**Chapter 1:**

# Revisiting the Money Follows the Person Qualified Residence Criteria

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## Key Points

- The Money Follows the Person (MFP) demonstration, first authorized by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), has provided participating states with flexibility and enhanced funding to support over 100,000 Medicaid beneficiaries in transitioning from institutions to the community.
- MFP is one of numerous federal and state efforts to serve more people with disabilities in the community, which affirms their civil rights as set forth in the Americans with Disabilities Act (P.L. 101-336, as amended) and the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).
- Under the demonstration, states can help individuals transition into community settings that meet specific criteria. These so-called qualified residence criteria, defined in the DRA, have not changed since MFP's inception.
- The MFP qualified residence criteria differ from standards governing settings that receive Medicaid home- and community-based services (HCBS) payment, which were defined in the HCBS settings rule, published in 2014. Although MFP qualified residences must meet the requirements of the rule, a broader range of settings are eligible for Medicaid HCBS payment.
- In the Consolidated Appropriations Act, 2021 (P.L. 116-260), Congress directed MACPAC to submit a report identifying settings available to beneficiaries in MFP and sites in compliance with the HCBS settings rule. This chapter represents MACPAC's response to this mandate.
- To understand the trade-offs of maintaining the current criteria, we reviewed data on MFP transitions, conducted a survey of state MFP program directors, and conducted stakeholder interviews. We heard strong arguments on both sides of the issue.
  - Maintaining the existing MFP qualified residence criteria keeps the demonstration's focus on small and highly integrated community settings, which best support the civil rights and preferences of people with disabilities.
  - Aligning the qualified residence criteria with the HCBS settings rule could open up more settings to be eligible for MFP transitions and give states more choices to offer beneficiaries who want to transition to the community.
- After lengthy discussion of the advantages and disadvantages of the existing MFP qualified residence criteria and potential implications of changes, the Commission concluded that there was not enough empirical data to guide a decision on whether MFP qualified residence criteria should be aligned with the HCBS settings rule. Ultimately, a decision on this issue reflects a value judgment about the most appropriate use of MFP funds.

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Rebalancing, the shift in Medicaid spending on long-term services and supports (LTSS) from institutional services to home- and community-based services (HCBS), has been a federal and state policy goal for several decades. Rebalancing is a component of decades-long efforts to serve more people with disabilities in the community, where most people prefer to receive services. Rebalancing also affirms the civil rights of people with disabilities as set forth in the Americans with Disabilities Act (ADA, P.L. 101-336, as amended) and the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999). The federal government has supported rebalancing through several initiatives, including the Money Follows the Person (MFP) demonstration. First authorized by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), MFP has provided participating states with flexibility and enhanced funding to support over 100,000 Medicaid beneficiaries in transitioning from institutions to the community (Liao and Peebles 2020).

MFP supports participant transitions from institutions into specific settings as defined in the DRA. These qualified residence criteria have not changed since the demonstration's inception. MFP qualified residence criteria are narrower than those permitted for payment of Medicaid HCBS more generally. As described in the HCBS settings rule, finalized by the Centers for Medicare & Medicaid Services (CMS) in 2014, eligible HCBS settings are distinct from institutional settings and facilitate community integration, and are defined by the nature and quality of individuals' experiences rather than solely by the physical location (CMS 2014a). Thus, although MFP qualified residences must meet the requirements of the rule, a broader range of settings are eligible for Medicaid HCBS payment.[1]

In the most recent bill reauthorizing MFP, the Consolidated Appropriations Act, 2021 (CAA, P.L. 116-260), Congress directed MACPAC to submit a report that does the following:

- "identifies the types of home and community-based settings and associated services that are available to eligible individuals in both the MFP demonstration program and sites in compliance with the HCBS final rule; and
- if determined appropriate by the Commission, recommends policies to align the criteria for a qualified residence under subsection (b)(6) (as in effect on October 1, 2017) with the criteria in the HCBS final rule."

This chapter represents MACPAC's response to this mandate. Our analysis and conclusions are based on the following:

- review of data on MFP transitions, including the settings into which participants transitioned;
- a survey of state MFP program directors regarding their views on whether the MFP qualified residence criteria have been a barrier to transitions and whether they should be aligned with the settings rule; and
- interviews with stakeholders, including states, beneficiary advocates, provider organizations, and researchers, to understand the trade-offs of changing the MFP qualified residence criteria.

After lengthy discussion of the advantages and disadvantages of the existing MFP qualified residence criteria and potential implications of changes, the Commission concluded that there was not enough empirical data to guide a decision on whether MFP qualified residence criteria should be aligned with the HCBS settings rule. While our review revealed trade-offs of maintaining the current criteria, ultimately a decision regarding the criteria for qualified residences reflects a value judgment about the most appropriate use of MFP funds.

This chapter begins with background on MFP, including data on the settings into which participants transition, and the HCBS settings rule. It then reviews the differences between MFP qualified residences and settings eligible for Medicaid HCBS payment under the settings rule.

We then discuss stakeholder perspectives on the existing criteria, incorporating our survey results and themes from stakeholder interviews. Many advocates and a few states supported maintaining the existing criteria, saying they set a high bar by supporting transitions into the most integrated settings possible and avoid some of their concerns about settings that may be permitted under the HCBS settings rule. Others, however, said that changing the criteria would allow for more transitions, and it would be easier to administer compared with having two sets of criteria. We end the chapter by highlighting several additional concerns we heard from stakeholders about MFP operations and describing the type of information that would support future assessments of MFP.

## Historical Context for MFP

In considering the role and design of MFP, it is useful to understand how it fits into decades-long efforts to change how people receive LTSS. Deinstitutionalization, the shift to serving individuals with disabilities in the community rather than in institutions, began in the 1950s due to concerns about the high rates of individuals with severe mental illness living in public mental health facilities, the poor living conditions in such institutions, and the civil rights of individuals who are institutionalized (Parks and Radke 2014). In the 1960s, new funding was provided to increase mental health resources and services in the community, and the movement to deinstitutionalize expanded to include individuals with intellectual or developmental disabilities (ID/DD).

From the early 1970s until the 1990s, statutory changes, court decisions, and advocacy efforts to support community-based care for individuals with mental illness and ID/DD led to the closure of large state mental hospitals and large state facilities for people with ID/DD, reducing the number of individuals receiving care in large institutions (ACL 2017, Bagenstos 2012, Frontline 2005). The enactment of the ADA on July 26, 1990, marked a noteworthy change in civil rights law by prohibiting discrimination against individuals with disabilities in employment and public accommodations.

After the passage of the ADA, cases involving the institutionalization of individuals with disabilities who could be served in the community became a major area of litigation against states (Butler 2000). One of these cases, *Olmstead v. L.C.*, reached the Supreme Court, which ruled in 1999 that the unjustified institutionalization of individuals with disabilities violated the ADA. The ruling was based on two conclusions. First, the institutionalization of individuals with disabilities who can live in community settings perpetuates the unwarranted assumption that such persons are not able to live in a community. Second, the ruling noted that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." In *Olmstead*, the court concluded that states must provide treatment for individuals with disabilities in the most integrated setting possible if the individuals are not opposed, and such placement is appropriate and can be reasonably accommodated by the state.

