MFP Benchmarks
1) Transition 5200 people from qualified institutions to the community
2) Increase dollars to home and community based services
3) Increase hospital discharges to the community rather than to institutions
4) Increase probability of returning to the community during the six months following nursing home admission
5) Increase the percentage of long term care participants living in the community compared to an institution

Benchmark 1: Total Transitions = 5,671
Demonstration = 5,298 (94%)
Non-demonstration = 373 (6%)

Benchmark 2
CT Medicaid Long-Term Care Expenditures

Benchmark 3
Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility

Benchmark 4
Percent of SNF admissions returning to the community within 6 months

Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions

Participants happy with the way they live their life

* Indicates statistically significant differences
Total Number of Referrals Assigned to the Field by Year

![Graph](image1)

Note: Excludes nursing home closures

Total Number of Transitions by Year

![Graph](image2)

Referrals Assigned to the Field by Quarter

![Graph](image3)

Number of Transitions by Quarter

![Graph](image4)
Participants who are Working and/or Volunteering (cumulative data 12/2008-present)

Participants under age 65 who are working and those who would like to work

- Currently working: 3%, 4%, 6%
- Not working and don't want to work: 56%, 56%, 61%
- Not working but want to work: 44%, 44%, 39%

Participants 65 years and older who are working and those who would like to work

- Currently working: 0.6%, 1%, 1%
- Not working and don't want to work: 84%, 85%, 84%
- Not working but want to work: 16%, 15%, 16%

Participants under age 65 who are volunteering and those who would like to volunteer

- Currently volunteering: 6%, 8%, 8%
- Not volunteering and don't want to volunteer: 66%, 66%, 69%
- Not volunteering but want to volunteer: 34%, 34%, 31%

Participants 65 years and older who are volunteering and those who would like to volunteer

- Currently volunteering: 4%, 4%, 4%
- Not volunteering and don't want to volunteer: 82%, 84%, 85%
- Not volunteering but want to volunteer: 18%, 16%, 15%

Qualified Residence Type for Transitioned Referrals: 12/4/08 to 6/30/19

- Apartment Leased By Participant, Not Assisted Living: 72%
- Home Owned By Family Member: 14%
- Home Owned By Participant: 10%
- Group Home No More Than 4 People: 2%
- Apartment Leased By Participant, Assisted Living: 2%
MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed by Timepoint (cumulative through 06/30/19)

**Baseline** interviews done prior to transition, n=5463

**6 month** interviews done 6 months after transition, n=4407

**12 month** interviews done 12 months after transition, n=4018

**24 month** interviews done 24 months after transition, n=2907

*Indicates statistically significant differences*
Challenges to Transition as noted by TCs and SCMs

Transition Challenges for Participants Referred in 2018

- Physical health: 17.1%
- Mental health: 14.1%
- Services/supports: 18.6%
- Housing: 13.6%
- Consumer engagement: 10.3%
- Financial issues: 9.3%
- Waiver/HCBS: 2.4%
- Facility related: 3.8%
- Legal issues: 5.0%
- Other involved individuals: 2.6%
- MFP office/TC: 2.7%
- Other challenges: 0.5%
- Other involved individuals: 2.6%
Types of Challenges for Referrals: 1/1/2018-12/31/2018
Below are the six most common challenge types from 2018

**Physical health**
- Current, new or undisclosed physical health problem
- Inability to manage physical disability or physical illness in community
- Medical testing issues or delays
- Missing or waiting for physical health documents
- Other physical health issues

**Mental health**
- Current or history of substance/alcohol abuse w/ risk of relapse
- Current, new, or undisclosed mental health problem
- Dementia or cognitive issues
- Inability to manage mental health in community
- Other mental health issues

**Housing**
- Delays related to housing authority, agency or housing coordinator
- Delays related to lease, landlord, apartment manager, etc.
- Needs housing modifications before transition
- Ineligible or waiting for approval from RAP or other housing programs
- Lacks affordable, accessible community housing
- Housing related legal, criminal or credit issues, including evictions or unpaid rent
- Other housing related issues

**Consumer engagement**
- Disengagement or lack/loss of motivation
- Lack of awareness or unrealistic expectations
- Lack of independent living skills
- Language or communication skills
- Other consumer related issues

**Services and supports**
- Lack of alcohol, substance abuse, or addiction services
- Lack of AT or DME
- Lack of mental health services or supports
- Lack of PCA, home health, or other paid support staff
- Lack of transportation
- Lack of any other services or supports
- Lack of unpaid caregiver to provide care/informal support
- Other issues related to services or supports

