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MONEY FOLLOWS THE PERSON 101

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Introduction

The *Deficit Reduction Act of 2005* (DRA) made a number of very significant changes to Medicaid's coverage of long-term care services (LTC). For example, states now have the option to provide home and community-based services (HCBS) as a state plan benefit, and also have more authority to allow individuals to self-direct personal care services. Meanwhile, insurance companies were given a boost through the expansion of Medicaid's Long-Term Care Partnership program, which allows certain Medicaid applicants who have purchased LTC insurance policies to keep more of their assets than those who have not. And of course, Medicaid's LTC transfer-of-asset rules, under which individuals are denied coverage for financial gifts made prior to application, were made radically more punitive.

Included within the DRA's lineup of Medicaid LTC changes was the enactment of the Money Follows the Person program (MFP) (§6071 of the DRA), which is designed to help states move Medicaid-enrolled individuals from institutions back to the community. More than \$1.7 billion was authorized for the program, and "grants" to states (in the form of an enhanced federal reimbursement rate for services) were made in a competitive process in which the fed-

eral government selected 31 states in 2007 for participation in the five-year program. During the last several months, states have been submitting their operational protocols to the Centers for Medicare & Medicaid Services (CMS) for approval, and the 2008 calendar year will be the first year of widespread operation of the program.

What follows is a brief overview of the MFP program, including descriptions of the driving forces behind it, the history of federal support for programs similar to it, and the primary challenges states are likely to face in implementation. While the projected number of individuals expected to benefit from the MFP program may be modest, the ultimate success of the program (or lack thereof) will likely have a substantial impact on how Medicaid LTC is delivered in the future, and it is therefore important that advocates be familiar with both the purpose and structure of MFP.

What Exactly is 'Money Follows the Person'?

In the context of LTC, the definition of "money follows the person" might encompass a number of state and federal efforts to help individuals choose where they receive their services.¹ That may change as a result of the DRA,

¹ "Money Follows the Person has several connotations. MFP refers to an overall strategy for appropriating funds in a way that supports the individual's choice of settings." Robert Mollica, Susan Reinhard, Jennifer Farnham & Michael Morris, Rutgers Center for State Health Policy, *Money Follows the Person Toolbox 2* (2006), available at <http://www.cshp.rutgers.edu/cle/Products/MFPToolboxWEB.pdf>.

in which Congress chose to use the phrase as the title for a very specific Medicaid program. This DRA-created program encourages states to *transition* Medicaid-enrolled individuals from institutions to the community, where the individuals will maintain their Medicaid coverage and have it delivered through HCBS programs. Thus, it is their Medicaid coverage that is “following” the Medicaid enrollees from the institution to the community.

States, meanwhile, are provided a financial incentive to transition the individuals from facilities to the community. The federal government matches state Medicaid expenditures under a formula called the federal medical assistance percentage (FMAP). The percentage, which changes annually and varies by state, provides states with at least a 50 percent match for Medicaid services (for FY 2008, Mississippi has the highest match at 76.29 percent). Under MFP, states will receive an *enhanced* match for the HCBS services provided for the first twelve months to each individual transitioned under the program.

CMS chose 31 states for MFP awards and projects that \$1.4 billion will be spent by the federal government during the five years for which the DRA authorized the program (\$300 million less than Congress allocated for the program).² Approximately 37,000 Medicaid beneficiaries will be transitioned from institutions to the community under MFP, with Illinois expecting to transition a high of 3,357 and Delaware a low of 100.

Why MFP?

There is no question that individuals in need of LTC would, on the whole, prefer to receive care at home. Unfortunately, consumer preference has not historically been the main driver in the shaping of Medicaid policy in the LTC arena. Medicaid beneficiaries in need of LTC are entitled only to nursing facility coverage.³ HCBS coverage is strictly a state’s option to provide, and federal law places limits on state HCBS waiver expenditures.⁴ This preference for nursing facility care over community-based is behind what is referred to as Medicaid’s “institutional bias.”

This is beginning to change, as state and federal policymakers begin contemplating how to deliver LTC in the future, in no small part due to the burgeoning aging population.⁵ As things currently stand, Medicaid is already the single largest purchaser of LTC services in the nation, accounting for roughly 49% of national LTC spending.⁶ In 2005, Medicaid paid \$101 *billion* for LTC services, the majority of which was for institutional care (63%).⁷ With the challenges states and the federal government expect to confront in the coming years in meeting demand, they are, not surprisingly, looking for ways to “rebalance” Medicaid LTC expenditures from institutions to the community.

