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 = 7,571
Demonstration = 7,102 (94%)
Non-demonstration = 469 (6%)

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

Happy or unhappy with the way you live your life

Happy
Unhappy
Total Number of Referrals Assigned to the Field by Year

Year of Referral

Total Number of Transitions by Year

Year of Transition

Note: Excludes nursing home closures

Referrals Assigned to the Field by Quarter

Quarter

Number of Transitions by Quarter

Quarter
Participants who are Working and/or Volunteering (data 1/1/23-3/31/23)

| Participants under age 65 who are working and those who would like to work |
|-----------------------------|-----------------------------|-----------------------------|
| Working | Want to work | Don't want to work |
| 1 month | 66% | 32% | 2% |
| 12 month | 63% | 33% | 3% |

| Participants under age 65 who are volunteering and those who would like to volunteer |
|-----------------------------|-----------------------------|-----------------------------|
| Volunteering | Want to volunteer | Don't want to volunteer |
| 1 month | 69% | 25% | 6% |
| 12 month | 57% | 43% | 0% |

| Participants 65 years and older who are working and those who would like to work |
|-----------------------------|-----------------------------|-----------------------------|
| Working | Want to work | Don't want to work |
| 1 month | 78% | 22% | 0% |
| 12 month | 91% | 9% | 0% |

| Participants 65 years and older who are volunteering and those who would like to volunteer |
|-----------------------------|-----------------------------|-----------------------------|
| Volunteering | Want to volunteer | Don't want to volunteer |
| 1 month | 68% | 29% | 4% |
| 12 month | 75% | 25% | 0% |
Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 3/31/2023

- Apartment Leased By Participant, Not Assisted Living: 2%
- Home Owned By Family Member: 10%
- Home Owned By Participant: 15%
- Group Home No More Than 4 People: 3%
- Apartment Leased By Participant, Assisted Living: 71%

Race and Ethnicity for Participants Transitioned from 1/1/19 – 03/31/23
Note: Results are from responses to the HCBS CAHPS MFP Survey questions 87 and 89 at 1 and 12 month time points

Participants Who Are Hispanic

- 1 Month Community: 15.3%
- 1 Month Institution: 11.1%
- 12 Month Community: 15.5%
- 12 Month Institution: 12.9%

Participants' Self-Reported Race

- White: 67.3%, 72.7%, 64.9%, 82.6%
- Black or African American: 25.2%, 22.2%, 27.7%, 11.3%
- Asian: 5.4%, 4.0%, 5.5%, 5.2%
- Native Hawaiian: 2.0%, 2.0%, 2.0%, 2.0%
- American Indian: 2.0%, 2.0%, 2.0%, 2.0%
- Other: 2.0%, 2.0%, 2.0%, 2.0%
**MFP Quality of Life Dashboard**

Number of Quality of Life Interviews Completed from 1/1/2023-3/31/2023 (n=140)

- **1 month** interviews done 1 month after transition, n=80
- **12 month** interviews done 12 months after transition, n=60

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**HCBS CAHPS Composite Measures: Percent with Highest Score (e.g. always, yes)**

- **Staff are reliable and helpful**: 91% (1 month) vs. 87% (12 month)
- **Choosing the services that matter to you**: 72% (1 month) vs. 73% (12 month)
- **Staff listen and communicate well**: 62% (1 month) vs. 74% (12 month)
- **Planning your time and activities**: 61% (1 month) vs. 57% (12 month)

**Did any unpaid family members or friends help you with things around the house?**

- **1 month**: 56% (yes) vs. 44% (no)
- **12 month**: 58% (yes) vs. 42% (no)

**Depressive Symptoms**

- **1 month**: 39% (yes) vs. 62% (no)
- **12 month**: 40% (yes) vs. 60% (no)

**Do you like where you live?**

- **1 month**: 91% (yes) vs. 4% (sometimes) vs. 5% (no)
- **12 month**: 76% (yes) vs. 9% (sometimes) vs. 15% (no)

**Have or Need Assistive Technology (AT)?**

- **1 month**: 100% (Have AT) vs. 44% (Need AT)
- **12 month**: 100% (Have AT) vs. 35% (Need AT)
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Mar 2023

- Physical health, 17.1%
- Mental health, 12.9%
- Financial issues, 8.5%
- Consumer engagement, 8.0%
- Services/supports, 24.9%
- Housing, 12.9%
- Facility related, 3.2%
- Other involved individuals, 0.8%
- Waiver/HCBS, 2.6%
- MFP office /TC, 0.6%
- Other challenges, 0.9%