Since then, rebalancing efforts in Medicaid have worked to uphold the *Olmstead* decision by providing beneficiaries with services in the community. These efforts have also included support for HCBS infrastructure such as the Real Choice Systems Change grant program, Balancing Incentive Program, nursing facility diversion programs, and investments in transitions out of institutions to the community such as through MFP.

## MFP demonstration

It is in the context of deinstitutionalization and federal efforts to support rebalancing that MFP was to assist beneficiaries who want to move out of institutions into their own homes or small community-based settings by providing states with incentives to assist with their transitions. The DRA authorized MFP through fiscal year (FY) 2011, and it has since been extended through FY 2023 by a series of legislative actions.[2] Funds that go unspent in their award year can be used for four additional fiscal years. The most recent MFP funds provided in the CAA must be awarded to grantees by September 30, 2023; therefore, these funds are available through FY 2027.

The DRA specified the goals of the MFP demonstration as the following:

- rebalancing—that is, increasing the use of HCBS relative to institutional LTSS;
- eliminating barriers or mechanisms that prevent Medicaid beneficiaries from receiving LTSS in the settings of their choice;
- assuring continuity of service for beneficiaries who transition from institutional to community settings; and
- providing for quality assurance for services received through the demonstration.

State participation in the MFP demonstration is voluntary, and to participate, states must submit an application to CMS describing how they will implement the two primary program components: (1) a program to assist in transitioning qualified beneficiaries residing in institutions back to the community; and (2) a rebalancing strategy aimed at strengthening the state's overall ability to provide HCBS, in line with the goals specified in the DRA. As part of the application process, states project the number of beneficiaries to be transitioned annually and describe the services available as part of the demonstration.

From 2007 to 2012, CMS awarded MFP grants to 44 states and the District of Columbia that went on to launch transition programs (CMS 2019a).[3] MFP awards for these states ranged from $7.4 million in South Dakota to $398 million in Texas.[4] Two additional states (Florida and New Mexico) withdrew from the demonstration before serving any beneficiaries (CMS 2019a). In recent years, some states have phased out their programs given uncertainty about funding; as of 2021, 33 states and the District of Columbia were still participating (MACPAC 2022).

For a one-year period after their last day of institutionalization, MFP participants receive services designed to support their transition to the community. Some of these services are beyond what would have been available in the state's existing waiver or state plan programs (Table 1-1). MFP services fall into three categories:

- qualified HCBS are services that states already provide in their HCBS waiver programs;
- demonstration HCBS are those that states do not provide under their existing waiver programs but that are allowable Medicaid services or are existing services that states choose to expand only for MFP participants; and
- supplemental services are one-time or limited-duration services that help facilitate transitions to the community (e.g., a security deposit) (Lipson and Williams 2009).

As participants use HCBS, states earn an MFP-enhanced federal medical assistance percentage (FMAP) for some services.[5] The difference between what the state receives at the higher matching rate and its regular rate must be invested into a state rebalancing strategy that is intended to increase use of HCBS relative to institutional care, and states must set benchmarks for how progress will be measured.[6] States may also use awards to cover MFP administrative costs, including IT infrastructure investments needed to meet MFP reporting requirements (Irvin et al. 2017). As noted earlier, funds that go unspent in their award year can be used for four additional fiscal years.

**TABLE 1-1.** Money Follows the Person Demonstration Transition Services

| Service type | Definition | Service examples | Funding |
|---|---|---|---|
| Qualified HCBS | Services that beneficiaries would receive regardless of participation in MFP because they are covered under existing HCBS waivers or in the state plan | Personal assistance services | MFP-enhanced FMAP |
| Demonstration HCBS | Allowable Medicaid services not currently included in the state's HCBS programs<br><br>HCBS above what is available to non-MFP participants in the state | Assistive technologies<br><br>24-hour personal care | MFP-enhanced FMAP |
| Supplemental services | One-time or limited-duration services that facilitate an easier transition to the community | Beneficiary trial visit to the proposed community residence<br><br>Security deposit payment | Grant funded at a rate commensurate with a state's FMAP |

**Notes:** HCBS is home- and community-based services. MFP is Money Follows the Person. FMAP is federal medical assistance percentage. The amount of the increased FMAP varies by state and is equal to the state's regular FMAP plus 50 percent of the difference between the regular FMAP and 100 percent (not to exceed 90 percent).

**Source:** MACPAC analysis of Irvin et al. 2017, O'Malley Watts et al. 2015, and Lipson and Williams 2009.

## Eligible beneficiaries and residences

For a transition to be eligible for MFP, beneficiaries must have been residents of an institution for at least 60 consecutive days.[7] Requests and referrals for such assistance may be prompted by anyone acting on the beneficiary's behalf, including but not limited to beneficiaries, their families, advocates, case managers, and nursing facility social workers (Irvin et al. 2017). Some states use the Minimum Data Set, an assessment provided to all nursing home residents, to identify residents who want counseling on how to transition to the community, which may include participation in MFP (Irvin et al. 2017).

Transition coordinators and other staff identified by the state work with the beneficiary to develop a plan for the services they will need to successfully live in the community and to identify a qualified community residence. By statute, an MFP qualified residence is defined as the following:

- "(A) a home owned or leased by the individual or the individual's family member;
- (B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and
- (C) a residence, in a community-based residential setting in which no more than 4 unrelated individuals reside."

The definition of a home owned or leased by the individual or a family member is straightforward, but the definition of an apartment has required further clarification as it relates to assisted living. In 2009, CMS released guidance describing conditions that apartments in assisted living settings must meet to be MFP qualified residences (CMS 2009). For example, the guidance clarifies that to qualify for MFP, apartments must have living, sleeping, bathing, and cooking areas. The guidance also describes

certain terms that must be included in the lease and a requirement that MFP participants have a choice of providers for authorized Medicaid services that are not included in the service rate to the assisted living setting (CMS 2009).

As one advocate who was active in the discussions leading to the creation of MFP told us, the demonstration's specific, concrete criteria were designed to allow beneficiary rather than provider control. Living in one's own home provides individuals with the most privacy and dignity, as it provides them with the most control over their lives. Those living in their own homes have the most choice in terms of who provides their care, when to come and go, whether to have roommates, and when to eat, among other things. Some congregate settings, such as assisted living facilities or group homes, provide some degree of community integration but also come with some restrictions. For example, residents in group homes may encounter additional rules around mealtimes and bedtimes, mandatory participation in group activities and outings, further restrictions on how and when they can leave, and little choice in staffing or roommates.

