa o para movilizarse en su comunidad?

Happy / Feliz ..... 01 ➡ **GO TO QUESTION 37a / VAYA A PREGUNTA 37a**
Unhappy / No feliz..... 02 ➡ **GO TO QUESTION 37b / VAYA A PREGUNTA 37b**
DON'T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 38 / VAYA A PREGUNTA 38**
REFUSED? NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 38 / VAYA A PREGUNTA 38**

37a. ¿Diría usted que está un poco feliz o muy feliz?

A little happy/ un poco feliz ..... 01 ➡ **GO TO QUESTION 38 / VAYA A PREGUNTA 38**
Very happy / muy feliz..... 02 ➡ **GO TO QUESTION 38 / VAYA A PREGUNTA 38**
Don't Know / No sabe ..... DK ➡ **GO TO QUESTION 38 / VAYA A PREGUNTA 38**
Refused / Negó de contestar .... R ➡ **GO TO QUESTION 38 / VAYA A PREGUNTA 38**

37b. ¿Dirá usted que está un poco infeliz o muy infeliz?

A little unhappy / un poco infeliz..... 01
Very unhappy / muy infeliz 02
Don't Know / No sabe ..... DK
Refused / Negó de contestar ..... R

38. Tomando todo en consideración, durante la última semana ¿ha estado usted feliz o no ha estado feliz con la manera en que vive su vida?

Happy / Feliz	01	➡ **GO TOQUESTION38a / VAYA A PREGUNTA 38a**
Unhappy / No feliz	02	➡**GOTO QUESTION 38b / VAYA A PREGUNTA 38b**
DON'T KNOW / NO SABE	DK	➡ **GO TO QUESTION 39 / VAYA A PREGUNTA 39**
REFUSED / NEGÓ DE CONTESTAR	R	➡ **GO TO QUESTION 39 / VAYA A PREGUNTA 39**

38a. ¿Diría usted que está un poco feliz o está muy feliz?

A little happy / un poco feliz	01	➡ **GO TO QUESTION 39 / VAYA A PREGUNTA 39**
Very happy / muy feliz	02	➡ **GO TO QUESTION 39 / VAYA A PREGUNTA 39**
Don't Know / No sabe	DK	➡ **GO TO QUESTION 39 / VAYA A PREGUNTA 39**
Refused / Negó de contestar	R	➡ **GO TO QUESTION 39 / VAYA A PREGUNTA 39**

38b. ¿Diría usted que está un poco infeliz o muy infeliz?

A little unhappy / un poco infeliz	01
Very unhappy / muy infeliz	02
Don't Know / No sabe	DK
Refused / Negó de contestar	R

MODULE 7: HEALTH STATUS
MÓDULO 7: ESTADO DE SALUD

39. Durante la última semana, ¿se ha sentido triste o melancólico(a)?

Yes / Sí	01	
No	02	➡ **GO TO QUESTION 40 / VAYA A PREGUNTA 40**
DON'T KNOW / NO SABE	DK	➡ **GO TO QUESTION 40 / VAYA A PREGUNTA 40**
REFUSED / NEGÓ DE CONTESTAR	R	➡ **GO TO QUESTION 40 / VAYA A PREGUNTA 40**

39a. ¿Con qué frecuencia diría que se ha sentido triste o melancólico(a)? ¿Diría que es solamente a veces o es casi todo el tiempo?

Sometimes / A veces	01
Most of the Time / Casi todo el tiempo	02
DON'T KNOW / NO SABE	DK
REFUSED / NEGÓ DE CONTESTAR	R

40. Durante la última semana ¿se ha sentido irritable?

SONDEO: "irritable" quiere decir de mal humor o fácilmente molesto(a) por cosas en su vida.

Yes / Sí	01	
No	02	➡ **GO TO QUESTION 41 / VAYA A PREGUNTA 41**
DON'T KNOW / NO SABE	DK	➡ **GO TO QUESTION 41 / VAYA A PREGUNTA 41**
REFUSED / NEGÓ DE CONTESTAR	R	➡ **GO TO QUESTION 41 / VAYA A PREGUNTA 41**

40a. ¿Con qué frecuencia usted se ha sentido irritable? ¿Diría que es solamente a veces o es casi todo el tiempo?

SONDEO: “irritable” quiere decir de mal humor o fácilmente molesto(a) por cosas en su vida.

Sometimes / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON’T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

41. Durante la última semana ha sufrido de dolores?

Yes / Sí 01
No ..... 02 ➡ **GO TO QUESTION 42 / VAYA A PREGUNTA 42**
DON’T KNOW / NO SABE..... DK ➡ **GO TO QUESTION 42 / VAYA A PREGUNTA 42**
REFUSED / NEGÓ DE CONTESTAR .. R ➡ **GO TO QUESTION 42 / VAYA A PREGUNTA 42**

41a. ¿Con qué frecuencia usted ha sufrido de dolores? ¿Diría que es solamente a veces o es casi todo el tiempo?

Sometimes / A veces 01
Most of the Time / Casi todo el tiempo..... 02
DON’T KNOW / NO SABE ..... DK
REFUSED / NEGÓ DE CONTESTAR ..... R

CLOSEOUT
PARA TERMINAR

42. Esas son todas las preguntas que tengo para usted ahora. Nos gustaría hablar con usted en más o menos un año para saber cómo le va. En caso de que tengamos problemas en encontrarle a usted, ¿cuál es el nombre, la dirección y el número de teléfono de un familiar o amistad cercano que no vive con usted y que probablemente va a saber dónde está usted en el futuro? Por ejemplo, puede ser una madre, un padre, un hermano, hermana, tía, tío o amigo(a) íntimo(a).

No Contact Available / No hay ningún contacto ..... 01➡ **GO TO QUESTION 43 / VAYA A PREGUNTA 43**
Contact Available / hay contacto..... 02

42a. Contact Name: _____
Nombre de Contacto:

42b. Contact Street Address: _____
Calle del Contacto:

42c. Contact City: _____
Ciudad del Contacto:

42d. Contact State: _____
Estado del Contacto:

42e. Contact ZIP _____
Código Postal del Contacto:

42f. Contact Phone: _____
Teléfono del Contacto:

43. *Interviewer: Did you complete the interview with the sample member alone, the sample member who was assisted by another, or with a proxy?*

Entrevistador(a): ¿Usted completó la entrevista solamente con (el/la) miembro de la muestra, (el/la) miembro de la muestra fue ayudado por otra persona, o con un(a) apoderado(a) ("proxy")?

Sample Member Alone / Solo con (el/la) *miembro de la muestra* 01
Sample Member with Assistance / con (el/la) *miembro de la muestra* con ayuda 02
Proxy / apoderado(a) 03

44. *Interviewer: Record date the interview was completed:*

Entrevistador(a): Marque la fecha en que la entrevista fue completada.

[_____] [_____] [_____]
Month / Mes Day / Día Year / Año

➡ **END INTERVIEW / FIN DE LA ENTREVISTA**