MFP is a manifestation of this effort, and the level of commitment made by Congress in the

² See http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFP_FactSheet.pdf. The grantee states are: Arkansas, California, Connecticut, D.C., Delaware, Georgia, Hawaii, Iowa, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Washington, Wisconsin.

³ 42 U.S.C. §§1396a(a)(10)(A), 1396d(a)(4)(A)

⁴ 42 U.S.C. §1396n(c)(2)(D)

⁵ The change is also motivated by the Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), in which the Supreme Court declared that the unnecessary institutionalization of individuals in public programs may be unconstitutional.

⁶ Georgetown University Long-Term Care Financing Project, *National Spending for Long-Term Care 1(2007)*

⁷ *Id.*

DRA toward the program is a result of the relative success of the transition programs the federal government has been supporting at the state level for several years now. Before looking at the DRA-funded program, here is a brief overview of the pre-DRA programs.

Pre-DRA Federal Support for Transition Programs

In 1998, CMS (then the Health Care Financing Administration, or HCFA) and the federal Office of the Assistant Secretary for Planning and Evaluation (ASPE) created the *Nursing Home Transition Demonstration Program*.⁸ Between 1998 and 2001, the program awarded 12 states grants between \$150,000 and \$500,000 to transition institutionalized individuals to the community, and “permitted states to use grant funds for virtually any direct service or administrative item that held promise for assisting nursing home residents’ return to the community.”⁹ Among other things, states used their grants to: create brochures describing community-based options for individuals at risk of institutionalization; contract with independent living centers to help identify people for transition; create databases for consumers to consult about the transition program; and, most importantly, to help transitioning individuals with transition costs, such as moving expenses, security deposits for

apartments, and furniture and appliance purchases.

One example was Arkansas’ Passages program. Arkansas received a \$500,000 grant in 2000 and established a goal of transitioning 80 individuals.¹⁰ The state contracted with the state Area Agencies on Aging and independent living centers to do outreach and locate individuals eligible for transition. Passages participants had to be Medicaid enrollees¹¹ who did not require 24-hour skilled care and whose community-based costs would not exceed what the state was paying for their nursing facility care.

Two separate sources of financial assistance were available for those eligible. First, each participant was allotted approximately \$1,600 for transition services, including housing deposits, first month’s rent, utility deposits, home modifications, household items, and durable medical equipment. A second stream of funding was established to pay for services for individuals who needed more than the maximum level of Medicaid assistance available in the community, or who returned to the community before being enrolled in one of the HCBS waivers. The state ultimately transitioned 88 individuals back to the community.¹²

Federal support for transition programs continued with CMS’ Real Choice Systems

⁸ See generally Judy Kasper & Molly O’Malley, *Nursing Home Transition Programs: Perspectives of State Officials* (Kaiser Commission on Medicaid and the Uninsured, 2006).

⁹ Michael Schaefer, Steve Eiken, *Passages: Arkansas’s Nursing Home Transition Program 1* (U.S. Department of Health and Human Services 2003).

¹⁰ Id.

¹¹ States had the option to limit participation to Medicaid enrollees, but it was not required.

¹² Reports on other states’ ASPE/HCFA-supported transition programs can be found at <http://aspe.hhs.gov/index.cfm>. Click on “Home and Community-Based Services” and scroll through the reports until you reach December 2003. In addition to the report on the Arkansas program, reports on the programs operated in New Jersey, Colorado, Vermont, Pennsylvania, Florida, Texas, Wisconsin and Michigan are available.

Change Grants.¹³ In 2001 and 2002, 23 states received grants between \$552,000 and \$800,000 under the *Nursing Facility Transitions, State Program*. In 2003, nine states received “Money Follows the Person” grants between \$600,000 and \$700,000. While no two programs were identical, most of them operated in a similar fashion with the Arkansas program outlined above: states established eligibility criteria for the program, which did not always include Medicaid eligibility as a component; transition coordinators—be they staff from independent living centers, state agencies, or other entities—were trained and charged with educating institutionalized residents about community-based options; and financial assistance was provided to help eligible participants transition back to the community.

In addition to the direct federal grants to states to operate transition programs, CMS has provided states the opportunity to receive federal assistance for transition-related programs and/or services through the Medicaid program. For example, CMS issued a “Dear State Medicaid Director” letter in 2002 confirming for states that they could incorporate “community transition services” into their Medicaid HCBS programs, which could include security deposits for leases, essential household furnishings, moving expenses, “set up” fees for utilities, and health and safety assurances, such as pest eradication and a

one-time cleaning.¹⁴ Thus, for a state without a transition grant, or a state with a grant and looking to expand on its transition program, a state could have the federal government cover at least a portion of transition costs by adding “community transition services” to one of its Medicaid HCBS programs.