## MFP accomplishments

As of December 2019, MFP had transitioned 101,540 individuals over the course of the demonstration (Liao and Pebbles 2021). Of these:

- 36,625 (36.1 percent) were people age 65 and older;
- 38,961 (38.4 percent) were people with physical disabilities;
- 16,199 (16.0 percent) were people with ID/DD;
- 7,436 (7.3 percent) were people with mental illness; and
- 2,319 (2.3 percent) belonged to some other transition group (Liao and Peebles 2020).[8]

At the state level, cumulative transitions ranged from 143 in Maine to 13,207 in Ohio (Appendix 1A). The distribution of transitions by population also varied across states. States participating in MFP must select target groups for their MFP transition programs, so state variation and the absence of transitions for certain populations may reflect these decisions.

**Tracking transitions over time.** The number of MFP transitions declined from 2016 to 2019, with a small increase in transitions in 2020 (Table 1-2).[9] The decline, which was steepest from 2018 to 2019, coincided with the expected sunset of MFP under which states could use funds to transition beneficiaries through the end of 2018.

Subsequently, Congress authorized new funding several times, most recently under the CAA, which

**TABLE 1-2.** Money Follows the Person Demonstration Transitions, 2015–2021

| Year | Number of states reporting transitions | Number of transitions |
|---|---|---|
| 2015 | 41 | 8,340 |
| 2016 | 40 | 9,040 |
| 2017 | 39 | 7,803 |
| 2018 | 38 | 6,286 |
| 2019 | 36 | 4,417 |
| 2020 | 34 | 4,730 |
| 2021 | 34 | 4,624 |

**Source:** MACPAC, 2022, analysis of Transformed Medicaid Statistical Information System (T-MSIS) data from the Centers for Medicare & Medicaid Services.

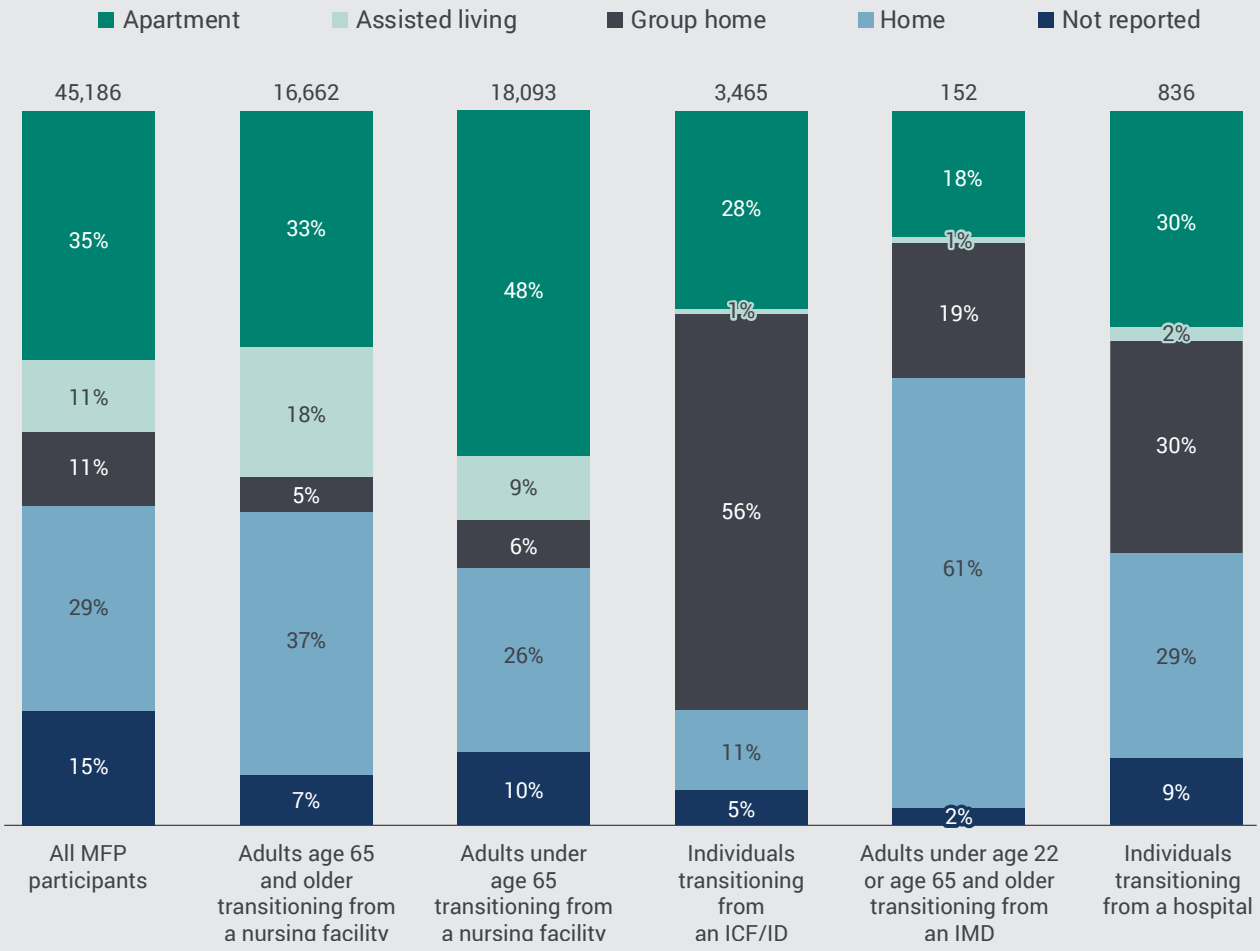
**Note:** State counts include the District of Columbia.

authorized funding through FY 2023. The short-term approach to funding extensions created uncertainty for states. For example, by the time the Medicaid Extenders Act of 2019 (P.L. 116-3) was enacted in January 2019, some states had already terminated their MFP transition programs.

In 2020, 34 states reported transitioning at least one beneficiary, compared with 41 in 2015.[10] Some states are considering reactivating their programs, so that figure may change.

**Transitions by setting.** From 2015 through 2021, nearly two-thirds (64 percent) of MFP participants transitioned to an apartment or home (Figure 1-1). Only 22 percent of participants were transitioned to congregate settings such as group homes or assisted living.

**FIGURE 1-1.** Money Follows the Person Participant Residences after Transitions, by Population, 2015–2021




**Notes:** MFP is Money Follows the Person. ICF/ID is intermediate care facilities for people with intellectual disabilities. IMD is institutions for mental diseases. Numbers may not add to 100 due to rounding. Excludes 54 individuals age 22 to 64 identified as having transitioned from IMDs, which may have reflected coding errors.

**Source:** MACPAC, 2022, analysis of Transformed Medicaid Statistical Information System (T-MSIS) data from the Centers for Medicare & Medicaid Services.

## Equity in MFP participation

Data about the racial and ethnic characteristics of MFP participants are incomplete. The most recent demographic data on MFP was missing race and ethnicity data for about 54 percent of transitions, making it difficult to draw conclusions about enrollment (Appendix 1B). In the 2015 annual report on MFP, evaluators compared the population of individuals eligible for MFP from a sample of 17 states to those who actually transitioned through the program in 2008, 2010, and 2012 (Irvin et al. 2017). Among adults age 65 and older, people of color were somewhat more represented among MFP participants than they were in the eligible population.