**Financial**
- Consumer credit or unpaid bills
- Lack of or insufficient financial resources
- SSDI, SSI, SAGA, SSA, VA or other cash benefits
- Medicaid eligibility or insurance issues
- Other financial benefits or issues
- Other financial challenge
Participants changed mind

Wouldn’t cooperate w/ care planning

Transitioned before informed consent signed

COP/Guardian refused participation

Exceeds physical health needs

Reinstitutionalized for 90+ days

Exceeds mental health needs

Not aware of referral

Moved out of state

Other

Closure Reason by Year of Closure

*Excludes NH closure and Chelsea/Touchpoints Manchester mass referrals of 12/23/16 or later

Comparison of Closures, Referrals and Transitions per Quarter
Doug Lagasse’s Story

Doug Lagasse is a goal setter and hard worker. He worked in the service and sales industries for over twenty years. He achieved the height of success, owning his home and his car. But he worked over twelve hours per day, ate for convenience, and did not prioritize exercise, social events and family time. Things changed two years ago when his lifestyle caught up with him and an illness put Doug in the hospital for a lengthy stay. When he was in the hospital, he was unable to walk. Doug knew he needed rehab and went to a nursing home.

His time in the nursing home lasted longer than he expected. He went from being financially and physically independent to being waited on and reliant on staff. He says being at the nursing home is “not reality when you’re there, they do everything for you. You get used to the level of care and you don’t have to ‘adult’. It’s easier for them to leave someone in bed then to get them up, bathe and dress. It’s easier for them to just let [residents] chill. I got up and fought every day. I went to recreation and tried to keep myself occupied because otherwise I’d melt into the background like everybody else.”

Doug was lucky to have a social worker (SW) at the nursing facility who suggested the Money Follows the Person (MFP) program to him. “[While in the hospital] I had lost my house and everything in it, the only place I had to live was [the nursing facility].” The SW thought he would be a good candidate for MFP and worked with him directly to introduce the MFP team. The first time he met his care manager she spent two hours laying out a transition plan including a goal analysis for his physical and mental progress and outlining the program. He says the care manager gave him a lot of direction and encouraged him to pursue life in the community again. The housing coordinator found him an apartment immediately: “The housing search was non-existent. That’s how good [the housing coordinator] was.” Because Doug had lost everything while he was at the nursing facility, he had no possessions. His transition coordinator provided him with “everything they thought I needed to get started. It was a big help.” He adds, “Without the program, I would have figured it out, but it wouldn’t have been solid. I have a home now.”

When he first moved into his apartment, Doug used the local paratransit service to attend doctor’s appointments and other community events. However, he now is able to drive his own car in the community. Doug has lost over 150 lbs since leaving the nursing facility. He attributes much of his success to a membership at a local wellness center where he uses the pool. Doug estimates that he swims for about four hours a day, five times a week (including water aerobics, laps and walking). Doug says his exercise routine not only has strengthened his weight loss goals but also is beneficial to his mental and emotional health. He says he never thought he would be able to go to a public pool but his goals keep him focused. At home, Doug focuses on his hobbies like playing guitar and singing.

Doug says his mental health has improved significantly since settling into his apartment. “The program has been an amazing tool to get back on my feet. Without the help I would have gotten out of the hospital and failed and ended up back at the hospital and it would have been a revolving door. Now I can move forward.” Doug looks forward to losing weight in the future. He doesn’t have a number in mind but knows he wants to feel good. “I now have a path to success instead of a path to failure. MFP helped me in ways that allow me to focus on my health and get better. I don’t want to stay disabled forever.”

MFP Demonstration Background

The Money Follows the Person Rebalancing Demonstration, created by Section 6071 of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), supports States’ efforts to “rebalance” their long-term support systems. The DRA reflects a growing consensus that long-term supports must be transformed from being institutionally-based and provider-driven to person-centered and consumer-controlled. The MFP Rebalancing Demonstration is a part of a comprehensive coordinated strategy to assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems.

One of the major objectives of the Money Follows the Person Rebalancing Demonstration is “to increase the use of home and community based, rather than institutional, long-term care services.” MFP supports grantees to do this by offering an enhanced Federal Medical Assistance Percentage (FMAP) on demonstration services for individuals who have transitioned from qualified institutions to qualified residences. In addition to this enhanced match, MFP also offers states the flexibility to provide Supplemental Services that would not ordinarily be covered by the Medicaid program (e.g. home computers, cooking lessons, peer-to-peer mentoring, transportation, additional transition services, etc.) that will assist in successful transitions. States are then expected to reinvest the savings over the cost of institutional services to rebalance their long-term care services for older adults and people with disabilities to a community-based orientation.