Additionally, CMS expanded federal reimbursement for state coverage of *targeted case management services*.¹⁵ It is through these services that institutional residents are connected to the benefits, services and other needs they will have in the community. In 2000, CMS informed states that they could receive federal match for targeted case management services provided to institutional residents up to 180 days prior to their transition (although this may soon change¹⁶). CMS also facilitated state transition efforts by making it easier for them to receive federal match for medical equipment purchased for facility residents who were in the process of transitioning.¹⁷

These are the examples of the federal government’s pre-DRA support for transition programs and efforts. In allocating almost \$2 billion in the DRA for the MFP program, Congress substantially increased its investment in rebalancing the delivery of LTC. Below are the specifics and highlights of the new program.

¹³ “Starting in FY 2001, Congress began funding the Systems Change for Community Living Grants Program to help states increase home and community services and to improve their quality.” Janet O’Keefe, et al., *Real Choice Systems Change Grant Program: FY 2001 Nursing Facility Transition Grantees: Final Report Part I-v*, (U.S. Dept. of Health and Human Services 2006). Since 2001, CMS has awarded approximately \$270 million in Real Choice grants to 50 states, D.C., and two U.S. territories. In all, 332 grants have been awarded during seven funding cycles. See <http://www.cms.hhs.gov/realchoice/>.

¹⁴ Dear State Medicaid Director Letter, May 9, 2002, SMDL #02-008, available at <http://www.cms.hhs.gov/smdl/downloads/smd050902a.pdf>

¹⁵ Dear State Medicaid Director Letter, July 25, 2000, available at <http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf>.

¹⁶ On December 4, 2007, CMS published an interim final rule limiting coverage for targeted case management services to 60 days. 72 Fed. Reg. 68077-68093 (Dec. 4, 2007). Effective date of the rule is March 3, 2008, and comments are due on February 4, 2008. It is not clear what the statutory basis for the change is.

¹⁷ Dear State Medicaid Director Letter, July 14, 2003, SMDL #03-006, available at <http://www.cms.hhs.gov/smdl/downloads/smd071403.pdf>.

Money Follows the Person: Program Details

It is important to note that the MFP program is a Medicaid program—the “grants” states receive will be through an enhanced Medicaid FMAP for HCBS services, and all individuals served will be Medicaid beneficiaries. Participation will be limited to individuals who are enrolled in Medicaid and have been institutionalized for not less than six months or more than two years. Once an individual is moved back to the community and is receiving services under a Medicaid HCBS program, he or she will be guaranteed continued HCBS coverage so long as s/he continues to meet Medicaid eligibility requirements and the state continues to operate the HCBS program into which the individual was enrolled upon transition.

Protocols

The 31 states selected for MFP are in the process of submitting their operational protocols (the program blueprints) to CMS for approval before initiating their programs. As of this writing, Wisconsin, Missouri, and New Hampshire have received approval for their protocols. Protocols contain “case study” examples that are designed to illustrate how each state ideally expects its particular program to operate.

For example, Maryland’s proposed protocol contains the hypothetical story of Calvin, a 56-year-old nursing facility resident.¹⁸ Calvin is first visited by what Maryland will call a *peer mentor*, an individual who either successfully transitioned from a facility to the community herself or has helped others transition. The peer mentors are charged in Maryland’s program with educating nursing facility residents through out-

reach, and Maryland will require facilities to allow the mentors to conduct their outreach (the state agency will be sending a letter to each facility at the outset of the program to notify them of this responsibility). The peer mentor tells Calvin about MFP, and once Calvin expresses his interest in the program, the peer mentor makes a referral to Maryland’s *Transition Center*, from which a transition coordinator visits Calvin.

The transition coordinator educates Calvin about Medicaid HCBS programs and his available housing options. She helps him fill out an application for the Medicaid waiver, which she enters in a MFP tracking system. This triggers a financial and clinical eligibility screening for Calvin. He is visited by a nurse working with the state agency who evaluates his needs, and her recommendations are sent to the transition coordinator. The transition coordinator meets with Calvin, and they agree on a plan of care. She also submits on Calvin’s behalf an application for an apartment at a building for aging individuals and persons with disabilities. Calvin is put on a waiting list, and his transition coordinator regularly calls the building for an update on availability.