# Comparing MFP with the HCBS Settings Rule

The HCBS settings rule was published in 2014, nine years after MFP was authorized, and sets a threshold for all residential and non-residential settings that receive any HCBS payment (CMS 2014a).

## Overview of the HCBS settings rule

Before the 2014 rule, few specific federal requirements existed for HCBS settings receiving Medicaid payment. The HCBS settings rule is intended to ensure that HCBS settings are distinct from institutional settings and facilitate community integration. The rule defines settings by the nature and quality of individuals' experiences rather than solely by their physical location.

Under the rule, beneficiaries who use HCBS should have the same degree of access to employment, control of personal resources, and engagement in community life as others in the community (CMS 2014a). The settings rule laid out qualities of eligible settings for HCBS (Box 1-1). Settings that are eligible for payment under Section 1915(c) waivers and Sections 1915(i) and 1915(k) state plan options must comply with the rule. In addition, CMS has indicated that it will include these requirements in the terms and conditions of Section 1115 demonstration waivers (CMS 2014b). CMS has extended the deadline to fully implement the rule multiple times (initially set at March 17, 2019, and extended most recently to March 17, 2023) due to the complexity of the undertaking and competing state priorities, including responding to the COVID-19 pandemic (CMS 2020).

The rule requires that each state submit a statewide transition plan to CMS describing how the state would assess HCBS settings for compliance with these requirements and how non-compliant settings would be brought into compliance. As of February 2022, 21 states had received final CMS approval of their statewide transition plans (CMS 2022). The rest have submitted a transition plan but are still working with CMS to address certain issues. Among the states with approved plans, most allow providers to self-assess their settings (MACPAC 2019). These provider self-assessments are supplemented by site visits, case manager reviews, or interviews of participants to validate their results. Activities to bring providers into compliance include providing guidance and technical assistance or implementing corrective action plans (MACPAC 2019).

The implementation process includes an additional step for certain settings. In March 2019, CMS released guidance describing the factors that the agency will use to determine whether a setting is presumed to have institutional qualities (CMS 2019b). These settings will be ineligible for Medicaid HCBS payment after March 17, 2023, unless those potential qualities are sufficiently mitigated and the state demonstrates the setting adheres to the regulatory criteria. States can demonstrate that these settings remain eligible for HCBS payment through the heightened scrutiny process, in which CMS evaluates justifications provided by each state. If a setting has isolating factors, but the state determined it complied by July 1, 2021, the state does not have to submit that setting to CMS for heightened scrutiny. States

were requested to submit an evidence package for settings that had not already completed remediation by October 31, 2021 (CMS 2020). Evidence packages for settings located in the same building as a public or private institution, or on the grounds of or adjacent to a public institution providing inpatient treatment, were requested to be submitted by March 31, 2021. Evidence packages must include information such as how a setting's policies and procedures support individuals' access to the community (CMS 2019b).

Some HCBS providers may choose not to comply with the settings rule. For example, assisted living facilities that serve few Medicaid beneficiaries may not wish to invest in the substantial changes that

## **BOX 1-1.** Qualities of Eligible Settings under the Medicaid Home- and Community-Based Services Settings Rule

The Medicaid home- and community-based services (HCBS) settings rule requires settings to have qualities that promote community integration based on an individual's needs as indicated in the person-centered service plan required under the same regulation. Under the rule, eligible settings:

- are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community;
- are selected by the individual among a variety of settings;
- ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- optimize individual autonomy in making life choices, including activities of daily living and environment and with whom to interact; and
- facilitate individual choice in services and providers.

If a residential setting is provider owned or controlled, it must do the following:

- consist of a specific, physical place that can be owned, rented, or occupied under a legally enforceable agreement, which provides the same responsibilities and protections from evictions that tenants have under the laws of the jurisdiction;
- give individuals privacy in their sleeping or living units;
- provide individuals with freedom and support to control their schedules and activities, including having food available at any time;
- allow individuals to have visitors of their choice at any time;
- be physically accessible to the individual; and
- support modifications of the first four conditions above with an assessed need, which is justified and documented in the person-centered service plan, which must also contain additional information regarding this modification.

**Source:** 42 CFR 441.301

might be needed to comply. In such cases, states must assist beneficiaries in transitioning to new settings or fund their services through state-only funds. The statewide transition plans describe how states will approach such transitions. For example, the approved plan for the District of Columbia describes its notification process and the policy governing transitions, indicating that individuals have the right to choose their new provider, and transitions will be completed using a person-centered process (DCDDS 2018).

### Differences in criteria for settings under MFP and the HCBS settings rule

MFP qualified residence criteria predate the HCBS settings rule, and the two sets of requirements differ substantially. All settings that qualify for MFP transitions must meet the requirements of the HCBS settings rule, as MFP participants all receive Medicaid-covered HCBS. However, the HCBS settings rule has a broader definition, and therefore, many qualified HCBS settings do not meet the MFP criteria.

In general, the HCBS settings rule permits a broader range of settings to receive HCBS payment, compared with those permitted under MFP. For example, a group home with five to eight beds may be permitted under the settings rule but would be disqualified from MFP transitions. An assisted living setting could also qualify for HCBS payment by having access to food at any time but would not meet MFP criteria if residents do not have their own cooking area.

## Stakeholder Perspectives on the MFP Qualified Residence Criteria

There are no data to compare costs or outcomes between MFP qualified residences and other settings that are eligible for HCBS payment. Thus, our assessment of the trade-offs of retaining or making changes to the qualified residence criteria is largely informed by stakeholder perspectives. For the purposes of our inquiry, we wanted to understand what factors beneficiaries, state and federal officials, providers, and researchers considered most important in determining whether the residence criteria should be aligned with the settings rule.

Thus, from June to August 2021, we fielded a survey of state MFP program directors regarding their perspectives on the MFP qualified residence criteria.[11] From August to October 2021, we also conducted 29 stakeholder interviews, talking with federal officials, state Medicaid officials, advocates, providers, and researchers. We selected states based on their varying experiences and perspectives on the qualified residence criteria as indicated through their responses to our survey. Stakeholders included organizations representing individuals with ID/DD, behavioral health conditions, and people age 65 and older, as well as providers.[12]

### Opinions on the residence criteria

Just over half of the 28 MFP program directors who responded to our survey (53.6 percent) reported that the qualified residence criteria were a barrier to transitions, 42.9 percent said they were not a barrier, and 3.6 percent were unsure. When asked to comment on whether this had been an issue for particular populations, respondents noted problems for the following:

- assisted living (five respondents);
- people with behavioral health conditions (four respondents); and
- people with a criminal background (two respondents).

When asked to comment on additional settings that should be permitted to make it easier for them to

transition participants, five responses made some reference to raising the existing four-person limit.

