DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid and State Operations

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Letter Summary

In the "Progress on the Promise" Report to the President under the New Freedom Initiative, the Department of Health and Human Services promised to work with states and people with disabilities to assure Medicaid-eligible persons with disabilities of all ages are served in the most appropriate setting according to their needs and preferences. This letter focuses on strategies available to states under current authority to assist individuals to avoid or leave unnecessary nursing facility placement. This letter highlights promising state practices, such as programs in which "money follows the person," and outlines some early lessons learned from states that previously awarded nursing facility transition grants.

Dear State Medicaid Director:

In 2000, slightly over 1 million Medicaid beneficiaries were residents in federally certified or state licensed nursing facilities.[1] Of those individuals, approximately 10.9 percent[2] were under the age of 65, representing about 109,146 Medicaid beneficiaries. The cost of long-term care represents a significant portion of all spending on Medicaid services. In particular, the cost of nursing home services (which have accounted for over 20 percent[3] of total Medicaid expenditures through most of the 1990's) are perceived as a serious cost driver for many states. During this same time period, nursing homes' expenditures as a percent of all long-term care expenditures have hovered around 60 percent.[4]

Based upon this data, the Center for Medicaid and State Operations believes there is tremendous potential to serve people who meet nursing facility level of care in private homes or in community residential settings that would be more acceptable to the beneficiary, without increasing costs to the states.

Many states have engaged in activities and developed programs that serve persons in the most appropriate community setting rather than in an institution. These programs and activities, developed under existing authority, have included diversion programs to maintain people in the community, transition programs to actively move individuals from institutional settings to alternative community placements, and program models in which the "money follow the person" to assure stability of community living.

[1] CMS, Online Survey and Certification and Reporting System (OSCAR), December 8, 2000.
[2] National Nursing Home Survey, National Center for Health Statistics, *Advanced Data Number 280*, January 1997.
[3] CMS, CMS Form 64, Office of State Agency Financial Management.
[4] CMS, CMS Form 64, Office of State Agency Financial Management.

Below are examples of states engaged in activities we consider promising practices. More detailed descriptions of two of the practices outlined below (Florida and Utah) currently appear on our website at www.cms.hhs.gov/promisingpractices. Detailed descriptions of the other practices will be available on the same website within the next three months. These examples are not intended to be exhaustive of states' efforts, but rather illustrative of the types of programs that exist. States are encouraged to submit their own programs that have been successful in addressing the unnecessary placement of persons in nursing facilities to Alissa DeBoy at Adeboy@cms.hhs.gov. These ideas will then be considered for our Promising Practices Series and published on our website so that all states might benefit.

State Innovation Under Existing Authority

Colorado

In 1998, Colorado implemented the Fast Track program to increase the number of persons discharged from hospitals to community-based settings instead of nursing homes. The purpose of the Fast Track program is to address some of the structural problems in the Medicaid system that act as barriers to community placement for persons who have been hospitalized. The focus of the project has been to provide on-site assessment for waiver services and Medicaid eligibility determination within a hospital setting to divert hospital discharges from nursing facility placements when appropriate. The program has adopted a series of accelerated procedures for conducting assessments of hospital patients, for determining financial eligibility for Medicaid, and for approving and arranging for community-based services. Between July 2000, and June 2001, out of 122 potential fast-track candidates referred by the hospital to the program, 87 (71 percent) were successfully fast-tracked to community settings.

Texas

In 2001, the Texas Department of Human Services implemented a law that provides for Medicaid funding to follow an individual when transitioning from a nursing facility to the community. The law specified that as individuals "relocate from nursing facilities to community care, funds will be transferred from Nursing Facilities to Community Care Services to cover the cost of the shift in services." The Texas law represents a good example of an initiative that can be undertaken relatively quickly, without requiring major restructuring of the long-term care system.

The Texas Department of Human Services has assisted more than 700 individuals to transition to community living since the effective date of the law in September 2001. The Department developed procedures for informing nursing facility residents, responding to requests for assessments and care planning, and then assisting with the transitions.

