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Medicaid's Money Follows the Person Rebalancing Demonstration Program

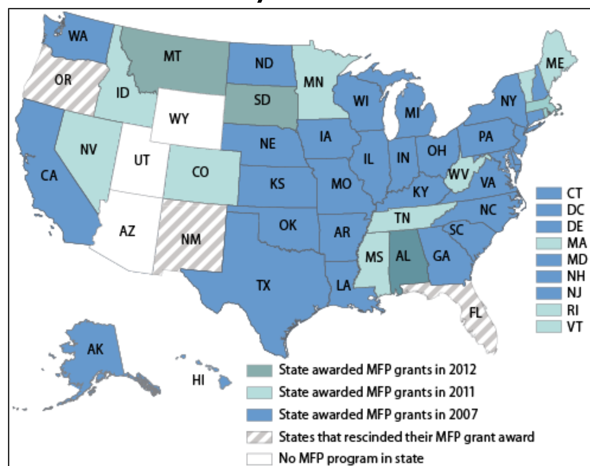
Overview

The Money Follows the Person (MFP) Rebalancing Demonstration Program (42 U.S.C. 1396a note) authorizes the Center for Medicare & Medicaid Services (CMS) to award competitive grants to states to transition Medicaid participants who reside in institutional settings that provide long-term services and supports (LTSS), such as nursing facilities, into community-based settings. MFP was designed to achieve the following objectives:

- Rebalancing: Increase the use of HCBS rather than institutional LTSS.
- Money follows the person: Eliminate barriers that restrict the use of Medicaid funds enabling eligible individuals to receive LTSS in the setting of their choice.
- Continuity of service: Increase the state Medicaid program's ability to provide Medicaid HCBS to eligible individuals who choose to transition.
- Quality assurance and quality improvement: Ensure procedures to provide quality assurance and continuous quality improvement for Medicaid HCBS.

According to CMS, states have transitioned over 100,000 individuals to community living from 2008 to 2019. A total of 43 states and the District of Columbia have participated in MFP over the course of the program (**Figure 1**).

Figure 1. Medicaid Money Follows the Person (MFP) Demonstration States by Grant Award Year



Source: R. Coughlin et al., *Money Follows the Person Demonstration: Overview of State Grantee Progress*, Mathematica Policy Research, January to December 2016, September 2017.

For more information, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*.

Relevant Legislation

The MFP program was first enacted in 2006 and has been extended with additional mandatory funding over time.

- The **Deficit Reduction Act of 2005 (DRA; P.L. 109-171), Section 6071,** established the MFP program and appropriated a total of $1.75 billion in funding from January 1, 2007, through September 30, 2011.
- The **Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), Section 2403,** amended the DRA to extend program funding for five years (from October 1, 2011, through September 30, 2016); it appropriated an additional $2.25 billion ($450 million for each fiscal year). It reduced the minimum stay requirements to be eligible from six months to 90 consecutive days in an inpatient facility.
- The **Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2,** amended the DRA to extend program funding through September 31, 2019, after a lapse in annual appropriations since October 1, 2016; however, state grantees could expend any unspent FY2016 amounts through FY2020. It appropriated an additional $112.0 million for FY2019, of which $500,000 was for quality assurance, technical assistance, and oversight.
- The **Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 5,** amended the DRA to appropriate an additional $20.0 million for a total of $132.0 million for FY2019.
- The **Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 4,** amended the DRA to appropriate an additional $122.5 million, for a total of $254.5 million for FY2019.
- The **Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Division N, Section 205,** amended the DRA to appropriate an additional $176.0 million for January 1, 2020, through May 22, 2020.
- The **Coronavirus Aid, Relief, and Economic Security Act (CARES; P.L. 116-136), Division A, Section 3811,** amended the DRA to extend program funding through November 30, 2020; it appropriated an additional $161.5 million for $337.5 million in total for January 1, 2020, through September 30, 2020, and a prorated amount based on FY2020 for October 1, 2020, through November 30, 2020 (extended through December 11 and 18, 2020, in P.L. 116-159 and in P.L. 116-215).