A large majority (71.4 percent) of MFP project directors supported aligning the MFP qualified settings criteria with the HCBS settings rule. This included some individuals who had not cited it as a barrier to transitions. Another 3.6 percent said it should be expanded but only to certain residences that qualify under the HCBS settings rule, 7.1 percent said the criteria should not be changed, and 17.9 percent were unsure.

In our interviews, stakeholders had mixed opinions on whether the qualified residence criteria should be changed to match the HCBS settings rule standards. Stakeholders were about evenly split on this question, and interviewees of the same type did not neatly separate into groups with the same perspective.

Those in favor of maintaining the current qualified residence criteria in MFP cited three key reasons. First, they preferred how the criteria have clear, enforceable requirements, such as having a lock on one's door and an individual lease. Second, the MFP settings meet a higher bar than other HCBS settings. These stakeholders said that this higher bar could incentivize states to shift their HCBS programs toward smaller settings that meet the qualified residence criteria. Although some interviewees acknowledged that this higher standard could limit the settings available for MFP transitions, they viewed it as a necessary limitation to improve HCBS and meet the goals of the MFP program. Third, some stakeholders said that the four-bed limit was a necessary restriction because quality of life may be better in smaller settings because of more opportunities for integration into the community and choice in activities.

Stakeholders who were in favor of alignment also cited three key reasons. First, some stakeholders said having a single, uniform definition of HCBS would prevent confusion or operational challenges. Second, some stakeholders thought the more flexible criteria of the settings rule would maximize transition opportunities. A few states predicted that they could make more MFP transitions if the requirements were aligned to match the more flexible settings rule, particularly around the four-bed limit and assisted living rules. Third, some interviewees said that the settings rule allows for more choice for people with disabilities than the MFP qualified residence criteria. These interviewees said that if a setting met the needs of an individual's person-centered plan, then it should be permitted under MFP. These interviewees also discussed settings that are not MFP qualified residences, such as farmsteads and intentional communities, arguing that these settings should qualify for MFP transitions if they are remediated after heightened scrutiny.

A few interviewees commented that the criteria should be aligned only under certain conditions or for certain parts of the criteria. For example, one researcher said that if MFP is permanently integrated into Medicaid statute rather than remaining a demonstration, then the criteria should align to minimize confusion. Others said that if the settings rule is implemented with more specific guidance as to which settings qualify, then MFP should be aligned with it. Other stakeholders commented that the four-bed limit was arbitrary, noting that five beds might be more financially feasible with no real difference in the beneficiary experience.

## Dissatisfaction with the HCBS settings rule implementation

Dissatisfaction with the settings rule implementation made some wary of changing the qualified settings criteria. With the settings rule implementation still in progress, some interviewees said their stance on aligning the MFP criteria with the settings rule was influenced by how the settings rule is being implemented. Multiple stakeholders said that more oversight from CMS was needed, sharing concerns that unless CMS specifically rejects certain settings, those that do not meet the principles of the settings rule

would continue to be eligible for payment, such as assisted living facilities located on the same campus as nursing facilities. Under the HCBS settings rule, these settings may receive HCBS payment if they meet its standards; however, disability advocates shared concerns that such settings do not provide meaningful integration into the community. For example, larger group homes may not allow for as much autonomy as small group homes due to the need to accommodate the schedules and preferences of many residents. Interviewees noted that states assessing their own HCBS settings without specific federal guidance would lead to weaker enforcement. A few stakeholders predicted that the lack of clarity on which settings qualify under the settings rule would lead to states making different decisions about similar settings. Federal officials said that the settings rule should provide individuals with the opportunity to move to the most integrated setting available.

### Assisted living transitions

The qualified residence criteria limit MFP transitions to assisted living in some states. Stakeholders cited two parts of the guidance as limiting transitions: full kitchens and individual leases. For example, one state said that the required full kitchen was a barrier, as some assisted living settings in that state provide residents with only a refrigerator and microwave but would otherwise qualify for MFP. Assisted living providers said that the individual lease requirement under MFP may not be an adequate measure of community integration, as whether individuals have individual leases does not necessarily determine whether they have their own space and can make their own decisions. Providers noted that the requirements for assisted living may prevent some people from transitioning into settings that would meet their care needs.

However, aspects of the guidance are already routine for assisted living providers in some states. Not all states cited the MFP qualified residence criteria as a barrier to transitioning beneficiaries to assisted living. Some states told us they regularly use assisted living as an MFP residence. For example, one state said that the lock requirements were already standard for assisted living in that state.

### Varying criteria across types of participants

Most stakeholders did not see the need to differentiate MFP residence criteria for different types of individuals. Many interviewees acknowledged that some settings were more ideal for specific populations—for example, assisted living for people age 65 and older and group homes for people with ID/DD. However, most stakeholders did not feel strongly that the residence criteria need to reflect this variation. Several interviewees said that ideally, MFP transitions are person centered, so different guidance for different populations is not necessary.

## Assessing the Advantages and Disadvantages of the MFP Qualified Residence Criteria

After reviewing the results of our analytic work, the Commission discussed varying views on aligning MFP residence criteria with the HCBS settings rule but concluded that there was not enough empirical data to guide such a decision. Ultimately, this decision reflects a value judgment about the most appropriate use of MFP funds.

As we heard from stakeholders, there are a number of advantages and disadvantages to the current MFP criteria, which we revisit in the following sections. Both maintaining the existing criteria or aligning them with the HCBS settings rule come with trade-offs between expanding the number of residences available for new transitions and

changing the focus of MFP away from small settings that optimize beneficiaries' control over their everyday lives.

## Rationale for retaining the existing criteria

The existing criteria best support the civil rights of people with disabilities affirmed by *Olmstead v. L.C.* by focusing on small and highly integrated community settings. Several stakeholders we interviewed said this focus incentivized states to shift their HCBS systems more generally toward smaller residences, which are also the types of residences that research suggests are preferred by most beneficiaries (Binette and Vasold 2018). Individuals living in their own homes or a family home have the greatest community living and choice outcomes across HCBS settings (Houseworth et al. 2018, Friedman 2019). Group homes with fewer residents offer more autonomy and community integration than larger group homes (Bradley 2015). Assisted living facilities vary substantially in terms of how much choice is offered to beneficiaries, and the MFP qualified residence criteria create a standard to ensure that beneficiaries have privacy and choice in their care, making their experience less institutional.

CMS has recognized person-centeredness as a key principle of HCBS in the settings rule, meaning that policy should ensure that beneficiaries have the choice of services they receive as well as a choice to receive services in the setting that works best for them (CMS 2014a). However, some advocates we spoke with were skeptical of how strictly CMS is implementing the HCBS settings rule to ensure that settings are integrated into the community. Given this concern, they said MFP should continue to set a higher bar for transitions that earn increased funding through the grant.