Florida

Florida is pilot testing a managed care model to increase incentives for maintaining individuals in community settings. Under the Long-Term Care Community Diversion Project, managed care organizations are paid a capitated rate to provide all Medicaid services to persons eligible for Medicaid (HCBS) Waivers for older persons. Participating managed care organizations are expected to coordinate acute and long-term care services for program enrollees, including all Medicare-covered services. Managed care organizations also are liable for unlimited nursing home payments for as long as the person remains enrolled. As a result, there are strong incentives to reduce nursing home placements and managed care organizations generally provide additional HCBS services not covered under the traditional waiver program. The pilot is operational in four counties, and participation among HCBS waiver participants is voluntary. According to a formal evaluation of the program, the pilot serves a more impaired population than the state's largest traditional HCBS waiver for older people.

New Jersey

Under New Jersey's Community Choice Initiative, the State employs 40 counselors who are exclusively dedicated to informing nursing home residents – and hospital patients awaiting nursing home admission – about HCBS and housing alternatives. The counselors, who are registered nurses and social workers, also provide assistance to residents who express a desire to move out of a nursing home. Counselors are notified as soon as a Medicaid participant enters a nursing home, and start working with the participant on community-based alternatives. Counselors also provide assistance to persons who have been in nursing homes for many years. Between 1998 and 2001, over 3,400 people were discharged from nursing homes with the help of Community Choice. In the first three years of the Community Choice Initiative, New Jersey's Medicaid nursing home population decreased by 1,500 (5 percent).

Utah

The State of Utah responded to the *Olmstead* decision by addressing the need to fully inform nursing home residents of their options regarding long-term care services. Utah's Department of Health developed a plan whereby representatives from Area Agencies on Aging (AAA) and Independent Living Centers visited almost all of the State's nursing homes in six months to conduct on-site resident education programs. The educators made group presentations, passed out literature covering all of Utah's home and community-based long-term care programs, and conducted one-on-one follow-up interview sessions for interested residents. Upon a resident's request, AAAs conducted needs assessments to determine if the person's needs could be met using available community resources. About one-fifth of Utah's nursing home residents voluntarily attended the education sessions, and fifteen percent of these residents received assessments. Thirty of the 63 people determined appropriate for a less restrictive setting have transitioned to the community.

Vermont

In 1996, Vermont changed the waiting list policy for its Medicaid HCBS waiver for older people and people with physical disabilities. Instead of serving applicants on a "first come, first serve" basis, Vermont gave higher priority to nursing home residents, hospital patients awaiting nursing home placement, and people residing at home who are at great risk of institutionalization. The State also established a statewide system of local Long-Term Care Community Coalitions to improve the infrastructure for HCBS. In addition, Vermont created a new flexible fund solely for the coalitions to pay for supports not available through other funding sources. Between 1996 and 2000, Vermont decreased its reliance on nursing homes. During that time, the share of Vermont's long-term care expenditures for older people and people with physical disabilities spent on nursing homes decreased from 88 percent to 78 percent.

Washington

The State of Washington employs numerous innovative mechanisms to reduce the number of nursing home residents on Medicaid. All current residents have the option to receive case management from nursing home case managers to assist them in leaving the nursing home. Washington also helps Medicaid-eligible residents keep their home or obtain and furnish a home after transition. Under post-eligibility treatment of income rules, Medicaid residents can use their own income for up to six months--up to 100 percent of the poverty level--to make rent, mortgage, utility, and other payments to maintain their home in the community. Transitioned nursing home residents also can receive a one-time payment of up to $800 of state-only funds to help with rent, security deposits, utilities, household goods, assistive technology, furniture, or home modifications. To keep the supply of nursing home beds from growing too high, Washington's certificate of need program includes use of HCBS in the calculation of unmet need for nursing home beds. As a result of these combined efforts, the number of Medicaid nursing home residents declined by 16 percent (16,234 to 13,693) from July 1995 to July 2000.