- The **Consolidated Appropriations Act, 2021 (P.L. 116-260), Division CC, Section 204,** amended the DRA to extend program funding through September 30, 2023; $450 million in total was appropriated for FY2021 and for each fiscal year thereafter, for a total of $1.35 billion. It reduces the minimum stay requirements to be eligible from 90 to 60 consecutive days in an inpatient facility; allows for days admitted for short-term rehabilitative services, which were previously excluded, to be counted; and extends funding to carry out research and evaluation and requires certain reports to Congress. These amendments took effect January 26, 2021.

Current Status

P.L. 116-260 appropriated $450 million in federal funding for each of FY2021, FY2022, and FY2023. CMS has authority to make grant awards to states through FY2023 for any appropriated funds. States who do not currently participate in the MFP program may be eligible.

Timing and Availability of Funds

MFP grant awards are for a five-year project period. After the initial grant award, states may receive supplemental awards in subsequent fiscal years. States may expend grant awards in the first fiscal year of an award and for up to four additional years after the award year.

Program Waiver Authority

The MFP program authorizes states to waive certain requirements that traditionally apply to Medicaid state plan eligibility and covered services and include the following:

- Statewideness: permits implementation in a selected geographic area or areas.
- Comparability: permits enrollment of a selected category or categories of eligible individuals.
- Income and Resource Eligibility Rules: permits application of institutional eligibility rules to individuals transitioning to the community.
- Provider agreements: permits implementation of participant-directed services wherein the participant retains certain employer related functions for selecting, hiring, and managing personal care attendants.

Maintenance of Effort

For any fiscal year during the MFP project period, a state's total Medicaid HCBS expenditures must not be less than the greater of such expenditures (1) for FY2005 or (2) any succeeding year before the first year of the MFP project.

Transition Requirements

States must identify eligible Medicaid participants living in an institution who want to transition out of the institution and assist them to do so. An eligible individual is one who

- resides for at least 60 days in a qualifying inpatient facility (hospital, nursing facility, institution for mental diseases [IMD] for eligible individuals, intermediate care facility for individuals with intellectual disability [ICF/ID]); and
- receives Medicaid and requires institutional care.

Eligible individuals must transition to a "qualified residence," which is defined as

- a home owned or leased by the individual or the individual's family member;
- an apartment with an individual lease, with lockable access and egress, and living, sleeping, bathing, and cooking areas they control; and
- a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

Covered Services and Enhanced Federal Match

Eligible individuals who transition receive MFP services for 365 days. These services are categorized as qualified, demonstration, and supplemental. States must continue to provide Medicaid-covered HCBS state plan or waiver services to individuals after the 12-month period, as long as they are eligible. State grantees receive an enhanced federal match to the state share (federal medical assistance percentage or FMAP) for certain HCBS expenditures and higher than usual payments for other MFP services for up to 12 months after transition. The enhanced FMAP is equal to a state's regular FMAP plus half of the difference between the state's regular FMAP and 100, and cannot exceed 90% (i.e., enhanced FMAP ranges from 75% to 90%). States that provide HCBS through managed care may request an MFP-specific HCBS managed care rate for MFP participants. The following lists MFP covered services and their associated Medicaid FMAP rate:

- Qualified HCBS: Services beneficiaries would have received regardless of their MFP status (i.e., state plan and waiver services); Enhanced FMAP.
- Demonstration HCBS: Allowable services not currently in state's HCBS offerings, or qualified HCBS above what is already available (e.g., 24-hour personal care); Enhanced FMAP.
- Supplemental Services: Services to facilitate a transition that are not HCBS or otherwise reimbursable (e.g., security deposit, utility set up); State's Regular FMAP.
- Administrative Expenses: Certain administrative expenses associated with MFP grant operation; 100% FMAP (rather than typical 50% FMAP for administrative expenses).

Selected Lessons Learned from MFP Evaluations

Transitions from institutional settings into the community are complex. For successful transitions, some research suggests there is a need for planning and infrastructure to be in place, including case management services to support individuals before, during, and after a transition. Inadequate supply of affordable and accessible housing and wait lists for public housing or vouchers often limit the ability of low-income participants to pay market rent. As Medicaid is statutorily prohibited from paying for housing, states have used MFP funds to hire housing coordinators and formed partnerships with state and local housing authorities, landlords, and developers to address housing supply. Through the MFP program, states have reportedly developed knowledge about executing successful transitions and serving individuals with complex care needs in the community (see Mathematica Policy Research MFP publications at www.mathematica.com).

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