If an individual wants to move into a setting that qualifies under the HCBS settings rule but not MFP, such as certain assisted living facilities, other Medicaid authorities may be used to assist in their transition. States can build transition services into authorities such as Section 1915(c) waivers, 43 percent of which we found included transition services as of March 2020, and Section 1115 demonstrations, 79 percent of which include transition services (MACPAC 2020). Transition services offered through other authorities do not have additional restrictions on eligible residences for transition and will follow the HCBS settings rule. Thus, these may be services states can use to transition individuals who cannot be transitioned through MFP due to the residence criteria or for other reasons, such as not meeting the length of stay requirement. States can also use rebalancing funds earned through MFP to support transitions outside the MFP program. For example, one state we interviewed uses MFP rebalancing funds to support transitions out of institutions for mental diseases (IMD), which are ineligible for MFP transitions due to the IMD exclusion.

Person-centeredness also encompasses the choice of how to live. The MFP qualified residence criteria specify settings in which individuals can make their own choices about how to live their lives rather than have those choices made by a provider. This right is guaranteed by the ADA and the *Olmstead* decision. Interviewees shared the positive outcomes they have seen from beneficiaries afforded this autonomy, such as gaining employment, becoming involved in their communities, and living in integrated settings long term.

Additionally, by incentivizing certain residences and providing MFP rebalancing funds, the MFP program assists states in building the infrastructure necessary to make HCBS available to additional beneficiaries. For example, some state officials shared that through MFP, they had built relationships with state housing authorities to connect beneficiaries with housing assistance, and other state officials shared that they used the MFP rebalancing funds for capital investments in affordable housing.

## Rationale for aligning the MFP qualified residence criteria with the HCBS settings rule

There are also strong arguments for aligning the MFP qualified settings criteria with the HCBS settings rule to increase transitions and expand the demonstration's reach. Because the settings rule generally permits a broader range of settings, aligning the criteria could open up more settings to be eligible for MFP transitions and give states more choices to offer beneficiaries who want to transition to the community. For example, removing MFP's current four-person limit would allow transitions to a wider range of congregate settings. One state also noted that the requirement for a full kitchen was a barrier to using assisted living facilities for MFP transitions. Two stakeholders noted that settings such as farmsteads and intentional communities, if they can be shown not to be isolating and otherwise meet the settings rule criteria, could be appropriate settings for MFP transitions. In each of these cases, residences would have to meet the requirements of the settings rule around choice and community integration.

Stakeholders in favor of aligning the MFP qualified settings criteria with the settings rule also noted that a single set of criteria would be easier for state implementation. One state told us that being able to align definitions across stakeholders, including contractors and managed care plans, would be beneficial as all parties would be working from a common understanding. Streamlining definitions would also mean that instead of splitting transition services across multiple authorities, states could focus on MFP as the main funding stream and use a single set of program rules. Having one funding stream for transitions could, for example, simplify administration so that states use one set of rules for claiming federal funds.

# Other Concerns about MFP

In the course of our work, stakeholders raised other concerns about MFP, unrelated to the qualified residence criteria.

## Other factors that affect MFP transitions

Housing affordability and accessibility are major challenges for states as they seek to transition people through MFP. Because Medicaid cannot generally pay for housing outside a nursing or other medical facility, individuals transitioning to the community often need additional assistance to cover rent and maintenance costs. One state shared that it had successfully collaborated with state housing authorities to address this issue. Another state discussed using its MFP rebalancing fund to provide rental assistance.

Similarly, HCBS workforce capacity is a challenge to transitions. Multiple states mentioned that smaller settings, such as group homes of four beds, are more difficult to staff because they need more staff per person than in a larger facility. The providers we talked to emphasized that the workforce shortage limited their ability to serve people in the community. Advocates and providers noted that low HCBS payment rates, even during the one-year period of increased funds through MFP, limited how much they could pay HCBS workers.

The length of stay requirement was also cited as a barrier to transitioning individuals through MFP. The length of stay requirement for MFP transitions was recently shortened from 90 to 60 days by the CAA, a change viewed positively by most of those we interviewed. First, shortening the length of stay helps states serve more people. Second, many interviewees noted that the longer someone is in an institutional setting, the more difficult it is to transition them back to the community. During long stays, beneficiaries may have lost their housing

and community supports and may need to relearn skills for living independently. Although some stakeholders advocated for further shortening the length of stay, others noted that by doing so, MFP may be used to transition beneficiaries who would have been able to transition relatively easily without the additional assistance.

## Funding uncertainty

The uncertainty of MFP funding caused challenges for states in operating the demonstration. All the states that we interviewed shared that short-term funding extensions and uncertainty about the future caused problems retaining MFP staff and maintaining connections with community-based organizations and providers that help facilitate transitions. For example, we heard that in one state, the transition specialist team shrunk from 10 to 4 due to the funding uncertainty.[13] As one state official pointed out, the end of MFP's current funding in 2023 is quickly approaching and states will soon need to make decisions about the future of MFP.

## Lack of recent evaluation data

The last evaluation report for MFP covers the period through 2015. Since then, relatively little information has been made available about MFP's outcomes. CAA funded new evaluations that are forthcoming. This information would be useful in understanding how MFP has worked in recent years, in identifying opportunities for improvement if the demonstration is to be continued beyond FY 2023, and for understanding how it might be incorporated into existing HCBS programs if it ends. In particular, information on the demographic characteristics of MFP participants would be useful to understanding if MFP is reaching a representative range of beneficiaries. In addition, surveys of beneficiary satisfaction after transition might help identify where attention should be focused as the MFP program evolves.

# Endnotes

[1] The HCBS settings rule will be fully implemented March 17, 2023.

[2] MFP was first authorized in the DRA through FY 2011. It was subsequently extended by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), Medicaid Extenders Act of 2019 (P.L. 116-3), Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136), and CAA.

[3] States that received MFP grants and had MFP participants were Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin. Oregon withdrew from the program in 2010 after transitioning individuals to the community and rescinded its MFP grant (Liao and Peebles 2020, CMS 2019a).

[4] This excludes $595,839 awarded to New Mexico, which did not make any MFP transitions.

[5] The amount of the increased match varies by state and is equal to the state's regular match plus 50 percent of the difference between the regular match and 100 percent, not to exceed 90 percent.

[6] States used MFP funding to implement a variety of systems changes, many of which benefit individuals not eligible for MFP transitions, such as those who have resided in an institution for fewer than 90 days. In 2015, at least 29 grantee states reported having transition programs for individuals who did not meet MFP eligibility criteria, and 12 had formal transition programs for individuals residing in intermediate care facilities for individuals with ID/DD (Irvin et al. 2017).

[7] This was reduced from six months in the DRA to 90 days in the ACA and again to 60 days in the CAA.

[8] Percentages do not add to 100 due to rounding.

[9] We obtained unpublished data on recent MFP transitions directly from CMS. These data are from the Transformed Medicaid Statistical Information System (T-MSIS) and may differ somewhat from CMS publications based on MFP-specific data files; for example, a report on transitions in 2019 differs by about 250 transitions from what we report here (Liao and Peebles 2020).

[10] The quality of state-reported MFP data in T-MSIS varies and could differ from what states report in their MFP semiannual reports because of data quality, timeliness of T-MSIS data submissions, or other reasons.