Wisconsin

Wisconsin helped more than 150 people leave nursing homes in 2001 by targeting resources to people who wanted to move from nursing homes and return to the community. Funds were made available under the Community Options Program – Waiver (COP-W) and Community Integration Program II (CIP II), each part of a Medicaid HCBS waiver that serves older persons and persons with physical disabilities. Wisconsin allocates most HCBS waiver funding to counties, who operate the waivers at the local level. Most counties have waiting lists, requiring applicants to wait several months or longer before they can receive services. To target persons who live in a nursing home and who have indicated that they would like to live in the community, Wisconsin set aside approximately $1.9 million of state and Medicaid HCBS waiver funds in 2001 to pay for one-time transition expenses and for ongoing services. The funds were initially available to a person leaving the nursing home. Once this person no longer needs waiver services, the funds will remain available for other people in that county who need home and community-based services.

Wisconsin also provides HCBS Waiver funds (under the state's "CIP II" program) for persons who relocate from a nursing home because the facility is downsizing or closing. State law provides that when all or part of a nursing home voluntarily closes, the Wisconsin Department of Health and Family Services may create new HCBS waiver "slots." Each resident is eligible to benefit from an assessment to identify whether the person is willing to live in the community. Medicaid participants who move from the closing nursing home can access CIP II funding immediately upon leaving the nursing home. For each participant who transitions to the community, the State adds the average funding for one HCBS waiver participant to the county's waiver allocation. Since the funds remain in the HCBS waiver budget even after the participant leaves the program, the state replaces the nursing home payment for a participant with a less expensive HCBS waiver payment.

Wisconsin also has implemented a new program in approximately one-third of the State that relies on Centers for Medicare & Medicaid Services (CMS) Medicaid waivers to integrate all Medicaid long-term care funding into a coherent package. Such funding includes HCBS waivers, and most services in the Medicaid State Plan except hospital, physician, and certain other acute care services. The program, entitled "Family Care," allows funding to follow the person to the most appropriate and preferred setting, be it a community, assisted living, nursing facility or other setting.

Lessons Learned from early Nursing Facility Transition grants

The CMS has been awarding nursing facility transition grants since 1998. In the past two years, awards were made to 23 states totaling $15.8 million as part of the Systems Change Grants for Community Living. Prior to the Systems Change grants, CMS, in association with the Assistant Secretary of Planning and Evaluation, awarded grants to 12 states from 1998 to 2000 totaling $4,700,000 under the Nursing Home Transitions Demonstration Program. The evaluation of the Nursing Home Transitions Demonstration Program is currently underway, using a case study approach based upon site visits to nine grantee states.

Under this initiative, states have implemented new programs or augmented existing programs that provided a coordinator to help individuals in nursing facilities obtain housing and supports in the community, and used flexible funds to pay for housing deposits, furnishings, and other items a person may need during transition. While the evaluation is not complete, states conducting nursing home transition programs under the Nursing Facility Transition grants have identified some common elements of success that include:

- Dedicated staff are hired specifically to facilitate transitions for nursing home residents wishing to return to community life.

- Persons hired to facilitate nursing home transitions are highly dedicated to the challenge. Often the most dedicated transition facilitators are people who themselves have lived in institutional settings and have successfully returned to the community.

- Adequate and flexible funding is made available to establish a community residence for transitioned individuals. These funds can be used for security deposits, utility set up, moving expenses, furnishings, and other necessary expenses.

- Nursing facility transition programs are closely coordinated with community-based services programs to ensure that community services are available for transitioned residents as soon as they return to community life.

- Program staff work with public housing authorities and private landlords to ensure people leaving nursing homes have access to housing in the community.

- Transition programs implement aggressive outreach efforts to notify nursing facility residents of the opportunities for receiving assistance with moving back to community life.

- Nursing facility residents who request assistance with transition services take an active role in planning their own return to community life.

In closing, we encourage states to continue their efforts to remove barriers to full participation in the community on the part of persons with disabilities and ensure that individuals of any age who have a disability long-term illness can live or remain in the community and receive quality HCBS and supports. We hope you find this information useful and encourage you to share with us other promising practices for transitioning persons with disabilities of all ages out of nursing facilities.

Any questions concerning this letter may be referred to Mary Jean Duckett at (410) 786-3294.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

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