When an apartment is finally available, Calvin is able to tap into the transition funds that are available to the enrollees of the Maryland Medicaid waiver into which he is being enrolled. The funds pay for his security deposit, utility hookups, furniture, dishes, sheets and towels. As a Maryland MFP participant, Calvin is also able to access supplemental services, including a food card, a transportation fund, and “flexible funds” (up to \$700), which he can use for a number of different purposes. After a year passes, Calvin’s “MFP eligibility expired, but he didn’t notice, since none of his services or supports through the Older Adults Waiver were affected.”

¹⁸ Maryland’s proposed protocol and other state protocols will soon be available on NSCLC’s website.

Issues

The case study examples in the states' operational protocols vary in specificity (the above is a very condensed description of Maryland's operational protocol story on Calvin), although most include information about how outreach is conducted and who is responsible for the outreach, the identity of the transition coordinators, and what services are available to the MFP participants. Most of the important information identified in the case study is fleshed out in greater detail in the protocol. For example, with regard to the peer mentors identified in Calvin's story, Maryland's protocol describes what the state will do to train the peer mentors and what their responsibilities beyond educating prospective MFP participants will be (e.g., conducting annual MFP quality of life surveys).

Public process

Putting aside what the operational protocols contain, it is important to note *how* they should be developed. The MFP statute mandates that states engage in a "public process" in the development of their MFP program, and most states have organized MFP "stakeholder" or "steering committee" groups made up of agency representatives, consumers, consumer advocates, provider groups, and others.

Information relating to the public process is described in the protocols. For example, Connecticut, Kentucky and Maryland identify the specific individuals on the states' stakeholder/steering committees (which collectively include individuals from legal aid organizations, protection and advocacy organizations, AARP, the Alzheimer's Association, Medicaid HCBS waiver participants, and LTC ombudsman representa-

tives). New Hampshire, meanwhile, identified the groups represented on the stakeholder group and listed the dates and locations of the public forums held on MFP.

Federal law requires that the MFP public process not be limited to the development of the program, so consumers and advocates interested in participating in the process should contact the state's MFP project coordinator to learn more about the state's stakeholder committee and any upcoming public meetings.

Housing

Locating affordable, accessible housing is expected to be one of the biggest challenges facing consumers in the implementation of state MFP programs. "Organizations with experience helping people move to the community almost always identify the lack of accessible, affordable housing as the primary barrier to relocation."¹⁹ Indeed, the challenge is so significant that the U.S. Department of Housing and Urban Development (HUD) has involved itself in the issue. HUD sent a letter to the state housing authority directors of MFP states in August 2007 requesting that the directors submit to HUD their strategies for helping implement MFP.²⁰

States are employing different strategies to ensure that housing is available for MFP participants. For example, Connecticut will be contracting with a third party to develop a web-based housing registry that will include an inventory of affordable and accessible housing, and will also provide state-funded housing subsidies to MFP participants. The transition center Maryland will be contracting with will include housing specialists who will work with transitioning individuals. Maryland also plans to

¹⁹ Robert Mollica, Susan Reinhard, Jennifer Farnham & Michael Morris, Rutgers Center for State Health Policy, *Money Follows the Person Toolbox 33* (2006), available at <http://www.cshp.rutgers.edu/cle/Products/MFPToolboxWEB.pdf>.

²⁰ Letter from U.S. Dept. of Housing and Urban Development Secretary Alphonso Jackson to executive directors, July 9, 2007.

hire a statewide housing consultant, and will provide “bridge rent” to certain individuals with developmental disabilities. Kentucky’s MFP program will be contracting with the state’s housing corporation for three housing coordinators, while Virginia will be working with a housing “task force” that will develop a housing “action plan” that will be used throughout the demonstration. Many states are also incorporating environmental home modification services into their HCBS waivers, or will be providing them specifically to MFP participants.

Time will tell which strategy proves most effective at helping transitioning individuals move into housing that is at least suitable to their needs, if not to their liking. In Maryland’s protocol, Calvin is asked by his transition coordinator to file applications with multiple housing units after his transition is delayed by a waiting list at his first choice of residence. Meanwhile, Texas mentions in its proposed protocol that, without additional funding from HUD, it may be hard for it to meet the housing demand of the MFP population. The housing issue will clearly be one of the most closely monitored developments in MFP.