[11] We also asked state MFP program directors about the status of their MFP transition programs and their state's implementation of the settings rule. Twenty-eight of the 42 program directors (67 percent) contacted responded to the survey. Four respondents had terminated their programs, and one had terminated but was considering rejoining. We kept responses from the terminated programs as they reflect their past experience; moreover, these states could possibly rejoin MFP.

[12] Interviewees included federal officials from the Administration for Community Living and CMS; state officials from Connecticut, Iowa, Minnesota, North Carolina, North Dakota, and Ohio; state association representatives from ADvancing States and the National Association of State Directors of Developmental Disabilities Services; beneficiary advocates and advocacy organizations, including Access Living, AARP, Autism Speaks, Autistic Self Advocacy Network, Bazelon Center for Mental Health Law, Justice in Aging, Kansas ADAPT, National Health Law Program, Serena Lowe, The Arc, Together for Choice, and Voice of Reason; provider associations, including the American Health Care Association/National Center for Assisted Living, American Network of Community Options and Resources, and LeadingAge; and researchers Ari Ne'eman, Carol Irvin, and Joe Caldwell.

[13] Although states participating in MFP were required to submit plans describing how they would sustain staffing, transition services, and structural changes after the demonstration's intended sunset, our interviews suggest that some states struggled to maintain MFP during short-term extensions (O'Malley Watts et al. 2015).

# References

Administration for Community Living (ACL), U.S. Department of Health and Human Services. 2017. History of the DD Act. Washington, DC: ACL. https://acl.gov/about-acl/history-dd-act.

Bagenstos, S.R. 2012. The past and future of deinstitutionalization litigation. Public law and legal theory working paper series, working paper no. 265. *Cardozo Law Review* 34, no. 1: 1–59. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2005301.

Binette, J., and K. Vasold. 2018. *Home and community preferences: A national survey of adults age 18-plus*. Washington, DC: AARP Research, August 2018. https://doi.org/10.26419/res.00231.001.

Bradley, V. 2015. *Housing for people with intellectual and developmental disabilities: How do we ensure a home of their own?* Alexandria, VA: Human Services Research Institute. https://www.nationalcoreindicators.org/upload/presentation/Housing_NASDDDS_final.pdf.

Butler, N. 2000. "In the most appropriate setting": The rights of mentally disabled individuals under the Americans with Disabilities Act in the wake of Olmstead V.L.C. *Catholic University Law Review* 49, no. 4: 1021–1052. https://scholarship.law.edu/cgi/viewcontent.cgi?article=1391&context=lawreview.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022. Statewide transition plans. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/hcbs/transition-plan/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Letter from Calder Lynch to state Medicaid directors regarding "Home and community-based settings regulation—implementation timeline extension and revised frequently asked questions." July 14, 2020. Baltimore, MD: CMS. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20003.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019a. Total MFP grant awards and initial award dates. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2020-01/mfp-grant-awards-12162019.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. Letter from Chris Traylor to state Medicaid directors regarding "Home and community-based settings regulation—heightened scrutiny." March 22, 2019. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014a. Medicaid program; state plan home and community-based services, 5-year period for waivers, provider payment reassignment, and home and community-based setting requirements for Community First Choice and home and community-based services (HCBS) waivers. Final rule. *Federal Register* 79, no. 11 (January 16); 2948-3039. https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014b. Questions and answers—1915(i) state plan home and community-based services, 5-year period for waivers, provider payment reassignment, setting requirements for Community First Choice, and 1915(c) home and community-based services waivers—CMS 2249-F and 2296-F. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2019-12/final-q-and-a.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2009. *Policy guidance: Addendum housing qualified residence (B) apartment with an individual lease.* Baltimore, MD: CMS.

Coughlin, R., J. Ward, N. Denny-Brown, et al. 2017. *Money Follows the Person demonstration: Overview of state grantee progress, January to December 2016.* Cambridge, MA: Mathematica Policy Research. https://www.mathematica.org/publications/money-follows-the-person-demonstration-overview-of-state-grantee-progress-january-to-december-2016.

District of Columbia Department on Disability Services (DCDDS). 2018. Statewide transition plan. Washington, DC: DDS. https://dds.dc.gov/publication/statewide-transition-plan-clean.

Friedman, C. 2019. Deinstitutionalization or transinstitutionalization?: Residence type, personal outcomes, and people with IDD. Towson, MD: The Council for Quality Leadership. https://www.c-q-l.org/resources/articles/deinstitutionalization-or-transinstitutionalization-residence-type-personal-outcomes-and-people-with-idd/.

Frontline. 2005. Deinstitutionalization: A psychiatric "Titanic." Public Broadcasting Service, May 10. https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

Houseworth, J., R. Tichá, J. Smith, and R. Ajaj. 2018. *Policy research brief: Developments in living arrangements and choice for persons with intellectual and developmental disabilities*. Minneapolis, MN: University of Minnesota, Institute on Community Integration. https://ici.umn.edu/products/prb/271/#Cover.

Irvin, C., A. Bohl, K. Stewart, et al. 2017. *Money Follows the Person 2015 annual evaluations report*. Washington, DC: Mathematica. https://www.medicaid.gov/sites/default/files/2019-12/mfp-2015-annual-report.pdf.

Liao, K., and V. Peebles. 2020. *Money Follows the Person: State transitions as of December 31, 2019*. Washington, DC: Mathematica. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2019-transitions-brief.pdf.

Lipson, D., and S.R. Williams. 2009. *Implications of state program features for attaining MFP transition goals.* Cambridge, MA: Mathematica Policy Research. https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/MFPTransitionGoalsJun26.pdf

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022. Analysis of Transformed Medicaid Statistical Information System (T-MSIS) data from the Centers for Medicare & Medicaid Services.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. *Compendium of Medicaid home- and community-based services waiver waiting list administration.* August 2020. Washington, DC: MACPAC. https://www.macpac.gov/publication/compendium-of-medicaid-home-and-community-based-services-waiver-waiting-list-administration/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. *Implementation of the home- and community-based services settings rule.* December 2019. Washington, DC: MACPAC. https://www.macpac.gov/publication/implementation-of-the-home-and-community-based-services-settings-rule/.

O'Malley Watts, M., E.L. Reaves, and M. Musumeci. 2015. *Money Follows the Person: A 2013 state survey of transitions, services, and costs.* Washington, DC: Kaiser Family Foundation. http://kff.org/medicaid/report/money-follows-the-person-a-2013-survey-of-transitions-services-and-costs/.

Parks, J., and A.Q. Radke. 2014. *The vital role of state psychiatric hospitals.* Alexandria, VA: Medicaid Directors Council, National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014(2).pdf.