Frequency of Transition Challenges by Year of Referral

- Physical health
- Mental health
- Financial issues
- Consumer engagement
- Services/supports
- Waiver/HCBS
- Housing
- Facility related
- Other involved individuals
- MFP office /TC
- Other challenges
Participants with Each Challenge who Transitioned by Referral Year

Types of Challenges for Referrals: 1/1/2023 - 03/31/2023
Below are the four most common challenge types for the current quarter

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

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
Frequency of Closure Reason by Year of Closure

Note: Excludes: died, nursing home closure, completed participation, non-demo transition services completed

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

Brenton always enjoyed the simple things in life. A good book or cooking a good meal could make the hours fly by. One of his favorite things to do was a road trip with friends and take in new sights. Turning off the GPS and taking the road less traveled was a priority. Brenton worked hard at his day job, putting in hours at a veterinary clinic and bettering the lives of beloved pets. In 2019, Brenton began to experience chronic urinary tract infections (UTIs). Around the same time, he started an immunosuppressant medication to help with psoriatic arthritis. Because of this, Brenton was getting sick constantly and the UTIs were getting worse. For these reasons and other health issues, his job at the veterinary clinic became too physically demanding. Because of his hard-working nature, despite the advice from others he chose to take a less demanding job at a convenience store rather than apply for disability benefits.

Brenton’s health continued to deteriorate throughout the year. Eventually he had no choice but to stop working all together. He learned the UTIs were a result of urethral stricture disease, and only surgery would stop the chronic infections. But with no job, Brenton had no insurance. Private insurance would not cover him because of all his health conditions. He felt hopeless. Without medical intervention, the infections continued. He rapidly lost weight and became extremely malnourished. He felt weak and fatigued all the time, often collapsing at home after doing too much.

It wasn’t long before Brenton was evicted from his apartment. With no way to pay rent, a marshal came to serve the eviction notice. But when the marshal saw the condition Brenton was in, he made the wise choice to call 911. Brenton was devastated to not only lose the place he called home, but also everything he owned and worked for.

What seemed like the worst-case scenario turned into a life saving measure for Brenton. It took two weeks in the ICU to stabilize his condition. His medical team focused on helping Brenton regain some of the 100 pounds that he had lost. Protein shakes were required with every meal. They also assured him that being admitted to the hospital was the right move as he would not have made it much longer.

When Brenton was ready to leave the hospital, he was admitted to a nursing facility to continue his rehabilitation. He recalls feeling trapped and out of place with not many people to talk to, given that most other residents were decades older. The food was far from ideal, especially for someone who had a passion for cooking. He still managed to gain the weight he desperately needed, thanks to ordering take out and from friends and family bringing in his favorites.

After three years in the facility and delays due to COVID, Brenton could finally see a light at the end of the tunnel. A staff member at the facility told him about the Money Follows the Person (MFP) program, and the facility social worker helped him apply. He was also approved for disability benefits. Brenton said the MFP process wasn’t fast or easy, but it was worth it. Working with a specialized care manager, transition coordinator, and housing coordinator, he found an in-law style apartment that he could afford. Because he lost all his belongings when he was evicted, MFP also helped get him furniture and household items.

Brenton’s health is now under control. He has the Medicaid insurance he needs and is working with his doctor to do the surgery. He has a new chapter of life, explaining, “I’m as happy as I could possibly be.” Living in the community again allowed him to rescue a dog from a local shelter and spend more time with his girlfriend. His apartment is in a wooded area, so he often spends mornings on the porch watching deer, or in his hammock reading a book. After years in a facility, he has a new appreciation of his alone time, privacy, and overall freedom.

MFP Demonstration Background

The Money Follows the Person (MFP) Demonstration, created by Section 6071 of the Deficit Reduction Act of 2005, supports States’ efforts to “rebalance” their long-term support systems, so that individuals can choose where to live and receive services. One of the major objectives of Money Follows the Person (MFP) is “to increase the use of home and community based, rather than institutional, long-term care services.” MFP supports this by offering grantee States an enhanced Federal Medical Assistance Percentage on qualified services. MFP also offers states the flexibility to provide supplemental services, such as assistive technology and enhanced transition services, to assist in successful transitions. States are then expected to reinvest the savings over the cost of institutional services to rebalance their long-term services and supports for older adults and people with disabilities to a community-based orientation.