Nursing Facility Cooperation

Some nursing facilities may look at the successful transition of an individual as a loss of a “customer,” which probably explains why facilities have not been uniformly supportive of transition programs. A number of states that received pre-DRA transition grants reported a lack of nursing facility cooperation,²¹ and the problem even became a crisis in Maryland. “In response to the refusal of several nursing homes to allow Center for Independent Living staff to meet with its residents, the State enacted a law (generally

referred to as the *Nursing Home Access Act*) requiring nursing facilities to allow advocates and case managers to discuss transition options with nursing facility residents.”²² Maryland, as noted above, intends to notify nursing facilities of their responsibility to provide access to the peer mentors in the state’s MFP program.

Other states also address the issue in their protocols. New Hampshire, for example, notes the lack of nursing facility “buy in” during previous transition operations and how the state addressed it. “The strategy that eventually proved effective with the Nursing Home Transition Project was that of engaging Nursing Home management/staff in one-on-one meetings to explain the program and quell fears of lost NF revenue.” Virginia has included “institutional providers” in most of its public committees, including its stakeholder “Leadership Committee,” and notes that institutional providers will in fact “assist in disseminating educational and marketing materials to individuals residing in your facilities...”

Other Issues

Certainly, CMS’ proposed constriction in states’ discretion to cover targeted case management services (see above) appears counterproductive. In its 2000 letter to states, CMS prefaced the information on the 180 day coverage states could provide by saying, “[S]hort term [nursing facility] stays often become long-term residence when complicated planning is required for a return home, special housing or housing modification needs to be arranged, or exceptional one time expenses need to be paid. *This attachment explains several means by which Medicaid may assist States to overcome these barriers to community transition.*”²³ (emphasis provided)

²¹ Janet O’Keefe et al., *Real Choice Systems Change Grant Program: FY 2001 Nursing Facility Transition Grantees: Final Report Part I-14* (U.S. Department of Health and Human Services 2006).

²² *Id.*

²³ Dear State Medicaid Director Letter, July 25, 2000, available at <http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf>.

CMS did not allege in its proposed interim final rule that 60 days worth of targeted case management coverage has proved sufficient for transitions, and cutting by two-thirds coverage for a service that the agency itself has recognized as being critical to the facilitation of transitions may very well undermine transition efforts.

There may also be issues relating to HCBS eligibility. For example, CMS recently informed New York that it could not extend the federal law's spousal impoverishment protections (42 U.S.C. §1396r-5) to the community spouses of medically needy HCBS enrollees. These protections ensure that the spouses of individuals in need of LTC do not have to go into poverty in order for the frail spouse to attain Medicaid coverage for expensive LTC services. Federal law mandates that states must extend the protections to the community spouses of institutionalized Medicaid enrollees, and provides states the discretion to extend them to the spouses of HCBS enrollees.

New York has historically provided the protections to all spouses of HCBS enrollees. However, when it submitted its Nursing Home Transition and Diversion waiver for approval in 2006, it was informed by CMS that the agency had changed its position, and is prospectively reading the federal law to limit the protections to only those spouses of HCBS enrollees whose income is within a certain limit.²⁴

The restrictions CMS now wants to place on state discretion in both targeted case management services and spousal impoverishment protections is ironic, given the federal government's own view of what is necessary to facilitate rebal-

ancing. In 2002, the U.S. Department of Health & Human Services declared that eliminating the institutional bias in HHS programs was in part dependent on giving "greater flexibility for states ...under Medicaid Home and Community-Based Care waivers."²⁵

Other issues are likely to surface. The challenges raised and addressed by the protocols are generally ones that are anticipated based on states' experiences in the smaller transition programs they ran under the prior federal grants. With the significant increase in funding, unanticipated problems are likely to surface.

Summary

Transitioning 37,000 individuals in the next five years from facilities to the community is a laudable goal, but there may be just as many new institutional admissions during the same time period, maybe more. Transitioning certainly is critical to rebalancing LTC, but so is institutional *diversion*, whereby individuals facing a need for LTC are able to line up services either before an institutional stay becomes necessary or very shortly thereafter. In 2007, the Administration on Aging awarded 12 states diversion grants of \$500,000 each,²⁶ but these amounts obviously pale in comparison to the MFP transition awards, and a similar investment in diversion may be necessary if the rebalancing goal is to be attained. For now, MFP is where the investment is, and with 2008 being the first year of implementation, advocates should begin helping clients gain access to the program and monitoring state progress.

²⁴ NSCLC has issued a memorandum opposing CMS' position on this issue. It is available on NSCLC's website.

²⁵ U.S. Dept. of Health and Human Services, *Delivering on the Promise: Self-Evaluation to Promote Community Living for People with Disabilities*. April 21, 2002.

²⁶ See http://www.aoa.gov/PRESS/pr/2007/September/9_24_07.asp