# APPENDIX 1A: Money Follows the Person Transitions by Population and State

**TABLE 1A-1.** Money Follows the Person Transitions by Population and State, Cumulative through 2019

| State | Total | Share of total MFP participants | | | | |
|---|---|---|---|---|---|---|
| | | Adults age 65 and older | Individuals with a physical disability | Individuals with intellectual or developmental disabilities | Individuals with mental health conditions | Other |
| **Total** | **101,540** | **36.1%** | **38.4%** | **16.0%** | **7.3%** | **2.3%** |
| Alabama | 354 | 73.4 | 26.6 | 0.0 | 0.0 | 0.0 |
| Arkansas | 899 | 18.4 | 30.5 | 51.1 | 0.1 | 0.0 |
| California | 4,290 | 31.8 | 38.9 | 25.2 | 2.1 | 2.0 |
| Colorado | 581 | 6.7 | 39.6 | 8.8 | 10.0 | 34.9 |
| Connecticut | 5,754 | 44.8 | 40.5 | 5.4 | 9.3 | 0.0 |
| Delaware | 328 | 35.4 | 53.4 | 8.8 | 2.4 | 0.0 |
| District of Columbia | 319 | 43.6 | 23.2 | 33.2 | 0.0 | 0.0 |
| Georgia | 4,328 | 21.6 | 57.4 | 15.1 | 5.9 | 0.0 |
| Hawaii | 733 | 57.6 | 40.4 | 2.0 | 0.0 | 0.0 |
| Idaho | 665 | 39.1 | 36.1 | 19.5 | 5.3 | 0.0 |
| Illinois | 3,177 | 25.0 | 30.9 | 10.2 | 33.9 | 0.0 |
| Indiana | 2,130 | 56.5 | 29.2 | 5.2 | 9.1 | 0.0 |
| Iowa | 769 | 0.0 | 0.0 | 87.0 | 0.0 | 13.0 |
| Kansas | 1,728 | 24.4 | 56.4 | 15.9 | 0.0 | 3.3 |
| Kentucky | 760 | 29.3 | 31.1 | 26.7 | 1.3 | 11.6 |
| Louisiana | 3,109 | 44.2 | 39.4 | 16.3 | 0.0 | 0.0 |
| Maine | 143 | 39.2 | 42.7 | 0.0 | 0.0 | 18.2 |
| Maryland | 3,466 | 46.7 | 40.8 | 9.6 | 0.0 | 2.9 |
| Massachusetts | 2,151 | 46.6 | 44.9 | 2.5 | 6.0 | 0.0 |
| Michigan | 2,979 | 49.3 | 50.7 | 0.0 | 0.0 | 0.0 |
| Minnesota | 614 | 12.4 | 14.5 | 7.7 | 8.0 | 57.5 |
| Mississippi | 616 | 23.9 | 35.9 | 39.8 | 0.5 | 0.0 |

**TABLE 1A-1.** (continued)

| State | Total | Share of total MFP participants | | | | |
|---|---|---|---|---|---|---|
| | | Adults age 65 and older | Individuals with a physical disability | Individuals with intellectual or developmental disabilities | Individuals with mental health conditions | Other |
| **Total** | **101,540** | **36.1%** | **38.4%** | **16.0%** | **7.3%** | **2.3%** |
| Missouri | 1,981 | 28.5 | 48.9 | 20.5 | 0.0 | 2.0 |
| Montana | 168 | 34.5 | 38.7 | 12.5 | 14.3 | 0.0 |
| Nebraska | 677 | 46.7 | 39.7 | 10.3 | 0.0 | 3.2 |
| Nevada | 424 | 34.7 | 58.5 | 6.8 | 0.0 | 0.0 |
| New Hampshire | 308 | 40.6 | 39.3 | 4.9 | 1.0 | 14.3 |
| New Jersey | 2,943 | 33.9 | 33.5 | 32.6 | 0.0 | 0.0 |
| New York | 3,946 | 29.6 | 31.0 | 15.6 | 0.0 | 23.7 |
| North Carolina | 1,190 | 27.9 | 31.3 | 40.8 | 0.0 | 0.0 |
| North Dakota | 490 | 23.3 | 41.4 | 31.2 | 0.0 | 4.1 |
| Ohio | 13,207 | 16.5 | 32.0 | 14.9 | 36.6 | 0.0 |
| Oklahoma | 800 | 20.1 | 40.4 | 39.1 | 0.0 | 0.4 |
| Oregon[1] | 306 | 34.3 | 47.1 | 16.3 | 0.0 | 2.3 |
| Pennsylvania | 3,625 | 54.5 | 29.1 | 10.0 | 0.0 | 6.5 |
| Rhode Island | 426 | 59.9 | 40.1 | 0.0 | 0.0 | 0.0 |
| South Carolina | 157 | 56.1 | 43.9 | 0.0 | 0.0 | 0.0 |
| South Dakota | 176 | 18.8 | 46.0 | 35.2 | 0.0 | 0.0 |
| Tennessee | 4,940 | 50.3 | 45.0 | 4.7 | 0.0 | 0.0 |
| Texas | 13,114 | 38.5 | 37.8 | 23.7 | 0.0 | 0.0 |
| Vermont | 421 | 71.3 | 28.7 | 0.0 | 0.0 | 0.0 |
| Virginia | 1,433 | 18.0 | 20.2 | 61.8 | 0.0 | 0.0 |
| Washington | 8,505 | 49.9 | 41.1 | 7.4 | 1.6 | 0.0 |
| West Virginia | 399 | 43.4 | 56.6 | 0.0 | 0.0 | 0.0 |
| Wisconsin | 2,011 | 41.0 | 47.7 | 11.2 | 0.0 | 0.0 |

**Notes:** MFP is Money Follows the Person. Numbers may not add to 100 due to rounding.

[1] Oregon ended MFP transitions in 2010 and rescinded its MFP award.

**Source:** MACPAC, 2022, analysis of Liao and Peebles 2020.

# APPENDIX 1B: Demographic Characteristics of Money Follows the Person Participants

**TABLE 1B-1.** Characteristics of Cumulative Money Follows the Person Participants, 2008 to 2015

| Characteristics | Number of MFP participants |
|---|---|
| **Total** | **61,047** |
| **Target population** | |
| People age 65 and older | 31.1% |
| People with physical disabilities | 40.0 |
| People with intellectual disabilities | 13.9 |
| People with psychiatric conditions | 1.3 |
| Other | 3.9 |
| **Race and ethnicity** | |
| White, non-Hispanic | 30.3 |
| Black, non-Hispanic | 11.9 |
| Asian American | 0.6 |
| Hispanic | 3.0 |
| American Indian or Alaska Native | 0.4 |
| Other or unknown | 0.1 |
| Missing | 53.7 |
| **Age group** | |
| Younger than 21 | 5.1 |
| 21–44 | 14.2 |
| 45–64 | 43.8 |
| 65–84 | 29.9 |
| 85 and older | 7.0 |
| **Gender** | |
| Female | 50.3 |
| Male | 49.6 |

**Note:** MFP is Money Follows the Person. Numbers may not add to 100 due to rounding. Does not include data for Minnesota, South Dakota, and West Virginia due to data limitations.

**Source:** Coughlin et al. 2017.